DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 419 and 485

[CMS–1501–P]

RIN 0938–AN46

Medicare Program; Proposed Changes to the Hospital Outpatient Prospective Payment System and Calendar Year 2006 Payment Rates

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would revise the Medicare hospital outpatient prospective payment system to implement applicable statutory requirements and changes arising from our continuing experience with this system and to implement certain related provisions of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. In addition, the proposed rule describes proposed changes to the amounts and factors used to determine the payment rates for Medicare hospital outpatient services paid under the prospective payment system. This proposed rule would also change the requirement for physician oversight of mid-level practitioners in critical access hospitals (CAHs). These changes would be applicable to services furnished on or after January 1, 2006.

DATES: To be ensured consideration, comments must be received at one of the addresses provided in the **ADDRESSES** section, no later than 5 p.m. on September 16, 2005.

ADDRESSES: In commenting, please refer to file code CMS–1501–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

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

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

2. *By regular mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1501–P, P.O. Box 8016, Baltimore, MD 21244–8018.

3. *By express or overnight mail.* You may send written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1501–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–7195 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of Comments on Paperwork Requirements: For comments that relate to information collection requirements, mail a copy of comments to the following addresses: Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Security and Standards Group, Office of Issuances, Room C4–24–02, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: James Wickliffe, CMS–1501–P; and, Office of Information and Regulatory Affairs, Office of Management and Budget, Room 3001, New Executive Office Building, Washington, DC 20503, Christopher Martin, CMS Desk Officer, CMS–1501–P.

Comments submitted to OMB may also be e-mailed to the following address: *Christopher_Martin@omb.eop.gov,* or faxed to OMB at (202) 395–6974.

Submitting Comments: We welcome comments from the public on all issues set forth in this rule to assist us in fully considering issues and developing policies. You can assist us by referencing the file code CMS–1501–P and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. CMS posts all electronic comments received before the close of the comment period on its public Web site as soon as possible after they have been received. Hard copy comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, MD 21244–1850, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

FOR FURTHER INFORMATION, CONTACT: Rebecca Kane, (410) 786–0378, Outpatient prospective payment issues, and Suzanne Asplen, (410) 786–4558, Partial hospitalization and community mental health center issues.

SUPPLEMENTARY INFORMATION:

Electronic Access

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Alphabetical List of Acronyms Appearing in the Proposed Rule

ACEP American College of Emergency Physicians
AHA American Hospital Association
AHIMA American Health Information Management Association
AMA American Medical Association
APC Ambulatory payment classification
AMP Average manufacturer price
ASP Average sales price
ASC Ambulatory surgical center
AWP Average wholesale price
BBA Balanced Budget Act of 1997, Pub. L. 105–33
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Pub. L. 106–554
BBRA Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Pub. L. 106–113
CAH Critical access hospital
CBSA Core-Based Statistical Areas
CCR (Cost center specific) cost-to-charge ratio
CMHC Community mental health center

CMS Centers for Medicare & Medicaid Services (formerly known as the Health Care Financing Administration)
CORF Comprehensive outpatient rehabilitation facility
CPT [Physicians'] Current Procedural Terminology, Fourth Edition, 2005, copyrighted by the American Medical Association
CRNA Certified registered nurse anesthetist
CY Calendar year
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DRG Diagnosis-related group
DSH Disproportionate share hospital
EACH Essential Access Community Hospital
E/M Evaluation and management
EPO Erythropoietin
ESRD End-stage renal disease
FACA Federal Advisory Committee Act, Pub. L. 92–463
FDA Food and Drug Administration
FI Fiscal intermediary
FSS Federal Supply Schedule
FY Federal fiscal year
GAO Government Accountability Office
HCPCS Healthcare Common Procedure Coding System
HCRIS Hospital Cost Report Information System
HHA Home health agency
HIPAA Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
IME Indirect medical education
IPPS (Hospital) inpatient prospective payment system
IVIG Intravenous immune globulin
LTC Long-term care
MedPAC Medicare Payment Advisory Commission
MDH Medicare-dependent hospital
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108–173
MSA Metropolitan Statistical Area
NCCI National Correct Coding Initiative
NCD National Coverage Determination
OCE Outpatient code editor
OMB Office of Management and Budget
OPD (Hospital) outpatient department
OPPS (Hospital) outpatient prospective payment system
PHP Partial hospitalization program
PM Program memorandum
PPI Producer Price Index
PPS Prospective payment system
PPV Pneumococcal pneumonia (virus)
PRA Paperwork Reduction Act
QIO Quality Improvement Organization
RFA Regulatory Flexibility Act
RRC Rural referral center
SBA Small Business Administration
SCH Sole community hospital
SDP Single drug pricer
SI Status indicator
TEFRA Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248
TOPS Transitional outpatient payments
USPDI United States Pharmacopoeia Drug Information

To assist readers in referencing sections contained in this document, we are providing the following outline of contents:

Outline of Contents

I. Background

A. Legislative and Regulatory Authority for the Hospital Outpatient Prospective Payment System

When the Medicare statute was originally enacted, Medicare payment for hospital outpatient services was based on hospital-specific costs. In an effort to ensure that Medicare and its beneficiaries pay appropriately for services and to encourage more efficient delivery of care, the Congress mandated replacement of the reasonable 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 Medicare, Medicaid, and SCHIP 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. Section 1833(t) of the Act was also amended by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, enacted on December 8, 2003. (Discussion of provisions related specifically to the CY 2006 OPPS is included in sections V. and VII. of this proposed rule.) The OPPS was first implemented for services furnished on or after August 1, 2000. Implementing regulations for the OPPS are located at 42 CFR part 419.

Under the OPPS, we pay for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC) group to which the service is

assigned. We use Healthcare Common Procedure Coding System (HCPCS) codes (which include certain Current Procedural Terminology (CPT) codes) and descriptors to identify and group the services within each APC group. The OPPS includes payment for most hospital outpatient services, except those identified in section I.B. of this proposed rule. Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the OPPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Section 611 of Pub. L. 108–173 provided for Medicare coverage of an initial preventive physical examination, subject to the applicable deductible and coinsurance, as an outpatient department service, payable under the OPPS. In addition, the OPPS includes payment for partial hospitalization services furnished by community mental health centers (CMHCs).

The OPPS rate is an unadjusted national payment amount that includes the Medicare payment and the beneficiary copayment. This rate is divided into a labor-related amount and a nonlabor-related amount. The labor-related amount is adjusted for area wage differences using the inpatient hospital wage index value for the locality in which the hospital or CMHC is located.

All services and items within an APC group are comparable clinically and with respect to resource use (section 1833(t)(2)(B) of the Act). In accordance with section 1833(t)(2) of the Act, subject to certain exceptions, services and items within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the APC group is more than 2 times greater than the lowest median cost for an item or service within the same APC group (referred to as the ''2 times rule''). In implementing this provision, we use the median cost of the item or service assigned to an APC group.

Special payments under the OPPS may be made for new technology items and services in one of two ways. Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs, biological agents, brachytherapy devices used for the treatment of cancer, and categories of medical devices for at least 2 but not more than 3 years. For new technology services that are not eligible for pass-through payments and for which we lack sufficient data to appropriately assign them to a clinical APC group, we have established special APC groups based on costs, which we refer to as ''APC cost bands.'' These cost bands allow us to price these new procedures more appropriately and consistently. Similar to pass-through payments, these special payments for new technology services are also temporary; that is, we retain a service within a new technology APC group until we acquire adequate data to assign it to a clinically appropriate APC group.

B. Excluded OPPS Services and Hospitals

Section 1833(t)(1)(B)(i) of the Act authorizes the Secretary to designate the hospital outpatient services that are paid under the OPPS. While most hospital outpatient services are payable under the OPPS, section 1833(t)(1)(B)(iv) of the Act excluded payment for ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule. Section 614 of Pub. L. 108–173 amended section 1833(t)(1)(B)(iv) of the Act to exclude OPPS payment for screening and diagnostic mammography services. The Secretary exercised the broad authority granted under the statute to exclude from the OPPS those services that are paid under fee schedules or other payment systems. Such excluded services include, for example, the professional services of physicians and nonphysician practitioners paid under the Medicare Physician Fee Schedule (MPFS); laboratory services paid under the clinical diagnostic laboratory fee schedule; services for beneficiaries with end-stage renal disease (ESRD) that are paid under the ESRD composite rate; and services and procedures that require an inpatient stay that are paid under the hospital inpatient prospective payment system (IPPS). We set forth the services that are excluded from payment under the OPPS in § 419.22 of the regulations.

Under § 419.20 of the regulations, we specify the types of hospitals and entities that are excluded from payment under the OPPS. These excluded entities include Maryland hospitals, but only for services that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act; critical access hospitals (CAHs); hospitals located outside of the 50 States, the District of Columbia, and Puerto Rico; and Indian Health Service hospitals.

C. Prior Rulemaking

On April 7, 2000, we published in the **Federal Register** a final rule with comment period (65 FR 18434) to implement a prospective payment system for hospital outpatient services. The hospital OPPS was first implemented for services furnished on or after August 1, 2000. Section 1833(t)(9) of the Act requires the Secretary to review certain components of the OPPS not less often than annually and to revise the groups, relative payment weights, and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Since implementing the OPPS, we have published final rules in the **Federal Register** annually to implement statutory requirements and changes arising from our experience with this system. For a full discussion of the changes to the OPPS, we refer readers to these **Federal Register** final rules.[1]

On November 15, 2004, we published in the **Federal Register** a final rule with comment period (69 FR 65681) that revised the OPPS to update the payment weights and conversion factor for services payable under the calendar year (CY) 2005 OPPS on the basis of claims data from January 1, 2003 through December 31, 2003, and to implement certain provisions of Pub. L. 108–173. In addition, we responded to public comments received on the January 6, 2004 interim final rule with comment period relating to Pub. L. 108–173 provisions that were effective January 1, 2004, and finalized those policies. Further, we responded to public comments received on the November 7, 2003 final rule with comment period pertaining to the APC assignment of HCPCS codes identified in Addendum B of that rule with the new interim (NI) comment indicators; and public comments received on the August 16, 2004 OPPS proposed rule (69 FR 50448).

Subsequent to publishing the November 15, 2004 final rule with comment period, we published a correction of final rule with comment period on December 30, 2004 (69 FR 78315). This document corrected technical errors that appeared in the November 15, 2004 final rule with

[1] Interim final rule with comment period, August 3, 2000 (65 FR 47670); interim final rule with comment period, November 13, 2000 (65 FR 67798); final rule and interim final rule with comment period, November 2, 2001 (66 FR 55850 and 55857); final rule, November 30, 2001 (66 FR 59856); final rule, December 31, 2001 (66 FR 67494); final rule, March 1, 2002 (67 FR 9556); final rule, November 1, 2002 (67 FR 66718); final rule with comment period, November 7, 2003 (68 FR 63398); correction of the November 7, 2003 final rule with comment period, December 31, 2003 (68 FR 75442); interim final rule with comment period, January 6, 2004 (69 FR 820); and final rule with comment period, November 15, 2004 (69 FR 65681).

comment period. It also provided additional information about the CY 2005 wage indices for the OPPS that was not published in the November 15, 2004 final rule with comment period.

D. APC Advisory Panel

1. Authority of the APC Panel

Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, requires that we consult with an outside panel of experts to review the clinical integrity of the payment groups and weights under the OPPS. The Advisory Panel on Ambulatory Payment Classification (APC) Groups (the APC Panel), discussed under section I.D.2. of this preamble, fulfills this requirement. The Act further specifies that the APC Panel will act in an advisory capacity. This expert panel, which is to be composed of 15 representatives of providers subject to the OPPS (currently employed full-time, not consultants, in their respective areas of expertise), reviews and advises us about the clinical integrity of the APC groups and their weights. The APC Panel is not restricted to using our data and may use data collected or developed by organizations outside the Department in conducting its review.

2. Establishment of the APC Panel

On November 21, 2000, the Secretary originally signed the charter establishing the APC Panel. The APC Panel is technical in nature and is governed by the provisions of the Federal Advisory Committee Act (FACA), as amended (Pub. L. 92–463). Since its initial chartering, the Secretary has twice renewed the APC Panel's charter: On November 1, 2002, and on November 8, 2004. The renewed charter indicates that the APC Panel continues to be technical in nature; is governed by the provisions of the FACA with a Designated Federal Official (DEO) to oversee the day-to-day administration of the FACA requirements and to provide to the Committee Management Officer all committee reports for forwarding to the Library of Congress; may convene up to three meetings per year; and is chaired by a Federal official who also serves as a CMS medical officer.

Originally, in establishing the APC 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 who nominated either colleagues or themselves. After carefully reviewing the applications, we chose 15 highly qualified individuals to serve on the APC Panel. Because of the loss of four APC Panel members due to the expiration of terms of office on March 31, 2004, we published a **Federal Register** notice on January 23, 2004 (69 FR 3370) that solicited nominations for APC Panel membership. From the 24 nominations that we received, we chose four new members. Six members' terms expired on March 31, 2005; therefore, a **Federal Register** notice was published on February 25, 2005, requesting nominations to the APC Panel. We received only 13 nominations before the nomination period closed on March 15, 2005. Therefore, we extended the deadline for nominations to May 9, 2005, and announced the extension in the **Federal Register** on April 8, 2005 (70 FR 18028). The entire APC Panel membership and information pertaining to it, including **Federal Register** notices, meeting dates, agenda topics, and meeting reports are identified on the CMS Web site: *http://www.cms.hhs.gov/faca/apc/apcmem.asp*.

3. APC Panel Meetings and Organizational Structure

The APC Panel first met on February 27, February 28, and March 1, 2001. Since that initial meeting, the APC Panel has held six subsequent meetings, with the last meeting taking place on February 23 and 24, 2005. (The APC Panel did not meet on February 25, 2004, as announced in the meeting notice published on December 30, 2004, (69 FR 78464).) Prior to each of these biennial meetings, we published a notice in the **Federal Register** to announce each meeting and, when necessary, to solicit and announce nominations for APC Panel membership. For a more detailed discussion about these announcements, refer to the following **Federal Register** notices: December 5, 2000 (65 FR 75943), December 14, 2001 (66 FR 64838), December 27, 2002 (67 FR 79107), July 25, 2003 (68 FR 44089), December 24, 2003 (68 FR 74621), August 5, 2004 (69 FR 47446), and December 30, 2004 (69 FR 78464).

During these meetings, the APC Panel established its operational structure that, in part, includes the use of three subcommittees to facilitate its required APC review process. Currently, the three subcommittees are the Data Subcommittee, the Observation Subcommittee, and the Packaging Subcommittee. The Data Subcommittee is responsible for studying the data issues confronting the APC Panel and for recommending viable options for resolving them. This subcommittee was initially established on April 23, 2001, as the Research Subcommittee and reestablished as the Data Subcommittee on April 13, 2004, and February 11, 2005. The Observation Subcommittee, which was established on June 24, 2003, and reestablished with new members on March 8, 2004, and February 11, 2005, reviews and makes recommendations to the APC Panel on all issues pertaining to observation services paid under the OPPS, such as coding and operational issues. The Packaging Subcommittee, which was established on March 8, 2004 and reestablished with new members on February 11, 2005, studies and makes recommendations on issues pertaining to services that are not separately payable under the OPPS but are bundled or packaged APC payments. Each of these subcommittees was established by a majority vote of the APC Panel during a scheduled APC Panel meeting. All subcommittee recommendations are discussed and voted upon by the full APC Panel.

For a detailed discussion of the APC Panel meetings, refer to the hospital OPPS final rules cited in section I.C. of this preamble. Full discussion of the recommendations resulting from the APC Panel's February 2005 meeting are included in the sections of this preamble that are specific to each recommendation.

E. Provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 To Be Implemented Beginning in CY 2006

On December 8, 2003, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Pub. L. 108–173, was enacted. Pub. L. 108–173 made changes to the Act relating to the Medicare OPPS. In the January 6, 2004 interim final rule with comment period and the November 15, 2004 final rule with comment period, we implemented provisions of Pub. L. 108–173 relating to the OPPS that were effective for CY 2004 and CY 2005, respectively. Provisions of Pub. L. 108–173 that were implemented in CY 2004 or CY 2005, and that are continuing in CY 2006, are discussed throughout this proposed rule. Moreover, in this proposed rule, we are proposing to implement the following provisions of Pub. L. 108–173 that affect the OPPS beginning in CY 2006:

1. Hold Harmless Provisions

Section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act and extended the hold harmless provision for small rural hospitals having 100 or fewer beds through December 31, 2005. Section 411 of Pub. L. 108–173 further amended section 1833(t)(7) of the Act to provide that hold-harmless transitional corridor payments shall apply through December

31, 2005 to sole community hospitals (SCHs) (as defined in section 1886(d)(5)(D)(iii) of the Act) located in a rural area. In accordance with these provisions, effective January 1, 2006, we are proposing to discontinue transitional corridor payments for small rural hospitals having 100 or fewer beds and for SCHs located in a rural area.

2. Study and Authorization of Adjustment for Rural Hospitals

Section 411(b) of Pub. L. 108–173 added a new paragraph (13) to section 1833(t) of the Act to authorize an ''Adjustment for Rural Hospitals''. This provision requires us to conduct a study to determine if costs incurred by hospitals located in rural areas by APCs exceed those costs incurred by hospitals located in urban areas. This provision further requires us to provide for an appropriate adjustment by January 1, 2006, if we find that the costs incurred by hospitals located in rural areas exceed those costs incurred by hospitals located in urban areas.

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

Section 621(a)(1) of Pub. L. 108–173 added section 1833(t)(14) to the Act that specifies payments for certain ''specified covered outpatient drugs'' beginning in 2006. Specifically, section 1833(t)(14)(A)(iii)(I) of the Act states that such payment shall be equal to what we determine to be the average acquisition cost for the drug, taking into account hospital acquisition cost survey data furnished by the Government Accountability Office (GAO). Section 1833(t)(14)(A)(iii)(II) of the Act further notes that if hospital acquisition cost data are not available, payment for specified covered outpatient drugs shall equal the average price for the drug established under section 1842(o), section 1847(A), or section 1847(B) of the Act as calculated and adjusted by the Secretary as necessary. Both payment approaches are subject to adjustments under section 1833(t)(14)(E) of the Act as discussed below.

4. Adjustment in Payment Rates for ''Specified Covered Outpatient Drugs'' for Overhead Costs

Section 621(a)(1) of Pub. L. 108–173 added section 1833(t)(14)(E) to the Act. Section 1833(t)(14)(E)(ii) of the Act authorizes us to make an adjustment to payments for ''specified covered outpatient drugs'' to take into account overhead and related expenses such as pharmacy services and handling costs, based on recommendations contained in a report prepared by the Medicare Payment Advisory Commission (MedPAC).

5. Budget Neutrality Adjustment

Section 621(a)(1) of Pub. L. 108–173 amended the Act by adding section 1833(t)(14)(H), which requires that additional expenditures resulting from adjustments in APC payment rates for specified covered outpatient drugs be taken into account beginning in CY 2006 and continuing in subsequent years, in establishing the OPPS conversion, weighting, and other adjustment factors.

F. CMS' Commitment to New Technologies

(If you choose to comment on issues in this section, please include the caption ''Commitment to New Technologies'' at the beginning of your comment.)

CMS is committed to ensuring that Medicare beneficiaries will have timely access to new medical treatments and technologies that are well-evaluated and demonstrated to be effective. We launched the Council on Technology and Innovation (CTI) to provide the Agency with improved methods for developing practical information about the clinical benefits of new medical technologies to result in faster and more efficient coverage and payment of these medical technologies. The CTI supports CMS efforts to develop better evidence on the safety, effectiveness, and cost of new and approved technologies to help promote their more effective use.

We want to provide doctors and patients with better information about the benefits of new medical treatments and/or technologies, especially compared to other treatment options. We also want beneficiaries to have access to valuable new medical innovations as quickly and efficiently as possible. We note there are a number of payment mechanisms in the OPPS and the IPPS designed to achieve appropriate payment of promising new technologies. In the OPPS, qualifying new medical devices may be paid on a cost basis by means of transitional pass-through payments, in addition to the APC payments for the procedures which utilize the devices. In addition, qualifying new services may be assigned for payment to New Technology APCs or, if appropriate, to regular clinical APCs. In the IPPS, qualifying new technologies may receive add-on payments to the standard diagnosis-related group (DRG) payments. We also note that collaborative efforts are underway to facilitate coordination between the Food and Drug Administration (FDA) and CMS with regard to streamlining the CMS coverage process by which new technologies come to the marketplace.

To promote timely access to new medical treatments and technologies, in this proposed rule we are proposing enhancements to both the OPPS pass-through payment criteria for devices as discussed in section IV.D.2. of this preamble and the qualifying process for assignment of new services to New Technology APCs or regular clinical APCs discussed in section III.C.3. of this preamble. We are proposing to make device pass-through eligibility available to a broader range of qualifying devices. We are also proposing to change the application and review process for assignment of new services to New Technology APCs to promote thoughtful review of the coding, clinical use and efficacy of new services by the wider medical community, encouraging appropriate dissemination of new technologies. These enhancements are explained in this proposed rule.

G. Summary of the Major Content of This Proposed Rule

In this proposed rule, we are setting forth proposed changes to the Medicare hospital OPPS for CY 2006. These changes would be effective for services furnished on or after January 1, 2006. The following is a summary of the major changes that we are proposing to make:

1. Proposed Updates to Payments for CY 2006

In section II. of this preamble, we set forth—

- The methodology used to recalibrate the proposed APC relative payment weights and the proposed recalibration of the relative payment weights for CY 2006.
- The proposed payment for partial hospitalization, including the proposed separate threshold for outlier payments for CMCHs.
- The proposed update to the conversion factor used to determine payment rates under the OPPS for CY 2006.
- The proposed retention of our current policy to apply the IPPS wage indices to wage adjust the APC median costs in determining the OPPS payment rate and the copayment standardized amount for CY 2006.
- The proposed update of statewide average default cost-to-charge ratios.
- Proposed changes relating to the expiring hold harmless payment provision.
- Proposed changes to payment for rural sole community hospitals for CY 2006.

- Proposed changes in the way we calculate hospital outpatient outlier payments for CY 2006.
- Calculation of the proposed national unadjusted Medicare OPPS payment.
- The proposed beneficiary copayment for OPPS services for CY 2006.

2. Proposed Ambulatory Payment Classification (APC) Group Policies

In section III. of this preamble, we discuss our proposal to establish a number of new APCs and to make changes to the assignment of HCPCS codes under a number of existing APCs based on our analyses of Medicare claims data and recommendations of the APC Panel. We also discuss in section III. of this preamble, the application of the 2 times rule and proposed exceptions to it; proposed changes for specific APCs; the proposed refinement of the New Technology cost bands; the proposed movement of procedures from the New Technology APCs; and the proposed additions of new procedure codes to the APC groups.

3. Proposed Payment Changes for Devices

In section IV. of this preamble, we discuss proposed changes to the device-dependent APCs and to the pass-through payment for three categories of devices.

4. Proposed Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents

In section V. of this preamble, we discuss proposed changes for drugs, biologicals, radiopharmaceutical agents, and vaccines.

5. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

In section VI. of this preamble, we discuss the proposed methodology for estimating total pass-through spending and whether there should be a pro rata reduction for transitional pass-through drugs, biologicals, radiopharmacials, and categories of devices for CY 2006.

6. Proposed Brachytherapy Payment Changes

In section VII. of this preamble, we include a discussion of our proposal concerning coding and payment for the sources of brachytherapy.

7. Proposed Coding and Payment for Drug Administration

In section VIII. of this preamble, we discuss our proposed coding and payment changes for drug administration services.

8. Hospital Coding for Evaluation and Management (E/M) Services

In section IX. of this preamble, we include a discussion of our proposal for developing the coding guidelines for evaluation and management services.

9. Proposed Payment for Blood and Blood Products

In section X. of this preamble, we discuss our proposed payment changes for blood and blood products.

10. Proposed Payment for Observation Services

In section XI. of this preamble, we discuss our proposed criteria and coding changes for separately payable observation services.

11. Procedures That Will Be Paid Only as Inpatient Services

In section XII. of this preamble, we discuss the procedures that we are proposing to remove from the inpatient list and assign to APCs.

12. Proposed Indicator Assignments

In section XIII. of this preamble, we discuss the proposed changes to the list of status indicators assigned to APCs and present our proposed comment indicators for the CY 2006 OPPS final rule.

13. Proposed Nonrecurring Policy Changes

In section XIV. of this preamble, we discuss proposed changes in payments for multiple diagnostic imaging procedures and in the interrupted procedures payment policies.

14. OPPS Policy and Payment Recommendations

In section XV. of this preamble, we address recommendations made by MedPAC, the APC Panel, and the GAO regarding the OPPS for CY 2006.

15. Physician Oversight in Critical Access Hospitals

In section XVI. of this preamble, we address physician oversight for services provided by nonphysician practitioners such as physician assistants, nurse practitioners, and clinical nurse specialists in critical access hospitals (CAHs).

II. Proposed Updates Affecting Payments for CY 2006

A. Recalibration of APC Relative Weights for CY 2006

(If you choose to comment on the issues in this section, please include the caption ''APC Relative Weights'' at the beginning of your comment.)

1. Database Construction

a. Database Source and Methodology

Section 1833(t)(9)(A) of the Act requires that the Secretary review and revise the relative payment weights for APCs at least annually. In the April 7, 2000 OPPS 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 a small number of APC changes, these relative payment weights continued to be in effect for CY 2001. This policy is discussed in the November 13, 2000 interim final rule (65 FR 67824 through 67827).

We are proposing to use the same basic methodology that we described in the April 7, 2000 final rule to recalibrate the APC relative payment weights for services furnished on or after January 1, 2006, and before January 1, 2007. That is, we would recalibrate the relative payment weights for each APC based on claims and cost report data for outpatient services. We are proposing to use the most recent available data to construct the database for calculating APC group weights. For the purpose of recalibrating APC relative payment weights for CY 2006, we used approximately 127 million final action claims for hospital OPD services furnished on or after January 1, 2004, and before January 1, 2005. Of the 127 million final action claims for services provided in hospital outpatient settings, 102 million claims were of the type of bill potentially appropriate for use in setting rates for OPPS services (but did not necessarily contain services payable under the OPPS). Of the 102 million claims, we were able to use 49 million whole claims to set the proposed OPPS APC relative weights for CY 2006 OPPS. From the 49 million whole claims, we created 81 million single records, of which 50 million were ''pseudo'' single claims (created from multiple procedure claims using the process we discuss in this section).

The proposed APC relative weights and payments in Addenda A and B to this proposed rule were calculated using claims from this period that had been processed before January 1, 2005. We selected claims for services paid under the OPPS and matched these claims to the most recent cost report filed by the individual hospitals represented in our claims data. We are proposing that the APC relative payment weights for CY 2006 under the OPPS would continue to be based on the median hospital costs for services in the APC groups. For the CY 2006 OPPS final rule, we are proposing to base APC median costs on

claims for services furnished in CY 2004 and processed before June 30, 2005.

b. Proposed Use of Single and Multiple Procedure Claims

For CY 2006, we are proposing to continue to use single procedure claims to set the medians on which the APC relative payment weights would be based. As noted in the November 15, 2004 final rule with comment period, we have received many requests asking that we ensure that the data from claims that contain charges for multiple procedures are included in the data from which we calculate the relative payment weights (69 FR 65730 through 65731). Requesters believe that relying solely on single procedure claims to recalibrate APC relative payment weights fails to take into account data for many frequently performed procedures, particularly those commonly performed in combination with other procedures. They believe that, by depending upon single procedure claims, we base relative payment weights on the least-costly services, thereby introducing downward bias to the medians on which the weights are based.

We agree that, optimally, it is desirable to use the data from as many claims as possible to recalibrate the APC relative payment weights, including those with multiple procedures. We generally use single procedure claims to set the median costs for APCs because we are, so far, unable to ensure that packaged costs can be appropriately allocated across multiple procedures performed on the same date of service. However, by bypassing specified codes that we believe do not have significant packaged costs, we are able to use more data from multiple procedure claims. In many cases this enables us to create multiple ''pseudo'' single claims from claims that, as submitted, contained multiple separately paid procedures on the same claim. We have used the date of service on the claims and a list of codes to be bypassed to create ''pseudo'' single claims from multiple procedure claims the same as we did in recalibrating the CY 2005 APC relative payment weights. We refer to these newly created single procedure claims as ''pseudo'' singles because they were submitted by providers as multiple procedure claims.

For CY 2003, we created ''pseudo'' single claims by bypassing HCPCS codes 93005 (Electrocardiogram, tracing), 71010 (Chest x-ray), and 71020 (Chest x-ray) on a submitted claim. However, we did not use claims data for the bypassed codes in the creation of the median costs for the APCs to which these three codes were assigned because the level of packaging that would have remained on the claim after we selected the bypass code was not apparent and, therefore, it was difficult to determine if the medians for these codes would be correct.

For CY 2004, we created ''pseudo'' single claims by bypassing these three codes and also by bypassing an additional 269 HCPCS codes in APCs. We selected these codes based on a clinical review of the services and because it was presumed that these codes had only very limited packaging and could appropriately be bypassed for the purpose of creating ''pseudo'' single claims. The APCs to which these codes were assigned were varied and included mammography, cardiac rehabilitation, and Level I plain film x-rays. To derive more ''pseudo'' single claims, we also split the claims where there were dates of service for revenue code charges on that claim that could be matched to a single procedure code on the claim on the same date.

As in CY 2003, we did not include the claims data for the bypassed codes in the creation of the APCs to which the 269 codes were assigned because, again, we had not established that such an approach was appropriate and would aid in accurately estimating the median cost for that APC. For CY 2004, from about 16.3 million otherwise unusable claims, we used about 9.5 million multiple procedure claims to create about 27 million ''pseudo'' single claims. For CY 2005, we created 383 bypass codes and from approximately 24 million otherwise unusable claims, we used about 18 million multiple procedure claims to create about 52 million ''pseudo'' single claims.

For CY 2006, we are proposing to continue using date of service matching as a tool for creation of ''pseudo'' single claims and to continue the use of a bypass list to create ''pseudo'' single claims. The process we are proposing for CY 2006 OPPS results in our being able to use some part of 90 percent of the total claims that are eligible for use in OPPS ratesetting and modeling in developing this proposed rule. This process enabled us to use, for CY 2006, 81 million single bills for ratesetting: 50 million ''pseudo'' singles and 31 million ''natural'' single bills (bills that were submitted containing only one separately payable major HCPCS code).

We are proposing to bypass the 404 codes identified in Table 1 to create new single claims and to use the line-item costs associated with the bypass codes on these claims in the creation of the median costs for the APCs into which they are assigned. Of the codes on this list, 345 were used for bypass in CY 2005. We are proposing to continue the use of the codes on the CY 2005 OPPS bypass list and expand it by adding 46 codes that, using data presented to the APC Panel at its February 2005 meeting, meet the same empirical criteria as those used in CY 2005 to create the bypass list. Our examination of the data against the criteria for inclusion on the bypass list, as discussed below for the addition of new codes, shows that the empirically selected codes used for bypass for the CY 2005 OPPS generally continue to meet the criteria or come very close to meeting the criteria, and we have received no comments against bypassing them.

To facilitate comment, Table 1 indicates the list of codes we are proposing to bypass for creation of ''pseudo'' singles for CY 2006 OPPS and indicates those used in the CY 2005 OPPS for bypass and those proposed to be added for the CY 2006 OPPS. Bypass codes shown in Table 1 with an asterisk indicate the HCPCs codes we are proposing to add to the list for the CY 2006 OPPS. The criteria we are proposing to use to determine the additional codes to add to the CY 2005 OPPS bypass list in order to create the bypass list for CY 2006 OPPS are discussed below.

The following empirical criteria were developed by reviewing the frequency and magnitude of packaging in the single claims for payable codes other than drugs and biologicals. We assumed that the representation of packaging on the single claims for any given code is comparable to packaging for that code in the multiple claims:

- There were 100 or more single claims for the code. This number of single claims ensured that observed outcomes were sufficiently representative of packaging that might occur in the multiple claims.
- Five percent or fewer of the single claims for the code had packaged costs on that single claim for the code. This criterion results in limiting the amount of packaging being redistributed to the payable procedure remaining on the claim after the bypass code is removed and ensures that the costs associated with the bypass code represent the cost of the bypassed service.
- The median cost of packaging observed in the single claim was equal to or less than $50. This limits the amount of error in redistributed costs.
- The code is not a code for an unlisted service.

We also added to the bypass list three codes (CPT codes 51701, 51702, and 51703 for bladder catheterization) which do not meet these criteria. These

codes have been packaged and have never been paid separately. For that reason, when these were the only services provided to the beneficiary, no payment was made to the hospital. The APC Panel's packaging subcommittee recommends that we make separate payment when they are the only service on the claim. See section II.A.4. of this preamble for further discussion of our proposal to pay them separately. We are proposing to add them to the bypass list because changing them from packaged to separately paid would result in the reduction of the number of single bills on which we could base median costs for other major separately paid procedures which are billed on the same claim with these procedure codes. Single bills which contain other procedures would become multiple procedure claims when these bladder catheterization codes were converted from packaged to separately paid status.

We examined the packaging on the single procedure claims in the CY 2004 data used for this proposed rule for these codes. We found that none of these codes met the empirical standards for the bypass list. However, we believe that when these services are performed on the same date as another separately paid procedure, any packaging that appears on the claim would appropriately be associated with the other procedures and not with these codes. Therefore, we believe that bypassing them does not adversely affect the medians for other procedures. Moreover, future separate payment for these codes does not harm the hospitals that furnish these services, in view of the historical absence of separate payment for them under the OPPS in the past. Hence, we propose to pay separately for these codes and to add them to the bypass list for the CY 2006 OPPS.

We specifically invite public comment on the ''pseudo'' single process, including the bypass list and the criteria.

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS

HCPCS code [1]	Short description	Status indicator
11056*	Trim skin lesions, 2 to 4	T
11057*	Trim skin lesions, over 4	T
11719	Trim nail(s)	T
11720	Debride nail, 1–5	T
11721	Debride nail, 6 or more	T
17003*	Destroy lesions, 2–14	T
31231*	Nasal endoscopy, dx	T
31579	Diagnostic laryngoscopy	T
51701*	Insert bladder catheter	X
51702*	Insert temp bladder catheter	X
51703*	Insert bladder catheter, complex	X
51798*	Us urine capacity measure	X
54240	Penis study	T
67820*	Revise eyelashes	S
70030*	X-ray eye for foreign body	X
70100	X-ray exam of jaw	X
70110	X-ray exam of jaw	X
70130	X-ray exam of mastoids	X
70140	X-ray exam of facial bones	X
70150	X-ray exam of facial bones	X
70160	X-ray exam of nasal bones	X
70200	X-ray exam of eye sockets	X
70210	X-ray exam of sinuses	X
70220	X-ray exam of sinuses	X
70250	X-ray exam of skull	X
70260	X-ray exam of skull	X
70328	X-ray exam of jaw joint	X
70330	X-ray exam of jaw joints	X
70336*	Magnetic image, jaw joint	S
70355	Panoramic x-ray of jaws	X
70360	X-ray exam of neck	X
70370*	Throat x-ray & fluoroscopy	X
70371	Speech evaluation, complex	X
70450	Ct head/brain w/o dye	S
70480	Ct orbit/ear/fossa w/o dye	S
70486	Ct maxillofacial w/o dye	S
70544	Mr angiography head w/o dye	S
70551*	Mri brain w/o dye	S
71010	Chest x-ray	X
71015	Chest x-ray	X
71020	Chest x-ray	X
71021	Chest x-ray	X
71022	Chest x-ray	X
71023*	Chest x-ray and fluoroscopy	X
71030	Chest x-ray	X
71034	Chest x-ray and fluoroscopy	X
71090	X-ray & pacemaker insertion	X
71100	X-ray exam of ribs	X
71101	X-ray exam of ribs/chest	X

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
71110	X-ray exam of ribs	X
71111	X-ray exam of ribs/chest	X
71120	X-ray exam of breastbone	X
71130	X-ray exam of breastbone	X
71250	Ct thorax w/o dye	S
72040	X-ray exam of neck spine	X
72050	X-ray exam of neck spine	X
72052	X-ray exam of neck spine	X
72069*	X-ray exam of trunk spine	X
72070	X-ray exam of thoracic spine	X
72072	X-ray exam of thoracic spine	X
72074	X-ray exam of thoracic spine	X
72080	X-ray exam of trunk spine	X
72090	X-ray exam of trunk spine	X
72100	X-ray exam of lower spine	X
72110	X-ray exam of lower spine	X
72114	X-ray exam of lower spine	X
72120	X-ray exam of lower spine	X
72125	Ct neck spine w/o dye	S
72128*	Ct chest spine w/o dye	S
72141	Mri neck spine w/o dye	S
72146	Mri chest spine w/o dye	S
72148	Mri lumbar spine w/o dye	S
72170	X-ray exam of pelvis	X
72190	X-ray exam of pelvis	X
72192	Ct pelvis w/o dye	S
72220	X-ray exam of tailbone	X
73000	X-ray exam of collar bone	X
73010	X-ray exam of shoulder blade	X
73020	X-ray exam of shoulder	X
73030	X-ray exam of shoulder	X
73050	X-ray exam of shoulders	X
73060	X-ray exam of humerus	X
73070	X-ray exam of elbow	X
73080	X-ray exam of elbow	X
73090	X-ray exam of forearm	X
73100	X-ray exam of wrist	X
73110	X-ray exam of wrist	X
73120	X-ray exam of hand	X
73130	X-ray exam of hand	X
73140	X-ray exam of finger(s)	X
73218	Mri upper extremity w/o dye	S
73221	Mri joint upr extrem w/o dye	S
73510	X-ray exam of hip	X
73520	X-ray exam of hips	X
73540	X-ray exam of pelvis & hips	X
73550	X-ray exam of thigh	X
73560	X-ray exam of knee, 1 or 2	X
73562	X-ray exam of knee, 3	X
73564	X-ray exam, knee, 4 or more	X
73565	X-ray exam of knees	X
73590	X-ray exam of lower leg	X
73600	X-ray exam of ankle	X
73610	X-ray exam of ankle	X
73620	X-ray exam of foot	X
73630	X-ray exam of foot	X
73650	X-ray exam of heel	X
73660	X-ray exam of toe(s)	X
73700	Ct lower extremity w/o dye	S
73718*	Mri lower extremity w/o dye	S
73721	Mri jnt of lwr extre w/o dye	S
74000	X-ray exam of abdomen	X
74010*	X-ray exam of abdomen	X
74210	Contrst x-ray exam of throat	S
74220	Contrast x-ray, esophagus	S
74230	Cine/vid x-ray, throat/esoph	S
74235	Remove esophagus obstruction	S
74240	X-ray exam, upper gi tract	S
74245	X-ray exam, upper gi tract	S
74246	Contrst x-ray uppr gi tract	S

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
74247	Contrst x-ray uppr gi tract	S
74249	Contrst x-ray uppr gi tract	S
74250	X-ray exam of small bowel	S
74300	X-ray bile ducts/pancreas	X
74301	X-rays at surgery add-on	X
74305	X-ray bile ducts/pancreas	X
74327	X-ray bile stone removal	S
74340	X-ray guide for GI tube	X
74350	X-ray guide, stomach tube	X
74355	X-ray guide, intestinal tube	X
74360	X-ray guide, GI dilation	S
74363	X-ray, bile duct dilation	S
74475	X-ray control, cath insert	S
74480	X-ray control, cath insert	S
74485	X-ray guide, GU dilation	S
74742	X-ray, fallopian tube	X
75894	X-rays, transcath therapy	S
75898	Follow-up angiography	X
75901	Remove cva device obstruct	X
75902	Remove cva lumen obstruct	X
75945	Intravascular us	S
75946	Intravascular us add-on	S
75960	Transcatheter intro, stent	S
75961	Retrieval, broken catheter	S
75962	Repair arterial blockage	S
75964	Repair artery blockage, each	S
75966	Repair arterial blockage	S
75968	Repair artery blockage, each	S
75970	Vascular biopsy	S
75978	Repair venous blockage	S
75980	Contrast xray exam bile duct	S
75982	Contrast xray exam bile duct	S
75984	Xray control catheter change	X
75992	Atherectomy, x-ray exam	S
75993	Atherectomy, x-ray exam	S
75994	Atherectomy, x-ray exam	S
75995	Atherectomy, x-ray exam	S
75996	Atherectomy, x-ray exam	S
76012	Percut vertebroplasty fluor	S
76013	Percut vertebroplasty, ct	S
76040	X-rays, bone evaluation	X
76061	X-rays, bone survey	X
76062	X-rays, bone survey	X
76066	Joint survey, single view	X
76070*	CT scan, bone density study	S
76075	Dexa, axial skeleton study	S
76076	Dexa, peripheral study	S
76078	Radiographic absorptiometry	X
76095	Stereotactic breast biopsy	T
76096	X-ray of needle wire, breast	X
76100	X-ray exam of body section	X
76101	Complex body section x-ray	X
76360	Ct scan for needle biopsy	S
76380	CAT scan follow-up study	S
76393	Mr guidance for needle place	S
76511	Echo exam of eye	S
76512	Echo exam of eye	S
76516	Echo exam of eye	S
76519	Echo exam of eye	S
76536	Us exam of head and neck	S
76645	Us exam, breast(s)	S
76700	Us exam, abdom, complete	S
76705	Echo exam of abdomen	S
76770	Us exam abdo back wall, comp	S
76775	Us exam abdo back wall, lim	S
76778*	Us exam kidney transplant	S
76801*	Ob us < 14 wks, single fetus	S
76811*	Ob us, detailed, sngl fetus	S
76817*	Transvaginal us, obstetric	S
76830	Transvaginal us, non-ob	S

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
76856	Us exam, pelvic, complete	S
76857	Us exam, pelvic, limited	S
76870	Us exam, scrotum	S
76880	Us exam, extremity	S
76941	Echo guide for transfusion	S
76945	Echo guide, villus sampling	S
76946	Echo guide for amniocentesis	S
76948	Echo guide, ova aspiration	S
76950*	Echo guidance radiotherapy	S
76970*	Ultrasound exam follow-up	S
76977	Us bone density measure	X
77280	Set radiation therapy field	X
77285	Set radiation therapy field	X
77295*	Set radiation therapy field	X
77300	Radiation therapy dose plan	X
77301	Radiotherapy dose plan, imrt	X
77315	Teletx isodose plan complex	X
77326	Radiation therapy dose plan	X
77327	Brachytx isodose calc interm	X
77328	Brachytx isodose plan compl	X
77331	Special radiation dosimetry	X
77332	Radiation treatment aid(s)	X
77333	Radiation treatment aid(s)	X
77334	Radiation treatment aid(s)	X
77336	Radiation physics consult	X
77370	Radiation physics consult	X
77402*	Radiation treatment delivery	S
77403	Radiation treatment delivery	S
77404*	Radiation treatment delivery	S
77408*	Radiation treatment delivery	S
77409	Radiation treatment delivery	S
77411	Radiation treatment delivery	S
77412	Radiation treatment delivery	S
77413	Radiation treatment delivery	S
77414	Radiation treatment delivery	S
77416	Radiation treatment delivery	S
77417	Radiology port film(s)	X
77418	Radiation tx delivery, imrt	S
77470	Special radiation treatment	S
78350	Bone mineral, single photon	X
80502	Lab pathology consultation	X
85060	Blood smear interpretation	X
86585	TB tine test	X
86850	RBC antibody screen	X
86870	RBC antibody identification	X
86880	Coombs test, direct	X
86885	Coombs test, indirect, qual	X
86886	Coombs test, indirect, titer	X
86890	Autologous blood process	X
86900	Blood typing, ABO	X
86901	Blood typing, Rh (D)	X
86905	Blood typing, RBC antigens	X
86906	Blood typing, Rh phenotype	X
86930	Frozen blood prep	X
86970	RBC pretreatment	X
88104	Cytopathology, fluids	X
88106	Cytopathology, fluids	X
88107	Cytopathology, fluids	X
88108	Cytopath, concentrate tech	X
88160	Cytopath smear, other source	X
88161	Cytopath smear, other source	X
88172	Cytopathology eval of fna	X
88182	Cell marker study	X
88300	Surgical path, gross	X
88304	Tissue exam by pathologist	X
88305	Tissue exam by pathologist	X
88311	Decalcify tissue	X
88312	Special stains	X
88313	Special stains	X
88321	Microslide consultation	X

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
88323	Microslide consultation	X
88325	Comprehensive review of data	X
88331	Path consult intraop, 1 bloc	X
88342	Immunohistochemistry	X
88346	Immunofluorescent study	X
88347	Immunofluorescent study	X
90801	Psy dx interview	S
90804*	Psytx, office, 20–30 min	S
90805	Psytx, off, 20–30 min w/e&m	S
90806	Psytx, off, 45–50 min	S
90807	Psytx, off, 45–50 min w/e&m	S
90808	Psytx, office, 75–80 min	S
90809	Psytx, off, 75–80, w/e&m	S
90810	Intac psytx, off, 20–30 min	S
90818	Psytx, hosp, 45–50 min	S
90826	Intac psytx, hosp, 45–50 min	S
90845	Psychoanalysis	S
90846	Family psytx w/o patient	S
90847	Family psytx w/patient	S
90853	Group psychotherapy	S
90857	Intac group psytx	S
90862	Medication management	X
92002	Eye exam, new patient	V
92004	Eye exam, new patient	V
92012	Eye exam established pat	V
92014	Eye exam & treatment	V
92020*	Special eye evaluation	S
92081*	Visual field examination(s)	S
92082	Visual field examination(s)	S
92083	Visual field examination(s)	S
92135	Opthalmic dx imaging	S
92136	Ophthalmic biometry	S
92225	Special eye exam, initial	S
92226	Special eye exam, subsequent	S
92230	Eye exam with photos	T
92250	Eye exam with photos	S
92275	Electroretinography	S
92285	Eye photography	S
92286	Internal eye photography	S
92520	Laryngeal function studies	X
92541*	Spontaneous nystagmus test	X
92546	Sinusoidal rotational test	X
92548	Posturography	X
92552	Pure tone audiometry, air	X
92553	Audiometry, air & bone	X
92555	Speech threshold audiometry	X
92556	Speech audiometry, complete	X
92557*	Comprehensive hearing test	X
92567	Tympanometry	X
92582	Conditioning play audiometry	X
92585	Auditor evoke potent, compre	S
92604*	Reprogram cochlear implt 7 >	X
93005	Electrocardiogram, tracing	S
93225	ECG monitor/record, 24 hrs	X
93226	ECG monitor/report, 24 hrs	X
93231	Ecg monitor/record, 24 hrs	X
93232	ECG monitor/report, 24 hrs	X
93236	ECG monitor/report, 24 hrs	X
93270	ECG recording	X
93278	ECG/signal-averaged	S
93303	Echo transthoracic	S
93307	Echo exam of heart	S
93320	Doppler echo exam, heart	S
93731	Analyze pacemaker system	S
93732*	Analyze pacemaker system	S
93733	Telephone analy, pacemaker	S
93734	Analyze pacemaker system	S
93735*	Analyze pacemaker system	S
93736	Telephonic analy, pacemaker	S
93741*	Analyze ht pace device sngl	S

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING "PSEUDO" SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
93743	Analyze ht pace device dual	S
93797	Cardiac rehab	S
93798	Cardiac rehab/monitor	S
93875	Extracranial study	S
93880	Extracranial study	S
93882	Extracranial study	S
93886	Intracranial study	S
93888	Intracranial study	S
93922	Extremity study	S
93923	Extremity study	S
93924	Extremity study	S
93925	Lower extremity study	S
93926	Lower extremity study	S
93930*	Upper extremity study	S
93931	Upper extremity study	S
93965	Extremity study	S
93970	Extremity study	S
93971	Extremity study	S
93975	Vascular study	S
93976	Vascular study	S
93978	Vascular study	S
93979	Vascular study	S
93990	Doppler flow testing	S
94015	Patient recorded spirometry	X
95115	Immunotherapy, one injection	X
95117*	Immunotherapy injections	X
95165	Antigen therapy services	X
95805	Multiple sleep latency test	S
95806*	Sleep study, unattended	S
95807	Sleep study, attended	S
95812	Electroencephalogram (EEG)	S
95813	Eeg, over 1 hour	S
95816	Electroencephalogram (EEG)	S
95819	Electroencephalogram (EEG)	S
95822	Sleep electroencephalogram	S
95864	Muscle test, 4 limbs	S
95867*	Muscle test, head or neck	S
95872	Muscle test, one fiber	S
95900	Motor nerve conduction test	S
95921	Autonomic nerv function test	S
95925*	Somatosensory testing	S
95926	Somatosensory testing	S
95930	Visual evoked potential test	S
95937	Neuromuscular junction test	S
95950	Ambulatory eeg monitoring	S
95953	EEG monitoring/computer	S
95970*	Analyze neurostim, no prog	S
95972*	Analyze neurostim, complex	S
95974*	Cranial neurostim, complex	S
96000	Motion analysis, video/3d	S
96100	Psychological testing	X
96115	Neurobehavior status exam	X
96117*	Neuropsych test battery	X
96900	Ultraviolet light therapy	S
96910	Photochemotherapy with UV–B	S
96912	Photochemotherapy with UV–A	S
96913	Photochemotherapy, UV–A or B	S
98925*	Osteopathic manipulation	S
98940	Chiropractic manipulation	S
99213	Office/outpatient visit, est	V
99214	Office/outpatient visit, est	V
99241	Office consultation	V
99242*	Office consultation	V
99243	Office consultation	V
99244	Office consultation	V
99245	Office consultation	V
99273	Confirmatory consultation	V
99274	Confirmatory consultation	V
99275	Confirmatory consultation	V
D0473	Micro exam, prep & report	S

TABLE 1.—PROPOSED CY 2006 HCPCS BYPASS CODES FOR CREATING ''PSEUDO'' SINGLE CLAIMS FOR CALCULATING MEDIAN COSTS—Continued

HCPCS code [1]	Short description	Status indicator
G0101	CA screen; pelvic/breast exam	V
G0127	Trim nail(s)	T
G0166	Extrnl counterpulse, per tx	T
G0175	OPPS Service, sched team conf	V
HCPCS	Descriptor	SI
Q0091	Obtaining screen pap smear	T

[1] HCPCS codes shown with an asterisk are bypass codes we are proposing to add to the list for CY 2006.

2. Proposed Calculation of Median Costs for CY 2006

In this section of the preamble, we discuss the use of claims to calculate the proposed OPPS payment rates for CY 2006. The hospital outpatient prospective payment page on the CMS Web site on which this proposed rule is posted provides an accounting of claims used in the development of the proposed rates: *http://www.cms.hhs.gov/providers/hopps*. The accounting of claims used in the development of the proposed rule is included on the Web site under supplemental materials for the CY 2006 proposed rule. That accounting provides additional detail regarding the number of claims derived at each stage of the process. In addition, below we discuss the files of claims that comprise the data sets that are available for purchase under a CMS data user contract. Our CMS Web site, *http://www.cms.hhs.gov/providers/hopps*, includes information about purchasing the following two OPPS data files: ''OPPS Limited Data Set'' and ''OPPS Identifiable Data Set.''

We are proposing to use the following methodology to establish the relative weights to be used in calculating the proposed OPPS payment rates for CY 2006 shown in Addenda A and B to this proposed rule. This methodology is as follows:

We used outpatient claims for full CY 2004 to set the proposed relative weights for CY 2006. To begin the calculation of the relative weights for CY 2006, we pulled all claims for outpatient services furnished in CY 2004 from the national claims history file. This is not the population of claims paid under the OPPS, but all outpatient claims (including, for example, CAH claims, and hospital claims for clinical laboratory services for persons who are neither inpatients nor outpatients of the hospital).

We then excluded claims with condition codes 04, 20, 21, and 77. These are claims that providers submitted to Medicare knowing that no payment will be made. For example, providers submit claims with a condition code 21 to elicit an official denial notice from Medicare and document that a service is not covered. We then excluded claims for services furnished in Maryland, Guam, and the U.S. Virgin Islands because hospitals in those geographic areas are not paid under the OPPS.

We divided the remaining claims into the three groups shown below. Groups 2 and 3 comprise the 102 million claims that contain hospital bill types paid under the OPPS.

1. Claims that were not bill types 12X, 13X, 14X (hospital bill types), or 76X (CMHC bill types). Other bill types, such as ambulatory surgical centers (ASCs), bill type 83, are not paid under the OPPS and, therefore, these claims were not used to set OPPS payment.

2. Claims that were bill types 12X, 13X, or 14X (hospital bill types). These claims are hospital outpatient claims.

3. Claims that were bill type 76X (CMHC). (These claims are later combined with any claims in item 2 above with a condition code 41 to set the per diem partial hospitalization rate determined through a separate process.)

For the cost-to-charge ratio (CCR) calculation process, we used the same approach as that used in developing the final APC rates for CY 2005 (69 FR 65744). That is, we first limited the population of cost reports to only those for hospitals that filed outpatient claims in CY 2004 before determining whether the CCRs for such hospitals were valid. This initial limitation changed the distribution of CCRs used during the trimming process discussed below.

We then calculated the CCRs at a departmental level and overall for each hospital for which we had claims data. We did this using hospital-specific data from the Hospital Cost Report Information System (HCRIS). We used the most recent available cost report data, in most cases, cost reports for CY 2002 or CY 2003. We used the most recent cost report available whether submitted or settled. If the most recent available cost report was submitted but not settled, we looked at the last settled cost report to determine the ratio of submitted to settled cost, and we then adjusted the most recent available submitted but not settled cost report using that ratio. We propose to use the most recently submitted cost reports to calculate the CCRs to be used to calculate median costs for the OPPS CY 2006 final rule.

We then flagged CAHs, which are not paid under the OPPS, and hospitals with invalid CCRs. These included claims from hospitals without a CCR; those from hospitals paid an all-inclusive rate; those from hospitals with obviously erroneous CCRs (greater than 90 or less than .0001); and those from hospitals with CCRs that were identified as outliers (3 standard deviations from the geometric mean after removing error CCRs). In addition, we trimmed the CCRs at the departmental level by removing the CCRs for each cost center as outliers if they exceeded +/− 3 standard deviations of the geometric mean. This is the same methodology that we used in developing the final CY 2005 CCRs. For CY 2006, we are proposing to trim at the departmental CCR level to eliminate aberrant CCRs that, if found in high volume hospitals, could skew the medians. We used a four-tiered hierarchy of cost center CCRs to match a cost center to a revenue code with the top tier being the most common cost center and the last tier being the default CCR. If a hospital's departmental CCR was deleted by trimming, we set the departmental CCR for that cost center to ''missing,'' so that another departmental CCR in the revenue center hierarchy could apply. If no other departmental CCR could apply to the revenue code on the claim, we used the hospital's overall CCR for the revenue code in question. The hierarchy of CCRs is available for inspection and comment at the CMS Web site: *http://www.cms.hhs.gov/providers/hopps/default.asp*.

We then converted the charges on the claim by applying the CCR that we believed was best suited to the revenue

code indicated on the line with the charge. Table 2 below in this preamble contains a list of the allowed revenue codes. Revenue codes not included in Table 2 are those not allowed under the OPPS because their services cannot be paid under the OPPS (for example, inpatient room and board charges) and, thus charges with those revenue codes were not packaged for creation of the OPPS median costs. If a hospital did not have a CCR that was appropriate to the revenue code reported for a line-item charge (for example, a visit reported under the clinic revenue code, but the hospital did not have a clinic cost center), we applied the hospital-specific overall CCR, except as discussed in section X. of this preamble, for calculation of costs for blood.

Thus, we applied CCRs as described above to claims with bill types 12X, 13X, or 14X, excluding all claims from CAHs and hospitals in Maryland, Guam, and the U.S. Virgin Islands, and flagged hospitals with invalid CCRs. We excluded claims from all hospitals for which CCRs were flagged as invalid.

We identified claims with condition code 41 as partial hospitalization services of CMHCs and moved them to another file. These claims were combined with the 76X claims identified previously to calculate the proposed partial hospitalization per diem rate.

We then excluded claims without a HCPCS code. We also moved claims for observation services to another file. We moved to another file claims that contained nothing but flu and pneumococcal pneumonia (''PPV'') vaccine. Influenza and PPV vaccines are paid at reasonable cost and, therefore, these claims are not used to set OPPS rates. We note that the two above mentioned separate files containing partial hospitalization claims and the observation services claims are included in the files that are available for purchase as discussed above.

We next copied line-item costs for drugs, blood, and devices (the lines stay on the claim, but are copied off onto another file) to a separate file. No claims were deleted when we copied these lines onto another file. These line-items are used to calculate the per unit median for drugs, radiopharmaceuticals, and blood and blood products. The line-item costs were also used to calculate the per administration cost of drugs, radiopharmaceuticals, and biologicals (other than blood and blood products).

We then divided the remaining claims into five groups.

1. *Single Major Claims:* Claims with a single separately payable procedure, all of which would be used in median setting.

2. *Multiple Major Claims:* Claims with more than one separately payable procedure or multiple units for one payable procedure. As discussed below, some of these can be used in median setting.

3. *Single Minor Claims:* Claims with a single HCPCS code that is not separately payable. These claims may have a single packaged procedure or a drug code.

4. *Multiple Minor Claims:* Claims with multiple HCPCS codes that are not separately payable without examining dates of service. For example, pathology codes are not used unless the pathology service is the single code on the bill or unless the pathology code is on a separate date of service from the other procedure on the claim. The multiple minor file has claims with multiple occurrences of pathology codes, with packaged costs that cannot be appropriately allocated across the multiple pathology codes. However, by matching dates of service for the code and the reported costs through the ''pseudo'' single creation process discussed earlier, a claim with multiple pathology codes may become several ''pseudo'' single claims with a unique pathology code and its associated costs on each day. These ''pseudo'' singles for the pathology codes would then be considered a separately payable code and would be used the same as claims in the single major claim file.

5. *Non-OPPS Claims:* Claims that contain no services payable under the OPPS. These claims are excluded from the files used for the OPPS. Non-OPPS claims have codes paid under other fee schedules, for example, durable medical equipment or clinical laboratory.

We note that the claims listed in numbers 1, 2, and 4 above are included in the data files that can be purchased as described above.

We set aside the single minor claims and the non-OPPS claims (numbers 3 and 5 above) because we did not use either in calculating median cost. We then examined the multiple major and multiple minor claims (numbers 2 and 4 above) to determine if we could convert any of them to single major claims using the process described previously. We first grouped items on the claims by date of service. If each major procedure on the claim had a different date of service and if the line-items for packaged HCPCS and packaged revenue codes had dates of service, we split the claim into multiple ''pseudo'' single claims based on the date of service.

After those single claims were created, we used the list of ''bypass codes'' in Table 1 of this preamble to remove separately payable procedures that we determined contain limited costs or no packaged costs from a multiple procedure bill. A discussion of the creation of the list of bypass codes used for the creation of ''pseudo'' single claims is contained in section II.A.1.b. of this preamble.

When one of the two separately payable procedures on a multiple procedure claim was on the bypass code list, we split the claim into two single procedure claims records. The single procedure claim record that contained the bypass code did not retain packaged services. The single procedure claim record that contained the other separately payable procedure (but no bypass code) retained the packaged revenue code charges and the packaged HCPCS charges. This enables us to use a claim that would otherwise be a multiple procedure claim and could not be used.

We excluded those claims that we were not able to convert to singles even after applying both of the techniques for creation of ''pseudo'' singles. We then packaged the costs of packaged HCPCS codes (codes with status indicator ''N'' listed in Addendum B to this proposed rule) and packaged revenue codes into the cost of the single major procedure remaining on the claim. The list of packaged revenue codes is shown in Table 2 below.

After removing claims for hospitals with error CCRs, claims without HCPCS codes, claims for immunizations not covered under the OPPS, and claims for services not paid under the OPPS, 55 million claims were left. Of these 55 million claims, we were able to use some portion of 49 million whole claims (90 percent of the potentially usable claims) to create the 81 million single and ''pseudo'' single claims for use in the CY 2006 median payment ratesetting.

We also excluded (1) claims that had zero costs after summing all costs on the claim; (2) claims for which CMS lacked an appropriate provider wage index; and (3) claims containing token charges (charges of less than $1.01) or for which intermediary systems had allocated charges as if the charges were submitted on the claim. We are proposing to delete claims containing token charges. We do not believe that a charge of less than $1.01 would yield a cost that would be valid to set weights for a significant separately paid service. Moreover, effective for services furnished on or after July 1, 2004, the OCE assigns payment flag number 3 to claims on which hospitals submitted token charges for a service with status

indicator ''S'' or ''T'' (a major separately paid service under OPPS) for which the intermediary is required to allocate the sum of charges for services with a status indicator equaling ''S'' or ''T'' based on the weight for the APC to which each code is assigned. We do not believe that these charges, which were token charges as submitted by the hospital, are valid reflections of hospital resource and that they should not be used to set median costs. Therefore, we are proposing to delete these claims.

For the remaining claims, we then wage adjusted 60 percent of the cost of the claim (which we have previously determined to be the labor-related portion), as has been our policy since the initial implementation of the OPPS, to adjust for geographic variation in labor-related costs. We made this adjustment by determining the wage index that applied to the hospital that furnished the service and dividing the cost for the separately paid HCPCS code furnished by the hospital by that wage index. As has been our policy since the inception of the OPPS, we are proposing to use the pre-reclassified wage indices for standardization because we believe that they better reflect the true costs of items and services in the area in which the hospital is located than the post-reclassification wage indices, and would result in the most accurate adjusted median costs.

We then excluded claims that were outside 3 standard deviations from the geometric mean cost for each HCPCS code. We used the remaining claims to calculate median costs for each separately payable HCPCS code; first, to determine the applicability of the ''2 times'' rule, and second, to determine APC medians based on the claims containing the HCPCS codes assigned to each APC. As stated previously, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (''the 2 times rule''). Finally, we reviewed the medians and reassigned HCPCS codes to different APCs as deemed appropriate. Section III.B. of this preamble includes a discussion of the HCPCS code assignment changes that resulted from examination of the medians and for other reasons. The APC medians were recalculated after we reassigned the affected HCPCS codes.

A detailed discussion of the medians for blood and blood products is included in section X. of this preamble. A discussion of the medians for APCs that require one or more devices when the service is performed is included in section IV.A. of this preamble. A discussion of the median for observation services is included in section XI. of this preamble and a discussion of the median for partial hospitalization is included below in section II.B. of this preamble.

TABLE 2.—CY 2006 PROPOSED PACKAGED SERVICES BY REVENUE CODE

Revenue code	Description
250	PHARMACY.
251	GENERIC.
252	NONGENERIC.
254	PHARMACY INCIDENT TO OTHER DIAGNOSTIC.
255	PHARMACY INCIDENT TO RADIOLOGY.
257	NONPRESCRIPTION DRUGS.
258	IV SOLUTIONS.
259	OTHER PHARMACY.
260	IV THERAPY, GENERAL CLASS.
262	IV THERAPY/PHARMACY SERVICES.
263	SUPPLY/DELIVERY.
264	IV THERAPY/SUPPLIES.
269	OTHER IV THERAPY.
270	M&S SUPPLIES.
271	NONSTERILE SUPPLIES.
272	STERILE SUPPLIES.
274	PROSTHETIC/ORTHOTIC DEVICES.
275	PACEMAKER DRUG.
276	INTRAOCULAR LENS SOURCE DRUG.
278	OTHER IMPLANTS.
279	OTHER M&S SUPPLIES.
280	ONCOLOGY.
289	OTHER ONCOLOGY.
290	DURABLE MEDICAL EQUIPMENT.
343	DIAGNOSTIC RADIOPHARMS.
344	THERAPEUTIC RADIOPHARMS.
370	ANESTHESIA.
371	ANESTHESIA INCIDENT TO RADIOLOGY.
372	ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC.
379	OTHER ANESTHESIA.
390	BLOOD STORAGE AND PROCESSING.
399	OTHER BLOOD STORAGE AND PROCESSING.
560	MEDICAL SOCIAL SERVICES.
569	OTHER MEDICAL SOCIAL SERVICES.
621	SUPPLIES INCIDENT TO RADIOLOGY.
622	SUPPLIES INCIDENT TO OTHER DIAGNOSTIC.
624	INVESTIGATIONAL DEVICE (IDE).
630	DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS.
631	SINGLE SOURCE.
632	MULTIPLE.
633	RESTRICTIVE PRESCRIPTION.
681	TRAUMA RESPONSE, LEVEL I.
682	TRAUMA RESPONSE, LEVEL II.
683	TRAUMA RESPONSE, LEVEL III.
684	TRAUMA RESPONSE, LEVEL IV.
689	TRAUMA RESPONSE, OTHER.
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.
942	EDUCATION/TRAINING.

3. Proposed Calculation of Scaled OPPS Payment Weights

Using the median APC costs discussed previously, we calculated the proposed relative payment weights for each APC for CY 2006 shown in Addenda A and B to this proposed rule. As in prior years, we scaled all the relative payment weights to APC 0601 (Mid Level Clinic Visit) because it is one of the most frequently performed services in the hospital outpatient setting. We assigned APC 0601 a relative payment weight of 1.00 and divided the median cost for each APC by the median cost for APC 0601 to derive the relative payment weight for each APC. Using CY 2004 data, the median cost for APC 0601 is $60.57 for CY 2006.

Section 1833(t)(9)(B) of the Act requires that APC reclassification and recalibration changes, wage index changes, and other adjustments be made in a manner that assures that aggregate payments under the OPPS for CY 2006 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 2005 relative weights to aggregate payments using the CY 2006 proposed relative weights. Based on this comparison, we are proposing to make an adjustment to the relative weights for purposes of budget neutrality. The unscaled relative payment weights were adjusted by .999207669 for budget neutrality. The proposed relative payment weights are listed in Addenda A and B to this proposed rule. The proposed relative payment weights incorporate the recalibration adjustments discussed in sections II.A.1. and 2.

Section 1833(t)(14)(H) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, states that ''Additional expenditures resulting from this paragraph shall not be taken into account in establishing the conversion factor, weighting and other adjustment factors for 2004 and 2005 under paragraph (9) but shall be taken into account for subsequent years.'' Section 1833(t)(14) of the Act provides the payment rates for certain ''specified covered outpatient drugs.'' Therefore, the incremental cost of those specified covered outpatient drugs (as discussed in section V. of this preamble) is included in the budget neutrality calculations.

Under section 1833(t)(16)(C) of the Act, as added by section 621(b)(1) of Pub. L. 108–173, payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) is to be made at charges adjusted to cost for services furnished on or after January 1, 2004, and before January 1, 2006. As we stated in our January 6, 2004 interim final rule, charges for the brachytherapy sources will not be used in determining outlier payments and payments for these items will be excluded from budget neutrality calculations. (We provide a discussion of brachytherapy payment issues at section VII. of this proposed rule.)

4. Proposed Changes to Packaged Services

Payments for packaged services under the OPPS are bundled into the payments providers receive for separately payable services provided on the same day. Packaged services are identified by the status indicator ''N.'' Hospitals include charges for packaged services on their claims, and the costs associated with these packaged services are then bundled into the costs for separately payable procedures on the claims for purposes of median cost calculations. Hospitals may use CPT codes to report any packaged services that were performed, consistent with CPT coding guidelines.

As a result of requests from the public, a Packaging Subcommittee to the APC Panel was established to review all the procedural CPT codes with a status indicator of ''N.''

Providers have often suggested that many packaged services could be provided alone, without any other separately payable services on the claim, and requested that these codes not be assigned status indicator ''N.'' The Packaging Subcommittee reviewed every code that was packaged in the CY 2004 OPPS. Based on comments we have received and their own expert judgment, the subcommittee identified a set of packaged codes that are often provided separately and subsequently reviewed utilization and median cost data for these codes. One of the main criteria utilized by the Packaging Subcommittee to determine whether a code should become unpackaged was how likely it was for the code to be billed without any other separately payable services on the claim. The Packaging Subcommittee also examined median costs from hospital claims for packaged services that were billed alone.

The Packaging Subcommittee identified areas for change for some packaged CPT codes that they believe could frequently be provided to patients as the sole service on a given date and that require significant hospital resources as determined from hospital claims data. During the February 2005 meeting, the APC Panel accepted the report of the Packaging Subcommittee and made the following recommendations:

(1) That packaged codes be reviewed by the Panel individually.

(2) That the Packaging Subcommittee continue to meet throughout the year to discuss problematic packaged codes.

(3) That CMS assign a modifier to CPT codes 36540 (Collect blood, venous device); 36600 (Withdrawal of arterial blood); and 51701 (Insertion of non-indwelling bladder catheter), for use when there are no other separately payable codes on the claim. The modifier would flag the outpatient code editor (OCE) to assign payment to the claim.

(4) That CMS maintain the current packaged status indicator for CPT code 76937 (Ultrasound guidance for vascular access).

(5) That CMS change the status indicators for CPT immunization administration codes 90471 and 90472 to allow separate payment and ensure consistency with other injection codes.

(6) That CMS gather more data on CPT code 94762 (Overnight pulse oximetry) to determine how often this code is billed without any other separately payable codes and whether it is performed more frequently alone in rural settings than other settings.

(7) No changes to the packaged status of CPT codes 77790 (radiation source handling) and 94760 and 94761 (both codes measure blood oxygen levels).

(8) That CMS provide education and consistent guidelines to providers and fiscal intermediaries on correct billing procedures for packaged codes in general and in particular for CPT codes 36540, 36600, and 51701 and the recommended modifier, if approved.

(9) That the Packaging Subcommittee review CPT codes 42550 (Injection for salivary x-ray) and 38792 (Sentinel node imaging).

(10) That CPT code 97602 (Nonselective wound care) be referred to the Physician Payment Group within CMS for evaluation of its bundled status as it relates to services provided under the OPPS and that the Physician Payment Group report its conclusions back to the APC Panel.

For CY 2006, we are proposing to maintain CPT codes 36540 (Collect blood venous device) and 36600 (Withdrawal of arterial blood) as packaged services and not adopt the APC Panel's recommendation to add a modifier. We note CPT code 36540 is also bundled under the Medicare Physician Fee Schedule (MPFS), and our data demonstrate that the service is generally billed with other separately payable services. We also have relatively few single claims for CPT code 36600, compared to the procedure's overall frequency. Both of these codes have relatively low resource utilization. As these procedures are almost always provided with other separately payable services, hospitals' payments for those other services include the costs of CPT codes 36540 and 36600.

For CY 2006, we are proposing to pay separately for CPT code 51701 (Insertion of non-indwelling bladder catheter), and to map it to APC 0340 (Minor Ancillary Procedures), with status indicator ''X'', and a median cost of $38.52. The APC Panel recommended that we pay separately for this code only when there are no other separately payable services on the claim. However, we are proposing to pay separately for this code every time it is billed. We believe that it is more appropriate to make payment for each procedure rather than increase hospitals' administrative burden by requiring specific coding changes to indicate that there are no other separately payable procedures on the claim. Based on our review of the data, the cost for this procedure is not insignificant, and the volume of single and multiple claims is modest. When we reviewed related codes, including CPT code 51702 (Insertion of temporary indwelling bladder catheter, simple) and CPT code 51703 (Insertion of temporary indwelling bladder catheter, complicate), we noted that these codes also had substantial median costs and a moderate volume of single claims. Therefore, for CY 2006, we are also proposing to pay separately for CPT codes 51702 and 51703, mapping them to APC 0340 with a median cost of $38.52 and APC 0164 (Level I Urinary

and Anal Procedures) with a median cost of $71.54, respectively. CPT codes 51701, 51702, and 51703 will be placed on the bypass list, as discussed in section II.A.1.b. of this proposed rule.

For CY 2006, we are proposing to accept the APC Panel recommendation that CPT code 76937 (Ultrasound guidance for vascular access) remain packaged. We are concerned that there may be unnecessary overuse of this procedure if it is separately payable. In addition, we believe that the service would always be provided with another separately payable procedure, so its costs would be appropriately bundled with the definitive vascular access service. As stated in the CY 2005 final rule with comment period (69 FR 65697), CMS and the Packaging Subcommittee reviewed CY 2004 claims data for CPT code 76937 and determined that this code should remain packaged.

For CY 2006, see section VIII. of this preamble on drug administration regarding CPT codes 90471 and 90472.

For CY 2006, we are proposing to accept the APC Panel recommendations that CPT codes 77790 (Radiation handling), 94760 (Pulse oximetry for oxygen saturation, single determination), and 94761 (Pulse oximetry for oxygen saturation, multiple determinations) remain packaged. We believe that CPT code 77790 is integral to the provision of brachytherapy and should always be billed on the same day with brachytherapy sources and their loading, ensuring that the provider would receive appropriate payment for the radiation source handling and loading bundled with the payment for the brachytherapy service. The small number of single claims for this code in our data verifies that this code is rarely billed alone without other payable services on the claim, and those few single claims may be miscoded claims. Our data review of CPT codes 94760 and 94761 revealed that these codes have low resource utilization, and are most frequently provided with other services. Similar to CPT code 77790, there are many fewer single claims for CPT codes 94760 and 94761 than multiple procedure claims that include CPT codes 94760 and 94761. CPT codes 94760 and 94761 describe services that are very commonly performed in the hospital outpatient setting, and unpackaging these codes would likely significantly decrease the number of single claims available for use in calculating median costs for other services.

For CY 2006, we are proposing to accept the APC Panel recommendation to gather data and review CPT codes 94762, 42550, and 38792 with the Packaging Subcommittee. We will analyze single and multiple procedure claims' volumes and resource utilization data, and review these studies with the Packaging Subcommittee.

We referred CPT code 97602 (non-selective wound care) for MPFS evaluation of its bundled status as CPT code 97602 relates to services provided under the OPPS. CPT code 97602 is assigned status indicator ''A'' in this OPPS proposed rule, meaning that while it is no longer payable under the OPPS, it is payable under a fee schedule other than OPPS. Under the MPFS, the nonselective wound care services described by CPT code 97602 are ''bundled'' into the selective wound care debridement codes (CPT codes 97597 and 97598). Under the MPFS, a separate payment is never made for ''bundled'' services and, because of this designation, the provider does not receive separate payment for non-selective wound care described by CPT code 97602. While this code now falls under the MPFS rules, payment policy for this ''bundled'' service has not changed and separate payment is not made.

The APC Panel Packaging Subcommittee remains active, and additional issues and new data concerning the packaging status of codes will be shared for its consideration as information becomes available. We continue to encourage submission of common clinical scenarios involving currently packaged HCPCS codes to the Packaging Subcommittee for its ongoing review. Additional detailed suggestions for the Packaging Subcommittee should be submitted to *APCPanel@cms.hhs.gov,* with ''Packaging Subcommittee'' in the subject line.

B. Proposed Payment for Partial Hospitalization

(If you choose to comment on issues in this section, please include the caption ''Partial Hospitalization'' at the beginning of your comment.)

1. Background

Partial hospitalization is an intensive outpatient program of psychiatric services provided to patients as an alternative to inpatient psychiatric care for beneficiaries who have an acute mental illness. A partial hospitalization program (PHP) may be provided by a hospital to its outpatients or by a Medicare-certified CMHC. Section 1833(t)(1)(B)(i) of the Act provides the Secretary with the authority to designate the hospital outpatient services to be covered under the OPPS. Section 419.21(c) of the Medicare regulations that implement this provision specifies that payments under the OPPS will be made for partial hospitalization services furnished by CMHCs. Section 1883(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. Payment to providers under the OPPS for PHPs represents the provider's overhead costs associated with the program. Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we established a per diem payment methodology for the PHP APC, effective for services furnished on or after August 1, 2000. For a detailed discussion, refer to the April 7, 2000 OPPS final rule (65 FR 18452).

2. Proposed PHP APC Update for CY 2006

To calculate the proposed CY 2006 PHP per diem payment, we used the same methodology that was used to compute the CY 2005 PHP per diem payment. For CY 2005, the per diem amount was based on 12 months of hospital and CMHC PHP claims data (for services furnished from January 1, 2003 through December 31, 2003). We used data from all hospital bills reporting condition code 41, which identifies the claim as partial hospitalization, and all bills from CMHCs because CMHCs are Medicare providers only for the purpose of providing partial hospitalization services. We used CCRs from the most recently available hospital and CMHC cost reports to convert each provider's line-item charges as reported on bills, to estimate the provider's cost for a day of PHP services. Per diem costs were then computed by summing the line-item costs on each bill and dividing by the number of days on the bill.

In a Program Memorandum issued on January 17, 2003 (Transmittal A–03–004), we directed fiscal intermediaries to recalculate hospital and CMHC CCRs using the most recently settled cost reports by April 30, 2003. Following the initial update of CCRs, fiscal intermediaries were further instructed to continue to update a provider's CCR and enter revised CCRs into the outpatient provider specific file. Therefore, for CMHCs, we use CCRs from the outpatient provider specific file.

Historically, the median per diem cost for CMHCs has greatly exceeded the median per diem cost for hospital-based PHPs and has fluctuated significantly

from year to year while the median per diem cost for hospital-based PHPs has remained relatively constant ($200–$225). Medicare providers are required to maintain uniform charges for all payers. We believe that hospitals have multiple payers and are far less likely to significantly change their charges for PHP from year to year. However, many CMHCs have indicated that Medicare is their only payer. As a result, we believe that these providers may have increased and decreased their charges in response to Medicare payment policies. As discussed in more detail in the next section and in the final rule establishing the CY 2004 OPPS (68 FR 63470), we believe that some CMHCs manipulated their charges in order to inappropriately receive outlier payments.

In the CY 2003 update, the difference in median per diem cost for CMHCs and hospital-based PHPs was so great, $685 for CMHCs and $225 for hospital-based PHPs, that we applied an adjustment factor of .583 to CMHC costs to account for the difference between ''as submitted'' and ''final settled'' cost reports. By doing so, the CMHC median per diem cost was reduced to $384, resulting in a combined hospital-based and CMHC PHP median per diem cost of $273. As with all APCs in the OPPS, the median cost for each APC was scaled to be relative to the cost of a mid-level office visit and the conversion factor was applied. The resulting per diem rate for PHP for CY 2003 was $240.03.

In the CY 2004 OPPS update, the median per diem cost for CMHCs grew to $1038, while the median per diem cost for hospital-based PHPs was again $225. After applying the .583 adjustment factor to the median CMHC per diem cost, the median CMHC per diem cost was $605. As the CMHC median per diem cost exceeded the average per diem cost of inpatient psychiatric care, we proposed a per diem rate for CY 2004 based solely on hospital-based PHP data. The proposed PHP per diem for CY 2004, after scaling, was $208.95. However, by the time we published the OPPS final rule for CY 2004, we had received updated CCRs for CMHCs. Using the updated CCRs significantly lowered the CMHC median per diem cost to $440. As a result, we determined that the higher per diem cost for CMHCs was not due to the difference between ''as submitted'' and ''final settled'' cost reports, but were the result of excessive increases in charges which may have been done in order to receive higher outlier payments. Therefore, in calculating the PHP median per diem cost for CY 2004, we did not apply the .583 adjustment factor to CMHC costs to compute the PHP APC. Using the updated CCRs for CMHCs, the combined hospital-based and CMHC median per diem cost for PHP was $303. After scaling, we established the CY 2004 PHP APC of $286.82.

Then, in the CY 2005 OPPS update, the CMHC median per diem cost was $310 and the hospital-based PHP median per diem cost was $215. No adjustments were determined to be necessary and, after scaling, the combined median per diem cost of $289 was reduced to $281.33. We believed that the reduction in the CMHC median per diem cost indicated that the use of updated CCRs had accounted for the previous increase in CMHC charges, and represented a more accurate estimate of CMHC per diem costs for PHP.

For CY 2006, we analyzed 12 months of data for hospital and CMHC PHP claims for services furnished between January 1, 2004, and December 31, 2004. The data indicated that the median per diem cost for CMHCs had dropped to $143, while the median per diem cost for hospital-based PHPs was $209. It appears that CMHCs significantly reduced their charges in CY 2004. The average charge per day for CMHCs in CY 2003 was $1,184 and the average cost per day was $335. In CY 2004, the CMHC average charge per day dropped to $765 and the average cost per day was $167. We have determined that a combination of lower charges and slightly lower CCRs for CMHCs resulted in a significant decline in the CMHC median per diem cost.

Following the methodology used for the CY 2005 OPPS update, the combined hospital-based and CMHC median per diem cost would be $149, a decrease of 48 percent compared to the CY 2005 combined median per diem amount. We believe that after scaling this amount to the cost of a mid-level office visit, the resulting APC rate would be too low to cover the per diem cost for all PHPs.

We are considering an alternative update methodology for the PHP APC for CY 2006 that would mitigate this drastic reduction in payment for PHP. One alternative would be to base the PHP APC on hospital-based PHP data alone. The median per diem cost of hospital-based PHPs has remained in the $200–225 range over the last 5 years, while the median per diem cost for CMHC PHPs has fluctuated significantly from a high of $1,037 to a low of $143. Under this alternative, we would use $209, the median per diem cost for hospital-based PHPs during CY 2004 to establish the PHP APC for CY 2006. However, we believe using this amount would also result in an unacceptable drop in Medicare payments for all PHPs in CY 2006 compared to payments in CY 2005.

Another alternative we are considering is to apply a different trimming methodology to CMHC costs in an effort to eliminate the effect of data for those CMHCs that appeared to have excessively increased their charges in order to receive outlier payments. We compared CMHC per diem costs in CY 2003 to CMHC per diem costs in CY 2004 and determined the percentage change. Initially, we trimmed CMHCs claims where the CMHC's per diem costs changed by 50 percent or more from CY 2003 to CY 2004. After combining the remaining CMHC claims with the hospital-based PHP claims, we calculated a median per diem cost of $160.75. However, this approach did not eliminate the data for all of the CMHCs with unreasonable per diem costs. We then analyzed the resulting median per diem cost if we trimmed CMHC claims where the difference in CMHC per diem costs from 2003 to 2004 was 25 percent. This trimming approach resulted in a combined CMHC and hospital-based PHP median per diem cost of $176. We also trimmed the CMHC claims from the CY 2003 data to see how trimming aberrant data would affect the combined hospital/CMHC median per diem cost. We found that trimming the claims from the CMHCs with a 25 percent difference in per diem cost from CY 2003 to CY 2004 reduced the $289 median per diem cost to $218.

We believe it is important to eliminate aberrant data and we believe trimming certain CMHC data would provide an incentive for CMHCs to stabilize their charges so that we could use their data in future updates of the PHP APC. However, we believe that the trimming methods described above would also result in an unacceptably large decrease in payment. In addition, the trimming method we used was based on percentage change in cost per day, and may not have identified all the CMHCs that may have manipulated their charges in order to receive more outlier payments, for example, CMHCs with high charges and no reduction in charges compared to CY 2003.

Although we prefer to use both CMHC and hospital data to establish the PHP APC, we continue to be concerned about the volatility of the CMHC data. The analyses we have conducted seem to indicate that eliminating aberrant CMHC data results in a median per diem cost more in line with hospital data. We will continue to analyze the CMHC data in developing payment rates, however, if the data continues to

be unstable, we may use only hospital data in the future.

We are considering an approach that would lessen the PHP payment reduction for CY 2006, yet, ensure an adequate payment amount and continue to ensure access to the partial hospitalization benefit for Medicare beneficiaries. For CY 2006, we are proposing to apply a 15-percent reduction in the combined hospital-based and CMHC median per diem cost that was used to establish the CY 2005 PHP APC. That amount would then be scaled to be relative to the cost of a mid-level office visit to establish the PHP APC for CY 2006. We believe a reduction in the CY 2005 median per diem cost would strike an appropriate balance between using the best available data and providing adequate payment for a program that often spans 5–6 hours a day. We believe 15 percent is an appropriate reduction because it recognizes decreases in median per diem costs in both the hospital data and the CMHC data, and also reduces the risk of any adverse impact on access to these services that might result from a large single-year rate reduction. However, we would propose that the reduction in payments for PHP be a transitional measure, and will continue to monitor CMHC costs and charges for these services and work with CMHCs to improve their reporting so that payments can be calculated based on better empirical data, consistent with the approach we have used to calculate payments in other areas of the OPPS.

To apply the methodology, we would reduce $289 (the CY 2005 combined hospital-based and CMHC median per diem cost) by 15 percent, resulting in a combined median per diem cost of $245.65. After scaling, we are proposing the resulting APC amount for PHP of $240.51 for CY 2006, of which $48.10 is the beneficiary's coinsurance. We will continue to analyze the data to determine whether there is a more targeted approach that would allow use of the CMHC and hospital PHP claims data to establish the final PHP rate for CY 2006.

3. Proposed Separate Threshold for Outlier Payments to CMHCs

In the November 7, 2003 final rule with comment period (68 FR 63469), we indicated that, given the difference in PHP charges between hospitals and CMHCs, we did not believe it was appropriate to make outlier payments to CMHCs using the outlier percentage target amount and threshold established for hospitals. There was a significant difference in the amount of outlier payments made to hospitals and CMHCs for PHP. Further analysis indicated the use of OPPS outlier payments for CMHCs was contrary to the intent of the general OPPS outlier policy. Therefore, for CYs 2004 and 2005, we established a separate outlier threshold for CMHCs. We designated a portion of the estimated 2.0 percent outlier target amount specifically for CMHCs, consistent with the percentage of projected payments to CMHCs under the OPPS in each of those years, excluding outlier payments.

As stated in the November 15, 2004 final rule with comment period, CMHCs were projected to receive 0.6 percent of the estimated total OPPS payments in CY 2005 (69 FR 65848). The CY 2005 CMHC outlier threshold is met when the cost of furnishing services by a CMHC exceeds 3.5 times the PHP APC payment amount. The current outlier payment percentage is 50 percent of the amount of costs in excess of the threshold.

CMS and the Office of the Inspector General are continuing to monitor the excessive outlier payments to CMHCs. As previously stated in section II.B.2. above, we used CY 2004 claims data to calculate the proposed CY 2006 per diem payment. These data show the effect of the separate outlier threshold for CMHCs that was effective January 1, 2004. During CY 2004, the separate outlier threshold for CMHCs resulted in $1.8 million in outlier payments to CMHCs, within the 2.0 percent of total OPPS payments identified for CMHCs. In CY 2003, more than $30 million was paid to CMHCs in outlier payments. We believe this difference in outlier payments indicates that the separate outlier threshold for CMHCs has been successful in keeping outlier payments to CMHCs in line with the percentage of OPPS payments made to CMHCs.

As noted in section II.H. of this preamble, for CY 2006, we are proposing to set the target for hospital outpatient outlier payments at 1.0 percent of total OPPS payments. We are also proposing to allocate a portion of that 1.0 percent, 0.006 percent (or 0.006 percent of total OPPS payments), to CMHCs for PHP services. As discussed in section II.G. below, we are proposing a dollar threshold in addition to an APC multiplier threshold for hospital OPPS outlier payments. However, because PHP is the only APC for which CMHCs may receive payment under the OPPS, we would not expect to redirect outlier payments by imposing a dollar threshold. Therefore, we are not proposing a dollar threshold for CMHC outliers. We are proposing to set the outlier threshold for CMHCs for CY 2006 at 3.45 percent times the APC payment amount and the CY 2006 outlier payment percentage applicable to costs in excess of the threshold at 50 percent. As we did with the hospital outlier threshold, we used hospital charge inflation factor to inflate charges to CY 2006.

C. Proposed Conversion Factor Update for CY 2006

(If you choose to comment on issues in this section, please include the caption ''Conversion Factor'' at the beginning of your comment.)

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 CY 2006, the update is equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act.

The forecast of the hospital market basket increase for FY 2006 published in the IPPS proposed rule on May 4, 2005 is 3.2 percent (70 FR 23384). To set the OPPS proposed conversion factor for CY 2006, we increased the CY 2005 conversion factor of $56.983, as specified in the November 15, 2004 final rule with comment period (69 FR 65842), by 3.2 percent.

In accordance with section 1833(t)(9)(B) of the Act, we further adjusted the conversion factor for CY 2005 to ensure that the revisions we are making to our updates by means of the wage index are made on a budget-neutral basis. We calculated a proposed budget neutrality factor of 1.002015212 for wage index changes by comparing total payments from our simulation model using the FY 2006 IPPS proposed wage index values to those payments using the current (FY 2005) IPPS wage index values. In addition, to accommodate the proposed rural adjustment discussed in section II.G. of this preamble, we calculated a proposed budget neutrality factor of 0.99652023 by comparing payments with the rural adjustment to those without. For CY 2006, allowed pass-through payments are estimated to decrease to 0.05 percent of total OPPS payments, down from 0.1 percent in CY 2005. The proposed conversion factor is also adjusted by the difference in estimated pass-through payments of 0.05 percent. Finally, decreasing proposed payments for outliers to 1.0 percent of total payments returned 1.0 percent to the conversion factor.

The proposed market basket increase update factor of 3.2 percent for CY 2006, the required wage index budget neutrality adjustment of approximately 1.002015212, the return of 1.0 percent

in total payments from a reduced outlier target, the 0.05 percent adjustment to the pass-through estimate, and the adjustment for the proposed rural payment adjustment of 0.99652023 result in a proposed conversion factor for CY 2006 of $59.350.

D. Proposed Wage Index Changes for CY 2006

(If you choose to comment on issues in this section, please include the caption ''Wage Index'' at the beginning of your comment.)

Section 1833(t)(2)(D) of the Act requires the Secretary to determine a wage adjustment factor to adjust, for geographic wage differences, the portion of the OPPS payment rate and the copayment standardized amount attributable to labor and labor-related cost. This adjustment must be made in a budget neutral manner. As we have done in prior years, we are proposing to adopt the IPPS wage indices and extend these wage indices to TEFRA hospitals that participate in the OPPS but not the IPPS.

As discussed in section II.A. of this preamble, we standardize 60 percent of estimated costs (labor-related costs) for geographic area wage variation using the IPPS wage indices that are calculated prior to adjustments for reclassification to remove the effects of differences in area wage levels in determining the OPPS payment rate and the copayment standardized amount.

As published in the original OPPS April 7, 2000 final rule (65 FR 18545), OPPS has consistently adopted the final IPPS wage indices as the wage indices for adjusting the OPPS standard payment amounts for labor market differences. As initially explained in the September 8, 1998 OPPS proposed rule, we believed and continue to believe that using the IPPS wage index as the source of an adjustment factor for OPPS is reasonable and logical, given the inseparable, subordinate status of the hospital outpatient within the hospital overall. In accordance with section 1886(d)(3)(E) of the Act, the IPPS wage index is updated annually. In this proposed rule, we are proposing to use the proposed FY 2006 hospital IPPS wage index published in the **Federal Register** on May 4, 2005 (70 FR 23550 through 23581), and as corrected and posted on the CMS Web site, to determine the wage adjustments for the OPPS payment rate and the copayment standardized amount for CY 2006. In accordance with our established policy, we are proposing to use the FY 2006 final version of these wage indices to determine the wage adjustments and copayment standardized amount that we will publish in our final rule for CY 2006.

We note that the FY 2006 IPPS wage indices continue to reflect a number of changes implemented in FY 2005 as a result of the new OMB standards for defining geographic statistical areas, the implementation of an occupational mix adjustment as part of the wage index, and new wage adjustments provided for under Pub. L. 108–173. The following is a brief summary of the proposed changes in the FY 2005 IPPS wage indices, continued for FY 2006, and any adjustments that we are proposing applying to the OPPS for CY 2006. We refer the reader to the FY 2006 IPPS proposed rule (70 FR 23367 through 23384, May 4, 2005) for a detailed discussion of the changes to the wage indices.)

1. The proposed continued use of the new Core Based Statistical Areas (CBSAs) issued by the Office of Management and Budget (OMB) as revised standards for designating geographical statistical areas based on the 2000 Census data, to define labor market areas for hospitals for purposes of the IPPS wage index. The OMB revised standards were published in the **Federal Register** on December 27, 2000 (65 FR 82235), and OMB announced the new CBSAs on June 6, 2003, through an OMB bulletin. In the FY 2005 hospital IPPS final rule, CMS adopted the new OMB definitions for wage index purposes. In the FY 2006 IPPS proposed rule, we again stated that hospitals located in MSAs would be urban and hospitals that are located in Micropolitan Areas or Outside CBSAs would be rural. To help alleviate the decreased payments for previously urban hospitals that became rural under the new MSA definitions, we allowed these hospitals to maintain their assignment to the MSA where they previously had been located for the 3-year period from FY 2005 through FY 2007. To be consistent with IPPS, we will continue the policy we began in CY 2005 of applying the same criterion to TEFRA hospitals paid under the OPPS but not under the IPPS and to maintain that MSA designation for determining a wage index for the specified period. Beginning in FY 2008, these hospitals will receive their statewide rural wage index, although those hospitals paid under the IPPS will be eligible to apply for reclassification. In addition to this ''hold harmless'' provision, the FY 2005 IPPS final rule implemented a one-year transition for hospitals that experienced a decrease in their FY 2005 wage index compared to their FY 2004 wage index due solely to the changes in labor market definitions. These hospitals received 50 percent of their wage indices based on the new MSA configurations and 50 percent based on the FY 2004 labor market areas. In the FY 2006 IPPS proposed rule, we discussed the cessation of the one-year transition and proposed that hospitals receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006. Again, for the sake of consistency with IPPS, we also are proposing that TEFRA hospitals would receive 100 percent of their wage index based upon the new CBSA configurations beginning in FY 2006.

2. We again proposed to apply the proposed occupational mix adjustment for FY 2006 IPPS to 10-percent of the average hourly wage and leave 90 percent of the average hourly wage unadjusted for occupational mix. As noted in the FY 2006 IPPS proposed rule, we are, essentially, using the same CMS Wage Index Occupational Mix Survey and Bureau of Labor Statistics data to calculate the adjustment. Because there are no significant differences between the FY 2005 and the FY 2006 occupational mix survey data and results, we believe it is appropriate to adopt the IPPS rule and apply the same occupational mix adjustment to 10 percent of the proposed FY 2006 wage index.

3. The reclassifications of hospitals to geographic areas for purposes of the wage index. For purposes of the OPPS wage index, we are proposing to adopt all of the IPPS reclassifications proposed for FY 2006, including reclassifications that the Medicare Geographic Classification Review Board (MGCRB) approved under the one-time appeal process for hospitals under section 508 of Pub. L. 108–173. We note that section 508 reclassifications will terminate March 31, 2007.

4. The proposed continuation of an adjustment to the wage index to reflect the ''out-migration'' of hospital employees who reside in one county but commute to work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173 (FY 2006 IPPS proposed rule (70 FR 23381 and 23382, May 4, 2005)). Hospitals paid under the IPPS located in the qualifying section 505 ''out-migration'' counties receive a wage index increase unless they have already been reclassified under section 1886(d)(10) of the Act, redesignated under section 1886(d)(8)(B) of the Act, or reclassified under section 508. As discussed in the FY 2006 IPPS proposed rule, we proposed that reclassified hospitals not receive the out-migration adjustment unless they waive their reclassified

status. For OPPS purposes, we are continuing our policy from CY 2005 to apply the same 505 criterion to TEFRA hospitals paid under the OPPS but not paid under the IPPS. Because TEFRA hospitals cannot reclassify under sections 1886(d)(8) and 1886(d)(10) of the Act or section 508, they are eligible for the out-migration adjustment. Therefore, TEFRA hospitals located in a qualifying section 505 county will also receive an increase to their wage index under OPPS. Addendum L shows the hospitals, including TEFRA hospitals, that we currently believe will receive the out-migration adjustment. However, because we are proposing to adopt the final FY 2006 IPPS wage index, we will adopt any changes in a hospital's classification status that would make them either eligible or ineligible for the out-migration adjustment.

The following proposed FY 2006 IPPS wage indices that were published in the May 4, 2005 **Federal Register** (70 FR 23550 through 2323581) are reprinted as Addenda in this OPPS proposed rule: Addendum H—Wage Index for Urban Areas; Addendum I—Wage Index for Rural Areas; Addendum J—Wage Index for Hospitals That Are Reclassified; Addendum K—Puerto Rico Wage Index by CBSA; Addendum L—Out-Migration Wage Adjustment; Addendum M—Hospital Reclassifications and Redesignations by Individual Hospital and CBSA; Addendum N—Hospital Reclassifications and Redesignations by Individual Hospital under Section 508 of Pub. L. 108–173; and Addendum O—Hospitals Redesignated as Rural Under Section 1886(d)(8)(E) of the Act. We are proposing to use these FY 2006 IPPS indices, as they are finalized, to adjust the payment rates and coinsurance amounts that we will publish in the OPPS final rule for CY 2006.

With the exception of reclassifications resulting from the implementation of the one-time appeal process under section 508 of Pub. L. 108–173, all changes to the wage index resulting from geographic labor market area reclassifications or other adjustments must be incorporated in a budget neutral manner. Accordingly, in calculating the OPPS budget neutrality estimates for CY 2006, we have included the wage index changes that result from MGCRB reclassifications, implementation of section 505 of Pub. L. 108–173, and other refinements made in the FY 2006 IPPS proposed rule, such as the hold harmless provision for hospitals changing status from urban to rural under the new CBSA geographic statistical area definitions. However, section 508 set aside $900 million to implement the section 508 reclassifications. We considered the increased Medicare payments that the section 508 reclassifications would create in both the IPPS and OPPS when we determined the impact of the one-time appeal process. Because the increased OPPS payments already counted against the $900 million limit, we did not consider these reclassifications when we calculated the OPPS budget neutrality adjustment.

E. Proposed Statewide Average Default Cost-to-Charge Ratios

(If you choose to comment on issues in this section, please include the caption ''Cost-to-Charge Ratios'' at the beginning of your comment.)

CMS uses CCRs to determine outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the OPPS. Some hospitals do not have a valid CCR. These hospitals include, but are not limited to, hospitals that are new and have not yet submitted a cost report, hospitals that have a CCR that falls outside predetermined floor and ceiling thresholds for a valid CCR, or hospitals that have recently given up their all-inclusive rate status. Last year we updated the default urban and rural CCRs for CY 2005 in our final rule published on November 15, 2004 (69 FR 65821 through 65825). We are proposing to update the default ratios using the most recent cost report data for CY 2006.

We calculated the proposed statewide default CCRs using the same CCRs that we use to adjust charges to costs on claims data. Table 3 lists the proposed CY 2006 default urban and rural CCRs by State. These CCRs are the ratio of total costs to total charges from each provider's most recently submitted cost report, for those cost centers relevant to outpatient services. We also adjusted these ratios to reflect final settled status by applying the differential between settled to submitted costs and charges from the most recent pair of settled to submitted cost reports.

The majority of submitted cost reports, 80.79 percent, were for CY 2003. We only used valid CCRs to calculate these default ratios. That is, we removed the CCRs for all-inclusive hospitals, CAHs, and hospitals in Guam and the U.S. Virgin Islands because these entities are not paid under the OPPS, or in the case of all-inclusive hospitals, because their CCRs are suspect. We further identified and removed any obvious error CCRs and trimmed any outliers. We limited the hospitals used in the calculation of the default CCRs to those hospitals that billed for services under the OPPS during CY 2003.

Finally, we calculated an overall average CCR, weighted by a measure of volume, for each State except Maryland. This measure of volume is the total lines on claims and is the same one that we use in our impact tables. For Maryland, we used an overall weighted average CCR for all hospitals in the nation as a substitute for Maryland CCRs, which appear in Table 3. Very few providers in Maryland are eligible to receive payment under the OPPS, which limits the data available to calculate an accurate and representative CCR. The overall decrease in default statewide CCRs can be attributed to the general decline in the ratio between costs and charges widely observed in the cost report data.

TABLE 3.—STATEWIDE AVERAGE COST-TO-CHARGE RATIOS

State	Urban/rural	Previous default CCR	Default CCR
ALABAMA	RURAL	0.31552	0.26710
ALABAMA	URBAN	0.29860	0.24570
ALASKA	RURAL	0.59388	0.61850
ALASKA	URBAN	0.38555	0.42710
ARIZONA	RURAL	0.39748	0.32760
ARIZONA	URBAN	0.30922	0.26980
ARKANSAS	RURAL	0.35936	0.31750
ARKANSAS	URBAN	0.38278	0.30470
CALIFORNIA	RURAL	0.40335	0.29310
CALIFORNIA	URBAN	0.32427	0.24210
COLORADO	RURAL	0.51041	0.43060

TABLE 3.—STATEWIDE AVERAGE COST-TO-CHARGE RATIOS—Continued

State	Urban/rural	Previous default CCR	Default CCR
COLORADO	URBAN	0.41863	0.32170
CONNECTICUT	RURAL	0.42702	0.47250
CONNECTICUT	URBAN	0.46592	0.44620
DELAWARE	RURAL	0.36289	0.36300
DELAWARE	URBAN	0.45061	0.45940
DISTRICT OF COLUMBIA	URBAN	0.38690	0.37510
FLORIDA	RURAL	0.31782	0.24300
FLORIDA	URBAN	0.28363	0.22400
GEORGIA	RURAL	0.39829	0.33820
GEORGIA	URBAN	0.40262	0.32100
HAWAII	RURAL	0.44420	0.41020
HAWAII	URBAN	0.34815	0.34470
IDAHO	RURAL	0.49682	0.46450
IDAHO	URBAN	0.51942	0.49170
ILLINOIS	RURAL	0.41825	0.34060
ILLINOIS	URBAN	0.36825	0.29960
INDIANA	RURAL	0.44596	0.36860
INDIANA	URBAN	0.44205	0.37230
IOWA	RURAL	0.50166	0.41990
IOWA	URBAN	0.46963	0.38780
KANSAS	RURAL	0.48065	0.38970
KANSAS	URBAN	0.34698	0.29270
KENTUCKY	RURAL	0.36987	0.31080
KENTUCKY	URBAN	0.37381	0.32470
LOUISIANA	RURAL	0.34317	0.29910
LOUISIANA	URBAN	0.34357	0.27730
MAINE	RURAL	0.47857	0.38800
MAINE	URBAN	0.54084	0.44890
MARYLAND	RURAL	0.70380	0.36521
MARYLAND	URBAN	0.68104	0.32997
MASSACHUSETTS	URBAN	0.44439	0.38810
MICHIGAN	RURAL	0.44890	0.39410
MICHIGAN	URBAN	0.41143	0.37420
MINNESOTA	RURAL	0.48514	0.47130
MINNESOTA	URBAN	0.45259	0.37410
MISSISSIPPI	RURAL	0.34264	0.30290
MISSISSIPPI	URBAN	0.37097	0.29320
MISSOURI	RURAL	0.42187	0.34160
MISSOURI	URBAN	0.38128	0.31080
MONTANA	RURAL	0.51173	0.47890
MONTANA	URBAN	0.49396	0.44810
NEBRASKA	RURAL	0.49386	0.42370
NEBRASKA	URBAN	0.42043	0.33870
NEVADA	RURAL	0.42878	0.50620
NEVADA	URBAN	0.22854	0.22330
NEW HAMPSHIRE	RURAL	0.50083	0.43580
NEW HAMPSHIRE	URBAN	0.39954	0.33220
NEW JERSEY	URBAN	0.49024	0.34030
NEW MEXICO	RURAL	0.44932	0.33890
NEW MEXICO	URBAN	0.50857	0.43310
NEW YORK	RURAL	0.52062	0.43940
NEW YORK	URBAN	0.54625	0.42550
NORTH CAROLINA	RURAL	0.37776	0.35410
NORTH CAROLINA	URBAN	0.42726	0.38110
NORTH DAKOTA	RURAL	0.52829	0.41170
NORTH DAKOTA	URBAN	0.47341	0.36740
OHIO	RURAL	0.42562	0.41160
OHIO	URBAN	0.42718	0.32810
OKLAHOMA	RURAL	0.40628	0.32900
OKLAHOMA	URBAN	0.36264	0.29190
OREGON	RURAL	0.47915	0.42460
OREGON	URBAN	0.49958	0.43760
PENNSYLVANIA	RURAL	0.40582	0.36010
PENNSYLVANIA	URBAN	0.33807	0.28010
PUERTO RICO	URBAN	0.42208	0.41370
RHODE ISLAND	URBAN	0.43930	0.35100
SOUTH CAROLINA	RURAL	0.35996	0.29370
SOUTH CAROLINA	URBAN	0.36961	0.29160
SOUTH DAKOTA	RURAL	0.49599	0.39210
SOUTH DAKOTA	URBAN	0.44259	0.33940
TENNESSEE	RURAL	0.36663	0.30290

TABLE 3.—STATEWIDE AVERAGE COST-TO-CHARGE RATIOS—Continued

State	Urban/rural	Previous default CCR	Default CCR
TENNESSEE	URBAN	0.36464	0.28310
TEXAS	RURAL	0.41763	0.33640
TEXAS	URBAN	0.33611	0.30300
UTAH	RURAL	0.49748	0.47090
UTAH	URBAN	0.46733	0.45230
VERMONT	RURAL	0.47278	0.46750
VERMONT	URBAN	0.54533	0.44250
VIRGINIA	RURAL	0.39408	0.33500
VIRGINIA	URBAN	0.38604	0.32550
WASHINGTON	RURAL	0.54246	0.43420
WASHINGTON	URBAN	0.54658	0.41360
WEST VIRGINIA	RURAL	0.42671	0.35070
WEST VIRGINIA	URBAN	0.45616	0.40700
WISCONSIN	RURAL	0.50126	0.42300
WISCONSIN	URBAN	0.46268	0.38480
WYOMING	RURAL	0.54596	0.51580
WYOMING	URBAN	0.41265	0.41080

F. Expiring Hold Harmless Provision for Transitional Corridor Payments for Certain Rural Hospitals

When the OPPS was implemented, every provider was eligible to receive an additional payment adjustment (transitional corridor payment) if the payments it received for covered OPD services under the OPPS were less than the payments it would have received for the same services under the prior reasonable cost-based system (section 1833(t)(7) of the Act). Section 1833(t)(7) of the Act provides that the transitional corridor payments are temporary payments for most providers, with two exceptions, to ease their transition from the prior reasonable cost-based payment system to the OPPS system. Cancer hospitals and children's hospitals receive the transitional corridor payments on a permanent basis. Section 1833(t)(7)(D)(i) of the Act originally provided for transitional corridor payments to rural hospitals with 100 or fewer beds for covered OPD services furnished before January 1, 2004. However, section 411 of Pub. L. 108–173 amended section 1833(t)(7)(D)(i) of the Act to extend these payments through December 31, 2005, for rural hospitals with 100 or fewer beds. Section 411 also extended the transitional corridor payments to sole community hospitals located in rural areas for services furnished during the period that begins with the provider's first cost reporting period beginning on or after January 1, 2004, and ends on December 31, 2005. Accordingly, the authority for making transitional corridor payments under section 1833(t)(7)(D)(i) of the Act, as amended by section 411 of Pub . L. 108–173, will expire for rural hospitals having 100 or fewer beds and sole community hospitals located in rural areas on December 31, 2005. For CY 2006, transitional corridor payments will continue to be available to cancer and children's hospitals. (We note that the succeeding section II.G. of this preamble discusses an additional provision of section 411 of Pub. L. 108–173 that related to a study to determine appropriate adjustment to payments for rural hospitals under the OPPS beginning January 2006.)

G. Proposed Adjustment for Rural Hospitals

(If you choose to comment on issues in this section, please include the caption ''Rural Hospital Adjustment'' at the beginning of your comment.)

Section 411 of Pub. L. 108–173 added a new paragraph (13) to section 1833(t) of the Act. New section 1833(t)(13)(A) specifically instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient costs. Moreover, under new section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

To conduct the study required under section 1833(t)(13)(A), as added by section 411 of Pub. L. 108–173, we believe that a simple comparison of unit costs is insufficient because the costs faced by hospitals, whether urban or rural, will be a function of many factors. These include the local labor supply, and the complexity and volume of services provided. Therefore, we used regression analysis to study differences in the outpatient cost per unit between rural and urban hospitals in order to compare costs after accounting for the influence of these other factors.

Our regression analysis included all 4,077 hospitals billing under OPPS for which we could model accurate cost per unit estimates. For each hospital, total outpatient costs and descriptive information were derived from CY 2004 Medicare claims and the hospital's most recently submitted cost report. The description of claims used, our methodology for creating costs from charges, and a description of the specific hospitals included in our modeling are discussed in section II.A. of this preamble. We excluded separately payable drugs and biologicals, and clinical laboratory services paid on a fee schedule from our analysis. We excluded the 49 hospitals in Puerto Rico because their wage indices and unit costs are so different that they would have skewed results. Finally, we excluded facilities whose unit outpatient costs were outside of 3 standard deviations from the geometric mean unit outpatient cost.

Total unit outpatient cost for each hospital was calculated by dividing total outpatient cost by the total number of APC units discounted for the joint performance of multiple procedures. (See section II.G.2. below for a definition of discounted units.) We modeled both explanatory and payment regression models. In an ''explanatory model'' approach, all variables that are hypothesized to be important determinants of cost are included in the cost regression, whether or not they are going to be used as payment adjustments. In a ''payment model'' approach, the only independent variables included in the cost regression are those variables that are used as payment adjustments. The regression

equations for both models were specified in double logarithmetic form. The dependent variable in the explanatory regression equation was unit outpatient cost. The dependent variable in the payment regressions was standardized unit outpatient costs, that is, unit outpatient costs adjusted to reflect payment by dividing through by the provider's service-mix index which was adjusted by the provider's wage index. The service-mix index is a measure of the resource intensity of services provided by each hospital. Both regression equation models included quantitative independent variables transformed into natural logarithms and categorical independent variables. Categorical independent (dummy) variables included hospital characteristics such as rural location or type of hospital (short stay or specialty hospital).

1. Factors Contributing to Unit Cost Differences Between Rural Hospitals and Urban Hospitals

In considering potential independent variables that might explain differences in unit outpatient costs between urban and rural hospitals, we determined that several factors would be important:

- First, unit outpatient costs are expected to vary directly with the prices of inputs used to produce outpatient services, especially labor. Wage rates tend to be lower in rural areas than in urban areas.
- Second, there may be economies of scale in producing outpatient services, which imply that unit costs will vary inversely with the volume of outpatient services provided.
- Third, independent of the volume of outpatient services, hospitals that provide more complex outpatient services are expected to have higher unit costs than hospitals with less complex service-mixes. Typically, greater complexity involves a combination of higher equipment and labor costs. Rural hospitals usually have less volume and perform less complex services than urban hospitals.
- Fourth, the size of a hospital may influence the volume and service-mix of outpatient services. Large hospitals generally provide a wider range of more complex services than do small hospitals. Large hospitals may also have larger volumes in ancillary departments that are shared between outpatient and inpatient services, and as a result, benefit from greater economies of scale than do small hospitals. Rural hospitals tend to be smaller than urban hospitals. Our primary measure of outpatient volume is units of APCs, which only reflects the volume of Medicare services paid under the outpatient PPS. This measure does not include the inpatient utilization of shared ancillary departments or non-Medicare outpatient services. For all these reasons, it seems appropriate to include a broader measure of facility size in the explanatory regression model. Therefore, as explained below, we used the total number of facility beds to measure facility size. Unit outpatient costs may be positively or negatively related to facility size depending on whether complexity effects or scale economies are more important.

2. Explanatory Variables

We used the hospital wage index as our measure of labor input prices. To reflect the complexity of outpatient services, we used a service-mix index defined as the ratio of the number of discounted units weighted by APC relative weights divided by the number of unweighted discounted units. Discounted units are the total number of units after we adjust for the multiple procedure reduction of 50 percent that applies to payment for surgical services when two surgical procedures are performed during the same operative session and for selected radiology procedures, as proposed (see section XIV. of the preamble). For example, if a procedure is paid at 100 percent of payment 1,000 times and the same procedure is paid at 50 percent of payment 100 times, the discounted units for that procedure equal 1,050 units (the sum of 1,000 units at full payment plus 100 units at 50 percent payment). We then calculate the total weight for that procedure by multiplying the discounted units by the full weight for the procedure. The service-mix index reflects the average APC weight of each facility's outpatient services. Outpatient service volume was measured as the total number of unweighted discounted units. We used the total number of facility beds as the broader measure of facility size. We also included categorical variables to indicate the types of specialty hospitals that participate in OPPS, specifically cancer, children's, long-term care, rehabilitation, and psychiatric hospitals. Finally, we included a categorical variable for rural/urban location to capture variation unexplained by the other independent variables in the model. For all of the rural dummy variables discussed below, urban hospitals are the reference group. Table 4 provides descriptive statistics for the dependent variable and key independent variables by urban and rural status. Without controlling for the other influences on per unit cost, rural hospitals have lower cost per unit than urban hospitals. However, when standardized for the service-mix wage indices, average unit costs are nearly identical between urban and rural hospitals

TABLE 4.—MEANS AND STANDARD DEVIATIONS (IN PARENTHESIS) FOR KEY VARIABLES BY URBAN-RURAL LOCATION

	Rural	Urban
Unit Outpatient Cost	$163.78	$195.54
	($65.69)	($93.59)
Standardized Unit Outpatient Cost	$75.04	$75.15
	($26.97)	($45.00)
Wage Index	0.8798	1.0214
	(0.0771)	(0.1487)
Service-Mix Index	2.4121	2.7741
	(0.8915)	(1.4579)
Outpatient Volume	18,645	35,744
	(19,578)	(42,626)
Beds	76.70	198
	(55.82)	(169)
Number of Hospitals	1,257	2,820

3. Results

Overall, all rural hospitals give some indication of having higher cost per unit, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. In an explanatory model regressing unit costs on all independent variables discussed above, the coefficient for the rural categorical variable was 0.024 (p=0.058), which suggests that rural hospitals are approximately 2.4 percent more costly than urban hospitals after accounting for the impact of other explanatory variables. The results of this regression appear in Table 5. This regression demonstrated reasonably good explanatory power with an adjusted R2 of 0.53 (rounded). Adjusted R2 is the percentage of variation in the dependent variable explained by the independent variables and is a standard measure of how well the regression model fits the data. The regression coefficients of the key explanatory variables all move in the expected direction: positive for the wage index, indicating that rural hospitals can be expected to have lower unit outpatient costs because they tend to be located in areas with lower wage rates; positive for the outpatient service-mix index, consistent with the hypothesis that rural hospitals' less complex outpatient service-mixes result in lower unit costs than those of the typical urban hospital; negative for outpatient service volume, implying that, on average, rural hospitals' lower service volumes are a source of higher unit cost compared to urban hospitals; and positive for the facility size variable (beds), suggesting that facility size is more reflective of complexity than any economies of scale. The rural dummy variable has a coefficient of 0.02414. If the unit costs of rural hospitals are the same as the unit costs of urban hospitals, the probability of observing a value as extreme as or more extreme than 2.4 percent would be approximately 6 percent or less. This explanatory regression model provides some evidence that outpatient services provided by rural hospitals are more costly than outpatient services provided by urban hospitals, but the evidence is weak. The payment regression that accompanies this explanatory model indicates an adjustment for all rural hospitals of 3.7 percent.

TABLE 5.—REGRESSION RESULTS FOR UNIT OUTPATIENT COST: RURAL VERSUS URBAN

Variable	Explanatory			Payment		
	Regression coefficient	t Value [1]	p Value [2]	Regression coefficient	t Value [1]	p Value [2]
Intercept	4.89665	124.65	<.0001	4.24092	0.00624	<0.0001
Wage Index	0.64435	17.96	<.0001	.....	.....	.....
Service-Mix Index	0.75813	58.51	<.0001	.....	.....	.....
Outpatient Volume	−0.06532	−14.40	<.0001	.....	.....	.....
Beds	0.04475	6.17	<.0001	.....	.....	.....
Rural	0.02414	1.89	0.0582	0.03656	3.25	0.0012
Children's Hospital	0.06497	1.33	0.1824	.....	.....	.....
Psychiatric Hospital	−0.44446	−15.13	<.0001	.....	.....	.....
Long-Term Care Hospital	−0.08759	−2.77	.0.0057	.....	.....	.....
Rehabilitation Hospital	−0.25295	−7.85	<.0001	.....	.....	.....
Cancer Hospital	0.30897	3.45	0.0006	.....	.....	.....
R2	0.5285	.....	.....	.....	.....	.....

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variable, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e, the base of natural logarithms.

[1] A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

[2] A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than −2 indicate a probability less than 5 percent, p-value<0.05, that the estimated coefficient is zero.

In order to assess whether the small difference in costs was uniform across rural hospitals or whether all of the variation was attributable to a specific class of rural hospitals, we included more specific categories of rural hospitals in our explanatory regression analysis. We divided rural hospitals into rural SCHs, rural hospitals with less than 100 beds that are not rural sole community hospitals, and other rural hospitals. The first two categories of rural hospitals are currently eligible for payments under the expiring hold-harmless provision. Because it appears that rural SCHs are responsible for the variation in rural hospital costs, we then collapsed the last remaining categories in an ''all other'' rural hospital category.

We found that rural SCHs demonstrated significantly higher cost per unit than urban hospitals after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. The results of this regression appear in Table 6. With the exception of the new rural variables, the independent variables have the same sign and significance as in Table 5. Rural SCHs have a positive and significant coefficient; all other rural hospitals do not. The rural SCH ''dummy'' variable has an explanatory regression coefficient of 0.05668 and an observed probability that the coefficient is zero of less than 0.001. If the unit costs of rural SCHs are the same as those of urban hospitals, the probability of observing a value as extreme or more extreme than 5.8 percent would be less than 0.1 percent. Accordingly, we have determined that rural SCHs are more costly than urban hospitals, holding all other variables constant. Notably, we observed no significant difference between all other rural hospitals and urban hospitals.

TABLE 6.—REGRESSION RESULTS FOR UNIT OUTPATIENT COST: RURAL SOLE COMMUNITY HOSPITALS

Variable	Explanatory			Payment		
	Regression coefficient	t Value [1]	pValue [2]	Regression coefficient	t Value [1]	pValue [2]
Intercept	4.89444	124.70	<.0001	4.24474	768.57	<.0001
Wage Index	0.64022	17.85	<.0001	.....	.....	.....
Service-Mix Index	0.75798	58.56	<.0001	.....	.....	.....
Outpatient Volume	−0.06538	−14.43	<.0001	.....	.....	.....
Beds	0.04533	6.26	<.0001	.....	.....	.....
Rural SCH	0.05668	3.42	0.0006	0.06354	3.94	<.0001
All Other Rural	0.00415	0.29	0.7715	.....	.....	.....
Children's Hospital	0.06475	1.33	0.1835	.....	.....	.....
Psychiatric Hospital	−0.44345	−15.11	<.0001	.....	.....	.....
Long-Term Care Hospital	−0.08644	−2.73	0.0063	.....	.....	.....
Rehabilitation Hospital	−0.25234	−7.83	<.0001	.....	.....	.....
Cancer Hospital	0.30957	3.46	0.0005	.....	.....	.....
R2	0.5295	.....	.....	.....	.....	.....

NOTE: Coefficients of all quantitative variables are elasticities since both the dependent variables, unit outpatient cost, and all quantitative independent variables were in natural logarithms. To calculate percentage differences for categorical variables, their coefficients must be raised to the power, e, the base of natural logarithms.

[1] A t value is an indicator of our degree of confidence that the regression coefficient is different from zero, taking into account the statistical variability of the estimated coefficient.

[2] A p value is the probability of observing the specific t value when the estimated coefficient is zero. The t values greater than 2 and less than −2 indicate a probability less than 5 percent, p-value <0.05, that the estimated coefficient is zero.

Based on the above analysis and as noted in the explanatory regression in Table 6, we believe that a payment adjustment for rural SCHs is warranted. The accompanying payment regression, also appearing in Table 6, indicates a cost impact of 6.6 percent. Thus, in accordance with the authority provided in section 1833(t)(13)(B) of the Act, as added by section 411 of Pub. L. 108–173, we are proposing a 6.6 percent payment increase for rural SCHs for CY 2006. This adjustment would apply to all services and procedures paid under the OPPS, excluding drugs and biologicals. We note that this adjustment would be budget neutral, and would be applied before calculating outliers and coinsurance. We may revisit this adjustment in the future.

Additional descriptive statistics are available on the CMS Web site.

H. Proposed Hospital Outpatient Outlier Payments

(If you choose to comment on issues in this section, please include the caption ''Outlier Payments'' at the beginning of your comment.)

Currently, the OPPS pays outlier payments on a service-by-service basis. For CY 2005, the outlier threshold is met when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,175 fixed dollar threshold. We introduced a fixed dollar threshold in CY 2005 in addition to the traditional multiple threshold to better target outliers to those high cost and complex procedures where a very costly case could present a hospital with significant financial loss. If a provider meets both of these conditions, the multiple threshold and the fixed dollar threshold, the outlier payment is calculated as 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC payment rate. For CMHCs, the outlier threshold is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.5 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.5 times the APC payment rate.

As explained in our CY 2005 final rule (69 FR 65844), we set our projected target for aggregate outlier payments at 2.0 percent of aggregate total payments under OPPS. Our outlier thresholds were set so that estimated CY 2005 aggregate outlier payments would equal 2.0 percent of aggregate total payments under OPPS.

For CY 2006, we are proposing to set our projected target for aggregate outlier payments at 1.0 percent of aggregate total payments under OPPS. A portion of that 1.0 percent, an amount equal to .006 percent of aggregate total payments under OPPS, would be allocated to CMHCs for partial hospitalization program service outliers. In its March 2004 Report, MedPAC recommended that Congress should eliminate the outlier policy under the outpatient prospective payment system. While this would require a statutory change, many of the reasons cited by MedPAC for the elimination of the outlier policy are equally applicable to any reduction in the size of the percentage of total payments dedicated to outlier payments, including the following: the narrow definition of many of the services provided in hospital outpatient departments suggests that variability in costs should not be great; the distribution of outlier payments benefits some hospital groups more than others; the outlier policy is susceptible to ''gaming'' through charge inflation; and, the OPPS is the only ambulatory payment system with an outlier policy.

In order to ensure that estimated CY 2006 aggregate outlier payments would equal 1.0 percent of estimated aggregate total payments under OPPS, we are proposing that the outlier threshold be modified so that outlier payments are triggered when the cost of furnishing a service or procedure by a hospital exceeds 1.75 times the APC payment amount and exceeds the APC payment rate plus a $1,575 fixed dollar threshold. We choose to modify the fixed dollar threshold to target 1.0 percent of estimated aggregate total payment under OPPS and not modify the current 1.75 multiple to further our policy of targeting outlier payments to complex and expensive procedures with sufficient variability to pose a financial risk for hospitals. Modifying the multiple would do less to target outlier payments to complex and expensive procedures. For example, if we were to establish a multiple of 2.00 rather than 1.75, then an APC with a payment rate of $20,000 would see the outlier threshold associated with the multiple increase from $35,000 to $40,000. Raising the fixed dollar threshold to

$1,575 only increases the threshold for expensive procedures by $400. For this reason, we believe it is more appropriate to focus the modification necessary to target 1.0 percent of aggregate OPPS payments on the fixed dollar threshold and increase it from $1,175 in CY 2005 to our proposed $1,575 in CY 2006 and have the multiple threshold remain at 1.75.

For CY 2006, the outlier threshold for CMHCs is met when the cost of furnishing a service or procedure by a CMHC exceeds 3.45 times the APC payment rate. If a CMHC provider meets this condition, the outlier payment is calculated as 50 percent of the amount by which the cost exceeds 3.45 times the APC payment rate.

The following is an example of an outlier calculation for CY 2006 under our proposed policy. A hospital charges $26,000 for a procedure. The APC payment for the procedure is $3,000, including a rural adjustment, if applicable. Using the provider's cost-to-charge ratio of 0.30, the estimated cost to the hospital is $7,800. To determine whether this provider is eligible for outlier payments for this procedure, the provider must determine whether the cost for the service exceeds both the APC outlier cost threshold (1.75 × APC payment) and the fixed dollar threshold ($1,575 + APC payment). In this example, the provider meets both criteria:

(1) $7,800 exceeds $5,250 (1.75 × $3,000)

(2) $7,800 exceeds $4,575 ($1,575 + $3,000)

To calculate the outlier payment, which is 50 percent of the amount by which the cost of furnishing the service exceeds 1.75 times the APC rate, subtract $5,250 (1.75 × $3,000) from $7,800 (resulting in $2,550). The provider is eligible for 50 percent of the difference, in this case $1,275 ($2,550/2). The formula is (cost − (1.75 × APC payment rate))/2.

I. Calculation of the Proposed National Unadjusted Medicare Payment

(If you choose to comment on issues in this section, please include the caption ''Payment Rate for APCs'' at the beginning of your comment.)

The basic methodology for determining prospective payment rates for OPD services under the OPPS is set forth in existing regulations at § 419.31 and § 419.32. The payment rate for services and procedures for which payment is made under the OPPS is the product of the conversion factor calculated in accordance with section II.C. of this proposed rule, and the relative weight determined under section II.A. of this proposed rule. Therefore, the national unadjusted payment rate for APCs contained in Addendum A to this proposed rule and for payable HCPCS codes in Addendum B to this proposed rule (Addendum B is provided as a convenience for readers) was calculated by multiplying the proposed CY 2006 scaled weight for the APC by the proposed CY 2006 conversion factor.

However, to determine the payment that would be made in a calendar year under the OPPS to a specific hospital for an APC for a service other than a drug, in a circumstance in which the multiple procedure discount does not apply, we take the following steps:

Step 1. Calculate 60 percent (the labor-related portion) of the national unadjusted payment rate. Since initial implementation of the OPPS, we have used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. (Refer to the April 7, 2000 final rule with comment period (65 FR 18496 through 18497), for a detailed discussion of how we derived this percentage.)

Step 2. Determine the wage index area in which the hospital is located and identify the wage index level that applies to the specific hospital. The wage index values assigned to each area reflect the new geographic statistical areas as a result of revised OMB standards (urban and rural) to which hospitals would be assigned for FY 2006 under the IPPS, reclassifications through the Medicare Classification Geographic Review Board, section 1866(d)(8)(B) ''Lugar'' hospitals, and section 401 of Pub. L. 108–173, and the reclassifications of hospitals under the one-time appeals process under section 508 of Pub. L. 108–173. Assess whether the previous MSA-based wage index is higher than the CBSA-based wage index, and, if higher, apply a 50/50 blend. The wage index values include the occupational mix adjustment described in section II.D. of this proposed rule that was developed for the IPPS.

Step 3. Adjust the wage index of hospitals located in certain qualifying counties that have a relatively high percentage of hospital employees who reside in the county, but who work in a different county with a higher wage index, in accordance with section 505 of Pub. L. 108–173. Addendum K contains the qualifying counties and the proposed wage index increase developed for the IPPS. This step is to be followed only if the hospital has chosen not to accept reclassification under Step 2 above.

Step 4. Multiply the applicable wage index determined under Steps 2 and 3 by the amount determined under Step 1 that represents the labor-related portion of the national unadjusted payment rate.

Step 5. Calculate 40 percent (the nonlabor-related portion) of the national unadjusted payment rate and add that amount to the resulting product of Step 4. The result is the wage index adjusted payment rate for the relevant wage index area.

Step 6. If a provider is a sole community hospital, as defined in § 419.92, and located in a rural area, as defined in § 412.63(b) or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act, multiply the wage index adjusted payment rate by 1.066 to calculate the total payment.

J. Proposed Beneficiary Copayments for CY 2006

(If you choose to comment on issues in this section, please include the caption ''Beneficiary Copayment'' at the beginning of your comment.)

1. Background

Section 1833(t)(3)(B) of the Act requires the Secretary to set rules for determining copayment amounts to be paid by beneficiaries for covered OPD services. Section 1833(t)(8)(C)(ii) of the Act specifies that the Secretary must reduce the national unadjusted copayment amount for a covered OPD service (or group of such services) furnished in a year in a manner so that the effective copayment rate (determined on a national unadjusted basis) for that service in the year does not exceed specified percentages. For all services paid under the OPPS in CY 2006, and in calendar years thereafter, the specified percentage is 40 percent of the APC payment rate. Section 1833(t)(3)(B)(ii) of the Act provides that, for a covered OPD service (or group of such services) furnished in a year, the national unadjusted coinsurance amount cannot be less than 20 percent of the OPD fee schedule amount.

2. Proposed Copayment for CY 2006

For CY 2006, we are proposing to determine copayment amounts for new and revised APCs using the same methodology that we implemented for CY 2004 (see the November 7, 2003 OPPS final rule with comment period, 68 FR 63458). The proposed unadjusted copayment amounts for services payable under the OPPS that would be effective January 1, 2006, are shown in Addendum A and Addendum B of this proposed rule.

3. Calculation of the Proposed Unadjusted Copayment Amount for CY 2006

To calculate the unadjusted copayment amount for an APC group, take the following steps:

Step 1. Calculate the beneficiary payment percentage for the APC by dividing the APC's national unadjusted copayment by its payment rate. For example, using APC 0001, $9.95 is 40 percent of $24.89.

Step 2. Calculate the wage adjusted payment rate for the APC, for the provider in question, as indicated in section II.I. above.

Step 3. Multiply the percentage calculated in Step 1 by the payment rate calculated in Step 2. The result is the wage adjusted copayment amount for the APC.

III. Proposed Ambulatory Payment Classification (APC) Group Policies

A. Background

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered hospital outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups of services, so that services within each group are comparable clinically and with respect to the use of resources. In accordance with these provisions, we developed a grouping classification system, referred to as the Ambulatory Payment Classification Groups (or APCs), as set forth in § 419.31 of the regulations. We use Level I and Level II HCPCS codes and descriptors to identify and group the services within each APC. The APCs are organized such that each group is homogeneous both clinically and in terms of resource use. Using this classification system, we have established distinct groups of surgical, diagnostic, and partial hospitalization services, and medical visits. We also have developed separate APC groups for certain medical devices, drugs, biologicals, radiopharmaceuticals, and devices of brachytherapy.

We have packaged into each procedure or service within an APC group the cost associated with those items or services that are directly related and integral to performing a procedure or furnishing a service. Therefore, we do not make separate payment for packaged items or services. For example, packaged items and services include: use of an operating, treatment, or procedure room; use of a recovery room; use of an observation bed; anesthesia; medical/surgical supplies; pharmaceuticals (other than those for which separate payment may be allowed under the provisions discussed in section V. of this preamble); and incidental services such as venipuncture. Our packaging methodology is discussed in section II.A. of this proposed rule.

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

Section 1833(t)(9)(A) of the Act requires the Secretary to review the components of the OPPS not less than annually and to revise the groups and relative payment weights and make other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. Section 1833(t)(9)(A) of the Act, as amended by section 201(h) of the BBRA of 1999, also requires the Secretary, beginning in CY 2001, to consult with an outside panel of experts to review the APC groups and the relative payment weights (the APC Panel recommendations for CY 2006 OPPS and our responses to them are discussed in sections III.B. and III.C.4. of this preamble).

Finally, as discussed earlier, section 1833(t)(2) of the Act provides that, subject to certain exceptions, the items and services within an APC group cannot be considered comparable with respect to the use of resources if the highest median (or mean cost, if elected by the Secretary) for an item or service in the group is more than 2 times greater than the lowest median cost for an item or service within the same group (referred to as the ''2 times rule''). We use the median cost of the item or service in implementing this provision. The statute authorizes the Secretary to make exceptions to the 2 times rule in unusual cases, such as low-volume items and services.

B. Proposed Changes—Variations Within APCs

(If you choose to comment on issues in this section, please include the caption ''2 Times Rule'' at the beginning of your comment.)

1. Application of the 2 Times Rule

In accordance with section 1833(t)(2) of the Act and § 419.31 of the regulations, we annually review the items and services within an APC group to determine with respect to comparability of the use of resources if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group (''2 times rule''). We make exceptions to this limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. The statute provides no exception 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 because these drugs are assigned to individual APC's.

During the APC Panel's February 2005 meeting, we presented median cost and utilization data for the period of January 1, 2004, through September 30, 2004, concerning a number of APCs that violate the 2 times rule and asked the APC Panel for its recommendation. After carefully considering the information and data we presented, the APC Panel recommended moving a total of 65 HCPCS codes from their currently assigned APC to a different APC to resolve the 2 times rule violations. Of the 65 HCPCS code reassignments recommended by the APC Panel, we concur with 58 of the recommended reassignments. Therefore, we are proposing to reassign these HCPCS codes as shown in Table 7.

TABLE 7.—PROPOSED MOVEMENT OF HCPCS CODES AMONG APCS BASED ON THE APC PANEL'S RECOMMENDATIONS FOR CY 2006

HCPCS code	Description	CY 2005 APC	Proposed CY 2006 APC
45307	Proctosigmoidoscopy fb	0146	0428
45320	Proctosigmoidoscopy ablate	0147	0428
45321	Proctosigmoidoscopy volvul	0147	0428

TABLE 7.—PROPOSED MOVEMENT OF HCPCS CODES AMONG APCS BASED ON THE APC PANEL'S RECOMMENDATIONS FOR CY 2006—Continued

HCPCS code	Description	CY 2005 APC	Proposed CY 2006 APC
45335	Sigmoidoscopy w/submuc inj	0147	0146
45337	Sigmoidoscopy & decompress	0147	0146
46606	Anoscopy and biopsy	0147	0146
46610	Anoscopy, remove lesion	0147	0428
46612	Anoscopy, remove lesions	0147	0428
46614	Anoscopy, control bleeding	0147	0146
46615	Anoscopy	0147	0428
56405	I & D of vulva/perineum	0192	0189
57155	Insert uteri tandems/ovoids	0193	0192
65265	Remove foreign body from eye	0236	0237
65285	Repair of eye wound	0236	0672
66220	Repair eye lesion	0236	0672
67025	Replace eye fluid	0236	0237
67027	Implant eye drug system	0237	0672
67036	Removal of inner eye fluid	0237	0672
67038	Strip retinal membrane	0237	0672
67039	Laser treatment of retina	0237	0672
67121	Remove eye implant material	0236	0237
75790	Visualize A-V shunt	0281	0279
75820	Vein x-ray, arm/leg	0281	0668
75822	Vein x-ray, arms/legs	0281	0668
75831	Vein x-ray, kidney	0287	0279
75840	Vein x-ray, adrenal gland	0287	0280
75842	Vein x-ray, adrenal glands	0287	0280
75860	Vein x-ray, neck	0287	0668
75870	Vein x-ray, skull	0287	0668
75872	Vein x-ray, skull	0287	0279
75880	Vein x-ray, eye socket	0287	0668
86077	Physician blood bank service	0343	0433
86079	Physician blood bank service	0343	0433
88104	Cytopathology, fluids	0343	0433
88107	Cytopathology, fluids	0343	0433
88160	Cytopath smear, other source	0342	0433
88161	Cytopath smear, other source	0343	0433
88162	Cytopath smear, other source	0342	0433
88184	Flowcytometry/tc, 1 marker	0342	0344
88185	Flowcytometry/tc, add-on	0342	0343
88187	Flowcytometry/read, 2–8	0342	0433
88188	Flowcytometry/read, 9–15	0342	0433
88189	Flowcytometry/read, 16 & >	0344	0343
88312	Special stains	0342	0433
88313	Special stains	0342	0433
88318	Chemical histochemistry	0342	0433
88323	Microslide consultation	0344	0343
88329	Path consult introp	0342	0433
88332	Path consult intraop, add'l	0342	0433
88342	Immunohistochemistry	0344	0343
88346	Immunofluorescent study	0344	0343
88347	Immunofluorescent study	0344	0343
88355	Analysis, skeletal muscle	0344	0343
89230	Collect sweat for test	0343	0433
92004	Eye exam, new patient	0602	0601
92014	Eye exam & treatment	0602	0601

The seven HCPCS code movements that the APC Panel recommended, but upon further review we are proposing not to accept, are discussed below. We include in our discussion our proposal specific to each of them to resolve the 2 times rule violations.

a. APC 0146: Level I Sigmoidoscopy, APC 0147: Level II Sigmoidoscopy, APC 0428: Level III Sigmoidoscopy.

APCs 0146 and 0147 were exceptions to the 2 times rule in CY 2005. Our analysis of these two APCs based on the most current CY 2004 data revealed greater violations of the 2 times rule and changing relative frequencies of simple and complex procedures in these two APCs. Thus, for CY 2006, the APC Panel assisted us in reconfiguring these two APCs into three related APCs to resolve the two times violations and improve their clinical and resource homogeneity based on the most current hospital claims data and to remove these APCs from the list of exceptions. The APC Panel recommended moving CPT codes 45303 (Proctosigmoidoscopy dilate) and 45305 (Proctosigmoidoscopy w/bx) from APC 0147 to APC 0146 because the median cost for these codes appeared too high, and was likely based primarily on aberrant CY 2004 claims. In addition, the APC Panel recommended that CMS move CPT code 45309 (Proctosigmoidoscopy removal) from APC 0147 to a new proposed APC 0428.

Based on the results of our review of several years of claims data and our study of hospital resource homogeneity, we disagree that these claims data are aberrant. We are proposing to move CPT codes 45303 and 45305 to APC 0147 and to keep CPT 45309 in APC 0147, to resolve the 2 times rule violation.

b. APC 0342: Level I Pathology, APC 0433: Level II Pathology, APC 0343: Level III Pathology.

To resolve a 2 times rule violation, the APC Panel recommended moving CPT codes 88108 (Cytopath, concentrate tech) and 88112 (Cytopath, cell enhance tech) from APC 0343 to a proposed new APC 0433. The APC Panel also recommended moving CPT codes 88319 (Enzyme histochemistry) and 88321 (Microslide consultation) from APC 0342 to a proposed new APC 0433. Based on the results of our review of several years of claims data and the study of hospital resource homogeneity, we are proposing a different way to resolve the 2 times rule violation: We are proposing to place CPT codes 88319 and 88112 in APC 0343 and to place CPT codes 88108 and 88321 in APC 0433.

2. Proposed Exceptions to the 2 Times Rule

As discussed earlier, we may make exceptions to the 2 times limit on the variation of costs within each APC group in unusual cases such as low-volume items and services. Taking into account the APC changes that we are proposing for CY 2006 based on the APC Panel recommendations discussed in section III.B.1. of this preamble and the use of CY 2004 claims data to calculate the median cost of procedures classified in the APCs, we reviewed all the APCs to determine which APCs would not meet the 2 times limit. We used the following criteria to decide whether to propose exceptions to the 2 times rule for affected APCs:

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

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

Table 8 below contains the APCs that we are proposing to exempt from the 2 times rule based on the criteria cited above. In cases in which a recommendation of the APC Panel appeared to result in or allow a violation of the 2 times rule, we generally accepted the APC Panel's recommendation because these recommendations were based on explicit consideration of resource use, clinical homogeneity, hospital specialization, and the quality of the data used to determine the APC payment rates that we are proposing for CY 2006. The median cost for hospital outpatient services for these and all other APCs can be found on the CMS Web site: *http//www.cms.hhs.gov.*

TABLE 8.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2006

APC	APC description
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow.
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow.
0019	Level I Excision/ Biopsy.
0024	Level I Skin Repair.
0040	Level I Implantation of Neurostimulator Electrodes.
0043	Closed Treatment Fracture Finger/Toe/Trunk.
0046	Open/Percutaneous Treatment Fracture or Dislocation.
0060	Manipulation Therapy.
0080	Diagnostic Cardiac Catheterization.
0081	Non-Coronary Angioplasty or Atherectomy.
0093	Vascular Reconstruction/Fistula Repair without Device.
0099	Electrocardiograms.
0105	Revision/Removal of Pacemakers, AICD, or Vascular.
0120	Infusion Therapy Except Chemotherapy.
0140	Esophageal Dilation without Endoscopy.
0141	Level I Upper GI Procedures.
0148	Level I Anal/Rectal Procedures.
0164	Level I Urinary and Anal Procedures.
0191	Level I Female Reproductive Proc.
0204	Level I Nerve Injections.
0209	Extended EEG Studies and Sleep Studies, Level II.
0235	Level I Posterior Segment Eye Procedures.
0251	Level I ENT Procedures.
0252	Level II ENT Procedures.
0262	Plain Film of Teeth.
0274	Myelography.
0297	Level II Therapeutic Radiologic Procedures.
0303	Treatment Device Construction.
0312	Radioelement Applications.
0325	Group Psychotherapy.
0330	Dental Procedures.
0341	Skin Tests.
0353	Level II Injections.
0373	Neuropsychological Testing.
0397	Vascular Imaging.
0409	Red Blood Cell Tests.
0432	Health and Behavior Services.
0600	Low Level Clinic Visits.
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.
0004	Level I Needle Biopsy/ Aspiration Except Bone Marrow.
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow.

TABLE 8.—PROPOSED APC EXCEPTIONS TO THE 2 TIMES RULE FOR CY 2006—Continued

APC	APC description
0019	Level I Excision/ Biopsy.

C. New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''New Technology APCs'' at the beginning of your comment.)

1. Background

In the November 30, 2001 final rule (66 FR 59903), we finalized changes to the time period a service was eligible for payment under a New Technology APC. Beginning in CY 2002, we retain services within New Technology APC groups until we gather sufficient claims data to enable 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. 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.

2. Proposed Refinement of New Technology Cost Bands

In the November 7, 2003 final rule with comment period, we last restructured the New Technology APC groups to make the cost intervals more consistent across payment levels (68 FR 63416). We established payment levels in $50, $100, and $500 intervals and expanded the number of New Technology APCs. We also retained two parallel sets of New Technology APCs, one set with a status indicator of ''S'' (Significant Procedure, Not Discounted When Multiple) and the other set with a status indicator of ''T'' (Significant Procedures, Multiple Reduction Applies). We did this restructuring because the number of procedures assigned to New Technology APCs had increased, and narrower cost bands were necessary to avoid significant payment inaccuracies for New Technology services. Therefore, we dedicated two new series of APCs to the restructured New Technology APCs, which allowed us to narrow the cost bands and afforded us the flexibility to create additional bands as future needs dictated.

As the number of procedures that qualify for placement in the New Technology APCs has continued to increase over the past 2 years, the $0 to $50 cost band represented by ''S'' status APC 1501 (New Technology, Level I, $0-$50) and ''T'' status APC 1538 (New Technology, Level I, $0-$50) spans too broad of a cost interval to accurately represent the lower costs of an ever-increasing number of procedures that qualify for New Technology payment. Therefore, we are proposing to refine this cost band to five $10 increments, resulting in the creation of an additional 10 New Technology APCs to accommodate the two parallel sets of New Technology APCs, one set with a status indicator of ''S'' and the other set with a status indicator of ''T.'' We are also proposing to eliminate the two $0 to $50 cost band New Technology APCs 1501 and 1538, so that the cost bands of all New Technology APCs would continue to be mutually exclusive. Table 9 contains a listing of the 10 additional New Technology APCs that we are proposing for CY 2006.

TABLE 9.—PROPOSED NEW TECHNOLOGY APCS FOR CY 2006

APC	Descriptor	Status indicator	Proposed CY 2006 payment rate
1491	New Technology—Level IA ($0–$10)	S	$5
1492	New Technology—Level IB ($10–$20)	S	15
1493	New Technology—Level IC ($20–$30)	S	25
1494	New Technology—Level ID ($30–$40)	S	35
1495	New Technology—Level IE ($40–$50)	S	45
1496	New Technology—Level IA ($0–$10)	T	5
1497	New Technology—Level B ($10–$20)	T	15
1498	New Technology—Level IC ($20–$30)	T	25
1499	New Technology—Level D ($30–$40)	T	35
1500	New Technology—Level E ($40–$50)	T	45

As we explained in the November 30, 2001 final rule (66 FR 59897), we generally keep a procedure in the New Technology APC to which it is initially assigned until we have collected data sufficient to enable us to move the procedure to a clinically appropriate APC. However, in cases where we find that our original New Technology APC assignment was based on inaccurate or inadequate information, or where the New Technology APCs are restructured, we may, based on more recent resource utilization information (including claims data) or the availability of refined New Technology APC bands, reassign the procedure or service to a different New Technology APC that most appropriately reflects its cost. Therefore, we are proposing to discontinue New Technology APCs 1501 and 1538, and reassign the procedures currently assigned to them to proposed New Technology APCs 1491 through 1500. Table 10 summarizes these proposed New Technology APC reassignments.

TABLE 10.—PROPOSED MOVEMENT OF HCPCS CODES FROM NEW TECHNOLOGY APCS 1501 AND 1538 TO NEW TECHNOLOGY APCS 1491 THROUGH 1500 FOR CY 2006

HCPCS/CPT code	Descriptor	CY 2005 new technology APC assignment	CY 2006 proposed new technology APC reassignment
0003T	Cervicography	1501	1492
90473	Immunization Admin, one vaccine by intranasal or oral	N/A	1491
90474	Immunization Admin, each additional vaccine by intranasal or oral	N/A	1491
G0375	Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes.	1501	1491
G0376	Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes	1501	1492

3. Proposed Requirements for Assigning Services to New Technology APCs

In the April 7, 2000 final rule (65 FR 18477), we created a set of New Technology APCs to pay for certain new technology services under the OPPS. We described a group of criteria for use in determining whether a service is eligible for assignment to a New Technology APC. We subsequently modified this set of criteria in our November 30, 2001 final rule (66 FR 59897 to 59901), effective January 1, 2002. These modifications were based on changes in the data (we were no longer required to use 1996 data to set payment rates) and on our continuing experience with the assignment of services to New Technology APCs.

Based on our history of reviewing applications for New Technology APC assignments under the OPPS, we have encountered situations where there is extremely limited clinical experience with new technology services regarding their use and efficacy in the typical Medicare population. In some cases, there may be ambiguity regarding how the new technology services fit within the standard coding framework for established procedures, and there may be no specific coding available for the new technology services in other settings or for use by other payers. Nevertheless, applicants requesting assignment of services to New Technology APCs request that we provide billing and payment mechanisms under the OPPS for the new technology services through the establishment of codes, descriptors, and payment rates. As stated in section I.F. of this preamble, we remain committed to the overarching goal of ensuring that Medicare beneficiaries have timely access to the most effective new medical treatments and technologies in clinically appropriate settings. We believe that our current New Technology APC assignment process helps to assure such access, and that an enhancement to the New Technology service application process may further encourage appropriate dissemination of and Medicare beneficiary access to new technology services.

We are interested in promoting review of the coding, clinical use, and efficacy of new technology services by the greater medical community through our New Technology service application and review process for the OPPS. Therefore, in addition to our current information requirements at the time of application, we are proposing to require that an application for a code for a new technology service be submitted to the American Medical Association's (AMA's) CPT Editorial Panel before we accept a New Technology APC application for review. This will not change our current criteria for assignment of a service to a New Technology APC. This requirement will encourage timely review by the wider medical community as CMS is reviewing the service for possible new coding and assignment to a New Technology APC under the OPPS. There is only one CPT code application that is used by applicants requesting consideration for either Category I or III codes. We would accept either a Category I or Category III code application to the CPT Editorial Panel. The application requests relevant clinical information regarding new services, including their appropriate use and the patient populations expected to benefit from the services which will provide us with useful additional information. CPT code applications are reviewed by the CPT Editorial Panel, whose members bring diverse clinical expertise to that review. We believe that consideration by the CPT Editorial Panel may facilitate appropriate dissemination of the new technology services across delivery settings and may bring to light other needed coding changes or clarifications. We are further proposing that a copy of the submitted CPT application be filed with us as part of the application for a New Technology APC assignment under the OPPS, along with CPT's letter acknowledging or accepting the coding application. We remind the public that we do not consider an application complete until all informational requirements are provided. In addition, we remind the public that when we assign a new service a HCPCS code and provide for payment under the OPPS, these actions do not imply coverage by the Medicare program, but indicate only how the procedure or service may be paid if covered by the program. Fiscal intermediaries must determine whether a service meets all program requirements for coverage, for example, that it is reasonable and necessary to treat the beneficiary's condition and whether it is excluded from payment. CMS may also make National Coverage Determinations (NCDs) on new technology procedures.

4. Proposed Movement of Procedures From New Technology APCs to Clinical APCs

The procedures discussed below represent New Technology services for which we believe we have sufficient data to reassign to a clinically appropriate APC.

a. Proton Beam Therapy

(If you choose to comment on issues in this section, please include the caption ''Proton Beam Therapy'' at the beginning of your comment.)

In the August 16, 2004 proposed rule (69 FR 50467), we proposed to reassign CPT codes 77523 (Proton treatment delivery, intermediate) and 77525 (Proton treatment delivery, complex) from New Technology APC 1511 (New Technology, Level XI, $900-$1,000) to clinical APC 0419 (Proton Beam Therapy, Level II). In response to this proposal, we received numerous comments urging that we maintain CPT codes 77523 and 77525 in New Technology APC 1511 at a payment rate of $950 for CY 2005, arguing that the proposed payment rate of $678.31 for

CY 2005 would halt diffusion of this technology and negatively impact patient access to this cancer treatment. Commenters explained that the low volume of claims submitted by only two facilities provided volatile and insufficient data for movement into the proposed clinical APC 0419. They further explained that the extraordinary capital expense of between $70 and $125 million and high operating costs of a proton beam facility necessitate adequate payment for this service to protect the financial viability of this emerging technology.

In the November 15, 2004 final rule with comment period (69 FR 65719 through 65720), we considered the concerns expressed by numerous commenters that patient access to proton beam therapy might be impeded by a significant reduction in OPPS payment. Therefore, we set the CY 2005 payment rate for CPT codes 77523 and 77525 by calculating a 50/50 blend of the median cost for intermediate and complex proton beam therapies of $690.45 derived from CY 2003 claims and the CY 2004 New Technology payment rate of $950. We used the result of this calculation ($820) to assign intermediate and complex proton beam therapies (CPT codes 77523 and 77525) to New Technology APC 1510 (New Technology—Level X ($800-$900) for a blended payment rate of $850 for CY 2005.

Our examination of the CY 2004 claims data has revealed a second year of a stable, albeit modest, number of claims on which to set the CY 2006 payment rates for CPT codes 77523 and 77525. However, unlike the median of $690.45 for the CY 2005 Level II proton beam radiation therapy clinical APC containing CPT codes 77523 and 77525 derived from the CY 2003 claims data, the median for a comparable Level II proton beam radiation therapy clinical APC is $934.46 derived from CY 2004 claims data. This more recent median appears to more accurately reflect the significant capital expense and high operating costs of a proton beam therapy facility, and supports patient access to proton beam therapy. Therefore, we are proposing to move CPT codes 77523 and 77525 from New Technology APC 1510 to clinical APC 0667 (Level II Proton Beam Radiation Therapy) based on a median cost of $934.46 for CY 2006.

b. Stereotactic Radiosurgery

(If you choose to comment on issues in this section, please include the caption ''Stereotactic Radiosurgery'' at the beginning of your comment.)

In a correction to the November 7, 2003 final rule with comment period, issued on December 31, 2003 (68 FR 75442), we considered a commenter's request to combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code in order to capture the costs of this treatment in single procedure claims because the majority of patients receive the planning and delivery of this treatment on the same day. We responded to the commenter's request by explaining that several other commenters stated that HCPCS code G0242 was being misused to code for the planning phase of linear accelerator-based stereotactic radiosurgery planning. Because the claims data for HCPCS code G0242 represented costs for linear accelerator-based stereotactic radiosurgery planning (due to misuse of the code), in addition to Cobalt 60-based stereotactic radiosurgery planning, we were uncertain of how to combine these data with HCPCS code G0243 to determine an accurate payment rate for a combined code for planning and delivery of Cobalt 60-based stereotactic radiosurgery.

In consideration of the misuse of HCPCS code G0242 and the potential for causing greater confusion by combining HCPCS codes G0242 and G0243 into a single procedure code, for CY 2004 we created a planning code for linear accelerator-based stereotactic radiosurgery (HCPCS code G0338) to distinguish this service from Cobalt 60-based stereotactic radiosurgery planning. We maintained both HCPCS codes G0242 and G0243 for the planning and delivery of Cobalt 60-based stereotactic radiosurgery, consistent with the use of the two G-codes for planning (HCPCS code G0338) and delivery (HCPCS codes G0173, G0251, G0339, G0340, as applicable) of each type of linear accelerator-based stereotactic radiosurgery (SRS). We indicated that we intended to maintain these new codes in their current New Technology APCs until we had sufficient hospital claims data reflecting the costs of the services to consider moving them to clinical APCs.

During the February 2005 APC Panel meeting, the APC Panel discussed the clinical and resource cost similarities between planning for Cobalt 60-based and linear accelerator-based SRS. The APC Panel also discussed the use of CPT codes instead of specific G-codes to describe the services involved in SRS planning, noting the clinical similarities in radiation treatment planning regardless of the mode of treatment delivery. Acknowledging the possible need for CMS to separately track planning for SRS, the APC Panel eventually recommended that we create a single HCPCS code to encompass both Cobalt 60-based and linear accelerator-based SRS planning. However, a hospital association and other presenters at the APC Panel meeting urged that we discontinue the use of G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. Lastly, one presenter urged that we combine HCPCS codes G0242 (Cobalt 60-based stereotactic radiosurgery planning) and G0243 (Cobalt 60-based stereotactic radiosurgery delivery) into a single procedure code to reflect that the majority of patients receive the planning and delivery of this treatment on the same day as a single fully integrated service.

The APC Panel recommended that we make no changes to the coding or APC placement of SRS delivery codes G0173, G0243, G0251, G0339, and G0340 for CY 2006. We first established the above full group of delivery codes in 2004, so we have only one year of hospital claims data reflecting costs of the services. In addition, presenters to the APC Panel described current ongoing deliberations amongst interested professional societies around the descriptions and coding for SRS. The APC Panel and presenters suggested that we wait for the outcome of these deliberations prior to making any significant changes to SRS delivery coding or payment rates.

In an effort to balance the recommendations of the APC Panel with the recommendations of presenters at the APC Panel meeting, in accordance with the APC Panel recommendations, we are proposing to make no changes to the APC placement of the following SRS treatment delivery codes for CY 2006: HCPCS codes G0173, G0243, G0251, G0339, and G0340.

We recognize concerns expressed by some presenters urging that we discontinue the use of the G-codes for SRS planning, and instead, recognize the current CPT codes that describe the specific component services involved in SRS planning to reduce the burden on hospitals of maintaining duplicative codes for the same services to accommodate different payers. In addition, we have no need to separately track SRS planning services, which share clinical and resource homogeneity with other radiation treatment planning

services described by current CPT codes.

When HCPCS code G0242 was established for SRS planning, several radiology planning services were considered in determining its APC placement. In the November 30, 2001 final rule, in which we described our determination of the total cost for SRS planning based on our claims experience, we added the median costs of the following CPT codes that we found to be regularly billed with SRS delivery (CPT code 61793 in the available hospital data): 77295, 77300, 77370, and 77315. Our examination of the costs from the CY 2004 claims data for the above-mentioned CPT codes closely approximates the CY 2004 median costs reported for HCPCS codes G0242 and G0338. The APC median costs for the above-mentioned CPT codes based on the CY 2004 claims data total $1,297, while the median cost for HCPCS code G0242 is $1,366 and the median cost for HCPCS code G0338 is $1,100 based on the CY 2004 claims data. In addition, three of the above-mentioned CPT codes are included on the proposed bypass list for CY 2006, so we would not anticipate that the billing of these codes on the same day as an SRS treatment service would cause significant problems with multiple bills for SRS services. Therefore, we are proposing to discontinue HCPCS codes G0242 and G0338 for the reporting of charges for SRS planning under the OPPS, and to instruct hospitals to bill charges for SRS planning using all of the available CPT codes that most accurately reflect the services provided.

We acknowledge one APC Panel presenter's concern that the coding structure of Cobalt 60-based SRS, using either the current SRS planning G code or the appropriate CPT codes for planning services as we are proposing for CY 2006, may not necessarily reflect the same day, integrated Cobalt 60-based SRS service furnished to the majority of patients receiving Cobalt 60-based SRS. Thus, we are seeking public comment on the clinical, administrative, or other concerns that could arise if we were to bundle Cobalt 60-based SRS planning services, currently reported using HCPCS code G0242 and proposed for CY 2006 to be billed using the appropriate CPT codes for planning services, into the Cobalt 60-based SRS treatment service, currently reported under the OPPS using HCPCS code G0243. Under such a scenario, the SRS treatment service described by HCPCS code G0243 would be placed in a higher paying New Technology APC to reflect payment for the costs of the SRS planning and delivery as an integrated service. Hospitals would be prohibited from billing other radiation planning services along with the Cobalt 60-based SRS treatment delivery code. In contrast to Cobalt 60-based SRS coding, we would not consider bundling the planning for linear accelerator-based SRS with the treatment delivery services, given the various timeframes for planning that may occur with linear accelerator-based SRS.

c. Other Services in New Technology APCs

(If you choose to comment on issues in this section, please include the caption ''Other New Technology Services'' at the beginning of your comment.)

Other than proton beam and stereotactic radiosurgery services, there are 10 procedures currently assigned to New Technology APCs for which we have data adequate to support their assignment to clinical APCs. We are proposing to reassign these procedures to clinically appropriate APCs, using CY 2004 claims data to establish median costs on which payments would be based. These procedures and their proposed APC assignments are displayed below in Table 11.

TABLE 11.—PROPOSED APC REASSIGNMENT OF NEW TECHNOLOGY PROCEDURES INTO CLINICAL APCS FOR CY 2006

HCPCS	Descriptor	CY 2005 APC	CY 2005 status indicator	Proposed CY 2006 APC	Proposed CY 2006 status indicator	CY 2005 payment amount	Proposed CY 2006 payment amount
0027T	Endoscopic epidural lysis	1547	T	0220	T	$850	$1,025.57
33225	L ventric pacing lead add-on	1525	S	0418	T	3,750	6,457.83
61623	Endovasc tempory vessel occl	1555	T	0081	T	1,650	2,035.19
92974	Cath place, cardio brachytx	1559	T	0103	T	2,250	869.34
93580	Transcath closure of asd	1559	T	0434	T	2,250	5,363.85
93581	Transcath closure of vsd	1559	T	0434	T	2,250	5,363.85
95965	Meg, spontaneous	1528	S	0430	T	5,250	673.76
95966	Meg, evoked, single	1516	S	0430	T	1,450	673.76
95967	Meg, evoked, each add'l	1511	S	0430	T	950	673.76
C9713	Non-contact laser vap prosta	1525	S	0429	T	3,750	2,500.01

We are proposing to move these 10 procedures to new or established clinical APCs that contain services that exhibit clinical and resource homogeneity. HCPCS code C9713 (Noncontact laser vaporization of prostate, including coagulation control of intraoperative and post-operative bleeding) is similar to CPT code 52647 (Noncontact laser coagulation of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)) and CPT code 52648 (Contact laser vaporization with or without transurethral resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)) with respect to their clinical characteristics and hospital resource utilization. However, instead of mapping HCPCS code C9713 to APC 163 (Level IV Cystourethroscopy and other Genitourinary Procedures), where CPT codes 52647 and 52648 are currently mapped for CY 2005, we are proposing to create a Level V APC for Cystourethroscopy and Other Genitourinary Procedures. These codes are more clinically sound in this new Level V APC. We are also proposing to map CPT codes 52647 and 52648 to this new Level V APC. In addition, we are proposing to move CPT codes 50080 and 50081 from APC 0163 to this new Level V APC, since they are similar clinically and use similar hospital resources. We believe that this configuration would improve homogeneity as well as result in a

clinically coherent Level V APC, where the procedures utilize similar hospital resources.

D. Proposed APC-Specific Policies

1. Hyperbaric Oxygen Therapy (APC 0659)

(If you choose to comment on issues in this section, please include the caption ''Hyperbaric Oxygen'' at the beginning of your comment.)

When hyperbaric oxygen therapy (HBOT) is prescribed for promoting the healing of chronic wounds, it typically is prescribed on average for 90 minutes, which would be billed using multiple units of HBOT to achieve full body hyperbaric oxygen therapy. In addition to the therapeutic time spent at full hyperbaric oxygen pressure, treatment involves additional time for achieving full pressure (descent), providing air breaks to prevent neurological and other complications from occurring during the course of treatment, and returning the patient to atmospheric pressure (ascent). The OPPS recognizes HCPCS code C1300 (Hyperbaric oxygen under pressure, full body chamber, per 30 minute interval) for HBOT provided in the hospital outpatient setting.

We explained in the August 16, 2004 proposed rule (69 FR 50495) that our CY 2003 claims data revealed that many providers were improperly reporting charges for 90 to 120 minutes under only one unit rather than three or four units of HBOT. This inaccurate coding resulted in an inflated median cost of $177.96 for HBOT, derived using single service claims and ''pseudo'' single service claims. Because of these single claims coding anomalies, we proposed to calculate a ''per unit'' median cost for APC 0659, using only multiple units or multiple occurrences of HBOT, excluding claims with only one unit of HBOT and excluding packaged costs. To convert HBOT charges to costs, we used the CCR from the respiratory therapy cost center when available; otherwise, we used the hospital's overall CCR. Using this ''per unit'' methodology, we proposed a median cost for APC 0659 of $82.91 for CY 2005.

In the November 15, 2004 final rule with comment period (69 FR 65758), we agreed with commenters that there was sufficient evidence that the CCR for HBOT was not reflected solely in the respiratory therapy cost center; rather, the CCR for HBOT was reflected in a variety of cost centers. Therefore, we calculated a ''per unit'' median of $93.26 for HBOT, using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR.

Our examination of the CY 2004 single procedure claims filed for HCPCS code C1300 revealed similar coding anomalies to those encountered in the CY 2003 single procedure claims data. Therefore, for CY 2006 ratesetting, we recalculated a ''per unit'' median cost for HCPCS code C1300 using only multiple units or multiple occurrences of HBOT and each hospital's overall CCR, which is the same methodology we used for setting the CY 2005 payment rate for HBOT. Excluding claims with only one unit of HBOT, we used a total of 26,556 claims to calculate the median for APC 0659 for CY 2006. Applying the methodology described above, we are proposing a median cost for APC 0659 of $93.71 for CY 2006.

2. Allergy Testing (APC 0370)

(If you choose to comment on issues in this section, please include the caption ''Allergy Testing'' at the beginning of your comment.)

A number of providers have expressed confusion related to the reporting of units for allergy testing described by CPT codes 95004 through 95078. Most of the CPT codes in the code range are assigned to APC 0370 (Allergy Tests) for the CY 2005 OPPS. Nine of these CPT codes assigned to APC 0370 instruct providers to specify the number of tests or use the singular word ''test'' in their descriptors, while five of these CPT codes assigned to APC 0370 do not contain such an instruction or do not contain ''tests'' or ''testing'' in their descriptors. Some providers have stated that the lack of clarity related to the reporting of units has resulted in erroneous reporting of charges for multiple allergy tests under one unit (that is, ''per visit'') for the CPT codes that instruct providers to specify the number of tests.

In light of the variable hospital billing that may be inconsistent with the CPT code descriptors, we have examined carefully the CY 2004 single and multiple procedure claims data for the allergy test codes that reside in APC 0370 to set the CY 2006 payment rates. Our examination of the CY 2004 claims data revealed that many of the services for which providers billed multiple units of an allergy test reported a consistent charge for each unit. Conversely, some providers that billed only a single unit of an allergy test reported a charge many times greater than the ''per test'' charge reported by providers billing multiple units of an allergy test.

Our analysis of the claims data appears to validate reports made by a number of providers that the charges reported on many of the single procedure claims represent a ''per visit'' charge, rather than a ''per test'' charge, including claims for the allergy test codes that instruct providers to specify the number of tests. Because the OPPS relies only on these single procedure claims in establishing payment rates, we believe this inaccurate coding would have resulted in an inflated CY 2006 median cost of $66.44 for services that are in the CY 2005 configuration of APC 0370.

Therefore, we are proposing to move the allergy test CPT codes that instruct providers to specify the number of tests or use the singular word ''test'' in their descriptors from APC 0370 (Allergy Tests) to proposed APC 0381 (Single Allergy Tests) for CY 2006. We are proposing to calculate a ''per unit'' median cost for proposed APC 0381 using a total of 306 claims containing multiple units or multiple occurrences of a single CPT code. Packaging on the claims was allocated equally to each unit of the CPT code. Using this ''per unit'' methodology, we are proposing a median cost for APC 0381 of $11.37 for CY 2006. Because we believe the single procedure claims for the codes remaining in APC 0370 reflect accurate coding of these services, we are proposing to use the standard OPPS methodology to calculate the median for APC 0370. Table 12 below lists the proposed assignment of CPT codes to APC 0370 and proposed APC 0381 for CY 2006.

TABLE 12.—PROPOSED ASSIGNMENT OF CPT CODES TO APC 0370 AND PROPOSED APC 0381 FOR CY 2006

APC 0370	Proposed APC 0381
95056, Photosensitivity tests	95004, Percut allergy skin tests.
95060, Eye allergy tests	95010, Percut allergy titrate test.
95078, Provoactive testing	95015, Id allergy titrate-drug/bug.
95180, Rapid desensitization	95024, Id allergy test, drug/bug.
95199U, Unlisted allergy/clinical immunologic service or procedure	95027, Id allergy titrate-airborne.
	95028, Id allergy test-delayed type.

TABLE 12.—PROPOSED ASSIGNMENT OF CPT CODES TO APC 0370 AND PROPOSED APC 0381 FOR CY 2006—Continued

APC 0370	Proposed APC 0381
	95044, Allergy patch tests. 95052, Photo patch test. 95065, Nose allergy test.

3. Stretta Procedure (APC 0322)

(If you choose to comment on issues in this section, please include the caption ''Stretta'' at the beginning of your comment.)

CPT code 43257, effective January 1, 2005, is used for esophagoscopy with delivery of thermal energy to the muscle of the lower esophageal sphincter and/or gastric cardia for the treatment of gastresophageal reflux disease. This code describes the Stretta procedure, including use of the Stretta System and all endoscopies associated with the Stretta procedure. Prior to CY 2005, the Stretta procedure was recognized under HCPCS code C9701 in the OPPS. For the CY 2005 OPPS, C9701 was deleted and CPT code 43257 was utilized for the Stretta procedure. In CY 2005, the Stretta procedure was transitioned from a New Technology APC to clinical APC 0422 (Level II Upper GI Procedures) based on several years of hospital cost data. Procedures within APC 0422 were similar to the Stretta procedure in terms of clinical characteristics and resource use.

For CY 2006, we are proposing to use both CY 2004 single claims for C9701 and multiple procedure claims containing one unit of HCPCS code C9701 and one unit of either CPT code 43234 or CPT code 43235 to calculate the Stretta procedure's contribution to the median for APC 0422. Claims reporting one endoscopy code (43234 or 43235) along with HCPCS code C9701 are included in the proposed median calculation because, in CY 2002, CMS authorized the separate and additional billing of a single endoscopy code with HCPCS code C9701, while CPT code 43257 now includes all endoscopies performed during the procedure.

Using this proposed methodology, we calculated a median for CPT code 43257 (HCPCS code C9701 in the CY 2004 claims data) of $1669.43. Using these claims in the calculation of the median cost for APC 0422, we calculated a median cost of $1385.77. We are proposing to use this methodology, applied to the more complete final rule claims set, to calculate the final CY 2006 OPPS median cost for APC 0422.

4. Vascular Access Procedures (APCs 0032, 0109, 0115, 0119, 0124, and 0187)

(If you choose to comment on issues in this section, please include the caption ''Vascular Access Procedures'' at the beginning of your comment.)

Many of the codes that currently describe vascular access procedures were new in the 2004 version of CPT and were assigned into APC groups by crosswalking the newly created CPT codes to the deleted codes' APC assignments. Although the new codes were implemented in January 2004, because of the delay between a bill being submitted to Medicare and when the bill data are viable for analysis, we did not have cost and utilization data for the new codes available for analysis until this year in preparation for the CY 2006 OPPS.

Since those original APC assignments were made, we have received requests from the public for specific APC assignment changes. We were reluctant to make changes without data to support reassignments and, therefore, made few changes to those original APC assignments.

As an outcome of an analysis of procedure-specific median costs and 2 times rule violations in preparation for the CY 2006 update of the OPPS, we developed a new APC configuration for vascular access procedure codes and several other related codes. The proposed new assignments are supported by CY 2004 hospital claims data and are based on median cost and clinical considerations.

Thus, for CY 2006, we are proposing to reassign many of the CPT codes that are currently in the following APCs:

- APC 0032 (Insertion of Central Venous/Arterial Catheter).
- APC 0109 (Removal of Implanted Devices).
- APC 0115 (Cannula/Access Device Procedures).
- APC 0119 (Implantation of Infusion Pump).
- APC 0124 (Revision of Implanted Infusion Pump).
- APC 0187 (Miscellaneous Placement/Repositioning).

The configuration that we are proposing places all of the procedures currently assigned to APC 0187 into more clinically appropriate APCs. We are also proposing to reassign all of the vascular access procedure codes currently assigned to any of the identified APCs to existing or newly reconfigured clinical APCs to create more clinical and median cost homogeneity. As a result of the proposed reassignments, those APCs are comprised of a different mix of codes than is currently the case for the CY 2005 OPPS. There are no codes assigned to APC 0187 because the only procedures that remained in APC 0187 after reassigning the vascular access procedures as we are proposing were CPT code 75940 (X-ray placement of vein filter) and CPT code 76095 (Stereotactic breast biopsy), which we reassigned to more clinically appropriate APCs. We are proposing to reassign CPT code 75940 to APC 0297 (Level II Therapeutic Radiologic Procedures) and CPT code 76095 to APC 0264 (Level II Miscellaneous Radiology Procedures).

We are proposing to create three new APCs, APC 0621 (Level I Vascular Access Codes), APC 0622 (Level II Vascular Access Codes), and APC 0623 (Level III Vascular Access Codes) and assign procedures to each of these based on median cost and clinical homogeneity. We are also proposing to rename APCs 0109 and 0115 as follows: APC 0109 (Removal of Implanted Devices); and APC 0115 (Cannula/Access Device Procedures). Table 13 displays the procedures and their current and the CY 2006 proposed APC assignments.

TABLE 13.—CURRENT AND PROPOSED APC ASSIGNMENTS FOR VASCULAR ACCESS PROCEDURES AND RELATED PROCEDURES FOR CY 2006

CPT code	Descriptor	CY 2005 APC	Proposed CY 2006 APC
APC 0621—Level I Vascular Access Procedure			
36555	Insertion non-tunneled cv cath	0187	0621
36556	Insertion non-tunneled cv cath	0187	0621
36568	Insert tunneled cv cath	0187	0621
36569	Insert tunneled cv cath	0187	0621
36575	Repair tunneled cv cath	0187	0621
36576	Repair tunneled cv cath	0187	0621
36580	Replace tunneled cv cath	0187	0621
36584	Replace tunneled cv cath	0187	0621
36589	Remove tunneled cv cath	0109	0621
36590	Remove tunneled cv cath	0187	0621
36596	Mech removal tunneled cv cath	0187	0621
36597	Reposition venous catheter	0187	0621
APC 0622—Level II Vascular Access Procedures			
36557	Insert tunneled cv cath	0032	0622
36558	Insert tunneled cv cath	0032	0622
36578	Replace tunneled cv cath	0187	0622
36581	Replace tunneled cv cath	0032	0622
36585	Replace tunneled cv cath	0032	0622
36570	Insert tunneled cv cath	0032	0622
36571	Insert tunneled cv cath	0032	0622
36595	Mech removal tunneled cv cath	0187	0622
36262	Removal intra-arterial inf. Pump	0124	0622
APC 0623—Level III Vascular Access Procedures			
36560	Insert tunneled cv cath	0115	0623
36561	Insert tunneled cv cath	0115	0623
36563	Insert tunneled cv cath	0119	0623
36565	Insert tunneled cv cath	0115	0623
36582	Replace tunneled cv cath	0115	0623
36583	Insertion of access device	0119	0623
36640	Insertion catheter, artery	0032	0623
36260	Insertion of infusion pump	0119	0623
36261	Revision of infusion pump	0124	0623
APC 0115—Cannula/Access Device Procedures			
36835	Artery to vein shunt	0115	0115
35903	Excision, graft, extremity	0115	0115
36815	Insertion of cannula	0115	0115
36861	Cannula declotting	0115	0115
35761	Exploration of artery/vein	0115	0115
49419	Insert abdominal cath for chemo	0115	0115
36800	Insertion of cannula	0115	0115
37204	Transcatheter occlusion	0115	0115
36810	Insertion of cannula	0115	0115
APC 0109—Removal of Implanted Devices			
33284	Remove pt-activated heart recorder	0109	0109
63746	Removal of spinal shunt	0109	0109

We presented this proposal to the APC Panel at its February, 2005 meeting. The APC Panel was supportive of the proposed reassignments and recommended that we make these changes. Therefore, for the stated reasons, we are proposing the APC modifications for CY 2006 OPPS as summarized in Table 13 above.

E. Proposed Addition of New Procedure Codes

(If you choose to comment on issues in this section, please include the caption ''New Procedure Codes'' at the beginning of your comment.)

During the second quarter of CY 2005, we created 11 HCPCS codes that were not addressed in the November 15, 2004 final rule with comment period that updated the CY 2005 OPPS. We have designated the payment status of those codes and added them to the April update of the CY 2005 OPPS (Transmittal 514). The codes are shown in Table 14 below. In this proposed rule, we are soliciting comment on the APC assignment of these services.

Further, consistent with our annual APC updating policy, we are proposing to assign the new HCPCS codes for CY 2006 to the appropriate APC's and

would incorporate them into our final rule for CY 2006.

TABLE 14.—NEW HCPCS CODES IMPLEMENTED IN APRIL 2005

HCPCS code	Description
C9127	Injection, paclitaxel protein-bound particles, per 1 mg.
C9128	Injection, pegaptamib sodium, per 0.3 mg.
C9223	Injection, adenosine for therapeutic or diagnostic use, 6 mg (not to be used to report any adenosine phosphate compounds, instead use A9270).
C9440	Vinorelbine tartrate, brand name, per 10 mg.
C9723	Dynamic infrared blood perfusion imaging (DIRI).
C9724	Endoscopic full-thickness plication in the gastric cardia using endoscopic plication system (EPS); includes endoscopy.
Q4079	Injection, natalizumab, 1 mg.
Q9941	Injection, Immune Globulin, Intravenous, Lyophilized, 1g.
Q9942	Injection, Immune Globulin, Intravenous, Lyophilized, 10 mg.
Q9943	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 1g.
Q9944	Injection, Immune Globulin, Intravenous, Non-Lyophilized, 10 mg.

IV. Proposed Payment Changes for Devices

A. Device-Dependent APCs

(If you choose to comment on issues in this section, please include the caption ''Device-Dependent APCs'' at the beginning of your comment.)

Device-dependent APCs are populated by HCPCS codes that usually, but not always, require that a device be implanted or used to perform the procedure. For the CY 2002 OPPS, we used external data, in part, to establish the device-dependent APC medians used for weight setting. At that time, many devices were eligible for pass-through payment. For the CY 2002 OPPS, we estimated that the total amount of pass-through payments would far exceed the limit imposed by statute. To reduce the amount of a pro rata adjustment to all pass-through items, we packaged 75 percent of the cost of the devices, using external data furnished by commenters on the August 24, 2001 proposed rule and information furnished on applications for pass-through payment, into the median cost for the device-dependent APCs associated with these pass-through devices. The remaining 25 percent of the cost was considered to be pass-through payment.

In the CY 2003 OPPS, we determined APC medians for device-dependent APCs using a three pronged approach. First, we used only claims with device codes on the claim to set the medians for these APCs. Second, we used external data, in part, to set the medians for selected device-dependent APCs by blending that external data with claims data to establish the APC medians. Finally, we also adjusted the median for any APC (whether device-dependent or not) that declined more than 15 percent. In addition, in the CY 2003 OPPS, we deleted the device codes (''C'' codes) from the HCPCS file in the belief that hospitals would include the charges for the devices on their claims, notwithstanding the absence of specific codes for devices used.

In the CY 2004 OPPS, we used only claims containing device codes to set the medians for device-dependent APCs and again used external data in a 50-percent blend with claims data to adjust medians for a few device-dependent codes when it appeared that the adjustments were important to ensure access to care. However, hospital device code reporting was optional.

In the CY 2005 OPPS, which was based on CY 2003 claims data, there were no device codes on the claims and, therefore, we could not use device-coded claims in median calculations as a proxy for completeness of the coding and charges on the claims. For the CY 2005 OPPS, we adjusted device-dependent APC medians for those device-dependent APCs for which the CY 2005 OPPS payment median was less than 95 percent of the CY 2004 OPPS payment median. In these cases, the CY 2005 OPPS payment median was adjusted to 95 percent of the CY 2004 OPPS payment median. We also reinstated the device codes and made the use of the device codes mandatory where an appropriate code exists to describe a device utilized in a procedure and also implemented HCPCS code edits to facilitate complete reporting of the charges for the devices used in the procedures assigned to the device-dependent APCs.

We are proposing to base the CY 2006 OPPS device-dependent APC medians on CY 2004 claims, the most current data available. In CY 2004, the use of device codes was optional. Thus, for the CY 2006 OPPS, we calculated median costs for these APCs using all single bills without regard to whether there was a device code on the claim. We calculated median costs for this set of APCs using the standard median calculation methodology. This methodology uses single procedure claims to set the median costs for the APC. We then compared these unadjusted median costs to the adjusted median costs that we used to set the payment rates for the CY 2005 OPPS. We found that 21 APCs experienced increases in median cost compared to the CY 2005 OPPS adjusted median costs, 1 APC median was unchanged, 16 APCs experienced decreases in median costs, and 8 APCs are proposed to be reconfigured in such a way that no valid comparison was possible. Table 15 shows the comparison of these median costs.

As we stated previously, in CY 2004, CMS reissued HCPCS codes for devices and asked that hospitals voluntarily code devices utilized to provide services. As part of our development of the proposed medians for this proposed rule, we examined CY 2004 claims that contained device codes that met our device edits, as posted on the OPPS Web site at *http://www.cms.hhs.gov/providers/hopps/default.asp*. We found that, in many cases, the number of claims that passed the device edits was quite small. To use these claims to set medians for the CY 2006 OPPS would mean that the medians for some of these APCs would be set based on very small numbers of claims, reflecting the fact that in CY 2004 when device coding was optional under the OPPS relatively few hospitals chose to code for devices. For example, if we used only claims that passed the device code edits, the median for APC 0089 (Insertion/Replacement of Permanent Pacemaker and Electrodes), would be based on 34 claims that passed the device edits (0.78 percent of all claims), rather than on 1,934 single bills out of 4,424 total bills (43.72 percent of all claims). Median

costs for insertion/replacement of a permanent pacemaker and electrodes developed based upon these 34 claims from a small subset of hospitals are unlikely to be representative of the resource costs of most hospitals that provided the service. Moreover, there are a few procedures for which no device codes are required although the procedures require a device to be used. For this set of services, subsetting the claims to those that pass the device edits does not change the group of single bills available for median calculation. For these reasons, we decided not to use only claims that passed the device edits to set the median costs for device-dependent APCs for the CY 2006 OPPS.

When we considered whether to base the weights for these APCs on the unadjusted median costs, we found that for 10 of the 38 APCs for which the APC composition is stable, basing the payment weight on the unadjusted median cost would result in a reduction of more than 15 percent in the median cost for the CY 2006 OPPS compared to the CY 2005 OPPS.

We fully expect to use the unadjusted median costs for device-dependent APCs as the basis of their payment weights for the CY 2007 OPPS because device coding is required for CY 2005 and device editing is being implemented in CY 2005, so that all CY 2005 claims should reflect the costs of devices used to provide services. Nevertheless we recognize that a payment reduction of more than 15 percent from the CY 2005 OPPS to the CY 2006 OPPS may be problematic for hospitals that provide the services contained in these APCs. Therefore, for the CY 2006 OPPS, as we have consistently done for device-dependent APCs, we are proposing to adjust the median costs for the device-dependent APCs listed in Table 15 for which comparisons with prior years are valid to the higher of the CY 2006 unadjusted APC median or 85 percent of the adjusted median on which payment was based for the CY 2005 OPPS. This would result in the use of adjusted medians for 10 device-dependent APCs. We view this as a transitional step from the adjusted medians of past years to the use of unadjusted medians based solely on hospital claims data with device codes in future years.

We expect that this would be the last year in which we would make an across the board adjustment to the median costs for these device-dependent APCs based on comparisons to the prior year's payment medians. We believe that mandatory reporting of device codes for services furnished in CY 2005, combined with the editing of claims for the presence of device codes, where such codes are appropriate, would result in claims data that more fully reflect the relative costs of these services and that across the board adjustments to median costs for these APCs would no longer be appropriate.

We recognize that the APC Panel recommended that CMS set a corridor of median costs for device-dependent APCs at no less than 90 percent of the CY 2005 payment median nor more than 110 percent of the CY 2005 payment median for purposes of setting the payment rate for the CY 2006 OPPS for these APCs. We do not believe that setting a corridor to control both increases and decreases in median costs is consistent with the use of adjusted medians as a means of transitioning hospitals to the use of the unadjusted claims data. The purpose of the transition is to moderate the rate of decline in payments so that hospitals can determine how to best adjust to payments based on unadjusted claims data. Limiting the rate of increase in payments based on such claims data would be inconsistent with that purpose. Therefore, we are proposing to adjust median costs to the greater of the median from claims data or 85 percent of the CY 2005 median used to set the payment rate in CY 2005 and not to impose a limit on the extent to which a median cost can increase.

TABLE 15.—PROPOSED MEDIAN COST ADJUSTMENTS FOR DEVICE-DEPENDENT APCS FOR CY 2006

APC	Description	Status indicator	Adjusted final CY 2005 OPPS median cost (percent)	Proposed unadjusted CY 2006 APC median cost	Change from CY 2005 adjusted to CY 2006 unadjusted median cost (percent)	Proposed CY 2006 OPPS adjusted median cost	CY 2006 single frequency (CY 2004 claims)	CY 2006 total frequency (CY 2004 claims)
0039	Implantation of Neurostimulator.	S	$12,878.01	$9,905.38	−23	$10,946.31	809	1,809
0040	Level II Implantation of Neurostimulator Electrodes.	S	2,885.37	3,338.79	16	3,338.79	2,615	11,986
0080	Diagnostic Cardiac Catheterization.	T	2,123.65	2,240.92	6	2,240.92	267,077	393,166
0081	Non-Coronary Angioplasty or Atherectomy.	T	1,918.04	2,078.67	8	2,078.67	2,046	130,737
0082	Coronary Atherectomy	T	6,035.25	4,819.40	−20	5,129.96	27	359
0083	Coronary Angioplasty and Percutaneous Valvuloplasty.	T	3,241.85	3,071.03	−5	3,071.03	539	5,492
0085	Level II Electrophysiologic Evaluation.	T	2,034.82	2,123.46	4	2,123.46	3,088	20,401
0086	Ablate Heart Dysrhythm Focus.	T	2,637.96	2,670.78	1	2,670.78	919	9,160
0087	Cardiac Electrophysiologic Recording/Mapping.	T	2,180.19	853.76	−61	1,853.16	330	12,969
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	6,416.90	6,373.13	−1	6,373.13	1,934	4,424
0090	Insertion/Replacement of Pacemaker Pulse Generator.	T	5,301.99	5,380.07	1	5,380.07	740	6,412

TABLE 15.—PROPOSED MEDIAN COST ADJUSTMENTS FOR DEVICE-DEPENDENT APCS FOR CY 2006—Continued

APC	Description	Status indicator	Adjusted final CY 2005 OPPS median cost (percent)	Proposed unadjusted CY 2006 APC median cost	Change from CY 2005 adjusted to CY 2006 unadjusted median cost (percent)	Proposed CY 2006 OPPS adjusted median cost	CY 2006 single frequency (CY 2004 claims)	CY 2006 total frequency (CY 2004 claims)
0104	Transcatheter Placement of Intracoronary Stents.	T	4,750.06	4,767.70	0	4,767.70	1,103	8,137
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes.	T	3,229.10	1,908.38	−41	2,744.73	489	3,938
0107	Insertion of Cardioverter-Defibrillator.	T	18,460.10	15,166.64	−18	15,691.08	445	8,073
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	24,788.26	18,165.78	−27	21,070.02	520	6,003
0115	Cannula/device access procedures.	T	1,502.71	1,899.17	26	1,899.17	3,022	10,115
0202	Level X Female Reproductive Proc.	T	2,322.83	2,437.07	5	2,437.07	7,951	15,303
0222	Implantation of Neurological Device.	T	12,714.60	9,742.78	−23	10,807.41	1,678	5,629
0225	Level I Implementation of Neurostimulator Electrodes.	S	12,327.52	14,162.16	15	14,162.16	185	939
0227	Implantation of Drug Infusion Device.	T	8,806.84	8,236.41	−6	8,236.41	442	2,776
0229	Transcatherter Placement of Intravascular Shunts.	T	3,638.52	3,889.41	7	3,889.41	778	46,625
0259	Level VI ENT Procedures ..	T	26,006.74	21,424.48	−18	22,105.73	554	964
0315	Level II Implantation of Neurostimulator.	T	20,633.70	12,170.26	−41	17,538.65	229	327
0384	GI Procedures with Stents	T	1,585.92	1,287.07	−19	1,348.03	6,268	20,711
0385	Level I Prosthetic Urological Procedures.	S	4,080.56	4,564.66	12	4,564.66	553	783
0386	Level II Prosthetic Urological Procedures.	S	6,674.53	7,251.44	9	7,251.44	3,213	4,549
0418	Left ventricular lead	T	4,363.37	6,595.80	51	6,595.80	202	4,712
0425	Level II Arthroplasty with prosthesis.	T	5,715.97	6,046.77	6	6,046.77	375	882
0648	Breast Reconstruction with Prosthesis.	T	2,957.76	3,044.08	3	3,044.08	398	1,320
0652	Insertion of Intraperitoneal Catheters.	T	1,626.29	1,743.61	7	1,743.61	3,067	4,986
0653	Vascular Reconstruction/Fistula Repair with Device.	T	1,644.53	1,842.52	12	1,842.52	800	28,788
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	6,170.83	6,090.43	−1	6,090.43	1,807	20,809
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	7,913.85	8,072.56	2	8,072.56	7,353	13,991
0656	Transcatheter Placement of Intracoronary Drug Eluting Stents.	T	6,156.14	6,633.18	8	6,633.18	2,394	19,898
0670	Intravenous and Intracardiac Ultrasound.	S	1,779.08	1,533.52	−14	1,533.52	111	7,041
0674	Prostate Cryoablation	T	6,569.33	5,780.04	−12	5,780.04	1,248	2,080
0680	Insertion of Patient Activated Event Recorders.	S	3,744.69	3,796.10	1	3,796.10	1,400	2,226
0681	Knee Arthroplasty	T	5,374.98	8,276.89	54	8,276.89	492	683
	No adjustment; major HCPCS migration:							
0122	Level II Tube changes and Repositioning.	T	485.26	420.72	.....	420.72	5,138	14,701
0427	Level III Tube changes and Repositioning (new for 2006).	T	.....	615.37	.....	615.37	2,485	5,376

TABLE 15.—PROPOSED MEDIAN COST ADJUSTMENTS FOR DEVICE-DEPENDENT APCS FOR CY 2006—Continued

APC	Description	Status indicator	Adjusted final CY 2005 OPPS median cost (percent)	Proposed unadjusted CY 2006 APC median cost	Change from CY 2005 adjusted to CY 2006 unadjusted median cost (percent)	Proposed CY 2006 OPPS adjusted median cost	CY 2006 single frequency (CY 2004 claims)	CY 2006 total frequency (CY 2004 claims)
0166	Level I Urethral procedures (contains part of deleted DD APC 167).	T	1,040.53	1,066.53		1,066.53	778	2,282
0167	Urethral procedures (deleted APC; codes moved to 167 and 168 for '06).	T	1,664.80	NA		NA	NA	NA
0168	Level II Urethral procedures (contains part of deleted DD APC 167).	T	1,801.96	1,705.82		1,705.82	7,684	10,018
0621	Level I VAD	T	new in 06	500.77		500.77	60,115	113,720
0622	Level II VAD	T	new in 06	1,283.33		1,283.33	21,792	54,816
0623	Level III VAD	T	new in 06	1,635.94		1,635.94	23,963	62,538

B. APC Panel Recommendations Pertaining to APC 0107 and APC 0108

The median costs for APC 0107 (Implantation of Cardioverter-Defibrillator) and APC 0108 (Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads and Insertion of Cardioverter-Defibrillator) have been adjusted each year since CY 2003 when pass-through payment expired for cardioverter-defibrillators, because the unadjusted medians have differed significantly from the prior year's payment medians. Moreover, because we use single procedure claims to set the median costs, the median costs for these APCs have always been set on a relatively small number of claims as compared to the total frequency of claims for the services under the OPPS. For example, for this CY 2006 OPPS proposed rule, the unadjusted median cost for APC 0107 was set based on 445 single procedure claims, which is 5.5 percent of the 8,073 claims on which a procedure code in the APC was billed. Similarly, the unadjusted median cost for APC 0108 was set based on 520 single procedure claims, which is 8.7 percent of the 6,003 claims on which a procedure code in the APC was billed. Commenters have frequently told us that using the single procedure median costs for these APCs does not accurately reflect the costs of the procedures because claims from typical clinical circumstances involving multiple procedures are not used to establish the medians.

At the February 2005 APC Panel meeting, the APC Panel recommended that CMS package CPT codes 93640 and 93641 (electrophysiologic evaluation at time of initial implantation or replacement of cardioverter-defibrillator leads). The APC Panel recommended that we always package the costs for these codes because the definitions of the codes state that these evaluations are done at the time of lead implantation. Therefore, CPT codes 93640 and 93641 would never be correctly reported without a code in APC 0107 or APC 0108 also being reported. In addition, when a service assigned to APC 0107 or APC 0108 is provided, we would expect that CPT codes 93640 or 93641 for electrophysiologic evaluation and testing would also be performed frequently, and CY 2004 claims data for services in APC 0107 and APC 0108 confirm this. The APC Panel believed that packaging the costs of CPT codes 93640 and 93641 would result in more single bills available for setting the median costs for APC 0107 and APC 0108, and thus would likely yield more appropriate median costs for those APCs. Those medians would then include the costs of the electrophysiologic testing commonly performed at the time of the implantable cardioverter-defibrillator (ICD) insertion.

The APC Panel further recommended that CMS treat CPT code 33241 (Subcutaneous removal of cardioverter-defibrillator) as a bypass code when the code appeared on the same claims with services assigned to APC 0107 or APC 0108. The APC Panel recommended bypassing charges for this code only when it appeared on the same claim with codes in APC 0107 or APC 0108, because when a cardioverter defibrillator (ICD) is removed and replaced in the same operative session, it is appropriate to attribute all of the packaged costs on the claim to the implantation of the device rather than to the removal of the device. The line costs for CPT code 33241 that are removed from the claims in this case would be discarded and would not be used to set the median for APC 0105 (the APC in which the code is located).

We modeled the median costs that would be calculated for APCs 0107 and 0108, if we were to make the changes recommended by the APC Panel for these APCs, under four possible scenarios: (1) The cardioverter-defibrillator device is inserted without removal or testing; (2) the device is inserted and tested with no removal; (3) the device is removed and inserted but not tested; and (4) the device is removed, inserted, and tested. We then compared the sum of the unadjusted median costs, the sum of the proposed adjusted median costs and the sum of the costs that we modeled using the APC Panel recommendations. These results are shown in Table 16 below.

TABLE 16.—TOTAL MEDIAN COSTS FOR APCS 0107 AND 0108

	APC 0107 Using unadjusted median cost (1)	APC 0107 Using adjusted median cost (2)	APC 0107 With panel changes (3)	APC 0108 Using unadjusted median cost (4)	APC 0108 Using adjusted median cost (5)	APC 0108 With panel changes (6)
Median for codes in APC	$15,166.64	$15,691.08	$15,961.14	$18,165.78	$21,070.02	$21,517.00
50% of median for APC 0105 (CPT code 33241; removal); multiple procedure discount	674.90	674.90	674.90	674.90	674.90	674.90
Proposed median for APC 0084 (CPT code 93640/93641; testing)	604.67	604.67	(1)	604.67	604.67	(1)
(A) Median total if device is inserted only (neither removal nor testing)	15,166.64	15,691.08	15,961.14	18,165.78	21,070.02	21,517.00
(B) Median total if device is inserted and tested (no removal)	15,771.31	16,295.75	15,961.14	18,770.45	21,674.69	21,517.00
(C) Median total if device is removed and inserted (no testing)	15,841.54	16,365.98	16,636.04	18,840.68	21,744.92	22,191.90
(D) Median total if device is removed, inserted and tested	16,446.21	16,970.65	16,636.04	19,445.35	22,349.59	22,191.90

[1] NA (testing is packaged).

We also found that if we were to adopt the APC Panel recommendations for APCs 0107 and 0108 for the CY 2006 OPPS, the number of single bills that would be available for use in median setting would increase significantly, as shown in Table 17.

TABLE 17.—SINGLE BILLS FOR APC 0107 AND APC 0108

	Single bills without recommended changes	Single bills with recommended changes	Total frequency
APC 0107	445	4500	8073
APC 0108	520	1447	6003

In general, we believe that the recommendations of the APC Panel show great potential for providing a far more robust set of single bills for use in setting medians for APCs 0107 and 0108 and, therefore, for improving the accuracy of the median costs acquired from the claims data. However, for the CY 2006 OPPS, adopting the APC Panel recommendations would result in higher total payments for services related to cardioverter-defibrillator insertion for some possible clinical scenarios than under the proposed adjustment methodology but would result in lower total payments in other cases. Moreover, the effects are not identical for both APCs. Both APCs require the insertion of an ICD, but the codes in APC 0108 also require the repair, revision or insertion of leads. Because the APCs are so closely related clinically and both APCs include payments for expensive implanted cardioverter-defibrillators, we are proposing to apply the same payment policy to both APC 0107 and APC 0108. We would like to receive input from the APC Panel and from the affected parties regarding the results of modeling the methodology before we decide whether to implement this multiple procedure claim strategy for both of these APCs.

Specifically, we are proposing to set the medians for these APCs at 85 percent of their CY 2005 payment medians and have based our modeling of the scaler and the impact analysis on that proposal, although we believe that the APC Panel recommendations have significant merit, particularly when we move to complete reliance on claims data in updating the OPPS for CY 2007. Although we are proposing to adjust the median costs for these APCs in the same manner as other device-dependent APCs, we will consider, based on the public comments, whether it would be appropriate to apply the multiple procedure claims methodology to these APCs for the CY 2006 OPPS. We look forward to specifically receiving public comments on the APC Panel recommendations regarding packaging and bypassing services frequently performed with procedures assigned to APC 0107 and APC 0108, with the goal of increasing single bills available for ratesetting in order to improve the accuracy of median costs based upon hospital claims.

C. Pass-Through Payments for Devices

(If you choose to comment on issues in this section, please include the caption ''Transitional Pass-Through Payments for Devices'' at the beginning of your comment.)

1. Expiration of Transitional Pass-Through Payments for Certain Devices

Section 1833(t)(6)(B)(iii) of the Act requires that, under the OPPS, 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. In our November 15, 2004 final rule with comment period (69 FR 65773), we specified three device categories currently in effect that would cease to be eligible for pass-through payment effective January 1, 2006.

The device category codes became effective April 1, 2001, under the provisions of the BIPA. Prior to pass-through device categories, we paid for pass-through devices under the OPPS on a brand-specific basis. All of the initial 97 category codes that were established as of April 1, 2001, have

expired; 95 categories expired after CY 2002 and 2 categories expired after CY 2003. All of the categories listed in Table 18, along with their expected expiration dates, were created since we published the criteria and process for creating additional device categories for pass-through payment on November 2, 2001 (66 FR 55850 through 55857). We based the expiration dates for the category codes listed in Table 18 on the date on which a category was first eligible for pass-through payment.

There are three categories for devices that would have been eligible for pass-through payments for at least 2 years as of December 31, 2005. In the November 15, 2004 final rule with comment period, we finalized the December 31, 2005 expiration dates for these three categories—C1814 (Retinal tamponade device, silicone oil), C1818 (Integrated keratoprosthesis), and C1819 (Tissue localization excision device). Each category includes devices for which pass-through payment was first made under the OPPS in CY 2003 or CY 2004.

In the November 1, 2002 final rule, we established a policy for payment of devices included in pass-through categories that are due to expire (67 FR 66763). For CY 2003, we packaged the costs of the devices no longer eligible for pass-through payments into the costs of the procedures with which the devices were billed in CY 2001. There were few exceptions to this established policy (brachytherapy sources for other than prostate brachytherapy, which is now also separately paid in accordance with section 621(b)(2) of Pub. L. 108-173). For CY 2005, we continued to apply this policy, the same as we did in CY 2003 and 2004, to categories of devices that expired on December 31, 2004.

2. Proposed Policy for CY 2006

For CY 2006, we are proposing to implement the final decision we made in the November 15, 2004 final rule with comment period that finalizes the expiration date for pass-through status for device categories C1814, C1818, and C1819. Therefore, as of January 1, 2006, we will discontinue pass-through payment for C1814, C1818, and C1819. In accordance with our established policy, we are proposing to package the costs of the devices assigned to these three categories into the costs of the procedures with which the devices were billed in CY 2004, the year of hospital claims data used for this proposed OPPS update.

TABLE 18.—LIST OF CURRENT PASS-THROUGH DEVICE CATEGORIES BY EXPIRATION DATE

HCPCS codes	Category long descriptor	Date(s) populated	Expiration date
C1814	Retinal tamponade device, silicone oil	4/1/03	12/31/05
C1818	Integrated keratoprosthesis	7/1/03	12/31/05
C1819	Tissue localization excision device	1/1/04	12/31/05

D. Other Policy Issues Relating To Pass-Through Device Categories

(If you choose to comment on issues in this section, please include the caption ''Pass-Through Device Categories'' at the beginning of your comment.)

1. Provisions for Reducing Transitional Pass-Through Payments to Offset Costs Packaged Into APC Groups

a. Background

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

For the CY 2002 and CY 2003 OPPS updates, to estimate the portion of each APC payment rate that could reasonably be attributed to the cost of an associated device eligible for pass-through payment, we used claims data from the period used for recalibration of the APC rates. That is, for CY 2002 OPPS updating, we used CY 2000 claims data and for CY 2003 OPPS updating, we used CY 2001 claims data. For CY 2002, we used median cost claims data based on specific revenue centers used for device related costs because C-code cost data were not available until CY 2003. For CY 2003, we calculated a median cost for every APC without packaging the costs of associated C-codes for device categories that were billed with the APC. We then calculated a median cost for every APC with the costs of the associated device category C-codes that were billed with the APC packaged into the median. Comparing the median APC cost without device packaging to the median APC cost including device packaging enabled us to determine the percentage of the median APC cost that is attributable to the associated pass-through devices. By applying those percentages to the APC payment rates, we determined the applicable amount to be deducted from the pass-through payment, the ''offset'' amount. We created an offset list comprised of any APC for which the device cost was at least 1 percent of the APC's cost.

The offset list that we have published each year is a list of offset amounts associated with those APCs with identified offset amounts developed using the methodology described above. As a rule, we do not know in advance which procedures residing in certain APCs may be billed with new device categories. Therefore, an offset amount is applied only when a new device category is billed with a HCPCS procedure code that is assigned to an APC appearing on the offset list. The list of potential offsets for CY 2005 is currently published on the CMS Web site: *http://www.cms.hhs.gov*, as ''Device-Related Portions of Ambulatory Payment Classification Costs for 2005.''

For CY 2004, we modified our policy for applying offsets to device pass-through payments. Specifically, we indicated that we would apply an offset to a new device category only when we could determine that an APC contains costs associated with the device. We continued our existing methodology for determining the offset amount, described earlier. We were able to use this methodology to establish the device offset amounts for CY 2004 because providers reported device codes (C-codes) on the CY 2002 claims used for the CY 2004 OPPS update. For the CY 2005 update to the OPPS, our data consisted of CY 2003 claims that did not contain device codes and, therefore, for CY 2005 we utilized the device percentages as developed for CY 2004. In the CY 2004 OPPS update, we reviewed the device categories eligible

for continuing pass-through payment in CY 2004 to determine whether the costs associated with the device categories are packaged into the existing APCs. Based on our review of the data for the device categories existing in CY 2004, we determined that there were no close or identifiable costs associated with the devices relating to the respective APCs that are normally billed with them. Therefore, for those device categories, we set the offset to $0 for CY 2004. We continued this policy of setting offsets to $0 for the device categories that continued to receive pass-through payment in CY 2005.

For the CY 2006 OPPS update, CY 2004 hospital claims are available for analysis. Hospitals billed device C-codes in CY 2004 on a voluntary basis. We have reviewed our CY 2004 data, examining hospital claims for services that included device C-codes and utilizing the methodology for calculating device offsets noted above. The numbers of claims for services in many of the APCs for which we calculated device percentages using CY 2004 data were quite small. Many of these APCs already had relatively few single claims available for median calculations compared with the total bill frequencies because of our inability to use many multiple bills in establishing median costs for all APCs, and subsetting the single claims to only those including C-codes often reduced those single bills by 80 percent or more. Our claims demonstrate that relatively few hospitals specifically coded for devices utilized in CY 2004. Thus, we do not feel confident that CY 2004 claims reporting C-codes represent the typical costs of all hospitals providing the services. Therefore, we do not propose to use CY 2004 claims with device coding to propose CY 2006 device offset amounts at this time. In addition, we do not propose to use CY 2005's methodology, for which we utilized the device percentages as developed for CY 2004. Two years have passed since we developed the device offsets for CY 2004, and the device offsets originally calculated from CY 2002 hospitals' claims data may not appropriately reflect the contributions of device costs to procedural costs in the current outpatient hospital environment. In addition, a number of the APCs on the CY 2004 and CY 2005 device offset percentage lists are either no longer in existence or have been so significantly reconfigured that the past device offsets likely do not apply.

b. Proposed Policy for CY 2006

For CY 2006, we are proposing to continue to review each new device category on a case-by-case basis as we have done in CY 2004 and CY 2005, to determine whether device costs associated with the new category are packaged into the existing APC structure. If we do not determine that for any new device category that device costs associated with the new category are packaged into existing APCs, we are proposing to continue our current policy of setting the offset for the new category to $0 for CY 2006. There are currently no established categories that would continue for pass-through payment in CY 2006. However, we may establish new categories in any quarter. If we create a new device category and determine that our data contain a sufficient number of claims with identifiable costs associated with the devices in any APC, we would adjust the APC payment if the offset is greater than $0. If we determine that a device offset greater than $0 is appropriate for any new category that we create, we are proposing to announce the offset amounts in the program transmittal that announces the new category.

For CY 2006, we are proposing to use available partial year or full year CY 2005 hospital claims data to calculate device percentages and potential offsets for CY 2006 applications for new device categories. Effective January 1, 2005, we require hospitals to report device C-codes and their costs when hospitals bill for services which utilize devices described by the existing C-codes. In addition, during CY 2005 we are implementing device edits for many services which require devices and for which appropriate device C-codes exist. Therefore, we expect that the number of claims including device codes and their respective costs will be much more robust and representative for CY 2005 than for CY 2004. We also note that offsets would not be used for any existing categories at this time. If a new device category is created for payment, for CY 2006 we are proposing to examine the available CY 2005 claims data, including device costs, to determine whether device costs associated with the new category are already packaged into the existing APC structure, as indicated earlier. If we conclude that some related device costs are packaged into existing APCs, we are proposing to utilize the methodology described earlier and first used for the CY 2003 OPPS to determine an appropriate device offset percentage for those APCs with which the new category would be reported.

Our proposal not to publish a list of APCs with device percentages at this time would be a transitional policy for CY 2006 because of the previously discussed limitations of the CY 2004 OPPS data with respect to device costs associated with procedures. We expect that we will reexamine our previous methodology for calculating the device percentages and offset amounts for the CY 2007 OPPS update, which will be based on CY 2005 hospitals claims data where device C-code reporting is required.

2. Criteria for Establishing New Pass-Through Device Categories

a. Surgical Insertion and Implantation Criterion

One of our criteria, as set forth in § 419.66(b)(3) of the regulations, for establishing a new category of devices for pass-through payment is that the item be surgically inserted or implanted. The criterion that a device be surgically inserted or implanted is one of our original criteria adopted when we implemented the BBRA requirement that we establish pass-through payment for devices. This criterion helps us define whether an item is a device, as distinguished from other items, such as materials and supplies. We further clarified our definition of the surgical insertion and implantation criterion in the November 13, 2000 final rule (65 FR 67805). In that rule we stated that we consider a device to be surgically inserted or implanted if it is introduced into the human body through a surgically created incision. We also stated that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically inserted or implanted.

In our November 15, 2004 final rule with comment period, we responded to comments received on our August 16, 2004 proposed rule, which requested that we revisit our surgical insertion and implantation criterion for establishing a new device category. The commenters specifically requested that CMS eliminate the current requirement that items that are included in new pass-through device categories must be surgically inserted or implanted through a surgically created incision. The commenters expressed concern that the current requirement may prevent access to innovative and less invasive technologies, particularly in the areas of gynecologic, urologic, colorectal and gastrointestinal procedures. These commenters asked that CMS change the surgical insertion or implantation criterion to allow pass-through payment for potential new device categories that include items introduced into the human body through a natural orifice, as well as through a surgically created incision. Several of the commenters

recommended that CMS allow the creation of a new pass-through category for items implanted or inserted through a natural orifice, as long as the other existing criteria are met.

In responding to the commenters, we stated in the November 15, 2004 final rule with comment period (69 FR 65774) that we were also interested in hearing the views of other parties and receiving additional information on these issues. While we appreciate and welcome additional comments on these issues from the medical device makers, we were also interested in hearing the views of Medicare beneficiaries, of the hospitals that are paid under the OPPS, and of physicians and other practitioners who attend to patients in the hospital outpatient setting. For that reason, we solicited additional comments on this topic within the 60-day comment period for the November 15, 2004 final rule with comment period (69 FR 65774 through 65775). In framing their comments, we asked that commenters consider the following questions specific to devices introduced into the body through natural orifices:

1. Whether orifices include those that are either naturally or surgically created, as in the case of ostomies. If you believe this includes only natural orifices, why do you distinguish between natural and surgically created orifices?

2. How would you define ''new,'' with respect to time and to predecessor technology? What additional criteria or characteristics do you believe distinguish ''new'' devices that are surgically introduced through an existing orifice from older technology that also is inserted through an orifice?

3. What characteristics do you consider to distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies such as sutures, clips or customized surgical kits that are used incident to a service or procedure?

4. Are there differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope?

b. Public Comments Received and Our Responses

Below is a summary of the public comments we received on the four stated surgical insertion and implantation device criterion questions and our response to them.

Comment: Most commenters generally framed their responses to the four questions listed above. Commenters were generally in favor of modifying our surgical insertion and implantation criterion so that devices that are placed into patients without the need for a surgical incision would not be ineligible for pass-through payment, claiming that devices that are inserted through a natural orifice offer important benefits to Medicare beneficiaries, such as avoidance of more costly and more invasive surgery. One commenter stated that procedures that could be performed with minimal morbidity and on an outpatient basis are the trend for surgery and should be encouraged. Another commenter believed that our criterion of surgical insertion or implantation through a surgically created incision was ineffective as a clear and comprehensive description of surgical procedures, including endoscopic and laparoscopic procedures.

Regarding the first specific question we posed, whether devices introduced into the body through natural orifices includes orifices that are either naturally or surgically created, commenters generally stated we should include devices as potentially eligible for pass-through categories whether they are introduced through orifices that are either naturally or surgically created, as in the case of ostomies, if the devices meet other cost and clinical criteria, in order to encourage the development of new technologies.

Regarding the second question restated above, which asked how the public would define ''new'' with respect to time and to predecessor technology, some commenters stated that they believed the current clinical and cost criteria are sufficient and that no additional criteria or characteristics are needed. Several commenters indicated that the timeframe for what we consider ''new'' could be clarified if the device in question was not FDA approved or in use in the OPD during the year that hospital claims are used for that calendar year's OPPS update, that is, it should be considered ''new.'' Some commenters elaborated by example. They stated that if we change the surgical insertion or implantation requirement to include devices inserted through natural orifices in 2005, devices approved by the FDA and in use in the OPD in 2003 or previously would not be eligible, while devices approved by FDA in 2004 or later and used in the OPD settings would be eligible for pass-through consideration. Another commenter stated that the definition of ''new'' device should include those devices that require only an FDA investigational device exemption (IDE) clearance. The commenter further stated that these devices should be granted ''new'' status at the time of FDA release as an IDE. The commenter stated that if FDA required a premarket approval (PMA) for the device, a determination of newness should be made on a case by case basis.

Regarding the question of what characteristics distinguish a device that might be eligible for a pass-through category even if inserted through an existing orifice from materials and supplies that are used incident to a service or procedure, some commenters generally stated their belief that the current clinical and cost criteria are sufficient to distinguish devices that might be eligible from materials and supplies. Other commenters stated that the device must be an integral part of the procedure or that it should include the characteristic of having a diagnostic or therapeutic purpose, without which the procedure could not be performed. Thus, according to these commenters, the device must function for a specific procedure, while supplies may be used for many procedures. One commenter pointed out that many devices are now implanted through the use of naturally occurring orifices or without significant incisions. This commenter indicated that the requirement of a ''traditional incision'' no longer serves the purpose of distinguishing between devices that are and are not implanted, or between devices and supplies and instruments. The commenter stated that retaining the requirement of a traditional incision could create incentives to use more invasive technology, if that is the technology that is eligible for pass-through payments and less invasive technology is not. This commenter suggested excluding tools and disposable supplies by excluding any item that is used primarily for the purpose of cutting or delivering an implantable device. However, the commenter recommended not reducing payment when delivery systems are packaged with the device. The commenter further recommended that the term incision be clearly defined to include all procedures involving the cutting, breaking or puncturing of tissue or skin, regardless of how small that cut is, provided that the device is attached to or inserted into the body via this cut or puncture or break. Another commenter stated that there are items included in a surgical kit that have significant cost and are single use, for example, guide wires, implying that it is sometimes difficult to determine what a supply is.

Regarding our question about whether there are differences with respect to instruments that are seen as supplies or equipment for open procedures when those same instruments are passed through an orifice using a scope,

commenters believed that the definitions of supplies and eligible devices are independent of the use of a scope during a procedure, and stated there were no distinguishing features of supplies or equipment. A commenter reiterated that the current clinical and cost criteria are sufficient to distinguish eligible devices (that is, those with ''a specific therapeutic use'') from materials and supplies. Commenters believed that the use of a scope should not be a factor in the distinction between devices and supplies.

One commenter urged us to consider the points that the surgical incision requirement is not mandated by statute and that CMS's criterion to limit devices to only those that are surgically inserted or implanted may have been based upon concern that less restrictive criteria would cause spending on pass-though items to exceed the pool of money set to fund the pass-though payments. This commenter indicated that this concern would no longer be valid, given the relatively few items currently paid on a pass-through basis.

Response: As we stated in the November 15, 2004 final rule, we share the view that it is important to ensure access for Medicare beneficiaries to new technologies that offer substantial clinical improvement in the treatment of their medical conditions. We also recognize that since the beginning of the OPPS, there have been beneficial advances in technologies and services for many conditions, which have both markedly altered the courses of medical care and ultimately improved the health outcomes of many beneficiaries.

We carefully considered the comments and are proposing to maintain our current criterion that a device must be surgically inserted or implanted, but are also proposing to modify the way we currently interpret this criterion under § 419.66(b)(3) of the regulations. We are proposing to consider eligible those items that are surgically inserted or implanted either through a natural orifice or a surgically created orifice (such as through an ostomy), as well as those that are inserted or implanted through a surgically created incision. We will maintain all of our other criteria in § 419.66 of the regulations, as elaborated in our various rules, such as the November 1, 2002 final rule (67 FR 66781 through 66787). Specifically, the clarification made at the time we clarified the surgically inserted or implanted criterion in our August 3, 2000 interim final rule with comment period, namely, that we do not consider an item used to cut or otherwise create a surgical opening to be a device that is surgically implanted or inserted (65 FR 67805).

With this revision of our definition of devices that are surgically inserted or implanted, we remind the public that device category eligibility for transitional pass-through payment continues to depend on meeting our substantial clinical improvement criterion, where we compare the clinical outcomes of treatment options using the device to currently available treatments, including treatments using devices in existing or previously established pass-through device categories. We expect that requested new pass-through device categories that successfully demonstrate substantial clinical improvement for Medicare beneficiaries would describe new devices, where the additional device costs would not be reflected in the hospital claims data providing the costs of treatments available during the time period used for the most recent OPPS update.

c. Existing Device Category Criterion

One of our criteria, as set forth in § 419.66(c)(1) of the regulations, to establish a new device category for pass-through payment, is that the devices that would populate the category not be described by any existing or previously existing category. Commenters to our various proposed rules, as well as applicants for new device categories, have expressed concern that some of our existing and previously existing device category descriptors are overly broad, and that the category descriptors as they are currently written may preclude some new technologies from qualifying for establishment of a new device category for pass-through payment. Such parties have recommended that we consider modifying the descriptors for existing device categories, especially when a device would otherwise meet all the other criteria for establishing a new device category to qualify for pass-through payment.

We agree that implementation of the requirement that a new device category not be described by an existing or previously existing category merits review. Beginning with CY 2006, 3 years will have elapsed since 95 of the 97 initial device categories we established on April 1, 2001 will have expired: 95 categories expired after December 31, 2002, and 2 categories expired after December 31, 2003. Several additional years will have passed since those categories were first populated in CY 2000 or CY 2001. Thus, while some of the initial device category descriptors sufficed at the time they were first created, further clarification as to the types of devices that they are meant to describe is indicated. Therefore, we are proposing to create an additional category for devices that meet all of the criteria required to establish a new category for pass-through payment in instances where we believe that an existing or previously existing category descriptor does not appropriately describe the new type of device. This may entail the need to clarify or refine the short or long descriptors of the previous category. We would evaluate each situation on a case by case basis. We are proposing that any such clarification would be made prospectively from the date the new category would be made effective.

We are also proposing to revise § 419.66(c)(1) of the regulations, accordingly, to reflect as one of the criteria for establishing a device category our determination that a device is not appropriately described by any of the existing categories or by any category previously in effect. In order to determine if a ''new'' device is appropriately described by an existing or previously existing category of devices, we are proposing to apply two tests based upon our evaluation of information provided to us in the device category application. First, we will expect an applicant for a new device category to show that their device is not similar to devices (including related predicate devices) whose costs are reflected in our OPPS claims data in the most recent OPPS update. Second, we will require an applicant for a new device category to demonstrate that utilization of their device provides a substantial clinical improvement for Medicare beneficiaries compared with currently available treatments, including procedures utilizing devices in existing or previously existing device categories. We would consider a new device that meets both of these tests not to be appropriately described by one of the existing or previously existing pass-through device categories.

V. Proposed Payment Changes for Drugs, Biologicals, and Radiopharmaceutical Agents

A. Transitional Pass-Through Payment for Additional Costs of Drugs and Biologicals

(If you choose to comment on issues in this section, please include the caption ''Pass-Through'' at the beginning of your comment.)

1. Background

Section 1833(t)(6) of the Act provides for temporary additional payments or ''transitional pass-through payments'' for certain drugs and biological agents. As originally enacted by the BBRA, this

provision required the Secretary to make additional payments to hospitals for current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act (Pub. L. 107–186); current drugs and biological agents and brachytherapy used for the treatment of cancer; and current radiopharmaceutical drugs and biological products. For those drugs and biological agents referred to as ''current,'' the transitional pass-through payment began on the first date the hospital OPPS was implemented (before enactment of BIPA (Pub. L. 106–554), on December 21, 2000).

Transitional pass-through payments are also required for certain ''new'' drugs, devices, and biological agents that were not being paid for as a hospital OPD 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 drug, device, or biological. Under the statute, transitional pass-through payments can be made for at least 2 years but not more than 3 years. In Addenda A and B to this proposed rule, pass-through drugs and biological agents are identified by status indicator ''G.''

The process to apply for transitional pass-through payment for eligible drugs and biological agents can be found on our CMS Web site: *http://www.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 to the Office of Management and Budget (OMB) for approval, as required under the Paperwork Reduction Act (PRA). Notification of new drugs and biologicals application processes is generally posted on the OPPS Web site at: *http://www.cms.hhs.gov/providers/hopps.*

2. Expiration in CY 2005 of Pass-Through Status for Drugs and Biologicals

Section 1833(t)(6)(C)(i) of the Act specifies that the duration of transitional pass-through payments for drugs and biologicals must be no less than 2 years and no longer than 3 years. The drugs whose pass-through status will expire on December 31, 2005, meet that criterion. Table 19 below lists the 10 drugs and biologicals for which we are proposing that pass-through status would expire on December 31, 2005.

TABLE 19.—PROPOSED LIST OF DRUGS AND BIOLOGICALS FOR WHICH PASS-THROUGH STATUS EXPIRES DECEMBER 31, 2005

HCPCS	APC	Short descriptor
C9123 ..	9123	Transcyte, per 247 sq cm.
C9205 ..	9205	Oxaliplatin.
C9211 ..	9211	Inj, alefacept, IV.
C9212 ..	9212	Inj, alefacept, IM.
J0180 ..	9208	Agalsidase beta injection.
J1931 ..	9209	Laronidase injection.
J2469 ..	9210	Palonosetron HCl.
J3486 ..	9204	Ziprasidone mesylate.
J9041 ..	9207	Bortezomib injection.
Q9955	9203	Inj perflexane lip micros, ml.

3. Drugs and Biologicals With Proposed Pass-Through Status in CY 2006

We are proposing to continue pass-through status in CY 2006 for 14 drugs and biologicals. These items, which are listed in Table 20 below, were given pass-through status as of April 1, 2005. The APCs and HCPCS codes for drugs and biologicals that we are proposing to continue with pass-through status in CY 2006 are assigned status indicator ''G'' in Addendum A and Addendum B of this proposed rule.

Section 1833(t)(6)(D)(i) of the Act sets the payment rate for pass-through eligible drugs (assuming that no pro rata reduction in pass-through payment is necessary) as the amount determined under section 1842(o) of the Act. We note that this section of the Act also states that if a drug or biological is covered under a competitive acquisition contract under section 1847(B), then the payment rate be equal to the average price for the drug or biological for all competitive acquisition areas and year established as calculated and adjusted by the Secretary. The competitive acquisition program has not yet been implemented as of the development of this proposed rule; therefore, we do not have payment rates for certain drugs and biologicals that would be covered under this program at this time. Section 1847(A) of the Act, as added by section 303(c) of Pub. L. 108–173, establishes the use of the average sales price (ASP) methodology as the basis for payment of drugs and biologicals described in section 1842(o)(1)(C) of the Act and furnished on or after January 1, 2005. This payment methodology is set forth in § 419.64 of the regulations. Similar to the payment policy established for pass-through drugs and biologicals in CY 2005, we are proposing to pay under the OPPS for drugs and biologicals with pass-through status in CY 2006 consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment these drugs and biologicals would receive in the physician office setting.

Section 1833(t)(6)(D)(i) of the Act also sets the amount of additional payment for pass-through eligible drugs and biologicals (the pass-through payment amount). The pass-through payment amount is the difference between the amount authorized under section 1842(o) of the Act, 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.

As we explain in section V.B. of this proposed rule, we are proposing to continue to make separate payment in CY 2006 for new drugs and biologicals with a HCPCS code consistent with the provisions of section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, at a rate that is equivalent to the payment they would receive in a physician office setting, whether or not we have received a pass-through application for the item. Accordingly, in CY 2006, the pass-through payment amount would equal zero for those new drugs and biologicals that we determine have pass-through status. That is, when we subtract the amount to be paid for pass-through drugs and biologicals under section 1842(o) of the Act, as amended by section 621 of Pub. L. 108–173, from the portion of the otherwise applicable fee schedule amount, or the APC payment rate associated with the drug or biological that would be the amount paid for drugs and biologicals under section 1842(o) of the Act as amended by section 621 of Pub. L. 108–173, the resulting difference is equal to zero.

We are proposing to use payment rates based on the ASP data from the fourth quarter of 2004 for budget neutrality estimates, impact analyses, and to complete Addenda A and B of this proposed rule because these are the most recent numbers available to us during the development of this proposed rule. These payment rates were also the basis for drug payments in the physician office setting effective April 1, 2005. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B of this proposed rule when we publish our final rule and also on a quarterly basis on our Web site during CY 2006 if later quarter ASP submissions indicate that adjustments to the payment rates for these pass-

through drugs and biologicals are necessary.

Table 20 lists the drugs and biologicals for which we are proposing that pass-through status continue in CY 2006. We assigned pass-through status to these drugs and biologicals as of April 1, 2005. We also have included in Addenda A and B to this proposed rule the proposed CY 2006 APC payment rates for these pass-through drugs and biologicals.

TABLE 20.—PROPOSED LIST OF DRUGS AND BIOLOGICALS WITH PASS-THROUGH STATUS IN CY 2006

HCPCS code	APC	Short descriptor
C9220 ..	9220	Sodium hyaluronate.
C9221 ..	9221	Graftjacket Reg Matrix.
C9222 ..	9222	Graftjacket SftTis.
J0128 ..	9216	Abarelix injection.
J0878 ..	9124	Daptomycin injection.
J2357 ..	9300	Omalizumab injection.
J2783 ..	0738	Rasburicase.
J2794 ..	9125	Risperidone, long acting.
J7518 ..	9219	Mycophenolic acid.
J8501 ..	0868	Oral aprepitant.
J9035 ..	9214	Bevacizumab injection.
J9055 ..	9215	Cetuximab injection.
J9305 ..	9213	Pemetrexed injection.
Q4079	9126	Injection, Natalizumab, 1 MG.

B. Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status

(If you choose to comment on issues in this section, please include the caption ''NonPass-Throughs'' at the beginning of your comment.)

1. Background

Under the OPPS, we currently pay for drugs, biologicals including blood and blood products, and radiopharmaceuticals that do not have pass-through status in one of two ways: packaged payment and separate payment (individual APCs). We explained in the April 7, 2000 final rule (65 FR 18450) that we generally package the cost of drugs and radiopharmaceuticals into the APC payment rate for the procedure or treatment with which the products are usually furnished. Hospitals do not receive separate payment from Medicare for packaged items and supplies, and hospitals may not bill beneficiaries separately for any packaged items and supplies whose costs are recognized and paid for within the national OPPS payment rate for the associated procedure or service. (Program Memorandum Transmittal A–01–133, issued on November 20, 2001, explains in greater detail the rules regarding separate payment for packaged services.)

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. In general, packaging the costs of items and services into the payment for the primary procedure or service with which they are associated encourages hospital efficiencies and also enables hospitals to manage their resources with maximum flexibility. Notwithstanding our commitment to package as many costs as possible, we are aware that packaging payments for certain drugs, biologicals, and radiopharmaceuticals, 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.

Section 1833(t)(16)(B) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires that the threshold for establishing separate APCs for drugs and biologicals be set at $50 per administration for CYs 2005 and 2006. For CY 2005, we finalized our policy to continue paying separately for drugs, biologicals, and radiopharmaceuticals whose median cost per day exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose median cost per day is less than $50 into the procedures with which they are billed. For CY 2005, we also adopted an exception policy to our packaging rule for one particular class of drugs, the oral and injectible 5HT3 forms of anti-emetic treatments (69 FR 65779 through 65780).

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

For CY 2006, the threshold for establishing separate APCs for drugs and biologicals is required to be set at $50 per administration according to section 1833(t)(16)(B) of the Act. Therefore, we are proposing to continue our existing policy of paying separately for drugs, biologicals, and radiopharmaceuticals whose per day cost exceeds $50 and packaging the cost of drugs, biologicals, and radiopharmaceuticals whose per day cost is less than $50 into the procedures with which they are billed. We are also proposing to continue our policy of exempting the oral and injectible 5HT3 anti-emetic products from our packaging rule (Table 21), thereby making separate payment for all of the 5HT3 anti-emetic products. As stated in our CY 2005 final rule with comment period (69 FR 65779 through 65780), chemotherapy is very difficult for many patients to tolerate as the side effects are often debilitating. In order for beneficiaries to achieve the maximum therapeutic benefit from chemotherapy and other therapies with side effects of nausea and vomiting, anti-emetic use is often an integral part of the treatment regimen. We want to continue to ensure that our payment rules do not impede a beneficiary's access to the particular anti-emetic that is most effective for him or her as determined by the beneficiary and his or her physician.

TABLE 21.—PROPOSED ANTI-EMETICS TO EXEMPT FROM $50 PACKAGING REQUIREMENT

HCPCS code	Short description
J2405	Ondansetron HCl injection.
Q0179	Ondansetron HCl 8 mg oral.
Q0180	Dolasetron mesylate oral.
J1260	Dolasetron mesylate.
J1626	Granisetron HCl injection.
Q0166	Granisetron HCl 1 mg oral.
J2469	Palonosetron HCl.

For the CY 2006 proposed payment rates, we calculated the per day cost of all drugs, biologicals, and radiopharmaceuticals that had a HCPCS code in CY 2004 and were paid (via packaged or separate payment) under the OPPS using claims data from January 1, 2004, to December 31, 2004. In CY 2004, multisource drugs and radiopharmaceuticals had two HCPCS codes that distinguished the innovator multisource (brand) drug or radiopharmaceutical from the noninnovator multisource (generic) drug or radiopharmaceutical. We aggregated claims for both the brand and generic HCPCS codes in our packaging analysis of these multisource products. Items such as single indication orphan drugs, certain vaccines, and blood and blood products were excluded from these calculations and our treatment of these items is discussed separately in sections V.F., E., and I., respectively, of this preamble.

In order to calculate the per day cost for drugs, biologicals, and radiopharmaceuticals to determine their packaging status in CY 2006, we are proposing several changes in the methodology that was described in detail in the CY 2004 OPPS proposed rule (68 FR 47996 through 47997) and finalized in the CY 2004 final rule with comment period (68 FR 63444 through 63447). For CY 2006, to calculate the per day cost of the drugs, biologicals, and radiopharmaceuticals, we took the following steps:

Step 1. After application of the cost-to-charge ratios, we aggregated all line-items for a single date of service on a single claim for each product. This resulted in creation of a single line-item with the total number of units and the total cost of a drug or radiopharmaceutical given to a patient in a single day.

Step 2. We then created a separate record for each drug or radiopharmaceutical by date of service, regardless of the number of lines on which the drug or radiopharmaceutical was billed on each claim. For example, ''drug X'' is billed on a claim with two different dates of service, and for each date of service, the drug is billed on two line-items with a cost of $10 and 5 units for each line-item. In this case, the computer program would create two records for this drug, and each record would have a total cost of $20 and 10 units of the product.

Step 3. We trimmed records with unit counts per day greater or less than 3 standard deviations from the geometric mean (This is a new step in the methodology we are proposing for CY 2006).

Step 4. For each remaining record for a drug or radiopharmaceutical, we calculated the cost per unit of the drug. If the HCPCS descriptor for ''drug X'' is ''per 1 mg'' and one record was created for a total of 10 mg (as indicated by the total number of units for the drug on the claim for each unique date of service), then the computer program divided the total cost for the record by 10 to give a per unit cost. We then weighted this unit cost by the total number of units in the record. We did this by generating a number of line-items equivalent to the number of units in that particular claim. Thus, a claim with 100 units of ''drug X'' and a total cost of $200 would be given 100 line-items, each with a cost of $2, while a claim of 50 units with a cost of $50 would be given 50 line items, each with a cost of $1.

Step 5. We then trimmed the unit records with cost per unit greater or less than 3 standard deviations from the geometric mean.

Step 6. We aggregated the remaining unit records to determine the mean cost per unit of the drug or radiopharmaceutical.

Step 7. Using only the records that remained after records with unit counts per day greater or less than 3 standard deviations from the geometric mean were trimmed (step 3), the total number of units billed for each item and the total number of unique per-day records for each item were determined. We divided the count of the total number of units by the total number of unique per-day records for each item to calculate an average number of units per day.

Step 8. Instead of using median cost as done in previous years, we used the payment rate for each drug and biological effective April 1, 2005 furnished in the physician office setting, which was calculated using the ASP methodology, and multiplied the payment rate by the average number of units per day for each drug or biological to arrive at its per day cost. For items that did not have an ASP-based payment rate, we used their mean unit cost derived from the CY 2004 hospital claims data to determine their per day cost. Our reasoning for using these cost data is discussed in section V.B.3.a. of this preamble.

Step 9. We then packaged the items with per day cost based on the ASP methodology or mean cost less than $50 and made items with per day cost greater than $50 separately payable.

In the past, many commenters have alleged that hospitals do not accurately bill the number of units for drugs and radiopharmaceuticals. We have consistently decided not to identify which hospital claims contain correctly coded units because we do not believe we should be identifying when a dosage is clinically appropriate from hospital claims information. Variations among patients with respect to appropriate doses, the variety of indications with different dosing regimens for some agents, and the possibility of off-label uses make it difficult to know when units are incorrect. However, we do believe that trimming the units would improve the accuracy of estimates by removing those records with the most extreme units, without requiring us to speculate about clinically appropriate dosing. Therefore, we believe that trimming the records with unit counts greater or less than 3 standard deviations from the geometric mean will eliminate claims from our analysis that may not appropriately represent the actual number of units of a drug or radiopharmaceutical furnished by a hospital to a patient during a specific clinical encounter. Because it reduces extreme variation, trimming on greater or less than 3 standard deviations from the geometric mean makes this trim more conservative and removes fewer records. This change in methodology gives us even greater confidence in the cost estimates we use for our packaging decisions. We are seeking comments on the changes that we are proposing in our methodology for packaging drugs and radiopharmaceuticals.

Section 1833(t)(16)(B) of the Act that requires the threshold for establishing separate APCs for drugs and biologicals to be set at $50 per administration will expire at the end of CY 2006. Therefore, we will be evaluating other packaging thresholds for these products for the CY 2007 OPPS update. We are specifically requesting comments on the use of alternative thresholds for packaging drugs and radiopharmaceuticals in CY 2007.

3. Proposed Payment for Drugs, Biologicals, and Radiopharmaceuticals Without Pass-Through Status That Are Not Packaged

a. Proposed Payment for Specified Covered Outpatient Drugs

(1) Background

Section 1833(t)(14) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires special classification of certain separately paid radiopharmaceutical agents, drugs, and biologicals and mandates specific payments for these items. Under section 1833(t)(14)(B)(i) of the Act, a ''specified covered outpatient drug'' is a covered outpatient drug, as defined in section 1927(k)(2) of the Act, for which a separate APC exists and that either is a radiopharmaceutical agent or is a drug or biological for which payment was made on a pass-through basis on or before December 31, 2002.

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

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

Section 1833(t)(14)(F) of the Act defines the categories of drugs based on section 1861(t)(1) and sections 1927(k)(7)(A)(ii), (k)(7)(A)(iii), and (k)(7)(A)(iv) of the Act. The categories of drugs are ''sole source drugs (includes a biological product or a single source drug),'' ''innovator multiple source drugs,'' and ''noninnovator multiple source drugs.'' The definitions of these specified categories for drugs, biologicals, and radiopharmaceutical agents were discussed in the January 6, 2004 OPPS interim final rule with comment period (69 FR 822), along with our use of the Medicaid average manufacturer price database to determine the appropriate classification

of these products. Because of the many comments received on the January 6, 2004 interim final rule with comment period, the classification of many of the drugs, biologicals, and radiopharmaceuticals changed from that initially published. We announced these changes to the public on February 27, 2004, Transmittal 112, Change Request 3144. We also implemented additional classification changes through Transmittals 132 (Change Request 3154, released March 30, 2004) and Transmittal 194 (Change Request 3322, released June 4, 2004).

Section 1833(t)(14)(A) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, also provides that payment for these specified covered outpatient drugs for CYs 2004 and 2005 is to be based on its ''reference average wholesale price.'' Section 1833(t)(14)(G) of the Act) defines reference AWP as the AWP determined under section 1842(o) of the Act as of May 1, 2003. Section 1833(t)(14)(A)(ii) of the Act, as added by section 621(a) of Pub. L. 108–173 requires that in CY 2005—

- A sole source drug must be paid no less than 83 percent and no more than 95 percent of the reference AWP.
- An innovator multiple source drug must be paid no more than 68 percent of the reference AWP.
- A noninnovator multiple source drug must be paid no more than 46 percent of the reference AWP.

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

For CY 2005, we finalized our policy to determine the payment rates for specified covered outpatient drugs under the provisions of Pub. L. 108–173 by comparing the payment amount calculated under the median cost methodology as done for procedural APCs to the AWP percentages specified in section 1833(t)(14)(A)(ii) of the Act.

(2) Proposed Changes for CY 2006 Related to Pub. L. 108–173

Section 1833(t)(14)(A)(iii) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires that payment for specified covered outpatient drugs in CY 2006 be equal to the average acquisition cost for the drug for that year as determined by the Secretary but subject to any adjustment for overhead costs and taking into account the hospital acquisition cost survey data collected by the GAO in 2004 and 2005. If hospital acquisition cost data are not available, then the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847(A), or section 1847(B) of the Act as calculated and adjusted by the Secretary as necessary.

(3) Data Sources Available for Setting CY 2006 Payment Rates

Section 1833(t)(14)(D) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, outlines the provisions of the hospital outpatient drug acquisition cost survey mandated for the GAO. This provision directs the GAO to collect data on hospital acquisition costs of specified covered outpatient drugs and to provide information based on these data that can be taken into consideration for setting CY 2006 payment rates for these products under the OPPS. Accordingly, the GAO conducted a survey of 1,400 acute care, Medicare-certified hospitals requesting hospitals to provide purchase prices for specified covered outpatient drugs purchased from July 1, 2003 to June 30, 2004. The survey yielded a response rate of 83 percent where 1,157 hospitals provided usable information. To ensure that its methodology for data collection and analysis were sound, the GAO consulted an advisory panel of experts in pharmaceutical economics, pharmacy, medicine, survey sampling and Medicare payment.

The GAO reported the average and median purchase prices for 55 specified covered outpatient drug categories for the period July 1, 2003 to June 30, 2004. These items represented 86 percent of the Medicare spending for specified covered outpatient drugs during the first 9 months of 2004. The initial GAO data did not include any radiopharmaceuticals. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations.

Another source of drug pricing information that we have is the ASP data from the fourth quarter of 2004, which were used to set payment rates for drugs and biologicals in the physician office setting effective April 1, 2005. We have ASP-based prices for approximately 475 drugs and biologicals (including contrast agents) payable under the OPPS; however, we currently do not have any ASP data on radiopharmaceuticals. Payments for most of the drugs and biologicals paid in the physician office setting are based on the ASP+6 percent. Payments for items with no reported ASP are based on wholesale acquisition cost (WAC).

Lastly, the third source of cost data we have for drugs, biologicals, and radiopharmaceuticals are the mean and median costs derived from the CY 2004 hospital claims data. In our data analysis, we compared the payment rates for drugs and biologicals using data from all three sources described above. As section 1833(t)(14)(A)(iii) of the Act clearly specifies that payment for specified covered outpatient drugs in CY 2006 be equal to the ''average'' acquisition cost for the drug, we limited our analysis to the mean costs of drugs determined using the GAO acquisition cost survey and the hospital claims data, instead of using median costs.

We estimated aggregate expenditures for all drugs and biologicals (excluding radiopharmaceuticals) that would be separately payable in CY 2006 and for the 55 drugs and biologicals reported by the GAO using mean cost from the claims data, the GAO mean purchase price, and the ASP-based payment amount (ASP+6 percent in most cases), and then calculated the equivalent average ASP-based payment rate under each of the three payment methodologies. The results are presented in Table 22 below.

TABLE 22.—COMPARISON OF RELATIVE PRICING FOR OPPS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES

Type of pricing data	Time period of pricing data	ASP equivalent (55 GAO drugs only) (percent)	ASP equivalent (all separately billable drugs)
GAO mean purchase price	12 months ending June 2004	ASP+3	N/A
ASP+6%	4th quarter of 2004	ASP+6	ASP+6%

TABLE 22.—COMPARISON OF RELATIVE PRICING FOR OPPS DRUGS AND BIOLOGICALS UNDER VARIOUS PAYMENT METHODOLOGIES—Continued

Type of pricing data	Time period of pricing data	ASP equivalent (55 GAO drugs only) (percent)	ASP equivalent (all separately billable drugs)
Mean cost from claims data	1st 9 months of 2004	ASP+8	ASP+8%

Prior to any adjustments for the differing time periods of the pricing data, the results indicated that using the GAO mean purchase prices as the basis for paying the 55 drugs and biologicals would be equivalent to paying for those drugs and biologicals, on average, at ASP+3 percent. Additionally, using mean unit cost to set the payment rates for the drugs and biologicals that would be separately payable in CY 2006 would be equivalent to basing their payment rates, on average, at ASP+8 percent.

In determining the payment rates for drugs and biologicals in CY 2006, we are not proposing to use the GAO mean purchase prices for the 55 drugs and biologicals because the GAO data reflect hospital acquisition costs from a less recent period of time. The survey was conducted from July 1, 2003 to June 30, 2004; thus, the purchase prices are generally reflective of the time that is the midpoint of this period, which is January 1, 2004. The hospital purchase price data also does not fully account for rebates from manufacturers or payments from group purchasing organizations made to hospitals. We also note that it would be difficult to update the GAO mean purchase prices during CY 2006 and in future years.

We are also not proposing, in general, to use mean costs from CY 2004 hospital claims data to set payment rates for drugs and biologicals in CY 2006. In previous OPPS rules, we stated that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median cost of drug administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of acquiring the item (66 FR 59896 and 67 FR 66769). However, findings from a MedPAC survey of hospital charging practices indicated that hospitals set charges for drugs, biologicals, and radiopharmaceuticals high enough to reflect their handling costs as well as their acquisition costs; therefore, the mean costs calculated using charges from hospital claims data converted to costs are representative of hospital acquisition costs for these products, as well as their overhead costs. For CY 2006, the statute specifies that payments for specified covered outpatient drugs are required to be equal to the ''average'' acquisition cost for the drug. Payments based on mean costs would represent the products' acquisition costs plus overhead costs, instead of acquisition costs only. Therefore, we believe that it is appropriate for us to use a source of cost information other than the CY 2004 hospital claims data to set the payment rates for most drugs and biologicals in CY 2006.

We are proposing to pay ASP+6 percent for separately payable drugs and biologicals in CY 2006. Given the data as described above, we believe this is our best estimate of average acquisition costs for CY 2006. We note that the comparison between the GAO purchase price data and the ASP data indicated that the GAO data on average were equivalent to ASP+3 percent. However, as noted earlier, this comparison is problematic for two reasons. First, there are differences in the time periods for two sources of data. The GAO data are from the 12 months ending June 2004 and the ASP data are from the fourth quarter of 2004. It could be argued that prices increased in the intervening time period. However, we do not have a source of reliable information on specific price changes for this time period for the drugs studied by the GAO. In the future, we will have better information on price trends for Medicare Part B drugs as more quarters of pricing information are reported under the ASP system.

We also note the comparison between the GAO data and the ASP data is problematic as the ASP data include rebates and other price concessions and the GAO data do not. Inclusion of these rebates and price concession in the GAO data would decrease the GAO prices relative to the ASP prices, suggesting that ASP+6 percent may be an overestimate of hospitals' average acquisition costs. Unfornately, we do not have a source of information on the magnitude of the rebates and price concessions for the specific drugs in the GAO data at this time.

At the present time, therefore, it is difficult to adjust the GAO prices for inflation, rebates, and price concessions to make the comparison with ASP more precise. We will continue to examine new data to improve our future estimates of acquisition costs. In future years, our proposed pricing will be modified as appropriate to reflect the most recent data and analyses available. We also note that, in addition to the importance of making accurate estimates of acquisition costs for drug pricing, there are important implications for prices of other services due to the required budget neutrality of the OPPS. For example, drugs and biological prices set at ASP+3 percent instead of ASP+6 percent would have made available approximately an additional $60 million for other items and services under the OPPS.

We note that ASP data are unavailable for some drugs and biologicals. For the few drugs and biologicals, other than radiopharmaceuticals as discussed later, where ASP data are unavailable, we are proposing to use the mean costs from the CY 2004 hospital claims data to determine their packaging status for ratesetting. Until we receive ASP data for these items, payment will be based on their mean cost.

Our proposal uses payment rates based on ASP data from the fourth quarter of 2004 because these are the most recent numbers available to us during the development of this proposed rule. To be consistent with the ASP-based payments that would be made when these drugs and biologicals are furnished in physician offices, we plan to make any appropriate adjustments to the amounts shown in Addenda A and B to this proposed rule for these items based on more recent ASP data from the second quarter of 2005, which will be the basis for setting payment rates for drugs and biologicals in the physician office setting effective October 1, 2005, prior to our publication of the CY 2006 OPPS final rule and also on a quarterly basis on our Web site during CY 2006. We note that we would determine the packaging status of each drug or biological only once during the year during the update process; however, for the separately payable drugs and biologicals, we would update their ASP-based payment rates on a quarterly basis.

We intend for the quarterly updates of the ASP-based payment rates for separately payable drugs and biologicals to function as future surveys of hospital acquisition cost data, as section 1833(t)(14)(D)(ii) of the Act instructs us to conduct periodic subsequent surveys to determine hospital acquisition cost for each specified covered outpatient drug.

We are specifically requesting comments on our proposal to pay for drugs and biologicals (including contrast agents) under the OPPS using the ASP-based methodology that is also used to set the payment rates for drugs and biologicals furnished in physician offices and the adequacy of the payment rates to account for acquisition costs of the drugs and biologicals.

In CY 2005, we applied an equitable adjustment to determine the payment rate for darbepoetin alfa (Q0137) pursuant to section 1833(t)(2)(E) of the Act. However, for CY 2006, we are proposing to establish the payment rate for this biological using the ASP methodology. The ASP data represents market prices for this biological; therefore, we believe it is appropriate to use the ASP methodology to establish payment rates for darbepoetin alfa because this method will permit market forces to determine the appropriate payment for this biological. We are seeking comments on the proposed payment policy for this biological.

Effective April 1, 2005, several HCPCS codes were created to describe various concentrations of low osmolar contrast material (LOCM). These new codes are Q9945 through Q9951. However, in Transmittal 514 (April 2005 Update of the OPPS), we instructed hospitals to continue reporting LOCM in CY 2005 using the existing HCPCS codes A4644, A4645, and A4646 and made Q9945 through Q9951 not payable under the OPPS. For CY 2006, we are proposing to activate the new Q-codes for hospitals and discontinue the use of HCPCS codes A4644 through A4646 for billing LOCM products. We have CY 2004 hospital claims data for HCPCS codes A4644 through A4646, which show that the mean costs per day for these products are greater than $50. Because we do not have CY 2004 hospital claims data for HCPCS codes Q9945 through Q9951, we crosswalked the cost data for the HCPCS A-codes to the new Q-codes. There is no predecessor code which crosswalks to HCPCS code Q9951 for LOCM with a concentration of 400 or greater mg/ml of iodine. Therefore, our general payment policy of paying separately for new codes while hospital data are being collected applies to HCPCS code Q9951. As our historical hospital mean per day costs for the three A codes exceed the packaging threshold and our payment policy for new codes without predecessors applies to one of the new codes, we are proposing to pay for the HCPCS codes Q9945 through Q9951 separately in CY 2006 at payment rates calculated using the ASP methodology. We note that because the new Q-codes describing LOCM are more descriptively discriminating and have different units than the previous A-codes for LOCM as well as widely varying ASPs, we expect that the packaging status of these Q-codes may change in future years when we have specific OPPS claims data for these new codes. We are seeking comments specifically on our proposed policy to pay separately for LOCM described by HCPCS codes Q9945 through Q9951 in CY 2006.

(4) CY 2006 Proposed Payment Policy for Radiopharmaceutical Agents

We do not have ASP data for radiopharmaceuticals. Therefore, for CY 2006, we are proposing to calculate per day costs of radiopharmaceuticals using mean unit cost from the CY 2004 hospital claims data to determine the items' packaging status similar to the drugs and biologicals with no ASP data. In a separate report, the GAO provided CMS with hospital purchase price information for nine radiopharmaceutical agents. As part of the GAO survey described earlier, the GAO surveyed 1,400 acute-care, Medicare-certified hospitals requesting hospitals to provide purchase prices for radiopharmaceuticals from July 1, 2003 to June 30, 2004. The radiopharmaceutical part of the survey yielded a response rate of 61 percent, where 808 hospitals provided usable information. The GAO reported the average and median purchase prices for nine radiopharmaceuticals for the period July 1, 2003 to June 30, 2004. These items represented 9 percent of the Medicare spending for specified covered outpatient drugs during the first 9 months of 2004. The report noted that the purchase price information accounted for volume and other discounts provided at the time of purchase, but excluded subsequent rebates from manufacturers and payments from group purchasing organizations.

When we examined differences between the CY 2005 payment rates for these nine radiopharmaceutical agents and their GAO mean purchase prices, we saw that the GAO purchase prices were substantially lower for several of these agents. We also saw similar patterns when we compared the CY 2005 payment rates for radiopharmaceutical agents with their CY 2004 median and mean costs from hospital claims data. Our intent is to maintain consistency, whenever possible between the payment rates for these agents from CY 2005 to CY 2006, because such rapid reductions could adversely affect beneficiary access to services utilizing radiopharmaceuticals.

As we do not have ASPs for radiopharmaceuticals that best represent market prices, we are proposing as a temporary 1-year policy for CY 2006 to pay for radiopharmaceutical agents that are separately payable in CY 2006 based on the hospital's charge for each radiopharmaceutical agent adjusted to cost. As MedPAC has indicated that hospitals currently include the charge for pharmacy overhead costs in their charge for the radiopharmaceutical, if we pay for these items using charges converted to cost, we believe that payment at cost would be the best available proxy for the average acquisition cost of the radiopharmaceutical along with its handling cost until we receive ASP information and overhead information on these agents. We expect that hospitals' different purchasing and preparation and handling practices for radiopharmaceuticals would be reflected in their charges, which would be converted to costs using hospital-specific cost-to-charge ratios. To better identify the separately payable radiopharmaceutical agents to which this policy would apply, we propose to assign them to status indicator ''H'' in Addendum B of this rule. Should ASP data be unavailable for radiopharmaceuticals for CY 2007, it is not apparent to us what methodology we could use to establish payment rates for these items in CY 2007 other than the hospital CY 2006 claims-based methodology. We are seeking comments specifically on the proposed payment policy for separately payable radiopharmaceutical agents in CY 2006.

Section 303(h) of Pub. L. 108–173 exempted radiopharmaceuticals from ASP pricing in the physician office setting where the fewer numbers (relative to the hospital outpatient setting) of radiopharmaceuticals are priced locally by Medicare contractors. However, radiopharmaceuticals are subject to ASP reporting. We currently do not require reporting for radiopharmaceuticals because we do not pay for any of the radiopharmaceuticals using the ASP methodology. However, for CY 2006, we are proposing to begin collecting ASP data on all radiopharmaceutical agents for purposes of ASP-based payment of

radiopharmaceuticals beginning in CY 2007.

We recognize that there are significant complex issues surrounding the reporting of ASPs for radiopharmaceutical agents. Most radiopharmaceuticals must be compounded from a ''cold kit'' containing necessary nonradioactive materials for the final product to which a radioisotope is added. There are critical timing issues, given the short half-lives of many radioisotopes used for diagnostic or therapeutic purposes. Significant variations in practices exist with respect to what entity purchases the constituents and who then compounds the radiopharmaceutical to develop a final product for administration to a patient. For example, manufacturers may sell the components of a radiopharmaceutical to independent radiopharmacies. These radiopharmacies may then sell unit or multi-doses to many hospitals; however, some hospitals also may purchase the components of the radiopharmaceutical and prepare the radiopharmaceutical themselves. In some cases, hospitals may generate the radioisotope on-site, rather than purchasing it. The costs associated with acquiring the radiopharmaceutical in these instances may significantly vary. Also, there may only be manufacturer pricing for the components; however, the price set by the manufacturer for one component of a radiopharmaceutical may not directly translate into the acquisition cost of the ''complete'' radiopharmaceutical, which may result from the combination of several components. In general, for drugs other than radiopharmaceuticals, the products sold by manufacturers with National Drug Codes (NDCs) correspond directly with the HCPCS codes for the products administered to patients so ASPs may be directly calculated for the HCPCS codes. In the case of radiopharmaceuticals this 1:1 relationship may not hold, potentially making the calculation of ASPs for radiopharmaceuticals more complex. In addition, some hospitals may generate their own radioisotopes, which they then use for radiopharmaceutical compounding, and they may sell these complete products to other sites. The costs associated with this practice could be difficult to capture through ASP reporting. We seek very specific comments on these and all other relevant issues surrounding implementation of ASP reporting for radiopharmaceuticals. We discuss in section V.B.3.a.(5) of this preamble under the MedPAC report on APC payment rate adjustments, our CY 2006 proposed payment policies for overhead costs of drugs, biologicals, and radiopharmaceuticals.

In section V.D. of the preamble we discuss the methodology that we are proposing to use to determine the CY 2006 payment rates for new drugs, biologicals, and radiopharmaceuticals.

While payments for drugs, biologicals and radiopharmaceuticals are taken into account when calculating budget neutrality, we note that we are proposing to pay for drugs, biologicals and radiopharmaceuticals without scaling these payment amounts. We believe that these payment amounts are the best proxies we have for the average acquisition costs of drugs, biologicals, and radiopharmaceuticals for CY 2006; therefore, Congress would not have intended for us to scale these payment rates. In section V.B.3.a.(5) of this preamble, we also discuss that we propose to add 2 percent of the ASP to the payment rates for drugs and biologicals with rates based on the ASP methodology to provide payment to hospitals for pharmacy overhead costs associated with furnishing these products. We are proposing to scale these additional payment amounts for pharmacy overhead costs. We are seeking comments on whether it is appropriate to exempt payment rates for drugs, biologicals, and radiopharmaceuticals from scaling and scale the additional payment amount for pharmacy overhead costs.

We note that further discussion of the budget neutrality implications of the various drug payment proposals that we considered is included in section XIV.C. of this preamble.

(5) MedPAC Report on APC Payment Rate Adjustment of Specified Covered Outpatient Drugs

Section 1833(t)(14)(E) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, requires MedPAC to submit a report to the Secretary, not later than July 1, 2005, on adjusting the APC rates for specified covered outpatient drugs to take into account overhead and related expenses, such as pharmacy services and handling costs. This provision also requires that the MedPAC report include the following: A description and analysis of the data available for adjusting such overhead expenses; recommendation as to whether a payment adjustment should be made; and the methodology for adjusting payment, if an adjustment is recommended. Section 1833(t)(14)(E)(ii) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, authorizes the Secretary to adjust the APC weights for specified covered outpatient drugs to reflect the MedPAC recommendation.

The statute mandates MedPAC to report on whether drug APC payments under the OPPS should be adjusted to account for pharmacy overhead and nuclear medicine handling costs associated with providing specified covered outpatient drugs. In creating its framework for analysis, MedPAC interviewed stakeholders, analyzed cost report data, conducted four individual hospital case studies, and received technical advice on grouping items with similar handling costs from a team of experts in hospital pharmacy, hospital finance, cost accounting, and nuclear medicine.

MedPAC concluded that the handling costs for drugs, biologicals, and radiopharmaceuticals delivered in the hospital outpatient department are not insignificant, as medications typically administered in outpatient departments generally require greater pharmacy preparation time than do those provided to inpatients. MedPAC found that little information is currently available about the magnitude of these costs. According to the MedPAC analysis, hospitals historically set charges for drugs, biologicals, and radiopharmaceuticals at levels that reflected their respective handling costs, and payments covered both drug acquisition and handling. Moreover, hospitals vary considerably in their likelihood of providing services which utilize drugs, biologicals, or radiopharmaceuticals with different handling costs.

MedPAC developed seven drug categories for pharmacy and nuclear medicine handling costs, according to the level of resources used to prepare the products (Table 23). Characteristics associated with the level of handling resources required included radioactivity, toxicity, mode of administration, and the need for special handling. Groupings ranged from dispensing an oral medication on the low end of relative cost to providing radiopharmaceuticals on the high end. MedPAC collected cost data from four hospitals that were then used to develop relative median costs for all categories but radiopharmaceuticals (Category 7+). The case study facilities were not able to provide sufficient cost information regarding the handling of outpatient radiopharmaceuticals to develop a cost relative for Category 7+. The MedPAC study classified about 230 different drugs, biologicals, and radiopharmaceuticals into the seven categories based on input from their expert panel and each case study facility.

TABLE 23.—MEDPAC RECOMMENDED DRUG CATEGORIES AND MEDIAN COST RELATIVES

Drug category	Description	Median cost relative
Category 1	Orals (oral tablets, capsules, solutions)	0.36
Category 2	Injection/Sterile Preparation (draw up a drug for administration)	1.00
Category 3	Single IV Solution/Sterile Preparation (adding a drug or drugs to a sterile IV solution) or Controlled Substances.	1.28
Category 4	Compounded/Reconstituted IV Preparations (requiring calculations performed correctly and then compounded correctly).	1.61
Category 5	Specialty IV or Agents requiring special handling in order to preserve their therapeutic value or Cytotoxic Agents, oral (chemotherapeutic, teratogenic, or toxic) requiring PPE.	2.70
Category 6	Cytotoxic Agents (chemotherapeutic, teratogenic, or toxic) in all formulations except oral requiring personal protective equipment (PPE).	5.33
Category 7+	Radiopharmaceuticals: Basic and Complex Diagnostic Agents, PET Agents, Therapeutic Agents, and Radioimmunoconjugates.	(1)

[1] Not available.

In its report, MedPAC recommended the following:

(1) Establish separate, budget neutral payments to cover the costs hospitals incur for handling separately payable drugs, biologicals, and radiopharmaceuticals; and

(2) Define a set of handling fee APCs that group drugs, biologicals, and radiopharmaceuticals based on attributes of the products that affect handling costs; instruct hospitals to submit charges for these APCs; and base payment rates for the handling fee APCs on submitted charges reduced to costs.

MedPAC found some differences in the categorizations of drug and radiopharmaceutical products by different experts and across the case study sites. In the majority of cases where groupings disagreed, hospitals used different forms of the products which were coded with the same HCPCS code. For example, a drug may be purchased as a prepackaged liquid or as a powder requiring reconstitution. Such a drug would vary in the handling resources required for its preparation and would fall into a different drug category depending on its form. In addition, the handling cost groupings may vary depending on the intended method of drug delivery, such as via intravenous push or intravenous infusion. For a number of commonly used drugs, MedPAC provided two categories in their final consensus categorizations, with the categories 2 and 3 reported as the most frequent combination. For example, MedPAC placed HCPCS codes J1260 (Injection, dolasetron mesylate, 10 mg) and J2020 (Injection, linezolid, 200 mg) in consensus categories 2 and 3, acknowledging that the appropriate categorization could vary depending on the clinical preparation and use of the drug. We note that we have no information regarding hospitals' frequencies of use of various forms of drugs provided in the outpatient department under the OPPS, as the case studies only included four facilities and the technical advisory committee was similarly small. Thus, in many cases it is impossible to exclusively and appropriately assign a drug to a certain overhead category that would apply to all hospital outpatient uses of the drug because of the different handling resources required to prepare different forms of the drugs.

There are over 100 separately payable drugs, biologicals, and radiopharmaceuticals that are separately payable under the OPPS but for which MedPAC provided no consensus categorizations in its seven drug groups. We independently examined these products and considered the handling cost categories that could be appropriately assigned to each product as described by an individual HCPCS code. As discussed above, many of the drugs had several forms which would place them in different handling cost groupings depending on the specific form of the drug prepared by the hospital pharmacy for a patient's treatment. Additionally, we believe that hospitals may have difficulty discriminating among the seven categories for some drugs, because the applicability of a given category description to a specific clinical situation may be ambiguous. Indeed, in the MedPAC study, initially only about 80 percent of the case study pharmacists agreed with the expert panel category assignments; however, concurrence increased that percentage to almost 90 percent after discussion and review. Nevertheless, there remained a number of drugs for which differences in categorization by the case study facilities and the expert panel persisted.

In light of our concerns over our ability to appropriately assign drugs to the seven MedPAC drug categories so that the categories accurately describe the drugs' attributes in all of the OPPS hospitals and the MedPAC recommendations, for CY 2006 we are proposing to establish three distinct HCPCS C-codes and three corresponding APCs for drug handling categories to differentiate overhead costs for drugs and biologicals, by combining several of the categories identified in the MedPAC report. We collapsed the MedPAC categories 2, 3, and 4 into a single category described by HCPCS code CXXXX, and MedPAC categories 5 and 6 into another category described by HCPCS code CYYYY, while maintaining MedPAC category 1 as described by HCPCS code CWWWW. Our rationale for not creating an overhead payment category for radiopharmaceuticals is discussed below. We believe that merging categories in this way generally resolves the categorization dilemmas resulting from the most common scenarios where drugs may fall into more than one grouping and minimizes the administrative burden on hospitals to determine which category applies to the handling of a drug in a specific clinical situation. In addition, these broader handling cost groupings minimize any undesirable payment policy incentives to utilize particular forms of drugs or specific preparation methods. We have only collapsed those categories whose MedPAC relative weights differ by less than a factor of two, consistent with the principle outlined in section 1833(t)(2) of the Act that provides that items and services within an APC group cannot be considered comparable with respect to the use of resources if the median of the highest cost item or service within an APC group is more than 2 times greater than the median of the lowest cost item or service within that same group.

As noted previously, we believe that pharmacy overhead costs are captured in the pharmacy revenue cost centers and reflected in the median cost of drug

administration APCs, and the payment rate we established for a drug, biological, or radiopharmaceutical APC was intended to pay only for the cost of acquiring the item (66 FR 59896 and 67 FR 66769). As a MedPAC survey of hospital charging practices indicated that hospitals' charges for drugs, biologicals, and radiopharmaceuticals reflect their handling costs as well as their acquisition costs, we believe pharmacy overhead costs would be incorporated into the OPPS payment rates for drugs, biologicals, and radiopharmaceuticals if the rates are based on hospital claims data. However, in light of our proposal to establish three distinct C-codes for drug handling categories, we are proposing to instruct hospitals to charge the appropriate pharmacy overhead C-code for overhead costs associated with each administration of each separately payable drug and biological based on the code description which best reflects the service the hospital provides to prepare the product for administration to a patient. We would then collect hospital charges for these C-codes for 2 years, and consider basing payment for the corresponding drug handling APCs on the charges reduced to costs in CY 2008, similar to the payment methodology for other procedural APCs. Median hospital costs for the drug handling APCs should reflect the CY 2006 practice patterns across all OPPS hospitals of handling drugs whose preparation is described by each of the C-codes, reflecting the differential utilization of various forms of drugs and alternative methods of preparation and delivery through hospitals' billing and charges for the C-codes. Table 24 contains the drug handling categories, C-codes, and APCs we are proposing for CY 2006.

TABLE 24.—PROPOSED CY 2006 DRUG HANDLING CATEGORIES, C-CODES, AND APCS

Drug handling category	C code	Drug candling APC	Description
Category 1	CWWWW	WWWW	• Orals (oral tablets, capsules, solutions).
Category 2	CXXXX	XXXX	• Injection/Sterile Preparation (draw up a drug for administration). • Single IV Solution/Sterile Preparation (adding a drug or drugs to a sterile IV solution) or Controlled Substances. • Compounded/Reconstituted IV Preparations (requiring calculations performed correctly and then compounded correctly).
Category 3	CYYYY	YYYY	• Specialty IV or Agents requiring special handling in order to preserve their therapeutic value or Cytotoxic Agents, oral (chemotherapeutic, teratogenic, or toxic) requiring PPE. • Cytotoxic Agents (chemotherapeutic, teratogenic, or toxic) in all formulations except oral requiring personal protective equipment (PPE).

We believe that these three categories are sufficiently distinct and reflective of the resources necessary for drug handling to permit appropriate hospital billing and to capture the varying overhead costs of the drugs and biologicals separately payable under the OPPS. We are not proposing to adopt the median cost relatives reported for MedPAC's six categories (excluding radiopharmaceuticals). It is very difficult to accurately crosswalk the cost relatives for the six categories to the three categories we are proposing. In addition, we are not confident that the cost relatives that were based on cost data from four hospitals appropriately reflect the median relative resource costs of all hospitals that would bill these drug handling services under the OPPS. Instead, we believe it is most appropriate to collect hospital charges for the drug handling services based on attributes of the products that affect the hospital resources required for their handling, and consider making future payments under the OPPS using the proposed C-codes based on the medians of charges converted to costs for the drug handling APC associated with each administration of a separately payable drug or biological.

For CY 2006, pursuant to section 1833(t)(14)(E)(ii) of the Act, we propose an adjustment to cover the costs hospitals incur for handling separately payable drugs and biologicals. As we do not currently have separate hospital charge data on pharmacy overhead, we are proposing for CY 2006 to pay for drug and biological overhead costs based on 2 percent of the ASP. As described earlier, we estimated aggregate expenditure for all separately payable OPPS drugs and biologicals (excluding radiopharmaceuticals) using mean costs from the claims data and then determined the equivalent average ASP-based rates. Our calculations indicated that using mean unit costs to set the payment rates for all separately payable drugs and biologicals would be equivalent to basing their payment rates on the ASP+8 percent. As noted previously, because pharmacy overhead costs are already built into the charges for drugs, biologicals, and radiopharmaceuticals as indicated by the MedPAC study described above, we believe that payment for drugs and biologicals and overhead at a combined ASP+8 percent would serve as a proxy for representing both the acquisition cost and overhead cost of each of these products. Moreover, as we are proposing to pay for all separately payable drugs and biologicals using the ASP methodology, where payment rates for most of these items are set at the ASP+6 percent, we believe that an additional 2 percent of the ASP would provide adequate additional payment for the overhead cost of these products and be consistent with historical hospital costs for drug acquisition and handling. Even though we are not proposing to scale the payment rates for drugs and biologicals based on the ASP methodology, we are proposing to scale the additional payment amount of 2 percent of the ASP for pharmacy overhead costs. Therefore, for CY 2006, we are proposing to pay an additional 2 percent of the ASP scaled for budget neutrality for overhead costs associated with separately payable drugs and biologicals, along with paying ASP+6 percent for the acquisition costs of the drugs and biologicals. The payment rate for a separately payable drug or biological shown in Addenda A and B to this proposed rule represents the payment rate for the drug or biological in addition to payment for its overhead costs. We are specifically seeking comments on this proposed policy for paying for pharmacy overhead costs in CY 2006 and on the proposed policy regarding hospital billing of drug handling charges associated with each administration of each separately payable drug or biological using the proposed C-codes.

As discussed earlier, we are proposing to pay for separately payable radiopharmaceutical agents based on their charges in the claims submitted by hospitals converted to costs. MedPAC found that the handling resource costs

associated with radiopharmaceuticals were especially difficult to study because of the varying resource requirements for handling them in a variety of hospital outpatient settings for different clinical uses. These various methods of preparation of radiopharmaceuticals, and the individual radiopharmaceuticals themselves, differ significantly in the costs of their handling, with substantial variation in such factors as site of preparation, personnel time, shielding, transportation, equipment, waste disposal, and regulatory compliance requirements. However, as MedPAC also found that handling costs for drugs, biologicals, and radiopharmaceuticals were built into hospitals' charges for the products themselves, we believe that the charges from hospital claims converted to costs are representative of hospital acquisition costs for these agents, as well as their overhead costs. These costs would appropriately reflect each hospital's potentially diverse patterns of acquisition or production of radiopharmaceuticals for use in the outpatient hospital setting and their related handling costs that vary across radiopharmaceutical products and the circumstances of their production and use. Therefore, we are not proposing to create separate handling categories for radiopharmaceutical agents for CY 2006.

However, because we are proposing to collect ASP information for radiopharmaceuticals in CY 2006, we are seeking specific comments on appropriate categories for potentially capturing radiopharmaceutical handling costs. We believe that these handling costs may vary depending on many factors. The handling cost categories should exclude any resources covered by specific diagnostic procedures or administration codes for patient services that utilize the radiopharmaceuticals. However, the handling cost categories should include all aspects of radiopharmaceutical handling and preparation, including transportation, storage, compounding, required shielding, inventory management, revision of dosages based on patient conditions, documentation, disposal, and regulatory compliance. The MedPAC study contractor suggested a variety of discriminating factors which may be related to the magnitude of radiopharmaceutical handling costs, including the complexity of the calculations and manipulations involved with compounding, the intended use of the product for diagnostic or therapeutic purposes, the item's status as a radioimmunoconjugate or non-radioimmunoconjugate, short-lived agents produced in-house, and preparation of the radiopharmaceutical in-house versus production in a commercial radiopharmacy. We are seeking comments on the construction of radiopharmaceutical handling cost categories that would meaningfully reflect differences in the levels of necessary hospital resources and that could easily be understood and applied by hospitals characterizing their preparation of radiopharmaceuticals.

b. Proposed CY 2006 Payment for Nonpass-Through Drugs, Biologicals, and Radiopharmaceuticals With HCPCS Codes, But Without OPPS Hospital Claims Data

Pub. L. 108–173 does not address the OPPS payment in CY 2005 and after for new drugs, biologicals, and radiopharmaceuticals that have assigned HCPCS codes, but that do not have a reference AWP or approval for payment as pass-through drugs or biologicals. Because there is no statutory provision that dictated payment for such drugs and biologicals in CY 2005, and because we had no hospital claims data to use in establishing a payment rate for them, we investigated several payment options for CY 2005 and discussed them in detail in the CY 2005 OPPS final rule with comment period (69 FR 65797 through 65799).

For CY 2006, we are proposing to use the same methodology that we used in CY 2005. That is, we are proposing to pay for these new drugs and biologicals with HCPCS codes but which do not have pass-through status at a rate that is equivalent to the payment they would receive in the physician office setting, which would be established in accordance with the ASP methodology described in the CY 2005 Medicare Physician Fee Schedule final rule (69 FR 66299). As discussed in the OPPS CY 2005 final rule (69 FR 65797), new drugs, biologicals, and radiopharmaceuticals may be expensive and we are concerned that packaging these new items may jeopardize beneficiary access to them. In addition, we do not want to delay separate payment for these items solely because a pass-through application was not submitted. We note that this payment methodology is the same as the methodology that would be used to calculate the OPPS payment amount that pass-through drugs and biologicals would be paid in CY 2006 in accordance with section 1842(o) of the Act, as amended by section 303(b) of Pub. L. 108–173, and section 1847A of the Act. Thus, we are proposing to continue to treat new drugs, biologicals, and radiopharmaceuticals with established HCPCS codes the same, irrespective of whether pass-through status has been determined. We are also proposing to assign status indicator ''K'' to HCPCS codes for new drugs and biologicals for which we have not received a pass-through application.

There are several drugs, biologicals, and radiopharmaceuticals that were payable during CY 2004 or their HCPCS codes were created effective January 1, 2005 for which we do not have any CY 2004 hospital claims data. In order to determine the packaging status of these items for CY 2006, we calculated an estimate of per day cost of each of these items by multiplying the payment rate for each product as determined using the ASP methodology by an estimated average number of units of each product that would be furnished to a patient during one administration. We are proposing to package items for which we estimated the per administration cost to be less than $50 and pay separately for items with estimated per administration cost greater than $50. Payment for the separately payable items would be based on rates determined using the ASP methodology established in the physician office setting. There are two codes 90393 (Vaccina ig, im) and Q9953 (Inj Fe-based MR contrast, ml) for which we were not able to determine payment rates based on the ASP methodology. Because we are unable to estimate the per administration cost of these items, we are proposing to package them in CY 2006. We are specifically seeking comments on our proposed policy for determining per administration cost of these drugs, biologicals, and radiopharmaceuticals that are payable under the OPPS, but do not have any CY 2004 claims data.

TABLE 25.—PROPOSED CY ASP PAYMENT RATE FOR DRUGS, BIOLOGICALS, AND RADIOPHARMACEUTICALS WITHOUT CY 2004 CLAIMS DATA

HCPCS code	Description	APC	ASP-based payment rate	Est. average number of units per administration	Proposed 2006 status indicator
C1093	TC99M fanolesomab	1093	$1,197.00	1	H
C9206	Integra, per cm2	9206	9.06	19	K
J0135	Adalimumab injection	1083	294.63	2	K
J0288	Ampho b cholesteryl sulfate	0735	12.00	35	K
J0395	Arbutamine HCl injection	9031	160.00	1	K
J1180	Dyphylline injection	9166	7.59	8.4	K
J1457	Gallium nitrate injection	1085	1.28	340	K
J3315	Triptorelin pamoate	9122	363.24	1	K
J7350	Injectable human tissue	9055	3.47	33	K
J9357	Valrubicin, 200 mg	9167	369.60	4	K
Q2012	Pegademase bovine, 25 iu	9168	158.05	56	K
Q2018	Urofollitropin, 75 iu	7037	43.87	2	K
90581	Anthrax vaccine, sc	9169	126.46	1	K
J0200	Alatrofloxacin mesylate		14.75	2.5	N
J7674	Methacholine chloride, neb		0.40	8.875	N
J0190	Inj biperiden lactate/5 mg		3.16	1	N
J3530	Nasal vaccine inhalation		15.00	1	N

C. Proposed Coding and Billing Changes for Specified Covered Outpatient Drugs

(If you choose to comment on issues in this section, please include the caption ''Drug Coding and Billing'' at the beginning of your comment.)

1. Background

As discussed in the January 6, 2004 interim final rule with comment period (69 FR 826), we instructed hospitals to bill for sole source drugs using the existing HCPCS codes, which were priced in accordance with the provisions of section 1833(t)(14)(A)(i) of the Act, as added by Pub. L. 108–173. However, at that time, the existing HCPCS codes did not allow us to differentiate payment amounts for innovator multiple source and noninnovator multiple source forms of the drug. Therefore, effective April 1, 2004, we implemented new HCPCS codes via Program Transmittal 112 (Change Request 3144, February 27, 2004) and Program Transmittal 132 (Change Request 3154, March 30, 2004) that providers were instructed to use to bill for innovator multiple source drugs in order to receive appropriate payment in accordance with section 1833(t)(14)(A)(i)(II) of the Act. We also instructed providers to continue to use the existing HCPCS codes to bill for noninnovator multiple source drugs to receive payment in accordance with section 1833(t)(14)(A)(i)(III) of the Act. These coding policies allowed hospitals to appropriately code for drugs, biologicals, and radiopharmaceuticals based on their classification and to be paid accordingly. We continued this coding practice in CY 2005 with payment made in accordance with section 1833(t)(14)(A)(ii) of the Act.

2. Proposed Policy for CY 2006

For CY 2006, we are proposing to base the payment rates for drugs and biologicals and their pharmacy overhead costs on the ASP methodology that is used to set payment rates for these items in the physician office setting. Under this methodology, a single payment rate for the drug is calculated by considering the prices for both the innovator multiple source (brand) and noninnovator multiple source (generic) forms of the drug. Therefore, under the OPPS, we believe that there is no longer a need to differentiate between the brand and generic forms of a drug. Thus, we are proposing to discontinue use of the C-codes that were created to represent the innovator multiple source drugs. In CY 2006, hospitals would use the HCPCS codes for noninnovator multiple source (generic) drugs to bill for both the brand and generic forms of a drug as they did prior to implementation of section 1833(t)(14)(A) in Pub. L. 108–173. We are specifically requesting comments on this proposed policy.

D. Proposed Payment for New Drugs, Biologicals, and Radiopharmaceuticals Before HCPCS Codes Are Assigned

(If you choose to comment on issues in this section, please include the caption ''HCPCS Codes'' at the beginning of your comment.)

1. Background

Historically, hospitals have used a HCPCS code for an unlisted or unclassified drug, biological, or radiopharmaceutical or used an appropriate revenue code to bill for drugs, biologicals, and radiopharmaceuticals furnished in the outpatient department that do not have an assigned HCPCS code. The codes for not otherwise classified drugs, biologicals, and radiopharmaceuticals are assigned packaged status under the OPPS. That is, separate payment is not made for the code, but charges for the code would be eligible for an outlier payment and, in future OPPS updates, the charges for the code are packaged with the separately payable service with which the code is reported for the same date of service.

Drugs and biologicals that are newly approved by the FDA and for which a HCPCS code has not yet been assigned by the National HCPCS Alpha-Numeric Workgroup could qualify for pass-through payment under the OPPS. An application must be submitted to CMS in order for a drug or biological to be assigned pass-through status, a temporary C-code assigned for billing purposes, and an APC payment amount to be determined. Pass-through applications are reviewed on a flow basis, and payment for drugs and biologicals approved for pass-through status is implemented throughout the year as part of the quarterly updates of the OPPS.

2. Proposed Policy for CY 2006

Section 1833(t)(15) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, provides for payment for new drugs and biologicals until HCPCS codes are assigned under the OPPS. Under this provision, we are required to make payment for an outpatient drug or

biological that is furnished as part of the covered OPD services for which a HCPCS code has not been assigned in an amount equal to 95 percent of AWP. This provision applies only to payments made under the OPPS on or after January 1, 2004.

We initially adopted the methodology for determining payment under section 1833(t)(15) of the Act on an interim basis on May 28, 2004, via Transmittal 188, Change Request 3287, and finalized the methodology for CY 2005 in our CY 2005 OPPS final rule with comment period. In that final rule with comment period, we also expanded the methodology to include payment for new radiopharmaceuticals to which a HCPCS code is not assigned (69 FR 65804 through 65807). We instructed hospitals to bill for a drug or biological that is newly approved by the FDA by reporting the NDC for the product along with a new HCPCS code, C9399 (Unclassified drug or biological). When HCPCS code C9399 appears on a claim, the OCE suspends the claim for manual pricing by the fiscal intermediary. The fiscal intermediary prices the claim at 95 percent of its AWP using the Red Book or an equivalent recognized compendium, and processes the claim for payment. This approach enables hospitals to bill and receive payment for a new drug, biological, or radiopharmaceutical concurrent with its approval by the FDA. The hospital does not have to wait for the next OPPS quarterly release or for approval of a product-specific HCPCS code to receive payment for a newly approved drug, biological, or radiopharmaceutical. In addition, the hospital does not have to resubmit claims for adjustment. Hospitals would discontinue billing HCPCS code C9399 and the NDC upon implementation of a HCPCS code, status indicator, and appropriate payment amount with the next OPPS quarterly update.

For CY 2006, we are proposing to continue the same methodology for paying for new drugs, biologicals, and radiopharmaceuticals without HCPCS codes.

E. Proposed Payment for Vaccines

(If you choose to comment on issues in this section, please include the caption ''Vaccines'' at the beginning of your comment.)

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

Influenza, pneumococcal, and hepatitis B vaccines and their administration are specifically covered by Medicare under section 1861(s)(10) of the Act. We are proposing to continue to pay influenza and pneumococcal vaccines at reasonable cost in CY 2006. However, hepatitis B vaccines so far have been paid under clinical APCs that also include other vaccines. For CY 2006, we are proposing to pay for all hepatitis B vaccines at reasonable cost, consistent with the payment methodology for influenza and pneumococcal vaccines. Influenza and pneumococcal vaccines are exempt from coinsurance and deductible payments under sections 1833(a)(3) and 1833(b) of the Act and have been assigned to status indicator ''L''. However, hepatitis B vaccines have no similar coinsurance or deductible exemption. Therefore, we are proposing to assign these items to status indicator ''F''.

Previously, under the OPPS, separately payable vaccines other than influenza and pneumococcal were grouped into clinical APCs 355 and 356 for payment purposes. Payment rates for these APCs were based on the APCs' median costs, calculated from the costs of all of the vaccines grouped within the APCs. For CY 2006, we are proposing to pay for each separately payable vaccine under its own APC, consistent with our policy for separately payable drugs other than vaccines, instead of aggregating them into clinical APCs with other vaccines. We believe this policy would allow us to more appropriately establish a payment rate for each separately payable vaccine based on the ASP methodology. We are specifically requesting comments on our proposed vaccine policies for CY 2006. Proposed policy changes to coding and payments for the administration of these vaccines are discussed in section VIII. of this preamble.

F. Proposed Changes in Payment for Single Indication Orphan Drugs

(If you choose to comment on issues in this section, please include the caption ''Orphan Drugs'' at the beginning of your comment.)

Section 1833 (t)(1)((B)(i) of the Act gives the Secretary the authority to designate the hospital outpatient services to be covered. The Secretary has specified coverage for certain drugs as orphan drugs (section 1833(t)(14)(B)(ii)(III) of the Act, as added by section 621(a)(1) of Pub. L. 108–173). Section 1833 (t)(14)(C) of the Act, as added by section 621(a)(1) of Pub. L. 108–173, gives the Secretary the authority in CYs 2004 and 2005 to specify the amount of payment for an orphan drug that has been designated as such by the Secretary.

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 costs 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 costs of this special type of drug. Therefore, we are proposing to continue paying for them separately.

In the November 1, 2002 final rule (67 FR 66772), we identified 11 single indication orphan drugs that are used solely for orphan conditions by applying the following criteria:

- The drug is designated as an orphan drug by the FDA and approved by the FDA for treatment of only one or more orphan condition(s).
- The current United States Pharmacopoeia Drug Information (USPDI) shows that the drug has neither an approved use nor an off-label use for other than the orphan condition(s).

Eleven single indication orphan drugs were identified as having met these criteria and payments for these drugs were made outside of the OPPS on a reasonable cost basis.

In the November 7, 2003 final rule with comment period (68 FR 63452), we discontinued payment for orphan drugs on a reasonable cost basis and made separate payments for each single indication orphan drug under its own APC. Payments for the orphan drugs were made at 88 percent of the AWP listed for these drugs in the April 1, 2003 single drug pricer, unless we were presented with verifiable information

that showed that our payment rate did not reflect the price that was widely available to the hospital market. For CY 2004, Ceredase (alglucerase) and Cerezyme (imiglucerase) were paid at 94 percent of the AWP because external data submitted by commenters on the August 12, 2003 proposed rule caused us to believe that payment at 88 percent of the AWP would be insufficient to ensure beneficiaries' access to these drugs.

In the December 31, 2003 correction of the November 7, 2003 final rule with comment period (68 FR 75442), we added HCPCS code J9017 (Arsenic trioxide, 1 mg) to our list of single indication orphan drugs. In the November 15, 2004 final rule with comment period (69 FR 65807), we retained the same criteria for identifying single indication orphan drugs and added two HCPCS codes to our list—C9218 (Injection, Azactidine, per 1 mg) and J9010 (Alemtuzumab, 10 mg) (69 FR 65808). As of CY 2005, the following are the 14 orphan drugs that we have identified as meeting our criteria: C9218 (Injection, Azactidine, per 1 mg); J0205 (Injection, Alglucerase, per 10 units); J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg); J9300 (Gemtuzumab ozogamicin, 5mg); J1785 (Injection, Imiglucerase, per unit); J2355 (Injection, Oprelvekin, 5 mg); J3240 (Injection, Thyrotropin alpha, 0.9 mg); J7513 (Daclizumab, parenteral, 25 mg); J9010 (Alemtuzumab, 10 mg); J9015 (Aldesleukin, per single use vial); J9017 (Arsenic trioxide, 1 mg); J9160 (Denileukin diftitox, 300 mcg); J9216 (Interferon, gamma 1-b, 3 million units); and Q2019 (Injection, Basiliximab, 20 mg).

In the November 15, 2004 final rule with comment period (69 FR 65808), we stated that had we not classified these drugs as single indication orphan drugs for payment under the OPPS, they would have met the definition of single source specified covered outpatient drugs and received lower payments, which could have impeded beneficiary access to these unique drugs dedicated to the treatment of rare diseases. Instead, for CY 2005, under our authority at section 1833(t)(14)(C) of the Act, we set payment for all 14 single indication orphan drugs at the higher of 88 percent of the AWP or the ASP+6 percent. For CY 2005, we also updated on a quarterly basis the payment rates through comparison of the most current ASP and AWP information available to us. Given that CY 2005 was the first year of mandatory ASP reporting by manufacturers, we did not want potential significant fluctuations in the ASPs to affect payments to hospitals furnishing these drugs, which in turn might cause access problems for beneficiaries. Therefore, in the November 15, 2004 final rule, we did not implement the proposed 95 percent AWP cap on payments for single indication orphan drugs which was described in the August 16, 2004 proposed rule (69 FR 50518), as we intended to monitor the impact of our payment policy and consider the need for a cap in future OPPS updates if appropriate (69 FR 65809).

As a part of the GAO study on hospital acquisition costs of specified covered outpatient drugs, the GAO provided the average hospital purchase prices for four orphan drugs: J0256 (Injection, Alpha 1-proteinase inhibitor, 10 mg), J1785 (Injection, Imiglucerase, per unit), J9160 (Denileukin difitox, 300 mcg), and J9010 (Alemtuzumab, 10 mg).

For alpha 1-proteinase inhibitor (J0256), the hospitals in the study sample represented only about 14 percent of the estimated total number of hospitals purchasing the drug. The mean hospital purchase price was about 73 percent of the payment rate based on ASP+6 percent rate and about 63 percent of the CY 2005 payment rate updated in April 2005. We believe the GAO acquisition data for alpha 1-proteinase inhibitor are likely not representative of hospital acquisition costs for the drug because the number of hospitals providing data was so small compared to the total number of hospitals expected to utilize the drug. Furthermore, we recognize that the GAO data on hospital drug acquisition costs do not reflect the current acquisition costs experienced by hospitals but instead, rely on past cost data from late CY 2003 through early CY 2004. On the other hand, the ASP data are more current and thus are likely more reflective of present hospital acquisition costs for alpha 1-proteinase inhibitor.

In contrast to the GAO data for alpha 1-proteinase inhibitor, the GAO data for imiglucerase (J1785) reflect hospital purchase prices from about 69 percent of the hospitals expected to utilize the drug. For this drug, the mean hospital purchase price was about 93 percent of the CY 2005 payment rate for imiglucerase updated in April 2005, which was based on ASP+6 percent rate. Thus, the ASP-based payment rate also would appear to be appropriately reflective of hospital acquisition costs for imiglucerase, and to be consistent with the GAO mean purchase price.

For denileukin difitox (J9160) and alemtuzumab (J9010), the GAO data for these drugs reflect hospital purchase prices from about 77 percent and 66 percent of the hospitals expected to acquire these drugs, respectively. The mean hospital purchase price for denileukin difitox was about 94 percent of the payment rate based on the ASP+6 percent rate and about 79 percent of the CY 2005 payment rate. As for alemtuzumab, the mean hospital purchase price was about 95 percent of the payment rate based on the ASP+6 percent rate and about 89 percent of the CY 2005 payment rate. For both of these drugs, the ASP-based payment rates also appear to be appropriately reflective of their hospital acquisition costs, based on confirmation by the GAO average purchase price data from over two-thirds of the hospitals expected to acquire the drugs.

During the quarterly updates to payment rates for single indication orphan drugs for CY 2005, we observed significant improvement in the accuracy and consistency of manufacturers' reporting of the ASPs for these orphan drugs. Overall, we found that the ASPs as compared to the AWPs were less likely to experience dramatic fluctuations in prices from quarter to quarter. We expect that as the ASP system continues to mature, manufacturers will further refine their quarterly reporting, leading to even greater stability and accuracy in their reporting of sales prices. As the ASPs reflect the average sales prices to all purchasers, the ASP data also include drug sales to hospitals. Past commenters have indicated to us that some orphan drugs are administered principally in hospitals, and to the extent that this is true their ASPs should predominantly be based upon the sales of drugs used by hospitals. For three of the orphan drugs for which the GAO provided average purchase prices from a large percentage of hospitals expected to acquire the drugs, the GAO data were very consistent with the ASP+6 percent. For the fourth drug, the GAO mean was significantly lower than the ASP+6 percent and the confidence interval around that mean was quite tight, although only a small proportion of hospitals expected to acquire the drug reported their purchase prices. Thus, we believe that proposing to pay for orphan drugs based on an ASP methodology is appropriate for the CY 2006 OPPS and should assure patients' continued access to these orphan drugs in the hospital outpatient department. Therefore, for CY 2006, we are proposing to pay for single indication orphan drugs at the ASP+6 percent. We believe that paying for orphan drugs using the ASP methodology is consistent with our proposed general drug payment policy for other separately payable drugs and

biologicals in the CY 2006 and reflects our general view that ASP-based payment rates serve as the best proxy for the average acquisition cost for these items as described in this section V. of the preamble. In addition, we are proposing to pay an additional 2 percent of the ASP scaled for budget neutrality to cover the handling costs of these drugs, also consistent with our proposed general pharmacy overhead payment policy for handling costs associated with separately payable drugs and biologicals. We believe that the ASPs plus 6 percent for orphan drugs will provide appropriate payment for hospital acquisition costs for these drugs that are administered by a relatively small number of providers, so that patients will continue to have access to orphan drugs in the hospital outpatient setting. Hospitals will also receive additional payments for costs associated with their storage, handling, and preparation of orphan drugs. Payment rates will be updated on a quarterly basis to reflect the most current ASPs available to us. Appropriate adjustments to the payment amounts shown in Addendum A and B would be made if the ASP submissions in a later quarter indicate that adjustments to the payment rates are necessary. These changes to the Addenda would be announced in our program instructions released on a quarterly basis and posted on our Web site at *http://www.cms.hhs.gov*. We are specifically requesting comments on our proposed payment policy for orphan drugs in CY 2006.

VI. Estimate of Transitional Pass-Through Spending in CY 2006 for Drugs, Biologicals, and Devices

(If you choose to comment on issues in this section, please include the caption ''Estimated Transitional Pass-Through Spending'' at the beginning of your comment.)

A. Total Allowed Pass-Through Spending

Section 1833(t)(6)(E) of the Act limits the total projected amount of transitional pass-through payments for drugs, biologicals, radiopharmaceuticals, and categories of devices for a given year to an ''applicable percentage'' of projected total Medicare and beneficiary payments under the hospital OPPS. For a year before CY 2004, the applicable percentage was 2.5 percent; for CY 2005 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 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 payments exceed the applicable percentage, but also to determine the appropriate reduction to the conversion factor for the projected level of pass-through spending in the following year.

For devices, making an estimate of pass-through spending in CY 2006 entails estimating spending for two groups of items. The first group consists of those items for which we have claims data for procedures that we believe used devices that were eligible for pass-through status in CY 2004 and CY 2005 and that would continue to be eligible for pass-through payment in CY 2006. The second group consists of those items for which we have no direct claims data, that is, items that became, or would become, eligible in CY 2005 and would retain pass-through status in CY 2006, as well as items that would be newly eligible for pass-through payment beginning in CY 2006.

B. Estimate of Pass-Through Spending for CY 2006

We are proposing to set the applicable percentage cap at 2.0 percent of the total OPPS projected payments for CY 2006. As we discuss in section IV.C. of this preamble, the three remaining device categories receiving pass-through payment in CY 2005 will expire on December 31, 2005. Therefore, we estimate pass-through spending attributable to the first group of items described above to equal zero.

To estimate CY 2006 pass-through spending for device categories in the second group, that is, items for which we have no direct claims data, we are proposing to use the following approach: For additional device categories that are approved for pass-through status after July 1, 2005, but before January 1, 2006, we are proposing to use price information from manufacturers and volume estimates based on claims for procedures that would most likely use the devices in question because we would have no CY 2004 claims data upon which to base a spending estimate. We are proposing to project these data forward to CY 2006 using inflation and utilization factors based on total growth in OPPS services as projected by CMS' Office of the Actuary (OACT) to estimate CY 2006 pass-through spending for this group of device categories. For device categories that become eligible for pass-through status in CY 2006, we are proposing to use the same methodology. We anticipate that any new categories for January 1, 2006, would be announced after the publication of this proposed rule, but before publication of the final rule. Therefore, the estimate of pass-through spending in the CY 2006 OPPS final rule would incorporate any pass-through spending for device categories made effective January 1, 2006, and during subsequent quarters of CY 2006.

With respect to CY 2006 pass-through spending for drugs and biologicals, as we explain in section V.A.3. of this proposed rule, the pass-through payment amount for new drugs and biologicals that we determine have pass-through status would equal zero. Therefore, our estimate of pass-through spending for drugs and biologicals with pass-through status in CY 2006 equals zero.

In accordance with the methodology described above and the methodology for estimating pass-through spending discussed in the August 16, 2004 proposed rule (69 FR 50526), we estimate that total pass-through spending for device categories that first become eligible for pass-through status after publication of this proposed rule for which pass-through payment continues in CY 2006 or become eligible during CY 2006 would equal approximately $12.5 million, which represents 0.05 percent of total OPPS projected payments for CY 2006. This figure includes estimates for the current device categories continuing into CY 2006, which equals zero, in addition to projections for categories that first become eligible during the second half of CY 2005 or in CY 2006.

This estimate of total pass-through spending for CY 2006 is significantly lower than previous years' estimates both because of the method we are proposing in section V.A.3. of this preamble for determining the amount of pass-through payment for drugs and biologicals with pass-through status, and the fact that there are no CY 2005 pass-through device categories that are being carried over to CY 2006.

Because we estimate pass-through spending in CY 2006 would not amount to 2.0 percent of total projected OPPS CY 2006 spending, we are proposing to return 1.95 percent of the pass-through pool to adjust the conversion factor, as we discuss in section II.C. of this preamble.

VII. Proposed Brachytherapy Payment Changes

(If you choose to comment on issues in this section, please include the caption ''Brachytherapy'' at the beginning of your comment.)

A. Background

Section 1833(t)(16)(C) and section 1833(t)(2)(H) of the Act, as added by sections 621(b)(1) and (b)(2) of Pub. L. 108–173, respectively, establish separate payment for devices of brachytherapy consisting of a seed or seeds (or radioactive source) based on a hospital's charges for the service, adjusted to cost. Charges for the brachytherapy devices may not be used in determining any outlier payments under the OPPS. In addition, consistent with our practice under the OPPS to exclude items paid at cost from budget neutrality consideration, these items must be excluded from budget neutrality as well. The period of payment under this provision is for brachytherapy sources furnished from January 1, 2004, through December 31, 2006.

Section 621(b)(3) of Pub. L. 108–173 requires the Government Accountability Office (GAO) to conduct a study to determine appropriate payment amounts for devices of brachytherapy, and to submit a report on its study to the Congress and the Secretary, including recommendations. We are awaiting the report and any recommendations on the payment of brachytherapy, which would pertain to brachytherapy payments after December 31, 2006.

In the OPPS interim final rule with comment period published on January 6, 2004 (69 FR 827), we implemented sections 621(b)(1) and (b)(2)(C) of Pub. L. 108–173. In that rule, we stated that we will pay for the brachytherapy sources listed in Table 4 of the interim final rule with comment period (69 FR 828) on a cost basis, as required by the statute. The status indicator for brachytherapy sources was changed to ''H.'' The definition of status indicator ''H'' was for pass-through payment only for devices, but the brachytherapy sources affected by sections 1833(t)(16)(C) and 1833(t)(2)(H) of the Act are not pass-through device categories. Therefore, we also changed, for CY 2004, the definition of payment status indicator ''H'' to include nonpass-through brachytherapy sources paid on a cost basis. This use of status indicator ''H'' was a pragmatic decision that allowed us to pay for brachytherapy sources in accordance with section 1833(t)(16)(C) of the Act, effective January 1, 2004, without having to modify our claims processing systems. We stated in the January 6, 2004 interim final rule with comment period that we would revisit the use and definition of status indicator ''H'' for this purpose in the OPPS update for CY 2005. In the November 15, 2004 final rule with comment period, we finalized this policy for CY 2005 (69 FR 65838).

As we indicated in the January 6, 2004 interim final rule with comment period, we began payment for the brachytherapy source in HCPCS code C1717 (Brachytx source, HCR lr-192) based on the hospital's charge adjusted to cost beginning January 1, 2004. Prior to enactment of Pub. L. 108–173, these sources were paid as packaged services in APC 0313. As a result of the requirement under Pub. L. 108–173 to pay for HCPCS code C1717 separately, we adjusted the payment rate for APC 0313, Brachytherapy, to reflect the unpackaging of the brachytherapy source. We finalized this payment methodology in our November 15, 2004 final rule with comment period (69 FR 65839).

Section 1833(t)(2)(H) of the Act, as added by section 621(b)(2)(C) of Pub. L. 108–173, mandated the creation of separate groups of covered OPD services that classify brachytherapy devices separately from other services or groups of services. The additional groups must be created in a manner that reflects the number, isotope, and radioactive intensity of the devices of brachytherapy furnished, including separate groups for Palladium-103 and Iodine-125 devices. At its meetings in February 2004, the APC Panel heard from parties that recommended the addition of two new codes to describe brachtherapy sources in a manner that reflects the number, radioisostope, and radioactive intensity of the sources. The presenters recommended two new brachytherapy HCPCS codes and APCs for high activity Iodine-125 and high activity Palladium-103. The APC Panel, in turn, recommended that CMS establish new HCPCS codes and new APCs, on a per source basis, for these two brachytherapy sources.

We considered this recommendation and agreed with the APC Panel. Therefore, in the November 15, 2004 final rule with comment period, we established the following two new brachytherapy source codes for CY 2005:

C2634 Brachytherapy source, High Activity Iodine-125, greater than 1.01 mCi (NIST), per source

C2635 Brachytherapy source, High Activity Palladium-103, greater than 2.2 mCi (NIST), per source

In addition, we believed the APC Panel's recommendation to establish new HCPCS codes that would distinguish high activity Iodine-125 from high activity Palladium-103 on a per source basis should have been implemented for other brachytherapy code descriptors, as well. Therefore, beginning January 1, 2005, we included ''per source'' in the HCPCS code descriptors for all those brachytherapy source descriptors for which units of payment were not already delineated. Table 40 published in the November 15, 2004 final rule with comment period included a complete listing of the HCPCS codes, long descriptors, APC assignments, and status indicators that we used for brachytherapy sources paid under the OPPS in CY 2005 (69 FR 65840 through 65841).

Further, for CY 2005, we added the following code of linear source Palladium-103 to be paid at cost: C2636 Brachytherapy linear source, Palladium-103, per 1 mm. We had indicated in our August 16, 2004 proposed rule that we were aware of a new linear source Palladium-103, which came to our attention in CY 2003 through an application for a new device category for pass-through payment. We stated that, while we decided not to create a new category for pass-through payment, we believed that the new linear source fell under the provisions of Pub. L. 108–173. Therefore, we made final our proposal to add HCPCS code C2636 as a new brachytherapy source to be paid at cost in CY 2005.

B. Proposed Changes Related to Pub. L. 108–173

We have consistently invited the public to submit recommendations for new codes to describe brachytherapy sources in a manner reflecting the number, radioisotope, and radioactivity intensity of the sources. We requested that commenters provide a detailed rationale to support recommended new codes and to send recommendations to us. We stated that we would endeavor to add new brachytherapy source codes and descriptors to our systems for payment on a quarterly basis. We have only very recently received one such request for coding and payment of a new brachytherapy source since we added separate APC payment beginning in CY 2005 for the three brachytherapy sources discussed above. We will evaluate this source prior to our final rule for CY 2006. Therefore, we are not proposing any coding changes to the sources of brachytherapy for CY 2006 at this time. Table 26 below includes a list of the separately payable brachytherapy

sources that we are proposing to continue for CY 2006.

TABLE 26.—PROPOSED SEPARATELY PAYABLE BRACHYTHERAPY SOURCES FOR CY 2006

HCPCS	Long descriptor	APC	APC title	New status indicator
C1716	Brachytherapy source, Gold 198, per source	1716	Brachytx source, Gold 198	H
C1717	Brachytherapy source, High Dose Rate Iridium 192, per source.	1717	Brachytx source, HDR Ir-192	H
C1718	Brachytherapy source, Iodine 125, per source.	1718	Brachytx source, Iodine 125	H
C1719	Brachytherapy source, Non-High Dose Rate Iridium 192, per source.	1719	Brachytx source, Non-HDR Ir-192	H
C1720	Brachytherapy source, Palladium 103, per source.	1720	Brachytx source, Palladium 103	H
C2616	Brachytherapy source, Yttrium-90, per source.	2616	Brachytx source, Yttrium-90	H
C2632	Brachytherapy solution, Iodine 125, per mCi	2632	Brachytx sol, I-125, per mCi	H
C2633	Brachytherapy source, Cesium-131, per source.	2633	Brachytx source, Cesium-131	H
C2634	Brachytherapy source, High Activity, Iodine-125, greater than 1.01 mCi (NIST), per source.	2634	Brachytx source, HA, I-125	H
C2635	Brachytherapy source, High Activity, Palladium-103, greater than 2.2 mCi (NIST), per source.	2635	Brachytx source, HA, P-103	H

VIII. Proposed Coding and Payment for Drug Administration

(If you choose to comment on issues in this section, please include the caption ''Drug Administration'' at the beginning of your comment.)

A. Background

From the start of the OPPS until the end of CY 2004, three HCPCS codes were used to bill drug administration services provided in the hospital outpatient department:

- Q0081 (Infusion therapy, using other than chemotherapeutic drugs, per visit)
- Q0083 (Chemotherapy administration by other than infusion technique only, per visit)
- Q0084 (Chemotherapy administration by infusion technique only, per visit) A fourth OPPS drug administration HCPCS code, Q0085 (Administration of chemotherapy by both infusion and another route, per visit) was active from the beginning of the OPPS through the end of CY 2003.

Each of these four HCPCS codes mapped to an APC (that is, Q0081 mapped to APC 0120, Q0083 mapped to APC 0116, Q0084 mapped to APC 0117, and Q0085 mapped to APC 0118), and APC payment rates for these codes were made on a per-visit basis. The per-visit payment included payment for all hospital resources (except separately payable drugs) associated with the drug administration procedures. For CY 2004, we discontinued using HCPCS code Q0085 to identify drug administration services, moving to a combination of HCPCS codes Q0083 and Q0084 that allowed more accurate calculations when determining OPPS payment rates.

In response to comments we received concerning the available opportunities to gather additional drug administration data (and subsequently facilitate development of more accurate payment rates for drug administration services in future years) and to reduce hospital administrative burden, we proposed for the CY 2005 OPPS to change our coding and payment methodologies related to drug administration services.

After examining comments and suggestions, including recommendations of the APC Panel, we adopted a crosswalk for the CY 2005 OPPS that identified all active CPT drug administration codes and the corresponding Q-codes, which hospitals had previously used to report their charges for the procedures. Hospitals were instructed to begin billing CPT codes for drug administration services in the hospital outpatient department effective January 1, 2005.

Payment rates for CY 2005 drug administration services were set using CY 2003 claims data. These data reflected per-visit costs associated with the four Q-codes listed above. To allow for the time necessary to collect data at the more specific CPT code level and to continue accurate payments based on available claims data, we used the Q-code crosswalk to map CPT drug administration codes to existing drug administration APCs. While hospitals were instructed to bill all relevant CPT codes that describe the services provided, the Outpatient Code Editor (OCE) collapsed payments for drug administration services attributed to the same APC and paid a single APC amount for those services for each visit, unless a modifier was used to identify drug administration services provided more than once in a separate encounter on the same day.

B. Proposed Changes for CY 2006

In 2004, the CPT Editorial Panel approved several new drug administration codes and revised several existing codes for use beginning in 2006. For use in the physician office setting in CY 2005, we established HCPCS G-codes that correspond with the expected new CPT codes that will become active in 2006.

For CY 2006 OPPS billing purposes, we are proposing to continue our policy of using CPT codes to bill for drug administration services provided in the hospital outpatient department. We anticipate that the current CPT codes will no longer be effective in CY 2006, and, therefore, we are proposing a CY 2006 crosswalk that maps current CPT codes to the CPT drug administration codes approved by the CPT Editorial Panel in 2004, which correspond to the G-codes used in the physician office setting for CY 2005 and which we expect to become active CPT codes for 2006.

The OPPS drug administration payment rates that we are proposing for CY 2006 are dependent on CY 2004 data

containing per-visit charges for HCPCS codes Q0081, Q0083, and Q0084. While HCPCS code Q0085 was used to inform payment rates for drug administration APCs for CY 2005, there are no data from this code to develop payment rates for drug administration APCs for CY 2006 because this code was not used in CY 2004. We are proposing to map the new CPT codes to existing drug administration APC groups (APC 0116, APC 0117, and APC 0120) as we did in CY 2005. Again, hospitals would be expected to bill all relevant CPT codes for services provided, but payment for services within the same APC group would be collapsed by the OCE into a single per-visit APC payment, unless a modifier is used to identify drug administration services provided more than once in a separate encounter on the same day.

Table 27 shows the crosswalk from the CY 2005 CPT codes to the expected CY 2006 CPT codes (indicated by definition and 2005 HCPCS G-code) and includes the proposed CY 2006 status indicators and APC payment groups for these services. At its February 2005 meeting, the APC Panel recommended that this crosswalk be used to establish drug administration payments for the CY 2006 OPPS. Therefore, we are proposing to use the crosswalk as illustrated in Table 27 to assign drug administration services to APC payment groups for CY 2006 OPPS.

TABLE 27.—PROPOSED CROSSWALK FROM EXPECTED CY 2006 DRUG ADMINISTRATION CPT CODES TO DRUG ADMINISTRATION APCS

[Note: G-codes are only for use in the physician office setting in CY 2005]

2005 CPT code	2005 HCPCS code	Description	CY 2006 Proposed status indicator	APC	OCE maximum APC units without modifier 59	OCE maximum APC units with modifier 59
90780	G0345	Intravenous Infusion, Hydration; Initial, up to one hour.	S	0120	1	4
90781	G0346	Intravenous Infusion, Hydration; each additional hour, up to eight (8) hours.	N		0	0
90780	G0347	Intravenous Infusion, for Therapeutic/Diagnostic; Initial, up to one hour.	S	0120	1	4
90781	G0348	Intravenous Infusion, for Therapeutic/Diagnostic; each additional hour, up to eight (8) hours.	N		0	0
	G0349	Intravenous Infusion, for Therapeutic/Diagnostic; additional sequential infusion, up to one hour.	N		0	0
	G0350	Intravenous Infusion, for Therapeutic/Diagnostic; concurrent infusion.	N		0	0
90782	G0351	Therapeutic or Diagnostic Injection; subcutaneous or intramuscular.	X	0353	N/A	N/A
90784	G0353	Intravenous Push; single or initial substance/drug.	X	0359	N/A	N/A
90784	G0354	Intravenous Push; each additional sequential intravenous push.	X	0359	N/A	N/A
90783	90783	Injection, ia	X	0359	N/A	N/A
90788	90788	Injection of antibiotic	X	0359	N/A	N/A
96549	96549	Chemotherapy, unspecified	S	0116	1	2
96400	G0355	Chemotherapy Administration, subcutaneous or intramuscular non-hormonal antineoplastic.	S	0116	1	2
96400	G0356	Chemotherapy Administration, subcutaneous or intramuscular hormonal antineoplastic.	S	0116	1	2
96542	96542	Chemotherapy injection	S	0116	1	2
96405	96405	Intralesional chemo admin	S	0116	1	2
96406	96406	Intralesional chemo admin	S	0116	1	2
96408	G0357	Intravenous, push technique, single or initial substance/drug.	S	0116	1	2
96408	G0358	Intravenous, push technique, each additional substance/drug.	S	0116	1	2
96420	96420	Chemotherapy, push technique	S	0116	1	2
96440	96440	Chemotherapy, intracavitary	S	0116	1	2
96445	96445	Chemotherapy, intracavitary	S	0116	1	2
96450	96450	Chemotherapy, into CNS	S	0116	1	2
96410	G0359	Chemotherapy Administration, Intravenous Infusion Technique; up to one hour, single or initial substance/drug.	S	0117	1	2
96412	G0360	Chemotherapy Administration, Intravenous Infusion Technique; Each additional hour, one to eight (8) hours.	N		0	0
	G0362	Chemotherapy Administration, Intravenous Infusion Technique; Each additional sequential infusion (different substance/drug), up to one hour.	N		0	0
96414	G0361	Initiation of prolonged chemotherapy infusion (more than eight hours), requiring use of a portable or implantable pump.	S	0117	1	2
96422	96422	Chemotherapy, infusion method	S	0117	1	2

TABLE 27.—PROPOSED CROSSWALK FROM EXPECTED CY 2006 DRUG ADMINISTRATION CPT CODES TO DRUG ADMINISTRATION APCS—Continued

[Note: G-codes are only for use in the physician office setting in CY 2005]

2005 CPT code	2005 HCPCS code	Description	CY 2006 Proposed status indicator	APC	OCE maximum APC units without modifier 59	OCE maximum APC units with modifier 59
96423	96423	Chemo, infuse method add-on	N		0	0
96425	96425	Chemotherapy, infusion method	S	0117	1	2
	G0363	Irrigation of Implanted Venous Access Device for Drug Delivery Systems.	N		0	0
96520	96520	Port pump refill & main	T	0125	N/A	N/A
96530	96530	Syst pump refill & main	T	0125	N/A	N/A

C. Proposed Changes to Vaccine Administration

Hospitals currently use three HCPCS G-codes to indicate the administration of the following vaccines that have specific statutory coverage:

- G0008—Administration of Influenza Virus Vaccine
- G0009—Administration of Pneumococcal Vaccine
- G0010—Administration of Hepatitis B Vaccine

HCPCS codes G0008 and G0009 are exempt from beneficiary coinsurance and deductible applications and, as such, payment has been made outside of the OPPS since CY 2003 based on reasonable cost. We have made payment for HCPCS code G0010 through a clinical APC (that is, APC 0355) that included vaccines along with this vaccine administration code. Additional vaccine administration codes have been packaged or not paid under the OPPS.

We believe that HCPCS codes G0008, G0009 and G0010 are clinically similar and comparable in resource use to one another and to the administration of other immunizations and other therapeutic, prophylactic, or diagnostic injections. The appropriate APC assignment for these vaccine administration services is newly reconfigured APC 0353 (''Injection, Level II''). However, because of their statutory exemption regarding beneficiary deductible and coinsurance, for operational reasons we are unable to include HCPCS codes G0008 and G0009 in an APC with codes that do not share this exemption.

Therefore, for CY 2006, we are proposing to map HCPCS codes G0008 and G0009 to new APC 0350 (Administration of flu and PPV vaccines). As dictated by statute, HCPCS codes G0008 and G0009 will continue to be exempt from beneficiary coinsurance and deductible.

We are also proposing to change the status indicator for HCPCS code G0010 from ''K'' (Separate APC Payment) to ''B'' (Not paid under OPPS; Alternate code may be available), and to change the status indicators for vaccine administration codes 90471 and 90472 from ''N'' (Packaged) to ''X'' (Separate APC Payment), in agreement with the recommendation of the APC Panel to unpackage these services. Hospitals would code for hepatitis B vaccine administration using codes 96471 or 96472 (as appropriate), and payment would be mapped to reconfigured APC 0353 (''Injection, Level II'') that will include other injection services that are clinically similar and comparable in resource use.

Additionally, in order to pay appropriately for services that we believe are clinically similar and comparable in resource use and, barring technical restrictions, would otherwise be assigned to the same APC, we are proposing to calculate a combined median cost for all services assigned to APC 0350 and APC 0353 that would then serve as the median cost for both APCs. This combined median would be calculated using charges converted to costs from claims for services in both APCs and would have the effect of making the OPPS payment rates for APC 0350 and APC 0353 identical, although beneficiary copayment and deductible would not be applied to services in APC 0350.

In addition, we are proposing to change the status indicators for vaccine administration codes 90473 and 90474 from ''E'' (Not paid under OPPS) to ''S'' (Paid under OPPS) and make payments for these services when they are covered through proposed APC 1491 (New Technology—Level IA ($0-$10)). Finally, we are proposing to change the status indicators for the four remaining vaccine administration codes involving physician counseling (90465, 90466, 90467 and 90468) from ''N'' (Packaged) to ''B'' (Not paid under OPPS; Alternate code may be available). Hospitals providing immunization services with physician counseling would use the vaccine administration codes 90471, 90472, 90473, and 90473 to report such services, as we do not believe the provision of physician counseling significantly affects the hospital resources required for administration of immunizations. Table 28 displays the changes that we are proposing for CY 2006.

TABLE 28.—PROPOSED CY 2006 VACCINE ADMINISTRATION CODES AND APC MEDIAN COST

HCPCS	Description	CY 2005		CY 2006		
		SI	APC	SI	APC	Median
G0008	Influenza Vaccine Administration	L	Reasonable Cost	X	0350	$24.00
G0009	Pneumococcal Vaccine Administration	L	Reasonable Cost	X	0350	24.00
G0010	Hepatitis B Vaccine Administration	K	0355	B		
90465	Immunization Admin, under 8 yrs old, with counseling; first injection.	N		B		
90466	Immunization Admin, under 8 yrs old, with counseling; each additional injection.	N		B		

TABLE 28.—PROPOSED CY 2006 VACCINE ADMINISTRATION CODES AND APC MEDIAN COST—Continued

HCPCS	Description	CY 2005		CY 2006		
		SI	APC	SI	APC	Median
90467	Immunization Admin, under 8 yrs old, with counseling; first intranasal or oral.	N		B		
90468	Immunization Admin, under 8 yrs old, with counseling; each additional intranasal or oral.	N		B		
90471	Immunization Admin, one vaccine injection	N		X	0353	24.00
90472	Immunization Admin, each additional vaccine injection.	N		X	0353	24.00
90473	Immunization Admin, one vaccine by intranasal or oral.	E		S	1491	5.00
90474	Immunization Admin, each additional vaccine by intranasal or oral.	E		S	1491	5.00

IX. Hospital Coding for Evaluation and Management (E/M) Services

(If you choose to comment on issues in this section, please include the caption ''E/M Services'' at the beginning of your comment.)

In the November 15, 2004 final rule with comment period (69 FR 65838), we noted our primary concerns and direction for developing the proposed coding guidelines for emergency department and clinic visits. We intend to make available for public comment the proposed coding guidelines that we are considering through the CMS OPPS Web site as soon as we have completed them. We will notify the public through our listserve when these proposed guidelines become available. To subscribe to this listserve, please go to the following CMS Web site: *http://www.cms.hhs.gov/medlearn/listserv.asp* and follow the directions to the OPPS listserve. We will provide ample opportunity for the public to comment on the proposal.

We will continue to be considerate of the time necessary to educate clinicians and coders on the use of the new codes and guidelines and for hospitals to modify their systems. We anticipate providing a minimum notice of between 6 and 12 months prior to implementation of the new evaluation and management codes and guidelines. We will continue developing and testing the new codes even though we have not yet made plans for their implementation.

X. Proposed Payment for Blood and Blood Products

(If you choose to comment on issues in this section, please include the caption ''Blood and Blood Products'' at the beginning of your comment.)

A. Background

Since the implementation of the OPPS in August 2000, separate payments have been made for blood and blood products through APCs rather than packaging them into payments for the procedures with which they were administered. Hospital payments for the costs of blood and blood products, as well as the costs of collecting, processing, and storing blood and blood products, are made through the OPPS payments for specific blood product APCs. On April 12, 2001, CMS issued the original billing guidance for blood products to hospitals (Program Transmittal A–01–50). In response to requests for clarification of these instructions, CMS issued Transmittal 496 on March 4, 2005. The comprehensive billing guidelines in the Transmittal also addressed specific concerns and issues related to billing for blood-related services, which the public had brought to our attention.

In CY 2000, payments for blood and blood products were established based on external data provided by commenters due to limited Medicare claims data. From CY 2000 to CY 2002, payment rates for blood and blood products were updated for inflation. For CY 2003, as described in the November 1, 2002 final rule with comment period (67 FR 66773), we applied a special dampening methodology to blood and blood products that had significant reductions in payment rates from CY 2002 to CY 2003, when median costs were first calculated from hospital claims. Using the dampening methodology, we limited the decrease in payment rates for blood and blood products to approximately 15 percent. For CY 2004, as recommended by the APC Panel, we froze payment rates for blood and blood products at CY 2003 levels as we studied concerns raised by commenters and presenters at the August 2003 and February 2004 APC Panel meetings.

For CY 2005, we established new APCs that allowed each blood product to be assigned to its own separate APC, as several of the previous blood product APCs contained multiple blood products with no clinical homogeneity or whose product-specific median costs may not have been similar. Some of the blood product HCPCS codes were reassigned to the new APCs (Table 34 of the November 15, 2004 final rule with comment period (69 FR 65819)).

We also noted in the November 15, 2004 final rule with comment period that public comments to previous OPPS rules had stated that the CCRs that were used to adjust charges to costs for blood products in past years were too low. Past commenters indicated that this approach resulted in an underestimation of the true hospital costs for blood and blood products. In response to these comments and APC Panel recommendations from their February 2004 and September 2004 meetings, we conducted a thorough analysis of the OPPS CY 2003 claims (used to calculate the CY 2005 APC payment rates) to compare CCRs between those hospitals reporting a blood-specific cost center and those hospitals defaulting to the overall hospital CCR in the conversion of their blood product charges to costs. As a result of this analysis, we observed a significant difference in CCRs utilized for conversion of blood product charges to costs for those hospitals with and without blood-specific cost centers. The median hospital blood-specific CCRs were almost two times the median overall hospital CCR. As discussed in the November 15, 2004 final rule with comment period, we applied a methodology for hospitals not reporting a blood-specific cost center, which simulated a blood-specific CCR for each hospital that we then used to convert charges to costs for blood products. Thus, we developed simulated medians for all blood and blood products based on CY 2003 hospital claims data (69 FR 65816).

For CY 2005, we also identified a subset of blood products that had less than 1,000 units billed in CY 2003. For these low-volume blood products, we based the CY 2005 payment rate on a 50/50 blend of CY 2004 product-specific OPPS median costs and the CY 2005 simulated medians based on the application of blood-specific CCRs to all claims. We were concerned that, given the low frequency in which these products were billed, a few occurrences of coding or billing errors may have led to significant variability in the median calculation. The claims data may not have captured the complete costs of these products to hospitals as fully as possible. This low-volume adjustment methodology also allowed us to further study the issues raised by commenters and by presenters at the September 2004 APC Panel meeting, without putting beneficiary access to these low-volume blood products at risk.

B. Proposed Changes for CY 2006

For CY 2006, we are proposing to continue to make separate payments for blood and blood products under the OPPS through individual APCs for each product. We are also proposing to establish payment rates for these blood and blood products by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816), which utilized hospital-specific actual or simulated CCRs for blood cost centers to convert hospital charges to costs, with an adjustment applied to some products. We continue to believe that using blood-specific CCRs applied to hospital claims data will result in reasonably accurate payments that more fully reflect hospitals' true costs of providing blood and blood products than our general methodology of defaulting to the overall hospital CCR when more specific CCRs are unavailable.

For blood and blood products whose CY 2006 simulated medians experienced a decrease of more than 10 percent in comparison to their CY 2005 payment medians, we are proposing to limit the decrease in medians to 10 percent. Therefore, overall we are proposing to base median costs for blood and blood products in CY 2006 on the greater of: (1) Simulated medians calculated using CY 2004 claims data; or (2) 90 percent of the APC payment median for CY 2005 for such products. We recognize that possible errors in hospital billing or coding for blood products in CY 2004 may have contributed to these decreases in medians. In particular, hospitals may have been uncertain about which of their many different costs for providing blood and blood products should be captured in their charges for the products, based on variations in the specific circumstances of the services they provided. In addition, the six products affected by the proposed CY 2006 adjustment policy all were relatively low volume with fewer than 7,000 units billed in CY 2004. Three of these products were affected by the low-volume payment adjustment for CY 2005 because there were less than 1,000 units billed, and their CY 2005 payment medians would have decreased without the adjustment. In the interim, as hospitals become more familiar with the comprehensive billing guidelines for blood and blood products that are described in Program Transmittal 496, (Change Request 3681 dated March 4, 2005), we acknowledge the need to protect beneficiaries' access to a safe blood supply and are proposing to do so by limiting significant decreases in payment rates for blood and blood products from CY 2005 to CY 2006. We expect that our billing guidance will assist hospitals in more fully including all appropriate costs for providing blood and blood products in their charges for those products, so that our data for CY 2005, which will be used to set median costs for blood and blood products in the CY 2007 OPPS, should more accurately capture the hospital costs associated with each different blood product.

Displayed in Table 29 is the list of blood product HCPCS codes with their proposed CY 2006 payment medians. Overall, medians from CY 2005 and CY 2006 were relatively stable, and we expect that as hospitals improve their billing and coding practices, medians based on historical hospital claims data should continue to become more consistent and reflective of all hospital costs. For blood and blood products whose CY 2006 simulated median would have experienced a decrease from CY 2005 to CY 2006 of greater than 10 percent, the adjusted median is shown.

Therefore, for CY 2006, we are proposing to establish payment rates for blood and blood products under the OPPS by using the same simulation methodology described in the November 15, 2004 final rule with comment period (69 FR 65816). For blood and blood products whose 2006 medians would have otherwise experienced a decrease of more than 10 percent in comparison with their CY 2005 payment rates, we are proposing to adjust the simulated medians by limiting their decrease to 10 percent.

TABLE 29.—PROPOSED CY 2006 PAYMENT MEDIANS FOR BLOOD AND BLOOD PRODUCTS BY HCPCS/APC CODES

HCPCS	APC	CY 2004 units	Description	CY 2005 payment median	Proposed CY 2006 median, (limited if applicable)
P9016	0954	609026	RBC leukocytes reduced	$170.28	$165.16
P9021	0959	158964	Red blood cells unit	116.42	122.50
P9040	0969	46732	RBC leukoreduced irradiated	211.28	219.96
P9035	9501	37199	Platelet pheres leukoreduced	486.18	491.77
P9019	0957	37079	Platelets, each unit	49.50	50.19
P9017	9508	36807	Plasma 1 donor frz w/in 8 hr	65.10	72.64
P9031	1013	21899	Platelets leukocytes reduced	88.78	96.69
P9037	1019	13873	Plate pheres leukoredu irrad	603.62	574.05
P9034	9507	10419	Platelets, pheresis	449.86	416.30
P9033	0968	6031	Platelets leukoreduced irrad	158.50	*142.65
P9044	1009	5635	Cryoprecipitate reduced plasma	63.20	78.82
P9012	0952	5264	Cryoprecipitate each unit	49.58	*44.62
P9055	1017	4546	Plt, aph/pher, l/r, cmv-neg	489.46	518.94
P9056	1018	3759	Blood, l/r, irradiated	187.76	*168.98
P9038	9505	3149	RBC irradiated	122.09	144.08
P9010	0950	3012	Whole blood for transfusion	115.97	121.43

TABLE 29.—PROPOSED CY 2006 PAYMENT MEDIANS FOR BLOOD AND BLOOD PRODUCTS BY HCPCS/APC CODES—Continued

HCPCS	APC	CY 2004 units	Description	CY 2005 payment median	Proposed CY 2006 median, (limited if applicable)
P9051	1010	2854	Blood, l/r, cmv-neg	172.35	179.17
P9022	0960	2086	Washed red blood cells unit	199.18	*179.26
P9059	0955	1863	Plasma, frz between 8–24 hour	76.28	78.05
P9052	1011	1603	Platelets, hla-m, l/r, unit	583.87	661.91
P9036	9502	1166	Platelet pheresis irradiated	343.02	313.15
P9058	1022	1081	RBC, l/r, cmv-neg, irrad	280.94	258.88
P9032	9500	1080	Platelets, irradiated	91.11	*82.00
P9020	0958	944	Plaelet rich plasma unit	155.53	312.67
P9039	9504	862	RBC deglycerolized	305.13	388.09
P9050	9506	793	Granulocytes, pheresis unit	1,046.99	*942.29
P9023	0949	776	Frozen plasma, pooled, sd	80.16	*72.14
P9054	1016	681	Blood, l/r, froz/degly/wash	275.72	317.59
P9053	1020	549	Plt, pher, l/r cmv-neg, irr	573.06	612.79
P9048	0966	524	Plasmaprotein fract, 5%, 250 ml	332.32	*299.09
P9060	9503	488	Fr frz plasma donor retested	76.86	98.00
P9043	0956	43	Plasma protein fract, 5%, 50 ml	68.62	67.74
P9057	1021	27	RBC, frz/deg/wsh, l/r, irrad	327.11	*294.40

* Indicates adjusted median.

In addition, we are proposing to change the status indicator for CPT code 85060 (Blood smear, peripheral, interpretation by physician with written report) from ''X'' (separately paid under the OPPS) to ''B'' (not paid under the OPPS). When a hospital provides a physician interpretation of an abnormal peripheral blood smear interpretation for a hospital outpatient, the charge for the facility resources associated with the interpretation should be bundled into the charge reported for the ordered hematology lab service, such as, CPT code 85007 (Blood count; blood smear, microscopic examination with manual differential WBC count) or CPT code 85008 (Blood count; blood smear, microscopic examination without manual differential WBC count), which are paid under the Clinical Laboratory Fee Schedule (CLFS). A physician interpretation of an abnormal peripheral blood smear is considered a routine part of the ordered hematology lab service, such as CPT codes 85007 and 85008 paid under the CLFS, so hospitals would receive duplicate payment for the facility resources associated with a physician's blood smear interpretation if we were to continue to pay separately for CPT code 85060 under the OPPS for hospital outpatients. Therefore, for CY 2006, we are proposing to discontinue payment under the OPPS for CPT code 85060 by changing its status indicator from ''X'' to ''B.''

XI. Proposed Payment for Observation Services

(If you choose to comment on issues in this section, please include the caption ''Observation Services'' at the beginning of your comment.)

A. Background

Observation care is a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment, and reassessment, before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after surgery and to patients who present to the emergency department and who then require a significant period of treatment or monitoring before a decision is made concerning their next placement. For a detailed discussion of the clinical and payment history of observation services, refer to the November 1, 2002 final rule with comment period (67 FR 66794).

Before the implementation of the OPPS in CY 2000, payment for observation care was made on a reasonable cost basis. With the initiation of the OPPS, costs for observation services were packaged into payments for the services with which the observation care was associated but no separate payment for observation services was implemented.

For CY 2002, we implemented separate payment for observation services (APC 0339) under the OPPS for three medical conditions (chest pain, congestive heart failure, and asthma). Additional criteria, such as the billing of select diagnosis codes, an evaluation and management service, a minimum and maximum number of observation hours, and provision of certain condition-specific diagnostic tests, along with documentation of the physician's determination that the patient would benefit from observation care, were also required in order for hospitals to receive the separate APC payment (APC 0339) for observation services.

Taking into account numerous comments from providers about the increased administrative burden caused by reporting requirements associated with payment for APC 0339 and after reviewing comments and recommendations by the APC Panel, we removed the mandated diagnostic testing requirements beginning in CY 2005 (Transmittal 514, Change Request 3756, released March 30, 2005). Hospitals were instructed to rely on clinical judgment in combination with internal and external quality review processes to ensure that appropriate diagnostic testing is provided for patients receiving high quality, medically necessary observation care. In an effort to further reduce administrative burden related to accurate billing and in response to suggestions from hospitals and the APC Panel, effective January 1, 2005, we clarified our instructions for counting time in observation care to end at the time the outpatient is actually discharged from the hospital or admitted as an inpatient. Our expectation was that specific, medically necessary observation services were being provided to the patient up until

the time of discharge. However, we did not expect reported observation time to include the time patients remain in the observation area after treatment is finished for reasons such as waiting for transportation home.

In updating the CY 2005 OPPS, we also looked at CY 2003 claims data for all packaged visit-related observation care for all medical conditions in order to determine whether or not there were other diagnoses that would be candidates for separately payable observation services. This year, we again reviewed the most recent claims data (CY 2004) for packaged and unpackaged observation services to assess the current appropriateness of the three medical conditions for separately payable observation services and to determine if the list of diagnosis codes was complete for those conditions. The APC Panel recommended at the February 2005 APC Panel meeting that CMS expand the list of diagnoses eligible for separate observation payments.

The diagnoses currently associated with the three medical conditions continue to be frequently reported on OPPS visit-related claims with packaged observation services, and there are a large number of claims for separately payable observation care for the three medical conditions. At this time, our data show almost 80,000 claims from CY 2004 for separately payable observation services, compared with 67,182 for CY 2003 hospital claims. We have also explored other diagnoses that appeared in hospital claims data with packaged observation services. However, the data on packaged observation services continue to be incomplete and unreliable, reported using a number of different CPT codes with ''per day'' in their code descriptors. Some hospitals appear to be reporting observation services per day, while others appear to be reporting each hour of observation care as one unit, as we instructed them to do when reporting HCPCS code G0244 for separately payable observation. As described in section XI.B. of this preamble, we are proposing to make changes to hospital coding for all observation services for CY 2006, both separately payable and packaged. We are currently not convinced that there are other conditions for which there is a well-defined set of hospital services that are distinct from the services provided during a clinic or emergency visit. Moreover, hospital data from CY 2004 do not reflect our CY 2005 changes in separately payable observation policy. We also seek to gain additional experience with more consistent hospital billing for observation services, both packaged and separately payable, to guide our future analyses of observation care. Thus, we believe it is premature to expand the conditions for which we would separately pay for visit-related observation services.

B. Proposed CY 2006 Coding Changes for Observation Services

In response to comments received regarding the continuing administrative burden on hospitals when attempting to differentiate between packaged and separately payable observation services for purposes of billing correctly, and recommendations put forward by the APC Panel and participants at the February 2005 APC Panel meeting, we are proposing two changes in payment policy for observation services in CY 2006. First, we are proposing to discontinue HCPCS codes G0244 (Observation care by facility to patient), G0263 (Direct admission with CHF, CP, asthma), and G0264 (Assessment other than CHF, CP, asthma) and to create two new HCPCS codes to be used by hospitals to report all observation services whether separately payable or packaged, and direct admission for observation care:

- GXXXX—Hospital observation services, per hour
- GYYYY—Direct admission of patient for hospital observation care

Second, we are proposing to shift determination of whether or not observation services are separately payable under APC 0339 from the hospital billing department to the OPPS claims processing logic. That is, hospitals would bill GXXXX when observation services are provided to any patient admitted to ''observation status,'' regardless of the patient's status as an inpatient or outpatient. Hospitals would additionally bill GYYYY when observation services are the result of a direct admission to ''observation status'' without an associated emergency room visit, hospital outpatient clinic visit, or critical care service on the day of or day before the observation services. Both of these new HCPCS codes would be assigned a new status indicator that would trigger OCE logic during the processing of the claim to determine if the observation service is packaged with the other separately payable hospital services provided or if a separate APC payment for observation services is appropriate in accordance with the criteria discussed below in section XI.C. of this preamble. In addition, we are proposing to change the status indicator for CPT codes 99217 through 99220 and 99234 through 99236 from ''N'' (packaged) to ''B'' (code not recognized by OPPS). We will expect hospitals to utilize GXXXX to accurately report all observation services provided to beneficiaries, whether the observation would be packaged or separately payable, to assist us in developing consistent and complete hospital claims data regarding the utilization and costs of observation services. The units of service reported with GXXXX would equal the number of hours the patient is in observation status.

C. Proposed Criteria for Separately Payable Observation Services (APC 0339)

For CY 2006, we are proposing to continue applying the existing CY 2005 criteria (69 FR 65830), which determine if hospitals may receive separate payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma. In addition, we are proposing to continue our policy of packaging payment for all other observation services into the payments for the separately payable services with which the observation service is reported. As explained previously in section XI.B. of this section, the only changes we are proposing are related to the codes hospitals would use to report observation services, and the point at which a payment determination is made. Rather than requiring the hospital to determine prior to claims submission whether patient condition and the services furnished meet the criteria for payment of APC 0339, that determination would shift to the claims processing modules installed by the fiscal intermediaries to process all OPPS bills, thereby reducing the administrative burden on hospitals.

Criteria for separate observation service payments include documentation of specific ICD–9–CM diagnostic codes (International Classification of Diseases, Ninth Edition, Clinical Modification); the length of time a patient is in observation status; hospital services provided before, during, and after the patient receives observation care; and ongoing physician evaluation of the patient's status.

As we stated in Transmittal A–02–129, released in January 2003, we will continue to update any changes in the list of ICD–9–CM codes required for payment of HCPCS code GXXXX resulting from the October 1 annual update of ICD–9–CM in the October quarterly update of the OPPS. In addition, changes to the ICD–9–CM codes, which are listed in Table 30 below, would be included in the OPPS CY 2006 final rule.

Below are the criteria that we are proposing to continue using in CY 2006 to determine if hospitals may receive separate OPPS payment for medically necessary observation care provided to a patient with congestive heart failure, chest pain, or asthma.

1. Diagnosis Requirements

a. The beneficiary must have one of three medical conditions: Congestive heart failure, chest pain, or asthma.

b. The hospital bill must report as the reason for visit or principal diagnosis an appropriate ICD–9–CM code (as shown in Table 30 below) to reflect the condition.

c. The qualifying ICD–9–CM diagnosis code must be reported in Form Locator (FL) 76, Patient Reason for Visit, or FL 67, principal diagnosis, or both, in order for the hospital to receive separate payment for APC 0339. If a qualifying ICD–9–CM diagnosis code(s) is reported in the secondary diagnosis field but is not reported in either the Patient Reason for Visit field (FL 76) or in the principal diagnosis field (FL 67), separate payment for APC 0339 will not be allowed.

TABLE 30.—CY 2006 ELIGIBLE DIAGNOSIS CODES FOR BILLING OBSERVATION SERVICES

Required diagnosis for	Eligible ICD–9–CM code	Code descriptor
Chest pain	411.0	Postmyocardial infarction syndrome.
	411.1	Intermediate coronary syndrome.
	411.81	Coronary occlusion without myocardial infarction.
	411.89	Other acute ischemic heart disease.
	413.0	Angina decubitus.
	413.1	Prinzmetal angina.
	413.9	Other and unspecified angina pectoris.
	786.05	Shortness of breath.
	786.50	Chest pain, unspecified.
	786.51	Precordial pain.
	786.52	Painful respiration.
	786.59	Other chest pain.
Asthma	493.01	Extrinsic asthma with status asthmaticus.
	493.02	Extrinsic asthma with acute exacerbation.
	493.11	Intrinsic asthma with status asthmaticus.
	493.12	Intrinsic asthma with acute exacerbation.
	493.21	Chronic obstructive asthma with status asthmaticus.
	493.22	Chronic obstructive asthma with acute exacerbation.
	493.91	Asthma, unspecified with status asthmaticus.
	493.92	Asthma, unspecified with acute exacerbation.
Heart Failure	391.8	Other acute rheumatic heart disease.
	398.91	Rheumatic heart failure (congestive).
	402.01	Malignant hypertensive heart disease with congestive heart failure.
	402.11	Benign hypertensive heart disease with congestive heart failure.
	402.91	Unspecified hypertensive heart disease with congestive heart failure.
	404.01	Malignant hypertensive heart and renal disease with congestive heart failure.
	404.03	Malignant hypertensive heart and renal disease with congestive heart and renal failure.
	404.11	Benign hypertensive heart and renal disease with congestive heart failure.
	404.13	Benign hypertensive heart and renal disease with congestive heart and renal failure.
	404.91	Unspecified hypertensive heart and renal disease with congestive heart failure.
	404.93	Unspecified hypertensive heart and renal disease with heart and renal failure.
	428.0	Congestive heart failure.
	428.1	Left heart failure.
	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.
	428.9	Heart failure, unspecified.

2. Observation Time

a. Observation time must be documented in the medical record.

b. A beneficiary's time in observation (and hospital billing) begins with the beneficiary's admission to an observation bed.

c. A beneficiary's time in observation (and hospital billing) ends when all clinical or medical interventions have been completed, including followup care furnished by hospital staff and physicians that may take place after a physician has ordered the patient be released or admitted as an inpatient.

d. The number of units reported with HCPCS code GXXXX must equal or exceed 8 hours.

3. Additional Hospital Services

a. The hospital must provide on the same day or the day before and report on the bill:

• An emergency department visit (APC 0610, 0611, or 0612),
• A clinic visit (APC 0600, 0601, or 0602), or
• Critical care (APC 0620).

b. No procedure with a ''T'' status indicator can be reported on the same day or day before observation care is provided.

4. Physician Evaluation

a. The beneficiary must be in the care of a physician during the period of observation, as documented in the medical record by admission, discharge, and other appropriate progress notes that are timed, written, and signed by the physician.

b. The medical record must include documentation that the physician explicitly assessed patient risk to determine that the beneficiary would benefit from observation care.

D. Separate Payment for Direct Admission to Observation Care (APC 0600)

For CY 2006, we are proposing to continue paying for direct admission to observation at a rate equal to that of a Level I Clinic Visit when a Medicare beneficiary is directly admitted into a hospital outpatient department for observation care that does not qualify for separate payment under APC 0339. In order to receive separate payment for a direct admission into observation (APC 0600), the claim must show:

1. Both HCPCS codes GXXXX (Hourly Observation) and GYYYY (Direct Admit to Observation) with the same date of service.

2. That no services with a status indicator ''T'' or ''V'' were provided on the same day of service as HCPCS code GYYYY.

XII. Procedures That Will Be Paid Only as Inpatient Procedures

(If you choose to comment on issues in this section, please include the caption ''Inpatient Procedures'' at the beginning of your comment.)

A. Background

Section 1833(t)(B)(i) of the Act gives the Secretary broad authority to determine the services to be covered and paid for under the OPPS. Before implementation of the OPPS in August 2000, Medicare paid reasonable costs for services provided in the outpatient department. The claims submitted were subject to medical review by the fiscal intermediaries to determine the appropriateness of providing certain services in the outpatient setting. We did not specify in regulations those services that were appropriate to provide only in the inpatient setting and that, therefore, should be payable only when provided in that setting.

In the April 7, 2000 final rule with comment period, 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 because of the nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient. As we discussed in the April 7, 2000 final rule with comment period (65 FR 18455) and the November 30, 2001 final rule (66 FR 59856), we use the following criteria when reviewing procedures to determine whether or not they should be moved from the inpatient list and assigned to an APC group for payment under the OPPS:

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

In the November 1, 2002 final rule with comment period (67 FR 66792), we removed 43 procedures from the inpatient list for payment under OPPS. We also added the following criteria for use in reviewing procedures to determine whether they should be removed from the inpatient list and assigned to an APC group for payment under the OPPS:

• We have determined that the procedure is being performed in multiple hospitals on an outpatient basis; or
• We have determined that the procedure can be appropriately and safely performed in an ambulatory surgical center (ASC) and is on the list of approved ASC procedures or proposed by us for addition to the ASC list.

We believe that these additional criteria help us to identify procedures that are appropriate for removal from the inpatient list.

In the November 7, 2003 final rule with comment period (68 FR 63465), no significant changes were made to the inpatient list. In the November 15, 2004 final rule 5with comment period (69 FR 65834), we removed 22 procedures from the inpatient list, effective for services furnished on or after January 1, 2005.

B. Proposed Changes to the Inpatient List

We used the same methodology as described in the November 15, 2004 final rule with comment period (69 FR 65837) to identify a subset of procedures currently on the inpatient list that were being widely performed on an outpatient basis. These procedures were then clinically reviewed for possible removal from the inpatient list. We solicited input from the APC Panel on the appropriateness of the removal of 26 procedures from the inpatient list at the February 2005 APC Panel meeting. The APC Panel recommended that these 26 procedures be removed from the list and further recommended that CMS consider CPT code 37183 (Remove hepatic shunt (TIPS)) for removal. We agree with the APC Panel's recommendation that CPT code 37183 be removed from the inpatient list for CY 2006 and we are proposing to remove it from the inpatient list.

However, subsequent to the APC Panel's February 2005 meeting, we conducted further clinical evaluations of three procedures (CPT codes 33420, 65273, and 59856) included among the 26 procedures that the APC Panel recommended for removal from the inpatient list. Upon further clinical evaluation of CPT code 33420 (Valvotomy, mitral valve; closed heart), we believe that the utilization data suggesting that this procedure is an office-based procedure were errant. Additional sources of utilization data suggest that this procedure is predominately performed on an inpatient basis. Concomitant with not meeting our criteria of being performed on an outpatient basis in multiple hospitals and not appearing on the ASC list of approved procedures, we are not compelled to support the removal of this procedure from the inpatient list. For this reason, we are proposing to retain CPT code 33420 on the inpatient list for CY 2006.

CPT codes 65273 and 59856 were similarly reevaluated because of our concern with the HCPCS long descriptors for these two codes. The long descriptors for these codes are as follows: CPT code 65273 (Repair of laceration; conjunctiva, by mobilization and rearrangement, with hospitalization) and CPT code 59856 (Induced abortion, by one or more vaginal suppositories (eg, prostaglandin) with or without cervical dilation (eg, laminaria), including hospital admission and visits, delivery of fetus and secundines; with dilation and

curettage and/or evacuation). The long descriptors indicate that hospital admission or hospitalization is included in the codes for these two procedures, which leads us to believe that these two procedures do not meet the established criteria for removal from the inpatient list. The same code descriptor for CPT code 65273, but without hospitalization, is assigned to CPT code 65272, which is already separately payable under the OPPS. Therefore, we are proposing to retain CPT codes 65273 and 59856 on the inpatient list for CY 2006.

In addition, we are proposing to remove CPT code 62160 (Neuroendoscopy) from the inpatient list. Questions about this service have been raised to us by the hospital community because CPT code 62160 is an add-on CPT code (that is, a code that is commonly performed as an ''additional or supplemental'' procedure to the primary procedure). Two of the separately coded services that CPT indicates are to be used with the add-on code are currently payable under the OPPS. Further clinical evaluation of this add-on procedure and its use in various sites of service leads us to believe it is appropriate for removal from the inpatient list.

Therefore, for CY 2006, we are proposing to remove 25 procedures from the inpatient list and to assign 23 of these procedures to clinically appropriate APCs, as shown below in Table 31. We are not proposing to assign two of these procedures to APC groups, that is, CPT codes 00634 (Anesthesia for procedures in lumbar region; chemonucleoysis) and 01190 (Anesthesia for obturator neurectomy; intrapelvic) because they are anesthesia procedures for which a separate payment is not made under the OPPS. Payment for these two procedures would be packaged into the procedures with which they are billed. The proposed changes to the inpatient list would be effective for services furnished on or after January 1, 2006.

TABLE 31.—PROPOSED PROCEDURE CODES TO REMOVE FROM INPATIENT LIST AND PROPOSED APC ASSIGNMENT, EFFECTIVE JANUARY 1, 2006

HCPCS	Long descriptor	New APC assignment	Old status indicator	New status indicator
00634	ANESTHESIA FOR PROCEDURES IN LUMBAR REGION; CHEMONUCLEOLYSIS.	n/a	C	N
01190	ANESTHESIA FOR OBTURATOR NEURECTOMY; INTRAPELVIC	n/a	C	N
20662	APPLICATION OF HALO, INCLUDING REMOVAL; PELVIC	0049	C	T
20663	APPLICATION OF HALO, INCLUDING REMOVAL; FEMORAL	0049	C	T
20822	REPLANTATION, DIGIT, EXCLUDING THUMB (INCLUDES DISTAL TIP TO SUBLIMIS TENDON INSERTION), COMPLETE AMPUTATION.	0054	C	T
20972	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; METATARSAL.	0056	C	T
20973	FREE OSTEOCUTANEOUS FLAP WITH MICROVASCULAR ANASTOMOSIS; GREAT TOE WITH WEB SPACE.	0056	C	T
21150	RECONSTRUCTION MIDFACE, LEFORT II; ANTERIOR INTRUSION (EG, TREACHER-COLLINS SYNDROME).	0256	C	T
21175	RECONSTRUCTION, BIFRONTAL, SUPERIOR-LATERAL ORBITAL RIMS AND LOWER FOREHEAD, ADVANCEMENT OR ALTERATION (EG, PLAGIOCEPHALY, TRIGONOCEPHALY, BRACHYCEPHALY), WITH OR WITHOUT GRAFTS (INCLUDES OBTAINING AUTOGRAFTS).	0256	C	T
21195	RECONSTRUCTION OF MANDIBULAR RAMI AND/OR BODY, SAGITTAL SPLIT; WITHOUT INTERNAL RIGID FIXATION.	0256	C	T
21408	OPEN TREATMENT OF FRACTURE OF ORBIT, EXCEPT BLOWOUT; WITH BONE GRAFTING (INCLUDES OBTAINING GRAFT).	0256	C	T
21495	OPEN TREATMENT OF HYOID FRACTURE	0253	C	T
27475	ARREST, EPIPHYSEAL, ANY METHOD (EG, EPIPHYSIODESIS); DISTAL FEMUR.	0050	C	T
31293	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH MEDIAL ORBITAL WALL AND INFERIOR ORBITAL WALL DECOMPRESSION.	0075	C	T
31294	NASAL/SINUS ENDOSCOPY, SURGICAL; WITH OPTIC NERVE DECOMPRESSION.	0075	C	T
36510	CATHETERIZATION OF UMBILICAL VEIN FOR DIAGNOSIS OR THERAPY, NEWBORN.	n/a	C	T
37183	REMOVE HEPATIC SHUNT (TIPS)	0229	C	T
37195	THROMBOLYSIS, CEREBRAL, BY INTRAVENOUS INFUSION	0676	C	T
54560	EXPLORATION FOR UNDESCENDED TESTIS WITH ABDOMINAL EXPLORATION.	0183	C	T
55600	VESICULOTOMY	0183	C	T
59100	HYSTEROTOMY, ABDOMINAL (EG, FOR HYDATIDIFORM MOLE, ABORTION).	0195	C	T
61334	EXPLORATION OF ORBIT (TRANSCRANIAL APPROACH); WITH REMOVAL OF FOREIGN BODY.	0256	C	T
62160	NEUROENDOSCOPY	0122	C	T
64763	TRANSECTION OR AVULSION OF OBTURATOR NERVE, EXTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY.	0220	C	T
64766	TRANSECTION OR AVULSION OF OBTURATOR NERVE, INTRAPELVIC, WITH OR WITHOUT ADDUCTOR TENOTOMY.	0221	C	T

C. Ancillary Outpatient Services When Patient Expires (-CA Modifier)

(If you choose to comment on issues in this section, please include the caption ''Ancillary Outpatient Services'' at the beginning of your comment.)

In the November 1, 2002 final rule with comment period (67 FR 66798), we discussed the creation of a new HCPCS modifier -CA to address situations where a procedure on the OPPS inpatient list must be performed to resuscitate or stabilize a patient (whose status is that of an outpatient) with an emergent, life-threatening condition, and the patient dies before being admitted as an inpatient. In Transmittal A–02–129, issued on January 3, 2003, we instructed hospitals on the use of this modifier when submitting a claim on bill type 13x for a procedure that is on the inpatient list and assigned the payment status indicator (SI) ''C.'' Conditions to be met for hospital payment for a claim reporting a service billed with modifier -CA include a patient with an emergent, life-threatening condition on whom a procedure on the inpatient list is performed on an emergency basis to resuscitate or stabilize the patient. For CY 2003, a single payment for otherwise payable outpatient services billed on a claim with a procedure appended with this new -CA modifier was made under APC 0977 (New Technology Level VIII, $1,000–$1,250), due to the lack of available claims data to establish a payment rate based on historical hospital costs.

As discussed in the November 7, 2003 final rule with comment period, we created APC 0375 to pay for services furnished on the same date as a procedure with SI ''C'' and billed with the modifier -CA (68 FR 63467) because we were concerned that payment under a New Technology APC would not result in an appropriate payment. Payment under a New Technology APC is a fixed amount that does not have a relative payment weight and, therefore, is not subject to recalibration based on hospital costs. In the absence of hospital claims data to determine costs, the clinical APC 0375 payment rate for CY 2004 was set at of $1,150, which was the payment amount for the newly structured New Technology APC that replaced APC 0977.

For CY 2005, payment for otherwise payable outpatient services furnished on the same date of service that a procedure with SI ''C'' was performed on an emergent basis on an outpatient who died before inpatient admission and where modifier -CA was appended to the inpatient procedure continued to be made under APC 0375 (Ancillary Outpatient Services When Patient Expires) at a payment rate of $3,217.47. As discussed in the November 15, 2004 final rule with comment period (69 FR 65841), the payment median was set in accordance with the same methodology we followed to set payment rates for the other procedural APCs in CY 2005, based on the relative payment weight calculated for APC 0375. A review of the 18 hospital claims utilized for ratesetting revealed a reasonable mix of outpatient services that a hospital could be expected to furnish during an encounter with a patient with an emergency condition requiring immediate medical intervention, as well as a wide range of costs.

For CY 2006, we are not proposing any changes to our payment policy for services billed on the same date as a ''C'' status procedure appended with modifier -CA. We are proposing to continue to make one payment under APC 0375 for the services that meet the specific conditions discussed in previous rules for using modifier -CA, based on calculation of the relative payment weight for APC 0375, using charge data from CY 2004 claims for line items with a HCPCS code and status indicator ''V,'' ''S,'' ''T,'' ''X,'' ''N,'' ''K,'' ''G,'' and ''H,'' in addition to charges for revenue codes without a HCPCS code.

In accordance with this methodology, for CY 2006, we calculated a median cost of $2,528.61 for APC 0375 for the aggregated otherwise payable outpatient hospital services based on 300 CY 2004 hospital claims reporting modifier -CA with an inpatient procedure. These 300 claims were billed by 218 different hospital providers, each submitting between 1 and 10 claims with modifier -CA appended to a ''C'' status procedure. This median cost for APC 0375 is relatively consistent with the median calculated for the CY 2005 OPPS update, and, as expected, the hospital claims once again show a wide range of costs. Nevertheless, we are concerned with the very large increase in the volume of hospital claims billed with the -CA modifier from CY 2003 to CY 2004, growing from 18 to 300 claims over that 1-year time period. We acknowledge that modifier -CA was first introduced quite recently in CY 2003, and in CY 2003 and CY 2004 hospitals may have been experiencing a learning curve with respect to its appropriate use on claims for services payable under the OPPS.

However, our clinical review of the 300 claims reporting modifier -CA lends some support to our early concerns regarding the increased CY 2004 modifier volume and hospitals' possible incorrect use of the modifier for services that do not meet the payment conditions we established. Hospitals should be using this modifier only under circumstances described in section VI. of Transmittal A–02–129, which provided specific billing guidance for the use of modifier -CA. In addition to expected use of the -CA modifier for exploratory laparotomies and insertions of intra-aortic balloon assist devices, other unanticipated examples of ''C'' status procedures reported with the -CA modifier by hospitals in CY 2004 include knee arthroplasty, thyroidectomy, repair of nonunion or malunion of the femur, and thromboendarterectomy of the carotid, vertebral, or subclavian arteries. Moreover, few of the claims also include a clinic or emergency room visit on the same date of service as the procedure appended with modifier -CA, as might be expected for some patients presenting to a hospital with serious medical conditions which require urgent interventions with inpatient procedures. We are concerned that some procedures reported by hospitals with the -CA modifier in CY 2004 may not have been provided to patients with emergent, life-threatening conditions, where the inpatient procedure was performed on an emergency basis to resuscitate or stabilize the patient. Instead, those procedures may have been provided to hospital outpatients as scheduled inpatient procedures that were not emergency interventions for patients in critical or unstable condition and such circumstances would have been inconsistent with our billing and payment rules regarding correct use of the -CA modifier to receive payment for APC 0375. In light of these claims findings and our current analysis, we will continue to closely monitor hospital use of modifier -CA, following changes in the claims volume, noting inpatient procedures to which the -CA modifier is appended, examining other services billed on the same date as the inpatient procedure, and analyzing specific hospital patterns of billing for services with modifier -CA appended, to assess whether a proposal to change our policies regarding payment for APC 0375 would be warranted in the future or whether hospitals require further education regarding correct use of the modifier -CA.

XIII. Proposed Indicator Assignments

A. Proposed Status Indicator Assignments

(If you choose to comment on issues in the section, please include the caption ''Status

Indicator'' at the beginning of your comment.)

The payment status indicators (SIs) that we assign to HCPCS codes and APCs under the OPPS play an important role in determining payment for services under the OPPS because they indicate whether a service represented by a HCPCS code is payable under the OPPS or another payment system and also whether particular OPPS policies apply to the code. For CY 2006, we are providing our proposed status indicator assignments for APCs in Addendum A, for the HCPCS codes in Addendum B, and the definitions of the status indicators in Addendum D1 to this proposed rule.

Payment under the OPPS is based on HCPCS codes for medical and other health services. These codes are used for a wide variety of payment systems under Medicare, including, but not limited to, the Medicare fee schedule for physician services, the Medicare fee schedule for durable medical equipment and prosthetic devices, and the Medicare clinical laboratory fee schedule. For purposes of making payment under the OPPS, we must be able to signal the claims processing system through the OCE software as to HCPCS codes that 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 D1 contains the proposed definitions of each status indicator for purposes of the OPPS for CY 2006.

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, for CY 2006, we are proposing to use the following status indicators in the specified manner:

- ''A'' to indicate services that are billable to fiscal intermediaries but are paid under some payment method other than OPPS, such as under the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) fee schedule or the Medicare Physician Fee Schedule. Some, but not all, of these other payment systems are identified in Addendum D1 to this proposed rule.
- ''B'' to indicate the services that are billable to fiscal intermediaries but are not payable under the OPPS when submitted on an outpatient hospital Part B bill type, but that may be payable by fiscal intermediaries to other provider types when submitted on an appropriate bill type.
- ''C'' to indicate inpatient services that are not payable under the OPPS.
- ''D'' to indicate a code that is discontinued, effective January 1, 2006.
- ''E'' to indicate items or services that are not covered by Medicare or codes that are not recognized by Medicare.
- ''F'' to indicate acquisition of corneal tissue which is paid on a reasonable cost basis, certain CRNA services, and hepatitis B vaccines that are paid on a reasonable cost basis.
- ''G'' to indicate drugs and biologicals that are paid under the OPPS transitional pass-through rules.
- ''H'' to indicate pass-through devices, brachytherapy sources, and separately payable radiopharmaceuticals that are paid on a cost basis.
- ''K'' to indicate drugs and biologicals (including blood and blood products) and radiopharmaceutical agents that are paid in separate APCs under the OPPS, but that are not paid under the OPPS transitional pass-through rules.
- ''L'' to indicate flu and pneumococcal immunizations that are paid at reasonable cost but to which no coinsurance or copayment apply.
- ''M'' to indicate services that are only billable to carriers and not to fiscal intermediaries and that are not payable under the OPPS.
- ''N'' to indicate services that are paid under the OPPS, but 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.
- ''Q'' to indicate packaged services subject to separate payment under OPPS payment criteria.
- ''S'' to indicate significant services subject to separate payment under the OPPS.
- ''T'' to indicate significant services that are paid under the OPPS and to which the multiple procedure payment discount under the OPPS applies.
- ''V'' to indicate medical visits (including emergency department or clinic visits) that are paid under the OPPS.
- ''X'' to indicate ancillary services that are paid under the OPPS.
- ''Y'' to indicate nonimplantable durable medical equipment that must be billed directly to the durable medical equipment regional carrier rather than to the fiscal intermediary.

We are proposing the payment status indicators identified above, of which indicators ''M'' and ''Q'' are new for CY 2006, for each HCPCS code and each APC listed in Addenda A and B and are requesting comments on the appropriateness of the indicators we have assigned.

B. Proposed Comment Indicators for the CY 2006 OPPS Final Rule

(If you choose to comment on issues in the section, please include the caption ''Comment Indicator'' at the beginning of your comment.)

We are proposing to continue our use of the two comment indicators finalized in the November 15, 2004 final rule with comment period (69 FR 65827 and 65828) to identify in the CY 2006 OPPS final rule the assignment status of a specific HCPCS code to an APC and the timeframe when comments on the HCPCS APC assignment will be accepted. The two comment indicators are listed below, and in Addendum D2 of this proposed rule:

- ''NF''—New code, final APC assignment; Comments were accepted on a proposed APC assignment in the Proposed Rule; APC assignment is no longer open to comment.
- ''NI''—New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

XIV. Proposed Nonrecurring Policy Changes

A. Proposed Payments for Multiple Diagnostic Imaging Procedures

(If you choose to comment on issues in this section, please include the caption ''Multiple Diagnostic Imaging Procedures'' at the beginning of your comment.)

Currently, under the OPPS, hospitals billing for diagnostic imaging procedures receive full APC payments for each service on a claim, regardless of how many procedures are performed using a single imaging modality and whether or not contiguous areas of the body are studied in the same session. In its March 2005 Report to Congress, MedPAC recommended that the Secretary should improve Medicare coding edits that detect unbundled diagnostic imaging services and reduce the technical component payment for multiple imaging services when they are performed on contiguous areas of the body (Recommendation 3–B). MedPAC pointed out that Medicare's payment rates are based on each service being provided independently and that the rates do not account for efficiencies that may be gained when multiple studies using the same imaging modality are performed in the same session. Those efficiencies are especially likely when contiguous body areas are the focus of the imaging because the patient and

equipment have already been prepared for the second and subsequent procedures, potentially yielding resource savings in areas such as clerical time, technical preparation, and supplies, elements of hospital costs for imaging procedures that are reflected in APC payment rates under the OPPS.

Under the OPPS, we have a longstanding policy of reducing payment for multiple surgical procedures performed on the same patient in the same operative session (§ 419.44(a) of the regulations). In such cases, full payment is made for the procedure with the highest APC payment rate, and each subsequent procedure is paid at 50 percent of its respective APC payment rate. We believe that a similar policy for payment of diagnostic imaging services would be more appropriate than our current policy because it would lead to more appropriate payment for multiple imaging procedures of contiguous body areas that are performed during the same session.

In our efforts to determine whether or not such a policy would improve the accuracy of OPPS payments, we identified 11 ''families'' of imaging procedures by imaging modality (ultrasound, computerized tomography (CT) and computerized tomography angiography (CTA), magnetic resonance imaging (MRI) and magnetic resonance angiography (MRA)) and contiguous body area (for example, CT and CTA of Chest/Thorax/Abdomen/Pelvis), as displayed in Table 32. Using those Families of procedures, we examined OPPS bills for CY 2004 and found that there were numerous claims reporting more than one imaging procedure within the same Family provided to a beneficiary by a hospital on the same day. For instance, of the approximately 2.7 million OPPS claims billed for services within Family 2 (CT and CTA of the Chest/Thorax/Abdomen/Pelvis), approximately 1.1 million were claims for multiple procedures within Family 2. In particular, there were 288,200 claims for the combination of CPT codes 72192 (CT of the pelvis without dye) and 74150 (CT of the abdomen without dye).

TABLE 32.—MULTIPLE IMAGING PROCEDURES FAMILIES BY IMAGING MODALITY AND CONTIGUOUS BODY AREA

Family	Imaging modality/contiguous body area
Family 1—Ultrasound (Chest/Abdomen/Pelvis—Non-Obstetrical):	
76604	Us exam, chest, b-scan.
76645	Us exam, breast(s).
76700	Us exam, abdom, complete.
76705	Echo exam of abdomen.
76770	Us exam abdo back wall, comp.
76775	Us exam abdo back wall, lim.
76778	Us exam kidney transplant.
76830	Transvaginal us, non-ob.
76831	Echo exam, uterus.
76856	Us exam, pelvic, complete.
76857	Us exam, pelvic, limited.
Family 2—CT and CTA (Chest/Thorax/Abd/Pelvis):	
71250	Ct thorax w/o dye.
71260	Ct thorax w/ dye.
71270	Ct thorax w/o & w/ dye.
72192	Ct pelvis w/o dye.
72193	Ct pelvis w/ dye.
72194	Ct pelvis w/o & w/ dye.
74150	Ct abdomen w/o dye.
74160	Ct abdomen w/ dye.
74170	Ct abdomen w/o & w/ dye.
71275	Ct angiography, chest.
72191	Ct angiography, pelv w/o & w/ dye.
74175	Ct angiography, abdom w/o & w/ dye.
75635	Ct angio abdominal arteries.
0067T	Ct colonography; dx.
Family 3—CT and CTA (Head/Brain/Orbit/Maxillofacial/Neck):	
70450	Ct head/brain w/o dye.
70460	Ct head/brain w/ dye.
70470	Ct head/brain w/o & w/ dye.
70480	Ct orbit/ear/fossa w/o dye.
70481	Ct orbit/ear/fossa w/ dye.
70482	Ct orbit/ear/fossa w/o & w/ dye.
70486	Ct maxillofacial w/o dye.
70487	Ct maxillofacial w/ dye.
70488	Ct maxillofacial w/o & w/ dye.
70490	Ct soft tissue neck w/o dye.
70491	Ct soft tissue neck w/ dye.
70492	Ct soft tissue neck w/o & w/ dye.
70496	Ct angiography, head.
70498	Ct angiography, neck.
Family 4—MRI and MRA (Chest/Abd/Pelvis):	
71550	Mri chest w/o dye.
71551	Mri chest w/ dye.
71552	Mri chest w/o & w/ dye.
72195	Mri pelvis w/o dye.
72196	Mri pelvis w/ dye.
72197	Mri pelvis w/o &w/ dye.
74181	Mri abdomen w/o dye.

TABLE 32.—MULTIPLE IMAGING PROCEDURES FAMILIES BY IMAGING MODALITY AND CONTIGUOUS BODY AREA—Continued

Family	Imaging modality/contiguous body area
74182	Mri abdomen w/ dye.
74183	Mri abdomen w/o and w/ dye.
C8900	MRA w/contrast, abdomen.
C8901	MRA w/o contrast, abdomen.
C8902	MRA w/o fol w/contrast, abd.
C8903	MRI w/contrast, breast, unilateral.
C8904	MRI w/o contrast, breast, unilateral.
C8905	MRI w/o fol w/contrast, breast, uni.
C8906	MRI w/contrast, breast, bilateral.
C8907	MRI w/o contrast, breast, bilateral.
C8908	MRI w/o fol w/contrast, breast, bilat.
C8909	MRA w/contrast, chest.
C8910	MRA w/o contrast, chest.
C8911	MRA w/o fol w/contrast, chest.
C8918	MRA w/contrast, pelvis.
C8919	MRA w/o contrast, pelvis.
C8920	MRA w/o fol w/contrast, pelvis.
Family 5—MRI and MRA (Head/Brain/Neck):	
70540	Mri orbit/face/neck w/o dye.
70542	Mri orbit/face/neck w/ dye.
70543	Mri orbit/face/neck w/o & w/dye.
70551	Mri brain w/o dye.
70552	Mri brain w/dye.
70553	Mri brain w/o & w/dye.
70544	Mr angiography head w/o dye.
70545	Mr angiography head w/dye.
70546	Mr angiography head w/o & w/dye.
70547	Mr angiography neck w/o dye.
70548	Mr angiography neck w/dye.
70549	Mr angiography neck w/o & w/dye.
Family 6—MRI and MRA (Spine):	
72141	Mri neck spine w/o dye.
72142	Mri neck spine w/dye.
72146	Mri chest spine w/o dye.
72147	Mri chest spine w/dye.
72148	Mri lumbar spine w/o dye.
72149	Mri lumbar spine w/dye.
72156	Mri neck spine w/o & w/dye.
72157	Mri chest spine w/o & w/dye.
72158	Mri lumbar spine w/o & w/dye.
Family 7—CT (Spine):	
72125	CT neck spine w/o dye.
72126	Ct neck spine w/dye.
72127	Ct neck spine w/o & w/dye.
72128	Ct chest spine w/o dye.
72129	Ct chest spine w/dye.
72130	Ct chest spine w/o & w/dye.
72131	Ct lumbar spine w/o dye.
72132	Ct lumbar spine w/dye.
72133	Ct lumbar spine w/o & w/dye.
Family 8—MRI and MRA (Lower Extremities):	
73718	Mri lower extremity w/o dye.
73719	Mri lower extremity w/dye.
73720	Mri lower ext w/ & w/o dye.
73721	Mri joint of lwr extre w/o dye.
73722	Mri joint of lwr extr w/dye.
73723	Mri joint of lwr extr w/o & w/dye.
C8912	MRA w/contrast, lwr extremity.
C8913	MRA w/o contrast, lwr extremity.
C8914	MRA w/o fol w/contrast, lwr extremity.
Family 9—CT and CTA (Lower Extremities):	
73700	Ct lower extremity w/o dye.
73701	Ct lower extremity w/dye.
73702	Ct lower extremity w/o & w/dye.
73706	Ct angio lower ext w/o & w/dye.
Family 10—Mr and MRI (Upper Extremities and Joints):	
73218	Mri upper extr w/o dye.
73219	Mri upper extr w/dye.
73220	Mri upper extremity w/o & w/dye.
73221	Mri joint upper extr w/o dye.
73222	Mri joint upper extr w/dye.

TABLE 32.—MULTIPLE IMAGING PROCEDURES FAMILIES BY IMAGING MODALITY AND CONTIGUOUS BODY AREA—Continued

Family	Imaging modality/contiguous body area
73223	Mri joint upper extr w/o & w/dye.
Family 11—CT and CTA (Upper Extremities):	
73200	Ct upper extremity w/o dye.
73201	Ct upper extremity w/dye.
73202	Ct upper extremity w/o & w/dye.
73206	Ct angio upper extr w/o & w/dye.

The imaging procedures described by CPT codes 72192 and 74150 study two adjacent body regions. Appropriate diagnostic evaluation of many constellations of patients' signs and symptoms and potentially affected organ systems may involve assessment of pathology in both the abdomen and pelvis, body areas that are anatomically and functionally closely related. Therefore, both studies are frequently performed in the same session to provide the necessary clinical information to diagnose and treat a patient. Although each procedure, by itself, entails the use of hospital resources, including certain staff, equipment, and supplies, some of those resource costs are not incurred twice when the procedures are performed in the same session and thus, should not be paid as if they were. Beginning with the beneficiary's arrival in the outpatient department, costs are incurred only once for registering the patient, taking the patient to the procedure room, positioning the patient on the table for the CT scan, among others. We believe it is clear that reducing the payment for the second and subsequent procedures within the identified families would result in more accurate payments with respect to the hospital resources utilized for multiple imaging procedures performed in the same session.

OPPS bills do not contain detailed information on the hospitals' costs that are incurred in furnishing imaging procedures. Much of the costs are packaged and included in the overall charges for the procedures. Even if bundled costs are reported with charges on separate lines either with HCPCS codes or with revenue codes, when there are multiple procedures on the claims, it is impossible for us to accurately attribute bundled costs to each procedure. However, our analysis of CY 2004 hospital claims convinced us that some discounting of multiple imaging procedures is warranted. In order to determine the level of adjustment that would be appropriate for the second and subsequent procedures performed within a family in the same session, we used the MPFS methodology and data.

Under the resource-based practice expense methodology used for Medicare payments to physicians, specific practice expense inputs of clinical labor, supplies and equipment are used to calculate ''relative value units'' on which physician payments are based. When multiple images are acquired in a single session, most of the clinical labor activities are not performed twice and many of the supplies are not furnished twice. Specifically, we consider that the following clinical labor activities included in the ''technical component'' (TC) of the MPFS are not duplicated for subsequent procedures: Greeting, positioning and escorting the patient; providing education and obtaining consent; retrieving prior exams; setting up the IV; and preparing and cleaning the room. In addition, we consider that supplies, with the exception of film, are not duplicated for subsequent procedures. Equipment time and indirect costs are allocated based on clinical labor time in the physician payment methodology and, therefore, these inputs should be reduced accordingly.

We performed analyses and found that excluding those practice expense inputs, along with the corresponding portion of equipment time and indirect costs, supports a 50-percent reduction in the payment for the TC portion of subsequent procedures. The items and services that make up hospitals' facility costs are generally very similar to those that are counted in the TC portion of the MPFS for diagnostic imaging procedures. We believe that the analytic justification for a 50-percent reduction of the TC for the second and subsequent imaging procedures using the MPFS input data also provides a basis for a similar relative reduction to payments for multiple imaging procedures performed in the hospital outpatient department. Therefore, we are proposing to make a 50-percent reduction in the OPPS payments for some second and subsequent imaging procedures performed in the same session, similar to our policy of reducing payments for some second and subsequent surgical procedures.

We are proposing to apply the multiple imaging procedure reduction only to individual services described by codes within one Family, not across Families. Reductions would apply when more than one procedure within the Family is performed in the same session. For example, no reduction would apply to an MRI of the brain (CPT code 70552) in code Family 5, when performed in the same session as an MRI of the spinal canal and contents (CPT code 72142) in code Family 6. We are proposing to make full payment for the procedure with the highest APC payment rate, and payment at 50 percent of the applicable APC payment rate for every additional procedure, when performed in the same session.

B. Interrupted Procedure Payment Policies (Modifiers -52, -73, and -74)

(If you choose to comment on issues in this section, please include the caption ''Interrupted Procedures'' at the beginning of your comment.)

Since implementation of the OPPS in 2000, we have required hospitals to report modifiers -52, -73, and -74 to indicate procedures that were terminated before their completion. Modifier -52 indicates partial reduction or discontinuation of services that do not require anesthesia, while modifiers -73 and -74 are used for procedures requiring anesthesia, where the patient was taken to the treatment room and the procedure was discontinued before anesthesia administration or after anesthesia administration/procedure initiation respectively. The elective cancellation of procedures is not reported. Hospitals are paid 50 percent of the APC payment for services with -73 appended and 100 percent for procedures with modifier -52 or -74 reported, in accordance with § 419.44(b) of the regulations. In January 2005, we clarified in Program Transmittal 442 the definition of anesthesia for purposes of billing for services furnished in the hospital outpatient department in the context of reporting modifiers -73 and -74. The APC Panel considered the

current OPPS payment policies for interrupted procedures at its February 2005 meeting and made a number of recommendations that are addressed in the following discussion.

Current OPPS policy requires providers to use modifier -52 to indicate that a service that did not require anesthesia was partially reduced or discontinued at the physician's discretion. The physician may discontinue or cancel a procedure that is not completed in its entirety due to a number of circumstances, such as adverse patient reaction or medical judgment that completion of the full study is unnecessary. Based on an analysis of CY 2004 hospital claims data, in the outpatient hospital setting modifier -52 is used infrequently. The modifier is reported most often to identify interrupted or reduced radiological and imaging procedures, and our current policy is to make full payment for procedures with a -52 modifier.

We are now reconsidering our payment policy for interrupted or reduced services not requiring anesthesia and reported with a -52 modifier. At its February 2005 meeting, the APC Panel recommended continuing current OPPS payment policy at 100 percent of the APC payment for reduced services reported with modifier -52, although the Panel members acknowledged their limited familiarity with the specific outpatient hospital services and their clinical circumstances that would warrant the reporting of modifier -52. We have examined our data to determine the appropriateness of our current policy regarding payment for services that are reduced, and although some hospital resources are used to provide even an incomplete service, such as a radiology service, we are skeptical that it is accurate to pay the full rate for a discontinued or reduced radiological service. Compared to surgical procedures that require anesthesia, a number of general and procedure-specific supplies, and reserved procedure rooms that must be cleaned and prepared prior to performance of each specific procedure, the costs to the hospital outpatient department for the rooms and supplies typically associated with procedures not requiring anesthesia are much more limited. For example, the scheduling maintained for radiological services not requiring anesthesia generally exhibits greater flexibility than that for surgical procedures, and the procedure rooms are used for many unscheduled services that are fit in, when possible, between those that are scheduled. Consequently, we believe that the loss of revenue that may result from a surgical procedure being discontinued prior to its initiation in the procedure room is usually more substantial than that lost as the result of a discontinued service not requiring anesthesia, such as a radiology procedure. Nonetheless, under our current policy, Medicare makes the full APC payment for discontinued or reduced radiological procedures and only 50 percent of the APC payment for surgical procedures that are discontinued prior to initiation of the procedure or the administration of anesthesia.

Therefore, we are proposing to pay 50 percent of the APC payment amount for a discontinued procedure that does not require anesthesia where modifier -52 is reported. We believe that this proposed payment would appropriately recognize the hospital's costs involved with the delivery of a typical reduced service, similar to our payment policies for interrupted procedures that require anesthesia.

When a procedure requiring anesthesia is discontinued after the beneficiary was prepared for the procedure and taken to the room where it was to be performed but before the administration of anesthesia, hospitals currently report modifier -73 and receive 50 percent of the APC payment for the planned service. The APC Panel recommended that we make full APC payment for services with modifier -73 reported, because significant hospital resources were expended to prepare the patient and the treatment room or operating room for the procedure. Although the circumstances that require use of modifier -73 occur infrequently, we continue to believe that hospitals realize significant savings when procedures are discontinued prior to initiation but after the beneficiary is taken to the procedure room. We believe savings are recognized for treatment/operating room time, single use devices, drugs, equipment, supplies, and recovery room time. Thus, we believe our policy of paying 50 percent of the procedure's APC payment when modifier -73 is reported remains appropriate.

Further, we are exploring the possibility of applying a payment reduction for interrupted procedures in which anesthesia was to be used (and may have been administered) and the procedure was initiated. Currently, those cases are reported using modifier -74, and we make the full APC payment for the planned service. We are now reviewing that policy and are soliciting comments that include information regarding what costs are incurred by providers in these cases.

The payment policy for interrupted procedures reported with modifier -74 was originally adopted because we believed that the facility costs incurred for discontinued procedures that were initiated to some degree were as significant to the hospital provider as for a completed procedure, including resources for patient preparation, operating room use, and recovery room care. However, we have come to question that underlying assumption, especially as many surgical procedures have come to require specialized and costly devices and equipment, and our APC payments include the costs for those devices and equipment. We now believe that there are costs that are not incurred in the event of a procedure's discontinuation, if a hospital is managing its use of devices, supplies, and equipment efficiently and conservatively. For example, the patient's recovery time may be less than the recovery time would have been for the planned procedure, because less extensive surgery was performed or costly devices planned for the procedure may not be used.

The APC Panel recommended that we continue to pay 100 percent of the procedural APC payment when modifier -74 is appended to the surgical service because, in its opinion, procedures may frequently be terminated prior to completion because the patient is experiencing adverse effects from the surgical service or the anesthesia. The Panel speculated that, in fact, significant additional resources could be expended in such a situation to stabilize and treat the patient if a procedure were discontinued because of patient complications. However, we believe that many of such additional services, including critical care, drugs, blood and blood products, and x-rays that may be necessary to manage and treat such patients, are separately payable under the OPPS and thus the hospital's costs need not be paid through the APC payment for the planned procedure. Because the OPPS is paying for the time in the operating room, recovery room, outpatient department staff, and supplies related to the typical procedure, it would seem that those costs may be lower in those infrequent cases when the procedure is initiated but not completed. We acknowledge that the costs on claims reporting a service with modifier -74 may be particularly diverse, depending upon the point in the procedure the service is interrupted. Thus, we are seeking comment on the clinical circumstances in which modifier -74 is used in the

hospital outpatient department, and the degree to which hospitals may experience cost savings in such situations where procedures are not completed. We are specifically interested in comments regarding the disposition of devices and specialized equipment that are not used because a procedure is discontinued after its initiation. In particular, we are interested in obtaining information about when during the procedure the decision to discontinue is made.

XV. OPPS Policy and Payment Recommendations

A. MedPAC Recommendations

1. Report to the Congress: Medicare Payment Policy (March 2005)

The Medicare Payment Advisory Commission (MedPAC) submits reports to Congress in March and June that summarize payment policy recommendations. The March 2005 MedPAC report included the following two recommendations relating specifically to the hospital OPPS:

a. Recommendation 1: The Congress should increase payment rates for the outpatient prospective payment system by the projected increase in the hospital market basket index less 0.4 percent for calendar year 2006. A discussion regarding hospital update payments, and the effect of the market basket update in relation to other factors influencing OPPS proposed payment rates, is included in section II.C. (''Proposed Conversion Factor Update for CY 2006'') of this preamble.

b. Recommendation 2: The Congress should extend hold-harmless payments under the outpatient prospective payment system for rural sole community hospitals and other rural hospitals with 100 or fewer beds through calendar year 2006. A discussion of the expiration of the hold-harmless provision is included in section II.F. of this preamble. See also section II.G. (''Proposed Adjustment for Rural Hospitals'') of this preamble for a discussion of section 411 of Pub. L. 108–173.

2. Report to the Congress: Issues in a Modernized Medicare Program—Payment for Pharmacy Handling Costs in Hospital Outpatient Departments (June 2005)

A discussion of the MedPAC recommendations relating to pharmacy overhead payments in the hospital outpatient department can be found in section V. of the preamble of this proposed rule.

B. APC Panel Recommendations

Recommendations made by the APC Panel are discussed in sections of this preamble that correspond to topics addressed by the APC Panel. Minutes of the APC Panel's February 2005 meeting are available online at *http://www.cms.hhs.gov/faca/apc/default.asp.*

C. GAO Hospital Outpatient Drug Acquisition Cost Survey

A discussion of the June 30, 2005 GAO report entitled ''Medicare: Drug Purchase Prices for CMS Consideration in Hospital Outpatient Rate-Setting'' and section 621(a)(1) of the MMA is included in section V. of the preamble of this proposed rule.

XVI. Physician Oversight of Mid-Level Practitioners in Critical Access Hospitals

(If you choose to comment on issues in this section, please include the caption ''Physician Oversight of Nonphysician Practitioners'' at the beginning of your comment.)

A. Background

Section 1820 of the Act, as amended by section 4201 of the Balanced Budget Act of 1997, Pub. L. 105–33, provides for the establishment of Medicare Rural Hospital Flexibility Programs (MRHFPs), under which individual States may designate certain facilities as critical access hospitals (CAHs). Facilities that are so designated and meet the CAH conditions of participations (COPs) under 42 CFR Part 485, Subpart F, will be certified as CAHs by CMS. The MRHFP replaced the Essential Access Community Hospital (EACH)/ Rural Primary Care Hospital (RPCH) program.

B. Proposed Policy Change

Under the former EACH/RPCH program, physician oversight was required for services provided by nonphysician practitioners such as physician assistants (PAs), nurse practitioners (NPs), and clinical nurse specialists (CNSs) in a CAH. Under the MRHFP, the statute likewise required a physician oversight provision for nonphysician practitioners.

We note that under the EACH/RPCH program, we allowed for situations when the RPCH had an unusually high volume of outpatients (100 or more during a 2-week period) that were treated by nonphysician practitioners. We stated that it would be sufficient for a physician to review and sign a 25-percent sample of medical records for patients cared for by a mid-level practitioner unless State practice and laws require higher standards for physician oversight for mid-level practitioners.

However, the current regulation does not distinguish between inpatient and outpatient physician oversight. Although the CAH CoPs at § 485.631(b)(iv) provide that a doctor of medicine or osteopathy periodically reviews and signs the records of patients cared for by NPs, CNSs, or PAs, section 1820(c)(2)(B)(iv)(III) of the Act states that CAH inpatient care provided by a PA or NP is subject to the oversight of a physician. The review of outpatient records is not addressed in the statute. Presently, for patients cared for by nonphysician practitioners, the interpretative guidelines set forth in Appendix W of the State Operations Manual (CMS Publication 107) set parameters for inpatient and outpatient physician reviews. To maintain consistency from the EACH/RPCH program to the CAH program, we indicated that CAHs with a high volume of outpatients need to have a physician review and sign a random sample of 25 percent outpatient medical records. Therefore, the interpretative guidelines allow a physician to review and sign a 25-percent sample of outpatient records for patients under the care of a nonphysician practitioner.

Nonphysician practitioners recently brought to our attention their concerns regarding their ability to practice under their State laws governing scope of practice. Particularly, the nonphysician practitioners believe the current regulations and guidelines impede their ability to practice in CAHs. Certified nurse midwives, NPs, and CNSs disagree with the need for a physician to review records of patients that have been in their care when State law permits them to practice independently.

MedPAC, in its June 2002 Report to the Congress, stated that certified nurse midwives, NPs, CNSs, and PAs are health care practitioners who furnish many of the same health care services traditionally provided by physicians, such as diagnosing illnesses, performing physical examinations, ordering and interpreting laboratory tests, and providing preventive health services. In many States, advance practice nurses are permitted to practice independently or in collaboration with a physician. MedPAC reported that NPs have independent practice authority in 21 States, and CNSs have independent practice authority in 20 States. PAs, by law, must work under the supervision of a physician. Based on the American Medical Association's guidelines for PAs, the definition of supervision varies by State. Generally, the physician assistant is a representative of the

physician, treating the patient in the style and manner developed and directed by the supervising physician.

MedPAC further reported that several studies have shown comparable patient outcomes for the services provided by physician and nonphysician practitioners. MedPAC reported that research conducted by Mundinger *et al.*[2] in 2000, Brown and Grimes [3] in 1993, Ryan in 1993,[4] and the Office of Technology Assessment [5] in 1986 has shown that nonphysician practitioners can perform about 80 percent of the services provided by primary care physicians with comparable quality. A randomized trial of physicians and nurse practitioners providing care in ambulatory care settings who had the same authority, responsibilities, productivity, and administrative requirements were shown to have comparable patient outcomes (see pages 5 and 11 of the June 2002 MedPAC report). Nonphysician practitioners are trained with the expectation that they will exercise a certain degree of autonomy when providing patient care. About 90 percent of nurse practitioners and 50 percent of physician assistants provide primary care.

We believe sufficient control and oversight of these nonphysician practitioners is generated by State laws which allow independent practice authority. Moreover, it further appears that quality is not impaired by such nonphysician practitioners. We remain concerned, however, that in those States without independent practice laws we have a responsibility to continue to ensure the safety and quality of services provided to Medicare beneficiaries.

Therefore, we are proposing to revise the regulation at § 485.631(b)(iv) to defer to State law regarding the review of records for outpatients cared for by nonphysician practitioners. We are proposing that if State law allows these practitioners to practice independently, we would not require physicians to review and sign medical records of outpatients cared for by nonphysician practitioners. However, for those States that do not allow independent practice of nonphysician practitioners, we would continue to maintain that periodic review is performed by the physician on outpatient records under the care of a nonphysician practitioner. We believe a review of at least every 2 weeks provides a sufficient time period without unduly imposing an administrative burden on the physician or the CAH. In addition, we would allow the CAH to determine the sample size of the reviewed records in accordance with current standards of practice to allow the CAH flexibility in adapting the review to its particular circumstances. Specifically, we are proposing that the physician periodically (that is, at least once every 2 weeks) reviews and signs a sample of the outpatient records of nonphysician practitioners according to the facility policy and current standards of practice. We would still require periodic review and oversight of all inpatient records by physicians.

XVII. Files Available to the Public Via the Internet

The data referenced for Addendum C and Addendum P to this proposed rule are available on the following CMS Web site via Internet only: *http://www.cms.hhs.gov/providers/hopps/.* We are not republishing the data represented in these Addenda to this proposed rule because of their volume. For additional assistance, contact Rebecca Kane, at (410) 786–0378.

Addendum C—Healthcare Common Procedure Coding System (HCPCS) Codes by Ambulatory Payment Classification (APC)

This file contains the HCPCS codes sorted by the APCs into which they are assigned for payment under the OPPS. The file also includes the APC status indicators, relative weights, and OPPS payment amounts.

XVIII. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to evaluate fairly whether an information collection should be approved by OMB, section 35006(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of the agency.
- The accuracy of our estimates of the information collection burden,
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comments on each of these issues for the information requirement discussed below.

The following information collection requirements in this proposed rule and the associated burdens are subject to the PRA:

Proposed § 485.631(b)(1)(iv), (b)(1)(v), and (b)(1)(vi)—Condition of Participation: Staffing and Staff Responsibilities

Existing § 485.631(b)(1)(iv) requires, as a condition of participation for a CAH, that a doctor of medicine or osteopathy to periodically review and sign the records of patients cared for by nurse practitioners, clinical specialists, or physician assistants. This proposed rule would amend those requirements to require that a doctor of medicine or osteopathy (1) periodically review and sign the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants; and (2) periodically, but not less than every 2 weeks, review and sign a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policy and standard practice of the CAH when State law does not allow these nonphysician practitioners to practice independently. In addition, the proposed rule would provide that a doctor of medicine or osteopathy is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants when State law allows these nonphysician practitioners to practice independently.

The information collection requirements associated with these provisions are subject to the PRA. However, the collection requirement is currently approved under OMB control number 0938–0328 with an expiration date of January 31, 2008.

We have submitted a copy of this proposed rule to OMB for its review of the information collection requirements described above. These requirements are

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[2] Mundinger, M.O., Kane, R.I., Lenez, E.R., *et al.,* Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians, A Randomized Trial, *The Journal of the American Medical Association,* January 5, 2000, Vol. 283, No. 1, pages 59–68.

[3] Brown, S.A. and Grimes, D.E., Nurse Practitioners and Certified Nurse Midwives: A Meta Analysis of Studies on Nurses in Primary Care Roles, American Nurses Association, Washington, DC, March 1993.

[4] Ryan, S.A., Nurse Practitioners: Educational Issues, Practice Styles, and Service Barriers. In Clawson, D.K., Osterweis, M., eds: The Role of Physician Assistants and Nurse Practitioners in Primary Health Care, Association of Academic Health Centers, Washington, DC, 1993.

[5] Office of Technology Assessment, U.S. Congress: Nurse Practitioners, Physician Assistants, and Certified Nurse Midwives: A Policy Analysis, Health Technology Case Study 37, Washington, DC, U.S Government Printing Office, 1986.

not effective until they have been approved by OMB.

If you comment on any of these information collection and record keeping requirements, please mail copies directly to the following:

Centers for Medicare & Medicaid Services, Office of Strategic Operations and Regulatory Affairs, Regulations Development and Issuances Group, Attn: James Wickliffe, CMS–1501–P, 7500 Security Boulevard, Baltimore, MD 21244–1850; and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer.

Comments submitted to OMB may also be e-mailed to the following address: *Christopher_Martin@omb.eop.gov*, or faxed at (202) 395–6974.

XIX. Response to Comments

Because of the large number of items of correspondence we normally receive on a proposed rule, we are not able to acknowledge or respond to them individually. However, in preparing the final rule, we will consider all comments concerning the provisions of this proposed rule that we receive by the date and time specified in the DATES section of this preamble, and when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XX. Regulatory Impact Analysis

(If you choose to comment on issues in this section, please include the caption ''Impact'' at the beginning of your comment.)

A. OPPS: General

We have examined the impacts of this proposed rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 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.

1. Executive Order 12866

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 would be implemented by this proposed rule would result in expenditures exceeding $100 million in any 1 year. We estimate the total increase (from changes in this proposed rule as well as enrollment, utilization, and case-mix changes) in expenditures under the OPPS for CY 2006 compared to CY 2005 to be approximately $1.4 billion. Therefore, this proposed rule is an economically significant rule under Executive Order 12866, and a major rule under 5 U.S.C. 804(2).

2. Regulatory Flexibility Act (RFA)

The RFA requires agencies to determine whether a rule would 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 (65 FR 69432).

For purposes of the RFA, we have determined that approximately 37 percent of hospitals would 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.

3. Small Rural Hospitals

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we previously defined a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) (or New England County Metropolitan Area (NECMA)). However, under the new labor market definitions that we are adopted in the November 15, 2004 final rule with comment period, for CY 2005, (consistent with the FY 2005 IPPS final rule), we no longer employ NECMAs to define urban areas in New England. Therefore, we now define a small rural hospital as a hospital with fewer than 100 beds that is located outside of an MSA. 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 proposed rule would 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 proposed rule would have a significant impact on a substantial number of small entities.

4. 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 proposed rule does not mandate any requirements for State, local, or tribal governments. This proposed rule also does not impose unfunded mandates on the private sector of more than $110 million dollars.

5. Federalism

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

We have examined this proposed rule in accordance with Executive Order 13132, Federalism, and have determined that it would not have an impact on the rights, roles, and responsibilities of State, local or tribal

governments. The impact analysis (refer to Table 33) shows that payments to governmental hospitals (including State, local, and tribal governmental hospitals) would increase by 1.8 percent under this proposed rule.

B. Impact of Proposed Changes in This Proposed Rule

We are proposing 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 proposed rule, we are proposing to update the conversion factor and the wage index adjustment for hospital outpatient services furnished beginning January 1, 2006, as we discuss in sections II.C. and II.D., respectively, of this proposed rule. We also are proposing to revise the relative APC payment weights using claims data from January 1, 2004, through December 31, 2004. In response to a provision in Pub. L. 108–173 that we analyze the cost of outpatient services in rural hospitals relative to urban hospitals, we are proposing to increase payments to rural sole community hospitals. Refer to section II.G. of the preamble to this proposed rule for greater detail on this adjustment. Finally, we are proposing to remove 3 device categories from pass-through payment status. In particular, refer to section IV.C.1 of the preamble of this proposed rule with regard to the expiration of pass-through status for devices.

Under this proposed rule, the update change to the conversion factor as provided by statute would increase total OPPS payments by 3.2 percent in CY 2006. The inclusion in CY 2006 of payment for specific covered outpatient drugs within budget neutrality, and the expiration of additional drug payment outside budget neutrality, which were authorized by Pub. L. 108–173 result in a net increase of 1.9 percent. The changes to the APC weights, the introduction of a multiple procedure discount for diagnostic imaging, changes to the wage index, and the introduction of a payment adjustment for rural sole community hospitals would not increase OPPS payments because these changes to the OPPS are budget neutral. However, these updates do change the distribution of payments within the budget neutral system as shown in Table 33 and described in more detail in this section.

C. Alternatives Considered

Alternatives to the changes we are making and the reasons that we have chosen the options we have are discussed throughout this proposed rule. Some of the major issues discussed in this proposed rule and the options considered are discussed below.

1. Option Considered for Proposed Payment Policy for Separately Payable Drugs and Biologicals

As discussed in detail in section V.B.3 of the preamble of this proposed rule, section 1833(t)(14)(A)(iii) of the Act requires that payment for specified covered outpatient drugs in CY 2006, as adjusted for pharmacy overhead costs, be equal to the average acquisition cost for the drug for that year as determined by the Secretary and taking into account the hospital acquisition cost survey data collected by the GAO in 2004 and 2005. If hospital acquisition cost data are not available, then the law requires that payment be equal to payment rates established under the methodology described in section 1842(o), section 1847(A), or section 1847(B) of the Act as calculated and adjusted by the Secretary as necessary.

The payment policy that we are proposing for CY 2006 is to pay for all separately payable drugs and biologicals at the payment rates effective in the physician office setting as determined using the manufacturer's average sales price (ASP) methodology. Our proposal uses payment rates based on ASP data from the fourth quarter of 2004, which were used to set payment rates for drugs and biologicals in the physician office setting effective April 1, 2005, as these are the most recent numbers available to us during the development of this proposed rule. For the few drugs and biologicals, other than radiopharmaceuticals as discussed earlier, where ASP data are unavailable, we are proposing to use the mean costs from the CY 2004 hospital claims data to determine their packaging status and for ratesetting. We believe that the ASP-based payment rates serve as the best proxy for the average acquisition cost for the drug or biological because the rates calculated using the ASP methodology are based on the manufacturers' sales prices from the fourth quarter of 2004 and take into consideration information on sales prices to hospitals. Furthermore, payments for drugs and biologicals using the ASP methodology would allow for consistency of drug pricing between the physician offices and hospital outpatient departments.

An alternative payment option for separately payable drugs and biologicals (before payment for pharmacy overhead) we considered was using ASP+3 percent based on the average relationship between the GAO mean purchase prices and ASP. A second payment option we considered using was ASP+8 percent (again before payment for pharmacy overhead) based on the average relationship between the mean costs from hospital claims data and ASP.

We are not proposing to set payment rates for separately payable drugs and biologcals at ASP+3 percent because the GAO data reflect hospital acquisition costs from a less recent period of time as the midpoint of the time period when the survey was conducted is January 1, 2004, and it would be difficult to update the GAO mean purchase prices during CY 2006 and in future years. Because the changes in drug payments are required to be budget neutral by law, we note that paying for separately payable drugs and biologicals at ASP+3 percent relative to ASP+6 percent would have made available approximately an additional $60 million for other items and services paid under the OPPS.

We are also not proposing to use ASP+8 percent to set payment rates for drugs and biologicals in CY 2006. The statute specifies that CY 2006 payments for specified covered outpatient drugs are required to be equal to the ''average'' acquisition cost for the drug. Payment at ASP+8 percent for drugs or biologicals, which represents the average relationship between the mean cost from hospital claims data and ASP, would reflect the product's acquisition cost plus overhead cost, instead of acquisition cost only. Therefore, we believe that it would not be appropriate for us to use ASP+8 percent to set the payment rates for drugs and biologicals in CY 2006. Using ASP+8 percent to set payments for separately payable drugs and biologicals relative to ASP+6 percent would have reduced payments for other items and services paid under the OPPS by approximately $40 million as the law requires that changes in drug payments be made in a budget neutral manner.

2. Payment Adjustment for Rural Sole Community Hospitals

In section II.G. of the preamble of this proposed rule, we propose a 6.6 percent payment adjustment increase to rural sole community hospitals. Section 1833(t)(13)(A) of the Act instructs the Secretary to conduct a study to determine if rural hospital outpatient costs exceed urban hospital outpatient

costs. In addition, under new section 1833(t)(13)(B) of the Act, the Secretary is given authorization to provide an appropriate adjustment to rural hospitals, by January 1, 2006, if rural hospital costs are determined to be greater than urban hospital costs.

To conduct the study, we believe that a simple comparison of unit costs is insufficient because the costs faced by hospitals, whether urban or rural, will be a function of many factors. These include the local labor supply, and the complexity and volume of services provided. (We note that without controlling for the other influences on per unit cost, rural hospitals have lower cost per unit than urban hospitals.) Therefore, we rejected the option of using a simple comparison of unit costs and instead used regression analysis to analyze the differences in the outpatient cost per unit between rural and urban hospitals in order to compare costs after accounting for the influence of these other factors.

Our initial regression analysis found that all rural hospitals give some indication of having higher cost per unit, after controlling for labor input prices, service-mix complexity, volume, facility size, and type of hospital. Initially, we planned a small adjustment to all rural hospitals. However, in order to assess whether the small difference in costs was uniform across rural hospitals or whether all of the variation was attributable to a specific class of rural hospitals, we included more specific categories of rural hospitals in our explanatory regression analysis. Further analysis revealed that only rural sole community hospitals are more costly than urban hospitals holding all other variables constant. Notably, we observed no significant difference between all other rural hospitals and urban hospitals. Therefore, we propose not to pay a small adjustment increase to all rural hospitals, but to instead pay a 6.6 percent payment increase to rural sole community hospitals.

3. Change in the Percentage of Total OPPS Payments Dedicated to Outlier Payments

In section II.H. of the preamble of this proposed rule, we are proposing to change the percentage of total OPPS payments dedicated to outlier payments to 1.0 percent in CY 2006 from the current policy of 2.0 percent. We also are proposing to continue using a fixed-dollar threshold in addition to the threshold based on a multiple of the APC amount that we have applied since the beginning of the OPPS. In response to findings reported by the MedPAC in their March 2004 Report to Congress that the OPPS outlier policy did not provide sufficient insurance against large financial loses for certain complex procedures that ultimately could impact beneficiary access to services, we implemented the fixed-dollar threshold in the CY 2005 OPPS. Our decision to reduce the percentage of total payments dedicated to outlier payments continues to refine our outlier policy to improve its appropriateness for OPPS. Because OPPS pays by service, rather than by case, hospitals are already paid for every increased service associated with a costly case. A reduction in the size of the outlier pool combined with the fixed dollar threshold continues to target outlier payments to those services where one costly occurrence could pose a financial risk for hospitals, but limits these payments to the most complex and costly services. At the same time, reducing the outlier pool increases overall payments for all services by 1.0 percent.

Alternatives to this policy are either to remain at 2.0 percent or to increase the percentage of payments dedicated to outliers to the statutory limit of 3.0 percent. Increasing the percentage of payments dedicated to outliers could target more payment to outliers, but is at odds with OPPS payment by service rather than case. It is not possible to eliminate outlier payments entirely without a statutory change.

D. Limitations of Our Analysis

The distributional impacts presented here are the projected effects of the policy changes, as well as the statutory changes that would be effective for CY 2006, 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 are not proposing to make adjustments for future changes in variables such as service volume, service-mix, or number of encounters. As we have done in previous proposed rules, we are soliciting comments and information about the anticipated effects of these proposed changes on hospitals and our methodology for estimating them.

E. Estimated Impacts of This Proposed Rule on Hospitals

The estimated increase in the total payments made under OPPS is limited by the increase to the conversion factor set under the methodology in the statute. The distributional impacts presented do not include assumptions about changes in volume and service-mix. However, total payments actually made under the system also may be influenced by changes in volume and service-mix, which CMS cannot forecast. The enactment of Pub. L. 108–173 on December 8, 2003, provided for the payment of additional dollars in CY 2004 and CY 2005 to providers of OPPS services outside of the budget neutrality requirements for specified covered outpatient drugs. These provisions expire CY 2006, as noted in this proposed rule. Pub. L. 108–173 also provided for additional payment for wage indexes for specific hospitals reclassified under section 508 through 2007. Table 33 shows the estimated redistribution of hospital payments among providers as a result of a new APC structure, multiple procedure discount for diagnostic imaging, wage indices, and rural adjustment, which are budget neutral; the estimated distribution of increased payments in CY 2006 resulting from the combined impact of proposed APC recalibration, proposed wage effects, the proposed rural sole community hospital adjustment, and the proposed market basket update to the conversion factor; and, finally, estimated payments considering all proposed payments for CY 2006 relative to all payments for CY 2005 including the expiration of the provision in Pub. L. 108–173 that required payment for specified covered outpatient drugs outside budget neutrality and the proposed change in the percentage of total payments dedicated to outlier payments. The expiration of the requirement that payment for specified covered outpatient drugs need not be budget neutral, leaves most classes of hospitals with a positive update that is lower than the proposed market basket. We also estimate that a few classes of hospitals may receive less payment in CY 2006. Because updates to the conversion factor, including the market basket, any reintroduction of transitional pass-through dollars, and change in the percentage of total payments dedicated to outlier payments are applied uniformly, observed redistributions of payments in the impact table largely depends on the mix of services furnished by a hospital (for example, how the APCs for the hospital's most frequently furnished services would change) and the impact of the wage index changes on the hospital. However, the extent to which this proposed rule redistributes money during implementation would also depend on changes in volume, practice patterns, and case-mix of services billed between CY 2005 and CY 2006. Overall, the

proposed OPPS rates for CY 2006 would have a positive effect for all hospitals paid under OPPS. Proposed changes would result in a 1.9 percent increase in Medicare payments to all hospitals, exclusive of transitional pass-through payments.

To illustrate the impact of the proposed CY 2006 changes, our analysis begins with a baseline simulation model that uses the final CY 2005 weights, the FY 2005 final post-reclassification IPPS wage indices, as subsequently corrected, without changes in wage indices resulting from section 508 reclassifications, and the final CY 2005 conversion factor. Columns 2, 3, and 4 in Table 33 reflect the independent effects of the proposed changes in the APC reclassification and recalibration changes, the proposed multiple procedure discount for diagnostic imaging, the proposed wage indices, and the proposed adjustment for rural sole community hospitals respectively. These effects are budget neutral, which is apparent in the overall zero impact in payment for all hospitals in the top row. Column 2 shows the independent effect of changes resulting from the proposed reclassification of HCPCS codes among APC groups and the proposed recalibration of APC weights based on a complete year of CY 2004 hospital OPPS claims data. This column also shows the impact of incorporating drug payment at 106 percent of ASP plus overhead and, for radiopharmaceuticals, at cost, within budget neutrality. This column also includes the impact of a multiple procedure discount for diagnostic imaging services. We modeled the independent effect of APC recalibration by varying only the weights, the final CY 2005 weights versus the proposed CY 2006 weights, in our baseline model, and calculating the percent difference in payments. Column 3 shows the impact of updating the wage indices used to calculate payment by applying the proposed FY 2006 IPPS wage indices. The OPPS wage indices used in Column 3 do not include changes to the wage indices for hospitals reclassified under section 508 of Pub. L. 108–173. We modeled the independent effect of introducing the new wage indices by varying only the wage index, using the proposed CY 2006 scaled weights, and a CY 2005 conversion factor that included a budget neutrality adjustment for changes in wage effects between CY 2005 and CY 2006. Column 4 shows the budget neutral impact of adding a proposed 6.6 percent adjustment to payment for services other than drugs and biologicals to rural sole community hospitals. We modeled the independent effect of the proposed payment adjustment for rural sole community hospitals by varying only the presence of the rural adjustment, using CY 2006 scaled weights, FY 2006 wage index, and a CY 2005 conversion factor with the wage and rural budget neutrality adjustments.

Column 5 demonstrates the combined ''budget neutral'' impact of proposed APC recalibration and wage index updates on various classes of hospitals, as well as the impact of updating the conversion factor with the market basket. We modeled the independent effect of proposed budget neutrality adjustments and the market basket update by using the weights and wage indices for each year to model CY 2006 requirements, and using a CY 2005 conversion factor that included a budget neutrality adjustment for differences in wages, the proposed adjustment for rural sole community hospitals, and the market basket increase.

Finally, Column 6 depicts the full impact of the proposed CY 2006 policy on each hospital group by including the effect of all the changes for CY 2006 and comparing them to the full effect of all payments in CY 2005, including those required by Pub. L. 108–173. Column 6 shows the combined budget neutral effects of Columns 2 through 5, as well as the impact of changing the percentage of total payments dedicated to outlier payments to 1.0 percent, changing the percentage of total payments dedicated to transitional pass-through payments to 0.05 percent, the effects of expiring monies added to OPPS in CY 2005 as a result of Pub. L. 108–173, and the continued presence of payment for wage indices reclassified under section 508 of Pub. L. 108–173.

We modeled the independent effect of all changes in column 6 using the final weights for CY 2005 with additional money for drugs required by section 621 of Pub. L. 108–173 and the proposed weights for CY 2006. The wage indices in each year include wage index increases for hospitals eligible for reclassification under section 508 of Pub. L. 108–173. We used the final conversion factor for CY 2005 and the proposed CY 2006 conversion factor of $59.35. Column 6 also contains simulated outlier payments for each year. We used the charge inflation factor used in the proposed FY 2006 IPPS rule of 8.65 percent to increase individual costs on the CY 2004 claims to reflect CY 2005 and CY 2006 dollars respectively. Using the CY 2004 claims and an 8.65 percent charge inflation factor, we currently estimate that actual outlier payments for CY 2005, using a multiple threshold of 1.75 and a fixed dollar threshold of $1,175 will be 1.0 percent of total payments, which is 1.0 percent lower than the 2.0 percent that we projected in setting outlier policies for CY 2005. Outlier payments of only 1.0 percent appear in the CY 2005 comparison in Column 6. We used the same set of claims and a charge inflation factor of 18.04 percent to model the proposed CY 2006 outliers at 1.0 percent of total payments using a multiple threshold of 1.75 and a fixed dollar threshold of $1,575.

Column 1: Total Number of Hospitals

Column 1 in Table 33 shows the total number of hospital providers (4,212) for which we were able to use CY 2004 hospital outpatient claims to model CY 2005 and CY 2006 payments by classes of hospitals. We excluded all hospitals for which we could not accurately estimate CY 2005 or CY 2006 payment and entities that are not paid under the OPPS. The latter include critical access hospitals, all-inclusive hospitals, and hospitals located in Guam, the U.S. Virgin Islands, and the State of Maryland. This process is discussed in greater detail in section II.A. of this proposed rule. At this time we are unable to calculate a disproportionate share (DSH) variable for hospitals not participating in the IPPS. Hospitals for whom we do not have a DSH variable are grouped separately. Finally, because section 1833(t)(7)(D) of the Act permanently holds harmless cancer hospitals and children's hospitals, that is, these hospitals cannot receive less payment in CY 2006 than they did in the CY 2005, we removed these hospitals from our impact analyses.

Column 2: APC Recalibration

The combined effect of proposed APC reclassification and recalibration, including the proposal to pay for drugs and biologicals as 106 percent of ASP plus 2 percent of ASP for overhead, and the introduction of a proposed multiple procedure discount for diagnostic imaging resulted in larger changes in Column 2 than are typically observed for APC recalibration. In general, these changes have a greater negative impact on some classes of urban hospitals than on rural hospitals. APC changes effect the distribution of hospital payments by increasing payments to specific subsets of urban hospitals while decreasing payments made to large urban hospitals and rural hospitals.

Overall, these changes have no impact on all urban hospitals, which show no projected change in payments, although some classes of urban hospitals experience large decreases in payments. However, changes to the APC structure

for CY 2006 tend to favor, slightly, urban hospitals that are not located in large urban areas. Large urban hospitals experience a decline of 0.8 percent, while ''other'' urban hospitals experience an increase of 1.0 percent. Urban hospitals with between 100 and 199 beds and between 300 and 499 beds experienced decreases, while the largest urban hospitals, those with beds greater than 500, and moderately sized urban hospitals, those with beds between 200 and 299 beds report increases of at least 0.2 percent. The smallest urban hospitals do not appear to be impacted by changes to the APC structure. With regard to volume, all urban hospitals except those with the highest volume, experience a decrease in payments. The lowest volume hospitals experience the largest decrease of 5.8 percent. Urban hospitals providing the highest volume of services demonstrate a projected increase of 0.2 percent as a result of APC recalibration. Decreases for urban hospitals are also concentrated in some regions, specifically, New England, Pacific, South Atlantic, West South Central, and Mountain, with the first two experiencing the largest decreases of 1.2 and 1.8 percent respectively. On the other hand, a few regions experience moderate increases. Hospitals in the East South Central and West North Central regions experience increases of 1.5 and 2.6 percent respectively.

Overall, rural hospitals show a modest 0.1 percent decrease as a result of changes to the APC structure, and this 0.1 percent decrease appears to be concentrated in rural hospitals that are not rural sole community hospitals. Notwithstanding a modest overall decline, there is substantial variation among classes of rural hospitals. Specifically, rural hospitals with less than 100 beds and between 150 and 199 beds experience decreases, with hospitals having less than 50 beds experiencing the largest decrease of 0.9 percent. Rural hospitals with greater than 100 and less than 150 beds experience the largest increase of 1.4 percent. With regard to volume, all rural hospitals except those with the highest volume, experience a decrease in payments. The lowest volume hospitals experience the largest decrease of 2.9 percent. Rural hospitals providing the highest volume of services demonstrate a projected increase of 0.7 percent as a result of APC recalibration. Decreases for rural hospitals occur in every region except West North Central and the Middle Atlantic. The largest decreases are observed in West South Central and Mountain regions. On the other hand, hospitals in the Middle Atlantic and West North Central experience increases of 1.9 and 1.8 percent respectively.

Among other classes of hospitals, the largest observed impacts resulting from APC recalibration include declines of 0.4 percent for non-teaching hospitals and increases of 0.5 percent for major teaching hospitals. Hospitals without a valid DSH variable, most of which are TEFRA hospitals, experience decreases of 0.9 percent, and of these, those in urban areas experience a decline of 1.4 percent. Hospitals treating the most low-income patients (high DSH percentage) demonstrate declines of 0.3 percent, where as all other hospitals treating DSH patients appear to experience slight increases of 0.1 percent. Hospitals that are treating DSH patients and are also teaching hospitals experience increases of 0.4 percent. Classifying hospitals by type of ownership suggests that proprietary hospitals will lose 1.3 percent and voluntary and government hospitals will gain at least 0.1 percent.

Column 3: New Wage Index

Changes introduced by the proposed FY 2006 IPPS wage indices would have a modest impact in CY 2006, increasing payments to rural hospitals slightly and reducing payments to specific classes of urban hospitals. We estimate that rural hospitals, and specifically rural hospitals that are not sole community hospitals, will experience an increase in payments of 0.1 percent. With respect to facility size, only rural hospitals with between 150 and 199 beds experience a decrease in payments of 0.2 percent. Similarly, moderate rural volume hospitals experience a decrease of 0.1 percent. For both facility size and volume, no category of rural hospitals experiences an increase greater than 0.2 percent. Examining hospitals by region reveals slightly greater variability. We estimate that rural hospitals in several regions will experience decreases in payment up to 0.4 percent due to wage changes, including the Middle Atlantic, South Atlantic, West North Central, West South Central. However, rural hospitals in the remaining regions experience increases. We estimate that the Pacific region will see the largest increase of 1.8 percent.

Overall, urban hospitals experience no change in payments as a result of the new wage indices. With respect to facility size, we estimate that urban hospitals with between 300 and 499 beds will experience a decrease in payments of 0.1 percent. Urban hospitals with less than 99 beds experience the largest increase of 0.2 percent. When categorized by volume, no class of urban hospitals experience a decrease in payment as a result of changes to the wage index. We estimate that urban hospitals in all but the Pacific and East South Central region will experience modest decreases due to wage changes of no more than 0.4 percent. Urban hospitals in the Pacific region will experience an increase of 1.1 percent, and urban hospitals in the East South Central region will experience no change in payments.

Looking across other categories of hospitals, we estimate that updating the wage index will lead major teaching hospitals to lose 0.2 percent and hospitals without graduate medical education programs are estimated to gain 0.1 percent. Hospitals serving between 0.0 and 0.10 percent of low-income patients and between 0.23 and 0.35 percent of low-income patients lose up to 0.2 percent and 0.1 percent respectively, whereas hospitals serving other percentages of low-income patients gain by up to 0.1 percent or experience no change. Government hospitals will experience an increase of 0.1 percent.

Column 4: New Adjustment for Rural Sole Community Hospitals

As discussed in section II.G. of the preamble of this proposed rule, we have proposed to increase payments for all services except drugs and biologicals to rural sole community hospitals by 6.6 percent. This resulted in an adjustment to the conversion factor of 0.997. Targeting payments to these rural hospitals uniformly reduces payments to all other hospitals by 0.3 percent. The uniform reduction for all urban and other rural hospitals is evident in Column 4. The observed increase of 5.2 percent for rural sole community hospitals is lower than 6.6 percent because drugs and biologicals do not receive the proposed payment adjustment. The remaining classes of rural hospitals show variable increases that reflect the distribution of rural sole community hospitals. The largest increases are observed among rural hospitals with small numbers of beds, with moderate volume, and regions in the western half of the country.

Column 5: All Budget Neutrality Changes and Market Basket Update

With the exception of urban hospitals with the lowest volume of services, the addition of the market basket update alleviates any negative impacts on payments for CY 2006 created by the budget neutrality adjustments made in Columns 2, 3, and 4. In many instances, and especially among rural hospitals, the redistribution of payments created by proposed APC recalibration offset those introduced by updating the wage

indices. In some instances, especially for urban hospitals, APC recalibration changes compound the impact of updating the wage index. In addition, all urban and other rural hospitals experience a decrease in payment of 0.3 percent as a result of the proposed payment adjustment for rural sole community hospitals.

We estimate that the cumulative impact of proposed budget neutrality adjustments and the addition of the market basket would result in an increase in payments for urban hospitals of 2.8 percent, which is less than the market basket update of 3.2 percent. Large urban hospitals would experience an increase of 2.0 percent and other urban hospitals would experience an increase of 3.8 percent. This trend of updates lower than the market basket holds for most other classes of urban hospitals. For example, of all classes of urban hospitals, urban hospitals with the lowest volume are the only group to experience a negative market basket update, which is largely a function of the 5.8 percent decrease in payments attributable to proposed changes to the APC structure. Urban hospitals with moderate volume would also lose the bulk of the market basket update as a result of a −2.8 percent change resulting from proposed APC recalibration and the addition of the proposed payment adjustment for rural sole community hospitals. The same compounding effect holds true for urban hospitals in New England as well. Urban hospitals in New England would experience a 1.2 percent loss due to changes in APC structure, a 0.1 percent loss for changes to the wage index and a 0.3 percent loss for the new rural adjustment, reducing their increase to 1.5 percent. Urban hospitals in a few regions experience increases in payment for CY 2006 above the market basket, including the East South Central, Middle Atlantic, and West North Central regions.

We estimate that the cumulative impact of budget neutrality adjustments and the market basket update will result in an overall increase for rural hospitals of 5.0 percent, with rural sole community hospitals experiencing an update of 8.6 percent and other rural hospitals experiencing an update of 2.8 percent. In general, rural hospitals with more than 100 beds and high volume rural hospitals experience increases of more than 5.0 percent, which generally results from the combined impact of increases in payment from APC recalibration, wage changes, and the new adjustment for rural sole community hospitals. Rural hospitals also demonstrate large increases by region, with Middle Atlantic, West North Central, Mountain, and Pacific regions experiencing large increases. For these regions, in aggregate, the payment adjustment for rural sole community hospitals compensates for observed loses in the APC recalibration column.

The changes across columns for other classes of hospitals are fairly moderate and most show updates relatively close to the market basket. TEFRA hospitals that are not paid under OPPS show payment updates much lower than the market basket as a result of negative payment changes for proposed APC recalibration and the proposed adjustment for rural sole community hospitals. Proprietary hospitals also show an increase much less than the market basket as a result of negative payments under APC recalibration.

Column 6: All Proposed Changes for CY 2006

Column 6 compares all proposed changes for CY 2006 to final payment for CY 2005 and includes any additional dollars resulting from provisions in Pub. L. 108–173 in both years, changes in outlier payment percentages and proposed thresholds, and the difference in pass-through estimates. Overall, we estimate that hospitals would gain 1.9 percent under this proposed rule in CY 2006 relative to total spending in CY 2005, which included Pub. L. 108–173 dollars for drugs and wage indices. While hospitals receive the 3.2 percent increase due to the market basket appearing in Column 5 and the additional 1.0 percent in outlier payments that we estimate as not being paid in CY 2005, we estimate that hospitals also experience an overall 2.3 percent loss due to the expiration of additional payment for drugs in CY 2005. That is, without the additional 1.0 percent increase in outlier payments due to lower than expected payment for outliers in CY 2005, hospitals would receive a positive increase in payments of 0.9 percent. Paying the additional 1.0 percent in outlier payments in CY 2006 increases overall gains to 1.9 percent, which is lower than the market basket. Overall, the change in the outlier thresholds has a minimal redistributive impact by class of hospital and the vast majority of redistributive impacts observed between Columns 5 and 6 can be attributed to the loss of additional payment for drugs outside budget neutrality required by Pub. L. 108–173.

In general, urban hospitals appear to experience the largest negative impacts from the loss of additional payments for drugs because of the combined effects of decreases in payment from the proposed payment adjustment for rural sole community hospitals and, frequently, negative changes in payments due to APC recalibration. We estimate that hospitals in large urban areas will gain 0.8 percent in CY 2006 and hospitals in other urban areas will gain 2.6 percent. We estimate that some urban hospitals will experience a decrease in total payments between CY 2005 and CY 2006. Specifically, low volume urban hospitals will experience a decrease in payments of 2.1 percent, which includes the cumulative effect of negative payments from APC recalibration, a negative impact of the payment adjustment for rural sole community hospitals, and a loss of payments outside budget neutrality for drugs. We estimate that urban hospitals in New England would experience a loss of 0.2 percent in CY 2006. The reason for this is the same as that for low volume urban hospitals, except that the urban hospitals in New England also experience a decrease in payments from updating the wage index. Other classes of urban hospitals generally show increases between 1.0 and 3.0 percent. Urban hospitals in the East South Central and West North Central experience the largest increases for urban hospitals of 3.4 and 3.7 percent, respectively.

Overall, rural hospitals experience larger increases than those observed for urban hospitals because the proposed payment adjustment for rural sole community hospitals tends to buffer the loss of payments for drugs from Pub. L. 108–173. However, this adjustment is only for rural sole community hospitals. Overall, we estimate that rural hospitals will experience an increase in payments of 3.4 percent. But, we also estimate that rural sole community hospitals will experience an increase of 6.4 percent and that other rural hospitals will only experience an increase of 1.6 percent. No rural hospital experiences a decrease in payments between CY 2005 and CY 2006 and some classes of rural hospitals show increases comparable to the market basket. For example rural hospitals with more than 100 beds experience increases of at least 3.1 percent. Rural hospitals with moderate to high volume experience increases comparable to the market basket. Across the regions, rural hospitals in the Middle Atlantic, South Atlantic, West North Central, West South Central, Mountain, and Pacific all experience increases in payments greater than 3 percent. Low volume rural hospitals and rural hospitals in New England experience the lowest updates of only 1.0 percent.

Among other classes of hospitals, we estimate that TEFRA hospitals not paid

under IPPS would experience decreases in payments between CY 2005 and CY 2006 of 1.9 percent and that TEFRA hospitals in urban areas will experience a decrease in payments between CY 2005 and CY 2006 of 2.6 percent. Factoring in expiring payments for drugs through Pub. L. 108–173, we estimate that major teaching hospitals would only experience an increase of 0.8 percent.

G. Estimated Impacts of This Proposed Rule on Beneficiaries

For services for which the beneficiary pays a copayment 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 CY 2005 was $11.22. In this proposed rule, the minimum unadjusted copayment for APC 601 is $11.86 because the OPPS payment for the service will increase under this proposed rule. In another example, for a Level IV Needle Biopsy (APC 0037), the minimum unadjusted copayment in CY 2005 was $234.20. In this proposed rule, the minimum unadjusted copayment for APC 0037 is $223.91 because the minimum unadjusted copayment is limited to 40 percent of the APC payment rate for CY 2006, as discussed in section II. of the preamble to this proposed rule. However, in all cases, the statute limits beneficiary liability for copayment for a service to the inpatient hospital deductible for the applicable year.

In order to better understand the impact of changes in copayment on beneficiaries we modeled the percent change in total copayment liability using CY 2004 claims. We estimate that total beneficiary liability for copayments will decline as an overall percentage of total payments from 32 percent in CY 2005 to 30 percent in CY 2006.

Conclusion

The changes in this proposed rule would affect all classes of hospitals. Some hospitals experience significant gains and others less significant gains, but all hospitals would experience positive updates in OPPS payments in CY 2006. Table 33 demonstrates the estimated distributional impact of the OPPS budget neutrality requirements and an additional 1.9 percent increase in payments for CY 2006, after considering the expiring provision for additional drug payment under Pub. L. 108–173 and a change in the percentage of total payments dedicated to outliers and transitional pass-through payments, exclusive of transitional pass-through payments, across various classes of hospitals. The accompanying discussion, in combination with the rest of this proposed rule constitutes a regulatory impact analysis.

TABLE 33.—IMPACT OF PROPOSED CHANGES FOR CY 2006 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

Hospital category	(1) Number of hospitals	(2) APC changes	(3) New wage index	(4) New adj for rural sole community hospitals	(5) Cumulative (cols 2,3,4) with market basket update	(6) All changes
ALL HOSPITALS	4212	0.0	0.0	0.0	3.2	1.9
URBAN HOSPITALS	2949	0.0	0.0	−0.3	2.8	1.6
LARGE URBAN	1624	−0.8	0.0	−0.3	2.0	0.8
OTHER URBAN	1325	1.0	0.0	−0.3	3.8	2.6
RURAL HOSPITALS	1263	−0.1	0.1	1.8	5.0	3.4
SOLE COMMUNITY	478	0.0	0.0	5.2	8.6	6.4
OTHER RURAL	785	−0.1	0.1	−0.3	2.8	1.6
BEDS (URBAN):						
0–99 BEDS	917	0.0	0.2	−0.3	3.0	2.1
100–199 BEDS	964	−0.4	0.0	−0.3	2.4	1.4
200–299 BEDS	503	0.2	0.1	−0.3	3.1	2.3
300–499 BEDS	402	−0.1	−0.1	−0.3	2.6	1.5
500 + BEDS	163	0.5	0.0	−0.3	3.3	1.2
BEDS (RURAL):						
0—49 BEDS	551	−0.9	0.2	2.0	4.5	3.0
50–100 BEDS	419	−0.8	0.2	2.2	4.8	2.9
101–149 BEDS	180	1.4	0.0	1.1	5.8	4.7
150–199 BEDS	62	−0.3	−0.2	1.7	4.5	3.5
200 + BEDS	51	0.2	0.0	1.7	5.1	3.1
VOLUME (URBAN):						
LT 5,000 claim lines	600	−5.8	0.5	−0.3	−2.7	−2.1
5,000–10,999	180	−2.8	0.2	−0.3	0.2	0.2
11,000–20,999	299	−0.8	0.2	−0.3	2.2	2.3
21,000–42,999	575	−0.8	0.1	−0.3	2.2	1.8
GT 42,999	1295	0.2	0.0	−0.3	3.0	1.6
VOLUME (RURAL):						
LT 5,000 claim lines	119	−2.9	0.0	1.3	1.6	1.3
5,000—10,999	195	−2.1	0.0	2.1	3.2	2.2
11,000—20,999	325	−1.0	−0.1	2.0	4.1	3.3
21,000—42,999	364	−0.9	0.2	1.9	4.4	2.9
GT 42,999	260	0.7	0.0	1.6	5.7	3.8
REGION (URBAN):						
NEW ENGLAND	166	−1.2	−0.1	−0.3	1.5	−0.2
MIDDLE ATLANTIC	393	0.7	−0.1	−0.3	3.5	2.2
SOUTH ATLANTIC	453	−0.4	−0.4	−0.3	2.0	1.0
EAST NORTH CENT	466	0.5	−0.1	−0.3	3.2	1.7
EAST SOUTH CENT	197	1.5	0.0	−0.3	4.4	3.4
WEST NORTH CENT	184	2.6	−0.3	−0.3	5.2	3.7
WEST SOUTH CENT	445	−0.3	−0.1	−0.3	2.4	1.3

TABLE 33.—IMPACT OF PROPOSED CHANGES FOR CY 2006 HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM—Continued

Hospital category	(1) Number of hospitals	(2) APC changes	(3) New wage index	(4) New adj for rural sole community hospitals	(5) Cumulative (cols 2,3,4) with market basket update	(6) All changes
MOUNTAIN	163	−0.1	−0.2	−0.3	2.5	1.3
PACIFIC	431	−1.8	1.1	−0.3	2.1	1.3
PUERTO RICO	51	0.1	−0.3	−0.3	2.7	1.9
REGION (RURAL):						
NEW ENGLAND	37	−0.9	0.8	1.2	4.4	1.0
MIDDLE ATLANTIC	78	1.9	−0.4	1.4	6.1	4.2
SOUTH ATLANTIC	189	−0.4	−0.2	1.7	4.3	3.2
EAST NORTH CENT	171	−0.5	0.1	1.3	4.1	2.2
EAST SOUTH CENT	202	−0.9	0.5	0.5	3.3	2.9
WEST NORTH CENT	188	1.8	−0.3	2.5	7.3	4.8
WEST SOUTH CENT	242	−1.1	−0.2	2.2	4.1	3.5
MOUNTAIN	95	−1.0	0.1	4.4	6.8	5.0
PACIFIC	61	−0.6	1.8	2.6	7.1	5.2
TEACHING STATUS:						
NON-TEACHING	3115	−0.4	0.1	0.2	3.1	2.2
MINOR	769	0.2	0.0	−0.2	3.3	2.2
MAJOR	328	0.5	−0.2	−0.3	3.2	0.8
DSH PATIENT PERCENT:						
0	16	0.0	0.0	−0.3	2.8	2.8
GT 0–0.10	386	0.1	−0.2	−0.3	2.7	1.7
0.10–0.16	555	0.0	0.1	0.2	3.5	2.4
0.16–0.23	802	0.1	0.0	0.1	3.5	2.3
0.23–0.35	977	0.1	−0.1	0.0	3.2	1.9
GE 0.35	792	−0.3	0.1	−0.1	3.0	1.8
TEFRA: DSH NOT AVAIL [1]	684	−0.9	0.0	−0.3	1.9	−1.9
URBAN TEACHING/DSH:						
TEACHING & DSH	944	0.4	−0.1	−0.3	3.2	1.7
NO TEACHING/DSH	1401	−0.4	0.0	−0.3	2.5	1.7
NO TEACHING/NO DSH	16	0.0	0.0	−0.3	2.8	2.8
TEFRA: DSH NOT AVAIL [1]	588	−1.4	0.1	−0.3	1.5	−2.6
TYPE OF OWNERSHIP:						
VOLUNTARY	2397	0.2	0.0	0.0	3.3	2.0
PROPRIETARY	1091	−1.3	0.0	0.0	1.9	1.4
GOVERNMENT	724	0.1	0.1	0.2	3.7	1.8

Col (1) Total hospitals in CY 2006.
Col (2) This column shows the impact of changes resulting from the reclassification of HCPCS codes among APC groups and from the addition of multiple procedure discounting for radiology procedures (budget neutral overall).
Col (3) This column shows the adjustment for updating the wage index (budget neutral overall).
Col (4) This column shows the adjustment for rural sole community hospitals (budget neutral overall).
Col (5) This column shows the cumulative impact of cols 2 through 4 and the addition of the market basket update.
Col (6) The column shows the impact of the change in MMA dollars in CY 2006 (drugs and 508) and outlier changes.
[1] Complete DSH numbers are not available for hospitals that are not paid under IPPS.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 419

Hospitals, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant program-health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons stated in the preamble of this proposed rule, the Centers for Medicare & Medicaid Services is proposing to amend 42 CFR Chapter IV as set forth below:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

A. Part 419 is amended as follows:

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. Section 419.43 is amended by adding a new paragraph (g) to read as follows:

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

* * * * *

(g) *Payment adjustment for certain rural hospitals.* (1) *General rule.* CMS provides for additional payment for covered hospital outpatient service not excluded under paragraph (g)(4) of this section, furnished on or after January 1, 2006, if the hospital—

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

(ii) Is located in a rural area as defined in § 412.64(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (g)(1) of this section is determined by CMS and is based on the difference between costs incurred by hospitals that meet the criteria in paragraphs (g)(1)(i) and (g)(1)(ii) of this section and costs incurred by hospitals located in urban areas.

(3) *Budget neutrality.* CMS establishes the payment adjustment under

paragraph (g)(2) of this section in a budget neutral manner, excluding services and groups specified in paragraph (g)(4) of this section.

(4) *Excluded services and groups.* Drugs and biologicals that are paid under a separate APC and devices of brachytheraphy consisting of a seed or seeds (including a radioactive source) are excluded from qualification for the payment adjustment in paragraph (g)(2) of this section.

(5) *Copayment* The payment adjustment in paragraph (g)((2) of this section is applied before calculating copayment amounts.

(6) *Outliers:* The payment adjustment in paragraph (g) (2) of this section is applied before calculating outlier payments.

* * * * *

3. Section 419.66 is amended by revising paragraph (c)(1) to read as follows:

§ 419.66 Transitional pass-through payments: Medical devices.

* * * * *

(c) *Criteria for establishing device categories.* * * *

(1) CMS determines that a device to be included in the category is not appropriately described by any of the existing categories or by any category previously in effect, and was not being paid for as an outpatient service as of December 31, 1996.

* * * * *

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

B. Part 485 is amended as follows:

1. The authority citation for Part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. Section 485.631 is amended by—

a. Republishing paragraph (b)(1).

b. Revising paragraph (b)(1)(iv).

c. Adding new paragraphs (b)(1)(v) and (b)(1)(vi).

The revision and additions read as follows:

§ 485.631 Condition of participation: Staffing and staff responsibilities.

* * * * *

(b) *Standard: Responsibilities of the doctor of medicine or osteopathy.* (1) The doctor of medicine or osteopathy—

* * * * *

(iv) Periodically reviews and signs the records of all inpatients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants.

(v) Periodically, but not less than every 2 weeks, reviews and signs a sample of outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants according to the policies of the CAH and according to current standards of practice where State law does not allow these nonphysician practitioners to practice independently.

(vi) Is not required to review and sign outpatient records of patients cared for by nurse practitioners, clinical nurse specialists, certified nurse midwives, or physician assistants where State law allows these nonphysician practitioners to practice independently.

* * * * *

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

Dated: July 8, 2005.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 13, 2005.

Michael O. Leavitt,

Secretary.

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0001	Level I Photochemotherapy	S	0.4194	$24.89	$7.00	$4.98
0002	Level I Fine Needle Biopsy/Aspiration	T	0.9515	$56.47	.....	$11.29
0003	Bone Marrow Biopsy/Aspiration	T	2.6410	$156.74	.....	$31.35
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	1.7566	$104.25	$22.36	$20.85
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	3.5831	$212.66	$71.45	$42.53
0006	Level I Incision & Drainage	T	1.5430	$91.58	$22.18	$18.32
0007	Level II Incision & Drainage	T	11.3983	$676.49	.....	$135.30
0008	Level III Incision and Drainage	T	16.4242	$974.78	.....	$194.96
0009	Nail Procedures	T	0.6650	$39.47	$8.34	$7.89
0010	Level I Destruction of Lesion	T	0.5693	$33.79	$9.63	$6.76
0011	Level II Destruction of Lesion	T	2.0745	$123.12	$25.06	$24.62
0012	Level I Debridement & Destruction	T	0.8458	$50.20	$11.18	$10.04
0013	Level II Debridement & Destruction	T	1.1028	$65.45	$14.20	$13.09
0015	Level III Debridement & Destruction	T	1.6439	$97.57	$20.20	$19.51
0016	Level IV Debridement & Destruction	T	2.5717	$152.63	$33.42	$30.53
0017	Level VI Debridement & Destruction	T	18.3377	$1,088.34	$227.84	$217.67
0018	Biopsy of Skin/Puncture of Lesion	T	1.1673	$69.28	$16.04	$13.86
0019	Level I Excision/Biopsy	T	4.0363	$239.55	$71.87	$47.91
0020	Level II Excision/Biopsy	T	6.9118	$410.22	$106.93	$82.04
0021	Level III Excision/Biopsy	T	14.9098	$884.90	$219.48	$176.98
0022	Level IV Excision/Biopsy	T	19.5582	$1,160.78	$354.45	$232.16
0023	Exploration Penetrating Wound	T	4.7558	$282.26	.....	$56.45
0024	Level I Skin Repair	T	1.6011	$95.03	$31.11	$19.01
0025	Level II Skin Repair	T	5.4690	$324.59	$101.85	$64.92
0027	Level IV Skin Repair	T	18.3348	$1,088.17	$329.72	$217.63
0028	Level I Breast Surgery	T	19.4914	$1,156.81	$303.74	$231.36
0029	Level II Breast Surgery	T	31.9024	$1,893.41	$632.64	$378.68
0030	Level III Breast Surgery	T	39.9010	$2,368.12	$763.55	$473.62
0033	Partial Hospitalization	P	4.0524	$240.51	.....	$48.10
0035	Venous Cutdown	T	0.7125	$42.29	.....	$8.46
0036	Level II Fine Needle Biopsy/Aspiration	T	2.1675	$128.64	.....	$25.73
0037	Level IV Needle Biopsy/Aspiration Except Bone Marrow	T	9.4322	$559.80	$223.91	$111.96
0039	Level I Implantation of Neurostimulator	S	180.5784	$10,717.33	.....	$2,143.47
0040	Level I Implantation of Neurostimulator Electrodes	S	55.0791	$3,268.94	.....	$653.79
0041	Level I Arthroscopy	T	28.0044	$1,662.06	.....	$332.41
0042	Level II Arthroscopy	T	43.7761	$2,598.11	$804.74	$519.62
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.7614	$104.54	.....	$20.91
0045	Bone/Joint Manipulation Under Anesthesia	T	14.4289	$856.36	$268.47	$171.27
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	37.5315	$2,227.49	$535.76	$445.50
0047	Arthroplasty without Prosthesis	T	31.4675	$1,867.60	$537.03	$373.52
0048	Level I Arthroplasty with Prosthesis	T	42.9335	$2,548.10	$570.30	$509.62
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	20.2784	$1,203.52	.....	$240.70
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	23.7998	$1,412.52	.....	$282.50
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	36.3617	$2,158.07	.....	$431.61
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	43.7388	$2,595.90	.....	$519.18
0053	Level I Hand Musculoskeletal Procedures	T	15.6085	$926.36	$253.49	$185.27
0054	Level II Hand Musculoskeletal Procedures	T	25.2562	$1,498.96	.....	$299.79
0055	Level I Foot Musculoskeletal Procedures	T	19.9783	$1,185.71	$355.34	$237.14
0056	Level II Foot Musculoskeletal Procedures	T	40.1132	$2,380.72	.....	$476.14
0057	Bunion Procedures	T	27.4246	$1,627.65	$475.91	$325.53
0058	Level I Strapping and Cast Application	S	1.0884	$64.60	.....	$12.92
0060	Manipulation Therapy	S	0.4913	$29.16	.....	$5.83
0068	CPAP Initiation	S	1.2237	$72.63	$29.05	$14.53
0069	Thoracoscopy	T	30.5386	$1,812.47	$591.64	$362.49
0070	Thoracentesis/Lavage Procedures	T	3.1956	$189.66	.....	$37.93
0071	Level I Endoscopy Upper Airway	T	0.7879	$46.76	$11.31	$9.35
0072	Level II Endoscopy Upper Airway	T	1.4296	$84.85	$21.27	$16.97
0073	Level III Endoscopy Upper Airway	T	4.1420	$245.83	$73.38	$49.17
0074	Level IV Endoscopy Upper Airway	T	15.7042	$932.04	$295.70	$186.41
0075	Level V Endoscopy Upper Airway	T	21.2460	$1,260.95	$445.92	$252.19
0076	Level I Endoscopy Lower Airway	T	9.4163	$558.86	$189.82	$111.77
0077	Level I Pulmonary Treatment	S	0.3428	$20.35	$7.74	$4.07
0078	Level II Pulmonary Treatment	S	1.0190	$60.48	$14.55	$12.10
0079	Ventilation Initiation and Management	S	2.3375	$138.73	.....	$27.75
0080	Diagnostic Cardiac Catheterization	T	36.9679	$2,194.04	$838.92	$438.81
0081	Non-Coronary Angioplasty or Atherectomy	T	34.2913	$2,035.19	.....	$407.04
0082	Coronary Atherectomy	T	84.6276	$5,022.65	$1,080.41	$1,004.53
0083	Coronary Angioplasty and Percutaneous Valvuloplasty	T	50.6620	$3,006.79	.....	$601.36
0084	Level I Electrophysiologic Evaluation	S	9.9751	$592.02	.....	$118.40

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0085	Level II Electrophysiologic Evaluation	T	35.0288	$2,078.96	$426.25	$415.79
0086	Ablate Heart Dysrhythm Focus	T	44.0592	$2,614.91	$833.33	$522.98
0087	Cardiac Electrophysiologic Recording/Mapping	T	30.5711	$1,814.39	.....	$362.88
0088	Thrombectomy	T	36.3961	$2,160.11	$655.22	$432.02
0089	Insertion/Replacement of Permanent Pacemaker and Electrodes.	T	105.1359	$6,239.82	$1,681.06	$1,247.96
0090	Insertion/Replacement of Pacemaker Pulse Generator	T	88.7536	$5,267.53	$1,612.80	$1,053.51
0091	Level II Vascular Ligation	T	28.8685	$1,713.35	$348.23	$342.67
0092	Level I Vascular Ligation	T	26.3621	$1,564.59	$505.37	$312.92
0093	Vascular Reconstruction/Fistula Repair without Device	T	23.3454	$1,385.55	$277.34	$277.11
0094	Level I Resuscitation and Cardioversion	S	2.5248	$149.85	$47.41	$29.97
0095	Cardiac Rehabilitation	S	0.5858	$34.77	$13.90	$6.95
0096	Non-Invasive Vascular Studies	S	1.6233	$96.34	$38.53	$19.27
0097	Cardiac and Ambulatory Blood Pressure Monitoring	X	1.0177	$60.40	$23.79	$12.08
0098	Injection of Sclerosing Solution	T	1.1295	$67.04	.....	$13.41
0099	Electrocardiograms	S	0.3804	$22.58	.....	$4.52
0100	Cardiac Stress Tests	X	2.4855	$147.51	$41.44	$29.50
0101	Tilt Table Evaluation	S	4.2593	$252.79	$101.11	$50.56
0103	Miscellaneous Vascular Procedures	T	14.6476	$869.34	$223.63	$173.87
0104	Transcatheter Placement of Intracoronary Stents	T	78.6515	$4,667.97	.....	$933.59
0105	Revision/Removal of Pacemakers, AICD, or Vascular	T	22.2671	$1,321.55	$370.40	$264.31
0106	Insertion/Replacement/Repair of Pacemaker and/or Electrodes	T	45.2791	$2,687.31	.....	$537.46
0107	Insertion of Cardioverter-Defibrillator	T	258.8517	$15,362.85	$3,089.53	$3,072.57
0108	Insertion/Replacement/Repair of Cardioverter-Defibrillator Leads.	T	347.5867	$20,629.27	.....	$4,125.85
0109	Removal of Implanted Devices	T	10.9933	$652.45	$131.49	$130.49
0110	Transfusion	S	3.6428	$216.20	.....	$43.24
0111	Blood Product Exchange	S	12.3394	$732.34	$200.18	$146.47
0112	Apheresis, Photopheresis, and Plasmapheresis	S	26.6734	$1,583.07	$437.01	$316.61
0113	Excision Lymphatic System	T	21.3681	$1,268.20	.....	$253.64
0114	Thyroid/Lymphadenectomy Procedures	T	40.5805	$2,408.45	$485.91	$481.69
0115	Cannula/Access Device Procedures	T	31.3302	$1,859.45	$459.35	$371.89
0116	Chemotherapy Administration by Other Technique Except Infusion.	S	1.1401	$67.66	.....	$13.53
0117	Chemotherapy Administration by Infusion Only	S	3.2231	$191.29	$42.54	$38.26
0120	Infusion Therapy Except Chemotherapy	S	2.0101	$119.30	$28.21	$23.86
0121	Level I Tube changes and Repositioning	T	2.2663	$134.50	$43.80	$26.90
0122	Level II Tube changes and Repositioning	T	6.9405	$411.92	$84.48	$82.38
0123	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant.	S	22.8861	$1,358.29	.....	$271.66
0125	Refilling of Infusion Pump	T	1.9244	$114.21	.....	$22.84
0130	Level I Laparoscopy	T	31.7825	$1,886.29	$659.53	$377.26
0131	Level II Laparoscopy	T	43.1426	$2,560.51	$1,001.89	$512.10
0132	Level III Laparoscopy	T	62.7061	$3,721.61	$1,239.22	$744.32
0140	Esophageal Dilation without Endoscopy	T	5.4489	$323.39	$93.77	$64.68
0141	Level I Upper GI Procedures	T	8.1464	$483.49	$143.38	$96.70
0142	Small Intestine Endoscopy	T	9.3063	$552.33	$152.78	$110.47
0143	Lower GI Endoscopy	T	8.6475	$513.23	$186.06	$102.65
0146	Level I Sigmoidoscopy and Anoscopy	T	4.6164	$273.98	$64.40	$54.80
0147	Level II Sigmoidoscopy and Anoscopy	T	7.9318	$470.75	.....	$94.15
0148	Level I Anal/Rectal Procedures	T	3.7213	$220.86	$56.96	$44.17
0149	Level III Anal/Rectal Procedures	T	17.9907	$1,067.75	$293.06	$213.55
0150	Level IV Anal/Rectal Procedures	T	23.7573	$1,410.00	$437.12	$282.00
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	18.6489	$1,106.81	$245.46	$221.36
0152	Level I Percutaneous Abdominal and Biliary Procedures	T	12.2277	$725.71	.....	$145.14
0153	Peritoneal and Abdominal Procedures	T	21.5979	$1,281.84	$381.07	$256.37
0154	Hernia/Hydrocele Procedures	T	28.6544	$1,700.64	$464.85	$340.13
0155	Level II Anal/Rectal Procedures	T	16.1810	$960.34	.....	$192.07
0156	Level II Urinary and Anal Procedures	T	2.5635	$152.14	$40.52	$30.43
0157	Colorectal Cancer Screening: Barium Enema	S	2.2800	$135.32	.....	$27.06
0158	Colorectal Cancer Screening: Colonoscopy	T	7.6242	$452.50	.....	$113.13
0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	3.1312	$185.84	.....	$46.46
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	6.6450	$394.38	$105.06	$78.88
0161	Level II Cystourethroscopy and other Genitourinary Procedures.	T	18.4736	$1,096.41	$249.36	$219.28
0162	Level III Cystourethroscopy and other Genitourinary Procedures.	T	23.2858	$1,382.01	.....	$276.40
0163	Level IV Cystourethroscopy and other Genitourinary Procedures.	T	33.5826	$1,993.13	.....	$398.63

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0164	Level I Urinary and Anal Procedures	T	1.1802	$70.04	$17.21	$14.01
0165	Level III Urinary and Anal Procedures	T	16.5934	$984.82	.....	$196.96
0166	Level I Urethral Procedures	T	17.5942	$1,044.22	$218.73	$208.84
0168	Level II Urethral Procedures	T	28.1405	$1,670.14	$386.32	$334.03
0169	Lithotripsy	T	42.8184	$2,541.27	$1,016.50	$508.25
0170	Dialysis	S	5.8726	$348.54	.....	$69.71
0180	Circumcision	T	19.7926	$1,174.69	$304.87	$234.94
0181	Penile Procedures	T	30.7265	$1,823.62	$621.82	$364.72
0183	Testes/Epididymis Procedures	T	23.5344	$1,396.77	.....	$279.35
0184	Prostate Biopsy	T	4.3369	$257.40	$96.27	$51.48
0188	Level II Female Reproductive Proc	T	1.1348	$67.35	.....	$13.47
0189	Level III Female Reproductive Proc	T	2.3602	$140.08	.....	$28.02
0190	Level I Hysteroscopy	T	20.9699	$1,244.56	$424.28	$248.91
0191	Level I Female Reproductive Proc	T	0.1663	$9.87	$2.77	$1.97
0192	Level IV Female Reproductive Proc	T	4.2887	$254.53	.....	$50.91
0193	Level V Female Reproductive Proc	T	14.5183	$861.66	.....	$172.33
0194	Level VIII Female Reproductive Proc	T	20.6585	$1,226.08	$397.84	$245.22
0195	Level IX Female Reproductive Proc	T	26.5582	$1,576.23	$483.80	$315.25
0196	Dilation and Curettage	T	17.0200	$1,010.14	$338.23	$202.03
0197	Infertility Procedures	T	2.3465	$139.26	.....	$27.85
0198	Pregnancy and Neonatal Care Procedures	T	1.3621	$80.84	$32.19	$16.17
0200	Level VII Female Reproductive Proc	T	17.7919	$1,055.95	$263.69	$211.19
0201	Level VI Female Reproductive Proc	T	17.5250	$1,040.11	$329.65	$208.02
0202	Level X Female Reproductive Proc	T	40.2037	$2,386.09	$954.43	$477.22
0203	Level IV Nerve Injections	T	10.3544	$614.53	$245.81	$122.91
0204	Level I Nerve Injections	T	2.1811	$129.45	$40.13	$25.89
0206	Level II Nerve Injections	T	5.4672	$324.48	$75.55	$64.90
0207	Level III Nerve Injections	T	5.9837	$355.13	$86.92	$71.03
0208	Laminotomies and Laminectomies	T	42.1492	$2,501.56	.....	$500.31
0209	Extended EEG Studies and Sleep Studies, Level II	S	11.5189	$683.65	$273.46	$136.73
0212	Nervous System Injections	T	2.9606	$175.71	$70.28	$35.14
0213	Extended EEG Studies and Sleep Studies, Level I	S	2.2828	$135.48	$54.19	$27.10
0214	Electroencephalogram	S	1.1302	$67.08	$26.83	$13.42
0215	Level I Nerve and Muscle Tests	S	0.6087	$36.13	$14.45	$7.23
0216	Level III Nerve and Muscle Tests	S	2.6599	$157.87	.....	$31.57
0218	Level II Nerve and Muscle Tests	S	1.1356	$67.40	.....	$13.48
0220	Level I Nerve Procedures	T	17.2800	$1,025.57	.....	$205.11
0221	Level II Nerve Procedures	T	29.7854	$1,767.76	$463.62	$353.55
0222	Implantation of Neurological Device	T	178.2870	$10,581.33	.....	$2,116.27
0223	Implantation or Revision of Pain Management Catheter	T	27.9956	$1,661.54	.....	$332.31
0224	Implantation of Reservoir/Pump/Shunt	T	40.4614	$2,401.38	.....	$480.28
0225	Level II Implantation of Neurostimulator Electrodes	S	233.6295	$13,865.91	.....	$2,773.18
0226	Implantation of Drug Infusion Reservoir	T	138.2406	$8,204.58	.....	$1,640.92
0227	Implantation of Drug Infusion Device	T	135.8740	$8,064.12	.....	$1,612.82
0228	Creation of Lumbar Subarachnoid Shunt	T	51.4916	$3,056.03	.....	$611.21
0229	Transcatherter Placement of Intravascular Shunts	T	64.1626	$3,808.05	$771.23	$761.61
0230	Level I Eye Tests & Treatments	S	0.7823	$46.43	$14.97	$9.29
0231	Level III Eye Tests & Treatments	S	1.9191	$113.90	.....	$22.78
0232	Level I Anterior Segment Eye Procedures	T	6.6429	$394.26	$103.17	$78.85
0233	Level II Anterior Segment Eye Procedures	T	14.8995	$884.29	$266.33	$176.86
0234	Level III Anterior Segment Eye Procedures	T	21.8746	$1,298.26	$511.31	$259.65
0235	Level I Posterior Segment Eye Procedures	T	4.6382	$275.28	$67.10	$55.06
0236	Level II Posterior Segment Eye Procedures	T	16.9458	$1,005.73	.....	$201.15
0237	Level III Posterior Segment Eye Procedures	T	28.8091	$1,709.82	.....	$341.96
0238	Level I Repair and Plastic Eye Procedures	T	2.5816	$153.22	.....	$30.64
0239	Level II Repair and Plastic Eye Procedures	T	6.8784	$408.23	.....	$81.65
0240	Level III Repair and Plastic Eye Procedures	T	18.0686	$1,072.37	$315.31	$214.47
0241	Level IV Repair and Plastic Eye Procedures	T	23.1980	$1,376.80	$384.47	$275.36
0242	Level V Repair and Plastic Eye Procedures	T	30.4081	$1,804.72	$597.36	$360.94
0243	Strabismus/Muscle Procedures	T	22.0667	$1,309.66	$431.39	$261.93
0244	Corneal Transplant	T	38.1985	$2,267.08	$803.26	$453.42
0245	Level I Cataract Procedures without IOL Insert	T	13.3020	$789.47	$220.91	$157.89
0246	Cataract Procedures with IOL Insert	T	23.3535	$1,386.03	$495.96	$277.21
0247	Laser Eye Procedures Except Retinal	T	5.0102	$297.36	$104.31	$59.47
0248	Laser Retinal Procedures	T	4.6557	$276.32	$93.57	$55.26
0249	Level II Cataract Procedures without IOL Insert	T	27.8103	$1,650.54	$524.67	$330.11
0250	Nasal Cauterization/Packing	T	1.2838	$76.19	$26.67	$15.24
0251	Level I ENT Procedures	T	2.0010	$118.76	.....	$23.75
0252	Level II ENT Procedures	T	7.8317	$464.81	$113.41	$92.96

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0253	Level III ENT Procedures	T	16.0627	$953.32	$282.29	$190.66
0254	Level IV ENT Procedures	T	23.2980	$1,382.74	$321.35	$276.55
0256	Level V ENT Procedures	T	37.1513	$2,204.93	.....	$440.99
0258	Tonsil and Adenoid Procedures	T	22.1458	$1,314.35	$437.25	$262.87
0259	Level VI ENT Procedures	T	364.6725	$21,643.31	$8,034.61	$4,328.66
0260	Level I Plain Film Except Teeth	X	0.7521	$44.64	$17.85	$8.93
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.2843	$76.22	.....	$15.24
0262	Plain Film of Teeth	X	0.9186	$54.52	.....	$10.90
0263	Level I Miscellaneous Radiology Procedures	X	1.7397	$103.25	$24.29	$20.65
0264	Level II Miscellaneous Radiology Procedures	X	3.5080	$208.20	$79.41	$41.64
0265	Level I Diagnostic Ultrasound	S	1.0167	$60.34	$24.13	$12.07
0266	Level II Diagnostic Ultrasound	S	1.6319	$96.85	$38.74	$19.37
0267	Level III Diagnostic Ultrasound	S	2.6208	$155.54	$62.18	$31.11
0268	Ultrasound Guidance Procedures	S	1.0562	$62.69	.....	$12.54
0269	Level III Echocardiogram Except Transesophageal	S	3.2290	$191.64	$76.65	$38.33
0270	Transesophageal Echocardiogram	S	5.9919	$355.62	$142.24	$71.12
0272	Level I Fluoroscopy	X	1.3738	$81.54	$32.61	$16.31
0274	Myelography	S	3.0275	$179.68	$71.87	$35.94
0275	Arthrography	S	3.5617	$211.39	$69.09	$42.28
0276	Level I Digestive Radiology	S	1.5250	$90.51	$36.20	$18.10
0277	Level II Digestive Radiology	S	2.3744	$140.92	$56.36	$28.18
0278	Diagnostic Urography	S	2.6314	$156.17	$62.46	$31.23
0279	Level II Angiography and Venography except Extremity	S	8.8914	$527.70	$150.03	$105.54
0280	Level III Angiography and Venography except Extremity	S	20.6960	$1,228.31	$353.85	$245.66
0282	Miscellaneous Computerized Axial Tomography	S	1.6467	$97.73	$39.09	$19.55
0283	Computerized Axial Tomography with Contrast Material	S	4.4053	$261.45	$104.58	$52.29
0284	Magnetic Resonance Imaging and Magnetic Resonance Angiography with Contras.	S	6.3910	$379.31	$151.72	$75.86
0285	Myocardial Positron Emission Tomography (PET)	S	17.1020	$1,015.00	$318.72	$203.00
0288	Bone Density:Axial Skeleton	S	1.2511	$74.25	.....	$14.85
0296	Level I Therapeutic Radiologic Procedures	S	2.2350	$132.65	$53.06	$26.53
0297	Level II Therapeutic Radiologic Procedures	S	5.2293	$310.36	$122.13	$62.07
0299	Miscellaneous Radiation Treatment	S	5.8217	$345.52	.....	$69.10
0300	Level I Radiation Therapy	S	1.5129	$89.79	.....	$17.96
0301	Level II Radiation Therapy	S	2.2094	$131.13	.....	$26.23
0302	Level III Radiation Therapy	S	4.5936	$272.63	$103.28	$54.53
0303	Treatment Device Construction	X	2.8228	$167.53	$66.95	$33.51
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.7658	$104.80	$41.52	$20.96
0305	Level II Therapeutic Radiation Treatment Preparation	X	3.9854	$236.53	$91.38	$47.31
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.8858	$824.12	$325.27	$164.82
0312	Radioelement Applications	S	4.9806	$295.60	.....	$59.12
0313	Brachytherapy	S	12.8072	$760.11	.....	$152.02
0314	Hyperthermic Therapies	S	5.9674	$354.17	$98.36	$70.83
0315	Level II Implantation of Neurostimulator	T	289.3306	$17,171.77	.....	$3,434.35
0320	Electroconvulsive Therapy	S	5.3522	$317.65	$80.06	$63.53
0321	Biofeedback and Other Training	S	1.3517	$80.22	$21.61	$16.04
0322	Brief Individual Psychotherapy	S	1.2263	$72.78	.....	$14.56
0323	Extended Individual Psychotherapy	S	1.6153	$95.87	$19.99	$19.17
0324	Family Psychotherapy	S	2.0901	$124.05	.....	$24.81
0325	Group Psychotherapy	S	1.3130	$77.93	$17.03	$15.59
0330	Dental Procedures	S	7.1431	$423.94	.....	$84.79
0332	Computerized Axial Tomography and Computerized Angiography without Contras.	S	3.2546	$193.16	$77.26	$38.63
0333	Computerized Axial Tomography and Computerized Angio w/o Contrast Material.	S	5.2596	$312.16	$124.86	$62.43
0335	Magnetic Resonance Imaging, Miscellaneous	S	5.1347	$304.74	$121.89	$60.95
0336	Magnetic Resonance Imaging and Magnetic Resonance Angiography without Cont.	S	6.0467	$358.87	$143.54	$71.77
0337	MRI and Magnetic Resonance Angiography without Contrast Material followed.	S	8.7547	$519.59	$207.83	$103.92
0339	Observation	S	7.1080	$421.86	.....	$84.37
0340	Minor Ancillary Procedures	X	0.6355	$37.72	.....	$7.54
0341	Skin Tests	X	0.1107	$6.57	$2.62	$1.31
0342	Level I Pathology	X	0.1553	$9.22	$3.68	$1.84
0343	Level III Pathology	X	0.4764	$28.27	$11.10	$5.65
0344	Level IV Pathology	X	0.7960	$47.24	$15.66	$9.45
0345	Level I Transfusion Laboratory Procedures	X	0.2266	$13.45	$2.99	$2.69
0346	Level II Transfusion Laboratory Procedures	X	0.3418	$20.29	$4.52	$4.06

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0347	Level III Transfusion Laboratory Procedures	X	0.8395	$49.82	$12.30	$9.96
0348	Fertility Laboratory Procedures	X	0.7891	$46.83	.....	$9.37
0350	Administration of flu and PPV vaccines	X	0.3936	$23.36	$0.00	$0.00
0352	Level I Injections	X	0.1407	$8.35	.....	$1.67
0353	Level II Injections	X	0.3936	$23.36	.....	$4.67
0359	Level III Injections	X	0.8274	$49.11	.....	$9.82
0360	Level I Alimentary Tests	X	1.4672	$87.08	$34.83	$17.42
0361	Level II Alimentary Tests	X	3.6052	$213.97	$83.23	$42.79
0362	Contact Lens and Spectacle Services	X	2.6486	$157.19	.....	$31.44
0363	Level I Otorhinolaryngologic Function Tests	X	0.9087	$53.93	$17.44	$10.79
0364	Level I Audiometry	X	0.4686	$27.81	$9.06	$5.56
0365	Level II Audiometry	X	1.2300	$73.00	$18.95	$14.60
0366	Level III Audiometry	X	1.7663	$104.83	$27.36	$20.97
0367	Level I Pulmonary Test	X	0.6629	$39.34	$14.80	$7.87
0368	Level II Pulmonary Tests	X	0.9716	$57.66	$23.06	$11.53
0369	Level III Pulmonary Tests	X	2.7394	$162.58	$44.18	$32.52
0370	Allergy Tests	X	1.1181	$66.36	.....	$13.27
0372	Therapeutic Phlebotomy	X	0.5675	$33.68	$10.09	$6.74
0373	Neuropsychological Testing	X	2.1827	$129.54	.....	$25.91
0374	Monitoring Psychiatric Drugs	X	1.0367	$61.53	.....	$12.31
0375	Ancillary Outpatient Services When Patient Expires	T	42.3971	$2,516.27	.....	$503.25
0376	Level II Cardiac Imaging	S	5.1740	$307.08	$121.42	$61.42
0377	Level III Cardiac Imaging	S	6.8034	$403.78	$161.51	$80.76
0378	Level II Pulmonary Imaging	S	5.4748	$324.93	$129.97	$64.99
0379	Injection adenosine	K	.....	$33.44	.....	$6.69
0381	Single Allergy Tests	X	0.1876	$11.13	$2.34	$2.23
0384	GI Procedures with Stents	T	22.2381	$1,319.83	$286.66	$263.97
0385	Level I Prosthetic Urological Procedures	S	75.3020	$4,469.17	.....	$893.83
0386	Level II Prosthetic Urological Procedures	S	119.6251	$7,099.75	.....	$1,419.95
0387	Level II Hysteroscopy	T	32.3971	$1,922.77	$655.55	$384.55
0388	Discography	S	12.2736	$728.44	$291.37	$145.69
0389	Non-imaging Nuclear Medicine	S	1.4908	$88.48	$35.39	$17.70
0390	Level I Endocrine Imaging	S	2.5446	$151.02	$60.40	$30.20
0391	Level II Endocrine Imaging	S	2.8643	$170.00	$68.00	$34.00
0393	Red Cell/Plasma Studies	S	3.4282	$203.46	$81.38	$40.69
0394	Hepatobiliary Imaging	S	4.4428	$263.68	$105.47	$52.74
0395	GI Tract Imaging	S	3.8523	$228.63	$91.45	$45.73
0396	Bone Imaging	S	4.1238	$244.75	$97.90	$48.95
0397	Vascular Imaging	S	2.2543	$133.79	$53.51	$26.76
0398	Level I Cardiac Imaging	S	4.2898	$254.60	$101.84	$50.92
0399	Nuclear Medicine Add-on Imaging	S	1.5123	$89.76	$35.90	$17.95
0400	Hematopoietic Imaging	S	4.1147	$244.21	$97.68	$48.84
0401	Level I Pulmonary Imaging	S	3.3995	$201.76	$80.70	$40.35
0402	Brain Imaging	S	5.1612	$306.32	$122.52	$61.26
0403	CSF Imaging	S	3.5974	$213.51	$85.40	$42.70
0404	Renal and Genitourinary Studies Level I	S	3.8385	$227.81	$91.12	$45.56
0405	Renal and Genitourinary Studies Level II	S	4.2480	$252.12	$100.84	$50.42
0406	Tumor/Infection Imaging	S	4.2840	$254.26	$101.70	$50.85
0407	Radionuclide Therapy	S	3.9659	$235.38	$94.15	$47.08
0409	Red Blood Cell Tests	X	0.1252	$7.43	$2.22	$1.49
0411	Respiratory Procedures	S	0.3852	$22.86	.....	$4.57
0412	IMRT Treatment Delivery	S	5.3400	$316.93	.....	$63.39
0415	Level II Endoscopy Lower Airway	T	21.9955	$1,305.43	$459.92	$261.09
0416	Level I Intravascular and Intracardiac Ultrasound and Flow Reserve.	S	19.4657	$1,155.29	.....	$231.06
0417	Computerized Reconstruction	S	4.0566	$240.76	.....	$48.15
0418	Insertion of Left Ventricular Pacing Elect.	T	108.8092	$6,457.83	.....	$1,291.57
0421	Prolonged Physiologic Monitoring	X	1.6525	$98.08	.....	$19.62
0422	Level II Upper GI Procedures	T	22.8607	$1,356.78	$448.81	$271.36
0423	Level II Percutaneous Abdominal and Biliary Procedures	T	40.1041	$2,380.18	.....	$476.04
0425	Level II Arthroplasty with Prosthesis	T	99.7520	$5,920.28	$1,378.01	$1,184.06
0426	Level II Strapping and Cast Application	S	2.1147	$125.51	.....	$25.10
0427	Level III Tube Changes and Repositioning	T	10.1516	$602.50	$123.56	$120.50
0428	Level III Sigmoidoscopy and Anoscopy	T	19.8121	$1,175.85	.....	$235.17
0429	Level V Cystourethroscopy and other Genitourinary Procedures.	T	42.1231	$2,500.01	.....	$500.00
0430	Level IV Nerve and Muscle Tests	T	11.3524	$673.76	.....	$134.75
0432	Health and Behavior Services	S	0.6918	$41.06	.....	$8.21
0433	Level II Pathology	X	0.2569	$15.25	$6.10	$3.05

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0434	Cardiac Defect Repair	T	90.3765	$5,363.85		$1,072.77
0600	Low Level Clinic Visits	V	0.8649	$51.33		$10.27
0601	Mid Level Clinic Visits	V	0.9992	$59.30		$11.86
0602	High Level Clinic Visits	V	1.4220	$84.40		$16.88
0610	Low Level Emergency Visits	V	1.2889	$76.50	$19.40	$15.30
0611	Mid Level Emergency Visits	V	2.2615	$134.22	$35.60	$26.84
0612	High Level Emergency Visits	V	3.9673	$235.46	$54.12	$47.09
0620	Critical Care	S	8.2620	$490.35	$135.08	$98.07
0621	Level I Vascular Access Procedures	T	8.2610	$490.29		$98.06
0622	Level II Vascular Access Procedures	T	21.1708	$1,256.49		$251.30
0623	Level III Vascular Access Procedures	T	26.9877	$1,601.72		$320.34
0648	Breast Reconstruction with Prosthesis	T	50.2174	$2,980.40		$596.08
0651	Complex Interstitial Radiation Source Application	S	12.0898	$717.53		$143.51
0652	Insertion of Intraperitoneal Catheters	T	28.7639	$1,707.14		$341.43
0653	Vascular Reconstruction/Fistula Repair with Device	T	30.3956	$1,803.98		$360.80
0654	Insertion/Replacement of a permanent dual chamber pacemaker.	T	100.4722	$5,963.03		$1,192.61
0655	Insertion/Replacement/Conversion of a permanent dual chamber pacemaker.	T	133.1709	$7,903.69		$1,580.74
0656	Transcatheter Placement of Intracoronary Drug-Eluting Stents	T	109.4258	$6,494.42		$1,298.88
0657	Placement of Tissue Clips	S	1.7015	$100.98		$20.20
0658	Percutaneous Breast Biopsies	T	6.0773	$360.69		$72.14
0659	Hyperbaric Oxygen	S	1.5403	$91.42		$18.28
0660	Level II Otorhinolaryngologic Function Tests	X	1.6345	$97.01	$30.60	$19.40
0661	Level V Pathology	X	3.3622	$199.55	$79.82	$39.91
0662	CT Angiography	S	5.1387	$304.98	$121.99	$61.00
0664	Level I Proton Beam Radiation Therapy	S	12.8853	$764.74		$152.95
0665	Bone Density:AppendicularSkeleton	S	0.6435	$38.19		$7.64
0667	Level II Proton Beam Radiation Therapy	S	15.4156	$914.92		$182.98
0668	Level I Angiography and Venography except Extremity	S	6.4730	$384.17	$114.67	$76.83
0670	Level II Intravascular and Intracardiac Ultrasound and Flow Reserve.	S	25.2980	$1,501.44	$470.38	$300.29
0671	Level II Echocardiogram Except Transesophageal	S	1.6951	$100.60	$40.24	$20.12
0672	Level IV Posterior Segment Eye Procedures	T	36.7611	$2,181.77		$436.35
0673	Level IV Anterior Segment Eye Procedures	T	29.1257	$1,728.61	$649.56	$345.72
0674	Prostate Cryoablation	T	95.3518	$5,659.13		$1,131.83
0675	Prostatic Thermotherapy	T	43.5348	$2,583.79		$516.76
0676	Thrombolysis and Thrombectomy	T	2.3996	$142.42		$28.48
0678	External Counterpulsation	T	1.7197	$102.06		$20.41
0679	Level II Resuscitation and Cardioversion	S	5.5521	$329.52	$95.30	$65.90
0680	Insertion of Patient Activated Event Recorders	S	62.6232	$3,716.69		$743.34
0681	Knee Arthroplasty	T	136.5417	$8,103.75	$2,081.48	$1,620.75
0682	Level V Debridement & Destruction	T	6.8794	$408.29	$161.70	$81.66
0683	Level II Photochemotherapy	S	1.8920	$112.29	$25.23	$22.46
0685	Level III Needle Biopsy/Aspiration Except Bone Marrow	T	5.9902	$355.52	$115.47	$71.10
0686	Level III Skin Repair	T	13.7661	$817.02		$163.40
0687	Revision/Removal of Neurostimulator Electrodes	T	19.1476	$1,136.41	$454.56	$227.28
0688	Revision/Removal of Neurostimulator Pulse Generator Receiver.	T	42.8494	$2,543.11	$1,017.24	$508.62
0689	Electronic Analysis of Cardioverter-defibrillators	S	0.5709	$33.88		$6.78
0690	Electronic Analysis of Pacemakers and other Cardiac Devices	S	0.3738	$22.19	$8.87	$4.44
0691	Electronic Analysis of Programmable Shunts/Pumps	S	2.5138	$149.19	$59.67	$29.84
0692	Electronic Analysis of Neurostimulator Pulse Generators	S	2.0020	$118.82	$30.16	$23.76
0693	Level II Breast Reconstruction	T	42.0342	$2,494.73	$798.17	$498.95
0694	Mohs Surgery	T	3.8278	$227.18	$61.59	$45.44
0695	Level VII Debridement & Destruction	T	20.2244	$1,200.32	$266.59	$240.06
0697	Level I Echocardiogram Except Transesophageal	S	1.5288	$90.73	$36.29	$18.15
0698	Level II Eye Tests & Treatments	S	1.2381	$73.48	$16.48	$14.70
0699	Level IV Eye Tests & Treatments	T	9.9723	$591.86		$118.37
0700	Antepartum Manipulation	T	5.3371	$316.76		$63.35
0701	SR 89 chloride, per mCi	H				
0702	SM 153 lexidronam	H				
0704	IN 111 Satumomab pendetide per dose	H				
0705	Technetium TC99M tetrofosmin	H				
0726	Dexrazoxane hcl injection	K		$216.38		$43.28
0728	Filgrastim injection	K		$178.38		$35.68
0730	Pamidronate disodium	K		$58.41		$11.68
0731	Sargramostim injection	K		$21.11		$4.22
0732	Mesna injection	K		$13.68		$2.74

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0733	Non esrd epoetin alpha inj	K		$9.99		$2.00
0734	Injection, darbepoetin alfa (for non-ESRD)	K		$3.28		$.66
0735	Ampho b cholesteryl sulfate	K		$12.24		$2.45
0736	Amphotericin b liposome inj	K		$21.91		$4.38
0737	Ammonia N-13, per dose	H				
0738	Rasburicase	G		$109.17		$21.83
0750	Dolasetron mesylate	K		$6.55		$1.31
0763	Dolasetron mesylate oral	K		$48.54		$9.71
0764	Granisetron HCl injection	K		$7.24		$1.45
0765	Granisetron HCl oral	K		$33.50		$6.70
0768	Ondansetron hcl injection	K		$3.80		$.76
0769	Ondansetron hcl oral	K		$32.02		$6.40
0800	Leuprolide acetate	K		$441.74		$88.35
0802	Etoposide oral	K		$41.12		$8.22
0807	Aldesleukin/single use vial	K		$701.71		$140.34
0809	Bcg live intravesical vac	K		$121.74		$24.35
0810	Goserelin acetate implant	K		$196.24		$39.25
0811	Carboplatin injection	K		$77.15		$15.43
0812	Carmus bischl nitro inj	K		$141.27		$28.25
0814	Asparaginase injection	K		$55.41		$11.08
0819	Dacarbazine inj	K		$6.20		$1.24
0820	Daunorubicin	K		$35.28		$7.06
0821	Daunorubicin citrate liposom	K		$57.55		$11.51
0823	Docetaxel	K		$301.15		$60.23
0827	Floxuridine injection	K		$60.16		$12.03
0828	Gemcitabine HCL	K		$117.44		$23.49
0830	Irinotecan injection	K		$129.07		$25.81
0831	Ifosfomide injection	K		$53.53		$10.71
0832	Idarubicin hcl injection	K		$313.97		$62.79
0834	Interferon alfa-2a inj	K		$31.75		$6.35
0835	Inj cosyntropin	K		$69.27		$13.85
0836	Interferon alfa-2b inj recombinant, 1 million	K		$13.22		$2.64
0838	Interferon gamma 1-b inj	K		$277.77		$55.55
0840	Melphalan hydrochl	K		$523.18		$104.64
0842	Fludarabine phosphate inj	K		$262.39		$52.48
0843	Pegaspargase	K		$1,528.67		$305.73
0844	Pentostatin injection	K		$1,868.76		$373.75
0849	Rituximab	K		$447.93		$89.59
0850	Streptozocin injection	K		$153.31		$30.66
0851	Thiotepa injection	K		$44.55		$8.91
0852	Topotecan	K		$755.44		$151.09
0855	Vinorelbine tartrate	K		$62.84		$12.57
0856	Porfimer sodium	K		$2,457.78		$491.56
0857	Bleomycin sulfate injection	K		$54.17		$10.83
0858	Cladribine	K		$39.37		$7.87
0860	Plicamycin (mithramycin) inj	K		$80.54		$16.11
0861	Leuprolide acetate injection	K		$10.96		$2.19
0862	Mitomycin	K		$26.36		$5.27
0863	Paclitaxel injection	K		$19.11		$3.82
0864	Mitoxantrone hcl	K		$329.66		$65.93
0865	Interferon alfa-n3 inj, human leukocyte derived, 2	K		$8.77		$1.75
0868	Oral aprepitant	G		$4.75		$.95
0869	IVIG lyophil 1g	K		$39.46		$7.89
0870	IVIG lyophil 10 mg	K		$.40		$.08
0871	IVIG non-lyophil 1g	K		$57.26		$11.45
0872	IVIG non-lyophil 10 mg	K		$.57		$.11
0876	Caffeine citrate injection	K		$3.34		$.67
0880	Penicillin g benzathine inj	K		$72.25		$14.45
0884	Rho d immune globulin inj	K		$113.90		$22.78
0887	Azathioprine parenteral	K		$47.39		$9.48
0888	Cyclosporine oral	K		$3.94		$.79
0890	Lymphocyte immune globulin	K		$290.28		$58.06
0891	Tacrolimus oral	K		$3.37		$.67
0892	Edetate calcium disodium inj	K		$40.34		$8.07
0893	Calcitonin salmon injection	K		$35.68		$7.14
0895	Deferoxamine mesylate inj	K		$14.91		$2.98
0900	Alglucerase injection	K		$39.94		$7.99
0901	Alpha 1 proteinase inhibitor	K		$3.30		$.66
0902	Botulinum toxin a, per unit	K		$4.80		$.96

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0903	Cytomegalovirus imm IV/vial	K		$683.02		$136.60
0906	RSV-ivig	K		$15.56		$3.11
0910	Interferon beta-1b	K		$81.94		$16.39
0911	Streptokinase	K		$83.35		$16.67
0912	Interferon alfacon-1	K		$3.91		$.78
0913	Ganciclovir long act implant	K		$4,318.33		$863.67
0916	Injection imiglucerase /unit	K		$3.98		$.80
0917	Adenosine injection	K		$71.52		$14.30
0925	Factor viii	K		$.51		$.10
0926	Factor VIII (porcine)	K		$1.75		$.35
0927	Factor viii recombinant	K		$.94		$.19
0928	Factor ix complex	K		$.52		$.10
0929	Anti-inhibitor per iu	K		$1.12		$.22
0931	Factor IX non-recombinant	K		$.75		$.15
0932	Factor IX recombinant	K		$.86		$.17
0935	Clonidine hydrochloride	K		$57.46		$11.49
0949	Plasma, Pooled Multiple Donor, Solvent/Detergent T	K	1.1902	$70.64		$14.13
0950	Blood (Whole) For Transfusion	K	2.0032	$118.89		$23.78
0952	Cryoprecipitate	K	0.7361	$43.69		$8.74
0954	RBC leukocytes reduced	K	2.7246	$161.71		$32.34
0955	Plasma, Fresh Frozen	K	1.2876	$76.42		$15.28
0956	Plasma Protein Fraction	K	1.1175	$66.32		$13.26
0957	Platelet Concentrate	K	0.8279	$49.14		$9.83
0958	Platelet Rich Plasma	K	5.1580	$306.13		$61.23
0959	Red Blood Cells	K	2.0209	$119.94		$23.99
0960	Washed Red Blood Cells	K	2.9573	$175.52		$35.10
0961	Infusion, Albumin (Human) 5%, 50 ml	K	0.5119	$30.38		$6.08
0963	Albumin (human), 5%	K	1.3867	$82.30		$16.46
0964	Albumin (human), 25%	K	0.4878	$28.95		$5.79
0965	Albumin (human), 25%	K	1.1115	$65.97		$13.19
0966	Plasmaprotein fract,5%	K	4.9340	$292.83		$58.57
0967	Split unit of blood	K	1.2641	$75.02		$15.00
0968	Platelets leukocyte reduced irradiated	K	2.3532	$139.66		$27.93
0969	Red blood cell leukocyte reduced irradiated	K	3.6286	$215.36		$43.07
1009	Cryoprecip reduced plasma	K	1.3003	$77.17		$15.43
1010	Blood, L/R, CMV-neg	K	2.9558	$175.43		$35.09
1011	Platelets, HLA-m, L/R, unit	K	10.9193	$648.06		$129.61
1013	Platelet concentrate, L/R, unit	K	1.5950	$94.66		$18.93
1016	Blood, L/R, froz/deglycerol/washed	K	5.2392	$310.95		$62.19
1017	Platelets, aph/pher, L/R, CMV-neg, unit	K	8.5608	$508.08		$101.62
1018	Blood, L/R, irradiated	K	2.7877	$165.45		$33.09
1019	Platelets, aph/pher, L/R, irradiated, unit	K	9.4700	$562.04		$112.41
1020	Pit, pher,L/R,CMV,irrad	K	10.1091	$599.98		$120.00
1021	RBC, frz/deg/wsh, L/R, irrad	K	4.8566	$288.24		$57.65
1022	RBC, L/R, CMV neg, irrad	K	4.2707	$253.47		$50.69
1045	Iobenguane sulfate I-131	H				
1052	Injection, Voriconazole	K		$4.63		$.93
1064	I-131 sodium iodide capsule	H				
1065	I-131 sodium iodide solution	H				
1080	I-131 tositumomab, dx	H				
1081	I-131 tositumomab, tx	H				
1082	Treprostinil	K		$55.02		$11.00
1083	Injection, Adalimumab	K		$300.07		$60.01
1084	Denileukin diftitox	K		$1,235.23		$247.05
1085	Injection, Gallium Nitrate	K		$1.30		$.26
1086	Temozolomide,oral	K		$7.28		$1.46
1088	Dx I131 so iodide cap millic	H				
1091	IN 111 Oxyquinoline	H				
1092	IN 111 Pentetate	H				
1093	TC99M fanolesomab	H				
1096	TC 99M Exametazime, per dose	H				
1150	Th I131 so iodide sol millic	H				
1166	Cytarabine liposome	K		$366.40		$73.28
1167	Epirubicin hcl	K		$25.15		$5.03
1178	Busulfan IV	K	0.2851	$16.92		$3.38
1201	TC 99M SUCCIMER, PER Vial	H				
1203	Verteporfin for injection	K		$9.16		$1.83
1207	Octreotide injection, depot	K		$87.39		$17.48
1210	Inj dihydroergotamine mesylt	K		$27.82		$5.56

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1280	Corticotropin injection	K		$95.43		$19.09
1305	Apligraf	K	12.9206	$766.84		$153.37
1330	Ergonovine maleate injection	K	0.5262	$31.23		$6.25
1409	Factor viia recombinant	K		$1,080.03		$216.01
1436	Etidronate disodium inj	K		$68.69		$13.74
1491	New Technology - Level I ($0-$10)	S		$5.00		$1.00
1492	New Technology - Level I ($10-$20)	S		$15.00		$3.00
1493	New Technology - Level I ($20-$30)	S		$25.00		$5.00
1494	New Technology - Level I ($30-$40)	S		$35.00		$7.00
1495	New Technology - Level I ($40-$50)	S		$45.00		$9.00
1496	New Technology - Level I ($0-$10)	T		$5.00		$1.00
1497	New Technology - Level I ($10-$20)	T		$15.00		$3.00
1498	New Technology - Level I ($20-$30)	T		$25.00		$5.00
1499	New Technology - Level I ($30-$40)	T		$35.00		$7.00
1500	New Technology - Level I ($40-$50)	T		$45.00		$9.00
1502	New Technology - Level II ($50 - $100)	S		$75.00		$15.00
1503	New Technology - Level III ($100 - $200)	S		$150.00		$30.00
1504	New Technology - Level IV ($200 - $300)	S		$250.00		$50.00
1505	New Technology - Level V ($300 - $400)	S		$350.00		$70.00
1506	New Technology - Level VI ($400 - $500)	S		$450.00		$90.00
1507	New Technology - Level VII ($500 - $600)	S		$550.00		$110.00
1508	New Technology - Level VIII ($600 - $700)	S		$650.00		$130.00
1509	New Technology - Level IX ($700 - $800)	S		$750.00		$150.00
1510	New Technology - Level X ($800 - $900)	S		$850.00		$170.00
1511	New Technology - Level XI ($900 - $1000)	S		$950.00		$190.00
1512	New Technology - Level XII ($1000 - $1100)	S		$1,050.00		$210.00
1513	New Technology - Level XIII ($1100 - $1200)	S		$1,150.00		$230.00
1514	New Technology-Level XIV ($1200- $1300)	S		$1,250.00		$250.00
1515	New Technology - Level XV ($1300 - $1400)	S		$1,350.00		$270.00
1516	New Technology - Level XVI ($1400 - $1500)	S		$1,450.00		$290.00
1517	New Technology - Level XVII ($1500-$1600)	S		$1,550.00		$310.00
1518	New Technology - Level XVIII ($1600-$1700)	S		$1,650.00		$330.00
1519	New Technology - Level IXX ($1700-$1800)	S		$1,750.00		$350.00
1520	New Technology - Level XX ($1800-$1900)	S		$1,850.00		$370.00
1521	New Technology - Level XXI ($1900-$2000)	S		$1,950.00		$390.00
1522	New Technology - Level XXII ($2000-$2500)	S		$2,250.00		$450.00
1523	New Technology - Level XXIII ($2500-$3000)	S		$2,750.00		$550.00
1524	New Technology - Level XIV ($3000-$3500)	S		$3,250.00		$650.00
1525	New Technology - Level XXV ($3500-$4000)	S		$3,750.00		$750.00
1526	New Technology - Level XXVI ($4000-$4500)	S		$4,250.00		$850.00
1527	New Technology - Level XXVII ($4500-$5000)	S		$4,750.00		$950.00
1528	New Technology - Level XXVIII ($5000-$5500)	S		$5,250.00		$1,050.00
1529	New Technology - Level XXIX ($5500-$6000)	S		$5,750.00		$1,150.00
1530	New Technology - Level XXX ($6000-$6500)	S		$6,250.00		$1,250.00
1531	New Technology - Level XXXI ($6500-$7000)	S		$6,750.00		$1,350.00
1532	New Technology - Level XXXII ($7000-$7500)	S		$7,250.00		$1,450.00
1533	New Technology - Level XXXIII ($7500-$8000)	S		$7,750.00		$1,550.00
1534	New Technology - Level XXXIV ($8000-$8500)	S		$8,250.00		$1,650.00
1535	New Technology - Level XXXV ($8500-$9000)	S		$8,750.00		$1,750.00
1536	New Technology - Level XXXVI ($9000-$9500)	S		$9,250.00		$1,850.00
1537	New Technology - Level XXXVII ($9500-$10000)	S		$9,750.00		$1,950.00
1539	New Technology - Level II ($50 - $100)	T		$75.00		$15.00
1540	New Technology - Level III ($100 - $200)	T		$150.00		$30.00
1541	New Technology - Level IV ($200 - $300)	T		$250.00		$50.00
1542	New Technology - Level V ($300 - $400)	T		$350.00		$70.00
1543	New Technology - Level VI ($400 - $500)	T		$450.00		$90.00
1544	New Technology - Level VII ($500 - $600)	T		$550.00		$110.00
1545	New Technology - Level VIII ($600 - $700)	T		$650.00		$130.00
1546	New Technology - Level IX ($700 - $800)	T		$750.00		$150.00
1547	New Technology - Level X ($800 - $900)	T		$850.00		$170.00
1548	New Technology - Level XI ($900 - $1000)	T		$950.00		$190.00
1549	New Technology - Level XII ($1000 - $1100)	T		$1,050.00		$210.00
1550	New Technology - Level XIII ($1100 - $1200)	T		$1,150.00		$230.00
1551	New Technology-Level XIV ($1200- $1300)	T		$1,250.00		$250.00
1552	New Technology - Level XV ($1300 - $1400)	T		$1,350.00		$270.00
1553	New Technology - Level XVI ($1400 - $1500)	T		$1,450.00		$290.00
1554	New Technology - Level XVII ($1500-$1600)	T		$1,550.00		$310.00
1555	New Technology - Level XVIII ($1600-$1700)	T		$1,650.00		$330.00
1556	New Technology - Level XIX ($1700-$1800)	T		$1,750.00		$350.00

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
1557	New Technology - Level XX ($1800-$1900)	T		$1,850.00		$370.00
1558	New Technology - Level XXI ($1900-$2000)	T		$1,950.00		$390.00
1559	New Technology - Level XXII ($2000-$2500)	T		$2,250.00		$450.00
1560	New Technology - Level XXIII ($2500-$3000)	T		$2,750.00		$550.00
1561	New Technology - Level XXIV ($3000-$3500)	T		$3,250.00		$650.00
1562	New Technology - Level XXV ($3500-$4000)	T		$3,750.00		$750.00
1563	New Technology - Level XXVI ($4000-$4500)	T		$4,250.00		$850.00
1564	New Technology - Level XXVII ($4500-$5000)	T		$4,750.00		$950.00
1565	New Technology - Level XXVIII ($5000-$5500)	T		$5,250.00		$1,050.00
1566	New Technology - Level XXIX ($5500-$6000)	T		$5,750.00		$1,150.00
1567	New Technology - Level XXX ($6000-$6500)	T		$6,250.00		$1,250.00
1568	New Technology - Level XXXI ($6500-$7000)	T		$6,750.00		$1,350.00
1569	New Technology - Level XXXII ($7000-$7500)	T		$7,250.00		$1,450.00
1570	New Technology - Level XXXIII ($7500-$8000)	T		$7,750.00		$1,550.00
1571	New Technology - Level XXXIV ($8000-$8500)	T		$8,250.00		$1,650.00
1572	New Technology - Level XXXV ($8500-$9000)	T		$8,750.00		$1,750.00
1573	New Technology - Level XXXVI ($9000-$9500)	T		$9,250.00		$1,850.00
1574	New Technology - Level XXXVII ($9500-$10000)	T		$9,750.00		$1,950.00
1600	Technetium TC 99m sestamibi	H				
1603	Thallous chloride TL 201	H				
1604	IN 111 capromab pendetide, per dose	H				
1605	Abciximab injection	K		$450.56		$90.11
1607	Eptifibatide injection	K		$12.73		$2.55
1608	Etanercept injection	K		$152.10		$30.42
1609	Rho(D) immune globulin h, sd	K		$12.04		$2.41
1611	Hylan G-F 20 injection	K		$203.13		$40.63
1612	Daclizumab, parenteral	K		$381.45		$76.29
1613	Trastuzumab	K		$53.97		$10.79
1615	Basiliximab	K		$1,473.45		$294.69
1618	Vonwillebrandfactrcmplx, per iu	K		$.74		$.15
1619	Gallium ga 67	H				
1620	Technetium tc99m bicisate	H				
1622	Technetium tc99m mertiatide	H				
1624	Sodium phosphate p32	H				
1625	Indium 111-in pentetreotide	H				
1628	Chromic phosphate p32	H				
1655	Tinzaparin sodium injection	K		$2.53		$.51
1670	Tetanus immune globulin inj	K		$76.89		$15.38
1716	Brachytx source, Gold 198	H				
1717	Brachytx source, HDR Ir-192	H				
1718	Brachytx source, Iodine 125	H				
1719	Brachytx sour,Non-HDR Ir-192	H				
1720	Brachytx sour, Palladium 103	H				
1740	Diazoxide injection	K		$113.85		$22.77
1775	FDG, per dose (4-40 mCi/ml)	H				
2210	Methyldopate hcl injection	K		$9.58		$1.92
2616	Brachytx source, Yttrium-90	H				
2632	Brachytx sol, I-125, per mCi	H				
2633	Brachytx source, Cesium-131	H				
2634	Brachytx source, HA, I-125	H				
2635	Brachytx source, HA, P-103	H				
2636	Brachytx linear source, P-103	H				
2730	Pralidoxime chloride inj	K		$76.67		$15.33
2770	Quinupristin/dalfopristin	K		$105.48		$21.10
2940	Somatrem injection	K		$43.13		$8.63
3030	Sumatriptan succinate	K		$51.03		$10.21
7000	Amifostine	K		$435.98		$87.20
7005	Gonadorelin hydroch	K		$173.42		$34.68
7011	Oprelvekin injection	K		$249.04		$49.81
7015	Busulfan, oral	K		$1.98		$.40
7019	Aprotinin	K		$2.20		$.44
7024	Corticorelin ovine triflutat	K		$386.49		$77.30
7025	Digoxin immune FAB (ovine)	K		$552.14		$110.43
7026	Ethanolamine oleate	K		$64.53		$12.91
7027	Fomepizole	K		$12.31		$2.46
7028	Fosphenytoin	K		$5.19		$1.04
7030	Hemin	K		$6.51		$1.30
7034	Somatropin injection	K		$42.93		$8.59
7035	Teniposide	K		$266.21		$53.24

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
7036	Urokinase inj	K		$415.66		$83.13
7037	Urofollitropin	K		$44.73		$8.95
7038	Monoclonal antibodies	K		$885.29		$177.06
7040	Pentastarch 10% solution	K		$12.45		$2.49
7041	Tirofiban hcl	K		$7.89		$1.58
7042	Capecitabine, oral	K		$3.30		$.66
7043	Infliximab injection	K		$54.19		$10.84
7045	Trimetrexate glucoronate	K		$139.84		$27.97
7046	Doxorubicin hcl liposome inj	K		$365.61		$73.12
7048	Alteplase recombinant	K		$30.65		$6.13
7049	Filgrastim injection	K		$282.27		$56.45
7051	Leuprolide acetate implant	K		$2,262.01		$452.40
7308	Aminolevulinic acid hcl top	K		$96.79		$19.36
7316	Sodium hyaluronate injection	K		$110.64		$22.13
7515	Cyclosporine oral	K		$1.00		$.20
9001	Linezolid injection	K		$24.15		$4.83
9002	Tenecteplase	K		$2,052.60		$410.52
9003	Palivizumab	K	4.1486	$246.22		$49.24
9004	Gemtuzumab ozogamicin	K		$2,244.86		$448.97
9005	Reteplase injection	K		$898.74		$179.75
9006	Tacrolimus injection	K		$126.61		$25.32
9008	Baclofen Refill Kit-500mcg	K	0.2447	$14.52		$2.90
9009	Baclofen refill kit - per 2000 mcg	K	0.7208	$42.78		$8.56
9012	Arsenic Trioxide	K		$33.76		$6.75
9015	Mycophenolate mofetil oral	K		$2.50		$.50
9018	Botulinum toxin B	K		$7.89		$1.58
9019	Caspofungin acetate	K		$32.35		$6.47
9020	Sirolimus tablet	K		$6.85		$1.37
9022	IM inj interferon beta 1-a	K		$89.09		$17.82
9023	Rho d immune globulin	K		$25.08		$5.02
9024	Amphotericin b lipid complex	K		$11.95		$2.39
9025	Rubidium-Rb-82	H				
9030	Amphotericin B	K		$30.70		$6.14
9031	Arbutamine HCl injection	K		$163.13		$32.63
9032	Baclofen 10 MG injection	K		$188.00		$37.60
9033	Cidofovir injection	K		$782.91		$156.58
9038	Inj estrogen conjugate	K		$57.76		$11.55
9040	Intraocular Fomivirsen na	K		$203.91		$40.78
9042	Glucagon hydrochloride	K		$62.16		$12.43
9044	Ibutilide fumarate injection	K		$243.32		$48.66
9045	Iron dextran	K		$11.43		$2.29
9046	Iron sucrose injection	K		$.38		$.08
9047	Itraconazole injection	K		$36.93		$7.39
9051	Urea injection	K	1.0453	$62.04		$12.41
9054	Metabolically active tissue	K		$15.69		$3.14
9055	Injectable human tissue	K		$3.54		$.71
9057	Lepirudin	K		$128.16		$25.63
9100	Iodinated I-131 serumalbumin, per 5uci	H				
9104	Anti-thymocycte globulin rabbit	K		$299.45		$59.89
9105	Hep B imm glob	K	1.8810	$111.64		$22.33
9108	Thyrotropin alfa	K		$712.52		$142.50
9110	Alemtuzumab injection	K		$516.83		$103.37
9112	Inj Perflutren lipid micros, ml	K		$63.50		$12.70
9114	Nesiritide	K		$75.18		$15.04
9115	Inj, zoledronic acid	K		$202.39		$40.48
9117	Yttrium 90 ibritumomab tiuxetan	H				
9118	In-111 ibritumomab tiuxetan	H				
9119	Pegfilgrastim	K		$2,178.11		$435.62
9120	Inj, Fulvestrant	K		$82.90		$16.58
9121	Inj, Argatroban	K	0.1897	$11.26		$2.25
9122	Triptorelin pamoate	K		$369.95		$73.99
9123	Transcyte	K		$719.36		$143.87
9124	Injection, daptomycin	G		$.30		$.06
9125	Risperidone, long acting	G		$4.71		$.94
9126	Injection, natalizumab	G		$6.51		$1.30
9127	Paclitaxel protein pr	K		$8.59		$1.72
9128	Inj pegaptanib sodium	K		$1,074.18		$214.84
9130	Na chromateCr51, per 0.25mCi	H				
9132	51 Na Chromate, 50mCi	H				

ADDENDUM A.—LIST OF AMBULATORY PAYMENT CLASSIFICATIONS (APCS) WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COPAYMENT AMOUNTS CALENDAR YEAR 2006—Continued

APC	Group title	Status indicator	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
9133	Rabies ig, im/sc	K		$64.56		$12.91
9134	Rabies ig, heat treated	K		$69.78		$13.96
9135	Varicella-zoster ig, im	K		$96.57		$19.31
9136	Adenovirus vaccine, type 4	K	0.9498	$56.37		$11.27
9137	Bcg vaccine, percut	K		$124.53		$24.91
9138	Hep a/hep b vacc, adult im	K	0.9673	$57.41		$11.48
9139	Rabies vaccine, im	K		$128.03		$25.61
9140	Rabies vaccine, id	K	1.4957	$88.77		$17.75
9141	Measles-rubella vaccine, sc	K	0.9466	$56.18		$11.24
9142	Chicken pox vaccine, sc	K		$64.29		$12.86
9143	Meningococcal vaccine, sc	K		$56.74		$11.35
9144	Encephalitis vaccine, sc	K		$67.72		$13.54
9145	Meningococcal vaccine, im	K	0.8947	$53.10		$10.62
9146	Technetium TC99m Disofenin	H				
9147	Technetium TC 99M Depreotide	H				
9148	I-123 sodium iodide capsule	H				
9149	Dx I131 so iodide microcurie	H				
9150	I-125 serum albumin micro	H				
9151	Tc 99M ARCITUMOMAB PER VIAL	H				
9152	Baclofen Intrathecal kit-1am	K	0.8561	$50.81		$10.16
9153	Na Iothalamate I-125, 10 uCi	H				
9154	Technetium tc99m glucepatate	H				
9155	Technetium tc99mlabeledrbcs	H				
9156	Nonmetabolic active tissue	K		$53.75		$10.75
9157	LOCM <=149 mg/ml iodine	K		$.51		$.10
9158	LOCM 150-199mg/ml iodine	K		$2.00		$.40
9159	LOCM 200-249mg/ml iodine	K		$.78		$.16
9160	LOCM 250-299mg/ml iodine	K		$.66		$.13
9161	LOCM 300-349mg/ml iodine	K		$.41		$.08
9162	LOCM 350-399mg/ml iodine	K		$.27		$.05
9163	LOCM >= 400 mg/ml iodine	K		$.20		$.04
9164	Inj Gad-base MR contrast	K		$3.01		$.60
9165	Oral MR contrast	K		$9.01		$1.80
9166	Dyphylline injection	K		$7.74		$1.55
9167	Valrubicin	K		$376.83		$75.37
9168	Pegademase bovine	K		$161.15		$32.23
9169	Anthrax vaccine, sc	K		$128.94		$25.79
9200	Orcel	K	2.6890	$159.59		$31.92
9201	Dermagraft	K	6.2059	$368.32		$73.66
9202	Inj Octafluoropropane mic,ml	K		$41.42		$8.28
9203	Inj Perflexane lipid micros, ml	K		$13.49		$2.70
9205	Oxaliplatin	K		$84.05		$16.81
9206	Integra	K		$9.23		$1.85
9207	Injection, bortezomib	K		$28.90		$5.78
9208	Injection, agalsidase beta	K		$123.35		$24.67
9209	Injection, laronidase	K		$23.16		$4.63
9210	Injection, palonosetron HCL	K		$18.42		$3.68
9211	Inj, alefacept, IV	K		$570.97		$114.19
9212	Inj, alefacept, IM	K		$401.97		$80.39
9213	Injection, Pemetrexed	G		$41.29		$8.26
9214	Injection, Bevacizumab	G		$58.17		$11.63
9215	Injection, Cetuximab	G		$50.58		$10.12
9216	Abarelix Injection	G		$66.96		$13.39
9217	Leuprolide acetate suspnsion	K		$230.85		$46.17
9218	Injection, Azacitidine	K		$4.03		$.81
9219	Mycophenolic Acid	G		$2.47		$.49
9220	Sodium hyaluronate	G		$203.82		$40.76
9221	Graftjacket Reg Matrix	G		$1,234.26		$246.85
9222	Graftjacket SftTis	G		$890.67		$178.13
9300	Injection, Omalizumab	G		$15.98		$3.20
9500	Platelets, irradiated	K	1.3527	$80.28		$16.06
9501	Platelets, pheresis, leukocytes reduced	K	8.1126	$481.48		$96.30
9502	Platelet pheresis irradiated	K	5.1660	$306.60		$61.32
9503	Fresh frozen plasma, ea unit	K	1.6167	$95.95		$19.19
9504	RBC deglycerolized	K	6.4022	$379.97		$75.99
9505	RBC irradiated	K	2.3768	$141.06		$28.21
9506	Granulocytes, pheresis	K	15.5448	$922.58		$184.52
9507	Platelets, pheresis	K	6.8676	$407.59		$81.52
9508	Plasma, frozen w/in 8 hours	K	1.1983	$71.12		$14.22

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0003T	S		Cervicography	1492		$15.00		$3.00
0008T	T		Upper gi endoscopy w/suture	0422	22.8607	$1,356.78	$448.81	$271.36
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					
00140	N		Anesth, procedures on eye					
00142	N		Anesth, lens surgery					
00144	N		Anesth, corneal transplant					
00145	N		Anesth, vitreoretinal surg					
00147	N		Anesth, iridectomy					
00148	N		Anesth, eye exam					
00160	N		Anesth, nose/sinus surgery					
00162	N		Anesth, nose/sinus surgery					
00164	N		Anesth, biopsy of nose					
0016T	T		Thermotx choroid vasc lesion	0235	4.6382	$275.28	$67.10	$55.06
00170	N		Anesth, procedure on mouth					
00172	N		Anesth, cleft palate repair					
00174	N		Anesth, pharyngeal surgery					
00176	C		Anesth, pharyngeal surgery					
0017T	E		Photocoagulat macular drusen					
0018T	S		Transcranial magnetic stimul	0215	0.6087	$36.13	$14.45	$7.23
00190	N		Anesth, face/skull bone surg					
00192	C		Anesth, facial bone surgery					
0019T	E		Extracorp shock wave tx, ms					
0020T	B		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					
0026T	A		Measure remnant lipoproteins					
0027T	T		Endoscopic epidural lysis	0220	17.2800	$1,025.57		$205.11
0028T	N		Dexa body composition study					
0029T	A		Magnetic tx for incontinence					
00300	N		Anesth, head/neck/ptrunk					
0030T	A		Antiprothrombin antibody					
0031T	N		Speculoscopy					
00320	N		Anesth, neck organ, 1 & over					
00322	N		Anesth, biopsy of thyroid					
00326	N		Anesth, larynx/trach, < 1 yr					
0032T	N		Speculoscopy w/direct sample					
0033T	C		Endovasc taa repr incl subcl					
0034T	C		Endovasc taa repr w/o subcl					
00350	N		Anesth, neck vessel surgery					
00352	N		Anesth, neck vessel surgery					
0035T	C		Insert endovasc prosth, taa					
0036T	C		Endovasc prosth, taa, add-on					
0037T	C		Artery transpose/endovas taa					
0038T	C		Rad endovasc taa rpr w/cover					
0039T	C		Rad s/i, endovasc taa repair					
00400	N		Anesth, skin, ext/per/atrunk					
00402	N		Anesth, surgery of breast					
00404	C		Anesth, surgery of breast					
00406	C		Anesth, surgery of breast					
0040T	C		Rad s/i, endovasc taa prosth					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00410	N		Anesth, correct heart rhythm					
0041T	A		Detect ur infect agnt w/cpas					
0042T	N		Ct perfusion w/contrast, cbf					
0043T	A		Co expired gas analysis					
0044T	N		Whole body photography					
00450	N		Anesth, surgery of shoulder					
00452	C		Anesth, surgery of shoulder					
00454	N		Anesth, collar bone biopsy					
0045T	N		Whole body photography					
0046T	T		Cath lavage, mammary duct(s)	0021	14.9098	$884.90	$219.48	$176.98
00470	N		Anesth, removal of rib					
00472	N		Anesth, chest wall repair					
00474	C		Anesth, surgery of rib(s)					
0047T	T		Cath lavage, mammary duct(s)	0021	14.9098	$884.90	$219.48	$176.98
0048T	C		Implant ventricular device					
0049T	C		External circulation assist					
00500	N		Anesth, esophageal surgery					
0050T	C		Removal circulation assist					
0051T	C		Implant total heart system					
00520	N		Anesth, chest procedure					
00522	N		Anesth, chest lining biopsy					
00524	C		Anesth, chest drainage					
00528	N		Anesth, chest partition view					
00529	N		Anesth, chest partition view					
0052T	C		Replace component heart syst					
00530	N		Anesth, pacemaker insertion					
00532	N		Anesth, vascular access					
00534	N		Anesth, cardioverter/defib					
00537	N		Anesth, cardiac electrophys					
00539	N		Anesth, trach-bronch reconst					
0053T	C		Replace component heart syst					
00540	C		Anesth, chest surgery					
00541	N		Anesth, one lung ventilation					
00542	C		Anesth, release of lung					
00546	C		Anesth, lung,chest wall surg					
00548	N		Anesth, trachea,bronchi surg					
0054T	B		Bone surgery using computer					
00550	N		Anesth, sternal debridement					
0055T	B		Bone surgery using computer					
00560	C		Anesth, open heart surgery					
00561	C		Anesth, heart surg < age 1					
00562	C		Anesth, open heart surgery					
00563	N		Anesth, heart proc w/pump					
00566	N		Anesth, cabg w/o pump					
0056T	B		Bone surgery using computer					
00580	C		Anesth, heart/lung transplnt					
0058T	X		Cryopreservation, ovary tiss	0348	0.7891	$46.83		$9.37
0059T	X		Cryopreservation, oocyte	0348	0.7891	$46.83		$9.37
00600	N		Anesth, spine, cord surgery					
00604	C		Anesth, sitting procedure					
0060T	B		Electrical impedance scan					
0061T	B		Destruction of tumor, breast					
00620	N		Anesth, spine, cord surgery					
00622	C		Anesth, removal of nerves					
0062T	T		Rep intradisc annulus1 lev	0203	10.3544	$614.53	$245.81	$122.91
00630	N		Anesth, spine, cord surgery					
00632	C		Anesth, removal of nerves					
00634	N		Anesth for chemonucleolysis					
00635	N		Anesth, lumbar puncture					
0063T	T		Rep intradisc annulus>1lev	0203	10.3544	$614.53	$245.81	$122.91
00640	N		Anesth, spine manipulation					
0064T	A		Spectroscop eval expired gas					
0065T	A		Ocular photoscreen bilat					
0066T	E		Ct colonography screen					
00670	C		Anesth, spine, cord surgery					
0067T*	S		Ct colonography dx	0333	5.2596	$312.16	$124.86	$62.43

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
0068T	B		Interp/rept heart sound					
0069T	N		Analysis only heart sound					
00700	N		Anesth, abdominal wall surg					
00702	N		Anesth, for liver biopsy					
0070T	N		Interp only heart sound					
0071T	T		U/s leiomyomata ablate <200	0193	14.5183	$861.66		$172.33
0072T	T		U/s leiomyomata ablate >200	0193	14.5183	$861.66		$172.33
00730	N		Anesth, abdominal wall surg					
0073T	S		Delivery, comp imrt	0412	5.3400	$316.93		$63.39
00740	N		Anesth, upper gi visualize					
0074T	E		Online physician e/m					
00750	N		Anesth, repair of hernia					
00752	N		Anesth, repair of hernia					
00754	N		Anesth, repair of hernia					
00756	N		Anesth, repair of hernia					
0075T	C		Perq stent/chest vert art					
0076T	C		S&i stent/chest vert art					
00770	N		Anesth, blood vessel repair					
0077T	C		Cereb therm perfusion probe					
0078T	C		Endovasc aort repr w/device					
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					
0079T	C		Endovasc visc extnsn repr					
00800	N		Anesth, abdominal wall surg					
00802	C		Anesth, fat layer removal					
0080T	C		Endovasc aort repr rad s&i					
00810	N		Anesth, low intestine scope					
0081T	C		Endovasc visc extnsn s&i					
00820	N		Anesth, abdominal wall surg					
0082T	B		Stereotactic rad delivery					
00830	N		Anesth, repair of hernia					
00832	N		Anesth, repair of hernia					
00834	N		Anesth, hernia repair < 1 yr					
00836	N		Anesth hernia repair preemie					
0083T	N		Stereotactic rad tx mngmt					
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					
0084T	T		Temp prostate urethral stent	0164	1.1802	$70.04	$17.21	$14.01
00851	N		Anesth, tubal ligation					
0085T	X		Breath test heart reject	0340	0.6355	$37.72		$7.54
00860	N		Anesth, surgery of abdomen					
00862	N		Anesth, kidney/ureter surg					
00864	C		Anesth, removal of bladder					
00865	C		Anesth, removal of prostate					
00866	C		Anesth, removal of adrenal					
00868	C		Anesth, kidney transplant					
0086T	N		L ventricle fill pressure					
00870	N		Anesth, bladder stone surg					
00872	N		Anesth kidney stone destruct					
00873	N		Anesth kidney stone destruct					
0087T	X		Sperm eval hyaluronan	0348	0.7891	$46.83		$9.37
00880	N		Anesth, abdomen vessel surg					
00882	C		Anesth, major vein ligation					
0088T	T		Rf tongue base vol reduxn	0253	16.0627	$953.32	$282.29	$190.66
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
00914	N		Anesth, removal of prostate					
00916	N		Anesth, bleeding control					
00918	N		Anesth, stone removal					
00920	N		Anesth, genitalia surgery					
00921	N		Anesth, vasectomy					
00922	N		Anesth, sperm duct surgery					
00924	N		Anesth, testis exploration					
00926	N		Anesth, removal of testis					
00928	N		Anesth, removal of testis					
00930	N		Anesth, testis suspension					
00932	C		Anesth, amputation of penis					
00934	C		Anesth, penis, nodes removal					
00936	C		Anesth, penis, nodes removal					
00938	N		Anesth, insert penis device					
00940	N		Anesth, vaginal procedures					
00942	N		Anesth, surg on vag/urethral					
00944	C		Anesth, vaginal hysterectomy					
00948	N		Anesth, repair of cervix					
00950	N		Anesth, vaginal endoscopy					
00952	N		Anesth, hysteroscope/graph					
01112	N		Anesth, bone aspirate/bx					
01120	N		Anesth, pelvis surgery					
01130	N		Anesth, body cast procedure					
01140	C		Anesth, amputation at pelvis					
01150	C		Anesth, pelvic tumor surgery					
01160	N		Anesth, pelvis procedure					
01170	N		Anesth, pelvis surgery					
01173	N		Anesth, fx repair, pelvis					
01180	N		Anesth, pelvis nerve removal					
01190	N		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, dx knee arthroscopy					
01390	N		Anesth, knee area procedure					
01392	N		Anesth, knee area surgery					
01400	N		Anesth, knee joint surgery					
01402	C		Anesth, knee arthroplasty					
01404	C		Anesth, amputation at knee					
01420	N		Anesth, knee joint casting					
01430	N		Anesth, knee veins surgery					
01432	N		Anesth, knee vessel surg					
01440	N		Anesth, knee arteries surg					
01442	C		Anesth, knee artery surg					
01444	C		Anesth, knee artery repair					
01462	N		Anesth, lower leg procedure					
01464	N		Anesth, ankle/ft arthroscopy					
01470	N		Anesth, lower leg surgery					
01472	N		Anesth, achilles tendon surg					
01474	N		Anesth, lower leg surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01480	N		Anesth, lower leg bone surg					
01482	N		Anesth, radical leg surgery					
01484	N		Anesth, lower leg revision					
01486	C		Anesth, ankle replacement					
01490	N		Anesth, lower leg casting					
01500	N		Anesth, leg arteries surg					
01502	C		Anesth, lwr leg embolectomy					
01520	N		Anesth, lower leg vein surg					
01522	N		Anesth, lower leg vein surg					
01610	N		Anesth, surgery of shoulder					
01620	N		Anesth, shoulder procedure					
01622	N		Anes dx shoulder arthroscopy					
01630	N		Anesth, surgery of shoulder					
01632	C		Anesth, surgery of shoulder					
01634	C		Anesth, shoulder joint amput					
01636	C		Anesth, forequarter amput					
01638	C		Anesth, shoulder replacement					
01650	N		Anesth, shoulder artery surg					
01652	C		Anesth, shoulder vessel surg					
01654	C		Anesth, shoulder vessel surg					
01656	C		Anesth, arm-leg vessel surg					
01670	N		Anesth, shoulder vein surg					
01680	N		Anesth, shoulder casting					
01682	N		Anesth, airplane cast					
01710	N		Anesth, elbow area surgery					
01712	N		Anesth, uppr arm tendon surg					
01714	N		Anesth, uppr arm tendon surg					
01716	N		Anesth, biceps tendon repair					
01730	N		Anesth, uppr arm procedure					
01732	N		Anesth, dx elbow arthroscopy					
01740	N		Anesth, upper arm surgery					
01742	N		Anesth, humerus surgery					
01744	N		Anesth, humerus repair					
01756	C		Anesth, radical humerus surg					
01758	N		Anesth, humeral lesion surg					
01760	N		Anesth, elbow replacement					
01770	N		Anesth, uppr arm artery surg					
01772	N		Anesth, uppr arm embolectomy					
01780	N		Anesth, upper arm vein surg					
01782	N		Anesth, uppr arm vein repair					
01810	N		Anesth, lower arm surgery					
01820	N		Anesth, lower arm procedure					
01829	N		Anesth, dx wrist arthroscopy					
01830	N		Anesth, lower arm surgery					
01832	N		Anesth, wrist replacement					
01840	N		Anesth, lwr arm artery surg					
01842	N		Anesth, lwr arm embolectomy					
01844	N		Anesth, vascular shunt surg					
01850	N		Anesth, lower arm vein surg					
01852	N		Anesth, lwr arm vein repair					
01860	N		Anesth, lower arm casting					
01905	N		Anes, spine inject, x-ray/re					
01916	N		Anesth, dx arteriography					
01920	N		Anesth, catheterize heart					
01922	N		Anesth, cat or MRI scan					
01924	N		Anes, ther interven rad, art					
01925	N		Anes, ther interven rad, car					
01926	N		Anes, tx interv rad hrt/cran					
01930	N		Anes, ther interven rad, vei					
01931	N		Anes, ther interven rad, tip					
01932	N		Anes, tx interv rad, th vein					
01933	N		Anes, tx interv rad, cran v					
01951	N		Anesth, burn, less 4 percent					
01952	N		Anesth, burn, 4-9 percent					
01953	N		Anesth, burn, each 9 percent					
01958	N		Anesth, antepartum manipul					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
01960	N		Anesth, vaginal delivery					
01961	N		Anesth, cs delivery					
01962	N		Anesth, emer hysterectomy					
01963	N		Anesth, cs hysterectomy					
01964	N		Anesth, abortion procedures					
01967	N		Anesth/analg, vag delivery					
01968	N		Anes/analg cs deliver add-on					
01969	N		Anesth/analg cs hyst add-on					
01990	C		Support for organ donor					
01991	N		Anesth, nerve block/inj					
01992	N		Anesth, n block/inj, prone					
01995	N		Regional anesthesia limb					
01996	N		Hosp manage cont drug admin					
01999	N		Unlisted anesth procedure					
0500F	E		Initial prenatal care visit					
0501F	E		Prenatal flow sheet					
0502F	E		Subsequent prenatal care					
0503F	E		Postpartum care visit					
1000F	E		Tobacco use, smoking, assess					
1001F	E		Tobacco use, non-smoking					
10021	T		Fna w/o image	0002	0.9515	$56.47		$11.29
10022	T		Fna w/image	0036	2.1675	$128.64		$25.73
1002F	E		Assess anginal symptom/level					
10040	T		Acne surgery	0010	0.5693	$33.79	$9.63	$6.76
10060	T		Drainage of skin abscess	0006	1.5430	$91.58	$22.18	$18.32
10061	T		Drainage of skin abscess	0006	1.5430	$91.58	$22.18	$18.32
10080	T		Drainage of pilonidal cyst	0006	1.5430	$91.58	$22.18	$18.32
10081	T		Drainage of pilonidal cyst	0007	11.3983	$676.49		$135.30
10120	T		Remove foreign body	0006	1.5430	$91.58	$22.18	$18.32
10121	T		Remove foreign body	0021	14.9098	$884.90	$219.48	$176.98
10140	T		Drainage of hematoma/fluid	0007	11.3983	$676.49		$135.30
10160	T		Puncture drainage of lesion	0018	1.1673	$69.28	$16.04	$13.86
10180	T		Complex drainage, wound	0008	16.4242	$974.78		$194.96
11000	T		Debride infected skin	0015	1.6439	$97.57	$20.20	$19.51
11001	T		Debride infected skin add-on	0012	0.8458	$50.20	$11.18	$10.04
11004	C		Debride genitalia & perineum					
11005	C		Debride abdom wall					
11006	C		Debride genit/per/abdom wall					
11008	C		Remove mesh from abd wall					
11010	T		Debride skin, fx	0019	4.0363	$239.55	$71.87	$47.91
11011	T		Debride skin/muscle, fx	0019	4.0363	$239.55	$71.87	$47.91
11012	T		Debride skin/muscle/bone, fx	0019	4.0363	$239.55	$71.87	$47.91
11040	T		Debride skin, partial	0015	1.6439	$97.57	$20.20	$19.51
11041	T		Debride skin, full	0015	1.6439	$97.57	$20.20	$19.51
11042	T		Debride skin/tissue	0016	2.5717	$152.63	$33.42	$30.53
11043	T		Debride tissue/muscle	0016	2.5717	$152.63	$33.42	$30.53
11044	T		Debride tissue/muscle/bone	0682	6.8794	$408.29	$161.70	$81.66
11055	T		Trim skin lesion	0012	0.8458	$50.20	$11.18	$10.04
11056	T		Trim skin lesions, 2 to 4	0012	0.8458	$50.20	$11.18	$10.04
11057	T		Trim skin lesions, over 4	0013	1.1028	$65.45	$14.20	$13.09
11100	T		Biopsy, skin lesion	0018	1.1673	$69.28	$16.04	$13.86
11101	T		Biopsy, skin add-on	0018	1.1673	$69.28	$16.04	$13.86
11200	T		Removal of skin tags	0013	1.1028	$65.45	$14.20	$13.09
11201	T		Remove skin tags add-on	0015	1.6439	$97.57	$20.20	$19.51
11300	T		Shave skin lesion	0012	0.8458	$50.20	$11.18	$10.04
11301	T		Shave skin lesion	0012	0.8458	$50.20	$11.18	$10.04
11302	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11303	T		Shave skin lesion	0015	1.6439	$97.57	$20.20	$19.51
11305	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11306	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11307	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11308	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11310	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11311	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11312	T		Shave skin lesion	0013	1.1028	$65.45	$14.20	$13.09
11313	T		Shave skin lesion	0016	2.5717	$152.63	$33.42	$30.53

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11400	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11401	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11402	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11403	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11404	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11406	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11420	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11421	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11422	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11423	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11424	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11426	T		Removal of skin lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11440	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11441	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11442	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11443	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11444	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11446	T		Removal of skin lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11450	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11451	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11462	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11463	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11470	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11471	T		Removal, sweat gland lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11600	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11601	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11602	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11603	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11604	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11606	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11620	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11621	T		Removal of skin lesion	0019	4.0363	$239.55	$71.87	$47.91
11622	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11623	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11624	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11626	T		Removal of skin lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11640	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11641	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11642	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11643	T		Removal of skin lesion	0020	6.9118	$410.22	$106.93	$82.04
11644	T		Removal of skin lesion	0021	14.9098	$884.90	$219.48	$176.98
11646	T		Removal of skin lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11719	T		Trim nail(s)	0009	0.6650	$39.47	$8.34	$7.89
11720	T		Debride nail, 1-5	0009	0.6650	$39.47	$8.34	$7.89
11721	T		Debride nail, 6 or more	0009	0.6650	$39.47	$8.34	$7.89
11730	T		Removal of nail plate	0013	1.1028	$65.45	$14.20	$13.09
11732	T		Remove nail plate, add-on	0012	0.8458	$50.20	$11.18	$10.04
11740	T		Drain blood from under nail	0009	0.6650	$39.47	$8.34	$7.89
11750	T		Removal of nail bed	0019	4.0363	$239.55	$71.87	$47.91
11752	T		Remove nail bed/finger tip	0022	19.5582	$1,160.78	$354.45	$232.16
11755	T		Biopsy, nail unit	0019	4.0363	$239.55	$71.87	$47.91
11760	T		Repair of nail bed	0024	1.6011	$95.03	$31.11	$19.01
11762	T		Reconstruction of nail bed	0024	1.6011	$95.03	$31.11	$19.01
11765	T		Excision of nail fold, toe	0015	1.6439	$97.57	$20.20	$19.51
11770	T		Removal of pilonidal lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11771	T		Removal of pilonidal lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11772	T		Removal of pilonidal lesion	0022	19.5582	$1,160.78	$354.45	$232.16
11900	T		Injection into skin lesions	0012	0.8458	$50.20	$11.18	$10.04
11901	T		Added skin lesions injection	0012	0.8458	$50.20	$11.18	$10.04
11920	T		Correct skin color defects	0024	1.6011	$95.03	$31.11	$19.01
11921	T		Correct skin color defects	0024	1.6011	$95.03	$31.11	$19.01
11922	T		Correct skin color defects	0024	1.6011	$95.03	$31.11	$19.01
11950	T		Therapy for contour defects	0024	1.6011	$95.03	$31.11	$19.01
11951	T		Therapy for contour defects	0024	1.6011	$95.03	$31.11	$19.01
11952	T		Therapy for contour defects	0024	1.6011	$95.03	$31.11	$19.01
11954	T		Therapy for contour defects	0024	1.6011	$95.03	$31.11	$19.01

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
11960	T		Insert tissue expander(s)	0027	18.3348	$1,088.17	$329.72	$217.63
11970	T		Replace tissue expander	0027	18.3348	$1,088.17	$329.72	$217.63
11971	T		Remove tissue expander(s)	0022	19.5582	$1,160.78	$354.45	$232.16
11975	E		Insert contraceptive cap					
11976	T		Removal of contraceptive cap	0019	4.0363	$239.55	$71.87	$47.91
11977	E		Removal/reinsert contra cap					
11980	X		Implant hormone pellet(s)	0340	0.6355	$37.72		$7.54
11981	X		Insert drug implant device	0340	0.6355	$37.72		$7.54
11982	X		Remove drug implant device	0340	0.6355	$37.72		$7.54
11983	X		Remove/insert drug implant	0340	0.6355	$37.72		$7.54
12001	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12002	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12004	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12005	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12006	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12007	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12011	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12013	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12014	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12015	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12016	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12017	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12018	T		Repair superficial wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12020	T		Closure of split wound	0024	1.6011	$95.03	$31.11	$19.01
12021	T		Closure of split wound	0024	1.6011	$95.03	$31.11	$19.01
12031	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12032	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12034	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12035	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12036	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12037	T		Layer closure of wound(s)	0025	5.4690	$324.59	$101.85	$64.92
12041	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12042	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12044	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12045	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12046	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12047	T		Layer closure of wound(s)	0025	5.4690	$324.59	$101.85	$64.92
12051	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12052	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12053	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12054	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12055	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12056	T		Layer closure of wound(s)	0024	1.6011	$95.03	$31.11	$19.01
12057	T		Layer closure of wound(s)	0025	5.4690	$324.59	$101.85	$64.92
13100	T		Repair of wound or lesion	0025	5.4690	$324.59	$101.85	$64.92
13101	T		Repair of wound or lesion	0025	5.4690	$324.59	$101.85	$64.92
13102	T		Repair wound/lesion add-on	0024	1.6011	$95.03	$31.11	$19.01
13120	T		Repair of wound or lesion	0024	1.6011	$95.03	$31.11	$19.01
13121	T		Repair of wound or lesion	0024	1.6011	$95.03	$31.11	$19.01
13122	T		Repair wound/lesion add-on	0024	1.6011	$95.03	$31.11	$19.01
13131	T		Repair of wound or lesion	0024	1.6011	$95.03	$31.11	$19.01
13132	T		Repair of wound or lesion	0024	1.6011	$95.03	$31.11	$19.01
13133	T		Repair wound/lesion add-on	0024	1.6011	$95.03	$31.11	$19.01
13150	T		Repair of wound or lesion	0025	5.4690	$324.59	$101.85	$64.92
13151	T		Repair of wound or lesion	0024	1.6011	$95.03	$31.11	$19.01
13152	T		Repair of wound or lesion	0025	5.4690	$324.59	$101.85	$64.92
13153	T		Repair wound/lesion add-on	0024	1.6011	$95.03	$31.11	$19.01
13160	T		Late closure of wound	0027	18.3348	$1,088.17	$329.72	$217.63
14000	T		Skin tissue rearrangement	0686	13.7661	$817.02		$163.40
14001	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
14020	T		Skin tissue rearrangement	0686	13.7661	$817.02		$163.40
14021	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
14040	T		Skin tissue rearrangement	0686	13.7661	$817.02		$163.40
14041	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
14060	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
14061	T		Skin tissue rearrangement	0686	13.7661	$817.02		$163.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
14300	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
14350	T		Skin tissue rearrangement	0027	18.3348	$1,088.17	$329.72	$217.63
15000	T		Skin graft	0025	5.4690	$324.59	$101.85	$64.92
15001	T		Skin graft add-on	0025	5.4690	$324.59	$101.85	$64.92
15050	T		Skin pinch graft	0025	5.4690	$324.59	$101.85	$64.92
15100	T		Skin split graft	0027	18.3348	$1,088.17	$329.72	$217.63
15101	T		Skin split graft add-on	0027	18.3348	$1,088.17	$329.72	$217.63
15120	T		Skin split graft	0027	18.3348	$1,088.17	$329.72	$217.63
15121	T		Skin split graft add-on	0027	18.3348	$1,088.17	$329.72	$217.63
15200	T		Skin full graft	0027	18.3348	$1,088.17	$329.72	$217.63
15201	T		Skin full graft add-on	0025	5.4690	$324.59	$101.85	$64.92
15220	T		Skin full graft	0027	18.3348	$1,088.17	$329.72	$217.63
15221	T		Skin full graft add-on	0025	5.4690	$324.59	$101.85	$64.92
15240	T		Skin full graft	0686	13.7661	$817.02		$163.40
15241	T		Skin full graft add-on	0025	5.4690	$324.59	$101.85	$64.92
15260	T		Skin full graft	0686	13.7661	$817.02		$163.40
15261	T		Skin full graft add-on	0025	5.4690	$324.59	$101.85	$64.92
15342	T		Cultured skin graft, 25 cm	0024	1.6011	$95.03	$31.11	$19.01
15343	T		Culture skn graft add'l 25 cm	0024	1.6011	$95.03	$31.11	$19.01
15350	T		Skin homograft	0686	13.7661	$817.02		$163.40
15351	T		Skin homograft add-on	0686	13.7661	$817.02		$163.40
15400	T		Skin heterograft	0025	5.4690	$324.59	$101.85	$64.92
15401	T		Skin heterograft add-on	0025	5.4690	$324.59	$101.85	$64.92
15570	T		Form skin pedicle flap	0027	18.3348	$1,088.17	$329.72	$217.63
15572	T		Form skin pedicle flap	0027	18.3348	$1,088.17	$329.72	$217.63
15574	T		Form skin pedicle flap	0027	18.3348	$1,088.17	$329.72	$217.63
15576	T		Form skin pedicle flap	0686	13.7661	$817.02		$163.40
15600	T		Skin graft	0027	18.3348	$1,088.17	$329.72	$217.63
15610	T		Skin graft	0027	18.3348	$1,088.17	$329.72	$217.63
15620	T		Skin graft	0027	18.3348	$1,088.17	$329.72	$217.63
15630	T		Skin graft	0027	18.3348	$1,088.17	$329.72	$217.63
15650	T		Transfer skin pedicle flap	0027	18.3348	$1,088.17	$329.72	$217.63
15732	T		Muscle-skin graft, head/neck	0027	18.3348	$1,088.17	$329.72	$217.63
15734	T		Muscle-skin graft, trunk	0027	18.3348	$1,088.17	$329.72	$217.63
15736	T		Muscle-skin graft, arm	0027	18.3348	$1,088.17	$329.72	$217.63
15738	T		Muscle-skin graft, leg	0027	18.3348	$1,088.17	$329.72	$217.63
15740	T		Island pedicle flap graft	0686	13.7661	$817.02		$163.40
15750	T		Neurovascular pedicle graft	0027	18.3348	$1,088.17	$329.72	$217.63
15756	C		Free muscle flap, microvasc					
15757	C		Free skin flap, microvasc					
15758	C		Free fascial flap, microvasc					
15760	T		Composite skin graft	0027	18.3348	$1,088.17	$329.72	$217.63
15770	T		Derma-fat-fascia graft	0027	18.3348	$1,088.17	$329.72	$217.63
15775	T		Hair transplant punch grafts	0025	5.4690	$324.59	$101.85	$64.92
15776	T		Hair transplant punch grafts	0025	5.4690	$324.59	$101.85	$64.92
15780	T		Abrasion treatment of skin	0022	19.5582	$1,160.78	$354.45	$232.16
15781	T		Abrasion treatment of skin	0019	4.0363	$239.55	$71.87	$47.91
15782	T		Dressing change not for burn	0019	4.0363	$239.55	$71.87	$47.91
15783	T		Abrasion treatment of skin	0016	2.5717	$152.63	$33.42	$30.53
15786	T		Abrasion, lesion, single	0013	1.1028	$65.45	$14.20	$13.09
15787	T		Abrasion, lesions, add-on	0013	1.1028	$65.45	$14.20	$13.09
15788	T		Chemical peel, face, epiderm	0012	0.8458	$50.20	$11.18	$10.04
15789	T		Chemical peel, face, dermal	0015	1.6439	$97.57	$20.20	$19.51
15792	T		Chemical peel, nonfacial	0013	1.1028	$65.45	$14.20	$13.09
15793	T		Chemical peel, nonfacial	0012	0.8458	$50.20	$11.18	$10.04
15810	T		Salabrasion	0016	2.5717	$152.63	$33.42	$30.53
15811	T		Salabrasion	0016	2.5717	$152.63	$33.42	$30.53
15819	T		Plastic surgery, neck	0025	5.4690	$324.59	$101.85	$64.92
15820	T		Revision of lower eyelid	0027	18.3348	$1,088.17	$329.72	$217.63
15821	T		Revision of lower eyelid	0027	18.3348	$1,088.17	$329.72	$217.63
15822	T		Revision of upper eyelid	0027	18.3348	$1,088.17	$329.72	$217.63
15823	T		Revision of upper eyelid	0027	18.3348	$1,088.17	$329.72	$217.63
15824	T		Removal of forehead wrinkles	0027	18.3348	$1,088.17	$329.72	$217.63
15825	T		Removal of neck wrinkles	0027	18.3348	$1,088.17	$329.72	$217.63
15826	T		Removal of brow wrinkles	0027	18.3348	$1,088.17	$329.72	$217.63
15828	T		Removal of face wrinkles	0027	18.3348	$1,088.17	$329.72	$217.63

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
15829	T		Removal of skin wrinkles	0027	18.3348	$1,088.17	$329.72	$217.63
15831	T		Excise excessive skin tissue	0022	19.5582	$1,160.78	$354.45	$232.16
15832	T		Excise excessive skin tissue	0022	19.5582	$1,160.78	$354.45	$232.16
15833	T		Excise excessive skin tissue	0022	19.5582	$1,160.78	$354.45	$232.16
15834	T		Excise excessive skin tissue	0022	19.5582	$1,160.78	$354.45	$232.16
15835	T		Excise excessive skin tissue	0025	5.4690	$324.59	$101.85	$64.92
15836	T		Excise excessive skin tissue	0021	14.9098	$884.90	$219.48	$176.98
15837	T		Excise excessive skin tissue	0021	14.9098	$884.90	$219.48	$176.98
15838	T		Excise excessive skin tissue	0021	14.9098	$884.90	$219.48	$176.98
15839	T		Excise excessive skin tissue	0021	14.9098	$884.90	$219.48	$176.98
15840	T		Graft for face nerve palsy	0027	18.3348	$1,088.17	$329.72	$217.63
15841	T		Graft for face nerve palsy	0027	18.3348	$1,088.17	$329.72	$217.63
15842	T		Flap for face nerve palsy	0027	18.3348	$1,088.17	$329.72	$217.63
15845	T		Skin and muscle repair, face	0027	18.3348	$1,088.17	$329.72	$217.63
15850	T		Removal of sutures	0016	2.5717	$152.63	$33.42	$30.53
15851	T		Removal of sutures	0016	2.5717	$152.63	$33.42	$30.53
15852	X		Dressing change not for burn	0340	0.6355	$37.72		$7.54
15860	X		Test for blood flow in graft	0359	0.8274	$49.11		$9.82
15876	T		Suction assisted lipectomy	0027	18.3348	$1,088.17	$329.72	$217.63
15877	T		Suction assisted lipectomy	0027	18.3348	$1,088.17	$329.72	$217.63
15878	T		Suction assisted lipectomy	0686	13.7661	$817.02		$163.40
15879	T		Suction assisted lipectomy	0027	18.3348	$1,088.17	$329.72	$217.63
15920	T		Removal of tail bone ulcer	0019	4.0363	$239.55	$71.87	$47.91
15922	T		Removal of tail bone ulcer	0027	18.3348	$1,088.17	$329.72	$217.63
15931	T		Remove sacrum pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15933	T		Remove sacrum pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15934	T		Remove sacrum pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15935	T		Remove sacrum pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15936	T		Remove sacrum pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15937	T		Remove sacrum pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15940	T		Remove hip pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15941	T		Remove hip pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15944	T		Remove hip pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15945	T		Remove hip pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15946	T		Remove hip pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15950	T		Remove thigh pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15951	T		Remove thigh pressure sore	0022	19.5582	$1,160.78	$354.45	$232.16
15952	T		Remove thigh pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15953	T		Remove thigh pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15956	T		Remove thigh pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15958	T		Remove thigh pressure sore	0027	18.3348	$1,088.17	$329.72	$217.63
15999	T		Removal of pressure sore	0019	4.0363	$239.55	$71.87	$47.91
16000	T		Initial treatment of burn(s)	0012	0.8458	$50.20	$11.18	$10.04
16010	T		Treatment of burn(s)	0016	2.5717	$152.63	$33.42	$30.53
16015	T		Treatment of burn(s)	0017	18.3377	$1,088.34	$227.84	$217.67
16020	T		Treatment of burn(s)	0013	1.1028	$65.45	$14.20	$13.09
16025	T		Treatment of burn(s)	0013	1.1028	$65.45	$14.20	$13.09
16030	T		Treatment of burn(s)	0015	1.6439	$97.57	$20.20	$19.51
16035	C		Incision of burn scab, initi					
16036	C		Escharotomy addl incision					
17000	T		Destroy benign/premlg lesion	0010	0.5693	$33.79	$9.63	$6.76
17003	T		Destroy lesions, 2-14	0010	0.5693	$33.79	$9.63	$6.76
17004	T		Destroy lesions, 15 or more	0011	2.0745	$123.12	$25.06	$24.62
17106	T		Destruction of skin lesions	0011	2.0745	$123.12	$25.06	$24.62
17107	T		Destruction of skin lesions	0011	2.0745	$123.12	$25.06	$24.62
17108	T		Destruction of skin lesions	0011	2.0745	$123.12	$25.06	$24.62
17110	T		Destruct lesion, 1-14	0010	0.5693	$33.79	$9.63	$6.76
17111	T		Destruct lesion, 15 or more	0010	0.5693	$33.79	$9.63	$6.76
17250	T		Chemical cautery, tissue	0013	1.1028	$65.45	$14.20	$13.09
17260	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17261	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17262	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17263	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17264	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17266	T		Destruction of skin lesions	0016	2.5717	$152.63	$33.42	$30.53
17270	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
17271	T		Destruction of skin lesions	0013	1.1028	$65.45	$14.20	$13.09
17272	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17273	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17274	T		Destruction of skin lesions	0016	2.5717	$152.63	$33.42	$30.53
17276	T		Destruction of skin lesions	0016	2.5717	$152.63	$33.42	$30.53
17280	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17281	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17282	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17283	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17284	T		Destruction of skin lesions	0016	2.5717	$152.63	$33.42	$30.53
17286	T		Destruction of skin lesions	0015	1.6439	$97.57	$20.20	$19.51
17304	T		Chemosurgery of skin lesion	0694	3.8278	$227.18	$61.59	$45.44
17305	T		2 stage mohs, up to 5 spec	0694	3.8278	$227.18	$61.59	$45.44
17306	T		3 stage mohs, up to 5 spec	0694	3.8278	$227.18	$61.59	$45.44
17307	T		Mohs addl stage up to 5 spec	0694	3.8278	$227.18	$61.59	$45.44
17310	T		Extensive skin chemosurgery	0694	3.8278	$227.18	$61.59	$45.44
17340	T		Cryotherapy of skin	0012	0.8458	$50.20	$11.18	$10.04
17360	T		Skin peel therapy	0013	1.1028	$65.45	$14.20	$13.09
17380	T		Hair removal by electrolysis	0013	1.1028	$65.45	$14.20	$13.09
17999	T		Skin tissue procedure	0006	1.5430	$91.58	$22.18	$18.32
19000	T		Drainage of breast lesion	0004	1.7566	$104.25	$22.36	$20.85
19001	T		Drain breast lesion add-on	0004	1.7566	$104.25	$22.36	$20.85
19020	T		Incision of breast lesion	0008	16.4242	$974.78		$194.96
19030	N		Injection for breast x-ray					
19100	T		Bx breast percut w/o image	0005	3.5831	$212.66	$71.45	$42.53
19101	T		Biopsy of breast, open	0028	19.4914	$1,156.81	$303.74	$231.36
19102	T		Bx breast percut w/image	0005	3.5831	$212.66	$71.45	$42.53
19103	T		Bx breast percut w/device	0658	6.0773	$360.69		$72.14
19110	T		nipple exploration	0028	19.4914	$1,156.81	$303.74	$231.36
19112	T		Excise breast duct fistula	0028	19.4914	$1,156.81	$303.74	$231.36
19120	T		Removal of breast lesion	0028	19.4914	$1,156.81	$303.74	$231.36
19125	T		Excision, breast lesion	0028	19.4914	$1,156.81	$303.74	$231.36
19126	T		Excision, addl breast lesion	0028	19.4914	$1,156.81	$303.74	$231.36
19140	T		Removal of breast tissue	0028	19.4914	$1,156.81	$303.74	$231.36
19160	T		Removal of breast tissue	0028	19.4914	$1,156.81	$303.74	$231.36
19162	T		Remove breast tissue, nodes	0693	42.0342	$2,494.73	$798.17	$498.95
19180	T		Removal of breast	0029	31.9024	$1,893.41	$632.64	$378.68
19182	T		Removal of breast	0029	31.9024	$1,893.41	$632.64	$378.68
19200	C		Removal of breast					
19220	C		Removal of breast					
19240	T		Removal of breast	0030	39.9010	$2,368.12	$763.55	$473.62
19260	T		Removal of chest wall lesion	0021	14.9098	$884.90	$219.48	$176.98
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	1.7015	$100.98		$20.20
19296	S		Place po breast cath for rad	1524		$3,250.00		$650.00
19297	S		Place breast cath for rad	1523		$2,750.00		$550.00
19298	S		Place breast rad tube/caths	1524		$3,250.00		$650.00
19316	T		Suspension of breast	0029	31.9024	$1,893.41	$632.64	$378.68
19318	T		Reduction of large breast	0693	42.0342	$2,494.73	$798.17	$498.95
19324	T		Enlarge breast	0693	42.0342	$2,494.73	$798.17	$498.95
19325	T		Enlarge breast with implant	0648	50.2174	$2,980.40		$596.08
19328	T		Removal of breast implant	0029	31.9024	$1,893.41	$632.64	$378.68
19330	T		Removal of implant material	0029	31.9024	$1,893.41	$632.64	$378.68
19340	T		Immediate breast prosthesis	0030	39.9010	$2,368.12	$763.55	$473.62
19342	T		Delayed breast prosthesis	0648	50.2174	$2,980.40		$596.08
19350	T		Breast reconstruction	0028	19.4914	$1,156.81	$303.74	$231.36
19355	T		Correct inverted nipple(s)	0029	31.9024	$1,893.41	$632.64	$378.68
19357	T		Breast reconstruction	0648	50.2174	$2,980.40		$596.08
19361	C		Breast reconstruction					
19364	C		Breast reconstruction					
19366	T		Breast reconstruction	0029	31.9024	$1,893.41	$632.64	$378.68
19367	C		Breast reconstruction					
19368	C		Breast reconstruction					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
19369	C		Breast reconstruction					
19370	T		Surgery of breast capsule	0029	31.9024	$1,893.41	$632.64	$378.68
19371	T		Removal of breast capsule	0029	31.9024	$1,893.41	$632.64	$378.68
19380	T		Revise breast reconstruction	0030	39.9010	$2,368.12	$763.55	$473.62
19396	T		Design custom breast implant	0029	31.9024	$1,893.41	$632.64	$378.68
19499	T		Breast surgery procedure	0028	19.4914	$1,156.81	$303.74	$231.36
20000	T		Incision of abscess	0006	1.5430	$91.58	$22.18	$18.32
20005	T		Incision of deep abscess	0049	20.2784	$1,203.52		$240.70
2000F	E		Blood pressure, measured					
20100	T		Explore wound, neck	0023	4.7558	$282.26		$56.45
20101	T		Explore wound, chest	0027	18.3348	$1,088.17	$329.72	$217.63
20102	T		Explore wound, abdomen	0027	18.3348	$1,088.17	$329.72	$217.63
20103	T		Explore wound, extremity	0023	4.7558	$282.26		$56.45
20150	T		Excise epiphyseal bar	0051	36.3617	$2,158.07		$431.61
20200	T		Muscle biopsy	0021	14.9098	$884.90	$219.48	$176.98
20205	T		Deep muscle biopsy	0021	14.9098	$884.90	$219.48	$176.98
20206	T		Needle biopsy, muscle	0005	3.5831	$212.66	$71.45	$42.53
20220	T		Bone biopsy, trocar/needle	0019	4.0363	$239.55	$71.87	$47.91
20225	T		Bone biopsy, trocar/needle	0020	6.9118	$410.22	$106.93	$82.04
20240	T		Bone biopsy, excisional	0022	19.5582	$1,160.78	$354.45	$232.16
20245	T		Bone biopsy, excisional	0022	19.5582	$1,160.78	$354.45	$232.16
20250	T		Open bone biopsy	0049	20.2784	$1,203.52		$240.70
20251	T		Open bone biopsy	0049	20.2784	$1,203.52		$240.70
20500	T		Injection of sinus tract	0251	2.0010	$118.76		$23.75
20501	N		Inject sinus tract for x-ray					
20520	T		Removal of foreign body	0019	4.0363	$239.55	$71.87	$47.91
20525	T		Removal of foreign body	0022	19.5582	$1,160.78	$354.45	$232.16
20526	T		Ther injection, carp tunnel	0204	2.1811	$129.45	$40.13	$25.89
20550	T		Inject tendon/ligament/cyst	0204	2.1811	$129.45	$40.13	$25.89
20551	T		Inj tendon origin/insertion	0204	2.1811	$129.45	$40.13	$25.89
20552	T		Inj trigger point, 1/2 muscl	0204	2.1811	$129.45	$40.13	$25.89
20553	T		Inject trigger points, > 3	0204	2.1811	$129.45	$40.13	$25.89
20600	T		Drain/inject, joint/bursa	0204	2.1811	$129.45	$40.13	$25.89
20605	T		Drain/inject, joint/bursa	0204	2.1811	$129.45	$40.13	$25.89
20610	T		Drain/inject, joint/bursa	0204	2.1811	$129.45	$40.13	$25.89
20612	T		Aspirate/inj ganglion cyst	0204	2.1811	$129.45	$40.13	$25.89
20615	T		Treatment of bone cyst	0004	1.7566	$104.25	$22.36	$20.85
20650	T		Insert and remove bone pin	0049	20.2784	$1,203.52		$240.70
20660	C		Apply, rem fixation device					
20661	C		Application of head brace					
20662	T		Application of pelvis brace	0049	20.2784	$1,203.52		$240.70
20663	T		Application of thigh brace	0049	20.2784	$1,203.52		$240.70
20664	C		Halo brace application					
20665	X		Removal of fixation device	0340	0.6355	$37.72		$7.54
20670	T		Removal of support implant	0021	14.9098	$884.90	$219.48	$176.98
20680	T		Removal of support implant	0022	19.5582	$1,160.78	$354.45	$232.16
20690	T		Apply bone fixation device	0050	23.7998	$1,412.52		$282.50
20692	T		Apply bone fixation device	0050	23.7998	$1,412.52		$282.50
20693	T		Adjust bone fixation device	0049	20.2784	$1,203.52		$240.70
20694	T		Remove bone fixation device	0049	20.2784	$1,203.52		$240.70
20802	C		Replantation, arm, complete					
20805	C		Replant forearm, complete					
20808	C		Replantation hand, complete					
20816	C		Replantation digit, complete					
20822	T		Replantation digit, complete	0054	25.2562	$1,498.96		$299.79
20824	C		Replantation thumb, complete					
20827	C		Replantation thumb, complete					
20838	C		Replantation foot, complete					
20900	T		Removal of bone for graft	0050	23.7998	$1,412.52		$282.50
20902	T		Removal of bone for graft	0050	23.7998	$1,412.52		$282.50
20910	T		Remove cartilage for graft	0027	18.3348	$1,088.17	$329.72	$217.63
20912	T		Remove cartilage for graft	0027	18.3348	$1,088.17	$329.72	$217.63
20920	T		Removal of fascia for graft	0686	13.7661	$817.02		$163.40
20922	T		Removal of fascia for graft	0027	18.3348	$1,088.17	$329.72	$217.63
20924	T		Removal of tendon for graft	0050	23.7998	$1,412.52		$282.50
20926	T		Removal of tissue for graft	0686	13.7661	$817.02		$163.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	1.5430	$91.58	$22.18	$18.32
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	T		Bone/skin graft, metatarsal	0056	40.1132	$2,380.72		$476.14
20973	T		Bone/skin graft, great toe	0056	40.1132	$2,380.72		$476.14
20974	A		Electrical bone stimulation					
20975	X		Electrical bone stimulation	0340	0.6355	$37.72		$7.54
20979	A		Us bone stimulation					
20982	T		Ablate, bone tumor(s) perq	1557		$1,850.00		$370.00
20999	T		Musculoskeletal surgery	0049	20.2784	$1,203.52		$240.70
21010	T		Incision of jaw joint	0254	23.2980	$1,382.74	$321.35	$276.55
21015	T		Resection of facial tumor	0253	16.0627	$953.32	$282.29	$190.66
21025	T		Excision of bone, lower jaw	0256	37.1513	$2,204.93		$440.99
21026	T		Excision of facial bone(s)	0256	37.1513	$2,204.93		$440.99
21029	T		Contour of face bone lesion	0256	37.1513	$2,204.93		$440.99
21030	T		Removal of face bone lesion	0254	23.2980	$1,382.74	$321.35	$276.55
21031	T		Remove exostosis, mandible	0254	23.2980	$1,382.74	$321.35	$276.55
21032	T		Remove exostosis, maxilla	0254	23.2980	$1,382.74	$321.35	$276.55
21034	T		Removal of face bone lesion	0256	37.1513	$2,204.93		$440.99
21040	T		Removal of jaw bone lesion	0254	23.2980	$1,382.74	$321.35	$276.55
21044	T		Removal of jaw bone lesion	0256	37.1513	$2,204.93		$440.99
21045	C		Extensive jaw surgery					
21046	T		Remove mandible cyst complex	0256	37.1513	$2,204.93		$440.99
21047	T		Excise lwr jaw cyst w/repair	0256	37.1513	$2,204.93		$440.99
21048	T		Remove maxilla cyst complex	0256	37.1513	$2,204.93		$440.99
21049	T		Excis uppr jaw cyst w/repair	0256	37.1513	$2,204.93		$440.99
21050	T		Removal of jaw joint	0256	37.1513	$2,204.93		$440.99
21060	T		Remove jaw joint cartilage	0256	37.1513	$2,204.93		$440.99
21070	T		Remove coronoid process	0256	37.1513	$2,204.93		$440.99
21076	T		Prepare face/oral prosthesis	0254	23.2980	$1,382.74	$321.35	$276.55
21077	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21079	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21080	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21081	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21082	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21083	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21084	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21085	T		Prepare face/oral prosthesis	0253	16.0627	$953.32	$282.29	$190.66
21086	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21087	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21088	T		Prepare face/oral prosthesis	0256	37.1513	$2,204.93		$440.99
21089	T		Prepare face/oral prosthesis	0251	2.0010	$118.76		$23.75
21100	T		Maxillofacial fixation	0256	37.1513	$2,204.93		$440.99
21110	T		Interdental fixation	0252	7.8317	$464.81	$113.41	$92.96
21116	N		Injection, jaw joint x-ray					
21120	T		Reconstruction of chin	0254	23.2980	$1,382.74	$321.35	$276.55
21121	T		Reconstruction of chin	0254	23.2980	$1,382.74	$321.35	$276.55
21122	T		Reconstruction of chin	0254	23.2980	$1,382.74	$321.35	$276.55
21123	T		Reconstruction of chin	0254	23.2980	$1,382.74	$321.35	$276.55
21125	T		Augmentation, lower jaw bone	0254	23.2980	$1,382.74	$321.35	$276.55
21127	T		Augmentation, lower jaw bone	0256	37.1513	$2,204.93		$440.99
21137	T		Reduction of forehead	0254	23.2980	$1,382.74	$321.35	$276.55
21138	T		Reduction of forehead	0256	37.1513	$2,204.93		$440.99
21139	T		Reduction of forehead	0256	37.1513	$2,204.93		$440.99
21141	C		Reconstruct midface, lefort					
21142	C		Reconstruct midface, lefort					
21143	C		Reconstruct midface, lefort					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21145	C		Reconstruct midface, lefort					
21146	C		Reconstruct midface, lefort					
21147	C		Reconstruct midface, lefort					
21150	T		Reconstruct midface, lefort	0256	37.1513	$2,204.93		$440.99
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	T		Reconstruct orbit/forehead	0256	37.1513	$2,204.93		$440.99
21179	C		Reconstruct entire forehead					
21180	C		Reconstruct entire forehead					
21181	T		Contour cranial bone lesion	0254	23.2980	$1,382.74	$321.35	$276.55
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	T		Reconst lwr jaw w/o fixation	0256	37.1513	$2,204.93		$440.99
21196	C		Reconst lwr jaw w/fixation					
21198	T		Reconstr lwr jaw segment	0256	37.1513	$2,204.93		$440.99
21199	T		Reconstr lwr jaw w/advance	0256	37.1513	$2,204.93		$440.99
21206	T		Reconstruct upper jaw bone	0256	37.1513	$2,204.93		$440.99
21208	T		Augmentation of facial bones	0256	37.1513	$2,204.93		$440.99
21209	T		Reduction of facial bones	0256	37.1513	$2,204.93		$440.99
21210	T		Face bone graft	0256	37.1513	$2,204.93		$440.99
21215	T		Lower jaw bone graft	0256	37.1513	$2,204.93		$440.99
21230	T		Rib cartilage graft	0256	37.1513	$2,204.93		$440.99
21235	T		Ear cartilage graft	0254	23.2980	$1,382.74	$321.35	$276.55
21240	T		Reconstruction of jaw joint	0256	37.1513	$2,204.93		$440.99
21242	T		Reconstruction of jaw joint	0256	37.1513	$2,204.93		$440.99
21243	T		Reconstruction of jaw joint	0256	37.1513	$2,204.93		$440.99
21244	T		Reconstruction of lower jaw	0256	37.1513	$2,204.93		$440.99
21245	T		Reconstruction of jaw	0256	37.1513	$2,204.93		$440.99
21246	T		Reconstruction of jaw	0256	37.1513	$2,204.93		$440.99
21247	C		Reconstruct lower jaw bone					
21248	T		Reconstruction of jaw	0256	37.1513	$2,204.93		$440.99
21249	T		Reconstruction of jaw	0256	37.1513	$2,204.93		$440.99
21255	C		Reconstruct lower jaw bone					
21256	C		Reconstruction of orbit					
21260	T		Revise eye sockets	0256	37.1513	$2,204.93		$440.99
21261	T		Revise eye sockets	0256	37.1513	$2,204.93		$440.99
21263	T		Revise eye sockets	0256	37.1513	$2,204.93		$440.99
21267	T		Revise eye sockets	0256	37.1513	$2,204.93		$440.99
21268	C		Revise eye sockets					
21270	T		Augmentation, cheek bone	0256	37.1513	$2,204.93		$440.99
21275	T		Revision, orbitofacial bones	0256	37.1513	$2,204.93		$440.99
21280	T		Revision of eyelid	0256	37.1513	$2,204.93		$440.99
21282	T		Revision of eyelid	0253	16.0627	$953.32	$282.29	$190.66
21295	T		Revision of jaw muscle/bone	0252	7.8317	$464.81	$113.41	$92.96
21296	T		Revision of jaw muscle/bone	0254	23.2980	$1,382.74	$321.35	$276.55
21299	T		Cranio/maxillofacial surgery	0251	2.0010	$118.76		$23.75
21300	T		Treatment of skull fracture	0253	16.0627	$953.32	$282.29	$190.66
21310	T		Treatment of nose fracture	0251	2.0010	$118.76		$23.75
21315	T		Treatment of nose fracture	0251	2.0010	$118.76		$23.75
21320	T		Treatment of nose fracture	0252	7.8317	$464.81	$113.41	$92.96
21325	T		Treatment of nose fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21330	T		Treatment of nose fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21335	T		Treatment of nose fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21336	T		Treat nasal septal fracture	0046	37.5315	$2,227.49	$535.76	$445.50
21337	T		Treat nasal septal fracture	0253	16.0627	$953.32	$282.29	$190.66
21338	T		Treat nasoethmoid fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21339	T		Treat nasoethmoid fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21340	T		Treatment of nose fracture	0256	37.1513	$2,204.93		$440.99

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21343	C		Treatment of sinus fracture					
21344	C		Treatment of sinus fracture					
21345	T		Treat nose/jaw fracture	0254	23.2980	$1,382.74	$321.35	$276.55
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	37.1513	$2,204.93		$440.99
21356	T		Treat cheek bone fracture	0254	23.2980	$1,382.74	$321.35	$276.55
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	37.1513	$2,204.93		$440.99
21395	C		Treat eye socket fracture					
21400	T		Treat eye socket fracture	0252	7.8317	$464.81	$113.41	$92.96
21401	T		Treat eye socket fracture	0253	16.0627	$953.32	$282.29	$190.66
21406	T		Treat eye socket fracture	0256	37.1513	$2,204.93		$440.99
21407	T		Treat eye socket fracture	0256	37.1513	$2,204.93		$440.99
21408	T		Treat eye socket fracture	0256	37.1513	$2,204.93		$440.99
21421	T		Treat mouth roof fracture	0254	23.2980	$1,382.74	$321.35	$276.55
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	23.2980	$1,382.74	$321.35	$276.55
21445	T		Treat dental ridge fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21450	T		Treat lower jaw fracture	0251	2.0010	$118.76		$23.75
21451	T		Treat lower jaw fracture	0252	7.8317	$464.81	$113.41	$92.96
21452	T		Treat lower jaw fracture	0253	16.0627	$953.32	$282.29	$190.66
21453	T		Treat lower jaw fracture	0256	37.1513	$2,204.93		$440.99
21454	T		Treat lower jaw fracture	0254	23.2980	$1,382.74	$321.35	$276.55
21461	T		Treat lower jaw fracture	0256	37.1513	$2,204.93		$440.99
21462	T		Treat lower jaw fracture	0256	37.1513	$2,204.93		$440.99
21465	T		Treat lower jaw fracture	0256	37.1513	$2,204.93		$440.99
21470	T		Treat lower jaw fracture	0256	37.1513	$2,204.93		$440.99
21480	T		Reset dislocated jaw	0251	2.0010	$118.76		$23.75
21485	T		Reset dislocated jaw	0253	16.0627	$953.32	$282.29	$190.66
21490	T		Repair dislocated jaw	0256	37.1513	$2,204.93		$440.99
21493	T		Treat hyoid bone fracture	0252	7.8317	$464.81	$113.41	$92.96
21494	T		Treat hyoid bone fracture	0252	7.8317	$464.81	$113.41	$92.96
21495	T		Treat hyoid bone fracture	0253	16.0627	$953.32	$282.29	$190.66
21497	T		Interdental wiring	0253	16.0627	$953.32	$282.29	$190.66
21499	T		Head surgery procedure	0251	2.0010	$118.76		$23.75
21501	T		Drain neck/chest lesion	0008	16.4242	$974.78		$194.96
21502	T		Drain chest lesion	0049	20.2784	$1,203.52		$240.70
21510	C		Drainage of bone lesion					
21550	T		Biopsy of neck/chest	0021	14.9098	$884.90	$219.48	$176.98
21555	T		Remove lesion, neck/chest	0022	19.5582	$1,160.78	$354.45	$232.16
21556	T		Remove lesion, neck/chest	0022	19.5582	$1,160.78	$354.45	$232.16
21557	T		Remove tumor, neck/chest	0022	19.5582	$1,160.78	$354.45	$232.16
21600	T		Partial removal of rib	0050	23.7998	$1,412.52		$282.50
21610	T		Partial removal of rib	0050	23.7998	$1,412.52		$282.50
21615	C		Removal of rib					
21616	C		Removal of rib and nerves					
21620	C		Partial removal of sternum					
21627	C		Sternal debridement					
21630	C		Extensive sternum surgery					
21632	C		Extensive sternum surgery					
21685	T		Hyoid myotomy & suspension	0252	7.8317	$464.81	$113.41	$92.96
21700	T		Revision of neck muscle	0049	20.2784	$1,203.52		$240.70
21705	C		Revision of neck muscle/rib					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
21720	T		Revision of neck muscle	0049	20.2784	$1,203.52		$240.70
21725	T		Revision of neck muscle	0006	1.5430	$91.58	$22.18	$18.32
21740	C		Reconstruction of sternum					
21742	T		Repair stern/nuss w/o scope	0051	36.3617	$2,158.07		$431.61
21743	T		Repair sternum/nuss w/scope	0051	36.3617	$2,158.07		$431.61
21750	C		Repair of sternum separation					
21800	T		Treatment of rib fracture	0043	1.7614	$104.54		$20.91
21805	T		Treatment of rib fracture	0046	37.5315	$2,227.49	$535.76	$445.50
21810	C		Treatment of rib fracture(s)					
21820	T		Treat sternum fracture	0043	1.7614	$104.54		$20.91
21825	C		Treat sternum fracture					
21899	T		Neck/chest surgery procedure	0251	2.0010	$118.76		$23.75
21920	T		Biopsy soft tissue of back	0020	6.9118	$410.22	$106.93	$82.04
21925	T		Biopsy soft tissue of back	0022	19.5582	$1,160.78	$354.45	$232.16
21930	T		Remove lesion, back or flank	0022	19.5582	$1,160.78	$354.45	$232.16
21935	T		Remove tumor, back	0022	19.5582	$1,160.78	$354.45	$232.16
22100	T		Remove part of neck vertebra	0208	42.1492	$2,501.56		$500.31
22101	T		Remove part, thorax vertebra	0208	42.1492	$2,501.56		$500.31
22102	T		Remove part, lumbar vertebra	0208	42.1492	$2,501.56		$500.31
22103	T		Remove extra spine segment	0208	42.1492	$2,501.56		$500.31
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	T		Revision of thorax spine	0208	42.1492	$2,501.56		$500.31
22224	C		Revision of lumbar spine					
22226	C		Revise, extra spine segment					
22305	T		Treat spine process fracture	0043	1.7614	$104.54		$20.91
22310	T		Treat spine fracture	0043	1.7614	$104.54		$20.91
22315	T		Treat spine fracture	0043	1.7614	$104.54		$20.91
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	14.4289	$856.36	$268.47	$171.27
22520	T		Percut vertebroplasty thor	0050	23.7998	$1,412.52		$282.50
22521	T		Percut vertebroplasty lumb	0050	23.7998	$1,412.52		$282.50
22522	T		Percut vertebroplasty add'l	0050	23.7998	$1,412.52		$282.50
22532	C		Lat thorax spine fusion					
22533	C		Lat lumbar spine fusion					
22534	C		Lat thor/lumb, add'l seg					
22548	C		Neck spine fusion					
22554	C		Neck spine fusion					
22556	C		Thorax spine fusion					
22558	C		Lumbar spine fusion					
22585	C		Additional spinal fusion					
22590	C		Spine & skull spinal fusion					
22595	C		Neck spinal fusion					
22600	C		Neck spine fusion					
22610	C		Thorax spine fusion					
22612	T		Lumbar spine fusion	0208	42.1492	$2,501.56		$500.31
22614	T		Spine fusion, extra segment	0208	42.1492	$2,501.56		$500.31
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
22812	C		Fusion of spine					
22818	C		Kyphectomy, 1-2 segments					
22819	C		Kyphectomy, 3 or more					
22830	C		Exploration of spinal fusion					
22840	C		Insert spine fixation device					
22841	C		Insert spine fixation device					
22842	C		Insert spine fixation device					
22843	C		Insert spine fixation device					
22844	C		Insert spine fixation device					
22845	C		Insert spine fixation device					
22846	C		Insert spine fixation device					
22847	C		Insert spine fixation device					
22848	C		Insert pelv fixation device					
22849	C		Reinsert spinal fixation					
22850	C		Remove spine fixation device					
22851	C		Apply spine prosth device					
22852	C		Remove spine fixation device					
22855	C		Remove spine fixation device					
22899	T		Spine surgery procedure	0043	1.7614	$104.54		$20.91
22900	T		Remove abdominal wall lesion	0022	19.5582	$1,160.78	$354.45	$232.16
22999	T		Abdomen surgery procedure	0019	4.0363	$239.55	$71.87	$47.91
23000	T		Removal of calcium deposits	0021	14.9098	$884.90	$219.48	$176.98
23020	T		Release shoulder joint	0051	36.3617	$2,158.07		$431.61
23030	T		Drain shoulder lesion	0008	16.4242	$974.78		$194.96
23031	T		Drain shoulder bursa	0008	16.4242	$974.78		$194.96
23035	T		Drain shoulder bone lesion	0049	20.2784	$1,203.52		$240.70
23040	T		Exploratory shoulder surgery	0050	23.7998	$1,412.52		$282.50
23044	T		Exploratory shoulder surgery	0050	23.7998	$1,412.52		$282.50
23065	T		Biopsy shoulder tissues	0021	14.9098	$884.90	$219.48	$176.98
23066	T		Biopsy shoulder tissues	0022	19.5582	$1,160.78	$354.45	$232.16
23075	T		Removal of shoulder lesion	0021	14.9098	$884.90	$219.48	$176.98
23076	T		Removal of shoulder lesion	0022	19.5582	$1,160.78	$354.45	$232.16
23077	T		Remove tumor of shoulder	0022	19.5582	$1,160.78	$354.45	$232.16
23100	T		Biopsy of shoulder joint	0049	20.2784	$1,203.52		$240.70
23101	T		Shoulder joint surgery	0050	23.7998	$1,412.52		$282.50
23105	T		Remove shoulder joint lining	0050	23.7998	$1,412.52		$282.50
23106	T		Incision of collarbone joint	0050	23.7998	$1,412.52		$282.50
23107	T		Explore treat shoulder joint	0050	23.7998	$1,412.52		$282.50
23120	T		Partial removal, collar bone	0051	36.3617	$2,158.07		$431.61
23125	T		Removal of collar bone	0051	36.3617	$2,158.07		$431.61
23130	T		Remove shoulder bone, part	0051	36.3617	$2,158.07		$431.61
23140	T		Removal of bone lesion	0049	20.2784	$1,203.52		$240.70
23145	T		Removal of bone lesion	0050	23.7998	$1,412.52		$282.50
23146	T		Removal of bone lesion	0050	23.7998	$1,412.52		$282.50
23150	T		Removal of humerus lesion	0050	23.7998	$1,412.52		$282.50
23155	T		Removal of humerus lesion	0050	23.7998	$1,412.52		$282.50
23156	T		Removal of humerus lesion	0050	23.7998	$1,412.52		$282.50
23170	T		Remove collar bone lesion	0050	23.7998	$1,412.52		$282.50
23172	T		Remove shoulder blade lesion	0050	23.7998	$1,412.52		$282.50
23174	T		Remove humerus lesion	0050	23.7998	$1,412.52		$282.50
23180	T		Remove collar bone lesion	0050	23.7998	$1,412.52		$282.50
23182	T		Remove shoulder blade lesion	0050	23.7998	$1,412.52		$282.50
23184	T		Remove humerus lesion	0050	23.7998	$1,412.52		$282.50
23190	T		Partial removal of scapula	0050	23.7998	$1,412.52		$282.50
23195	T		Removal of head of humerus	0050	23.7998	$1,412.52		$282.50
23200	C		Removal of collar bone					
23210	C		Removal of shoulder blade					
23220	C		Partial removal of humerus					
23221	C		Partial removal of humerus					
23222	C		Partial removal of humerus					
23330	T		Remove shoulder foreign body	0020	6.9118	$410.22	$106.93	$82.04
23331	T		Remove shoulder foreign body	0022	19.5582	$1,160.78	$354.45	$232.16
23332	C		Remove shoulder foreign body					
23350	N		Injection for shoulder x-ray					
23395	T		Muscle transfer,shoulder/arm	0051	36.3617	$2,158.07		$431.61
23397	T		Muscle transfers	0052	43.7388	$2,595.90		$519.18

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
23400	T		Fixation of shoulder blade	0050	23.7998	$1,412.52		$282.50
23405	T		Incision of tendon & muscle	0050	23.7998	$1,412.52		$282.50
23406	T		Incise tendon(s) & muscle(s)	0050	23.7998	$1,412.52		$282.50
23410	T		Repair of tendon(s)	0052	43.7388	$2,595.90		$519.18
23412	T		Repair rotator cuff, chronic	0052	43.7388	$2,595.90		$519.18
23415	T		Release of shoulder ligament	0051	36.3617	$2,158.07		$431.61
23420	T		Repair of shoulder	0052	43.7388	$2,595.90		$519.18
23430	T		Repair biceps tendon	0052	43.7388	$2,595.90		$519.18
23440	T		Remove/transplant tendon	0052	43.7388	$2,595.90		$519.18
23450	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23455	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23460	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23462	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23465	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23466	T		Repair shoulder capsule	0052	43.7388	$2,595.90		$519.18
23470	T		Reconstruct shoulder joint	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
23472	C		Reconstruct shoulder joint					
23480	T		Revision of collar bone	0051	36.3617	$2,158.07		$431.61
23485	T		Revision of collar bone	0051	36.3617	$2,158.07		$431.61
23490	T		Reinforce clavicle	0051	36.3617	$2,158.07		$431.61
23491	T		Reinforce shoulder bones	0051	36.3617	$2,158.07		$431.61
23500	T		Treat clavicle fracture	0043	1.7614	$104.54		$20.91
23505	T		Treat clavicle fracture	0043	1.7614	$104.54		$20.91
23515	T		Treat clavicle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23520	T		Treat clavicle dislocation	0043	1.7614	$104.54		$20.91
23525	T		Treat clavicle dislocation	0043	1.7614	$104.54		$20.91
23530	T		Treat clavicle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
23532	T		Treat clavicle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
23540	T		Treat clavicle dislocation	0043	1.7614	$104.54		$20.91
23545	T		Treat clavicle dislocation	0043	1.7614	$104.54		$20.91
23550	T		Treat clavicle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
23552	T		Treat clavicle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
23570	T		Treat shoulder blade fx	0043	1.7614	$104.54		$20.91
23575	T		Treat shoulder blade fx	0043	1.7614	$104.54		$20.91
23585	T		Treat scapula fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23600	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
23605	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
23615	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23616	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23620	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
23625	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
23630	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23650	T		Treat shoulder dislocation	0043	1.7614	$104.54		$20.91
23655	T		Treat shoulder dislocation	0045	14.4289	$856.36	$268.47	$171.27
23660	T		Treat shoulder dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
23665	T		Treat dislocation/fracture	0043	1.7614	$104.54		$20.91
23670	T		Treat dislocation/fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23675	T		Treat dislocation/fracture	0043	1.7614	$104.54		$20.91
23680	T		Treat dislocation/fracture	0046	37.5315	$2,227.49	$535.76	$445.50
23700	T		Fixation of shoulder	0045	14.4289	$856.36	$268.47	$171.27
23800	T		Fusion of shoulder joint	0051	36.3617	$2,158.07		$431.61
23802	T		Fusion of shoulder joint	0051	36.3617	$2,158.07		$431.61
23900	C		Amputation of arm & girdle					
23920	C		Amputation at shoulder joint					
23921	T		Amputation follow-up surgery	0025	5.4690	$324.59	$101.85	$64.92
23929	T		Shoulder surgery procedure	0043	1.7614	$104.54		$20.91
23930	T		Drainage of arm lesion	0008	16.4242	$974.78		$194.96
23931	T		Drainage of arm bursa	0008	16.4242	$974.78		$194.96
23935	T		Drain arm/elbow bone lesion	0049	20.2784	$1,203.52		$240.70
24000	T		Exploratory elbow surgery	0050	23.7998	$1,412.52		$282.50
24006	T		Release elbow joint	0050	23.7998	$1,412.52		$282.50
24065	T		Biopsy arm/elbow soft tissue	0021	14.9098	$884.90	$219.48	$176.98
24066	T		Biopsy arm/elbow soft tissue	0021	14.9098	$884.90	$219.48	$176.98
24075	T		Remove arm/elbow lesion	0021	14.9098	$884.90	$219.48	$176.98
24076	T		Remove arm/elbow lesion	0022	19.5582	$1,160.78	$354.45	$232.16
24077	T		Remove tumor of arm/elbow	0022	19.5582	$1,160.78	$354.45	$232.16

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24100	T		Biopsy elbow joint lining	0049	20.2784	$1,203.52		$240.70
24101	T		Explore/treat elbow joint	0050	23.7998	$1,412.52		$282.50
24102	T		Remove elbow joint lining	0050	23.7998	$1,412.52		$282.50
24105	T		Removal of elbow bursa	0049	20.2784	$1,203.52		$240.70
24110	T		Remove humerus lesion	0049	20.2784	$1,203.52		$240.70
24115	T		Remove/graft bone lesion	0050	23.7998	$1,412.52		$282.50
24116	T		Remove/graft bone lesion	0050	23.7998	$1,412.52		$282.50
24120	T		Remove elbow lesion	0049	20.2784	$1,203.52		$240.70
24125	T		Remove/graft bone lesion	0050	23.7998	$1,412.52		$282.50
24126	T		Remove/graft bone lesion	0050	23.7998	$1,412.52		$282.50
24130	T		Removal of head of radius	0050	23.7998	$1,412.52		$282.50
24134	T		Removal of arm bone lesion	0050	23.7998	$1,412.52		$282.50
24136	T		Remove radius bone lesion	0050	23.7998	$1,412.52		$282.50
24138	T		Remove elbow bone lesion	0050	23.7998	$1,412.52		$282.50
24140	T		Partial removal of arm bone	0050	23.7998	$1,412.52		$282.50
24145	T		Partial removal of radius	0050	23.7998	$1,412.52		$282.50
24147	T		Partial removal of elbow	0050	23.7998	$1,412.52		$282.50
24149	T		Radical resection of elbow	0050	23.7998	$1,412.52		$282.50
24150	T		Extensive humerus surgery	0052	43.7388	$2,595.90		$519.18
24151	T		Extensive humerus surgery	0052	43.7388	$2,595.90		$519.18
24152	T		Extensive radius surgery	0052	43.7388	$2,595.90		$519.18
24153	T		Extensive radius surgery	0052	43.7388	$2,595.90		$519.18
24155	T		Removal of elbow joint	0051	36.3617	$2,158.07		$431.61
24160	T		Remove elbow joint implant	0050	23.7998	$1,412.52		$282.50
24164	T		Remove radius head implant	0050	23.7998	$1,412.52		$282.50
24200	T		Removal of arm foreign body	0019	4.0363	$239.55	$71.87	$47.91
24201	T		Removal of arm foreign body	0021	14.9098	$884.90	$219.48	$176.98
24220	N		Injection for elbow x-ray					
24300	T		Manipulate elbow w/anesth	0045	14.4289	$856.36	$268.47	$171.27
24301	T		Muscle/tendon transfer	0050	23.7998	$1,412.52		$282.50
24305	T		Arm tendon lengthening	0050	23.7998	$1,412.52		$282.50
24310	T		Revision of arm tendon	0049	20.2784	$1,203.52		$240.70
24320	T		Repair of arm tendon	0051	36.3617	$2,158.07		$431.61
24330	T		Revision of arm muscles	0051	36.3617	$2,158.07		$431.61
24331	T		Revision of arm muscles	0051	36.3617	$2,158.07		$431.61
24332	T		Tenolysis, triceps	0049	20.2784	$1,203.52		$240.70
24340	T		Repair of biceps tendon	0051	36.3617	$2,158.07		$431.61
24341	T		Repair arm tendon/muscle	0051	36.3617	$2,158.07		$431.61
24342	T		Repair of ruptured tendon	0051	36.3617	$2,158.07		$431.61
24343	T		Repr elbow lat ligmnt w/tiss	0050	23.7998	$1,412.52		$282.50
24344	T		Reconstruct elbow lat ligmnt	0051	36.3617	$2,158.07		$431.61
24345	T		Repr elbw med ligmnt w/tissu	0050	23.7998	$1,412.52		$282.50
24346	T		Reconstruct elbow med ligmnt	0051	36.3617	$2,158.07		$431.61
24350	T		Repair of tennis elbow	0050	23.7998	$1,412.52		$282.50
24351	T		Repair of tennis elbow	0050	23.7998	$1,412.52		$282.50
24352	T		Repair of tennis elbow	0050	23.7998	$1,412.52		$282.50
24354	T		Repair of tennis elbow	0050	23.7998	$1,412.52		$282.50
24356	T		Revision of tennis elbow	0050	23.7998	$1,412.52		$282.50
24360	T		Reconstruct elbow joint	0047	31.4675	$1,867.60	$537.03	$373.52
24361	T		Reconstruct elbow joint	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
24362	T		Reconstruct elbow joint	0048	42.9335	$2,548.10	$570.30	$509.62
24363	T		Replace elbow joint	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
24365	T		Reconstruct head of radius	0047	31.4675	$1,867.60	$537.03	$373.52
24366	T		Reconstruct head of radius	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
24400	T		Revision of humerus	0050	23.7998	$1,412.52		$282.50
24410	T		Revision of humerus	0050	23.7998	$1,412.52		$282.50
24420	T		Revision of humerus	0051	36.3617	$2,158.07		$431.61
24430	T		Repair of humerus	0051	36.3617	$2,158.07		$431.61
24435	T		Repair humerus with graft	0051	36.3617	$2,158.07		$431.61
24470	T		Revision of elbow joint	0051	36.3617	$2,158.07		$431.61
24495	T		Decompression of forearm	0050	23.7998	$1,412.52		$282.50
24498	T		Reinforce humerus	0051	36.3617	$2,158.07		$431.61
24500	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24505	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24515	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24516	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
24530	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24535	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24538	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24545	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24546	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24560	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24565	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24566	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24575	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24576	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24577	T		Treat humerus fracture	0043	1.7614	$104.54		$20.91
24579	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24582	T		Treat humerus fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24586	T		Treat elbow fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24587	T		Treat elbow fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24600	T		Treat elbow dislocation	0043	1.7614	$104.54		$20.91
24605	T		Treat elbow dislocation	0045	14.4289	$856.36	$268.47	$171.27
24615	T		Treat elbow dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
24620	T		Treat elbow fracture	0043	1.7614	$104.54		$20.91
24635	T		Treat elbow fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24640	T		Treat elbow dislocation	0043	1.7614	$104.54		$20.91
24650	T		Treat radius fracture	0043	1.7614	$104.54		$20.91
24655	T		Treat radius fracture	0043	1.7614	$104.54		$20.91
24665	T		Treat radius fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24666	T		Treat radius fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24670	T		Treat ulnar fracture	0043	1.7614	$104.54		$20.91
24675	T		Treat ulnar fracture	0043	1.7614	$104.54		$20.91
24685	T		Treat ulnar fracture	0046	37.5315	$2,227.49	$535.76	$445.50
24800	T		Fusion of elbow joint	0051	36.3617	$2,158.07		$431.61
24802	T		Fusion/graft of elbow joint	0051	36.3617	$2,158.07		$431.61
24900	C		Amputation of upper arm					
24920	C		Amputation of upper arm					
24925	T		Amputation follow-up surgery	0049	20.2784	$1,203.52		$240.70
24930	C		Amputation follow-up surgery					
24931	C		Amputate upper arm & implant					
24935	T		Revision of amputation	0052	43.7388	$2,595.90		$519.18
24940	C		Revision of upper arm					
24999	T		Upper arm/elbow surgery	0043	1.7614	$104.54		$20.91
25000	T		Incision of tendon sheath	0049	20.2784	$1,203.52		$240.70
25001	T		Incise flexor carpi radialis	0049	20.2784	$1,203.52		$240.70
25020	T		Decompress forearm 1 space	0049	20.2784	$1,203.52		$240.70
25023	T		Decompress forearm 1 space	0050	23.7998	$1,412.52		$282.50
25024	T		Decompress forearm 2 spaces	0050	23.7998	$1,412.52		$282.50
25025	T		Decompress forearm 2 spaces	0050	23.7998	$1,412.52		$282.50
25028	T		Drainage of forearm lesion	0049	20.2784	$1,203.52		$240.70
25031	T		Drainage of forearm bursa	0049	20.2784	$1,203.52		$240.70
25035	T		Treat forearm bone lesion	0049	20.2784	$1,203.52		$240.70
25040	T		Explore/treat wrist joint	0050	23.7998	$1,412.52		$282.50
25065	T		Biopsy forearm soft tissues	0021	14.9098	$884.90	$219.48	$176.98
25066	T		Biopsy forearm soft tissues	0022	19.5582	$1,160.78	$354.45	$232.16
25075	T		Removel forearm lesion subcu	0021	14.9098	$884.90	$219.48	$176.98
25076	T		Removel forearm lesion deep	0022	19.5582	$1,160.78	$354.45	$232.16
25077	T		Remove tumor, forearm/wrist	0022	19.5582	$1,160.78	$354.45	$232.16
25085	T		Incision of wrist capsule	0049	20.2784	$1,203.52		$240.70
25100	T		Biopsy of wrist joint	0049	20.2784	$1,203.52		$240.70
25101	T		Explore/treat wrist joint	0050	23.7998	$1,412.52		$282.50
25105	T		Remove wrist joint lining	0050	23.7998	$1,412.52		$282.50
25107	T		Remove wrist joint cartilage	0050	23.7998	$1,412.52		$282.50
25110	T		Remove wrist tendon lesion	0049	20.2784	$1,203.52		$240.70
25111	T		Remove wrist tendon lesion	0053	15.6085	$926.36	$253.49	$185.27
25112	T		Reremove wrist tendon lesion	0053	15.6085	$926.36	$253.49	$185.27
25115	T		Remove wrist/forearm lesion	0049	20.2784	$1,203.52		$240.70
25116	T		Remove wrist/forearm lesion	0049	20.2784	$1,203.52		$240.70
25118	T		Excise wrist tendon sheath	0050	23.7998	$1,412.52		$282.50
25119	T		Partial removal of ulna	0050	23.7998	$1,412.52		$282.50
25120	T		Removal of forearm lesion	0050	23.7998	$1,412.52		$282.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25125	T		Remove/graft forearm lesion	0050	23.7998	$1,412.52		$282.50
25126	T		Remove/graft forearm lesion	0050	23.7998	$1,412.52		$282.50
25130	T		Removal of wrist lesion	0050	23.7998	$1,412.52		$282.50
25135	T		Remove & graft wrist lesion	0050	23.7998	$1,412.52		$282.50
25136	T		Remove & graft wrist lesion	0050	23.7998	$1,412.52		$282.50
25145	T		Remove forearm bone lesion	0050	23.7998	$1,412.52		$282.50
25150	T		Partial removal of ulna	0050	23.7998	$1,412.52		$282.50
25151	T		Partial removal of radius	0050	23.7998	$1,412.52		$282.50
25170	T		Extensive forearm surgery	0052	43.7388	$2,595.90		$519.18
25210	T		Removal of wrist bone	0054	25.2562	$1,498.96		$299.79
25215	T		Removal of wrist bones	0054	25.2562	$1,498.96		$299.79
25230	T		Partial removal of radius	0050	23.7998	$1,412.52		$282.50
25240	T		Partial removal of ulna	0050	23.7998	$1,412.52		$282.50
25246	N		Injection for wrist x-ray					
25248	T		Remove forearm foreign body	0049	20.2784	$1,203.52		$240.70
25250	T		Removal of wrist prosthesis	0050	23.7998	$1,412.52		$282.50
25251	T		Removal of wrist prosthesis	0050	23.7998	$1,412.52		$282.50
25259	T		Manipulate wrist w/anesthes	0043	1.7614	$104.54		$20.91
25260	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25263	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25265	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25270	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25272	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25274	T		Repair forearm tendon/muscle	0050	23.7998	$1,412.52		$282.50
25275	T		Repair forearm tendon sheath	0050	23.7998	$1,412.52		$282.50
25280	T		Revise wrist/forearm tendon	0050	23.7998	$1,412.52		$282.50
25290	T		Incise wrist/forearm tendon	0050	23.7998	$1,412.52		$282.50
25295	T		Release wrist/forearm tendon	0049	20.2784	$1,203.52		$240.70
25300	T		Fusion of tendons at wrist	0050	23.7998	$1,412.52		$282.50
25301	T		Fusion of tendons at wrist	0050	23.7998	$1,412.52		$282.50
25310	T		Transplant forearm tendon	0051	36.3617	$2,158.07		$431.61
25312	T		Transplant forearm tendon	0051	36.3617	$2,158.07		$431.61
25315	T		Revise palsy hand tendon(s)	0051	36.3617	$2,158.07		$431.61
25316	T		Revise palsy hand tendon(s)	0051	36.3617	$2,158.07		$431.61
25320	T		Repair/revise wrist joint	0051	36.3617	$2,158.07		$431.61
25332	T		Revise wrist joint	0047	31.4675	$1,867.60	$537.03	$373.52
25335	T		Realignment of hand	0051	36.3617	$2,158.07		$431.61
25337	T		Reconstruct ulna/radioulnar	0051	36.3617	$2,158.07		$431.61
25350	T		Revision of radius	0051	36.3617	$2,158.07		$431.61
25355	T		Revision of radius	0051	36.3617	$2,158.07		$431.61
25360	T		Revision of ulna	0050	23.7998	$1,412.52		$282.50
25365	T		Revise radius & ulna	0050	23.7998	$1,412.52		$282.50
25370	T		Revise radius or ulna	0051	36.3617	$2,158.07		$431.61
25375	T		Revise radius & ulna	0051	36.3617	$2,158.07		$431.61
25390	T		Shorten radius or ulna	0050	23.7998	$1,412.52		$282.50
25391	T		Lengthen radius or ulna	0051	36.3617	$2,158.07		$431.61
25392	T		Shorten radius & ulna	0050	23.7998	$1,412.52		$282.50
25393	T		Lengthen radius & ulna	0051	36.3617	$2,158.07		$431.61
25394	T		Repair carpal bone, shorten	0053	15.6085	$926.36	$253.49	$185.27
25400	T		Repair radius or ulna	0050	23.7998	$1,412.52		$282.50
25405	T		Repair/graft radius or ulna	0050	23.7998	$1,412.52		$282.50
25415	T		Repair radius & ulna	0050	23.7998	$1,412.52		$282.50
25420	T		Repair/graft radius & ulna	0051	36.3617	$2,158.07		$431.61
25425	T		Repair/graft radius or ulna	0051	36.3617	$2,158.07		$431.61
25426	T		Repair/graft radius & ulna	0051	36.3617	$2,158.07		$431.61
25430	T		Vasc graft into carpal bone	0054	25.2562	$1,498.96		$299.79
25431	T		Repair nonunion carpal bone	0054	25.2562	$1,498.96		$299.79
25440	T		Repair/graft wrist bone	0051	36.3617	$2,158.07		$431.61
25441	T		Reconstruct wrist joint	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
25442	T		Reconstruct wrist joint	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
25443	T		Reconstruct wrist joint	0048	42.9335	$2,548.10	$570.30	$509.62
25444	T		Reconstruct wrist joint	0048	42.9335	$2,548.10	$570.30	$509.62
25445	T		Reconstruct wrist joint	0048	42.9335	$2,548.10	$570.30	$509.62
25446	T		Wrist replacement	0425	99.7520	$5,920.28	$1,378.01	$1,184.06
25447	T		Repair wrist joint(s)	0047	31.4675	$1,867.60	$537.03	$373.52
25449	T		Remove wrist joint implant	0047	31.4675	$1,867.60	$537.03	$373.52

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
25450	T		Revision of wrist joint	0051	36.3617	$2,158.07		$431.61
25455	T		Revision of wrist joint	0051	36.3617	$2,158.07		$431.61
25490	T		Reinforce radius	0051	36.3617	$2,158.07		$431.61
25491	T		Reinforce ulna	0051	36.3617	$2,158.07		$431.61
25492	T		Reinforce radius and ulna	0051	36.3617	$2,158.07		$431.61
25500	T		Treat fracture of radius	0043	1.7614	$104.54		$20.91
25505	T		Treat fracture of radius	0043	1.7614	$104.54		$20.91
25515	T		Treat fracture of radius	0046	37.5315	$2,227.49	$535.76	$445.50
25520	T		Treat fracture of radius	0043	1.7614	$104.54		$20.91
25525	T		Treat fracture of radius	0046	37.5315	$2,227.49	$535.76	$445.50
25526	T		Treat fracture of radius	0046	37.5315	$2,227.49	$535.76	$445.50
25530	T		Treat fracture of ulna	0043	1.7614	$104.54		$20.91
25535	T		Treat fracture of ulna	0043	1.7614	$104.54		$20.91
25545	T		Treat fracture of ulna	0046	37.5315	$2,227.49	$535.76	$445.50
25560	T		Treat fracture radius & ulna	0043	1.7614	$104.54		$20.91
25565	T		Treat fracture radius & ulna	0043	1.7614	$104.54		$20.91
25574	T		Treat fracture radius & ulna	0046	37.5315	$2,227.49	$535.76	$445.50
25575	T		Treat fracture radius/ulna	0046	37.5315	$2,227.49	$535.76	$445.50
25600	T		Treat fracture radius/ulna	0043	1.7614	$104.54		$20.91
25605	T		Treat fracture radius/ulna	0043	1.7614	$104.54		$20.91
25611	T		Treat fracture radius/ulna	0046	37.5315	$2,227.49	$535.76	$445.50
25620	T		Treat fracture radius/ulna	0046	37.5315	$2,227.49	$535.76	$445.50
25622	T		Treat wrist bone fracture	0043	1.7614	$104.54		$20.91
25624	T		Treat wrist bone fracture	0043	1.7614	$104.54		$20.91
25628	T		Treat wrist bone fracture	0046	37.5315	$2,227.49	$535.76	$445.50
25630	T		Treat wrist bone fracture	0043	1.7614	$104.54		$20.91
25635	T		Treat wrist bone fracture	0043	1.7614	$104.54		$20.91
25645	T		Treat wrist bone fracture	0046	37.5315	$2,227.49	$535.76	$445.50
25650	T		Treat wrist bone fracture	0043	1.7614	$104.54		$20.91
25651	T		Pin ulnar styloid fracture	0046	37.5315	$2,227.49	$535.76	$445.50
25652	T		Treat fracture ulnar styloid	0046	37.5315	$2,227.49	$535.76	$445.50
25660	T		Treat wrist dislocation	0043	1.7614	$104.54		$20.91
25670	T		Treat wrist dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
25671	T		Pin radioulnar dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
25675	T		Treat wrist dislocation	0043	1.7614	$104.54		$20.91
25676	T		Treat wrist dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
25680	T		Treat wrist fracture	0043	1.7614	$104.54		$20.91
25685	T		Treat wrist fracture	0046	37.5315	$2,227.49	$535.76	$445.50
25690	T		Treat wrist dislocation	0043	1.7614	$104.54		$20.91
25695	T		Treat wrist dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
25800	T		Fusion of wrist joint	0051	36.3617	$2,158.07		$431.61
25805	T		Fusion/graft of wrist joint	0051	36.3617	$2,158.07		$431.61
25810	T		Fusion/graft of wrist joint	0051	36.3617	$2,158.07		$431.61
25820	T		Fusion of hand bones	0053	15.6085	$926.36	$253.49	$185.27
25825	T		Fuse hand bones with graft	0054	25.2562	$1,498.96		$299.79
25830	T		Fusion, radioulnar jnt/ulna	0051	36.3617	$2,158.07		$431.61
25900	C		Amputation of forearm					
25905	C		Amputation of forearm					
25907	T		Amputation follow-up surgery	0049	20.2784	$1,203.52		$240.70
25909	C		Amputation follow-up surgery					
25915	C		Amputation of forearm					
25920	C		Amputate hand at wrist					
25922	T		Amputate hand at wrist	0049	20.2784	$1,203.52		$240.70
25924	C		Amputation follow-up surgery					
25927	C		Amputation of hand					
25929	T		Amputation follow-up surgery	0686	13.7661	$817.02		$163.40
25931	C		Amputation follow-up surgery					
25999	T		Forearm or wrist surgery	0043	1.7614	$104.54		$20.91
26010	T		Drainage of finger abscess	0006	1.5430	$91.58	$22.18	$18.32
26011	T		Drainage of finger abscess	0007	11.3983	$676.49		$135.30
26020	T		Drain hand tendon sheath	0053	15.6085	$926.36	$253.49	$185.27
26025	T		Drainage of palm bursa	0053	15.6085	$926.36	$253.49	$185.27
26030	T		Drainage of palm bursa(s)	0053	15.6085	$926.36	$253.49	$185.27
26034	T		Treat hand bone lesion	0053	15.6085	$926.36	$253.49	$185.27
26035	T		Decompress fingers/hand	0053	15.6085	$926.36	$253.49	$185.27
26037	T		Decompress fingers/hand	0053	15.6085	$926.36	$253.49	$185.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26040	T		Release palm contracture	0054	25.2562	$1,498.96		$299.79
26045	T		Release palm contracture	0054	25.2562	$1,498.96		$299.79
26055	T		Incise finger tendon sheath	0053	15.6085	$926.36	$253.49	$185.27
26060	T		Incision of finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26070	T		Explore/treat hand joint	0053	15.6085	$926.36	$253.49	$185.27
26075	T		Explore/treat finger joint	0053	15.6085	$926.36	$253.49	$185.27
26080	T		Explore/treat finger joint	0053	15.6085	$926.36	$253.49	$185.27
26100	T		Biopsy hand joint lining	0053	15.6085	$926.36	$253.49	$185.27
26105	T		Biopsy finger joint lining	0053	15.6085	$926.36	$253.49	$185.27
26110	T		Biopsy finger joint lining	0053	15.6085	$926.36	$253.49	$185.27
26115	T		Removel hand lesion subcut	0022	19.5582	$1,160.78	$354.45	$232.16
26116	T		Removel hand lesion, deep	0022	19.5582	$1,160.78	$354.45	$232.16
26117	T		Remove tumor, hand/finger	0022	19.5582	$1,160.78	$354.45	$232.16
26121	T		Release palm contracture	0054	25.2562	$1,498.96		$299.79
26123	T		Release palm contracture	0054	25.2562	$1,498.96		$299.79
26125	T		Release palm contracture	0053	15.6085	$926.36	$253.49	$185.27
26130	T		Remove wrist joint lining	0053	15.6085	$926.36	$253.49	$185.27
26135	T		Revise finger joint, each	0054	25.2562	$1,498.96		$299.79
26140	T		Revise finger joint, each	0053	15.6085	$926.36	$253.49	$185.27
26145	T		Tendon excision, palm/finger	0053	15.6085	$926.36	$253.49	$185.27
26160	T		Remove tendon sheath lesion	0053	15.6085	$926.36	$253.49	$185.27
26170	T		Removal of palm tendon, each	0053	15.6085	$926.36	$253.49	$185.27
26180	T		Removal of finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26185	T		Remove finger bone	0053	15.6085	$926.36	$253.49	$185.27
26200	T		Remove hand bone lesion	0053	15.6085	$926.36	$253.49	$185.27
26205	T		Remove/graft bone lesion	0054	25.2562	$1,498.96		$299.79
26210	T		Removal of finger lesion	0053	15.6085	$926.36	$253.49	$185.27
26215	T		Remove/graft finger lesion	0053	15.6085	$926.36	$253.49	$185.27
26230	T		Partial removal of hand bone	0053	15.6085	$926.36	$253.49	$185.27
26235	T		Partial removal, finger bone	0053	15.6085	$926.36	$253.49	$185.27
26236	T		Partial removal, finger bone	0053	15.6085	$926.36	$253.49	$185.27
26250	T		Extensive hand surgery	0053	15.6085	$926.36	$253.49	$185.27
26255	T		Extensive hand surgery	0054	25.2562	$1,498.96		$299.79
26260	T		Extensive finger surgery	0053	15.6085	$926.36	$253.49	$185.27
26261	T		Extensive finger surgery	0053	15.6085	$926.36	$253.49	$185.27
26262	T		Partial removal of finger	0053	15.6085	$926.36	$253.49	$185.27
26320	T		Removal of implant from hand	0021	14.9098	$884.90	$219.48	$176.98
26340	T		Manipulate finger w/anesth	0043	1.7614	$104.54		$20.91
26350	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26352	T		Repair/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26356	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26357	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26358	T		Repair/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26370	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26372	T		Repair/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26373	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26390	T		Revise hand/finger tendon	0054	25.2562	$1,498.96		$299.79
26392	T		Repair/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26410	T		Repair hand tendon	0053	15.6085	$926.36	$253.49	$185.27
26412	T		Repair/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26415	T		Excision, hand/finger tendon	0054	25.2562	$1,498.96		$299.79
26416	T		Graft hand or finger tendon	0054	25.2562	$1,498.96		$299.79
26418	T		Repair finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26420	T		Repair/graft finger tendon	0054	25.2562	$1,498.96		$299.79
26426	T		Repair finger/hand tendon	0054	25.2562	$1,498.96		$299.79
26428	T		Repair/graft finger tendon	0054	25.2562	$1,498.96		$299.79
26432	T		Repair finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26433	T		Repair finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26434	T		Repair/graft finger tendon	0054	25.2562	$1,498.96		$299.79
26437	T		Realignment of tendons	0053	15.6085	$926.36	$253.49	$185.27
26440	T		Release palm/finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26442	T		Release palm & finger tendon	0054	25.2562	$1,498.96		$299.79
26445	T		Release hand/finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26449	T		Release forearm/hand tendon	0054	25.2562	$1,498.96		$299.79
26450	T		Incision of palm tendon	0053	15.6085	$926.36	$253.49	$185.27
26455	T		Incision of finger tendon	0053	15.6085	$926.36	$253.49	$185.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26460	T		Incise hand/finger tendon	0053	15.6085	$926.36	$253.49	$185.27
26471	T		Fusion of finger tendons	0053	15.6085	$926.36	$253.49	$185.27
26474	T		Fusion of finger tendons	0053	15.6085	$926.36	$253.49	$185.27
26476	T		Tendon lengthening	0053	15.6085	$926.36	$253.49	$185.27
26477	T		Tendon shortening	0053	15.6085	$926.36	$253.49	$185.27
26478	T		Lengthening of hand tendon	0053	15.6085	$926.36	$253.49	$185.27
26479	T		Shortening of hand tendon	0053	15.6085	$926.36	$253.49	$185.27
26480	T		Transplant hand tendon	0054	25.2562	$1,498.96		$299.79
26483	T		Transplant/graft hand tendon	0054	25.2562	$1,498.96		$299.79
26485	T		Transplant palm tendon	0054	25.2562	$1,498.96		$299.79
26489	T		Transplant/graft palm tendon	0054	25.2562	$1,498.96		$299.79
26490	T		Revise thumb tendon	0054	25.2562	$1,498.96		$299.79
26492	T		Tendon transfer with graft	0054	25.2562	$1,498.96		$299.79
26494	T		Hand tendon/muscle transfer	0054	25.2562	$1,498.96		$299.79
26496	T		Revise thumb tendon	0054	25.2562	$1,498.96		$299.79
26497	T		Finger tendon transfer	0054	25.2562	$1,498.96		$299.79
26498	T		Finger tendon transfer	0054	25.2562	$1,498.96		$299.79
26499	T		Revision of finger	0054	25.2562	$1,498.96		$299.79
26500	T		Hand tendon reconstruction	0053	15.6085	$926.36	$253.49	$185.27
26502	T		Hand tendon reconstruction	0054	25.2562	$1,498.96		$299.79
26504	T		Hand tendon reconstruction	0054	25.2562	$1,498.96		$299.79
26508	T		Release thumb contracture	0053	15.6085	$926.36	$253.49	$185.27
26510	T		Thumb tendon transfer	0054	25.2562	$1,498.96		$299.79
26516	T		Fusion of knuckle joint	0054	25.2562	$1,498.96		$299.79
26517	T		Fusion of knuckle joints	0054	25.2562	$1,498.96		$299.79
26518	T		Fusion of knuckle joints	0054	25.2562	$1,498.96		$299.79
26520	T		Release knuckle contracture	0053	15.6085	$926.36	$253.49	$185.27
26525	T		Release finger contracture	0053	15.6085	$926.36	$253.49	$185.27
26530	T		Revise knuckle joint	0047	31.4675	$1,867.60	$537.03	$373.52
26531	T		Revise knuckle with implant	0048	42.9335	$2,548.10	$570.30	$509.62
26535	T		Revise finger joint	0047	31.4675	$1,867.60	$537.03	$373.52
26536	T		Revise/implant finger joint	0048	42.9335	$2,548.10	$570.30	$509.62
26540	T		Repair hand joint	0053	15.6085	$926.36	$253.49	$185.27
26541	T		Repair hand joint with graft	0054	25.2562	$1,498.96		$299.79
26542	T		Repair hand joint with graft	0053	15.6085	$926.36	$253.49	$185.27
26545	T		Reconstruct finger joint	0054	25.2562	$1,498.96		$299.79
26546	T		Repair nonunion hand	0054	25.2562	$1,498.96		$299.79
26548	T		Reconstruct finger joint	0054	25.2562	$1,498.96		$299.79
26550	T		Construct thumb replacement	0054	25.2562	$1,498.96		$299.79
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	25.2562	$1,498.96		$299.79
26556	C		Toe joint transfer					
26560	T		Repair of web finger	0053	15.6085	$926.36	$253.49	$185.27
26561	T		Repair of web finger	0054	25.2562	$1,498.96		$299.79
26562	T		Repair of web finger	0054	25.2562	$1,498.96		$299.79
26565	T		Correct metacarpal flaw	0054	25.2562	$1,498.96		$299.79
26567	T		Correct finger deformity	0054	25.2562	$1,498.96		$299.79
26568	T		Lengthen metacarpal/finger	0054	25.2562	$1,498.96		$299.79
26580	T		Repair hand deformity	0053	15.6085	$926.36	$253.49	$185.27
26587	T		Reconstruct extra finger	0053	15.6085	$926.36	$253.49	$185.27
26590	T		Repair finger deformity	0053	15.6085	$926.36	$253.49	$185.27
26591	T		Repair muscles of hand	0054	25.2562	$1,498.96		$299.79
26593	T		Release muscles of hand	0053	15.6085	$926.36	$253.49	$185.27
26596	T		Excision constricting tissue	0053	15.6085	$926.36	$253.49	$185.27
26600	T		Treat metacarpal fracture	0043	1.7614	$104.54		$20.91
26605	T		Treat metacarpal fracture	0043	1.7614	$104.54		$20.91
26607	T		Treat metacarpal fracture	0043	1.7614	$104.54		$20.91
26608	T		Treat metacarpal fracture	0046	37.5315	$2,227.49	$535.76	$445.50
26615	T		Treat metacarpal fracture	0046	37.5315	$2,227.49	$535.76	$445.50
26641	T		Treat thumb dislocation	0043	1.7614	$104.54		$20.91
26645	T		Treat thumb fracture	0043	1.7614	$104.54		$20.91
26650	T		Treat thumb fracture	0046	37.5315	$2,227.49	$535.76	$445.50
26665	T		Treat thumb fracture	0046	37.5315	$2,227.49	$535.76	$445.50
26670	T		Treat hand dislocation	0043	1.7614	$104.54		$20.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
26675	T		Treat hand dislocation	0043	1.7614	$104.54		$20.91
26676	T		Pin hand dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26685	T		Treat hand dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26686	T		Treat hand dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26700	T		Treat knuckle dislocation	0043	1.7614	$104.54		$20.91
26705	T		Treat knuckle dislocation	0043	1.7614	$104.54		$20.91
26706	T		Pin knuckle dislocation	0043	1.7614	$104.54		$20.91
26715	T		Treat knuckle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26720	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26725	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26727	T		Treat finger fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
26735	T		Treat finger fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
26740	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26742	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26746	T		Treat finger fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
26750	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26755	T		Treat finger fracture, each	0043	1.7614	$104.54		$20.91
26756	T		Pin finger fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
26765	T		Treat finger fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
26770	T		Treat finger dislocation	0043	1.7614	$104.54		$20.91
26775	T		Treat finger dislocation	0045	14.4289	$856.36	$268.47	$171.27
26776	T		Pin finger dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26785	T		Treat finger dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
26820	T		Thumb fusion with graft	0054	25.2562	$1,498.96		$299.79
26841	T		Fusion of thumb	0054	25.2562	$1,498.96		$299.79
26842	T		Thumb fusion with graft	0054	25.2562	$1,498.96		$299.79
26843	T		Fusion of hand joint	0054	25.2562	$1,498.96		$299.79
26844	T		Fusion/graft of hand joint	0054	25.2562	$1,498.96		$299.79
26850	T		Fusion of knuckle	0054	25.2562	$1,498.96		$299.79
26852	T		Fusion of knuckle with graft	0054	25.2562	$1,498.96		$299.79
26860	T		Fusion of finger joint	0054	25.2562	$1,498.96		$299.79
26861	T		Fusion of finger jnt, add-on	0054	25.2562	$1,498.96		$299.79
26862	T		Fusion/graft of finger joint	0054	25.2562	$1,498.96		$299.79
26863	T		Fuse/graft added joint	0054	25.2562	$1,498.96		$299.79
26910	T		Amputate metacarpal bone	0054	25.2562	$1,498.96		$299.79
26951	T		Amputation of finger/thumb	0053	15.6085	$926.36	$253.49	$185.27
26952	T		Amputation of finger/thumb	0053	15.6085	$926.36	$253.49	$185.27
26989	T		Hand/finger surgery	0043	1.7614	$104.54		$20.91
26990	T		Drainage of pelvis lesion	0049	20.2784	$1,203.52		$240.70
26991	T		Drainage of pelvis bursa	0049	20.2784	$1,203.52		$240.70
26992	C		Drainage of bone lesion					
27000	T		Incision of hip tendon	0049	20.2784	$1,203.52		$240.70
27001	T		Incision of hip tendon	0050	23.7998	$1,412.52		$282.50
27003	T		Incision of hip tendon	0050	23.7998	$1,412.52		$282.50
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	36.3617	$2,158.07		$431.61
27035	T		Denervation of hip joint	0052	43.7388	$2,595.90		$519.18
27036	C		Excision of hip joint/muscle					
27040	T		Biopsy of soft tissues	0020	6.9118	$410.22	$106.93	$82.04
27041	T		Biopsy of soft tissues	0020	6.9118	$410.22	$106.93	$82.04
27047	T		Remove hip/pelvis lesion	0022	19.5582	$1,160.78	$354.45	$232.16
27048	T		Remove hip/pelvis lesion	0022	19.5582	$1,160.78	$354.45	$232.16
27049	T		Remove tumor, hip/pelvis	0022	19.5582	$1,160.78	$354.45	$232.16
27050	T		Biopsy of sacroiliac joint	0049	20.2784	$1,203.52		$240.70
27052	T		Biopsy of hip joint	0049	20.2784	$1,203.52		$240.70
27054	C		Removal of hip joint lining					
27060	T		Removal of ischial bursa	0049	20.2784	$1,203.52		$240.70
27062	T		Remove femur lesion/bursa	0049	20.2784	$1,203.52		$240.70
27065	T		Removal of hip bone lesion	0049	20.2784	$1,203.52		$240.70
27066	T		Removal of hip bone lesion	0050	23.7998	$1,412.52		$282.50
27067	T		Remove/graft hip bone lesion	0050	23.7998	$1,412.52		$282.50
27070	C		Partial removal of hip bone					
27071	C		Partial removal of hip bone					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	23.7998	$1,412.52		$282.50
27086	T		Remove hip foreign body	0020	6.9118	$410.22	$106.93	$82.04
27087	T		Remove hip foreign body	0049	20.2784	$1,203.52		$240.70
27090	C		Removal of hip prosthesis					
27091	C		Removal of hip prosthesis					
27093	N		Injection for hip x-ray					
27095	N		Injection for hip x-ray					
27096	B		Inject sacroiliac joint					
27097	T		Revision of hip tendon	0050	23.7998	$1,412.52		$282.50
27098	T		Transfer tendon to pelvis	0050	23.7998	$1,412.52		$282.50
27100	T		Transfer of abdominal muscle	0051	36.3617	$2,158.07		$431.61
27105	T		Transfer of spinal muscle	0051	36.3617	$2,158.07		$431.61
27110	T		Transfer of iliopsoas muscle	0051	36.3617	$2,158.07		$431.61
27111	T		Transfer of iliopsoas muscle	0051	36.3617	$2,158.07		$431.61
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	1.7614	$104.54		$20.91
27194	T		Treat pelvic ring fracture	0045	14.4289	$856.36	$268.47	$171.27
27200	T		Treat tail bone fracture	0043	1.7614	$104.54		$20.91
27202	T		Treat tail bone fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27215	C		Treat pelvic fracture(s)					
27216	T		Treat pelvic ring fracture	0050	23.7998	$1,412.52		$282.50
27217	C		Treat pelvic ring fracture					
27218	C		Treat pelvic ring fracture					
27220	T		Treat hip socket fracture	0043	1.7614	$104.54		$20.91
27222	C		Treat hip socket fracture					
27226	C		Treat hip wall fracture					
27227	C		Treat hip fracture(s)					
27228	C		Treat hip fracture(s)					
27230	T		Treat thigh fracture	0043	1.7614	$104.54		$20.91
27232	C		Treat thigh fracture					
27235	T		Treat thigh fracture	0050	23.7998	$1,412.52		$282.50
27236	C		Treat thigh fracture					
27238	T		Treat thigh fracture	0043	1.7614	$104.54		$20.91
27240	C		Treat thigh fracture					
27244	C		Treat thigh fracture					
27245	C		Treat thigh fracture					
27246	T		Treat thigh fracture	0043	1.7614	$104.54		$20.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27248	C		Treat thigh fracture					
27250	T		Treat hip dislocation	0043	1.7614	$104.54		$20.91
27252	T		Treat hip dislocation	0045	14.4289	$856.36	$268.47	$171.27
27253	C		Treat hip dislocation					
27254	C		Treat hip dislocation					
27256	T		Treat hip dislocation	0043	1.7614	$104.54		$20.91
27257	T		Treat hip dislocation	0045	14.4289	$856.36	$268.47	$171.27
27258	C		Treat hip dislocation					
27259	C		Treat hip dislocation					
27265	T		Treat hip dislocation	0043	1.7614	$104.54		$20.91
27266	T		Treat hip dislocation	0045	14.4289	$856.36	$268.47	$171.27
27275	T		Manipulation of hip joint	0045	14.4289	$856.36	$268.47	$171.27
27280	C		Fusion of sacroiliac joint					
27282	C		Fusion of pubic bones					
27284	C		Fusion of hip joint					
27286	C		Fusion of hip joint					
27290	C		Amputation of leg at hip					
27295	C		Amputation of leg at hip					
27299	T		Pelvis/hip joint surgery	0043	1.7614	$104.54		$20.91
27301	T		Drain thigh/knee lesion	0008	16.4242	$974.78		$194.96
27303	C		Drainage of bone lesion					
27305	T		Incise thigh tendon & fascia	0049	20.2784	$1,203.52		$240.70
27306	T		Incision of thigh tendon	0049	20.2784	$1,203.52		$240.70
27307	T		Incision of thigh tendons	0049	20.2784	$1,203.52		$240.70
27310	T		Exploration of knee joint	0050	23.7998	$1,412.52		$282.50
27315	T		Partial removal, thigh nerve	0220	17.2800	$1,025.57		$205.11
27320	T		Partial removal, thigh nerve	0220	17.2800	$1,025.57		$205.11
27323	T		Biopsy, thigh soft tissues	0021	14.9098	$884.90	$219.48	$176.98
27324	T		Biopsy, thigh soft tissues	0022	19.5582	$1,160.78	$354.45	$232.16
27327	T		Removal of thigh lesion	0022	19.5582	$1,160.78	$354.45	$232.16
27328	T		Removal of thigh lesion	0022	19.5582	$1,160.78	$354.45	$232.16
27329	T		Remove tumor, thigh/knee	0022	19.5582	$1,160.78	$354.45	$232.16
27330	T		Biopsy, knee joint lining	0050	23.7998	$1,412.52		$282.50
27331	T		Explore/treat knee joint	0050	23.7998	$1,412.52		$282.50
27332	T		Removal of knee cartilage	0050	23.7998	$1,412.52		$282.50
27333	T		Removal of knee cartilage	0050	23.7998	$1,412.52		$282.50
27334	T		Remove knee joint lining	0050	23.7998	$1,412.52		$282.50
27335	T		Remove knee joint lining	0050	23.7998	$1,412.52		$282.50
27340	T		Removal of kneecap bursa	0049	20.2784	$1,203.52		$240.70
27345	T		Removal of knee cyst	0049	20.2784	$1,203.52		$240.70
27347	T		Remove knee cyst	0049	20.2784	$1,203.52		$240.70
27350	T		Removal of kneecap	0050	23.7998	$1,412.52		$282.50
27355	T		Remove femur lesion	0050	23.7998	$1,412.52		$282.50
27356	T		Remove femur lesion/graft	0050	23.7998	$1,412.52		$282.50
27357	T		Remove femur lesion/graft	0050	23.7998	$1,412.52		$282.50
27358	T		Remove femur lesion/fixation	0050	23.7998	$1,412.52		$282.50
27360	T		Partial removal, leg bone(s)	0050	23.7998	$1,412.52		$282.50
27365	C		Extensive leg surgery					
27370	N		Injection for knee x-ray					
27372	T		Removal of foreign body	0022	19.5582	$1,160.78	$354.45	$232.16
27380	T		Repair of kneecap tendon	0049	20.2784	$1,203.52		$240.70
27381	T		Repair/graft kneecap tendon	0049	20.2784	$1,203.52		$240.70
27385	T		Repair of thigh muscle	0049	20.2784	$1,203.52		$240.70
27386	T		Repair/graft of thigh muscle	0049	20.2784	$1,203.52		$240.70
27390	T		Incision of thigh tendon	0049	20.2784	$1,203.52		$240.70
27391	T		Incision of thigh tendons	0049	20.2784	$1,203.52		$240.70
27392	T		Incision of thigh tendons	0049	20.2784	$1,203.52		$240.70
27393	T		Lengthening of thigh tendon	0050	23.7998	$1,412.52		$282.50
27394	T		Lengthening of thigh tendons	0050	23.7998	$1,412.52		$282.50
27395	T		Lengthening of thigh tendons	0051	36.3617	$2,158.07		$431.61
27396	T		Transplant of thigh tendon	0050	23.7998	$1,412.52		$282.50
27397	T		Transplants of thigh tendons	0051	36.3617	$2,158.07		$431.61
27400	T		Revise thigh muscles/tendons	0051	36.3617	$2,158.07		$431.61
27403	T		Repair of knee cartilage	0050	23.7998	$1,412.52		$282.50
27405	T		Repair of knee ligament	0051	36.3617	$2,158.07		$431.61
27407	T		Repair of knee ligament	0051	36.3617	$2,158.07		$431.61

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27409	T		Repair of knee ligaments	0051	36.3617	$2,158.07		$431.61
27412	T		Autochondrocyte implant knee	0042	43.7761	$2,598.11	$804.74	$519.62
27415	T		Osteochondral knee allograft	0042	43.7761	$2,598.11	$804.74	$519.62
27418	T		Repair degenerated kneecap	0051	36.3617	$2,158.07		$431.61
27420	T		Revision of unstable kneecap	0051	36.3617	$2,158.07		$431.61
27422	T		Revision of unstable kneecap	0051	36.3617	$2,158.07		$431.61
27424	T		Revision/removal of kneecap	0051	36.3617	$2,158.07		$431.61
27425	T		Lateral retinacular release	0050	23.7998	$1,412.52		$282.50
27427	T		Reconstruction, knee	0052	43.7388	$2,595.90		$519.18
27428	T		Reconstruction, knee	0052	43.7388	$2,595.90		$519.18
27429	T		Reconstruction, knee	0052	43.7388	$2,595.90		$519.18
27430	T		Revision of thigh muscles	0051	36.3617	$2,158.07		$431.61
27435	T		Incision of knee joint	0051	36.3617	$2,158.07		$431.61
27437	T		Revise kneecap	0047	31.4675	$1,867.60	$537.03	$373.52
27438	T		Revise kneecap with implant	0048	42.9335	$2,548.10	$570.30	$509.62
27440	T		Revision of knee joint	0047	31.4675	$1,867.60	$537.03	$373.52
27441	T		Revision of knee joint	0047	31.4675	$1,867.60	$537.03	$373.52
27442	T		Revision of knee joint	0047	31.4675	$1,867.60	$537.03	$373.52
27443	T		Revision of knee joint	0047	31.4675	$1,867.60	$537.03	$373.52
27445	C		Revision of knee joint					
27446	T		Revision of knee joint	0681	136.5417	$8,103.75	$2,081.48	$1,620.75
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	T		Surgery to stop leg growth	0050	23.7998	$1,412.52		$282.50
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	20.2784	$1,203.52		$240.70
27497	T		Decompression of thigh/knee	0049	20.2784	$1,203.52		$240.70
27498	T		Decompression of thigh/knee	0049	20.2784	$1,203.52		$240.70
27499	T		Decompression of thigh/knee	0049	20.2784	$1,203.52		$240.70
27500	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27501	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27502	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27503	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27506	C		Treatment of thigh fracture					
27507	C		Treatment of thigh fracture					
27508	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27509	T		Treatment of thigh fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27510	T		Treatment of thigh fracture	0043	1.7614	$104.54		$20.91
27511	C		Treatment of thigh fracture					
27513	C		Treatment of thigh fracture					
27514	C		Treatment of thigh fracture					
27516	T		Treat thigh fx growth plate	0043	1.7614	$104.54		$20.91
27517	T		Treat thigh fx growth plate	0043	1.7614	$104.54		$20.91
27519	C		Treat thigh fx growth plate					
27520	T		Treat kneecap fracture	0043	1.7614	$104.54		$20.91
27524	T		Treat kneecap fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27530	T		Treat knee fracture	0043	1.7614	$104.54		$20.91
27532	T		Treat knee fracture	0043	1.7614	$104.54		$20.91
27535	C		Treat knee fracture					
27536	C		Treat knee fracture					
27538	T		Treat knee fracture(s)	0043	1.7614	$104.54		$20.91

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27540	C		Treat knee fracture					
27550	T		Treat knee dislocation	0043	1.7614	$104.54		$20.91
27552	T		Treat knee dislocation	0045	14.4289	$856.36	$268.47	$171.27
27556	C		Treat knee dislocation					
27557	C		Treat knee dislocation					
27558	C		Treat knee dislocation					
27560	T		Treat kneecap dislocation	0043	1.7614	$104.54		$20.91
27562	T		Treat kneecap dislocation	0045	14.4289	$856.36	$268.47	$171.27
27566	T		Treat kneecap dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
27570	T		Fixation of knee joint	0045	14.4289	$856.36	$268.47	$171.27
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	20.2784	$1,203.52		$240.70
27596	C		Amputation follow-up surgery					
27598	C		Amputate lower leg at knee					
27599	T		Leg surgery procedure	0043	1.7614	$104.54		$20.91
27600	T		Decompression of lower leg	0049	20.2784	$1,203.52		$240.70
27601	T		Decompression of lower leg	0049	20.2784	$1,203.52		$240.70
27602	T		Decompression of lower leg	0049	20.2784	$1,203.52		$240.70
27603	T		Drain lower leg lesion	0008	16.4242	$974.78		$194.96
27604	T		Drain lower leg bursa	0049	20.2784	$1,203.52		$240.70
27605	T		Incision of achilles tendon	0055	19.9783	$1,185.71	$355.34	$237.14
27606	T		Incision of achilles tendon	0049	20.2784	$1,203.52		$240.70
27607	T		Treat lower leg bone lesion	0049	20.2784	$1,203.52		$240.70
27610	T		Explore/treat ankle joint	0050	23.7998	$1,412.52		$282.50
27612	T		Exploration of ankle joint	0050	23.7998	$1,412.52		$282.50
27613	T		Biopsy lower leg soft tissue	0020	6.9118	$410.22	$106.93	$82.04
27614	T		Biopsy lower leg soft tissue	0022	19.5582	$1,160.78	$354.45	$232.16
27615	T		Remove tumor, lower leg	0046	37.5315	$2,227.49	$535.76	$445.50
27618	T		Remove lower leg lesion	0021	14.9098	$884.90	$219.48	$176.98
27619	T		Remove lower leg lesion	0022	19.5582	$1,160.78	$354.45	$232.16
27620	T		Explore/treat ankle joint	0050	23.7998	$1,412.52		$282.50
27625	T		Remove ankle joint lining	0050	23.7998	$1,412.52		$282.50
27626	T		Remove ankle joint lining	0050	23.7998	$1,412.52		$282.50
27630	T		Removal of tendon lesion	0049	20.2784	$1,203.52		$240.70
27635	T		Remove lower leg bone lesion	0050	23.7998	$1,412.52		$282.50
27637	T		Remove/graft leg bone lesion	0050	23.7998	$1,412.52		$282.50
27638	T		Remove/graft leg bone lesion	0050	23.7998	$1,412.52		$282.50
27640	T		Partial removal of tibia	0051	36.3617	$2,158.07		$431.61
27641	T		Partial removal of fibula	0050	23.7998	$1,412.52		$282.50
27645	C		Extensive lower leg surgery					
27646	C		Extensive lower leg surgery					
27647	T		Extensive ankle/heel surgery	0051	36.3617	$2,158.07		$431.61
27648	N		Injection for ankle x-ray					
27650	T		Repair achilles tendon	0051	36.3617	$2,158.07		$431.61
27652	T		Repair/graft achilles tendon	0051	36.3617	$2,158.07		$431.61
27654	T		Repair of achilles tendon	0051	36.3617	$2,158.07		$431.61
27656	T		Repair leg fascia defect	0049	20.2784	$1,203.52		$240.70
27658	T		Repair of leg tendon, each	0049	20.2784	$1,203.52		$240.70
27659	T		Repair of leg tendon, each	0049	20.2784	$1,203.52		$240.70
27664	T		Repair of leg tendon, each	0049	20.2784	$1,203.52		$240.70
27665	T		Repair of leg tendon, each	0050	23.7998	$1,412.52		$282.50
27675	T		Repair lower leg tendons	0049	20.2784	$1,203.52		$240.70
27676	T		Repair lower leg tendons	0050	23.7998	$1,412.52		$282.50
27680	T		Release of lower leg tendon	0050	23.7998	$1,412.52		$282.50
27681	T		Release of lower leg tendons	0050	23.7998	$1,412.52		$282.50
27685	T		Revision of lower leg tendon	0050	23.7998	$1,412.52		$282.50
27686	T		Revise lower leg tendons	0050	23.7998	$1,412.52		$282.50
27687	T		Revision of calf tendon	0050	23.7998	$1,412.52		$282.50
27690	T		Revise lower leg tendon	0051	36.3617	$2,158.07		$431.61
27691	T		Revise lower leg tendon	0051	36.3617	$2,158.07		$431.61
27692	T		Revise additional leg tendon	0051	36.3617	$2,158.07		$431.61
27695	T		Repair of ankle ligament	0050	23.7998	$1,412.52		$282.50
27696	T		Repair of ankle ligaments	0050	23.7998	$1,412.52		$282.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27698	T		Repair of ankle ligament	0050	23.7998	$1,412.52		$282.50
27700	T		Revision of ankle joint	0047	31.4675	$1,867.60	$537.03	$373.52
27702	C		Reconstruct ankle joint					
27703	C		Reconstruction, ankle joint					
27704	T		Removal of ankle implant	0049	20.2784	$1,203.52		$240.70
27705	T		Incision of tibia	0051	36.3617	$2,158.07		$431.61
27707	T		Incision of fibula	0049	20.2784	$1,203.52		$240.70
27709	T		Incision of tibia & fibula	0050	23.7998	$1,412.52		$282.50
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	23.7998	$1,412.52		$282.50
27732	T		Repair of fibula epiphysis	0050	23.7998	$1,412.52		$282.50
27734	T		Repair lower leg epiphyses	0050	23.7998	$1,412.52		$282.50
27740	T		Repair of leg epiphyses	0050	23.7998	$1,412.52		$282.50
27742	T		Repair of leg epiphyses	0051	36.3617	$2,158.07		$431.61
27745	T		Reinforce tibia	0051	36.3617	$2,158.07		$431.61
27750	T		Treatment of tibia fracture	0043	1.7614	$104.54		$20.91
27752	T		Treatment of tibia fracture	0043	1.7614	$104.54		$20.91
27756	T		Treatment of tibia fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27758	T		Treatment of tibia fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27759	T		Treatment of tibia fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27760	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27762	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27766	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27780	T		Treatment of fibula fracture	0043	1.7614	$104.54		$20.91
27781	T		Treatment of fibula fracture	0043	1.7614	$104.54		$20.91
27784	T		Treatment of fibula fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27786	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27788	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27792	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27808	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27810	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27814	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27816	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27818	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
27822	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27823	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27824	T		Treat lower leg fracture	0043	1.7614	$104.54		$20.91
27825	T		Treat lower leg fracture	0043	1.7614	$104.54		$20.91
27826	T		Treat lower leg fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27827	T		Treat lower leg fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27828	T		Treat lower leg fracture	0046	37.5315	$2,227.49	$535.76	$445.50
27829	T		Treat lower leg joint	0046	37.5315	$2,227.49	$535.76	$445.50
27830	T		Treat lower leg dislocation	0043	1.7614	$104.54		$20.91
27831	T		Treat lower leg dislocation	0043	1.7614	$104.54		$20.91
27832	T		Treat lower leg dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
27840	T		Treat ankle dislocation	0043	1.7614	$104.54		$20.91
27842	T		Treat ankle dislocation	0045	14.4289	$856.36	$268.47	$171.27
27846	T		Treat ankle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
27848	T		Treat ankle dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
27860	T		Fixation of ankle joint	0045	14.4289	$856.36	$268.47	$171.27
27870	T		Fusion of ankle joint	0051	36.3617	$2,158.07		$431.61
27871	T		Fusion of tibiofibular joint	0051	36.3617	$2,158.07		$431.61
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	20.2784	$1,203.52		$240.70
27886	C		Amputation follow-up surgery					
27888	C		Amputation of foot at ankle					
27889	T		Amputation of foot at ankle	0050	23.7998	$1,412.52		$282.50
27892	T		Decompression of leg	0049	20.2784	$1,203.52		$240.70

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
27893	T		Decompression of leg	0049	20.2784	$1,203.52		$240.70
27894	T		Decompression of leg	0049	20.2784	$1,203.52		$240.70
27899	T		Leg/ankle surgery procedure	0043	1.7614	$104.54		$20.91
28001	T		Drainage of bursa of foot	0007	11.3983	$676.49		$135.30
28002	T		Treatment of foot infection	0049	20.2784	$1,203.52		$240.70
28003	T		Treatment of foot infection	0049	20.2784	$1,203.52		$240.70
28005	T		Treat foot bone lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28008	T		Incision of foot fascia	0055	19.9783	$1,185.71	$355.34	$237.14
28010	T		Incision of toe tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28011	T		Incision of toe tendons	0055	19.9783	$1,185.71	$355.34	$237.14
28020	T		Exploration of foot joint	0055	19.9783	$1,185.71	$355.34	$237.14
28022	T		Exploration of foot joint	0055	19.9783	$1,185.71	$355.34	$237.14
28024	T		Exploration of toe joint	0055	19.9783	$1,185.71	$355.34	$237.14
28030	T		Removal of foot nerve	0220	17.2800	$1,025.57		$205.11
28035	T		Decompression of tibia nerve	0220	17.2800	$1,025.57		$205.11
28043	T		Excision of foot lesion	0021	14.9098	$884.90	$219.48	$176.98
28045	T		Excision of foot lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28046	T		Resection of tumor, foot	0055	19.9783	$1,185.71	$355.34	$237.14
28050	T		Biopsy of foot joint lining	0055	19.9783	$1,185.71	$355.34	$237.14
28052	T		Biopsy of foot joint lining	0055	19.9783	$1,185.71	$355.34	$237.14
28054	T		Biopsy of toe joint lining	0055	19.9783	$1,185.71	$355.34	$237.14
28060	T		Partial removal, foot fascia	0055	19.9783	$1,185.71	$355.34	$237.14
28062	T		Removal of foot fascia	0055	19.9783	$1,185.71	$355.34	$237.14
28070	T		Removal of foot joint lining	0055	19.9783	$1,185.71	$355.34	$237.14
28072	T		Removal of foot joint lining	0055	19.9783	$1,185.71	$355.34	$237.14
28080	T		Removal of foot lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28086	T		Excise foot tendon sheath	0055	19.9783	$1,185.71	$355.34	$237.14
28088	T		Excise foot tendon sheath	0055	19.9783	$1,185.71	$355.34	$237.14
28090	T		Removal of foot lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28092	T		Removal of toe lesions	0055	19.9783	$1,185.71	$355.34	$237.14
28100	T		Removal of ankle/heel lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28102	T		Remove/graft foot lesion	0056	40.1132	$2,380.72		$476.14
28103	T		Remove/graft foot lesion	0056	40.1132	$2,380.72		$476.14
28104	T		Removal of foot lesion	0055	19.9783	$1,185.71	$355.34	$237.14
28106	T		Remove/graft foot lesion	0056	40.1132	$2,380.72		$476.14
28107	T		Remove/graft foot lesion	0056	40.1132	$2,380.72		$476.14
28108	T		Removal of toe lesions	0055	19.9783	$1,185.71	$355.34	$237.14
28110	T		Part removal of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28111	T		Part removal of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28112	T		Part removal of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28113	T		Part removal of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28114	T		Removal of metatarsal heads	0055	19.9783	$1,185.71	$355.34	$237.14
28116	T		Revision of foot	0055	19.9783	$1,185.71	$355.34	$237.14
28118	T		Removal of heel bone	0055	19.9783	$1,185.71	$355.34	$237.14
28119	T		Removal of heel spur	0055	19.9783	$1,185.71	$355.34	$237.14
28120	T		Part removal of ankle/heel	0055	19.9783	$1,185.71	$355.34	$237.14
28122	T		Partial removal of foot bone	0055	19.9783	$1,185.71	$355.34	$237.14
28124	T		Partial removal of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28126	T		Partial removal of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28130	T		Removal of ankle bone	0055	19.9783	$1,185.71	$355.34	$237.14
28140	T		Removal of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28150	T		Removal of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28153	T		Partial removal of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28160	T		Partial removal of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28171	T		Extensive foot surgery	0055	19.9783	$1,185.71	$355.34	$237.14
28173	T		Extensive foot surgery	0055	19.9783	$1,185.71	$355.34	$237.14
28175	T		Extensive foot surgery	0055	19.9783	$1,185.71	$355.34	$237.14
28190	T		Removal of foot foreign body	0019	4.0363	$239.55	$71.87	$47.91
28192	T		Removal of foot foreign body	0021	14.9098	$884.90	$219.48	$176.98
28193	T		Removal of foot foreign body	0020	6.9118	$410.22	$106.93	$82.04
28200	T		Repair of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28202	T		Repair/graft of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28208	T		Repair of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28210	T		Repair/graft of foot tendon	0056	40.1132	$2,380.72		$476.14
28220	T		Release of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28222	T		Release of foot tendons	0055	19.9783	$1,185.71	$355.34	$237.14

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28225	T		Release of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28226	T		Release of foot tendons	0055	19.9783	$1,185.71	$355.34	$237.14
28230	T		Incision of foot tendon(s)	0055	19.9783	$1,185.71	$355.34	$237.14
28232	T		Incision of toe tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28234	T		Incision of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28238	T		Revision of foot tendon	0056	40.1132	$2,380.72		$476.14
28240	T		Release of big toe	0055	19.9783	$1,185.71	$355.34	$237.14
28250	T		Revision of foot fascia	0055	19.9783	$1,185.71	$355.34	$237.14
28260	T		Release of midfoot joint	0055	19.9783	$1,185.71	$355.34	$237.14
28261	T		Revision of foot tendon	0055	19.9783	$1,185.71	$355.34	$237.14
28262	T		Revision of foot and ankle	0055	19.9783	$1,185.71	$355.34	$237.14
28264	T		Release of midfoot joint	0056	40.1132	$2,380.72		$476.14
28270	T		Release of foot contracture	0055	19.9783	$1,185.71	$355.34	$237.14
28272	T		Release of toe joint, each	0055	19.9783	$1,185.71	$355.34	$237.14
28280	T		Fusion of toes	0055	19.9783	$1,185.71	$355.34	$237.14
28285	T		Repair of hammertoe	0055	19.9783	$1,185.71	$355.34	$237.14
28286	T		Repair of hammertoe	0055	19.9783	$1,185.71	$355.34	$237.14
28288	T		Partial removal of foot bone	0055	19.9783	$1,185.71	$355.34	$237.14
28289	T		Repair hallux rigidus	0055	19.9783	$1,185.71	$355.34	$237.14
28290	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28292	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28293	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28294	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28296	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28297	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28298	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28299	T		Correction of bunion	0057	27.4246	$1,627.65	$475.91	$325.53
28300	T		Incision of heel bone	0056	40.1132	$2,380.72		$476.14
28302	T		Incision of ankle bone	0055	19.9783	$1,185.71	$355.34	$237.14
28304	T		Incision of midfoot bones	0056	40.1132	$2,380.72		$476.14
28305	T		Incise/graft midfoot bones	0056	40.1132	$2,380.72		$476.14
28306	T		Incision of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28307	T		Incision of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28308	T		Incision of metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28309	T		Incision of metatarsals	0056	40.1132	$2,380.72		$476.14
28310	T		Revision of big toe	0055	19.9783	$1,185.71	$355.34	$237.14
28312	T		Revision of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28313	T		Repair deformity of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28315	T		Removal of sesamoid bone	0055	19.9783	$1,185.71	$355.34	$237.14
28320	T		Repair of foot bones	0056	40.1132	$2,380.72		$476.14
28322	T		Repair of metatarsals	0056	40.1132	$2,380.72		$476.14
28340	T		Resect enlarged toe tissue	0055	19.9783	$1,185.71	$355.34	$237.14
28341	T		Resect enlarged toe	0055	19.9783	$1,185.71	$355.34	$237.14
28344	T		Repair extra toe(s)	0055	19.9783	$1,185.71	$355.34	$237.14
28345	T		Repair webbed toe(s)	0055	19.9783	$1,185.71	$355.34	$237.14
28360	T		Reconstruct cleft foot	0056	40.1132	$2,380.72		$476.14
28400	T		Treatment of heel fracture	0043	1.7614	$104.54		$20.91
28405	T		Treatment of heel fracture	0043	1.7614	$104.54		$20.91
28406	T		Treatment of heel fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28415	T		Treat heel fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28420	T		Treat/graft heel fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28430	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
28435	T		Treatment of ankle fracture	0043	1.7614	$104.54		$20.91
28436	T		Treatment of ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28445	T		Treat ankle fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28450	T		Treat midfoot fracture, each	0043	1.7614	$104.54		$20.91
28455	T		Treat midfoot fracture, each	0043	1.7614	$104.54		$20.91
28456	T		Treat midfoot fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28465	T		Treat midfoot fracture, each	0046	37.5315	$2,227.49	$535.76	$445.50
28470	T		Treat metatarsal fracture	0043	1.7614	$104.54		$20.91
28475	T		Treat metatarsal fracture	0043	1.7614	$104.54		$20.91
28476	T		Treat metatarsal fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28485	T		Treat metatarsal fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28490	T		Treat big toe fracture	0043	1.7614	$104.54		$20.91
28495	T		Treat big toe fracture	0043	1.7614	$104.54		$20.91
28496	T		Treat big toe fracture	0046	37.5315	$2,227.49	$535.76	$445.50

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
28505	T		Treat big toe fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28510	T		Treatment of toe fracture	0043	1.7614	$104.54		$20.91
28515	T		Treatment of toe fracture	0043	1.7614	$104.54		$20.91
28525	T		Treat toe fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28530	T		Treat sesamoid bone fracture	0043	1.7614	$104.54		$20.91
28531	T		Treat sesamoid bone fracture	0046	37.5315	$2,227.49	$535.76	$445.50
28540	T		Treat foot dislocation	0043	1.7614	$104.54		$20.91
28545	T		Treat foot dislocation	0045	14.4289	$856.36	$268.47	$171.27
28546	T		Treat foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28555	T		Repair foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28570	T		Treat foot dislocation	0043	1.7614	$104.54		$20.91
28575	T		Treat foot dislocation	0043	1.7614	$104.54		$20.91
28576	T		Treat foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28585	T		Repair foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28600	T		Treat foot dislocation	0043	1.7614	$104.54		$20.91
28605	T		Treat foot dislocation	0043	1.7614	$104.54		$20.91
28606	T		Treat foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28615	T		Repair foot dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28630	T		Treat toe dislocation	0043	1.7614	$104.54		$20.91
28635	T		Treat toe dislocation	0045	14.4289	$856.36	$268.47	$171.27
28636	T		Treat toe dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28645	T		Repair toe dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28660	T		Treat toe dislocation	0043	1.7614	$104.54		$20.91
28665	T		Treat toe dislocation	0045	14.4289	$856.36	$268.47	$171.27
28666	T		Treat toe dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28675	T		Repair of toe dislocation	0046	37.5315	$2,227.49	$535.76	$445.50
28705	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28715	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28725	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28730	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28735	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28737	T		Revision of foot bones	0056	40.1132	$2,380.72		$476.14
28740	T		Fusion of foot bones	0056	40.1132	$2,380.72		$476.14
28750	T		Fusion of big toe joint	0056	40.1132	$2,380.72		$476.14
28755	T		Fusion of big toe joint	0055	19.9783	$1,185.71	$355.34	$237.14
28760	T		Fusion of big toe joint	0056	40.1132	$2,380.72		$476.14
28800	C		Amputation of midfoot					
28805	C		Amputation thru metatarsal					
28810	T		Amputation toe & metatarsal	0055	19.9783	$1,185.71	$355.34	$237.14
28820	T		Amputation of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28825	T		Partial amputation of toe	0055	19.9783	$1,185.71	$355.34	$237.14
28899	T		Foot/toes surgery procedure	0043	1.7614	$104.54		$20.91
29000	S		Application of body cast	0058	1.0884	$64.60		$12.92
29010	S		Application of body cast	0426	2.1147	$125.51		$25.10
29015	S		Application of body cast	0426	2.1147	$125.51		$25.10
29020	S		Application of body cast	0058	1.0884	$64.60		$12.92
29025	S		Application of body cast	0058	1.0884	$64.60		$12.92
29035	S		Application of body cast	0426	2.1147	$125.51		$25.10
29040	S		Application of body cast	0058	1.0884	$64.60		$12.92
29044	S		Application of body cast	0426	2.1147	$125.51		$25.10
29046	S		Application of body cast	0426	2.1147	$125.51		$25.10
29049	S		Application of figure eight	0058	1.0884	$64.60		$12.92
29055	S		Application of shoulder cast	0426	2.1147	$125.51		$25.10
29058	S		Application of shoulder cast	0058	1.0884	$64.60		$12.92
29065	S		Application of long arm cast	0426	2.1147	$125.51		$25.10
29075	S		Application of forearm cast	0426	2.1147	$125.51		$25.10
29085	S		Apply hand/wrist cast	0058	1.0884	$64.60		$12.92
29086	S		Apply finger cast	0058	1.0884	$64.60		$12.92
29105	S		Apply long arm splint	0058	1.0884	$64.60		$12.92
29125	S		Apply forearm splint	0058	1.0884	$64.60		$12.92
29126	S		Apply forearm splint	0058	1.0884	$64.60		$12.92
29130	S		Application of finger splint	0058	1.0884	$64.60		$12.92
29131	S		Application of finger splint	0058	1.0884	$64.60		$12.92
29200	S		Strapping of chest	0058	1.0884	$64.60		$12.92
29220	S		Strapping of low back	0058	1.0884	$64.60		$12.92
29240	S		Strapping of shoulder	0058	1.0884	$64.60		$12.92

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29260	S		Strapping of elbow or wrist	0058	1.0884	$64.60		$12.92
29280	S		Strapping of hand or finger	0058	1.0884	$64.60		$12.92
29305	S		Application of hip cast	0426	2.1147	$125.51		$25.10
29325	S		Application of hip casts	0426	2.1147	$125.51		$25.10
29345	S		Application of long leg cast	0426	2.1147	$125.51		$25.10
29355	S		Application of long leg cast	0426	2.1147	$125.51		$25.10
29358	S		Apply long leg cast brace	0426	2.1147	$125.51		$25.10
29365	S		Application of long leg cast	0426	2.1147	$125.51		$25.10
29405	S		Apply short leg cast	0426	2.1147	$125.51		$25.10
29425	S		Apply short leg cast	0426	2.1147	$125.51		$25.10
29435	S		Apply short leg cast	0426	2.1147	$125.51		$25.10
29440	S		Addition of walker to cast	0058	1.0884	$64.60		$12.92
29445	S		Apply rigid leg cast	0426	2.1147	$125.51		$25.10
29450	S		Application of leg cast	0058	1.0884	$64.60		$12.92
29505	S		Application, long leg splint	0058	1.0884	$64.60		$12.92
29515	S		Application lower leg splint	0058	1.0884	$64.60		$12.92
29520	S		Strapping of hip	0058	1.0884	$64.60		$12.92
29530	S		Strapping of knee	0058	1.0884	$64.60		$12.92
29540	S		Strapping of ankle	0058	1.0884	$64.60		$12.92
29550	S		Strapping of toes	0058	1.0884	$64.60		$12.92
29580	S		Application of paste boot	0058	1.0884	$64.60		$12.92
29590	S		Application of foot splint	0058	1.0884	$64.60		$12.92
29700	S		Removal/revision of cast	0058	1.0884	$64.60		$12.92
29705	S		Removal/revision of cast	0058	1.0884	$64.60		$12.92
29710	S		Removal/revision of cast	0426	2.1147	$125.51		$25.10
29715	S		Removal/revision of cast	0058	1.0884	$64.60		$12.92
29720	S		Repair of body cast	0058	1.0884	$64.60		$12.92
29730	S		Windowing of cast	0058	1.0884	$64.60		$12.92
29740	S		Wedging of cast	0058	1.0884	$64.60		$12.92
29750	S		Wedging of clubfoot cast	0058	1.0884	$64.60		$12.92
29799	S		Casting/strapping procedure	0058	1.0884	$64.60		$12.92
29800	T		Jaw arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29804	T		Jaw arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29805	T		Shoulder arthroscopy, dx	0041	28.0044	$1,662.06		$332.41
29806	T		Shoulder arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29807	T		Shoulder arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29819	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29820	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29821	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29822	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29823	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29824	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29825	T		Shoulder arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29826	T		Shoulder arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29827	T		Arthroscop rotator cuff repr	0042	43.7761	$2,598.11	$804.74	$519.62
29830	T		Elbow arthroscopy	0041	28.0044	$1,662.06		$332.41
29834	T		Elbow arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29835	T		Elbow arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29836	T		Elbow arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29837	T		Elbow arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29838	T		Elbow arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29840	T		Wrist arthroscopy	0041	28.0044	$1,662.06		$332.41
29843	T		Wrist arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29844	T		Wrist arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29845	T		Wrist arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29846	T		Wrist arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29847	T		Wrist arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29848	T		Wrist endoscopy/surgery	0041	28.0044	$1,662.06		$332.41
29850	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29851	T		Knee arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29855	T		Tibial arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29856	T		Tibial arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29860	T		Hip arthroscopy, dx	0041	28.0044	$1,662.06		$332.41
29861	T		Hip arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29862	T		Hip arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29863	T		Hip arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
29866	T		Autgrft implnt, knee w/scope	0042	43.7761	$2,598.11	$804.74	$519.62
29867	T		Allgrft implnt, knee w/scope	0042	43.7761	$2,598.11	$804.74	$519.62
29868	T		Meniscal trnspl, knee w/scpe	0042	43.7761	$2,598.11	$804.74	$519.62
29870	T		Knee arthroscopy, dx	0041	28.0044	$1,662.06		$332.41
29871	T		Knee arthroscopy/drainage	0041	28.0044	$1,662.06		$332.41
29873	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29874	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29875	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29876	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29877	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29879	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29880	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29881	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29882	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29883	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29884	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29885	T		Knee arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29886	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29887	T		Knee arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29888	T		Knee arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29889	T		Knee arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29891	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29892	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29893	T		Scope, plantar fasciotomy	0055	19.9783	$1,185.71	$355.34	$237.14
29894	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29895	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29897	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29898	T		Ankle arthroscopy/surgery	0041	28.0044	$1,662.06		$332.41
29899	T		Ankle arthroscopy/surgery	0042	43.7761	$2,598.11	$804.74	$519.62
29900	T		Mcp joint arthroscopy, dx	0053	15.6085	$926.36	$253.49	$185.27
29901	T		Mcp joint arthroscopy, surg	0053	15.6085	$926.36	$253.49	$185.27
29902	T		Mcp joint arthroscopy, surg	0053	15.6085	$926.36	$253.49	$185.27
29999	T		Arthroscopy of joint	0041	28.0044	$1,662.06		$332.41
30000	T		Drainage of nose lesion	0251	2.0010	$118.76		$23.75
30020	T		Drainage of nose lesion	0251	2.0010	$118.76		$23.75
30100	T		Intranasal biopsy	0252	7.8317	$464.81	$113.41	$92.96
30110	T		Removal of nose polyp(s)	0253	16.0627	$953.32	$282.29	$190.66
30115	T		Removal of nose polyp(s)	0253	16.0627	$953.32	$282.29	$190.66
30117	T		Removal of intranasal lesion	0253	16.0627	$953.32	$282.29	$190.66
30118	T		Removal of intranasal lesion	0254	23.2980	$1,382.74	$321.35	$276.55
30120	T		Revision of nose	0253	16.0627	$953.32	$282.29	$190.66
30124	T		Removal of nose lesion	0252	7.8317	$464.81	$113.41	$92.96
30125	T		Removal of nose lesion	0256	37.1513	$2,204.93		$440.99
30130	T		Removal of turbinate bones	0253	16.0627	$953.32	$282.29	$190.66
30140	T		Removal of turbinate bones	0254	23.2980	$1,382.74	$321.35	$276.55
30150	T		Partial removal of nose	0256	37.1513	$2,204.93		$440.99
30160	T		Removal of nose	0256	37.1513	$2,204.93		$440.99
30200	T		Injection treatment of nose	0252	7.8317	$464.81	$113.41	$92.96
30210	T		Nasal sinus therapy	0252	7.8317	$464.81	$113.41	$92.96
30220	T		Insert nasal septal button	0252	7.8317	$464.81	$113.41	$92.96
30300	X		Remove nasal foreign body	0340	0.6355	$37.72		$7.54
30310	T		Remove nasal foreign body	0253	16.0627	$953.32	$282.29	$190.66
30320	T		Remove nasal foreign body	0253	16.0627	$953.32	$282.29	$190.66
30400	T		Reconstruction of nose	0256	37.1513	$2,204.93		$440.99
30410	T		Reconstruction of nose	0256	37.1513	$2,204.93		$440.99
30420	T		Reconstruction of nose	0256	37.1513	$2,204.93		$440.99
30430	T		Revision of nose	0254	23.2980	$1,382.74	$321.35	$276.55
30435	T		Revision of nose	0256	37.1513	$2,204.93		$440.99
30450	T		Revision of nose	0256	37.1513	$2,204.93		$440.99
30460	T		Revision of nose	0256	37.1513	$2,204.93		$440.99
30462	T		Revision of nose	0256	37.1513	$2,204.93		$440.99
30465	T		Repair nasal stenosis	0256	37.1513	$2,204.93		$440.99
30520	T		Repair of nasal septum	0254	23.2980	$1,382.74	$321.35	$276.55
30540	T		Repair nasal defect	0256	37.1513	$2,204.93		$440.99
30545	T		Repair nasal defect	0256	37.1513	$2,204.93		$440.99
30560	T		Release of nasal adhesions	0251	2.0010	$118.76		$23.75

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
30580	T		Repair upper jaw fistula	0256	37.1513	$2,204.93		$440.99
30600	T		Repair mouth/nose fistula	0256	37.1513	$2,204.93		$440.99
30620	T		Intranasal reconstruction	0256	37.1513	$2,204.93		$440.99
30630	T		Repair nasal septum defect	0254	23.2980	$1,382.74	$321.35	$276.55
30801	T		Cauterization, inner nose	0252	7.8317	$464.81	$113.41	$92.96
30802	T		Cauterization, inner nose	0252	7.8317	$464.81	$113.41	$92.96
30901	T		Control of nosebleed	0250	1.2838	$76.19	$26.67	$15.24
30903	T		Control of nosebleed	0250	1.2838	$76.19	$26.67	$15.24
30905	T		Control of nosebleed	0250	1.2838	$76.19	$26.67	$15.24
30906	T		Repeat control of nosebleed	0250	1.2838	$76.19	$26.67	$15.24
30915	T		Ligation, nasal sinus artery	0091	28.8685	$1,713.35	$348.23	$342.67
30920	T		Ligation, upper jaw artery	0092	26.3621	$1,564.59	$505.37	$312.92
30930	T		Therapy, fracture of nose	0253	16.0627	$953.32	$282.29	$190.66
30999	T		Nasal surgery procedure	0251	2.0010	$118.76		$23.75
31000	T		Irrigation, maxillary sinus	0251	2.0010	$118.76		$23.75
31002	T		Irrigation, sphenoid sinus	0252	7.8317	$464.81	$113.41	$92.96
31020	T		Exploration, maxillary sinus	0254	23.2980	$1,382.74	$321.35	$276.55
31030	T		Exploration, maxillary sinus	0256	37.1513	$2,204.93		$440.99
31032	T		Explore sinus, remove polyps	0256	37.1513	$2,204.93		$440.99
31040	T		Exploration behind upper jaw	0254	23.2980	$1,382.74	$321.35	$276.55
31050	T		Exploration, sphenoid sinus	0256	37.1513	$2,204.93		$440.99
31051	T		Sphenoid sinus surgery	0256	37.1513	$2,204.93		$440.99
31070	T		Exploration of frontal sinus	0254	23.2980	$1,382.74	$321.35	$276.55
31075	T		Exploration of frontal sinus	0256	37.1513	$2,204.93		$440.99
31080	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31081	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31084	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31085	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31086	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31087	T		Removal of frontal sinus	0256	37.1513	$2,204.93		$440.99
31090	T		Exploration of sinuses	0256	37.1513	$2,204.93		$440.99
31200	T		Removal of ethmoid sinus	0256	37.1513	$2,204.93		$440.99
31201	T		Removal of ethmoid sinus	0256	37.1513	$2,204.93		$440.99
31205	T		Removal of ethmoid sinus	0256	37.1513	$2,204.93		$440.99
31225	C		Removal of upper jaw					
31230	C		Removal of upper jaw					
31231	T		Nasal endoscopy, dx	0072	1.4296	$84.85	$21.27	$16.97
31233	T		Nasal/sinus endoscopy, dx	0072	1.4296	$84.85	$21.27	$16.97
31235	T		Nasal/sinus endoscopy, dx	0074	15.7042	$932.04	$295.70	$186.41
31237	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31238	T		Nasal/sinus endoscopy, surg	0074	15.7042	$932.04	$295.70	$186.41
31239	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31240	T		Nasal/sinus endoscopy, surg	0074	15.7042	$932.04	$295.70	$186.41
31254	T		Revision of ethmoid sinus	0075	21.2460	$1,260.95	$445.92	$252.19
31255	T		Removal of ethmoid sinus	0075	21.2460	$1,260.95	$445.92	$252.19
31256	T		Exploration maxillary sinus	0075	21.2460	$1,260.95	$445.92	$252.19
31267	T		Endoscopy, maxillary sinus	0075	21.2460	$1,260.95	$445.92	$252.19
31276	T		Sinus endoscopy, surgical	0075	21.2460	$1,260.95	$445.92	$252.19
31287	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31288	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31290	C		Nasal/sinus endoscopy, surg					
31291	C		Nasal/sinus endoscopy, surg					
31292	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31293	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31294	T		Nasal/sinus endoscopy, surg	0075	21.2460	$1,260.95	$445.92	$252.19
31299	T		Sinus surgery procedure	0251	2.0010	$118.76		$23.75
31300	T		Removal of larynx lesion	0254	23.2980	$1,382.74	$321.35	$276.55
31320	T		Diagnostic incision, larynx	0256	37.1513	$2,204.93		$440.99
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31390	C		Removal of larynx & pharynx					
31395	C		Reconstruct larynx & pharynx					
31400	T		Revision of larynx	0256	37.1513	$2,204.93		$440.99
31420	T		Removal of epiglottis	0256	37.1513	$2,204.93		$440.99
31500	S		Insert emergency airway	0094	2.5248	$149.85	$47.41	$29.97
31502	T		Change of windpipe airway	0121	2.2663	$134.50	$43.80	$26.90
31505	T		Diagnostic laryngoscopy	0071	0.7879	$46.76	$11.31	$9.35
31510	T		Laryngoscopy with biopsy	0074	15.7042	$932.04	$295.70	$186.41
31511	T		Remove foreign body, larynx	0072	1.4296	$84.85	$21.27	$16.97
31512	T		Removal of larynx lesion	0074	15.7042	$932.04	$295.70	$186.41
31513	T		Injection into vocal cord	0072	1.4296	$84.85	$21.27	$16.97
31515	T		Laryngoscopy for aspiration	0074	15.7042	$932.04	$295.70	$186.41
31520	T		Diagnostic laryngoscopy	0072	1.4296	$84.85	$21.27	$16.97
31525	T		Diagnostic laryngoscopy	0074	15.7042	$932.04	$295.70	$186.41
31526	T		Diagnostic laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31527	T		Laryngoscopy for treatment	0075	21.2460	$1,260.95	$445.92	$252.19
31528	T		Laryngoscopy and dilation	0074	15.7042	$932.04	$295.70	$186.41
31529	T		Laryngoscopy and dilation	0074	15.7042	$932.04	$295.70	$186.41
31530	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31531	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31535	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31536	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31540	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31541	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31545	T		Remove vc lesion w/scope	0075	21.2460	$1,260.95	$445.92	$252.19
31546	T		Remove vc lesion scope/graft	0075	21.2460	$1,260.95	$445.92	$252.19
31560	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31561	T		Operative laryngoscopy	0075	21.2460	$1,260.95	$445.92	$252.19
31570	T		Laryngoscopy with injection	0074	15.7042	$932.04	$295.70	$186.41
31571	T		Laryngoscopy with injection	0075	21.2460	$1,260.95	$445.92	$252.19
31575	T		Diagnostic laryngoscopy	0072	1.4296	$84.85	$21.27	$16.97
31576	T		Laryngoscopy with biopsy	0075	21.2460	$1,260.95	$445.92	$252.19
31577	T		Remove foreign body, larynx	0073	4.1420	$245.83	$73.38	$49.17
31578	T		Removal of larynx lesion	0075	21.2460	$1,260.95	$445.92	$252.19
31579	T		Diagnostic laryngoscopy	0073	4.1420	$245.83	$73.38	$49.17
31580	T		Revision of larynx	0256	37.1513	$2,204.93		$440.99
31582	T		Revision of larynx	0256	37.1513	$2,204.93		$440.99
31584	C		Treat larynx fracture					
31585	T		Treat larynx fracture	0253	16.0627	$953.32	$282.29	$190.66
31586	T		Treat larynx fracture	0256	37.1513	$2,204.93		$440.99
31587	C		Revision of larynx					
31588	T		Revision of larynx	0256	37.1513	$2,204.93		$440.99
31590	T		Reinnervate larynx	0256	37.1513	$2,204.93		$440.99
31595	T		Larynx nerve surgery	0256	37.1513	$2,204.93		$440.99
31599	T		Larynx surgery procedure	0251	2.0010	$118.76		$23.75
31600	T		Incision of windpipe	0254	23.2980	$1,382.74	$321.35	$276.55
31601	T		Incision of windpipe	0254	23.2980	$1,382.74	$321.35	$276.55
31603	T		Incision of windpipe	0252	7.8317	$464.81	$113.41	$92.96
31605	T		Incision of windpipe	0252	7.8317	$464.81	$113.41	$92.96
31610	T		Incision of windpipe	0254	23.2980	$1,382.74	$321.35	$276.55
31611	T		Surgery/speech prosthesis	0254	23.2980	$1,382.74	$321.35	$276.55
31612	T		Puncture/clear windpipe	0254	23.2980	$1,382.74	$321.35	$276.55
31613	T		Repair windpipe opening	0254	23.2980	$1,382.74	$321.35	$276.55
31614	T		Repair windpipe opening	0256	37.1513	$2,204.93		$440.99
31615	T		Visualization of windpipe	0076	9.4163	$558.86	$189.82	$111.77
31620	S		Endobronchial us add-on	0670	25.2980	$1,501.44	$470.38	$300.29
31622	T		Dx bronchoscope/wash	0076	9.4163	$558.86	$189.82	$111.77
31623	T		Dx bronchoscope/brush	0076	9.4163	$558.86	$189.82	$111.77
31624	T		Dx bronchoscope/lavage	0076	9.4163	$558.86	$189.82	$111.77
31625	T		Bronchoscopy w/biopsy(s)	0076	9.4163	$558.86	$189.82	$111.77
31628	T		Bronchoscopy/lung bx, each	0076	9.4163	$558.86	$189.82	$111.77
31629	T		Bronchoscopy/needle bx, each	0076	9.4163	$558.86	$189.82	$111.77
31630	T		Bronchoscopy dilate/fx repr	0415	21.9955	$1,305.43	$459.92	$261.09
31631	T		Bronchoscopy, dilate w/stent	0415	21.9955	$1,305.43	$459.92	$261.09
31632	T		Bronchoscopy/lung bx, add'l	0076	9.4163	$558.86	$189.82	$111.77
31633	T		Bronchoscopy/needle bx add'l	0076	9.4163	$558.86	$189.82	$111.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
31635	T		Bronchoscopy w/fb removal	0076	9.4163	$558.86	$189.82	$111.77
31636	T		Bronchoscopy, bronch stents	0415	21.9955	$1,305.43	$459.92	$261.09
31637	T		Bronchoscopy, stent add-on	0076	9.4163	$558.86	$189.82	$111.77
31638	T		Bronchoscopy, revise stent	0415	21.9955	$1,305.43	$459.92	$261.09
31640	T		Bronchoscopy w/tumor excise	0415	21.9955	$1,305.43	$459.92	$261.09
31641	T		Bronchoscopy, treat blockage	0415	21.9955	$1,305.43	$459.92	$261.09
31643	T		Diag bronchoscope/catheter	0076	9.4163	$558.86	$189.82	$111.77
31645	T		Bronchoscopy, clear airways	0076	9.4163	$558.86	$189.82	$111.77
31646	T		Bronchoscopy, reclear airway	0076	9.4163	$558.86	$189.82	$111.77
31656	T		Bronchoscopy, inj for x-ray	0076	9.4163	$558.86	$189.82	$111.77
31700	T		Insertion of airway catheter	0072	1.4296	$84.85	$21.27	$16.97
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	4.1420	$245.83	$73.38	$49.17
31720	T		Clearance of airways	0071	0.7879	$46.76	$11.31	$9.35
31725	C		Clearance of airways					
31730	T		Intro, windpipe wire/tube	0073	4.1420	$245.83	$73.38	$49.17
31750	T		Repair of windpipe	0256	37.1513	$2,204.93		$440.99
31755	T		Repair of windpipe	0256	37.1513	$2,204.93		$440.99
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	23.2980	$1,382.74	$321.35	$276.55
31786	C		Remove windpipe lesion					
31800	C		Repair of windpipe injury					
31805	C		Repair of windpipe injury					
31820	T		Closure of windpipe lesion	0253	16.0627	$953.32	$282.29	$190.66
31825	T		Repair of windpipe defect	0254	23.2980	$1,382.74	$321.35	$276.55
31830	T		Revise windpipe scar	0254	23.2980	$1,382.74	$321.35	$276.55
31899	T		Airways surgical procedure	0076	9.4163	$558.86	$189.82	$111.77
32000	T		Drainage of chest	0070	3.1956	$189.66		$37.93
32002	T		Treatment of collapsed lung	0070	3.1956	$189.66		$37.93
32005	T		Treat lung lining chemically	0070	3.1956	$189.66		$37.93
32019	T		Insert pleural catheter	0070	3.1956	$189.66		$37.93
32020	T		Insertion of chest tube	0070	3.1956	$189.66		$37.93
32035	C		Exploration of chest					
32036	C		Exploration of chest					
32095	C		Biopsy through chest wall					
32100	C		Exploration/biopsy of chest					
32110	C		Explore/repair chest					
32120	C		Re-exploration of chest					
32124	C		Explore chest free adhesions					
32140	C		Removal of lung lesion(s)					
32141	C		Remove/treat lung lesions					
32150	C		Removal of lung lesion(s)					
32151	C		Remove lung foreign body					
32160	C		Open chest heart massage					
32200	C		Drain, open, lung lesion					
32201	T		Drain, percut, lung lesion	0070	3.1956	$189.66		$37.93
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	0685	5.9902	$355.52	$115.47	$71.10
32402	C		Open biopsy chest lining					
32405	T		Biopsy, lung or mediastinum	0685	5.9902	$355.52	$115.47	$71.10
32420	T		Puncture/clear lung	0070	3.1956	$189.66		$37.93
32440	C		Removal of lung					
32442	C		Sleeve pneumonectomy					
32445	C		Removal of lung					
32480	C		Partial removal of lung					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	30.5386	$1,812.47	$591.64	$362.49
32602	T		Thoracoscopy, diagnostic	0069	30.5386	$1,812.47	$591.64	$362.49
32603	T		Thoracoscopy, diagnostic	0069	30.5386	$1,812.47	$591.64	$362.49
32604	T		Thoracoscopy, diagnostic	0069	30.5386	$1,812.47	$591.64	$362.49
32605	T		Thoracoscopy, diagnostic	0069	30.5386	$1,812.47	$591.64	$362.49
32606	T		Thoracoscopy, diagnostic	0069	30.5386	$1,812.47	$591.64	$362.49
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					
32855	C		Prepare donor lung, single					
32856	C		Prepare donor lung, double					
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	3.1956	$189.66		$37.93
32997	C		Total lung lavage					
32999	T		Chest surgery procedure	0070	3.1956	$189.66		$37.93
33010	T		Drainage of heart sac	0070	3.1956	$189.66		$37.93
33011	T		Repeat drainage of heart sac	0070	3.1956	$189.66		$37.93
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	105.1359	$6,239.82	$1,681.06	$1,247.96

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33207	T		Insertion of heart pacemaker	0089	105.1359	$6,239.82	$1,681.06	$1,247.96
33208	T		Insertion of heart pacemaker	0655	133.1709	$7,903.69		$1,580.74
33210	T		Insertion of heart electrode	0106	45.2791	$2,687.31		$537.46
33211	T		Insertion of heart electrode	0106	45.2791	$2,687.31		$537.46
33212	T		Insertion of pulse generator	0090	88.7536	$5,267.53	$1,612.80	$1,053.51
33213	T		Insertion of pulse generator	0654	100.4722	$5,963.03		$1,192.61
33214	T		Upgrade of pacemaker system	0655	133.1709	$7,903.69		$1,580.74
33215	T		Reposition pacing-defib lead	0105	22.2671	$1,321.55	$370.40	$264.31
33216	T		Revise eltrd pacing-defib	0106	45.2791	$2,687.31		$537.46
33217	T		Insert lead pace-defib, dual	0106	45.2791	$2,687.31		$537.46
33218	T		Repair lead pace-defib, one	0106	45.2791	$2,687.31		$537.46
33220	T		Repair lead pace-defib, dual	0106	45.2791	$2,687.31		$537.46
33222	T		Revise pocket, pacemaker	0027	18.3348	$1,088.17	$329.72	$217.63
33223	T		Revise pocket, pacing-defib	0027	18.3348	$1,088.17	$329.72	$217.63
33224	T		Insert pacing lead & connect	0418	108.8092	$6,457.83		$1,291.57
33225	T		L ventric pacing lead add-on	0418	108.8092	$6,457.83		$1,291.57
33226	T		Reposition l ventric lead	0105	22.2671	$1,321.55	$370.40	$264.31
33233	T		Removal of pacemaker system	0105	22.2671	$1,321.55	$370.40	$264.31
33234	T		Removal of pacemaker system	0105	22.2671	$1,321.55	$370.40	$264.31
33235	T		Removal pacemaker electrode	0105	22.2671	$1,321.55	$370.40	$264.31
33236	C		Remove electrode/thoracotomy					
33237	C		Remove electrode/thoracotomy					
33238	C		Remove electrode/thoracotomy					
33240	B		Insert pulse generator					
33241	T		Remove pulse generator	0105	22.2671	$1,321.55	$370.40	$264.31
33243	C		Remove eltrd/thoracotomy					
33244	T		Remove eltrd, transven	0105	22.2671	$1,321.55	$370.40	$264.31
33245	C		Insert epic eltrd pace-defib					
33246	C		Insert epic eltrd/generator					
33249	B		Eltrd/insert pace-defib					
33250	C		Ablate heart dysrhythm focus					
33251	C		Ablate heart dysrhythm focus					
33253	C		Reconstruct atria					
33261	C		Ablate heart dysrhythm focus					
33282	S		Implant pat-active ht record	0680	62.6232	$3,716.69		$743.34
33284	T		Remove pat-active ht record	0109	10.9933	$652.45	$131.49	$130.49
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33460	C		Revision of tricuspid valve					
33463	C		Valvuloplasty, tricuspid					
33464	C		Valvuloplasty, tricuspid					
33465	C		Replace tricuspid valve					
33468	C		Revision of tricuspid valve					
33470	C		Revision of pulmonary valve					
33471	C		Valvotomy, pulmonary valve					
33472	C		Revision of pulmonary valve					
33474	C		Revision of pulmonary valve					
33475	C		Replacement, pulmonary valve					
33476	C		Revision of heart chamber					
33478	C		Revision of heart chamber					
33496	C		Repair, prosth valve clot					
33500	C		Repair heart vessel fistula					
33501	C		Repair heart vessel fistula					
33502	C		Coronary artery correction					
33503	C		Coronary artery graft					
33504	C		Coronary artery graft					
33505	C		Repair artery w/tunnel					
33506	C		Repair artery, translocation					
33508	N		Endoscopic vein harvest					
33510	C		CABG, vein, single					
33511	C		CABG, vein, two					
33512	C		CABG, vein, three					
33513	C		CABG, vein, four					
33514	C		CABG, vein, five					
33516	C		Cabg, vein, six or more					
33517	C		CABG, artery-vein, single					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
33720	C		Repair of heart defect					
33722	C		Repair of heart defect					
33730	C		Repair heart-vein defect(s)					
33732	C		Repair heart-vein defect					
33735	C		Revision of heart chamber					
33736	C		Revision of heart chamber					
33737	C		Revision of heart chamber					
33750	C		Major vessel shunt					
33755	C		Major vessel shunt					
33762	C		Major vessel shunt					
33764	C		Major vessel shunt & graft					
33766	C		Major vessel shunt					
33767	C		Major vessel shunt					
33770	C		Repair great vessels defect					
33771	C		Repair great vessels defect					
33774	C		Repair great vessels defect					
33775	C		Repair great vessels defect					
33776	C		Repair great vessels defect					
33777	C		Repair great vessels defect					
33778	C		Repair great vessels defect					
33779	C		Repair great vessels defect					
33780	C		Repair great vessels defect					
33781	C		Repair great vessels defect					
33786	C		Repair arterial trunk					
33788	C		Revision of pulmonary artery					
33800	C		Aortic suspension					
33802	C		Repair vessel defect					
33803	C		Repair vessel defect					
33813	C		Repair septal defect					
33814	C		Repair septal defect					
33820	C		Revise major vessel					
33822	C		Revise major vessel					
33824	C		Revise major vessel					
33840	C		Remove aorta constriction					
33845	C		Remove aorta constriction					
33851	C		Remove aorta constriction					
33852	C		Repair septal defect					
33853	C		Repair septal defect					
33860	C		Ascending aortic graft					
33861	C		Ascending aortic graft					
33863	C		Ascending aortic graft					
33870	C		Transverse aortic arch graft					
33875	C		Thoracic aortic graft					
33877	C		Thoracoabdominal graft					
33910	C		Remove lung artery emboli					
33915	C		Remove lung artery emboli					
33916	C		Surgery of great vessel					
33917	C		Repair pulmonary artery					
33918	C		Repair pulmonary atresia					
33919	C		Repair pulmonary atresia					
33920	C		Repair pulmonary atresia					
33922	C		Transect pulmonary artery					
33924	C		Remove pulmonary shunt					
33930	C		Removal of donor heart/lung					
33933	C		Prepare donor heart/lung					
33935	C		Transplantation, heart/lung					
33940	C		Removal of donor heart					
33944	C		Prepare 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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	3.1956	$189.66		$37.93
34001	C		Removal of artery clot					
34051	C		Removal of artery clot					
34101	T		Removal of artery clot	0088	36.3961	$2,160.11	$655.22	$432.02
34111	T		Removal of arm artery clot	0088	36.3961	$2,160.11	$655.22	$432.02
34151	C		Removal of artery clot					
34201	T		Removal of artery clot	0088	36.3961	$2,160.11	$655.22	$432.02
34203	T		Removal of leg artery clot	0088	36.3961	$2,160.11	$655.22	$432.02
34401	C		Removal of vein clot					
34421	T		Removal of vein clot	0088	36.3961	$2,160.11	$655.22	$432.02
34451	C		Removal of vein clot					
34471	T		Removal of vein clot	0088	36.3961	$2,160.11	$655.22	$432.02
34490	T		Removal of vein clot	0088	36.3961	$2,160.11	$655.22	$432.02
34501	T		Repair valve, femoral vein	0088	36.3961	$2,160.11	$655.22	$432.02
34502	C		Reconstruct vena cava					
34510	T		Transposition of vein valve	0088	36.3961	$2,160.11	$655.22	$432.02
34520	T		Cross-over vein graft	0088	36.3961	$2,160.11	$655.22	$432.02
34530	T		Leg vein fusion	0088	36.3961	$2,160.11	$655.22	$432.02
34800	C		Endovasc abdo repair w/tube					
34802	C		Endovasc abdo repr w/device					
34803	C		Endovas aaa repr w/3-p part					
34804	C		Endovasc abdo repr w/device					
34805	C		Endovasc abdo repair w/pros					
34808	C		Endovasc abdo occlud device					
34812	C		Xpose for endoprosth, aortic					
34813	C		Femoral endovas graft add-on					
34820	C		Xpose for endoprosth, iliac					
34825	C		Endovasc extend prosth, init					
34826	C		Endovasc exten prosth, add'l					
34830	C		Open aortic tube prosth repr					
34831	C		Open aortoiliac prosth repr					
34832	C		Open aortofemor prosth repr					
34833	C		Xpose for endoprosth, iliac					
34834	C		Xpose, endoprosth, brachial					
34900	C		Endovasc iliac repr w/graft					
35001	C		Repair defect of artery					
35002	C		Repair artery rupture, neck					
35005	C		Repair defect of artery					
35011	T		Repair defect of artery	0653	30.3956	$1,803.98		$360.80
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35180	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35182	C		Repair blood vessel lesion					
35184	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35188	T		Repair blood vessel lesion	0088	36.3961	$2,160.11	$655.22	$432.02
35189	C		Repair blood vessel lesion					
35190	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35201	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35206	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35207	T		Repair blood vessel lesion	0088	36.3961	$2,160.11	$655.22	$432.02
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	23.3454	$1,385.55	$277.34	$277.11
35231	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
35236	T		Repair blood vessel lesion	0093	23.3454	$1,385.55	$277.34	$277.11
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	23.3454	$1,385.55	$277.34	$277.11
35261	T		Repair blood vessel lesion	0653	30.3956	$1,803.98		$360.80
35266	T		Repair blood vessel lesion	0653	30.3956	$1,803.98		$360.80
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	30.3956	$1,803.98		$360.80
35301	C		Rechanneling of artery					
35311	C		Rechanneling of artery					
35321	T		Rechanneling of artery	0093	23.3454	$1,385.55	$277.34	$277.11
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	34.2913	$2,035.19		$407.04
35459	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35460	T		Repair venous blockage	0081	34.2913	$2,035.19		$407.04
35470	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35471	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35472	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35473	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35474	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35475	T		Repair arterial blockage	0081	34.2913	$2,035.19		$407.04
35476	T		Repair venous blockage	0081	34.2913	$2,035.19		$407.04
35480	C		Atherectomy, open					
35481	C		Atherectomy, open					
35482	C		Atherectomy, open					
35483	C		Atherectomy, open					
35484	T		Atherectomy, open	0081	34.2913	$2,035.19		$407.04
35485	T		Atherectomy, open	0081	34.2913	$2,035.19		$407.04
35490	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35491	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35492	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35493	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35494	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35495	T		Atherectomy, percutaneous	0081	34.2913	$2,035.19		$407.04
35500	T		Harvest vein for bypass	0081	34.2913	$2,035.19		$407.04

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35501	C		Artery bypass graft					
35506	C		Artery bypass graft					
35507	C		Artery bypass graft					
35508	C		Artery bypass graft					
35509	C		Artery bypass graft					
35510	C		Artery bypass graft					
35511	C		Artery bypass graft					
35512	C		Artery bypass graft					
35515	C		Artery bypass graft					
35516	C		Artery bypass graft					
35518	C		Artery bypass graft					
35521	C		Artery bypass graft					
35522	C		Artery bypass graft					
35525	C		Artery bypass graft					
35526	C		Artery bypass graft					
35531	C		Artery bypass graft					
35533	C		Artery bypass graft					
35536	C		Artery bypass graft					
35541	C		Artery bypass graft					
35546	C		Artery bypass graft					
35548	C		Artery bypass graft					
35549	C		Artery bypass graft					
35551	C		Artery bypass graft					
35556	C		Artery bypass graft					
35558	C		Artery bypass graft					
35560	C		Artery bypass graft					
35563	C		Artery bypass graft					
35565	C		Artery bypass graft					
35566	C		Artery bypass graft					
35571	C		Artery bypass graft					
35572	N		Harvest femoropopliteal vein					
35583	C		Vein bypass graft					
35585	C		Vein bypass graft					
35587	C		Vein bypass graft					
35600	C		Harvest artery for cabg					
35601	C		Artery bypass graft					
35606	C		Artery bypass graft					
35612	C		Artery bypass graft					
35616	C		Artery bypass graft					
35621	C		Artery bypass graft					
35623	C		Bypass graft, not vein					
35626	C		Artery bypass graft					
35631	C		Artery bypass graft					
35636	C		Artery bypass graft					
35641	C		Artery bypass graft					
35642	C		Artery bypass graft					
35645	C		Artery bypass graft					
35646	C		Artery bypass graft					
35647	C		Artery bypass graft					
35650	C		Artery bypass graft					
35651	C		Artery bypass graft					
35654	C		Artery bypass graft					
35656	C		Artery bypass graft					
35661	C		Artery bypass graft					
35663	C		Artery bypass graft					
35665	C		Artery bypass graft					
35666	C		Artery bypass graft					
35671	C		Artery bypass graft					
35681	C		Composite bypass graft					
35682	C		Composite bypass graft					
35683	C		Composite bypass graft					
35685	T		Bypass graft patency/patch	0093	23.3454	$1,385.55	$277.34	$277.11
35686	T		Bypass graft/av fist patency	0093	23.3454	$1,385.55	$277.34	$277.11
35691	C		Arterial transposition					
35693	C		Arterial transposition					
35694	C		Arterial transposition					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
35695	C		Arterial transposition					
35697	C		Reimplant artery each					
35700	C		Reoperation, bypass graft					
35701	C		Exploration, carotid artery					
35721	C		Exploration, femoral artery					
35741	C		Exploration popliteal artery					
35761	T		Exploration of artery/vein	0115	31.3302	$1,859.45	$459.35	$371.89
35800	C		Explore neck vessels					
35820	C		Explore chest vessels					
35840	C		Explore abdominal vessels					
35860	T		Explore limb vessels	0093	23.3454	$1,385.55	$277.34	$277.11
35870	C		Repair vessel graft defect					
35875	T		Removal of clot in graft	0088	36.3961	$2,160.11	$655.22	$432.02
35876	T		Removal of clot in graft	0088	36.3961	$2,160.11	$655.22	$432.02
35879	T		Revise graft w/vein	0088	36.3961	$2,160.11	$655.22	$432.02
35881	T		Revise graft w/vein	0088	36.3961	$2,160.11	$655.22	$432.02
35901	C		Excision, graft, neck					
35903	T		Excision, graft, extremity	0115	31.3302	$1,859.45	$459.35	$371.89
35905	C		Excision, graft, thorax					
35907	C		Excision, graft, abdomen					
36000	N		Place needle in vein					
36002	S		Pseudoaneurysm injection trt	0267	2.6208	$155.54	$62.18	$31.11
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	0623	26.9877	$1,601.72		$320.34
36261	T		Revision of infusion pump	0623	26.9877	$1,601.72		$320.34
36262	T		Removal of infusion pump	0622	21.1708	$1,256.49		$251.30
36299	N		Vessel injection procedure					
36400	N		Bl draw < 3 yrs fem/jugular					
36405	N		Bl draw < 3 yrs scalp vein					
36406	N		Bl draw < 3 yrs other vein					
36410	N		Non-routine bl draw > 3 yrs					
36415	A		Drawing blood					
36416	N		Capillary blood draw					
36420	T		Vein access cutdown < 1 yr	0035	0.7125	$42.29		$8.46
36425	T		Vein access cutdown > 1 yr	0035	0.7125	$42.29		$8.46
36430	S		Blood transfusion service	0110	3.6428	$216.20		$43.24
36440	S		Bl push transfuse, 2 yr or <	0110	3.6428	$216.20		$43.24
36450	S		Bl exchange/transfuse, nb	0110	3.6428	$216.20		$43.24
36455	S		Bl exchange/transfuse non-nb	0110	3.6428	$216.20		$43.24
36460	S		Transfusion service, fetal	0110	3.6428	$216.20		$43.24
36468	T		Injection(s), spider veins	0098	1.1295	$67.04		$13.41
36469	T		Injection(s), spider veins	0098	1.1295	$67.04		$13.41
36470	T		Injection therapy of vein	0098	1.1295	$67.04		$13.41
36471	T		Injection therapy of veins	0098	1.1295	$67.04		$13.41
36475	T		Endovenous rf, 1st vein	0092	26.3621	$1,564.59	$505.37	$312.92
36476	T		Endovenous rf, vein add-on	0092	26.3621	$1,564.59	$505.37	$312.92

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36478	T		Endovenous laser, 1st vein	0092	26.3621	$1,564.59	$505.37	$312.92
36479	T		Endovenous laser vein addon	0092	26.3621	$1,564.59	$505.37	$312.92
36481	N		Insertion of catheter, vein					
36500	N		Insertion of catheter, vein					
36510	N		Insertion of catheter, vein					
36511	S		Apheresis wbc	0111	12.3394	$732.34	$200.18	$146.47
36512	S		Apheresis rbc	0111	12.3394	$732.34	$200.18	$146.47
36513	S		Apheresis platelets	0111	12.3394	$732.34	$200.18	$146.47
36514	S		Apheresis plasma	0111	12.3394	$732.34	$200.18	$146.47
36515	S		Apheresis, adsorp/reinfuse	0112	26.6734	$1,583.07	$437.01	$316.61
36516	S		Apheresis, selective	0112	26.6734	$1,583.07	$437.01	$316.61
36522	S		Photopheresis	0112	26.6734	$1,583.07	$437.01	$316.61
36540	N		Collect blood venous device					
36550	T		Declot vascular device	0676	2.3996	$142.42		$28.48
36555	T		Insert non-tunnel cv cath	0621	8.2610	$490.29		$98.06
36556	T		Insert non-tunnel cv cath	0621	8.2610	$490.29		$98.06
36557	T		Insert tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36558	T		Insert tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36560	T		Insert tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36561	T		Insert tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36563	T		Insert tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36565	T		Insert tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36566	T		Insert tunneled cv cath	1564		$4,750.00		$950.00
36568	T		Insert tunneled cv cath	0621	8.2610	$490.29		$98.06
36569	T		Insert tunneled cv cath	0621	8.2610	$490.29		$98.06
36570	T		Insert tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36571	T		Insert tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36575	T		Repair tunneled cv cath	0621	8.2610	$490.29		$98.06
36576	T		Repair tunneled cv cath	0621	8.2610	$490.29		$98.06
36578	T		Replace tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36580	T		Replace tunneled cv cath	0621	8.2610	$490.29		$98.06
36581	T		Replace tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36582	T		Replace tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36583	T		Replace tunneled cv cath	0623	26.9877	$1,601.72		$320.34
36584	T		Replace tunneled cv cath	0621	8.2610	$490.29		$98.06
36585	T		Replace tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36589	T		Removal tunneled cv cath	0621	8.2610	$490.29		$98.06
36590	T		Removal tunneled cv cath	0621	8.2610	$490.29		$98.06
36595	T		Mech remov tunneled cv cath	0622	21.1708	$1,256.49		$251.30
36596	T		Mech remov tunneled cv cath	0621	8.2610	$490.29		$98.06
36597	T		Reposition venous catheter	0621	8.2610	$490.29		$98.06
36600	N		Withdrawal of arterial blood					
36620	N		Insertion catheter, artery					
36625	N		Insertion catheter, artery					
36640	T		Insertion catheter, artery	0623	26.9877	$1,601.72		$320.34
36660	C		Insertion catheter, artery					
36680	T		Insert needle, bone cavity	0002	0.9515	$56.47		$11.29
36800	T		Insertion of cannula	0115	31.3302	$1,859.45	$459.35	$371.89
36810	T		Insertion of cannula	0115	31.3302	$1,859.45	$459.35	$371.89
36815	T		Insertion of cannula	0115	31.3302	$1,859.45	$459.35	$371.89
36818	T		Av fuse, uppr arm, cephalic	0088	36.3961	$2,160.11	$655.22	$432.02
36819	T		Av fusion/uppr arm vein	0088	36.3961	$2,160.11	$655.22	$432.02
36820	T		Av fusion/forearm vein	0088	36.3961	$2,160.11	$655.22	$432.02
36821	T		Av fusion direct any site	0088	36.3961	$2,160.11	$655.22	$432.02
36822	C		Insertion of cannula(s)					
36823	C		Insertion of cannula(s)					
36825	T		Artery-vein autograft	0088	36.3961	$2,160.11	$655.22	$432.02
36830	T		Artery-vein graft	0088	36.3961	$2,160.11	$655.22	$432.02
36831	T		Open thrombect av fistula	0088	36.3961	$2,160.11	$655.22	$432.02
36832	T		Av fistula revision, open	0088	36.3961	$2,160.11	$655.22	$432.02
36833	T		Av fistula revision	0088	36.3961	$2,160.11	$655.22	$432.02
36834	T		Repair A-V aneurysm	0088	36.3961	$2,160.11	$655.22	$432.02
36835	T		Artery to vein shunt	0115	31.3302	$1,859.45	$459.35	$371.89
36838	T		Dist revas ligation, hemo	0088	36.3961	$2,160.11	$655.22	$432.02
36860	T		External cannula declotting	0676	2.3996	$142.42		$28.48
36861	T		Cannula declotting	0115	31.3302	$1,859.45	$459.35	$371.89

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
36870	T		Percut thrombect av fistula	0653	30.3956	$1,803.98		$360.80
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	T		Remove hepatic shunt (tips)	0229	64.1626	$3,808.05	$771.23	$761.61
37195	T		Thrombolytic therapy, stroke	0676	2.3996	$142.42		$28.48
37200	T		Transcatheter biopsy	0685	5.9902	$355.52	$115.47	$71.10
37201	T		Transcatheter therapy infuse	0676	2.3996	$142.42		$28.48
37202	T		Transcatheter therapy infuse	0676	2.3996	$142.42		$28.48
37203	T		Transcatheter retrieval	0103	14.6476	$869.34	$223.63	$173.87
37204	T		Transcatheter occlusion	0115	31.3302	$1,859.45	$459.35	$371.89
37205	T		Transcatheter stent	0229	64.1626	$3,808.05	$771.23	$761.61
37206	T		Transcatheter stent add-on	0229	64.1626	$3,808.05	$771.23	$761.61
37207	T		Transcatheter stent	0229	64.1626	$3,808.05	$771.23	$761.61
37208	T		Transcatheter stent add-on	0229	64.1626	$3,808.05	$771.23	$761.61
37209	T		Exchange arterial catheter	0103	14.6476	$869.34	$223.63	$173.87
37215	C		Transcath stent, cca w/eps					
37216	C		Transcath stent, cca w/o eps					
37250	S		Iv us first vessel add-on	0416	19.4657	$1,155.29		$231.06
37251	S		Iv us each add vessel add-on	0416	19.4657	$1,155.29		$231.06
37500	T		Endoscopy ligate perf veins	0092	26.3621	$1,564.59	$505.37	$312.92
37501	T		Vascular endoscopy procedure	0092	26.3621	$1,564.59	$505.37	$312.92
37565	T		Ligation of neck vein	0093	23.3454	$1,385.55	$277.34	$277.11
37600	T		Ligation of neck artery	0093	23.3454	$1,385.55	$277.34	$277.11
37605	T		Ligation of neck artery	0091	28.8685	$1,713.35	$348.23	$342.67
37606	T		Ligation of neck artery	0091	28.8685	$1,713.35	$348.23	$342.67
37607	T		Ligation of a-v fistula	0092	26.3621	$1,564.59	$505.37	$312.92
37609	T		Temporal artery procedure	0021	14.9098	$884.90	$219.48	$176.98
37615	T		Ligation of neck artery	0091	28.8685	$1,713.35	$348.23	$342.67
37616	C		Ligation of chest artery					
37617	C		Ligation of abdomen artery					
37618	C		Ligation of extremity artery					
37620	T		Revision of major vein	0091	28.8685	$1,713.35	$348.23	$342.67
37650	T		Revision of major vein	0091	28.8685	$1,713.35	$348.23	$342.67
37660	C		Revision of major vein					
37700	T		Revise leg vein	0091	28.8685	$1,713.35	$348.23	$342.67
37720	T		Removal of leg vein	0092	26.3621	$1,564.59	$505.37	$312.92
37730	T		Removal of leg veins	0092	26.3621	$1,564.59	$505.37	$312.92
37735	T		Removal of leg veins/lesion	0092	26.3621	$1,564.59	$505.37	$312.92
37760	T		Revision of leg veins	0091	28.8685	$1,713.35	$348.23	$342.67
37765	T		Phleb veins - extrem - to 20	0091	28.8685	$1,713.35	$348.23	$342.67
37766	T		Phleb veins - extrem 20+	0091	28.8685	$1,713.35	$348.23	$342.67
37780	T		Revision of leg vein	0091	28.8685	$1,713.35	$348.23	$342.67
37785	T		Ligate/divide/excise vein	0091	28.8685	$1,713.35	$348.23	$342.67
37788	C		Revascularization, penis					
37790	T		Penile venous occlusion	0181	30.7265	$1,823.62	$621.82	$364.72
37799	T		Vascular surgery procedure	0103	14.6476	$869.34	$223.63	$173.87
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	43.1426	$2,560.51	$1,001.89	$512.10
38129	T		Laparoscope proc, spleen	0130	31.7825	$1,886.29	$659.53	$377.26
38200	N		Injection for spleen x-ray					
38204	E		Bl donor search management					
38205	S		Harvest allogenic stem cells	0111	12.3394	$732.34	$200.18	$146.47
38206	S		Harvest auto stem cells	0111	12.3394	$732.34	$200.18	$146.47
38207	E		Cryopreserve stem cells					
38208	E		Thaw preserved stem cells					
38209	E		Wash harvest stem cells					
38210	E		T-cell depletion of harvest					
38211	E		Tumor cell deplete of harvst					
38212	E		Rbc depletion of harvest					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
38213	E		Platelet deplete of harvest					
38214	E		Volume deplete of harvest					
38215	E		Harvest stem cell concentrte					
38220	T		Bone marrow aspiration	0003	2.6410	$156.74		$31.35
38221	T		Bone marrow biopsy	0003	2.6410	$156.74		$31.35
38230	S		Bone marrow collection	0111	12.3394	$732.34	$200.18	$146.47
38240	S		Bone marrow/stem transplant	0123	22.8861	$1,358.29		$271.66
38241	S		Bone marrow/stem transplant	0123	22.8861	$1,358.29		$271.66
38242	S		Lymphocyte infuse transplant	0111	12.3394	$732.34	$200.18	$146.47
38300	T		Drainage, lymph node lesion	0007	11.3983	$676.49		$135.30
38305	T		Drainage, lymph node lesion	0008	16.4242	$974.78		$194.96
38308	T		Incision of lymph channels	0113	21.3681	$1,268.20		$253.64
38380	C		Thoracic duct procedure					
38381	C		Thoracic duct procedure					
38382	C		Thoracic duct procedure					
38500	T		Biopsy/removal, lymph nodes	0113	21.3681	$1,268.20		$253.64
38505	T		Needle biopsy, lymph nodes	0005	3.5831	$212.66	$71.45	$42.53
38510	T		Biopsy/removal, lymph nodes	0113	21.3681	$1,268.20		$253.64
38520	T		Biopsy/removal, lymph nodes	0113	21.3681	$1,268.20		$253.64
38525	T		Biopsy/removal, lymph nodes	0113	21.3681	$1,268.20		$253.64
38530	T		Biopsy/removal, lymph nodes	0113	21.3681	$1,268.20		$253.64
38542	T		Explore deep node(s), neck	0114	40.5805	$2,408.45	$485.91	$481.69
38550	T		Removal, neck/armpit lesion	0113	21.3681	$1,268.20		$253.64
38555	T		Removal, neck/armpit lesion	0113	21.3681	$1,268.20		$253.64
38562	C		Removal, pelvic lymph nodes					
38564	C		Removal, abdomen lymph nodes					
38570	T		Laparoscopy, lymph node biop	0131	43.1426	$2,560.51	$1,001.89	$512.10
38571	T		Laparoscopy, lymphadenectomy	0132	62.7061	$3,721.61	$1,239.22	$744.32
38572	T		Laparoscopy, lymphadenectomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
38589	T		Laparoscope proc, lymphatic	0130	31.7825	$1,886.29	$659.53	$377.26
38700	T		Removal of lymph nodes, neck	0113	21.3681	$1,268.20		$253.64
38720	T		Removal of lymph nodes, neck	0113	21.3681	$1,268.20		$253.64
38724	C		Removal of lymph nodes, neck					
38740	T		Remove armpit lymph nodes	0114	40.5805	$2,408.45	$485.91	$481.69
38745	T		Remove armpit lymph nodes	0114	40.5805	$2,408.45	$485.91	$481.69
38746	C		Remove thoracic lymph nodes					
38747	C		Remove abdominal lymph nodes					
38760	T		Remove groin lymph nodes	0113	21.3681	$1,268.20		$253.64
38765	C		Remove groin lymph nodes					
38770	C		Remove pelvis lymph nodes					
38780	C		Remove abdomen lymph nodes					
38790	N		Inject for lymphatic x-ray					
38792	N		Identify sentinel node					
38794	N		Access thoracic lymph duct					
38999	S		Blood/lymph system procedure	0110	3.6428	$216.20		$43.24
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	30.5386	$1,812.47	$591.64	$362.49
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					
4000F	E		Tobacco use txmnt counseling					
4001F	E		Tobacco use txmnt, pharmacol					
4002F	E		Statin therapy, rx					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
4006F	E		Beta-blocker therapy, rx					
4009F	E		Ace inhibitor therapy, rx					
4011F	E		Oral antiplatelet tx, rx					
40490	T		Biopsy of lip	0251	2.0010	$118.76		$23.75
40500	T		Partial excision of lip	0253	16.0627	$953.32	$282.29	$190.66
40510	T		Partial excision of lip	0254	23.2980	$1,382.74	$321.35	$276.55
40520	T		Partial excision of lip	0253	16.0627	$953.32	$282.29	$190.66
40525	T		Reconstruct lip with flap	0254	23.2980	$1,382.74	$321.35	$276.55
40527	T		Reconstruct lip with flap	0254	23.2980	$1,382.74	$321.35	$276.55
40530	T		Partial removal of lip	0254	23.2980	$1,382.74	$321.35	$276.55
40650	T		Repair lip	0252	7.8317	$464.81	$113.41	$92.96
40652	T		Repair lip	0252	7.8317	$464.81	$113.41	$92.96
40654	T		Repair lip	0252	7.8317	$464.81	$113.41	$92.96
40700	T		Repair cleft lip/nasal	0256	37.1513	$2,204.93		$440.99
40701	T		Repair cleft lip/nasal	0256	37.1513	$2,204.93		$440.99
40702	T		Repair cleft lip/nasal	0256	37.1513	$2,204.93		$440.99
40720	T		Repair cleft lip/nasal	0256	37.1513	$2,204.93		$440.99
40761	T		Repair cleft lip/nasal	0256	37.1513	$2,204.93		$440.99
40799	T		Lip surgery procedure	0251	2.0010	$118.76		$23.75
40800	T		Drainage of mouth lesion	0251	2.0010	$118.76		$23.75
40801	T		Drainage of mouth lesion	0252	7.8317	$464.81	$113.41	$92.96
40804	X		Removal, foreign body, mouth	0340	0.6355	$37.72		$7.54
40805	T		Removal, foreign body, mouth	0252	7.8317	$464.81	$113.41	$92.96
40806	T		Incision of lip fold	0251	2.0010	$118.76		$23.75
40808	T		Biopsy of mouth lesion	0251	2.0010	$118.76		$23.75
40810	T		Excision of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
40812	T		Excise/repair mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
40814	T		Excise/repair mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
40816	T		Excision of mouth lesion	0254	23.2980	$1,382.74	$321.35	$276.55
40818	T		Excise oral mucosa for graft	0251	2.0010	$118.76		$23.75
40819	T		Excise lip or cheek fold	0252	7.8317	$464.81	$113.41	$92.96
40820	T		Treatment of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
40830	T		Repair mouth laceration	0251	2.0010	$118.76		$23.75
40831	T		Repair mouth laceration	0252	7.8317	$464.81	$113.41	$92.96
40840	T		Reconstruction of mouth	0254	23.2980	$1,382.74	$321.35	$276.55
40842	T		Reconstruction of mouth	0254	23.2980	$1,382.74	$321.35	$276.55
40843	T		Reconstruction of mouth	0254	23.2980	$1,382.74	$321.35	$276.55
40844	T		Reconstruction of mouth	0256	37.1513	$2,204.93		$440.99
40845	T		Reconstruction of mouth	0256	37.1513	$2,204.93		$440.99
40899	T		Mouth surgery procedure	0251	2.0010	$118.76		$23.75
41000	T		Drainage of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
41005	T		Drainage of mouth lesion	0251	2.0010	$118.76		$23.75
41006	T		Drainage of mouth lesion	0254	23.2980	$1,382.74	$321.35	$276.55
41007	T		Drainage of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
41008	T		Drainage of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
41009	T		Drainage of mouth lesion	0251	2.0010	$118.76		$23.75
41010	T		Incision of tongue fold	0252	7.8317	$464.81	$113.41	$92.96
41015	T		Drainage of mouth lesion	0251	2.0010	$118.76		$23.75
41016	T		Drainage of mouth lesion	0252	7.8317	$464.81	$113.41	$92.96
41017	T		Drainage of mouth lesion	0252	7.8317	$464.81	$113.41	$92.96
41018	T		Drainage of mouth lesion	0252	7.8317	$464.81	$113.41	$92.96
41100	T		Biopsy of tongue	0252	7.8317	$464.81	$113.41	$92.96
41105	T		Biopsy of tongue	0253	16.0627	$953.32	$282.29	$190.66
41108	T		Biopsy of floor of mouth	0252	7.8317	$464.81	$113.41	$92.96
41110	T		Excision of tongue lesion	0253	16.0627	$953.32	$282.29	$190.66
41112	T		Excision of tongue lesion	0253	16.0627	$953.32	$282.29	$190.66
41113	T		Excision of tongue lesion	0253	16.0627	$953.32	$282.29	$190.66
41114	T		Excision of tongue lesion	0254	23.2980	$1,382.74	$321.35	$276.55
41115	T		Excision of tongue fold	0252	7.8317	$464.81	$113.41	$92.96
41116	T		Excision of mouth lesion	0253	16.0627	$953.32	$282.29	$190.66
41120	T		Partial removal of tongue	0254	23.2980	$1,382.74	$321.35	$276.55
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
41153	C		Tongue, mouth, neck surgery					
41155	C		Tongue, jaw, & neck surgery					
41250	T		Repair tongue laceration	0251	2.0010	$118.76		$23.75
41251	T		Repair tongue laceration	0251	2.0010	$118.76		$23.75
41252	T		Repair tongue laceration	0252	7.8317	$464.81	$113.41	$92.96
41500	T		Fixation of tongue	0254	23.2980	$1,382.74	$321.35	$276.55
41510	T		Tongue to lip surgery	0253	16.0627	$953.32	$282.29	$190.66
41520	T		Reconstruction, tongue fold	0252	7.8317	$464.81	$113.41	$92.96
41599	T		Tongue and mouth surgery	0251	2.0010	$118.76		$23.75
41800	T		Drainage of gum lesion	0251	2.0010	$118.76		$23.75
41805	T		Removal foreign body, gum	0254	23.2980	$1,382.74	$321.35	$276.55
41806	T		Removal foreign body,jawbone	0253	16.0627	$953.32	$282.29	$190.66
41820	T		Excision, gum, each quadrant	0252	7.8317	$464.81	$113.41	$92.96
41821	T		Excision of gum flap	0252	7.8317	$464.81	$113.41	$92.96
41822	T		Excision of gum lesion	0253	16.0627	$953.32	$282.29	$190.66
41823	T		Excision of gum lesion	0254	23.2980	$1,382.74	$321.35	$276.55
41825	T		Excision of gum lesion	0253	16.0627	$953.32	$282.29	$190.66
41826	T		Excision of gum lesion	0253	16.0627	$953.32	$282.29	$190.66
41827	T		Excision of gum lesion	0254	23.2980	$1,382.74	$321.35	$276.55
41828	T		Excision of gum lesion	0253	16.0627	$953.32	$282.29	$190.66
41830	T		Removal of gum tissue	0253	16.0627	$953.32	$282.29	$190.66
41850	T		Treatment of gum lesion	0253	16.0627	$953.32	$282.29	$190.66
41870	T		Gum graft	0254	23.2980	$1,382.74	$321.35	$276.55
41872	T		Repair gum	0253	16.0627	$953.32	$282.29	$190.66
41874	T		Repair tooth socket	0254	23.2980	$1,382.74	$321.35	$276.55
41899	T		Dental surgery procedure	0251	2.0010	$118.76		$23.75
42000	T		Drainage mouth roof lesion	0251	2.0010	$118.76		$23.75
42100	T		Biopsy roof of mouth	0252	7.8317	$464.81	$113.41	$92.96
42104	T		Excision lesion, mouth roof	0253	16.0627	$953.32	$282.29	$190.66
42106	T		Excision lesion, mouth roof	0253	16.0627	$953.32	$282.29	$190.66
42107	T		Excision lesion, mouth roof	0254	23.2980	$1,382.74	$321.35	$276.55
42120	T		Remove palate/lesion	0256	37.1513	$2,204.93		$440.99
42140	T		Excision of uvula	0252	7.8317	$464.81	$113.41	$92.96
42145	T		Repair palate, pharynx/uvula	0254	23.2980	$1,382.74	$321.35	$276.55
42160	T		Treatment mouth roof lesion	0253	16.0627	$953.32	$282.29	$190.66
42180	T		Repair palate	0251	2.0010	$118.76		$23.75
42182	T		Repair palate	0256	37.1513	$2,204.93		$440.99
42200	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42205	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42210	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42215	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42220	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42225	T		Reconstruct cleft palate	0256	37.1513	$2,204.93		$440.99
42226	T		Lengthening of palate	0256	37.1513	$2,204.93		$440.99
42227	T		Lengthening of palate	0256	37.1513	$2,204.93		$440.99
42235	T		Repair palate	0253	16.0627	$953.32	$282.29	$190.66
42260	T		Repair nose to lip fistula	0254	23.2980	$1,382.74	$321.35	$276.55
42280	T		Preparation, palate mold	0251	2.0010	$118.76		$23.75
42281	T		Insertion, palate prosthesis	0253	16.0627	$953.32	$282.29	$190.66
42299	T		Palate/uvula surgery	0251	2.0010	$118.76		$23.75
42300	T		Drainage of salivary gland	0253	16.0627	$953.32	$282.29	$190.66
42305	T		Drainage of salivary gland	0253	16.0627	$953.32	$282.29	$190.66
42310	T		Drainage of salivary gland	0251	2.0010	$118.76		$23.75
42320	T		Drainage of salivary gland	0251	2.0010	$118.76		$23.75
42325	T		Create salivary cyst drain	0251	2.0010	$118.76		$23.75
42326	T		Create salivary cyst drain	0252	7.8317	$464.81	$113.41	$92.96
42330	T		Removal of salivary stone	0253	16.0627	$953.32	$282.29	$190.66
42335	T		Removal of salivary stone	0253	16.0627	$953.32	$282.29	$190.66
42340	T		Removal of salivary stone	0253	16.0627	$953.32	$282.29	$190.66
42400	T		Biopsy of salivary gland	0005	3.5831	$212.66	$71.45	$42.53
42405	T		Biopsy of salivary gland	0253	16.0627	$953.32	$282.29	$190.66
42408	T		Excision of salivary cyst	0253	16.0627	$953.32	$282.29	$190.66
42409	T		Drainage of salivary cyst	0253	16.0627	$953.32	$282.29	$190.66
42410	T		Excise parotid gland/lesion	0256	37.1513	$2,204.93		$440.99
42415	T		Excise parotid gland/lesion	0256	37.1513	$2,204.93		$440.99
42420	T		Excise parotid gland/lesion	0256	37.1513	$2,204.93		$440.99

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
42425	T		Excise parotid gland/lesion	0256	37.1513	$2,204.93		$440.99
42426	C		Excise parotid gland/lesion					
42440	T		Excise submaxillary gland	0256	37.1513	$2,204.93		$440.99
42450	T		Excise sublingual gland	0254	23.2980	$1,382.74	$321.35	$276.55
42500	T		Repair salivary duct	0254	23.2980	$1,382.74	$321.35	$276.55
42505	T		Repair salivary duct	0256	37.1513	$2,204.93		$440.99
42507	T		Parotid duct diversion	0256	37.1513	$2,204.93		$440.99
42508	T		Parotid duct diversion	0256	37.1513	$2,204.93		$440.99
42509	T		Parotid duct diversion	0256	37.1513	$2,204.93		$440.99
42510	T		Parotid duct diversion	0256	37.1513	$2,204.93		$440.99
42550	N		Injection for salivary x-ray					
42600	T		Closure of salivary fistula	0253	16.0627	$953.32	$282.29	$190.66
42650	T		Dilation of salivary duct	0252	7.8317	$464.81	$113.41	$92.96
42660	T		Dilation of salivary duct	0251	2.0010	$118.76		$23.75
42665	T		Ligation of salivary duct	0254	23.2980	$1,382.74	$321.35	$276.55
42699	T		Salivary surgery procedure	0251	2.0010	$118.76		$23.75
42700	T		Drainage of tonsil abscess	0251	2.0010	$118.76		$23.75
42720	T		Drainage of throat abscess	0253	16.0627	$953.32	$282.29	$190.66
42725	T		Drainage of throat abscess	0256	37.1513	$2,204.93		$440.99
42800	T		Biopsy of throat	0253	16.0627	$953.32	$282.29	$190.66
42802	T		Biopsy of throat	0253	16.0627	$953.32	$282.29	$190.66
42804	T		Biopsy of upper nose/throat	0253	16.0627	$953.32	$282.29	$190.66
42806	T		Biopsy of upper nose/throat	0254	23.2980	$1,382.74	$321.35	$276.55
42808	T		Excise pharynx lesion	0253	16.0627	$953.32	$282.29	$190.66
42809	X		Remove pharynx foreign body	0340	0.6355	$37.72		$7.54
42810	T		Excision of neck cyst	0254	23.2980	$1,382.74	$321.35	$276.55
42815	T		Excision of neck cyst	0256	37.1513	$2,204.93		$440.99
42820	T		Remove tonsils and adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42821	T		Remove tonsils and adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42825	T		Removal of tonsils	0258	22.1458	$1,314.35	$437.25	$262.87
42826	T		Removal of tonsils	0258	22.1458	$1,314.35	$437.25	$262.87
42830	T		Removal of adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42831	T		Removal of adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42835	T		Removal of adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42836	T		Removal of adenoids	0258	22.1458	$1,314.35	$437.25	$262.87
42842	T		Extensive surgery of throat	0254	23.2980	$1,382.74	$321.35	$276.55
42844	T		Extensive surgery of throat	0256	37.1513	$2,204.93		$440.99
42845	C		Extensive surgery of throat					
42860	T		Excision of tonsil tags	0258	22.1458	$1,314.35	$437.25	$262.87
42870	T		Excision of lingual tonsil	0258	22.1458	$1,314.35	$437.25	$262.87
42890	T		Partial removal of pharynx	0256	37.1513	$2,204.93		$440.99
42892	T		Revision of pharyngeal walls	0256	37.1513	$2,204.93		$440.99
42894	C		Revision of pharyngeal walls					
42900	T		Repair throat wound	0252	7.8317	$464.81	$113.41	$92.96
42950	T		Reconstruction of throat	0254	23.2980	$1,382.74	$321.35	$276.55
42953	C		Repair throat, esophagus					
42955	T		Surgical opening of throat	0254	23.2980	$1,382.74	$321.35	$276.55
42960	T		Control throat bleeding	0250	1.2838	$76.19	$26.67	$15.24
42961	C		Control throat bleeding					
42962	T		Control throat bleeding	0256	37.1513	$2,204.93		$440.99
42970	T		Control nose/throat bleeding	0250	1.2838	$76.19	$26.67	$15.24
42971	C		Control nose/throat bleeding					
42972	T		Control nose/throat bleeding	0253	16.0627	$953.32	$282.29	$190.66
42999	T		Throat surgery procedure	0251	2.0010	$118.76		$23.75
43020	T		Incision of esophagus	0252	7.8317	$464.81	$113.41	$92.96
43030	T		Throat muscle surgery	0253	16.0627	$953.32	$282.29	$190.66
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					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	23.2980	$1,382.74	$321.35	$276.55
43135	C		Removal of esophagus pouch					
43200	T		Esophagus endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43201	T		Esoph scope w/submucous inj	0141	8.1464	$483.49	$143.38	$96.70
43202	T		Esophagus endoscopy, biopsy	0141	8.1464	$483.49	$143.38	$96.70
43204	T		Esoph scope w/sclerosis inj	0141	8.1464	$483.49	$143.38	$96.70
43205	T		Esophagus endoscopy/ligation	0141	8.1464	$483.49	$143.38	$96.70
43215	T		Esophagus endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43216	T		Esophagus endoscopy/lesion	0141	8.1464	$483.49	$143.38	$96.70
43217	T		Esophagus endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43219	T		Esophagus endoscopy	0384	22.2381	$1,319.83	$286.66	$263.97
43220	T		Esoph endoscopy, dilation	0141	8.1464	$483.49	$143.38	$96.70
43226	T		Esoph endoscopy, dilation	0141	8.1464	$483.49	$143.38	$96.70
43227	T		Esoph endoscopy, repair	0141	8.1464	$483.49	$143.38	$96.70
43228	T		Esoph endoscopy, ablation	0422	22.8607	$1,356.78	$448.81	$271.36
43231	T		Esoph endoscopy w/us exam	0141	8.1464	$483.49	$143.38	$96.70
43232	T		Esoph endoscopy w/us fn bx	0141	8.1464	$483.49	$143.38	$96.70
43234	T		Upper GI endoscopy, exam	0141	8.1464	$483.49	$143.38	$96.70
43235	T		Uppr gi endoscopy, diagnosis	0141	8.1464	$483.49	$143.38	$96.70
43236	T		Uppr gi scope w/submuc inj	0141	8.1464	$483.49	$143.38	$96.70
43237	T		Endoscopic us exam, esoph	0141	8.1464	$483.49	$143.38	$96.70
43238	T		Uppr gi endoscopy w/us fn bx	0141	8.1464	$483.49	$143.38	$96.70
43239	T		Upper GI endoscopy, biopsy	0141	8.1464	$483.49	$143.38	$96.70
43240	T		Esoph endoscope w/drain cyst	0141	8.1464	$483.49	$143.38	$96.70
43241	T		Upper GI endoscopy with tube	0141	8.1464	$483.49	$143.38	$96.70
43242	T		Uppr gi endoscopy w/us fn bx	0141	8.1464	$483.49	$143.38	$96.70
43243	T		Upper gi endoscopy & inject	0141	8.1464	$483.49	$143.38	$96.70
43244	T		Upper GI endoscopy/ligation	0141	8.1464	$483.49	$143.38	$96.70
43245	T		Uppr gi scope dilate strictr	0141	8.1464	$483.49	$143.38	$96.70
43246	T		Place gastrostomy tube	0141	8.1464	$483.49	$143.38	$96.70
43247	T		Operative upper GI endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43248	T		Uppr gi endoscopy/guide wire	0141	8.1464	$483.49	$143.38	$96.70
43249	T		Esoph endoscopy, dilation	0141	8.1464	$483.49	$143.38	$96.70
43250	T		Upper GI endoscopy/tumor	0141	8.1464	$483.49	$143.38	$96.70
43251	T		Operative upper GI endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43255	T		Operative upper GI endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43256	T		Uppr gi endoscopy w stent	0384	22.2381	$1,319.83	$286.66	$263.97
43257	T		Uppr gi scope w/thrml txmnt	0422	22.8607	$1,356.78	$448.81	$271.36
43258	T		Operative upper GI endoscopy	0141	8.1464	$483.49	$143.38	$96.70
43259	T		Endoscopic ultrasound exam	0141	8.1464	$483.49	$143.38	$96.70
43260	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43261	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43262	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43263	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43264	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43265	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43267	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43268	T		Endo cholangiopancreatograph	0384	22.2381	$1,319.83	$286.66	$263.97
43269	T		Endo cholangiopancreatograph	0384	22.2381	$1,319.83	$286.66	$263.97
43271	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43272	T		Endo cholangiopancreatograph	0151	18.6489	$1,106.81	$245.46	$221.36
43280	T		Laparoscopy, fundoplasty	0132	62.7061	$3,721.61	$1,239.22	$744.32
43289	T		Laparoscope proc, esoph	0130	31.7825	$1,886.29	$659.53	$377.26
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
43326	C		Revise esophagus & stomach					
43330	C		Repair of esophagus					
43331	C		Repair of esophagus					
43340	C		Fuse esophagus & intestine					
43341	C		Fuse esophagus & intestine					
43350	C		Surgical opening, esophagus					
43351	C		Surgical opening, esophagus					
43352	C		Surgical opening, esophagus					
43360	C		Gastrointestinal repair					
43361	C		Gastrointestinal repair					
43400	C		Ligate esophagus veins					
43401	C		Esophagus surgery for veins					
43405	C		Ligate/staple esophagus					
43410	C		Repair esophagus wound					
43415	C		Repair esophagus wound					
43420	C		Repair esophagus opening					
43425	C		Repair esophagus opening					
43450	T		Dilate esophagus	0140	5.4489	$323.39	$93.77	$64.68
43453	T		Dilate esophagus	0140	5.4489	$323.39	$93.77	$64.68
43456	T		Dilate esophagus	0140	5.4489	$323.39	$93.77	$64.68
43458	T		Dilate esophagus	0140	5.4489	$323.39	$93.77	$64.68
43460	C		Pressure treatment esophagus					
43496	C		Free jejunum flap, microvasc					
43499	T		Esophagus surgery procedure	0141	8.1464	$483.49	$143.38	$96.70
43500	C		Surgical opening of stomach					
43501	C		Surgical repair of stomach					
43502	C		Surgical repair of stomach					
43510	T		Surgical opening of stomach	0141	8.1464	$483.49	$143.38	$96.70
43520	C		Incision of pyloric muscle					
43600	T		Biopsy of stomach	0141	8.1464	$483.49	$143.38	$96.70
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					
43644	C		Lap gastric bypass/roux-en-y					
43645	C		Lap gastr bypass incl smll i					
43651	T		Laparoscopy, vagus nerve	0132	62.7061	$3,721.61	$1,239.22	$744.32
43652	T		Laparoscopy, vagus nerve	0132	62.7061	$3,721.61	$1,239.22	$744.32
43653	T		Laparoscopy, gastrostomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
43659	T		Laparoscope proc, stom	0130	31.7825	$1,886.29	$659.53	$377.26
43750	T		Place gastrostomy tube	0141	8.1464	$483.49	$143.38	$96.70
43752	X		Nasal/orogastric w/stent	0272	1.3738	$81.54	$32.61	$16.31
43760	T		Change gastrostomy tube	0121	2.2663	$134.50	$43.80	$26.90
43761	T		Reposition gastrostomy tube	0122	6.9405	$411.92	$84.48	$82.38
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	0422	22.8607	$1,356.78	$448.81	$271.36
43831	T		Place gastrostomy tube	0141	8.1464	$483.49	$143.38	$96.70
43832	C		Place gastrostomy tube					
43840	C		Repair of stomach lesion					
43842	C		Gastroplasty for obesity					
43843	C		Gastroplasty for obesity					
43845	C		Gastroplasty duodenal switch					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	8.1464	$483.49	$143.38	$96.70
43880	C		Repair stomach-bowel fistula					
43999	T		Stomach surgery procedure	0141	8.1464	$483.49	$143.38	$96.70
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	8.1464	$483.49	$143.38	$96.70
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					
44137	C		Remove intestinal allograft					
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	43.1426	$2,560.51	$1,001.89	$512.10
44201	T		Laparoscopy, jejunostomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
44202	C		Lap resect s/intestine singl					
44203	C		Lap resect s/intestine, addl					
44204	C		Laparo partial colectomy					
44205	C		Lap colectomy part w/ileum					
44206	T		Lap part colectomy w/stoma	0132	62.7061	$3,721.61	$1,239.22	$744.32
44207	T		L colectomy/coloproctostomy	0132	62.7061	$3,721.61	$1,239.22	$744.32
44208	T		L colectomy/coloproctostomy	0132	62.7061	$3,721.61	$1,239.22	$744.32
44210	C		Laparo total proctocolectomy					
44211	C		Laparo total proctocolectomy					
44212	C		Laparo total proctocolectomy					
44238	T		Laparoscope proc, intestine	0130	31.7825	$1,886.29	$659.53	$377.26
44239	T		Laparoscope proc, rectum	0130	31.7825	$1,886.29	$659.53	$377.26
44300	C		Open bowel to skin					
44310	C		Ileostomy/jejunostomy					
44312	T		Revision of ileostomy	0027	18.3348	$1,088.17	$329.72	$217.63
44314	C		Revision of ileostomy					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
44316	C		Devise bowel pouch					
44320	C		Colostomy					
44322	C		Colostomy with biopsies					
44340	T		Revision of colostomy	0027	18.3348	$1,088.17	$329.72	$217.63
44345	C		Revision of colostomy					
44346	C		Revision of colostomy					
44360	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44361	T		Small bowel endoscopy/biopsy	0142	9.3063	$552.33	$152.78	$110.47
44363	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44364	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44365	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44366	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44369	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44370	T		Small bowel endoscopy/stent	0384	22.2381	$1,319.83	$286.66	$263.97
44372	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44373	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44376	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44377	T		Small bowel endoscopy/biopsy	0142	9.3063	$552.33	$152.78	$110.47
44378	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44379	T		S bowel endoscope w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
44380	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44382	T		Small bowel endoscopy	0142	9.3063	$552.33	$152.78	$110.47
44383	T		Ileoscopy w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
44385	T		Endoscopy of bowel pouch	0143	8.6475	$513.23	$186.06	$102.65
44386	T		Endoscopy, bowel pouch/biop	0143	8.6475	$513.23	$186.06	$102.65
44388	T		Colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
44389	T		Colonoscopy with biopsy	0143	8.6475	$513.23	$186.06	$102.65
44390	T		Colonoscopy for foreign body	0143	8.6475	$513.23	$186.06	$102.65
44391	T		Colonoscopy for bleeding	0143	8.6475	$513.23	$186.06	$102.65
44392	T		Colonoscopy & polypectomy	0143	8.6475	$513.23	$186.06	$102.65
44393	T		Colonoscopy, lesion removal	0143	8.6475	$513.23	$186.06	$102.65
44394	T		Colonoscopy w/snare	0143	8.6475	$513.23	$186.06	$102.65
44397	T		Colonoscopy w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
44500	T		Intro, gastrointestinal tube	0121	2.2663	$134.50	$43.80	$26.90
44602	C		Suture, small intestine					
44603	C		Suture, small intestine					
44604	C		Suture, large intestine					
44605	C		Repair of bowel lesion					
44615	C		Intestinal stricturoplasty					
44620	C		Repair bowel opening					
44625	C		Repair bowel opening					
44626	C		Repair bowel opening					
44640	C		Repair bowel-skin fistula					
44650	C		Repair bowel fistula					
44660	C		Repair bowel-bladder fistula					
44661	C		Repair bowel-bladder fistula					
44680	C		Surgical revision, intestine					
44700	C		Suspend bowel w/prosthesis					
44701	N		Intraop colon lavage add-on					
44715	C		Prepare donor intestine					
44720	C		Prep donor intestine/venous					
44721	C		Prep donor intestine/artery					
44799	T		Unlisted procedure intestine	0142	9.3063	$552.33	$152.78	$110.47
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	T		Drain app abscess, percut	0037	9.4322	$559.80	$223.91	$111.96
44950	C		Appendectomy					
44955	C		Appendectomy add-on					
44960	C		Appendectomy					
44970	T		Laparoscopy, appendectomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
44979	T		Laparoscope proc, app	0130	31.7825	$1,886.29	$659.53	$377.26
45000	T		Drainage of pelvic abscess	0148	3.7213	$220.86	$56.96	$44.17
45005	T		Drainage of rectal abscess	0155	16.1810	$960.34		$192.07

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
45020	T		Drainage of rectal abscess	0155	16.1810	$960.34		$192.07
45100	T		Biopsy of rectum	0149	17.9907	$1,067.75	$293.06	$213.55
45108	T		Removal of anorectal lesion	0150	23.7573	$1,410.00	$437.12	$282.00
45110	C		Removal of rectum					
45111	C		Partial removal of rectum					
45112	C		Removal of rectum					
45113	C		Partial proctectomy					
45114	C		Partial removal of rectum					
45116	C		Partial removal of rectum					
45119	C		Remove rectum w/reservoir					
45120	C		Removal of rectum					
45121	C		Removal of rectum and colon					
45123	C		Partial proctectomy					
45126	C		Pelvic exenteration					
45130	C		Excision of rectal prolapse					
45135	C		Excision of rectal prolapse					
45136	C		Excise ileoanal reservior					
45150	T		Excision of rectal stricture	0149	17.9907	$1,067.75	$293.06	$213.55
45160	T		Excision of rectal lesion	0150	23.7573	$1,410.00	$437.12	$282.00
45170	T		Excision of rectal lesion	0150	23.7573	$1,410.00	$437.12	$282.00
45190	T		Destruction, rectal tumor	0150	23.7573	$1,410.00	$437.12	$282.00
45300	T		Proctosigmoidoscopy dx	0146	4.6164	$273.98	$64.40	$54.80
45303	T		Proctosigmoidoscopy dilate	0147	7.9318	$470.75		$94.15
45305	T		Proctosigmoidoscopy w/bx	0147	7.9318	$470.75		$94.15
45307	T		Proctosigmoidoscopy fb	0428	19.8121	$1,175.85		$235.17
45308	T		Proctosigmoidoscopy removal	0147	7.9318	$470.75		$94.15
45309	T		Proctosigmoidoscopy removal	0147	7.9318	$470.75		$94.15
45315	T		Proctosigmoidoscopy removal	0147	7.9318	$470.75		$94.15
45317	T		Proctosigmoidoscopy bleed	0147	7.9318	$470.75		$94.15
45320	T		Proctosigmoidoscopy ablate	0428	19.8121	$1,175.85		$235.17
45321	T		Proctosigmoidoscopy volvul	0428	19.8121	$1,175.85		$235.17
45327	T		Proctosigmoidoscopy w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
45330	T		Diagnostic sigmoidoscopy	0146	4.6164	$273.98	$64.40	$54.80
45331	T		Sigmoidoscopy and biopsy	0146	4.6164	$273.98	$64.40	$54.80
45332	T		Sigmoidoscopy w/fb removal	0146	4.6164	$273.98	$64.40	$54.80
45333	T		Sigmoidoscopy & polypectomy	0147	7.9318	$470.75		$94.15
45334	T		Sigmoidoscopy for bleeding	0147	7.9318	$470.75		$94.15
45335	T		Sigmoidoscopy w/submuc inj	0146	4.6164	$273.98	$64.40	$54.80
45337	T		Sigmoidoscopy & decompress	0146	4.6164	$273.98	$64.40	$54.80
45338	T		Sigmoidoscopy w/tumr remove	0147	7.9318	$470.75		$94.15
45339	T		Sigmoidoscopy w/ablate tumr	0147	7.9318	$470.75		$94.15
45340	T		Sig w/balloon dilation	0147	7.9318	$470.75		$94.15
45341	T		Sigmoidoscopy w/ultrasound	0147	7.9318	$470.75		$94.15
45342	T		Sigmoidoscopy w/us guide bx	0147	7.9318	$470.75		$94.15
45345	T		Sigmoidoscopy w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
45355	T		Surgical colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
45378	T		Diagnostic colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
45379	T		Colonoscopy w/fb removal	0143	8.6475	$513.23	$186.06	$102.65
45380	T		Colonoscopy and biopsy	0143	8.6475	$513.23	$186.06	$102.65
45381	T		Colonoscopy, submucous inj	0143	8.6475	$513.23	$186.06	$102.65
45382	T		Colonoscopy/control bleeding	0143	8.6475	$513.23	$186.06	$102.65
45383	T		Lesion removal colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
45384	T		Lesion remove colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
45385	T		Lesion removal colonoscopy	0143	8.6475	$513.23	$186.06	$102.65
45386	T		Colonoscopy dilate stricture	0143	8.6475	$513.23	$186.06	$102.65
45387	T		Colonoscopy w/stent	0384	22.2381	$1,319.83	$286.66	$263.97
45391	T		Colonoscopy w/endoscope us	0143	8.6475	$513.23	$186.06	$102.65
45392	T		Colonoscopy w/endoscopic fnb	0143	8.6475	$513.23	$186.06	$102.65
45500	T		Repair of rectum	0149	17.9907	$1,067.75	$293.06	$213.55
45505	T		Repair of rectum	0150	23.7573	$1,410.00	$437.12	$282.00
45520	T		Treatment of rectal prolapse	0098	1.1295	$67.04		$13.41
45540	C		Correct rectal prolapse					
45541	T		Correct rectal prolapse	0150	23.7573	$1,410.00	$437.12	$282.00
45550	C		Repair rectum/remove sigmoid					
45560	T		Repair of rectocele	0150	23.7573	$1,410.00	$437.12	$282.00
45562	C		Exploration/repair of rectum					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	3.7213	$220.86	$56.96	$44.17
45905	T		Dilation of anal sphincter	0149	17.9907	$1,067.75	$293.06	$213.55
45910	T		Dilation of rectal narrowing	0149	17.9907	$1,067.75	$293.06	$213.55
45915	T		Remove rectal obstruction	0148	3.7213	$220.86	$56.96	$44.17
45999	T		Rectum surgery procedure	0148	3.7213	$220.86	$56.96	$44.17
46020	T		Placement of seton	0150	23.7573	$1,410.00	$437.12	$282.00
46030	T		Removal of rectal marker	0148	3.7213	$220.86	$56.96	$44.17
46040	T		Incision of rectal abscess	0149	17.9907	$1,067.75	$293.06	$213.55
46045	T		Incision of rectal abscess	0150	23.7573	$1,410.00	$437.12	$282.00
46050	T		Incision of anal abscess	0148	3.7213	$220.86	$56.96	$44.17
46060	T		Incision of rectal abscess	0150	23.7573	$1,410.00	$437.12	$282.00
46070	T		Incision of anal septum	0155	16.1810	$960.34		$192.07
46080	T		Incision of anal sphincter	0149	17.9907	$1,067.75	$293.06	$213.55
46083	T		Incise external hemorrhoid	0148	3.7213	$220.86	$56.96	$44.17
46200	T		Removal of anal fissure	0150	23.7573	$1,410.00	$437.12	$282.00
46210	T		Removal of anal crypt	0149	17.9907	$1,067.75	$293.06	$213.55
46211	T		Removal of anal crypts	0150	23.7573	$1,410.00	$437.12	$282.00
46220	T		Removal of anal tag	0149	17.9907	$1,067.75	$293.06	$213.55
46221	T		Ligation of hemorrhoid(s)	0148	3.7213	$220.86	$56.96	$44.17
46230	T		Removal of anal tags	0149	17.9907	$1,067.75	$293.06	$213.55
46250	T		Hemorrhoidectomy	0150	23.7573	$1,410.00	$437.12	$282.00
46255	T		Hemorrhoidectomy	0150	23.7573	$1,410.00	$437.12	$282.00
46257	T		Remove hemorrhoids & fissure	0150	23.7573	$1,410.00	$437.12	$282.00
46258	T		Remove hemorrhoids & fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46260	T		Hemorrhoidectomy	0150	23.7573	$1,410.00	$437.12	$282.00
46261	T		Remove hemorrhoids & fissure	0150	23.7573	$1,410.00	$437.12	$282.00
46262	T		Remove hemorrhoids & fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46270	T		Removal of anal fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46275	T		Removal of anal fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46280	T		Removal of anal fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46285	T		Removal of anal fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46288	T		Repair anal fistula	0150	23.7573	$1,410.00	$437.12	$282.00
46320	T		Removal of hemorrhoid clot	0148	3.7213	$220.86	$56.96	$44.17
46500	T		Injection into hemorrhoid(s)	0155	16.1810	$960.34		$192.07
46600	X		Diagnostic anoscopy	0340	0.6355	$37.72		$7.54
46604	T		Anoscopy and dilation	0147	7.9318	$470.75		$94.15
46606	T		Anoscopy and biopsy	0146	4.6164	$273.98	$64.40	$54.80
46608	T		Anoscopy, remove for body	0147	7.9318	$470.75		$94.15
46610	T		Anoscopy, remove lesion	0428	19.8121	$1,175.85		$235.17
46611	T		Anoscopy	0147	7.9318	$470.75		$94.15
46612	T		Anoscopy, remove lesions	0428	19.8121	$1,175.85		$235.17
46614	T		Anoscopy, control bleeding	0146	4.6164	$273.98	$64.40	$54.80
46615	T		Anoscopy	0428	19.8121	$1,175.85		$235.17
46700	T		Repair of anal stricture	0150	23.7573	$1,410.00	$437.12	$282.00
46705	C		Repair of anal stricture					
46706	T		Repr of anal fistula w/glue	0150	23.7573	$1,410.00	$437.12	$282.00
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	23.7573	$1,410.00	$437.12	$282.00
46751	C		Repair of anal sphincter					
46753	T		Reconstruction of anus	0150	23.7573	$1,410.00	$437.12	$282.00
46754	T		Removal of suture from anus	0149	17.9907	$1,067.75	$293.06	$213.55
46760	T		Repair of anal sphincter	0150	23.7573	$1,410.00	$437.12	$282.00
46761	T		Repair of anal sphincter	0150	23.7573	$1,410.00	$437.12	$282.00

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
46762	T		Implant artificial sphincter	0150	23.7573	$1,410.00	$437.12	$282.00
46900	T		Destruction, anal lesion(s)	0016	2.5717	$152.63	$33.42	$30.53
46910	T		Destruction, anal lesion(s)	0017	18.3377	$1,088.34	$227.84	$217.67
46916	T		Cryosurgery, anal lesion(s)	0013	1.1028	$65.45	$14.20	$13.09
46917	T		Laser surgery, anal lesions	0695	20.2244	$1,200.32	$266.59	$240.06
46922	T		Excision of anal lesion(s)	0695	20.2244	$1,200.32	$266.59	$240.06
46924	T		Destruction, anal lesion(s)	0695	20.2244	$1,200.32	$266.59	$240.06
46934	T		Destruction of hemorrhoids	0155	16.1810	$960.34		$192.07
46935	T		Destruction of hemorrhoids	0155	16.1810	$960.34		$192.07
46936	T		Destruction of hemorrhoids	0149	17.9907	$1,067.75	$293.06	$213.55
46937	T		Cryotherapy of rectal lesion	0149	17.9907	$1,067.75	$293.06	$213.55
46938	T		Cryotherapy of rectal lesion	0150	23.7573	$1,410.00	$437.12	$282.00
46940	T		Treatment of anal fissure	0149	17.9907	$1,067.75	$293.06	$213.55
46942	T		Treatment of anal fissure	0148	3.7213	$220.86	$56.96	$44.17
46945	T		Ligation of hemorrhoids	0155	16.1810	$960.34		$192.07
46946	T		Ligation of hemorrhoids	0155	16.1810	$960.34		$192.07
46947	T		Hemorrhoidopexy by stapling	0150	23.7573	$1,410.00	$437.12	$282.00
46999	T		Anus surgery procedure	0148	3.7213	$220.86	$56.96	$44.17
47000	T		Needle biopsy of liver	0685	5.9902	$355.52	$115.47	$71.10
47001	N		Needle biopsy, liver add-on					
47010	C		Open drainage, liver lesion					
47011	T		Percut drain, liver lesion	0037	9.4322	$559.80	$223.91	$111.96
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					
47135	C		Transplantation of liver					
47136	C		Transplantation of liver					
47140	C		Partial removal, donor liver					
47141	C		Partial removal, donor liver					
47142	C		Partial removal, donor liver					
47143	C		Prep donor liver, whole					
47144	C		Prep donor liver, 3-segment					
47145	C		Prep donor liver, lobe split					
47146	C		Prep donor liver/venous					
47147	C		Prep donor liver/arterial					
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	0131	43.1426	$2,560.51	$1,001.89	$512.10
47371	T		Laparo ablate liver cryosurg	0131	43.1426	$2,560.51	$1,001.89	$512.10
47379	T		Laparoscope procedure, liver	0130	31.7825	$1,886.29	$659.53	$377.26
47380	C		Open ablate liver tumor rf					
47381	C		Open ablate liver tumor cryo					
47382	T		Percut ablate liver rf	0423	40.1041	$2,380.18		$476.04
47399	T		Liver surgery procedure	0002	0.9515	$56.47		$11.29
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	12.2277	$725.71		$145.14
47500	N		Injection for liver x-rays					
47505	N		Injection for liver x-rays					
47510	T		Insert catheter, bile duct	0152	12.2277	$725.71		$145.14
47511	T		Insert bile duct drain	0152	12.2277	$725.71		$145.14
47525	T		Change bile duct catheter	0427	10.1516	$602.50	$123.56	$120.50
47530	T		Revise/reinsert bile tube	0427	10.1516	$602.50	$123.56	$120.50
47550	C		Bile duct endoscopy add-on					
47552	T		Biliary endoscopy thru skin	0152	12.2277	$725.71		$145.14
47553	T		Biliary endoscopy thru skin	0152	12.2277	$725.71		$145.14

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
47554	T		Biliary endoscopy thru skin	0152	12.2277	$725.71		$145.14
47555	T		Biliary endoscopy thru skin	0152	12.2277	$725.71		$145.14
47556	T		Biliary endoscopy thru skin	0152	12.2277	$725.71		$145.14
47560	T		Laparoscopy w/cholangio	0130	31.7825	$1,886.29	$659.53	$377.26
47561	T		Laparo w/cholangio/biopsy	0130	31.7825	$1,886.29	$659.53	$377.26
47562	T		Laparoscopic cholecystectomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
47563	T		Laparo cholecystectomy/graph	0131	43.1426	$2,560.51	$1,001.89	$512.10
47564	T		Laparo cholecystectomy/explr	0131	43.1426	$2,560.51	$1,001.89	$512.10
47570	C		Laparo cholecystoenterostomy					
47579	T		Laparoscope proc, biliary	0130	31.7825	$1,886.29	$659.53	$377.26
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	12.2277	$725.71		$145.14
47700	C		Exploration of bile ducts					
47701	C		Bile duct revision					
47711	C		Excision of bile duct tumor					
47712	C		Excision of bile duct tumor					
47715	C		Excision of bile duct cyst					
47716	C		Fusion of bile duct cyst					
47720	C		Fuse gallbladder & bowel					
47721	C		Fuse upper gi structures					
47740	C		Fuse gallbladder & bowel					
47741	C		Fuse gallbladder & bowel					
47760	C		Fuse bile ducts and bowel					
47765	C		Fuse liver ducts & bowel					
47780	C		Fuse bile ducts and bowel					
47785	C		Fuse bile ducts and bowel					
47800	C		Reconstruction of bile ducts					
47801	C		Placement, bile duct support					
47802	C		Fuse liver duct & intestine					
47900	C		Suture bile duct injury					
47999	T		Bile tract surgery procedure	0152	12.2277	$725.71		$145.14
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	5.9902	$355.52	$115.47	$71.10
48120	C		Removal of pancreas lesion					
48140	C		Partial removal of pancreas					
48145	C		Partial removal of pancreas					
48146	C		Pancreatectomy					
48148	C		Removal of pancreatic duct					
48150	C		Partial removal of pancreas					
48152	C		Pancreatectomy					
48153	C		Pancreatectomy					
48154	C		Pancreatectomy					
48155	C		Removal of pancreas					
48160	E		Pancreas removal/transplant					
48180	C		Fuse pancreas and bowel					
48400	C		Injection, intraop add-on					
48500	C		Surgery of pancreatic cyst					
48510	C		Drain pancreatic pseudocyst					
48511	T		Drain pancreatic pseudocyst	0037	9.4322	$559.80	$223.91	$111.96
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					
48551	C		Prep donor pancreas					
48552	C		Prep donor pancreas/venous					
48554	E		Transpl allograft pancreas					
48556	C		Removal, allograft pancreas					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
48999	T		Pancreas surgery procedure	0004	1.7566	$104.25	$22.36	$20.85
49000	C		Exploration of abdomen					
49002	C		Reopening of abdomen					
49010	C		Exploration behind abdomen					
49020	C		Drain abdominal abscess					
49021	T		Drain abdominal abscess	0037	9.4322	$559.80	$223.91	$111.96
49040	C		Drain, open, abdom abscess					
49041	T		Drain, percut, abdom abscess	0037	9.4322	$559.80	$223.91	$111.96
49060	C		Drain, open, retrop abscess					
49061	T		Drain, percut, retroper absc	0037	9.4322	$559.80	$223.91	$111.96
49062	C		Drain to peritoneal cavity					
49080	T		Puncture, peritoneal cavity	0070	3.1956	$189.66		$37.93
49081	T		Removal of abdominal fluid	0070	3.1956	$189.66		$37.93
49085	T		Remove abdomen foreign body	0153	21.5979	$1,281.84	$381.07	$256.37
49180	T		Biopsy, abdominal mass	0685	5.9902	$355.52	$115.47	$71.10
49200	T		Removal of abdominal lesion	0130	31.7825	$1,886.29	$659.53	$377.26
49201	C		Remove abdom lesion, complex					
49215	C		Excise sacral spine tumor					
49220	C		Multiple surgery, abdomen					
49250	T		Excision of umbilicus	0153	21.5979	$1,281.84	$381.07	$256.37
49255	C		Removal of omentum					
49320	T		Diag laparo separate proc	0130	31.7825	$1,886.29	$659.53	$377.26
49321	T		Laparoscopy, biopsy	0130	31.7825	$1,886.29	$659.53	$377.26
49322	T		Laparoscopy, aspiration	0130	31.7825	$1,886.29	$659.53	$377.26
49323	T		Laparo drain lymphocele	0130	31.7825	$1,886.29	$659.53	$377.26
49329	T		Laparo proc, abdm/per/oment	0130	31.7825	$1,886.29	$659.53	$377.26
49400	N		Air injection into abdomen					
49419	T		Insrt abdom cath for chemotx	0115	31.3302	$1,859.45	$459.35	$371.89
49420	T		Insert abdom drain, temp	0652	28.7639	$1,707.14		$341.43
49421	T		Insert abdom drain, perm	0652	28.7639	$1,707.14		$341.43
49422	T		Remove perm cannula/catheter	0105	22.2671	$1,321.55	$370.40	$264.31
49423	T		Exchange drainage catheter	0152	12.2277	$725.71		$145.14
49424	N		Assess cyst, contrast inject					
49425	C		Insert abdomen-venous drain					
49426	T		Revise abdomen-venous shunt	0153	21.5979	$1,281.84	$381.07	$256.37
49427	N		Injection, abdominal shunt					
49428	C		Ligation of shunt					
49429	T		Removal of shunt	0105	22.2671	$1,321.55	$370.40	$264.31
49491	T		Rpr hern preemie reduc	0154	28.6544	$1,700.64	$464.85	$340.13
49492	T		Rpr ing hern premie, blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49495	T		Rpr ing hernia baby, reduc	0154	28.6544	$1,700.64	$464.85	$340.13
49496	T		Rpr ing hernia baby, blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49500	T		Rpr ing hernia, init, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49501	T		Rpr ing hernia, init blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49505	T		Prp i/hern init reduc>5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49507	T		Prp i/hern init block>5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49520	T		Rerepair ing hernia, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49521	T		Rerepair ing hernia, blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49525	T		Repair ing hernia, sliding	0154	28.6544	$1,700.64	$464.85	$340.13
49540	T		Repair lumbar hernia	0154	28.6544	$1,700.64	$464.85	$340.13
49550	T		Rpr rem hernia, init, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49553	T		Rpr fem hernia, init blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49555	T		Rerepair fem hernia, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49557	T		Rerepair fem hernia, blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49560	T		Rpr ventral hern init, reduc	0154	28.6544	$1,700.64	$464.85	$340.13
49561	T		Rpr ventral hern init, block	0154	28.6544	$1,700.64	$464.85	$340.13
49565	T		Rerepair ventrl hern, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49566	T		Rerepair ventrl hern, block	0154	28.6544	$1,700.64	$464.85	$340.13
49568	T		Hernia repair w/mesh	0154	28.6544	$1,700.64	$464.85	$340.13
49570	T		Rpr epigastric hern, reduce	0154	28.6544	$1,700.64	$464.85	$340.13
49572	T		Rpr epigastric hern, blocked	0154	28.6544	$1,700.64	$464.85	$340.13
49580	T		Rpr umbil hern, reduc < 5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49582	T		Rpr umbil hern, block < 5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49585	T		Rpr umbil hern, reduc > 5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49587	T		Rpr umbil hern, block > 5 yr	0154	28.6544	$1,700.64	$464.85	$340.13
49590	T		Repair spigilian hernia	0154	28.6544	$1,700.64	$464.85	$340.13

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
49600	T		Repair umbilical lesion	0154	28.6544	$1,700.64	$464.85	$340.13
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	43.1426	$2,560.51	$1,001.89	$512.10
49651	T		Laparo hernia repair recur	0131	43.1426	$2,560.51	$1,001.89	$512.10
49659	T		Laparo proc, hernia repair	0130	31.7825	$1,886.29	$659.53	$377.26
49900	C		Repair of abdominal wall					
49904	C		Omental flap, extra-abdom					
49905	C		Omental flap					
49906	C		Free omental flap, microvasc					
49999	T		Abdomen surgery procedure	0153	21.5979	$1,281.84	$381.07	$256.37
50010	C		Exploration of kidney					
50020	T		Renal abscess, open drain	0162	23.2858	$1,382.01		$276.40
50021	T		Renal abscess, percut drain	0037	9.4322	$559.80	$223.91	$111.96
50040	C		Drainage of kidney					
50045	C		Exploration of kidney					
50060	C		Removal of kidney stone					
50065	C		Incision of kidney					
50070	C		Incision of kidney					
50075	C		Removal of kidney stone					
50080	T		Removal of kidney stone	0429	42.1231	$2,500.01		$500.00
50081	T		Removal of kidney stone	0429	42.1231	$2,500.01		$500.00
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	5.9902	$355.52	$115.47	$71.10
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					
50323	C		Prep cadaver renal allograft					
50325	C		Prep donor renal graft					
50327	C		Prep renal graft/venous					
50328	C		Prep renal graft/arterial					
50329	C		Prep renal graft/ureteral					
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	5.9902	$355.52	$115.47	$71.10
50391	T		Instll rx agnt into rnal tub	0156	2.5635	$152.14	$40.52	$30.43
50392	T		Insert kidney drain	0161	18.4736	$1,096.41	$249.36	$219.28
50393	T		Insert ureteral tube	0161	18.4736	$1,096.41	$249.36	$219.28
50394	N		Injection for kidney x-ray					
50395	T		Create passage to kidney	0161	18.4736	$1,096.41	$249.36	$219.28
50396	T		Measure kidney pressure	0164	1.1802	$70.04	$17.21	$14.01
50398	T		Change kidney tube	0122	6.9405	$411.92	$84.48	$82.38
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50541	T		Laparo ablate renal cyst	0130	31.7825	$1,886.29	$659.53	$377.26
50542	T		Laparo ablate renal mass	0131	43.1426	$2,560.51	$1,001.89	$512.10
50543	T		Laparo partial nephrectomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
50544	T		Laparoscopy, pyeloplasty	0130	31.7825	$1,886.29	$659.53	$377.26
50545	C		Laparo radical nephrectomy					
50546	C		Laparoscopic nephrectomy					
50547	C		Laparo removal donor kidney					
50548	C		Laparo remove w/ ureter					
50549	T		Laparoscope proc, renal	0130	31.7825	$1,886.29	$659.53	$377.26
50551	T		Kidney endoscopy	0160	6.6450	$394.38	$105.06	$78.88
50553	T		Kidney endoscopy	0161	18.4736	$1,096.41	$249.36	$219.28
50555	T		Kidney endoscopy & biopsy	0160	6.6450	$394.38	$105.06	$78.88
50557	T		Kidney endoscopy & treatment	0162	23.2858	$1,382.01		$276.40
50561	T		Kidney endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
50562	T		Renal scope w/tumor resect	0160	6.6450	$394.38	$105.06	$78.88
50570	T		Kidney endoscopy	0160	6.6450	$394.38	$105.06	$78.88
50572	T		Kidney endoscopy	0160	6.6450	$394.38	$105.06	$78.88
50574	T		Kidney endoscopy & biopsy	0160	6.6450	$394.38	$105.06	$78.88
50575	T		Kidney endoscopy	0163	33.5826	$1,993.13		$398.63
50576	T		Kidney endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
50580	C		Kidney endoscopy & treatment					
50590	T		Fragmenting of kidney stone	0169	42.8184	$2,541.27	$1,016.50	$508.25
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	1.1802	$70.04	$17.21	$14.01
50688	T		Change of ureter tube	0122	6.9405	$411.92	$84.48	$82.38
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	43.1426	$2,560.51	$1,001.89	$512.10
50947	T		Laparo new ureter/bladder	0131	43.1426	$2,560.51	$1,001.89	$512.10
50948	T		Laparo new ureter/bladder	0131	43.1426	$2,560.51	$1,001.89	$512.10
50949	T		Laparoscope proc, ureter	0130	31.7825	$1,886.29	$659.53	$377.26
50951	T		Endoscopy of ureter	0160	6.6450	$394.38	$105.06	$78.88
50953	T		Endoscopy of ureter	0160	6.6450	$394.38	$105.06	$78.88

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
50955	T		Ureter endoscopy & biopsy	0161	18.4736	$1,096.41	$249.36	$219.28
50957	T		Ureter endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
50961	T		Ureter endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
50970	T		Ureter endoscopy	0160	6.6450	$394.38	$105.06	$78.88
50972	T		Ureter endoscopy & catheter	0160	6.6450	$394.38	$105.06	$78.88
50974	T		Ureter endoscopy & biopsy	0161	18.4736	$1,096.41	$249.36	$219.28
50976	T		Ureter endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
50980	T		Ureter endoscopy & treatment	0161	18.4736	$1,096.41	$249.36	$219.28
51000	T		Drainage of bladder	0164	1.1802	$70.04	$17.21	$14.01
51005	T		Drainage of bladder	0164	1.1802	$70.04	$17.21	$14.01
51010	T		Drainage of bladder	0165	16.5934	$984.82		$196.96
51020	T		Incise & treat bladder	0162	23.2858	$1,382.01		$276.40
51030	T		Incise & treat bladder	0162	23.2858	$1,382.01		$276.40
51040	T		Incise & drain bladder	0162	23.2858	$1,382.01		$276.40
51045	T		Incise bladder/drain ureter	0160	6.6450	$394.38	$105.06	$78.88
51050	T		Removal of bladder stone	0162	23.2858	$1,382.01		$276.40
51060	C		Removal of ureter stone					
51065	T		Remove ureter calculus	0162	23.2858	$1,382.01		$276.40
51080	T		Drainage of bladder abscess	0008	16.4242	$974.78		$194.96
51500	T		Removal of bladder cyst	0154	28.6544	$1,700.64	$464.85	$340.13
51520	T		Removal of bladder lesion	0162	23.2858	$1,382.01		$276.40
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	1.1802	$70.04	$17.21	$14.01
51701	X		Insert bladder catheter	0340	0.6355	$37.72		$7.54
51702	X		Insert temp bladder cath	0340	0.6355	$37.72		$7.54
51703	T		Insert bladder cath, complex	0164	1.1802	$70.04	$17.21	$14.01
51705	T		Change of bladder tube	0121	2.2663	$134.50	$43.80	$26.90
51710	T		Change of bladder tube	0122	6.9405	$411.92	$84.48	$82.38
51715	T		Endoscopic injection/implant	0168	28.1405	$1,670.14	$386.32	$334.03
51720	T		Treatment of bladder lesion	0156	2.5635	$152.14	$40.52	$30.43
51725	T		Simple cystometrogram	0156	2.5635	$152.14	$40.52	$30.43
51726	T		Complex cystometrogram	0156	2.5635	$152.14	$40.52	$30.43
51736	T		Urine flow measurement	0164	1.1802	$70.04	$17.21	$14.01
51741	T		Electro-uroflowmetry, first	0164	1.1802	$70.04	$17.21	$14.01
51772	T		Urethra pressure profile	0156	2.5635	$152.14	$40.52	$30.43
51784	T		Anal/urinary muscle study	0164	1.1802	$70.04	$17.21	$14.01
51785	T		Anal/urinary muscle study	0164	1.1802	$70.04	$17.21	$14.01
51792	T		Urinary reflex study	0164	1.1802	$70.04	$17.21	$14.01
51795	T		Urine voiding pressure study	0164	1.1802	$70.04	$17.21	$14.01
51797	T		Intraabdominal pressure test	0164	1.1802	$70.04	$17.21	$14.01
51798	X		Us urine capacity measure	0340	0.6355	$37.72		$7.54
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	23.2858	$1,382.01		$276.40
51900	C		Repair bladder/vagina lesion					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	43.1426	$2,560.51	$1,001.89	$512.10
51992	T		Laparo sling operation	0132	62.7061	$3,721.61	$1,239.22	$744.32
52000	T		Cystoscopy	0160	6.6450	$394.38	$105.06	$78.88
52001	T		Cystoscopy, removal of clots	0160	6.6450	$394.38	$105.06	$78.88
52005	T		Cystoscopy & ureter catheter	0161	18.4736	$1,096.41	$249.36	$219.28
52007	T		Cystoscopy and biopsy	0161	18.4736	$1,096.41	$249.36	$219.28
52010	T		Cystoscopy & duct catheter	0160	6.6450	$394.38	$105.06	$78.88
52204	T		Cystoscopy	0161	18.4736	$1,096.41	$249.36	$219.28
52214	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52224	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52234	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52235	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52240	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52250	T		Cystoscopy and radiotracer	0162	23.2858	$1,382.01		$276.40
52260	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52265	T		Cystoscopy and treatment	0160	6.6450	$394.38	$105.06	$78.88
52270	T		Cystoscopy & revise urethra	0161	18.4736	$1,096.41	$249.36	$219.28
52275	T		Cystoscopy & revise urethra	0161	18.4736	$1,096.41	$249.36	$219.28
52276	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52277	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52281	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52282	T		Cystoscopy, implant stent	0163	33.5826	$1,993.13		$398.63
52283	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52285	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52290	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52300	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52301	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52305	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52310	T		Cystoscopy and treatment	0160	6.6450	$394.38	$105.06	$78.88
52315	T		Cystoscopy and treatment	0161	18.4736	$1,096.41	$249.36	$219.28
52317	T		Remove bladder stone	0162	23.2858	$1,382.01		$276.40
52318	T		Remove bladder stone	0162	23.2858	$1,382.01		$276.40
52320	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52325	T		Cystoscopy, stone removal	0162	23.2858	$1,382.01		$276.40
52327	T		Cystoscopy, inject material	0162	23.2858	$1,382.01		$276.40
52330	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52332	T		Cystoscopy and treatment	0162	23.2858	$1,382.01		$276.40
52334	T		Create passage to kidney	0162	23.2858	$1,382.01		$276.40
52341	T		Cysto w/ureter stricture tx	0162	23.2858	$1,382.01		$276.40
52342	T		Cysto w/up stricture tx	0162	23.2858	$1,382.01		$276.40
52343	T		Cysto w/renal stricture tx	0162	23.2858	$1,382.01		$276.40
52344	T		Cysto/uretero, stone remove	0162	23.2858	$1,382.01		$276.40
52345	T		Cysto/uretero w/up stricture	0162	23.2858	$1,382.01		$276.40
52346	T		Cystouretero w/renal strict	0162	23.2858	$1,382.01		$276.40
52351	T		Cystouretero & or pyeloscope	0161	18.4736	$1,096.41	$249.36	$219.28
52352	T		Cystouretero w/stone remove	0162	23.2858	$1,382.01		$276.40
52353	T		Cystouretero w/lithotripsy	0163	33.5826	$1,993.13		$398.63
52354	T		Cystouretero w/biopsy	0162	23.2858	$1,382.01		$276.40
52355	T		Cystouretero w/excise tumor	0162	23.2858	$1,382.01		$276.40
52400	T		Cystouretero w/congen repr	0162	23.2858	$1,382.01		$276.40
52402	T		Cystourethro cut ejacul duct	0162	23.2858	$1,382.01		$276.40
52450	T		Incision of prostate	0162	23.2858	$1,382.01		$276.40
52500	T		Revision of bladder neck	0162	23.2858	$1,382.01		$276.40
52510	T		Dilation prostatic urethra	0161	18.4736	$1,096.41	$249.36	$219.28
52601	T		Prostatectomy (TURP)	0163	33.5826	$1,993.13		$398.63
52606	T		Control postop bleeding	0162	23.2858	$1,382.01		$276.40
52612	T		Prostatectomy, first stage	0163	33.5826	$1,993.13		$398.63
52614	T		Prostatectomy, second stage	0163	33.5826	$1,993.13		$398.63
52620	T		Remove residual prostate	0163	33.5826	$1,993.13		$398.63
52630	T		Remove prostate regrowth	0163	33.5826	$1,993.13		$398.63
52640	T		Relieve bladder contracture	0162	23.2858	$1,382.01		$276.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
52647	T		Laser surgery of prostate	0429	42.1231	$2,500.01		$500.00
52648	T		Laser surgery of prostate	0429	42.1231	$2,500.01		$500.00
52700	T		Drainage of prostate abscess	0162	23.2858	$1,382.01		$276.40
53000	T		Incision of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53010	T		Incision of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53020	T		Incision of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53025	T		Incision of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53040	T		Drainage of urethra abscess	0166	17.5942	$1,044.22	$218.73	$208.84
53060	T		Drainage of urethra abscess	0166	17.5942	$1,044.22	$218.73	$208.84
53080	T		Drainage of urinary leakage	0166	17.5942	$1,044.22	$218.73	$208.84
53085	T		Drainage of urinary leakage	0166	17.5942	$1,044.22	$218.73	$208.84
53200	T		Biopsy of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53210	T		Removal of urethra	0168	28.1405	$1,670.14	$386.32	$334.03
53215	T		Removal of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53220	T		Treatment of urethra lesion	0168	28.1405	$1,670.14	$386.32	$334.03
53230	T		Removal of urethra lesion	0168	28.1405	$1,670.14	$386.32	$334.03
53235	T		Removal of urethra lesion	0166	17.5942	$1,044.22	$218.73	$208.84
53240	T		Surgery for urethra pouch	0168	28.1405	$1,670.14	$386.32	$334.03
53250	T		Removal of urethra gland	0166	17.5942	$1,044.22	$218.73	$208.84
53260	T		Treatment of urethra lesion	0166	17.5942	$1,044.22	$218.73	$208.84
53265	T		Treatment of urethra lesion	0166	17.5942	$1,044.22	$218.73	$208.84
53270	T		Removal of urethra gland	0166	17.5942	$1,044.22	$218.73	$208.84
53275	T		Repair of urethra defect	0166	17.5942	$1,044.22	$218.73	$208.84
53400	T		Revise urethra, stage 1	0168	28.1405	$1,670.14	$386.32	$334.03
53405	T		Revise urethra, stage 2	0168	28.1405	$1,670.14	$386.32	$334.03
53410	T		Reconstruction of urethra	0168	28.1405	$1,670.14	$386.32	$334.03
53415	C		Reconstruction of urethra					
53420	T		Reconstruct urethra, stage 1	0168	28.1405	$1,670.14	$386.32	$334.03
53425	T		Reconstruct urethra, stage 2	0168	28.1405	$1,670.14	$386.32	$334.03
53430	T		Reconstruction of urethra	0168	28.1405	$1,670.14	$386.32	$334.03
53431	T		Reconstruct urethra/bladder	0168	28.1405	$1,670.14	$386.32	$334.03
53440	S		Correct bladder function	0385	75.3020	$4,469.17		$893.83
53442	T		Remove perineal prosthesis	0168	28.1405	$1,670.14	$386.32	$334.03
53444	S		Insert tandem cuff	0385	75.3020	$4,469.17		$893.83
53445	S		Insert uro/ves nck sphincter	0386	119.6251	$7,099.75		$1,419.95
53446	T		Remove uro sphincter	0168	28.1405	$1,670.14	$386.32	$334.03
53447	S		Remove/replace ur sphincter	0386	119.6251	$7,099.75		$1,419.95
53448	C		Remov/replc ur sphinctr comp					
53449	T		Repair uro sphincter	0168	28.1405	$1,670.14	$386.32	$334.03
53450	T		Revision of urethra	0168	28.1405	$1,670.14	$386.32	$334.03
53460	T		Revision of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53500	T		Urethrlys, transvag w/ scope	0168	28.1405	$1,670.14	$386.32	$334.03
53502	T		Repair of urethra injury	0166	17.5942	$1,044.22	$218.73	$208.84
53505	T		Repair of urethra injury	0168	28.1405	$1,670.14	$386.32	$334.03
53510	T		Repair of urethra injury	0166	17.5942	$1,044.22	$218.73	$208.84
53515	T		Repair of urethra injury	0168	28.1405	$1,670.14	$386.32	$334.03
53520	T		Repair of urethra defect	0168	28.1405	$1,670.14	$386.32	$334.03
53600	T		Dilate urethra stricture	0156	2.5635	$152.14	$40.52	$30.43
53601	T		Dilate urethra stricture	0164	1.1802	$70.04	$17.21	$14.01
53605	T		Dilate urethra stricture	0161	18.4736	$1,096.41	$249.36	$219.28
53620	T		Dilate urethra stricture	0165	16.5934	$984.82		$196.96
53621	T		Dilate urethra stricture	0164	1.1802	$70.04	$17.21	$14.01
53660	T		Dilation of urethra	0164	1.1802	$70.04	$17.21	$14.01
53661	T		Dilation of urethra	0164	1.1802	$70.04	$17.21	$14.01
53665	T		Dilation of urethra	0166	17.5942	$1,044.22	$218.73	$208.84
53850	T		Prostatic microwave thermotx	0675	43.5348	$2,583.79		$516.76
53852	T		Prostatic rf thermotx	0675	43.5348	$2,583.79		$516.76
53853	T		Prostatic water thermother	0162	23.2858	$1,382.01		$276.40
53899	T		Urology surgery procedure	0164	1.1802	$70.04	$17.21	$14.01
54000	T		Slitting of prepuce	0166	17.5942	$1,044.22	$218.73	$208.84
54001	T		Slitting of prepuce	0166	17.5942	$1,044.22	$218.73	$208.84
54015	T		Drain penis lesion	0008	16.4242	$974.78		$194.96
54050	T		Destruction, penis lesion(s)	0013	1.1028	$65.45	$14.20	$13.09
54055	T		Destruction, penis lesion(s)	0017	18.3377	$1,088.34	$227.84	$217.67
54056	T		Cryosurgery, penis lesion(s)	0012	0.8458	$50.20	$11.18	$10.04
54057	T		Laser surg, penis lesion(s)	0017	18.3377	$1,088.34	$227.84	$217.67

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54060	T		Excision of penis lesion(s)	0017	18.3377	$1,088.34	$227.84	$217.67
54065	T		Destruction, penis lesion(s)	0695	20.2244	$1,200.32	$266.59	$240.06
54100	T		Biopsy of penis	0021	14.9098	$884.90	$219.48	$176.98
54105	T		Biopsy of penis	0022	19.5582	$1,160.78	$354.45	$232.16
54110	T		Treatment of penis lesion	0181	30.7265	$1,823.62	$621.82	$364.72
54111	T		Treat penis lesion, graft	0181	30.7265	$1,823.62	$621.82	$364.72
54112	T		Treat penis lesion, graft	0181	30.7265	$1,823.62	$621.82	$364.72
54115	T		Treatment of penis lesion	0008	16.4242	$974.78		$194.96
54120	T		Partial removal of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54125	C		Removal of penis					
54130	C		Remove penis & nodes					
54135	C		Remove penis & nodes					
54150	T		Circumcision	0180	19.7926	$1,174.69	$304.87	$234.94
54152	T		Circumcision	0180	19.7926	$1,174.69	$304.87	$234.94
54160	T		Circumcision	0180	19.7926	$1,174.69	$304.87	$234.94
54161	T		Circumcision	0180	19.7926	$1,174.69	$304.87	$234.94
54162	T		Lysis penil circumic lesion	0180	19.7926	$1,174.69	$304.87	$234.94
54163	T		Repair of circumcision	0180	19.7926	$1,174.69	$304.87	$234.94
54164	T		Frenulotomy of penis	0180	19.7926	$1,174.69	$304.87	$234.94
54200	T		Treatment of penis lesion	0156	2.5635	$152.14	$40.52	$30.43
54205	T		Treatment of penis lesion	0181	30.7265	$1,823.62	$621.82	$364.72
54220	T		Treatment of penis lesion	0156	2.5635	$152.14	$40.52	$30.43
54230	N		Prepare penis study					
54231	T		Dynamic cavernosometry	0165	16.5934	$984.82		$196.96
54235	T		Penile injection	0164	1.1802	$70.04	$17.21	$14.01
54240	T		Penis study	0164	1.1802	$70.04	$17.21	$14.01
54250	T		Penis study	0164	1.1802	$70.04	$17.21	$14.01
54300	T		Revision of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54304	T		Revision of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54308	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54312	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54316	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54318	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54322	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54324	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54326	T		Reconstruction of urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54328	T		Revise penis/urethra	0181	30.7265	$1,823.62	$621.82	$364.72
54332	C		Revise penis/urethra					
54336	C		Revise penis/urethra					
54340	T		Secondary urethral surgery	0181	30.7265	$1,823.62	$621.82	$364.72
54344	T		Secondary urethral surgery	0181	30.7265	$1,823.62	$621.82	$364.72
54348	T		Secondary urethral surgery	0181	30.7265	$1,823.62	$621.82	$364.72
54352	T		Reconstruct urethra/penis	0181	30.7265	$1,823.62	$621.82	$364.72
54360	T		Penis plastic surgery	0181	30.7265	$1,823.62	$621.82	$364.72
54380	T		Repair penis	0181	30.7265	$1,823.62	$621.82	$364.72
54385	T		Repair penis	0181	30.7265	$1,823.62	$621.82	$364.72
54390	C		Repair penis and bladder					
54400	S		Insert semi-rigid prosthesis	0385	75.3020	$4,469.17		$893.83
54401	S		Insert self-contd prosthesis	0386	119.6251	$7,099.75		$1,419.95
54405	S		Insert multi-comp penis pros	0386	119.6251	$7,099.75		$1,419.95
54406	T		Remove muti-comp penis pros	0181	30.7265	$1,823.62	$621.82	$364.72
54408	T		Repair multi-comp penis pros	0181	30.7265	$1,823.62	$621.82	$364.72
54410	S		Remove/replace penis prosth	0386	119.6251	$7,099.75		$1,419.95
54411	C		Remov/replc penis pros, comp					
54415	T		Remove self-contd penis pros	0181	30.7265	$1,823.62	$621.82	$364.72
54416	S		Remv/repl penis contain pros	0386	119.6251	$7,099.75		$1,419.95
54417	C		Remv/replc penis pros, compl					
54420	T		Revision of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54430	C		Revision of penis					
54435	T		Revision of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54440	T		Repair of penis	0181	30.7265	$1,823.62	$621.82	$364.72
54450	T		Preputial stretching	0156	2.5635	$152.14	$40.52	$30.43
54500	T		Biopsy of testis	0037	9.4322	$559.80	$223.91	$111.96
54505	T		Biopsy of testis	0183	23.5344	$1,396.77		$279.35
54512	T		Excise lesion testis	0183	23.5344	$1,396.77		$279.35
54520	T		Removal of testis	0183	23.5344	$1,396.77		$279.35

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
54522	T		Orchiectomy, partial	0183	23.5344	$1,396.77		$279.35
54530	T		Removal of testis	0154	28.6544	$1,700.64	$464.85	$340.13
54535	C		Extensive testis surgery					
54550	T		Exploration for testis	0154	28.6544	$1,700.64	$464.85	$340.13
54560	T		Exploration for testis	0183	23.5344	$1,396.77		$279.35
54600	T		Reduce testis torsion	0183	23.5344	$1,396.77		$279.35
54620	T		Suspension of testis	0183	23.5344	$1,396.77		$279.35
54640	T		Suspension of testis	0154	28.6544	$1,700.64	$464.85	$340.13
54650	C		Orchiopexy (Fowler-Stephens)					
54660	T		Revision of testis	0183	23.5344	$1,396.77		$279.35
54670	T		Repair testis injury	0183	23.5344	$1,396.77		$279.35
54680	T		Relocation of testis(es)	0183	23.5344	$1,396.77		$279.35
54690	T		Laparoscopy, orchiectomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
54692	T		Laparoscopy, orchiopexy	0132	62.7061	$3,721.61	$1,239.22	$744.32
54699	T		Laparoscope proc, testis	0130	31.7825	$1,886.29	$659.53	$377.26
54700	T		Drainage of scrotum	0183	23.5344	$1,396.77		$279.35
54800	T		Biopsy of epididymis	0004	1.7566	$104.25	$22.36	$20.85
54820	T		Exploration of epididymis	0183	23.5344	$1,396.77		$279.35
54830	T		Remove epididymis lesion	0183	23.5344	$1,396.77		$279.35
54840	T		Remove epididymis lesion	0183	23.5344	$1,396.77		$279.35
54860	T		Removal of epididymis	0183	23.5344	$1,396.77		$279.35
54861	T		Removal of epididymis	0183	23.5344	$1,396.77		$279.35
54900	T		Fusion of spermatic ducts	0183	23.5344	$1,396.77		$279.35
54901	T		Fusion of spermatic ducts	0183	23.5344	$1,396.77		$279.35
55000	T		Drainage of hydrocele	0004	1.7566	$104.25	$22.36	$20.85
55040	T		Removal of hydrocele	0154	28.6544	$1,700.64	$464.85	$340.13
55041	T		Removal of hydroceles	0154	28.6544	$1,700.64	$464.85	$340.13
55060	T		Repair of hydrocele	0183	23.5344	$1,396.77		$279.35
55100	T		Drainage of scrotum abscess	0008	16.4242	$974.78		$194.96
55110	T		Explore scrotum	0183	23.5344	$1,396.77		$279.35
55120	T		Removal of scrotum lesion	0183	23.5344	$1,396.77		$279.35
55150	T		Removal of scrotum	0183	23.5344	$1,396.77		$279.35
55175	T		Revision of scrotum	0183	23.5344	$1,396.77		$279.35
55180	T		Revision of scrotum	0183	23.5344	$1,396.77		$279.35
55200	T		Incision of sperm duct	0183	23.5344	$1,396.77		$279.35
55250	T		Removal of sperm duct(s)	0183	23.5344	$1,396.77		$279.35
55300	N		Prepare, sperm duct x-ray					
55400	T		Repair of sperm duct	0183	23.5344	$1,396.77		$279.35
55450	T		Ligation of sperm duct	0183	23.5344	$1,396.77		$279.35
55500	T		Removal of hydrocele	0183	23.5344	$1,396.77		$279.35
55520	T		Removal of sperm cord lesion	0183	23.5344	$1,396.77		$279.35
55530	T		Revise spermatic cord veins	0183	23.5344	$1,396.77		$279.35
55535	T		Revise spermatic cord veins	0154	28.6544	$1,700.64	$464.85	$340.13
55540	T		Revise hernia & sperm veins	0154	28.6544	$1,700.64	$464.85	$340.13
55550	T		Laparo ligate spermatic vein	0131	43.1426	$2,560.51	$1,001.89	$512.10
55559	T		Laparo proc, spermatic cord	0130	31.7825	$1,886.29	$659.53	$377.26
55600	T		Incise sperm duct pouch	0183	23.5344	$1,396.77		$279.35
55605	C		Incise sperm duct pouch					
55650	C		Remove sperm duct pouch					
55680	T		Remove sperm pouch lesion	0183	23.5344	$1,396.77		$279.35
55700	T		Biopsy of prostate	0184	4.3369	$257.40	$96.27	$51.48
55705	T		Biopsy of prostate	0184	4.3369	$257.40	$96.27	$51.48
55720	T		Drainage of prostate abscess	0162	23.2858	$1,382.01		$276.40
55725	T		Drainage of prostate abscess	0162	23.2858	$1,382.01		$276.40
55801	C		Removal of prostate					
55810	C		Extensive prostate surgery					
55812	C		Extensive prostate surgery					
55815	C		Extensive prostate surgery					
55821	C		Removal of prostate					
55831	C		Removal of prostate					
55840	C		Extensive prostate surgery					
55842	C		Extensive prostate surgery					
55845	C		Extensive prostate surgery					
55859	T		Percut/needle insert, pros	0163	33.5826	$1,993.13		$398.63
55860	T		Surgical exposure, prostate	0165	16.5934	$984.82		$196.96
55862	C		Extensive prostate surgery					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
55865	C		Extensive prostate surgery					
55866	C		Laparo radical prostatectomy					
55870	T		Electroejaculation	0197	2.3465	$139.26		$27.85
55873	T		Cryoablate prostate	0674	95.3518	$5,659.13		$1,131.83
55899	T		Genital surgery procedure	0164	1.1802	$70.04	$17.21	$14.01
55970	E		Sex transformation, M to F					
55980	E		Sex transformation, F to M					
56405	T		I & D of vulva/perineum	0189	2.3602	$140.08		$28.02
56420	T		Drainage of gland abscess	0189	2.3602	$140.08		$28.02
56440	T		Surgery for vulva lesion	0194	20.6585	$1,226.08	$397.84	$245.22
56441	T		Lysis of labial lesion(s)	0193	14.5183	$861.66		$172.33
56501	T		Destroy, vulva lesions, sim	0017	18.3377	$1,088.34	$227.84	$217.67
56515	T		Destroy vulva lesion/s compl	0695	20.2244	$1,200.32	$266.59	$240.06
56605	T		Biopsy of vulva/perineum	0019	4.0363	$239.55	$71.87	$47.91
56606	T		Biopsy of vulva/perineum	0019	4.0363	$239.55	$71.87	$47.91
56620	T		Partial removal of vulva	0195	26.5582	$1,576.23	$483.80	$315.25
56625	T		Complete removal of vulva	0195	26.5582	$1,576.23	$483.80	$315.25
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	20.6585	$1,226.08	$397.84	$245.22
56720	T		Incision of hymen	0193	14.5183	$861.66		$172.33
56740	T		Remove vagina gland lesion	0194	20.6585	$1,226.08	$397.84	$245.22
56800	T		Repair of vagina	0194	20.6585	$1,226.08	$397.84	$245.22
56805	T		Repair clitoris	0193	14.5183	$861.66		$172.33
56810	T		Repair of perineum	0194	20.6585	$1,226.08	$397.84	$245.22
56820	T		Exam of vulva w/scope	0188	1.1348	$67.35		$13.47
56821	T		Exam/biopsy of vulva w/scope	0189	2.3602	$140.08		$28.02
57000	T		Exploration of vagina	0193	14.5183	$861.66		$172.33
57010	T		Drainage of pelvic abscess	0193	14.5183	$861.66		$172.33
57020	T		Drainage of pelvic fluid	0192	4.2887	$254.53		$50.91
57022	T		I & d vaginal hematoma, pp	0007	11.3983	$676.49		$135.30
57023	T		I & d vag hematoma, non-ob	0008	16.4242	$974.78		$194.96
57061	T		Destroy vag lesions, simple	0194	20.6585	$1,226.08	$397.84	$245.22
57065	T		Destroy vag lesions, complex	0194	20.6585	$1,226.08	$397.84	$245.22
57100	T		Biopsy of vagina	0192	4.2887	$254.53		$50.91
57105	T		Biopsy of vagina	0194	20.6585	$1,226.08	$397.84	$245.22
57106	T		Remove vagina wall, partial	0194	20.6585	$1,226.08	$397.84	$245.22
57107	T		Remove vagina tissue, part	0195	26.5582	$1,576.23	$483.80	$315.25
57109	T		Vaginectomy partial w/nodes	0195	26.5582	$1,576.23	$483.80	$315.25
57110	C		Remove vagina wall, complete					
57111	C		Remove vagina tissue, compl					
57112	C		Vaginectomy w/nodes, compl					
57120	T		Closure of vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57130	T		Remove vagina lesion	0194	20.6585	$1,226.08	$397.84	$245.22
57135	T		Remove vagina lesion	0194	20.6585	$1,226.08	$397.84	$245.22
57150	T		Treat vagina infection	0191	0.1663	$9.87	$2.77	$1.97
57155	T		Insert uteri tandems/ovoids	0192	4.2887	$254.53		$50.91
57160	T		Insert pessary/other device	0188	1.1348	$67.35		$13.47
57170	T		Fitting of diaphragm/cap	0191	0.1663	$9.87	$2.77	$1.97
57180	T		Treat vaginal bleeding	0189	2.3602	$140.08		$28.02
57200	T		Repair of vagina	0194	20.6585	$1,226.08	$397.84	$245.22
57210	T		Repair vagina/perineum	0194	20.6585	$1,226.08	$397.84	$245.22
57220	T		Revision of urethra	0202	40.2037	$2,386.09	$954.43	$477.22
57230	T		Repair of urethral lesion	0195	26.5582	$1,576.23	$483.80	$315.25
57240	T		Repair bladder & vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57250	T		Repair rectum & vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57260	T		Repair of vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57265	T		Extensive repair of vagina	0202	40.2037	$2,386.09	$954.43	$477.22
57267	T		Insert mesh/pelvic flr addon	0154	28.6544	$1,700.64	$464.85	$340.13
57268	T		Repair of bowel bulge	0195	26.5582	$1,576.23	$483.80	$315.25
57270	C		Repair of bowel pouch					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
57280	C		Suspension of vagina					
57282	C		Repair of vaginal prolapse					
57283	C		Colpopexy, intraperitoneal					
57284	T		Repair paravaginal defect	0202	40.2037	$2,386.09	$954.43	$477.22
57287	T		Revise/remove sling repair	0202	40.2037	$2,386.09	$954.43	$477.22
57288	T		Repair bladder defect	0202	40.2037	$2,386.09	$954.43	$477.22
57289	T		Repair bladder & vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57291	T		Construction of vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57292	C		Construct vagina with graft					
57300	T		Repair rectum-vagina fistula	0195	26.5582	$1,576.23	$483.80	$315.25
57305	C		Repair rectum-vagina fistula					
57307	C		Fistula repair & colostomy					
57308	C		Fistula repair, transperine					
57310	T		Repair urethrovaginal lesion	0202	40.2037	$2,386.09	$954.43	$477.22
57311	C		Repair urethrovaginal lesion					
57320	T		Repair bladder-vagina lesion	0195	26.5582	$1,576.23	$483.80	$315.25
57330	T		Repair bladder-vagina lesion	0195	26.5582	$1,576.23	$483.80	$315.25
57335	C		Repair vagina					
57400	T		Dilation of vagina	0194	20.6585	$1,226.08	$397.84	$245.22
57410	T		Pelvic examination	0193	14.5183	$861.66		$172.33
57415	T		Remove vaginal foreign body	0194	20.6585	$1,226.08	$397.84	$245.22
57420	T		Exam of vagina w/scope	0189	2.3602	$140.08		$28.02
57421	T		Exam/biopsy of vag w/scope	0189	2.3602	$140.08		$28.02
57425	T		Laparoscopy, surg, colpopexy	0130	31.7825	$1,886.29	$659.53	$377.26
57452	T		Examination of vagina	0189	2.3602	$140.08		$28.02
57454	T		Vagina examination & biopsy	0189	2.3602	$140.08		$28.02
57455	T		Biopsy of cervix w/scope	0189	2.3602	$140.08		$28.02
57456	T		Endocerv curettage w/scope	0189	2.3602	$140.08		$28.02
57460	T		Cervix excision	0193	14.5183	$861.66		$172.33
57461	T		Conz of cervix w/scope, leep	0194	20.6585	$1,226.08	$397.84	$245.22
57500	T		Biopsy of cervix	0192	4.2887	$254.53		$50.91
57505	T		Endocervical curettage	0189	2.3602	$140.08		$28.02
57510	T		Cauterization of cervix	0193	14.5183	$861.66		$172.33
57511	T		Cryocautery of cervix	0189	2.3602	$140.08		$28.02
57513	T		Laser surgery of cervix	0193	14.5183	$861.66		$172.33
57520	T		Conization of cervix	0194	20.6585	$1,226.08	$397.84	$245.22
57522	T		Conization of cervix	0195	26.5582	$1,576.23	$483.80	$315.25
57530	T		Removal of cervix	0195	26.5582	$1,576.23	$483.80	$315.25
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	26.5582	$1,576.23	$483.80	$315.25
57555	T		Remove cervix/repair vagina	0195	26.5582	$1,576.23	$483.80	$315.25
57556	T		Remove cervix, repair bowel	0202	40.2037	$2,386.09	$954.43	$477.22
57700	T		Revision of cervix	0194	20.6585	$1,226.08	$397.84	$245.22
57720	T		Revision of cervix	0194	20.6585	$1,226.08	$397.84	$245.22
57800	T		Dilation of cervical canal	0193	14.5183	$861.66		$172.33
57820	T		D & c of residual cervix	0196	17.0200	$1,010.14	$338.23	$202.03
58100	T		Biopsy of uterus lining	0188	1.1348	$67.35		$13.47
58120	T		Dilation and curettage	0196	17.0200	$1,010.14	$338.23	$202.03
58140	C		Removal of uterus lesion					
58145	T		Myomectomy vag method	0195	26.5582	$1,576.23	$483.80	$315.25
58146	C		Myomectomy abdom complex					
58150	C		Total hysterectomy					
58152	C		Total hysterectomy					
58180	C		Partial hysterectomy					
58200	C		Extensive hysterectomy					
58210	C		Extensive hysterectomy					
58240	C		Removal of pelvis contents					
58260	C		Vaginal hysterectomy					
58262	C		Vag hyst including t/o					
58263	C		Vag hyst w/t/o & vag repair					
58267	C		Vag hyst w/urinary repair					
58270	C		Vag hyst w/enterocele repair					
58275	C		Hysterectomy/revise vagina					
58280	C		Hysterectomy/revise vagina					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
58285	C		Extensive hysterectomy					
58290	C		Vag hyst complex					
58291	C		Vag hyst incl t/o, complex					
58292	C		Vag hyst t/o & repair, compl					
58293	C		Vag hyst w/uro repair, compl					
58294	C		Vag hyst w/enterocele, compl					
58300	E		Insert intrauterine device					
58301	T		Remove intrauterine device	0189	2.3602	$140.08		$28.02
58321	T		Artificial insemination	0197	2.3465	$139.26		$27.85
58322	T		Artificial insemination	0197	2.3465	$139.26		$27.85
58323	T		Sperm washing	0197	2.3465	$139.26		$27.85
58340	N		Catheter for hysterography					
58345	T		Reopen fallopian tube	0193	14.5183	$861.66		$172.33
58346	T		Insert heyman uteri capsule	0193	14.5183	$861.66		$172.33
58350	T		Reopen fallopian tube	0195	26.5582	$1,576.23	$483.80	$315.25
58353	T		Endometr ablate, thermal	0195	26.5582	$1,576.23	$483.80	$315.25
58356	T		Endometrial cryoablation	0202	40.2037	$2,386.09	$954.43	$477.22
58400	C		Suspension of uterus					
58410	C		Suspension of uterus					
58520	C		Repair of ruptured uterus					
58540	C		Revision of uterus					
58545	T		Laparoscopic myomectomy	0130	31.7825	$1,886.29	$659.53	$377.26
58546	T		Laparo-myomectomy, complex	0131	43.1426	$2,560.51	$1,001.89	$512.10
58550	T		Laparo-asst vag hysterectomy	0132	62.7061	$3,721.61	$1,239.22	$744.32
58552	T		Laparo-vag hyst incl t/o	0131	43.1426	$2,560.51	$1,001.89	$512.10
58553	T		Laparo-vag hyst, complex	0131	43.1426	$2,560.51	$1,001.89	$512.10
58554	T		Laparo-vag hyst w/t/o, compl	0131	43.1426	$2,560.51	$1,001.89	$512.10
58555	T		Hysteroscopy, dx, sep proc	0190	20.9699	$1,244.56	$424.28	$248.91
58558	T		Hysteroscopy, biopsy	0190	20.9699	$1,244.56	$424.28	$248.91
58559	T		Hysteroscopy, lysis	0190	20.9699	$1,244.56	$424.28	$248.91
58560	T		Hysteroscopy, resect septum	0387	32.3971	$1,922.77	$655.55	$384.55
58561	T		Hysteroscopy, remove myoma	0387	32.3971	$1,922.77	$655.55	$384.55
58562	T		Hysteroscopy, remove fb	0190	20.9699	$1,244.56	$424.28	$248.91
58563	T		Hysteroscopy, ablation	0387	32.3971	$1,922.77	$655.55	$384.55
58565	T		Hysteroscopy, sterilization	0202	40.2037	$2,386.09	$954.43	$477.22
58578	T		Laparo proc, uterus	0130	31.7825	$1,886.29	$659.53	$377.26
58579	T		Hysteroscope procedure	0190	20.9699	$1,244.56	$424.28	$248.91
58600	T		Division of fallopian tube	0195	26.5582	$1,576.23	$483.80	$315.25
58605	C		Division of fallopian tube					
58611	C		Ligate oviduct(s) add-on					
58615	T		Occlude fallopian tube(s)	0194	20.6585	$1,226.08	$397.84	$245.22
58660	T		Laparoscopy, lysis	0131	43.1426	$2,560.51	$1,001.89	$512.10
58661	T		Laparoscopy, remove adnexa	0131	43.1426	$2,560.51	$1,001.89	$512.10
58662	T		Laparoscopy, excise lesions	0131	43.1426	$2,560.51	$1,001.89	$512.10
58670	T		Laparoscopy, tubal cautery	0131	43.1426	$2,560.51	$1,001.89	$512.10
58671	T		Laparoscopy, tubal block	0131	43.1426	$2,560.51	$1,001.89	$512.10
58672	T		Laparoscopy, fimbrioplasty	0131	43.1426	$2,560.51	$1,001.89	$512.10
58673	T		Laparoscopy, salpingostomy	0131	43.1426	$2,560.51	$1,001.89	$512.10
58679	T		Laparo proc, oviduct-ovary	0130	31.7825	$1,886.29	$659.53	$377.26
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	T		Create new tubal opening	0195	26.5582	$1,576.23	$483.80	$315.25
58800	T		Drainage of ovarian cyst(s)	0193	14.5183	$861.66		$172.33
58805	C		Drainage of ovarian cyst(s)					
58820	T		Drain ovary abscess, open	0195	26.5582	$1,576.23	$483.80	$315.25
58822	C		Drain ovary abscess, percut					
58823	T		Drain pelvic abscess, percut	0193	14.5183	$861.66		$172.33
58825	C		Transposition, ovary(s)					
58900	T		Biopsy of ovary(s)	0193	14.5183	$861.66		$172.33
58920	T		Partial removal of ovary(s)	0195	26.5582	$1,576.23	$483.80	$315.25
58925	T		Removal of ovarian cyst(s)	0195	26.5582	$1,576.23	$483.80	$315.25
58940	C		Removal of ovary(s)					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
58956	C		Bso, omentectomy w/tah					
58960	C		Exploration of abdomen					
58970	T		Retrieval of oocyte	0197	2.3465	$139.26		$27.85
58974	T		Transfer of embryo	0197	2.3465	$139.26		$27.85
58976	T		Transfer of embryo	0197	2.3465	$139.26		$27.85
58999	T		Genital surgery procedure	0191	0.1663	$9.87	$2.77	$1.97
59000	T		Amniocentesis, diagnostic	0198	1.3621	$80.84	$32.19	$16.17
59001	T		Amniocentesis, therapeutic	0192	4.2887	$254.53		$50.91
59012	T		Fetal cord puncture,prenatal	0198	1.3621	$80.84	$32.19	$16.17
59015	T		Chorion biopsy	0198	1.3621	$80.84	$32.19	$16.17
59020	T		Fetal contract stress test	0192	4.2887	$254.53		$50.91
59025	T		Fetal non-stress test	0198	1.3621	$80.84	$32.19	$16.17
59030	T		Fetal scalp blood sample	0198	1.3621	$80.84	$32.19	$16.17
59050	E		Fetal monitor w/report					
59051	B		Fetal monitor/interpret only					
59070	T		Transabdom amnioinfus w/ us	0198	1.3621	$80.84	$32.19	$16.17
59072	T		Umbilical cord occlud w/ us	0198	1.3621	$80.84	$32.19	$16.17
59074	T		Fetal fluid drainage w/ us	0198	1.3621	$80.84	$32.19	$16.17
59076	T		Fetal shunt placement, w/ us	0198	1.3621	$80.84	$32.19	$16.17
59100	T		Remove uterus lesion	0195	26.5582	$1,576.23	$483.80	$315.25
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	43.1426	$2,560.51	$1,001.89	$512.10
59151	T		Treat ectopic pregnancy	0131	43.1426	$2,560.51	$1,001.89	$512.10
59160	T		D & c after delivery	0196	17.0200	$1,010.14	$338.23	$202.03
59200	T		Insert cervical dilator	0189	2.3602	$140.08		$28.02
59300	T		Episiotomy or vaginal repair	0193	14.5183	$861.66		$172.33
59320	T		Revision of cervix	0194	20.6585	$1,226.08	$397.84	$245.22
59325	C		Revision of cervix					
59350	C		Repair of uterus					
59400	B		Obstetrical care					
59409	T		Obstetrical care	0194	20.6585	$1,226.08	$397.84	$245.22
59410	B		Obstetrical care					
59412	T		Antepartum manipulation	0700	5.3371	$316.76		$63.35
59414	T		Deliver placenta	0193	14.5183	$861.66		$172.33
59425	B		Antepartum care only					
59426	B		Antepartum care only					
59430	B		Care after delivery					
59510	E		Cesarean delivery					
59514	C		Cesarean delivery only					
59515	E		Cesarean delivery					
59525	C		Remove uterus after cesarean					
59610	E		Vbac delivery					
59612	T		Vbac delivery only	0194	20.6585	$1,226.08	$397.84	$245.22
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	17.5250	$1,040.11	$329.65	$208.02
59820	T		Care of miscarriage	0201	17.5250	$1,040.11	$329.65	$208.02
59821	T		Treatment of miscarriage	0201	17.5250	$1,040.11	$329.65	$208.02
59830	C		Treat uterus infection					
59840	T		Abortion	0200	17.7919	$1,055.95	$263.69	$211.19
59841	T		Abortion	0200	17.7919	$1,055.95	$263.69	$211.19
59850	C		Abortion					
59851	C		Abortion					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
59852	C		Abortion					
59855	C		Abortion					
59856	C		Abortion					
59857	C		Abortion					
59866	T		Abortion (mpr)	0198	1.3621	$80.84	$32.19	$16.17
59870	T		Evacuate mole of uterus	0201	17.5250	$1,040.11	$329.65	$208.02
59871	T		Remove cerclage suture	0194	20.6585	$1,226.08	$397.84	$245.22
59897	T		Fetal invas px w/ us	0198	1.3621	$80.84	$32.19	$16.17
59898	T		Laparo proc, ob care/deliver	0130	31.7825	$1,886.29	$659.53	$377.26
59899	T		Maternity care procedure	0198	1.3621	$80.84	$32.19	$16.17
60000	T		Drain thyroid/tongue cyst	0252	7.8317	$464.81	$113.41	$92.96
60001	T		Aspirate/inject thyriod cyst	0004	1.7566	$104.25	$22.36	$20.85
60100	T		Biopsy of thyroid	0004	1.7566	$104.25	$22.36	$20.85
60200	T		Remove thyroid lesion	0114	40.5805	$2,408.45	$485.91	$481.69
60210	T		Partial thyroid excision	0114	40.5805	$2,408.45	$485.91	$481.69
60212	T		Partial thyroid excision	0114	40.5805	$2,408.45	$485.91	$481.69
60220	T		Partial removal of thyroid	0114	40.5805	$2,408.45	$485.91	$481.69
60225	T		Partial removal of thyroid	0114	40.5805	$2,408.45	$485.91	$481.69
60240	T		Removal of thyroid	0114	40.5805	$2,408.45	$485.91	$481.69
60252	T		Removal of thyroid	0256	37.1513	$2,204.93		$440.99
60254	C		Extensive thyroid surgery					
60260	T		Repeat thyroid surgery	0256	37.1513	$2,204.93		$440.99
60270	C		Removal of thyroid					
60271	C		Removal of thyroid					
60280	T		Remove thyroid duct lesion	0114	40.5805	$2,408.45	$485.91	$481.69
60281	T		Remove thyroid duct lesion	0114	40.5805	$2,408.45	$485.91	$481.69
60500	T		Explore parathyroid glands	0256	37.1513	$2,204.93		$440.99
60502	C		Re-explore parathyroids					
60505	C		Explore parathyroid glands					
60512	T		Autotransplant parathyroid	0022	19.5582	$1,160.78	$354.45	$232.16
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	31.7825	$1,886.29	$659.53	$377.26
60699	T		Endocrine surgery procedure	0114	40.5805	$2,408.45	$485.91	$481.69
61000	T		Remove cranial cavity fluid	0212	2.9606	$175.71	$70.28	$35.14
61001	T		Remove cranial cavity fluid	0212	2.9606	$175.71	$70.28	$35.14
61020	T		Remove brain cavity fluid	0212	2.9606	$175.71	$70.28	$35.14
61026	T		Injection into brain canal	0212	2.9606	$175.71	$70.28	$35.14
61050	T		Remove brain canal fluid	0212	2.9606	$175.71	$70.28	$35.14
61055	T		Injection into brain canal	0212	2.9606	$175.71	$70.28	$35.14
61070	T		Brain canal shunt procedure	0212	2.9606	$175.71	$70.28	$35.14
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	40.4614	$2,401.38		$480.28
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					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61316	C		Implt cran bone flap to abdo					
61320	C		Open skull for drainage					
61321	C		Open skull for drainage					
61322	C		Decompressive craniotomy					
61323	C		Decompressive lobectomy					
61330	T		Decompress eye socket	0256	37.1513	$2,204.93		$440.99
61332	C		Explore/biopsy eye socket					
61333	C		Explore orbit/remove lesion					
61334	T		Explore orbit/remove object	0256	37.1513	$2,204.93		$440.99
61340	C		Relieve cranial pressure					
61343	C		Incise skull (press relief)					
61345	C		Relieve cranial pressure					
61440	C		Incise skull for surgery					
61450	C		Incise skull for surgery					
61458	C		Incise skull for brain wound					
61460	C		Incise skull for surgery					
61470	C		Incise skull for surgery					
61480	C		Incise skull for surgery					
61490	C		Incise skull for surgery					
61500	C		Removal of skull lesion					
61501	C		Remove infected skull bone					
61510	C		Removal of brain lesion					
61512	C		Remove brain lining lesion					
61514	C		Removal of brain abscess					
61516	C		Removal of brain lesion					
61517	C		Implt brain chemotx add-on					
61518	C		Removal of brain lesion					
61519	C		Remove brain lining lesion					
61520	C		Removal of brain lesion					
61521	C		Removal of brain lesion					
61522	C		Removal of brain abscess					
61524	C		Removal of brain lesion					
61526	C		Removal of brain lesion					
61530	C		Removal of brain lesion					
61531	C		Implant brain electrodes					
61533	C		Implant brain electrodes					
61534	C		Removal of brain lesion					
61535	C		Remove brain electrodes					
61536	C		Removal of brain lesion					
61537	C		Removal of brain tissue					
61538	C		Removal of brain tissue					
61539	C		Removal of brain tissue					
61540	C		Removal of brain tissue					
61541	C		Incision of brain tissue					
61542	C		Removal of brain tissue					
61543	C		Removal of brain tissue					
61544	C		Remove & treat brain lesion					
61545	C		Excision of brain tumor					
61546	C		Removal of pituitary gland					
61548	C		Removal of pituitary gland					
61550	C		Release of skull seams					
61552	C		Release of skull seams					
61556	C		Incise skull/sutures					
61557	C		Incise skull/sutures					
61558	C		Excision of skull/sutures					
61559	C		Excision of skull/sutures					
61563	C		Excision of skull tumor					
61564	C		Excision of skull tumor					
61566	C		Removal of brain tissue					
61567	C		Incision of brain tissue					
61570	C		Remove foreign body, brain					
61571	C		Incise skull for brain wound					
61575	C		Skull base/brainstem surgery					
61576	C		Skull base/brainstem surgery					
61580	C		Craniofacial approach, skull					
61581	C		Craniofacial approach, skull					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61582	C		Craniofacial approach, skull					
61583	C		Craniofacial approach, skull					
61584	C		Orbitocranial approach/skull					
61585	C		Orbitocranial approach/skull					
61586	C		Resect nasopharynx, skull					
61590	C		Infratemporal approach/skull					
61591	C		Infratemporal approach/skull					
61592	C		Orbitocranial approach/skull					
61595	C		Transtemporal approach/skull					
61596	C		Transcochlear approach/skull					
61597	C		Transcondylar approach/skull					
61598	C		Transpetrosal approach/skull					
61600	C		Resect/excise cranial lesion					
61601	C		Resect/excise cranial lesion					
61605	C		Resect/excise cranial lesion					
61606	C		Resect/excise cranial lesion					
61607	C		Resect/excise cranial lesion					
61608	C		Resect/excise cranial lesion					
61609	C		Transect artery, sinus					
61610	C		Transect artery, sinus					
61611	C		Transect artery, sinus					
61612	C		Transect artery, sinus					
61613	C		Remove aneurysm, sinus					
61615	C		Resect/excise lesion, skull					
61616	C		Resect/excise lesion, skull					
61618	C		Repair dura					
61619	C		Repair dura					
61623	T		Endovasc tempory vessel occl	0081	34.2913	$2,035.19		$407.04
61624	C		Occlusion/embolization cath					
61626	T		Transcath occlusion, non-cns	0081	34.2913	$2,035.19		$407.04
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	17.2800	$1,025.57		$205.11
61791	T		Treat trigeminal tract	0206	5.4672	$324.48	$75.55	$64.90
61793	E		Focus radiation beam					
61795	S		Brain surgery using computer	0302	4.5936	$272.63	$103.28	$54.53
61850	C		Implant neuroelectrodes					
61860	C		Implant neuroelectrodes					
61863	C		Implant neuroelectrode					
61864	C		Implant neuroelectrde, add'l					
61867	C		Implant neuroelectrode					
61868	C		Implant neuroelectrde, add'l					
61870	C		Implant neuroelectrodes					
61875	C		Implant neuroelectrodes					
61880	T		Revise/remove neuroelectrode	0687	19.1476	$1,136.41	$454.56	$227.28
61885	S		Implant neurostim one array	0039	180.5784	$10,717.33		$2,143.47
61886	T		Implant neurostim arrays	0315	289.3306	$17,171.77		$3,434.35

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
61888	T		Revise/remove neuroreceiver	0688	42.8494	$2,543.11	$1,017.24	$508.62
62000	C		Treat skull fracture					
62005	C		Treat skull fracture					
62010	C		Treatment of head injury					
62100	C		Repair brain fluid leakage					
62115	C		Reduction of skull defect					
62116	C		Reduction of skull defect					
62117	C		Reduction of skull defect					
62120	C		Repair skull cavity lesion					
62121	C		Incise skull repair					
62140	C		Repair of skull defect					
62141	C		Repair of skull defect					
62142	C		Remove skull plate/flap					
62143	C		Replace skull plate/flap					
62145	C		Repair of skull & brain					
62146	C		Repair of skull with graft					
62147	C		Repair of skull with graft					
62148	C		Retr bone flap to fix skull					
62160	T		Neuroendoscopy add-on	0122	6.9405	$411.92	$84.48	$82.38
62161	C		Dissect brain w/scope					
62162	C		Remove colloid cyst w/scope					
62163	C		Neuroendoscopy w/fb removal					
62164	C		Remove brain tumor w/scope					
62165	C		Remove pituit tumor w/scope					
62180	C		Establish brain cavity shunt					
62190	C		Establish brain cavity shunt					
62192	C		Establish brain cavity shunt					
62194	T		Replace/irrigate catheter	0427	10.1516	$602.50	$123.56	$120.50
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	0427	10.1516	$602.50	$123.56	$120.50
62230	T		Replace/revise brain shunt	0224	40.4614	$2,401.38		$480.28
62252	S		Csf shunt reprogram	0691	2.5138	$149.19	$59.67	$29.84
62256	C		Remove brain cavity shunt					
62258	C		Replace brain cavity shunt					
62263	T		Lysis epidural adhesions	0203	10.3544	$614.53	$245.81	$122.91
62264	T		Epidural lysis on single day	0203	10.3544	$614.53	$245.81	$122.91
62268	T		Drain spinal cord cyst	0212	2.9606	$175.71	$70.28	$35.14
62269	T		Needle biopsy, spinal cord	0685	5.9902	$355.52	$115.47	$71.10
62270	T		Spinal fluid tap, diagnostic	0204	2.1811	$129.45	$40.13	$25.89
62272	T		Drain cerebro spinal fluid	0204	2.1811	$129.45	$40.13	$25.89
62273	T		Treat epidural spine lesion	0206	5.4672	$324.48	$75.55	$64.90
62280	T		Treat spinal cord lesion	0207	5.9837	$355.13	$86.92	$71.03
62281	T		Treat spinal cord lesion	0207	5.9837	$355.13	$86.92	$71.03
62282	T		Treat spinal canal lesion	0207	5.9837	$355.13	$86.92	$71.03
62284	N		Injection for myelogram					
62287	T		Percutaneous diskectomy	0221	29.7854	$1,767.76	$463.62	$353.55
62290	N		Inject for spine disk x-ray					
62291	N		Inject for spine disk x-ray					
62292	T		Injection into disk lesion	0212	2.9606	$175.71	$70.28	$35.14
62294	T		Injection into spinal artery	0212	2.9606	$175.71	$70.28	$35.14
62310	T		Inject spine c/t	0207	5.9837	$355.13	$86.92	$71.03
62311	T		Inject spine l/s (cd)	0207	5.9837	$355.13	$86.92	$71.03
62318	T		Inject spine w/cath, c/t	0207	5.9837	$355.13	$86.92	$71.03
62319	T		Inject spine w/cath l/s (cd)	0207	5.9837	$355.13	$86.92	$71.03
62350	T		Implant spinal canal cath	0223	27.9956	$1,661.54		$332.31
62351	T		Implant spinal canal cath	0208	42.1492	$2,501.56		$500.31
62355	T		Remove spinal canal catheter	0203	10.3544	$614.53	$245.81	$122.91
62360	T		Insert spine infusion device	0226	138.2406	$8,204.58		$1,640.92
62361	T		Implant spine infusion pump	0227	135.8740	$8,064.12		$1,612.82
62362	T		Implant spine infusion pump	0227	135.8740	$8,064.12		$1,612.82
62365	T		Remove spine infusion device	0221	29.7854	$1,767.76	$463.62	$353.55
62367	S		Analyze spine infusion pump	0691	2.5138	$149.19	$59.67	$29.84
62368	S		Analyze spine infusion pump	0691	2.5138	$149.19	$59.67	$29.84

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
63001	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63003	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63005	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63011	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63012	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63015	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63016	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63017	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63020	T		Neck spine disk surgery	0208	42.1492	$2,501.56		$500.31
63030	T		Low back disk surgery	0208	42.1492	$2,501.56		$500.31
63035	T		Spinal disk surgery add-on	0208	42.1492	$2,501.56		$500.31
63040	T		Laminotomy, single cervical	0208	42.1492	$2,501.56		$500.31
63042	T		Laminotomy, single lumbar	0208	42.1492	$2,501.56		$500.31
63043	C		Laminotomy, add'l cervical					
63044	C		Laminotomy, add'l lumbar					
63045	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63046	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63047	T		Removal of spinal lamina	0208	42.1492	$2,501.56		$500.31
63048	T		Remove spinal lamina add-on	0208	42.1492	$2,501.56		$500.31
63050	C		Cervical laminoplasty					
63051	C		C-laminoplasty w/graft/plate					
63055	T		Decompress spinal cord	0208	42.1492	$2,501.56		$500.31
63056	T		Decompress spinal cord	0208	42.1492	$2,501.56		$500.31
63057	T		Decompress spine cord add-on	0208	42.1492	$2,501.56		$500.31
63064	T		Decompress spinal cord	0208	42.1492	$2,501.56		$500.31
63066	T		Decompress spine cord add-on	0208	42.1492	$2,501.56		$500.31
63075	C		Neck spine disk surgery					
63076	C		Neck spine disk surgery					
63077	C		Spine disk surgery, thorax					
63078	C		Spine disk surgery, thorax					
63081	C		Removal of vertebral body					
63082	C		Remove vertebral body add-on					
63085	C		Removal of vertebral body					
63086	C		Remove vertebral body add-on					
63087	C		Removal of vertebral body					
63088	C		Remove vertebral body add-on					
63090	C		Removal of vertebral body					
63091	C		Remove vertebral body add-on					
63101	C		Removal of vertebral body					
63102	C		Removal of vertebral body					
63103	C		Remove vertebral body add-on					
63170	C		Incise spinal cord tract(s)					
63172	C		Drainage of spinal cyst					
63173	C		Drainage of spinal cyst					
63180	C		Revise spinal cord ligaments					
63182	C		Revise spinal cord ligaments					
63185	C		Incise spinal column/nerves					
63190	C		Incise spinal column/nerves					
63191	C		Incise spinal column/nerves					
63194	C		Incise spinal column & cord					
63195	C		Incise spinal column & cord					
63196	C		Incise spinal column & cord					
63197	C		Incise spinal column & cord					
63198	C		Incise spinal column & cord					
63199	C		Incise spinal column & cord					
63200	C		Release of spinal cord					
63250	C		Revise spinal cord vessels					
63251	C		Revise spinal cord vessels					
63252	C		Revise spinal cord vessels					
63265	C		Excise intraspinal lesion					
63266	C		Excise intraspinal lesion					
63267	C		Excise intraspinal lesion					
63268	C		Excise intraspinal lesion					
63270	C		Excise intraspinal lesion					
63271	C		Excise intraspinal lesion					
63272	C		Excise intraspinal lesion					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
63295	C		Repair of laminectomy defect					
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	17.2800	$1,025.57		$205.11
63610	T		Stimulation of spinal cord	0220	17.2800	$1,025.57		$205.11
63615	T		Remove lesion of spinal cord	0220	17.2800	$1,025.57		$205.11
63650	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
63655	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
63660	T		Revise/remove neuroelectrode	0687	19.1476	$1,136.41	$454.56	$227.28
63685	T		Implant neuroreceiver	0222	178.2870	$10,581.33		$2,116.27
63688	T		Revise/remove neuroreceiver	0688	42.8494	$2,543.11	$1,017.24	$508.62
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	51.4916	$3,056.03		$611.21
63744	T		Revision of spinal shunt	0228	51.4916	$3,056.03		$611.21
63746	T		Removal of spinal shunt	0109	10.9933	$652.45	$131.49	$130.49
64400	T		N block inj, trigeminal	0204	2.1811	$129.45	$40.13	$25.89
64402	T		N block inj, facial	0204	2.1811	$129.45	$40.13	$25.89
64405	T		N block inj, occipital	0204	2.1811	$129.45	$40.13	$25.89
64408	T		N block inj, vagus	0204	2.1811	$129.45	$40.13	$25.89
64410	T		N block inj, phrenic	0206	5.4672	$324.48	$75.55	$64.90
64412	T		N block inj, spinal accessor	0206	5.4672	$324.48	$75.55	$64.90
64413	T		N block inj, cervical plexus	0204	2.1811	$129.45	$40.13	$25.89
64415	T		Injection for nerve block	0204	2.1811	$129.45	$40.13	$25.89
64416	T		N block cont infuse, b plex	0204	2.1811	$129.45	$40.13	$25.89
64417	T		N block inj, axillary	0204	2.1811	$129.45	$40.13	$25.89
64418	T		N block inj, suprascapular	0204	2.1811	$129.45	$40.13	$25.89
64420	T		N block inj, intercost, sng	0204	2.1811	$129.45	$40.13	$25.89
64421	T		N block inj, intercost, mlt	0206	5.4672	$324.48	$75.55	$64.90
64425	T		N block inj ilio-ing/hypogi	0204	2.1811	$129.45	$40.13	$25.89
64430	T		N block inj, pudendal	0204	2.1811	$129.45	$40.13	$25.89
64435	T		N block inj, paracervical	0204	2.1811	$129.45	$40.13	$25.89
64445	T		Injection for nerve block	0204	2.1811	$129.45	$40.13	$25.89
64446	T		N blk inj, sciatic, cont inf	0206	5.4672	$324.48	$75.55	$64.90
64447	T		N block inj fem, single	0204	2.1811	$129.45	$40.13	$25.89
64448	T		N block inj fem, cont inf	0204	2.1811	$129.45	$40.13	$25.89
64449	T		N block inj, lumbar plexus	0204	2.1811	$129.45	$40.13	$25.89
64450	T		N block, other peripheral	0204	2.1811	$129.45	$40.13	$25.89
64470	T		Inj paravertebral c/t	0207	5.9837	$355.13	$86.92	$71.03
64472	T		Inj paravertebral c/t add-on	0206	5.4672	$324.48	$75.55	$64.90

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64475	T		Inj paravertebral l/s	0207	5.9837	$355.13	$86.92	$71.03
64476	T		Inj paravertebral l/s add-on	0206	5.4672	$324.48	$75.55	$64.90
64479	T		Inj foramen epidural c/t	0207	5.9837	$355.13	$86.92	$71.03
64480	T		Inj foramen epidural add-on	0207	5.9837	$355.13	$86.92	$71.03
64483	T		Inj foramen epidural l/s	0207	5.9837	$355.13	$86.92	$71.03
64484	T		Inj foramen epidural add-on	0207	5.9837	$355.13	$86.92	$71.03
64505	T		N block, spenopalatine gangl	0204	2.1811	$129.45	$40.13	$25.89
64508	T		N block, carotid sinus s/p	0204	2.1811	$129.45	$40.13	$25.89
64510	T		N block, stellate ganglion	0207	5.9837	$355.13	$86.92	$71.03
64517	T		N block inj, hypogas plxs	0204	2.1811	$129.45	$40.13	$25.89
64520	T		N block, lumbar/thoracic	0207	5.9837	$355.13	$86.92	$71.03
64530	T		N block inj, celiac pelus	0207	5.9837	$355.13	$86.92	$71.03
64550	A		Apply neurostimulator					
64553	S		Implant neuroelectrodes	0225	233.6295	$13,865.91		$2,773.18
64555	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64560	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64561	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64565	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64573	S		Implant neuroelectrodes	0225	233.6295	$13,865.91		$2,773.18
64575	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64577	S		Implant neuroelectrodes	0225	233.6295	$13,865.91		$2,773.18
64580	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64581	S		Implant neuroelectrodes	0040	55.0791	$3,268.94		$653.79
64585	T		Revise/remove neuroelectrode	0687	19.1476	$1,136.41	$454.56	$227.28
64590	T		Implant neuroreceiver	0222	178.2870	$10,581.33		$2,116.27
64595	T		Revise/remove neuroreceiver	0688	42.8494	$2,543.11	$1,017.24	$508.62
64600	T		Injection treatment of nerve	0203	10.3544	$614.53	$245.81	$122.91
64605	T		Injection treatment of nerve	0203	10.3544	$614.53	$245.81	$122.91
64610	T		Injection treatment of nerve	0203	10.3544	$614.53	$245.81	$122.91
64612	T		Destroy nerve, face muscle	0204	2.1811	$129.45	$40.13	$25.89
64613	T		Destroy nerve, spine muscle	0204	2.1811	$129.45	$40.13	$25.89
64614	T		Destroy nerve, extrem musc	0204	2.1811	$129.45	$40.13	$25.89
64620	T		Injection treatment of nerve	0203	10.3544	$614.53	$245.81	$122.91
64622	T		Destr paravertebrl nerve l/s	0203	10.3544	$614.53	$245.81	$122.91
64623	T		Destr paravertebral n add-on	0207	5.9837	$355.13	$86.92	$71.03
64626	T		Destr paravertebrl nerve c/t	0203	10.3544	$614.53	$245.81	$122.91
64627	T		Destr paravertebral n add-on	0207	5.9837	$355.13	$86.92	$71.03
64630	T		Injection treatment of nerve	0206	5.4672	$324.48	$75.55	$64.90
64640	T		Injection treatment of nerve	0206	5.4672	$324.48	$75.55	$64.90
64680	T		Injection treatment of nerve	0207	5.9837	$355.13	$86.92	$71.03
64681	T		Injection treatment of nerve	0203	10.3544	$614.53	$245.81	$122.91
64702	T		Revise finger/toe nerve	0220	17.2800	$1,025.57		$205.11
64704	T		Revise hand/foot nerve	0220	17.2800	$1,025.57		$205.11
64708	T		Revise arm/leg nerve	0220	17.2800	$1,025.57		$205.11
64712	T		Revision of sciatic nerve	0220	17.2800	$1,025.57		$205.11
64713	T		Revision of arm nerve(s)	0220	17.2800	$1,025.57		$205.11
64714	T		Revise low back nerve(s)	0220	17.2800	$1,025.57		$205.11
64716	T		Revision of cranial nerve	0220	17.2800	$1,025.57		$205.11
64718	T		Revise ulnar nerve at elbow	0220	17.2800	$1,025.57		$205.11
64719	T		Revise ulnar nerve at wrist	0220	17.2800	$1,025.57		$205.11
64721	T		Carpal tunnel surgery	0220	17.2800	$1,025.57		$205.11
64722	T		Relieve pressure on nerve(s)	0220	17.2800	$1,025.57		$205.11
64726	T		Release foot/toe nerve	0220	17.2800	$1,025.57		$205.11
64727	T		Internal nerve revision	0220	17.2800	$1,025.57		$205.11
64732	T		Incision of brow nerve	0220	17.2800	$1,025.57		$205.11
64734	T		Incision of cheek nerve	0220	17.2800	$1,025.57		$205.11
64736	T		Incision of chin nerve	0220	17.2800	$1,025.57		$205.11
64738	T		Incision of jaw nerve	0220	17.2800	$1,025.57		$205.11
64740	T		Incision of tongue nerve	0220	17.2800	$1,025.57		$205.11
64742	T		Incision of facial nerve	0220	17.2800	$1,025.57		$205.11
64744	T		Incise nerve, back of head	0220	17.2800	$1,025.57		$205.11
64746	T		Incise diaphragm nerve	0220	17.2800	$1,025.57		$205.11
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	17.2800	$1,025.57		$205.11

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
64763	T		Incise hip/thigh nerve	0220	17.2800	$1,025.57		$205.11
64766	T		Incise hip/thigh nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64771	T		Sever cranial nerve	0220	17.2800	$1,025.57		$205.11
64772	T		Incision of spinal nerve	0220	17.2800	$1,025.57		$205.11
64774	T		Remove skin nerve lesion	0220	17.2800	$1,025.57		$205.11
64776	T		Remove digit nerve lesion	0220	17.2800	$1,025.57		$205.11
64778	T		Digit nerve surgery add-on	0220	17.2800	$1,025.57		$205.11
64782	T		Remove limb nerve lesion	0220	17.2800	$1,025.57		$205.11
64783	T		Limb nerve surgery add-on	0220	17.2800	$1,025.57		$205.11
64784	T		Remove nerve lesion	0220	17.2800	$1,025.57		$205.11
64786	T		Remove sciatic nerve lesion	0221	29.7854	$1,767.76	$463.62	$353.55
64787	T		Implant nerve end	0220	17.2800	$1,025.57		$205.11
64788	T		Remove skin nerve lesion	0220	17.2800	$1,025.57		$205.11
64790	T		Removal of nerve lesion	0220	17.2800	$1,025.57		$205.11
64792	T		Removal of nerve lesion	0221	29.7854	$1,767.76	$463.62	$353.55
64795	T		Biopsy of nerve	0220	17.2800	$1,025.57		$205.11
64802	T		Remove sympathetic nerves	0220	17.2800	$1,025.57		$205.11
64804	C		Remove sympathetic nerves					
64809	C		Remove sympathetic nerves					
64818	C		Remove sympathetic nerves					
64820	T		Remove sympathetic nerves	0220	17.2800	$1,025.57		$205.11
64821	T		Remove sympathetic nerves	0054	25.2562	$1,498.96		$299.79
64822	T		Remove sympathetic nerves	0054	25.2562	$1,498.96		$299.79
64823	T		Remove sympathetic nerves	0054	25.2562	$1,498.96		$299.79
64831	T		Repair of digit nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64832	T		Repair nerve add-on	0221	29.7854	$1,767.76	$463.62	$353.55
64834	T		Repair of hand or foot nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64835	T		Repair of hand or foot nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64836	T		Repair of hand or foot nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64837	T		Repair nerve add-on	0221	29.7854	$1,767.76	$463.62	$353.55
64840	T		Repair of leg nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64856	T		Repair/transpose nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64857	T		Repair arm/leg nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64858	T		Repair sciatic nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64859	T		Nerve surgery	0221	29.7854	$1,767.76	$463.62	$353.55
64861	T		Repair of arm nerves	0221	29.7854	$1,767.76	$463.62	$353.55
64862	T		Repair of low back nerves	0221	29.7854	$1,767.76	$463.62	$353.55
64864	T		Repair of facial nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64865	T		Repair of facial nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64866	C		Fusion of facial/other nerve					
64868	C		Fusion of facial/other nerve					
64870	T		Fusion of facial/other nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64872	T		Subsequent repair of nerve	0221	29.7854	$1,767.76	$463.62	$353.55
64874	T		Repair & revise nerve add-on	0221	29.7854	$1,767.76	$463.62	$353.55
64876	T		Repair nerve/shorten bone	0221	29.7854	$1,767.76	$463.62	$353.55
64885	T		Nerve graft, head or neck	0221	29.7854	$1,767.76	$463.62	$353.55
64886	T		Nerve graft, head or neck	0221	29.7854	$1,767.76	$463.62	$353.55
64890	T		Nerve graft, hand or foot	0221	29.7854	$1,767.76	$463.62	$353.55
64891	T		Nerve graft, hand or foot	0221	29.7854	$1,767.76	$463.62	$353.55
64892	T		Nerve graft, arm or leg	0221	29.7854	$1,767.76	$463.62	$353.55
64893	T		Nerve graft, arm or leg	0221	29.7854	$1,767.76	$463.62	$353.55
64895	T		Nerve graft, hand or foot	0221	29.7854	$1,767.76	$463.62	$353.55
64896	T		Nerve graft, hand or foot	0221	29.7854	$1,767.76	$463.62	$353.55
64897	T		Nerve graft, arm or leg	0221	29.7854	$1,767.76	$463.62	$353.55
64898	T		Nerve graft, arm or leg	0221	29.7854	$1,767.76	$463.62	$353.55
64901	T		Nerve graft add-on	0221	29.7854	$1,767.76	$463.62	$353.55
64902	T		Nerve graft add-on	0221	29.7854	$1,767.76	$463.62	$353.55
64905	T		Nerve pedicle transfer	0221	29.7854	$1,767.76	$463.62	$353.55
64907	T		Nerve pedicle transfer	0221	29.7854	$1,767.76	$463.62	$353.55
64999	T		Nervous system surgery	0204	2.1811	$129.45	$40.13	$25.89
65091	T		Revise eye	0242	30.4081	$1,804.72	$597.36	$360.94
65093	T		Revise eye with implant	0241	23.1980	$1,376.80	$384.47	$275.36
65101	T		Removal of eye	0242	30.4081	$1,804.72	$597.36	$360.94
65103	T		Remove eye/insert implant	0242	30.4081	$1,804.72	$597.36	$360.94
65105	T		Remove eye/attach implant	0242	30.4081	$1,804.72	$597.36	$360.94
65110	T		Removal of eye	0242	30.4081	$1,804.72	$597.36	$360.94

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
65112	T		Remove eye/revise socket	0242	30.4081	$1,804.72	$597.36	$360.94
65114	T		Remove eye/revise socket	0242	30.4081	$1,804.72	$597.36	$360.94
65125	T		Revise ocular implant	0240	18.0686	$1,072.37	$315.31	$214.47
65130	T		Insert ocular implant	0241	23.1980	$1,376.80	$384.47	$275.36
65135	T		Insert ocular implant	0241	23.1980	$1,376.80	$384.47	$275.36
65140	T		Attach ocular implant	0242	30.4081	$1,804.72	$597.36	$360.94
65150	T		Revise ocular implant	0241	23.1980	$1,376.80	$384.47	$275.36
65155	T		Reinsert ocular implant	0242	30.4081	$1,804.72	$597.36	$360.94
65175	T		Removal of ocular implant	0240	18.0686	$1,072.37	$315.31	$214.47
65205	S		Remove foreign body from eye	0698	1.2381	$73.48	$16.48	$14.70
65210	S		Remove foreign body from eye	0698	1.2381	$73.48	$16.48	$14.70
65220	S		Remove foreign body from eye	0698	1.2381	$73.48	$16.48	$14.70
65222	S		Remove foreign body from eye	0698	1.2381	$73.48	$16.48	$14.70
65235	T		Remove foreign body from eye	0233	14.8995	$884.29	$266.33	$176.86
65260	T		Remove foreign body from eye	0236	16.9458	$1,005.73		$201.15
65265	T		Remove foreign body from eye	0237	28.8091	$1,709.82		$341.96
65270	T		Repair of eye wound	0240	18.0686	$1,072.37	$315.31	$214.47
65272	T		Repair of eye wound	0234	21.8746	$1,298.26	$511.31	$259.65
65273	C		Repair of eye wound					
65275	T		Repair of eye wound	0234	21.8746	$1,298.26	$511.31	$259.65
65280	T		Repair of eye wound	0236	16.9458	$1,005.73		$201.15
65285	T		Repair of eye wound	0672	36.7611	$2,181.77		$436.35
65286	T		Repair of eye wound	0232	6.6429	$394.26	$103.17	$78.85
65290	T		Repair of eye socket wound	0243	22.0667	$1,309.66	$431.39	$261.93
65400	T		Removal of eye lesion	0233	14.8995	$884.29	$266.33	$176.86
65410	T		Biopsy of cornea	0233	14.8995	$884.29	$266.33	$176.86
65420	T		Removal of eye lesion	0233	14.8995	$884.29	$266.33	$176.86
65426	T		Removal of eye lesion	0234	21.8746	$1,298.26	$511.31	$259.65
65430	S		Corneal smear	0698	1.2381	$73.48	$16.48	$14.70
65435	T		Curette/treat cornea	0239	6.8784	$408.23		$81.65
65436	T		Curette/treat cornea	0233	14.8995	$884.29	$266.33	$176.86
65450	S		Treatment of corneal lesion	0231	1.9191	$113.90		$22.78
65600	T		Revision of cornea	0240	18.0686	$1,072.37	$315.31	$214.47
65710	T		Corneal transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65730	T		Corneal transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65750	T		Corneal transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65755	T		Corneal transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65760	E		Revision of cornea					
65765	E		Revision of cornea					
65767	E		Corneal tissue transplant					
65770	T		Revise cornea with implant	0244	38.1985	$2,267.08	$803.26	$453.42
65771	E		Radial keratotomy					
65772	T		Correction of astigmatism	0233	14.8995	$884.29	$266.33	$176.86
65775	T		Correction of astigmatism	0233	14.8995	$884.29	$266.33	$176.86
65780	T		Ocular reconst, transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65781	T		Ocular reconst, transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65782	T		Ocular reconst, transplant	0244	38.1985	$2,267.08	$803.26	$453.42
65800	T		Drainage of eye	0233	14.8995	$884.29	$266.33	$176.86
65805	T		Drainage of eye	0233	14.8995	$884.29	$266.33	$176.86
65810	T		Drainage of eye	0234	21.8746	$1,298.26	$511.31	$259.65
65815	T		Drainage of eye	0234	21.8746	$1,298.26	$511.31	$259.65
65820	T		Relieve inner eye pressure	0232	6.6429	$394.26	$103.17	$78.85
65850	T		Incision of eye	0234	21.8746	$1,298.26	$511.31	$259.65
65855	T		Laser surgery of eye	0247	5.0102	$297.36	$104.31	$59.47
65860	T		Incise inner eye adhesions	0247	5.0102	$297.36	$104.31	$59.47
65865	T		Incise inner eye adhesions	0233	14.8995	$884.29	$266.33	$176.86
65870	T		Incise inner eye adhesions	0234	21.8746	$1,298.26	$511.31	$259.65
65875	T		Incise inner eye adhesions	0234	21.8746	$1,298.26	$511.31	$259.65
65880	T		Incise inner eye adhesions	0233	14.8995	$884.29	$266.33	$176.86
65900	T		Remove eye lesion	0233	14.8995	$884.29	$266.33	$176.86
65920	T		Remove implant of eye	0234	21.8746	$1,298.26	$511.31	$259.65
65930	T		Remove blood clot from eye	0234	21.8746	$1,298.26	$511.31	$259.65
66020	T		Injection treatment of eye	0233	14.8995	$884.29	$266.33	$176.86
66030	T		Injection treatment of eye	0232	6.6429	$394.26	$103.17	$78.85
66130	T		Remove eye lesion	0234	21.8746	$1,298.26	$511.31	$259.65
66150	T		Glaucoma surgery	0234	21.8746	$1,298.26	$511.31	$259.65

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
66155	T		Glaucoma surgery	0234	21.8746	$1,298.26	$511.31	$259.65
66160	T		Glaucoma surgery	0234	21.8746	$1,298.26	$511.31	$259.65
66165	T		Glaucoma surgery	0234	21.8746	$1,298.26	$511.31	$259.65
66170	T		Glaucoma surgery	0234	21.8746	$1,298.26	$511.31	$259.65
66172	T		Incision of eye	0673	29.1257	$1,728.61	$649.56	$345.72
66180	T		Implant eye shunt	0673	29.1257	$1,728.61	$649.56	$345.72
66185	T		Revise eye shunt	0673	29.1257	$1,728.61	$649.56	$345.72
66220	T		Repair eye lesion	0672	36.7611	$2,181.77		$436.35
66225	T		Repair/graft eye lesion	0673	29.1257	$1,728.61	$649.56	$345.72
66250	T		Follow-up surgery of eye	0233	14.8995	$884.29	$266.33	$176.86
66500	T		Incision of iris	0232	6.6429	$394.26	$103.17	$78.85
66505	T		Incision of iris	0232	6.6429	$394.26	$103.17	$78.85
66600	T		Remove iris and lesion	0234	21.8746	$1,298.26	$511.31	$259.65
66605	T		Removal of iris	0234	21.8746	$1,298.26	$511.31	$259.65
66625	T		Removal of iris	0232	6.6429	$394.26	$103.17	$78.85
66630	T		Removal of iris	0234	21.8746	$1,298.26	$511.31	$259.65
66635	T		Removal of iris	0234	21.8746	$1,298.26	$511.31	$259.65
66680	T		Repair iris & ciliary body	0234	21.8746	$1,298.26	$511.31	$259.65
66682	T		Repair iris & ciliary body	0234	21.8746	$1,298.26	$511.31	$259.65
66700	T		Destruction, ciliary body	0233	14.8995	$884.29	$266.33	$176.86
66710	T		Destruction, ciliary body	0233	14.8995	$884.29	$266.33	$176.86
66711	T		Ciliary endoscopic ablation	0233	14.8995	$884.29	$266.33	$176.86
66720	T		Destruction, ciliary body	0233	14.8995	$884.29	$266.33	$176.86
66740	T		Destruction, ciliary body	0234	21.8746	$1,298.26	$511.31	$259.65
66761	T		Revision of iris	0247	5.0102	$297.36	$104.31	$59.47
66762	T		Revision of iris	0247	5.0102	$297.36	$104.31	$59.47
66770	T		Removal of inner eye lesion	0247	5.0102	$297.36	$104.31	$59.47
66820	T		Incision, secondary cataract	0232	6.6429	$394.26	$103.17	$78.85
66821	T		After cataract laser surgery	0247	5.0102	$297.36	$104.31	$59.47
66825	T		Reposition intraocular lens	0234	21.8746	$1,298.26	$511.31	$259.65
66830	T		Removal of lens lesion	0232	6.6429	$394.26	$103.17	$78.85
66840	T		Removal of lens material	0245	13.3020	$789.47	$220.91	$157.89
66850	T		Removal of lens material	0249	27.8103	$1,650.54	$524.67	$330.11
66852	T		Removal of lens material	0249	27.8103	$1,650.54	$524.67	$330.11
66920	T		Extraction of lens	0249	27.8103	$1,650.54	$524.67	$330.11
66930	T		Extraction of lens	0249	27.8103	$1,650.54	$524.67	$330.11
66940	T		Extraction of lens	0245	13.3020	$789.47	$220.91	$157.89
66982	T		Cataract surgery, complex	0246	23.3535	$1,386.03	$495.96	$277.21
66983	T		Cataract surg w/iol, 1 stage	0246	23.3535	$1,386.03	$495.96	$277.21
66984	T		Cataract surg w/iol, 1 stage	0246	23.3535	$1,386.03	$495.96	$277.21
66985	T		Insert lens prosthesis	0246	23.3535	$1,386.03	$495.96	$277.21
66986	T		Exchange lens prosthesis	0246	23.3535	$1,386.03	$495.96	$277.21
66990	N		Ophthalmic endoscope add-on					
66999	T		Eye surgery procedure	0232	6.6429	$394.26	$103.17	$78.85
67005	T		Partial removal of eye fluid	0237	28.8091	$1,709.82		$341.96
67010	T		Partial removal of eye fluid	0237	28.8091	$1,709.82		$341.96
67015	T		Release of eye fluid	0237	28.8091	$1,709.82		$341.96
67025	T		Replace eye fluid	0237	28.8091	$1,709.82		$341.96
67027	T		Implant eye drug system	0672	36.7611	$2,181.77		$436.35
67028	T		Injection eye drug	0235	4.6382	$275.28	$67.10	$55.06
67030	T		Incise inner eye strands	0236	16.9458	$1,005.73		$201.15
67031	T		Laser surgery, eye strands	0247	5.0102	$297.36	$104.31	$59.47
67036	T		Removal of inner eye fluid	0672	36.7611	$2,181.77		$436.35
67038	T		Strip retinal membrane	0672	36.7611	$2,181.77		$436.35
67039	T		Laser treatment of retina	0672	36.7611	$2,181.77		$436.35
67040	T		Laser treatment of retina	0672	36.7611	$2,181.77		$436.35
67101	T		Repair detached retina	0236	16.9458	$1,005.73		$201.15
67105	T		Repair detached retina	0248	4.6557	$276.32	$93.57	$55.26
67107	T		Repair detached retina	0672	36.7611	$2,181.77		$436.35
67108	T		Repair detached retina	0672	36.7611	$2,181.77		$436.35
67110	T		Repair detached retina	0236	16.9458	$1,005.73		$201.15
67112	T		Rerepair detached retina	0672	36.7611	$2,181.77		$436.35
67115	T		Release encircling material	0236	16.9458	$1,005.73		$201.15
67120	T		Remove eye implant material	0236	16.9458	$1,005.73		$201.15
67121	T		Remove eye implant material	0237	28.8091	$1,709.82		$341.96
67141	T		Treatment of retina	0235	4.6382	$275.28	$67.10	$55.06

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67145	T		Treatment of retina	0248	4.6557	$276.32	$93.57	$55.26
67208	T		Treatment of retinal lesion	0236	16.9458	$1,005.73		$201.15
67210	T		Treatment of retinal lesion	0248	4.6557	$276.32	$93.57	$55.26
67218	T		Treatment of retinal lesion	0236	16.9458	$1,005.73		$201.15
67220	T		Treatment of choroid lesion	0235	4.6382	$275.28	$67.10	$55.06
67221	T		Ocular photodynamic ther	0235	4.6382	$275.28	$67.10	$55.06
67225	T		Eye photodynamic ther add-on	0235	4.6382	$275.28	$67.10	$55.06
67227	T		Treatment of retinal lesion	0236	16.9458	$1,005.73		$201.15
67228	T		Treatment of retinal lesion	0248	4.6557	$276.32	$93.57	$55.26
67250	T		Reinforce eye wall	0240	18.0686	$1,072.37	$315.31	$214.47
67255	T		Reinforce/graft eye wall	0237	28.8091	$1,709.82		$341.96
67299	T		Eye surgery procedure	0235	4.6382	$275.28	$67.10	$55.06
67311	T		Revise eye muscle	0243	22.0667	$1,309.66	$431.39	$261.93
67312	T		Revise two eye muscles	0243	22.0667	$1,309.66	$431.39	$261.93
67314	T		Revise eye muscle	0243	22.0667	$1,309.66	$431.39	$261.93
67316	T		Revise two eye muscles	0243	22.0667	$1,309.66	$431.39	$261.93
67318	T		Revise eye muscle(s)	0243	22.0667	$1,309.66	$431.39	$261.93
67320	T		Revise eye muscle(s) add-on	0243	22.0667	$1,309.66	$431.39	$261.93
67331	T		Eye surgery follow-up add-on	0243	22.0667	$1,309.66	$431.39	$261.93
67332	T		Rerevise eye muscles add-on	0243	22.0667	$1,309.66	$431.39	$261.93
67334	T		Revise eye muscle w/suture	0243	22.0667	$1,309.66	$431.39	$261.93
67335	T		Eye suture during surgery	0243	22.0667	$1,309.66	$431.39	$261.93
67340	T		Revise eye muscle add-on	0243	22.0667	$1,309.66	$431.39	$261.93
67343	T		Release eye tissue	0243	22.0667	$1,309.66	$431.39	$261.93
67345	T		Destroy nerve of eye muscle	0238	2.5816	$153.22		$30.64
67350	T		Biopsy eye muscle	0699	9.9723	$591.86		$118.37
67399	T		Eye muscle surgery procedure	0243	22.0667	$1,309.66	$431.39	$261.93
67400	T		Explore/biopsy eye socket	0241	23.1980	$1,376.80	$384.47	$275.36
67405	T		Explore/drain eye socket	0241	23.1980	$1,376.80	$384.47	$275.36
67412	T		Explore/treat eye socket	0241	23.1980	$1,376.80	$384.47	$275.36
67413	T		Explore/treat eye socket	0241	23.1980	$1,376.80	$384.47	$275.36
67414	T		Explr/decompress eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67415	T		Aspiration, orbital contents	0240	18.0686	$1,072.37	$315.31	$214.47
67420	T		Explore/treat eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67430	T		Explore/treat eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67440	T		Explore/drain eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67445	T		Explr/decompress eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67450	T		Explore/biopsy eye socket	0242	30.4081	$1,804.72	$597.36	$360.94
67500	S		Inject/treat eye socket	0231	1.9191	$113.90		$22.78
67505	T		Inject/treat eye socket	0238	2.5816	$153.22		$30.64
67515	T		Inject/treat eye socket	0238	2.5816	$153.22		$30.64
67550	T		Insert eye socket implant	0242	30.4081	$1,804.72	$597.36	$360.94
67560	T		Revise eye socket implant	0241	23.1980	$1,376.80	$384.47	$275.36
67570	T		Decompress optic nerve	0242	30.4081	$1,804.72	$597.36	$360.94
67599	T		Orbit surgery procedure	0238	2.5816	$153.22		$30.64
67700	T		Drainage of eyelid abscess	0238	2.5816	$153.22		$30.64
67710	T		Incision of eyelid	0239	6.8784	$408.23		$81.65
67715	T		Incision of eyelid fold	0240	18.0686	$1,072.37	$315.31	$214.47
67800	T		Remove eyelid lesion	0238	2.5816	$153.22		$30.64
67801	T		Remove eyelid lesions	0239	6.8784	$408.23		$81.65
67805	T		Remove eyelid lesions	0238	2.5816	$153.22		$30.64
67808	T		Remove eyelid lesion(s)	0240	18.0686	$1,072.37	$315.31	$214.47
67810	T		Biopsy of eyelid	0238	2.5816	$153.22		$30.64
67820	S		Revise eyelashes	0698	1.2381	$73.48	$16.48	$14.70
67825	T		Revise eyelashes	0238	2.5816	$153.22		$30.64
67830	T		Revise eyelashes	0239	6.8784	$408.23		$81.65
67835	T		Revise eyelashes	0240	18.0686	$1,072.37	$315.31	$214.47
67840	T		Remove eyelid lesion	0239	6.8784	$408.23		$81.65
67850	T		Treat eyelid lesion	0239	6.8784	$408.23		$81.65
67875	T		Closure of eyelid by suture	0239	6.8784	$408.23		$81.65
67880	T		Revision of eyelid	0233	14.8995	$884.29	$266.33	$176.86
67882	T		Revision of eyelid	0240	18.0686	$1,072.37	$315.31	$214.47
67900	T		Repair brow defect	0240	18.0686	$1,072.37	$315.31	$214.47
67901	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67902	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67903	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
67904	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67906	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67908	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67909	T		Revise eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67911	T		Revise eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67912	T		Correction eyelid w/ implant	0240	18.0686	$1,072.37	$315.31	$214.47
67914	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67915	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67916	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67917	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67921	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67922	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67923	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67924	T		Repair eyelid defect	0240	18.0686	$1,072.37	$315.31	$214.47
67930	T		Repair eyelid wound	0240	18.0686	$1,072.37	$315.31	$214.47
67935	T		Repair eyelid wound	0240	18.0686	$1,072.37	$315.31	$214.47
67938	S		Remove eyelid foreign body	0698	1.2381	$73.48	$16.48	$14.70
67950	T		Revision of eyelid	0240	18.0686	$1,072.37	$315.31	$214.47
67961	T		Revision of eyelid	0240	18.0686	$1,072.37	$315.31	$214.47
67966	T		Revision of eyelid	0240	18.0686	$1,072.37	$315.31	$214.47
67971	T		Reconstruction of eyelid	0241	23.1980	$1,376.80	$384.47	$275.36
67973	T		Reconstruction of eyelid	0241	23.1980	$1,376.80	$384.47	$275.36
67974	T		Reconstruction of eyelid	0241	23.1980	$1,376.80	$384.47	$275.36
67975	T		Reconstruction of eyelid	0240	18.0686	$1,072.37	$315.31	$214.47
67999	T		Revision of eyelid	0238	2.5816	$153.22		$30.64
68020	T		Incise/drain eyelid lining	0240	18.0686	$1,072.37	$315.31	$214.47
68040	S		Treatment of eyelid lesions	0698	1.2381	$73.48	$16.48	$14.70
68100	T		Biopsy of eyelid lining	0232	6.6429	$394.26	$103.17	$78.85
68110	T		Remove eyelid lining lesion	0699	9.9723	$591.86		$118.37
68115	T		Remove eyelid lining lesion	0240	18.0686	$1,072.37	$315.31	$214.47
68130	T		Remove eyelid lining lesion	0233	14.8995	$884.29	$266.33	$176.86
68135	T		Remove eyelid lining lesion	0239	6.8784	$408.23		$81.65
68200	S		Treat eyelid by injection	0230	0.7823	$46.43	$14.97	$9.29
68320	T		Revise/graft eyelid lining	0240	18.0686	$1,072.37	$315.31	$214.47
68325	T		Revise/graft eyelid lining	0242	30.4081	$1,804.72	$597.36	$360.94
68326	T		Revise/graft eyelid lining	0241	23.1980	$1,376.80	$384.47	$275.36
68328	T		Revise/graft eyelid lining	0241	23.1980	$1,376.80	$384.47	$275.36
68330	T		Revise eyelid lining	0234	21.8746	$1,298.26	$511.31	$259.65
68335	T		Revise/graft eyelid lining	0241	23.1980	$1,376.80	$384.47	$275.36
68340	T		Separate eyelid adhesions	0240	18.0686	$1,072.37	$315.31	$214.47
68360	T		Revise eyelid lining	0234	21.8746	$1,298.26	$511.31	$259.65
68362	T		Revise eyelid lining	0234	21.8746	$1,298.26	$511.31	$259.65
68371	T		Harvest eye tissue, alograft	0233	14.8995	$884.29	$266.33	$176.86
68399	T		Eyelid lining surgery	0238	2.5816	$153.22		$30.64
68400	T		Incise/drain tear gland	0238	2.5816	$153.22		$30.64
68420	T		Incise/drain tear sac	0240	18.0686	$1,072.37	$315.31	$214.47
68440	T		Incise tear duct opening	0238	2.5816	$153.22		$30.64
68500	T		Removal of tear gland	0241	23.1980	$1,376.80	$384.47	$275.36
68505	T		Partial removal, tear gland	0241	23.1980	$1,376.80	$384.47	$275.36
68510	T		Biopsy of tear gland	0240	18.0686	$1,072.37	$315.31	$214.47
68520	T		Removal of tear sac	0241	23.1980	$1,376.80	$384.47	$275.36
68525	T		Biopsy of tear sac	0240	18.0686	$1,072.37	$315.31	$214.47
68530	T		Clearance of tear duct	0240	18.0686	$1,072.37	$315.31	$214.47
68540	T		Remove tear gland lesion	0241	23.1980	$1,376.80	$384.47	$275.36
68550	T		Remove tear gland lesion	0242	30.4081	$1,804.72	$597.36	$360.94
68700	T		Repair tear ducts	0241	23.1980	$1,376.80	$384.47	$275.36
68705	T		Revise tear duct opening	0238	2.5816	$153.22		$30.64
68720	T		Create tear sac drain	0242	30.4081	$1,804.72	$597.36	$360.94
68745	T		Create tear duct drain	0241	23.1980	$1,376.80	$384.47	$275.36
68750	T		Create tear duct drain	0242	30.4081	$1,804.72	$597.36	$360.94
68760	S		Close tear duct opening	0698	1.2381	$73.48	$16.48	$14.70
68761	S		Close tear duct opening	0231	1.9191	$113.90		$22.78
68770	T		Close tear system fistula	0240	18.0686	$1,072.37	$315.31	$214.47
68801	S		Dilate tear duct opening	0698	1.2381	$73.48	$16.48	$14.70
68810	S		Probe nasolacrimal duct	0231	1.9191	$113.90		$22.78
68811	T		Probe nasolacrimal duct	0240	18.0686	$1,072.37	$315.31	$214.47

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
68815	T		Probe nasolacrimal duct	0240	18.0686	$1,072.37	$315.31	$214.47
68840	S		Explore/irrigate tear ducts	0231	1.9191	$113.90		$22.78
68850	N		Injection for tear sac x-ray					
68899	S		Tear duct system surgery	0230	0.7823	$46.43	$14.97	$9.29
69000	T		Drain external ear lesion	0006	1.5430	$91.58	$22.18	$18.32
69005	T		Drain external ear lesion	0008	16.4242	$974.78		$194.96
69020	T		Drain outer ear canal lesion	0006	1.5430	$91.58	$22.18	$18.32
69090	E		Pierce earlobes					
69100	T		Biopsy of external ear	0019	4.0363	$239.55	$71.87	$47.91
69105	T		Biopsy of external ear canal	0253	16.0627	$953.32	$282.29	$190.66
69110	T		Remove external ear, partial	0021	14.9098	$884.90	$219.48	$176.98
69120	T		Removal of external ear	0254	23.2980	$1,382.74	$321.35	$276.55
69140	T		Remove ear canal lesion(s)	0254	23.2980	$1,382.74	$321.35	$276.55
69145	T		Remove ear canal lesion(s)	0021	14.9098	$884.90	$219.48	$176.98
69150	T		Extensive ear canal surgery	0252	7.8317	$464.81	$113.41	$92.96
69155	C		Extensive ear/neck surgery					
69200	X		Clear outer ear canal	0340	0.6355	$37.72		$7.54
69205	T		Clear outer ear canal	0022	19.5582	$1,160.78	$354.45	$232.16
69210	X		Remove impacted ear wax	0340	0.6355	$37.72		$7.54
69220	T		Clean out mastoid cavity	0012	0.8458	$50.20	$11.18	$10.04
69222	T		Clean out mastoid cavity	0253	16.0627	$953.32	$282.29	$190.66
69300	T		Revise external ear	0254	23.2980	$1,382.74	$321.35	$276.55
69310	T		Rebuild outer ear canal	0256	37.1513	$2,204.93		$440.99
69320	T		Rebuild outer ear canal	0256	37.1513	$2,204.93		$440.99
69399	T		Outer ear surgery procedure	0251	2.0010	$118.76		$23.75
69400	T		Inflate middle ear canal	0251	2.0010	$118.76		$23.75
69401	T		Inflate middle ear canal	0251	2.0010	$118.76		$23.75
69405	T		Catheterize middle ear canal	0252	7.8317	$464.81	$113.41	$92.96
69410	T		Inset middle ear (baffle)	0251	2.0010	$118.76		$23.75
69420	T		Incision of eardrum	0251	2.0010	$118.76		$23.75
69421	T		Incision of eardrum	0253	16.0627	$953.32	$282.29	$190.66
69424	T		Remove ventilating tube	0252	7.8317	$464.81	$113.41	$92.96
69433	T		Create eardrum opening	0252	7.8317	$464.81	$113.41	$92.96
69436	T		Create eardrum opening	0253	16.0627	$953.32	$282.29	$190.66
69440	T		Exploration of middle ear	0254	23.2980	$1,382.74	$321.35	$276.55
69450	T		Eardrum revision	0256	37.1513	$2,204.93		$440.99
69501	T		Mastoidectomy	0256	37.1513	$2,204.93		$440.99
69502	T		Mastoidectomy	0254	23.2980	$1,382.74	$321.35	$276.55
69505	T		Remove mastoid structures	0256	37.1513	$2,204.93		$440.99
69511	T		Extensive mastoid surgery	0256	37.1513	$2,204.93		$440.99
69530	T		Extensive mastoid surgery	0256	37.1513	$2,204.93		$440.99
69535	C		Remove part of temporal bone					
69540	T		Remove ear lesion	0253	16.0627	$953.32	$282.29	$190.66
69550	T		Remove ear lesion	0256	37.1513	$2,204.93		$440.99
69552	T		Remove ear lesion	0256	37.1513	$2,204.93		$440.99
69554	C		Remove ear lesion					
69601	T		Mastoid surgery revision	0256	37.1513	$2,204.93		$440.99
69602	T		Mastoid surgery revision	0256	37.1513	$2,204.93		$440.99
69603	T		Mastoid surgery revision	0256	37.1513	$2,204.93		$440.99
69604	T		Mastoid surgery revision	0256	37.1513	$2,204.93		$440.99
69605	T		Mastoid surgery revision	0256	37.1513	$2,204.93		$440.99
69610	T		Repair of eardrum	0254	23.2980	$1,382.74	$321.35	$276.55
69620	T		Repair of eardrum	0254	23.2980	$1,382.74	$321.35	$276.55
69631	T		Repair eardrum structures	0256	37.1513	$2,204.93		$440.99
69632	T		Rebuild eardrum structures	0256	37.1513	$2,204.93		$440.99
69633	T		Rebuild eardrum structures	0256	37.1513	$2,204.93		$440.99
69635	T		Repair eardrum structures	0256	37.1513	$2,204.93		$440.99
69636	T		Rebuild eardrum structures	0256	37.1513	$2,204.93		$440.99
69637	T		Rebuild eardrum structures	0256	37.1513	$2,204.93		$440.99
69641	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69642	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69643	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69644	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69645	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69646	T		Revise middle ear & mastoid	0256	37.1513	$2,204.93		$440.99
69650	T		Release middle ear bone	0254	23.2980	$1,382.74	$321.35	$276.55

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
69660	T		Revise middle ear bone	0256	37.1513	$2,204.93		$440.99
69661	T		Revise middle ear bone	0256	37.1513	$2,204.93		$440.99
69662	T		Revise middle ear bone	0256	37.1513	$2,204.93		$440.99
69666	T		Repair middle ear structures	0256	37.1513	$2,204.93		$440.99
69667	T		Repair middle ear structures	0256	37.1513	$2,204.93		$440.99
69670	T		Remove mastoid air cells	0256	37.1513	$2,204.93		$440.99
69676	T		Remove middle ear nerve	0256	37.1513	$2,204.93		$440.99
69700	T		Close mastoid fistula	0256	37.1513	$2,204.93		$440.99
69710	E		Implant/replace hearing aid					
69711	T		Remove/repair hearing aid	0256	37.1513	$2,204.93		$440.99
69714	T		Implant temple bone w/stimul	0256	37.1513	$2,204.93		$440.99
69715	T		Temple bne implnt w/stimulat	0256	37.1513	$2,204.93		$440.99
69717	T		Temple bone implant revision	0256	37.1513	$2,204.93		$440.99
69718	T		Revise temple bone implant	0256	37.1513	$2,204.93		$440.99
69720	T		Release facial nerve	0256	37.1513	$2,204.93		$440.99
69725	T		Release facial nerve	0256	37.1513	$2,204.93		$440.99
69740	T		Repair facial nerve	0256	37.1513	$2,204.93		$440.99
69745	T		Repair facial nerve	0256	37.1513	$2,204.93		$440.99
69799	T		Middle ear surgery procedure	0251	2.0010	$118.76		$23.75
69801	T		Incise inner ear	0256	37.1513	$2,204.93		$440.99
69802	T		Incise inner ear	0256	37.1513	$2,204.93		$440.99
69805	T		Explore inner ear	0256	37.1513	$2,204.93		$440.99
69806	T		Explore inner ear	0256	37.1513	$2,204.93		$440.99
69820	T		Establish inner ear window	0256	37.1513	$2,204.93		$440.99
69840	T		Revise inner ear window	0256	37.1513	$2,204.93		$440.99
69905	T		Remove inner ear	0256	37.1513	$2,204.93		$440.99
69910	T		Remove inner ear & mastoid	0256	37.1513	$2,204.93		$440.99
69915	T		Incise inner ear nerve	0256	37.1513	$2,204.93		$440.99
69930	T		Implant cochlear device	0259	364.6725	$21,643.31	$8,034.61	$4,328.66
69949	T		Inner ear surgery procedure	0251	2.0010	$118.76		$23.75
69950	C		Incise inner ear nerve					
69955	T		Release facial nerve	0256	37.1513	$2,204.93		$440.99
69960	T		Release inner ear canal	0256	37.1513	$2,204.93		$440.99
69970	C		Remove inner ear lesion					
69979	T		Temporal bone surgery	0251	2.0010	$118.76		$23.75
69990	N		Microsurgery add-on					
70010	S		Contrast x-ray of brain	0274	3.0275	$179.68	$71.87	$35.94
70015	S		Contrast x-ray of brain	0274	3.0275	$179.68	$71.87	$35.94
70030	X		X-ray eye for foreign body	0260	0.7521	$44.64	$17.85	$8.93
70100	X		X-ray exam of jaw	0260	0.7521	$44.64	$17.85	$8.93
70110	X		X-ray exam of jaw	0260	0.7521	$44.64	$17.85	$8.93
70120	X		X-ray exam of mastoids	0260	0.7521	$44.64	$17.85	$8.93
70130	X		X-ray exam of mastoids	0260	0.7521	$44.64	$17.85	$8.93
70134	X		X-ray exam of middle ear	0261	1.2843	$76.22		$15.24
70140	X		X-ray exam of facial bones	0260	0.7521	$44.64	$17.85	$8.93
70150	X		X-ray exam of facial bones	0260	0.7521	$44.64	$17.85	$8.93
70160	X		X-ray exam of nasal bones	0260	0.7521	$44.64	$17.85	$8.93
70170	X		X-ray exam of tear duct	0264	3.5080	$208.20	$79.41	$41.64
70190	X		X-ray exam of eye sockets	0260	0.7521	$44.64	$17.85	$8.93
70200	X		X-ray exam of eye sockets	0260	0.7521	$44.64	$17.85	$8.93
70210	X		X-ray exam of sinuses	0260	0.7521	$44.64	$17.85	$8.93
70220	X		X-ray exam of sinuses	0260	0.7521	$44.64	$17.85	$8.93
70240	X		X-ray exam, pituitary saddle	0260	0.7521	$44.64	$17.85	$8.93
70250	X		X-ray exam of skull	0260	0.7521	$44.64	$17.85	$8.93
70260	X		X-ray exam of skull	0261	1.2843	$76.22		$15.24
70300	X		X-ray exam of teeth	0262	0.9186	$54.52		$10.90
70310	X		X-ray exam of teeth	0262	0.9186	$54.52		$10.90
70320	X		Full mouth x-ray of teeth	0262	0.9186	$54.52		$10.90
70328	X		X-ray exam of jaw joint	0260	0.7521	$44.64	$17.85	$8.93
70330	X		X-ray exam of jaw joints	0260	0.7521	$44.64	$17.85	$8.93
70332	S		X-ray exam of jaw joint	0275	3.5617	$211.39	$69.09	$42.28
70336	S		Magnetic image, jaw joint	0335	5.1347	$304.74	$121.89	$60.95
70350	X		X-ray head for orthodontia	0260	0.7521	$44.64	$17.85	$8.93
70355	X		Panoramic x-ray of jaws	0260	0.7521	$44.64	$17.85	$8.93
70360	X		X-ray exam of neck	0260	0.7521	$44.64	$17.85	$8.93
70370	X		Throat x-ray & fluoroscopy	0272	1.3738	$81.54	$32.61	$16.31

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
70371	X		Speech evaluation, complex	0272	1.3738	$81.54	$32.61	$16.31
70373	X		Contrast x-ray of larynx	0263	1.7397	$103.25	$24.29	$20.65
70380	X		X-ray exam of salivary gland	0260	0.7521	$44.64	$17.85	$8.93
70390	X		X-ray exam of salivary duct	0263	1.7397	$103.25	$24.29	$20.65
70450*	S		Ct head/brain w/o dye	0332	3.2546	$193.16	$77.26	$38.63
70460*	S		Ct head/brain w/dye	0283	4.4053	$261.45	$104.58	$52.29
70470*	S		Ct head/brain w/o & w/ dye	0333	5.2596	$312.16	$124.86	$62.43
70480*	S		Ct orbit/ear/fossa w/o dye	0332	3.2546	$193.16	$77.26	$38.63
70481*	S		Ct orbit/ear/fossa w/dye	0283	4.4053	$261.45	$104.58	$52.29
70482*	S		Ct orbit/ear/fossa w/o&w dye	0333	5.2596	$312.16	$124.86	$62.43
70486*	S		Ct maxillofacial w/o dye	0332	3.2546	$193.16	$77.26	$38.63
70487*	S		Ct maxillofacial w/dye	0283	4.4053	$261.45	$104.58	$52.29
70488*	S		Ct maxillofacial w/o & w dye	0333	5.2596	$312.16	$124.86	$62.43
70490*	S		Ct soft tissue neck w/o dye	0332	3.2546	$193.16	$77.26	$38.63
70491*	S		Ct soft tissue neck w/dye	0283	4.4053	$261.45	$104.58	$52.29
70492*	S		Ct sft tsue nck w/o & w/dye	0333	5.2596	$312.16	$124.86	$62.43
70496*	S		Ct angiography, head	0662	5.1387	$304.98	$121.99	$61.00
70498*	S		Ct angiography, neck	0662	5.1387	$304.98	$121.99	$61.00
70540*	S		Mri orbit/face/neck w/o dye	0336	6.0467	$358.87	$143.54	$71.77
70542*	S		Mri orbit/face/neck w/dye	0284	6.3910	$379.31	$151.72	$75.86
70543*	S		Mri orbt/fac/nck w/o & w dye	0337	8.7547	$519.59	$207.83	$103.92
70544*	S		Mr angiography head w/o dye	0336	6.0467	$358.87	$143.54	$71.77
70545*	S		Mr angiography head w/dye	0284	6.3910	$379.31	$151.72	$75.86
70546*	S		Mr angiograph head w/o&w dye	0337	8.7547	$519.59	$207.83	$103.92
70547*	S		Mr angiography neck w/o dye	0336	6.0467	$358.87	$143.54	$71.77
70548*	S		Mr angiography neck w/dye	0284	6.3910	$379.31	$151.72	$75.86
70549*	S		Mr angiograph neck w/o&w dye	0337	8.7547	$519.59	$207.83	$103.92
70551*	S		Mri brain w/o dye	0336	6.0467	$358.87	$143.54	$71.77
70552*	S		Mri brain w/ dye	0284	6.3910	$379.31	$151.72	$75.86
70553*	S		Mri brain w/o & w/ dye	0337	8.7547	$519.59	$207.83	$103.92
70557	S		Mri brain w/o dye	0336	6.0467	$358.87	$143.54	$71.77
70558	S		Mri brain w/ dye	0284	6.3910	$379.31	$151.72	$75.86
70559	S		Mri brain w/o & w/ dye	0337	8.7547	$519.59	$207.83	$103.92
71010	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71015	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71020	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71021	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71022	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71023	X		Chest x-ray and fluoroscopy	0272	1.3738	$81.54	$32.61	$16.31
71030	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71034	X		Chest x-ray and fluoroscopy	0272	1.3738	$81.54	$32.61	$16.31
71035	X		Chest x-ray	0260	0.7521	$44.64	$17.85	$8.93
71040	X		Contrast x-ray of bronchi	0263	1.7397	$103.25	$24.29	$20.65
71060	X		Contrast x-ray of bronchi	0263	1.7397	$103.25	$24.29	$20.65
71090	X		X-ray & pacemaker insertion	0272	1.3738	$81.54	$32.61	$16.31
71100	X		X-ray exam of ribs	0260	0.7521	$44.64	$17.85	$8.93
71101	X		X-ray exam of ribs/chest	0260	0.7521	$44.64	$17.85	$8.93
71110	X		X-ray exam of ribs	0260	0.7521	$44.64	$17.85	$8.93
71111	X		X-ray exam of ribs/ chest	0261	1.2843	$76.22	.....	$15.24
71120	X		X-ray exam of breastbone	0260	0.7521	$44.64	$17.85	$8.93
71130	X		X-ray exam of breastbone	0260	0.7521	$44.64	$17.85	$8.93
71250*	S		Ct thorax w/o dye	0332	3.2546	$193.16	$77.26	$38.63
71260*	S		Ct thorax w/dye	0283	4.4053	$261.45	$104.58	$52.29
71270*	S		Ct thorax w/o & w/ dye	0333	5.2596	$312.16	$124.86	$62.43
71275*	S		Ct angiography, chest	0662	5.1387	$304.98	$121.99	$61.00
71550*	S		Mri chest w/o dye	0336	6.0467	$358.87	$143.54	$71.77
71551*	S		Mri chest w/dye	0284	6.3910	$379.31	$151.72	$75.86
71552*	S		Mri chest w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
71555	B		Mri angio chest w or w/o dye	.....	.....	.....	.....	.....
72010	X		X-ray exam of spine	0260	0.7521	$44.64	$17.85	$8.93
72020	X		X-ray exam of spine	0260	0.7521	$44.64	$17.85	$8.93
72040	X		X-ray exam of neck spine	0260	0.7521	$44.64	$17.85	$8.93
72050	X		X-ray exam of neck spine	0261	1.2843	$76.22	.....	$15.24
72052	X		X-ray exam of neck spine	0261	1.2843	$76.22	.....	$15.24
72069	X		X-ray exam of trunk spine	0260	0.7521	$44.64	$17.85	$8.93
72070	X		X-ray exam of thoracic spine	0260	0.7521	$44.64	$17.85	$8.93

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
72072	X		X-ray exam of thoracic spine	0260	0.7521	$44.64	$17.85	$8.93
72074	X		X-ray exam of thoracic spine	0260	0.7521	$44.64	$17.85	$8.93
72080	X		X-ray exam of trunk spine	0260	0.7521	$44.64	$17.85	$8.93
72090	X		X-ray exam of trunk spine	0261	1.2843	$76.22		$15.24
72100	X		X-ray exam of lower spine	0260	0.7521	$44.64	$17.85	$8.93
72110	X		X-ray exam of lower spine	0261	1.2843	$76.22		$15.24
72114	X		X-ray exam of lower spine	0261	1.2843	$76.22		$15.24
72120	X		X-ray exam of lower spine	0261	1.2843	$76.22		$15.24
72125*	S		Ct neck spine w/o dye	0332	3.2546	$193.16	$77.26	$38.63
72126*	S		Ct neck spine w/dye	0283	4.4053	$261.45	$104.58	$52.29
72127*	S		Ct neck spine w/o & w/dye	0333	5.2596	$312.16	$124.86	$62.43
72128*	S		Ct chest spine w/o dye	0332	3.2546	$193.16	$77.26	$38.63
72129*	S		Ct chest spine w/dye	0283	4.4053	$261.45	$104.58	$52.29
72130*	S		Ct chest spine w/o & w/dye	0333	5.2596	$312.16	$124.86	$62.43
72131*	S		Ct lumbar spine w/o dye	0332	3.2546	$193.16	$77.26	$38.63
72132*	S		Ct lumbar spine w/dye	0283	4.4053	$261.45	$104.58	$52.29
72133*	S		Ct lumbar spine w/o & w/dye	0333	5.2596	$312.16	$124.86	$62.43
72141*	S		Mri neck spine w/o dye	0336	6.0467	$358.87	$143.54	$71.77
72142*	S		Mri neck spine w/dye	0284	6.3910	$379.31	$151.72	$75.86
72146*	S		Mri chest spine w/o dye	0336	6.0467	$358.87	$143.54	$71.77
72147*	S		Mri chest spine w/dye	0284	6.3910	$379.31	$151.72	$75.86
72148*	S		Mri lumbar spine w/o dye	0336	6.0467	$358.87	$143.54	$71.77
72149*	S		Mri lumbar spine w/dye	0284	6.3910	$379.31	$151.72	$75.86
72156*	S		Mri neck spine w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
72157*	S		Mri chest spine w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
72158*	S		Mri lumbar spine w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
72159	E		Mr angio spine w/o&w/dye					
72170	X		X-ray exam of pelvis	0260	0.7521	$44.64	$17.85	$8.93
72190	X		X-ray exam of pelvis	0260	0.7521	$44.64	$17.85	$8.93
72191*	S		Ct angiograph pelv w/o&w/dye	0662	5.1387	$304.98	$121.99	$61.00
72192*	S		Ct pelvis w/o dye	0332	3.2546	$193.16	$77.26	$38.63
72193*	S		Ct pelvis w/dye	0283	4.4053	$261.45	$104.58	$52.29
72194*	S		Ct pelvis w/o & w/dye	0333	5.2596	$312.16	$124.86	$62.43
72195*	S		Mri pelvis w/o dye	0336	6.0467	$358.87	$143.54	$71.77
72196*	S		Mri pelvis w/dye	0284	6.3910	$379.31	$151.72	$75.86
72197*	S		Mri pelvis w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
72198	B		Mr angio pelvis w/o & w/dye					
72200	X		X-ray exam sacroiliac joints	0260	0.7521	$44.64	$17.85	$8.93
72202	X		X-ray exam sacroiliac joints	0260	0.7521	$44.64	$17.85	$8.93
72220	X		X-ray exam of tailbone	0260	0.7521	$44.64	$17.85	$8.93
72240	S		Contrast x-ray of neck spine	0274	3.0275	$179.68	$71.87	$35.94
72255	S		Contrast x-ray, thorax spine	0274	3.0275	$179.68	$71.87	$35.94
72265	S		Contrast x-ray, lower spine	0274	3.0275	$179.68	$71.87	$35.94
72270	S		Contrast x-ray, spine	0274	3.0275	$179.68	$71.87	$35.94
72275	S		Epidurography	0274	3.0275	$179.68	$71.87	$35.94
72285	S		X-ray c/t spine disk	0388	12.2736	$728.44	$291.37	$145.69
72295	S		X-ray of lower spine disk	0388	12.2736	$728.44	$291.37	$145.69
73000	X		X-ray exam of collar bone	0260	0.7521	$44.64	$17.85	$8.93
73010	X		X-ray exam of shoulder blade	0260	0.7521	$44.64	$17.85	$8.93
73020	X		X-ray exam of shoulder	0260	0.7521	$44.64	$17.85	$8.93
73030	X		X-ray exam of shoulder	0260	0.7521	$44.64	$17.85	$8.93
73040	S		Contrast x-ray of shoulder	0275	3.5617	$211.39	$69.09	$42.28
73050	X		X-ray exam of shoulders	0260	0.7521	$44.64	$17.85	$8.93
73060	X		X-ray exam of humerus	0260	0.7521	$44.64	$17.85	$8.93
73070	X		X-ray exam of elbow	0260	0.7521	$44.64	$17.85	$8.93
73080	X		X-ray exam of elbow	0260	0.7521	$44.64	$17.85	$8.93
73085	S		Contrast x-ray of elbow	0275	3.5617	$211.39	$69.09	$42.28
73090	X		X-ray exam of forearm	0260	0.7521	$44.64	$17.85	$8.93
73092	X		X-ray exam of arm, infant	0260	0.7521	$44.64	$17.85	$8.93
73100	X		X-ray exam of wrist	0260	0.7521	$44.64	$17.85	$8.93
73110	X		X-ray exam of wrist	0260	0.7521	$44.64	$17.85	$8.93
73115	S		Contrast x-ray of wrist	0275	3.5617	$211.39	$69.09	$42.28
73120	X		X-ray exam of hand	0260	0.7521	$44.64	$17.85	$8.93
73130	X		X-ray exam of hand	0260	0.7521	$44.64	$17.85	$8.93
73140	X		X-ray exam of finger(s)	0260	0.7521	$44.64	$17.85	$8.93
73200*	S		Ct upper extremity w/o dye	0332	3.2546	$193.16	$77.26	$38.63

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
73201*	S		Ct upper extremity w/dye	0283	4.4053	$261.45	$104.58	$52.29
73202*	S		Ct uppr extremity w/o&w/dye	0333	5.2596	$312.16	$124.86	$62.43
73206*	S		Ct angio upr extrm w/o&w/dye	0662	5.1387	$304.98	$121.99	$61.00
73218*	S		Mri upper extremity w/o dye	0336	6.0467	$358.87	$143.54	$71.77
73219*	S		Mri upper extremity w/dye	0284	6.3910	$379.31	$151.72	$75.86
73220*	S		Mri uppr extremity w/o&w/dye	0337	8.7547	$519.59	$207.83	$103.92
73221*	S		Mri joint upr extrem w/o dye	0336	6.0467	$358.87	$143.54	$71.77
73222*	S		Mri joint upr extrem w/dye	0284	6.3910	$379.31	$151.72	$75.86
73223*	S		Mri joint upr extr w/o&w/dye	0337	8.7547	$519.59	$207.83	$103.92
73225	E		Mr angio upr extr w/o&w/dye					
73500	X		X-ray exam of hip	0260	0.7521	$44.64	$17.85	$8.93
73510	X		X-ray exam of hip	0260	0.7521	$44.64	$17.85	$8.93
73520	X		X-ray exam of hips	0261	1.2843	$76.22		$15.24
73525	S		Contrast x-ray of hip	0275	3.5617	$211.39	$69.09	$42.28
73530	X		X-ray exam of hip	0261	1.2843	$76.22		$15.24
73540	X		X-ray exam of pelvis & hips	0260	0.7521	$44.64	$17.85	$8.93
73542	S		X-ray exam, sacroiliac joint	0275	3.5617	$211.39	$69.09	$42.28
73550	X		X-ray exam of thigh	0260	0.7521	$44.64	$17.85	$8.93
73560	X		X-ray exam of knee, 1 or 2	0260	0.7521	$44.64	$17.85	$8.93
73562	X		X-ray exam of knee, 3	0260	0.7521	$44.64	$17.85	$8.93
73564	X		X-ray exam, knee, 4 or more	0260	0.7521	$44.64	$17.85	$8.93
73565	X		X-ray exam of knees	0260	0.7521	$44.64	$17.85	$8.93
73580	S		Contrast x-ray of knee joint	0275	3.5617	$211.39	$69.09	$42.28
73590	X		X-ray exam of lower leg	0260	0.7521	$44.64	$17.85	$8.93
73592	X		X-ray exam of leg, infant	0260	0.7521	$44.64	$17.85	$8.93
73600	X		X-ray exam of ankle	0260	0.7521	$44.64	$17.85	$8.93
73610	X		X-ray exam of ankle	0260	0.7521	$44.64	$17.85	$8.93
73615	S		Contrast x-ray of ankle	0275	3.5617	$211.39	$69.09	$42.28
73620	X		X-ray exam of foot	0260	0.7521	$44.64	$17.85	$8.93
73630	X		X-ray exam of foot	0260	0.7521	$44.64	$17.85	$8.93
73650	X		X-ray exam of heel	0260	0.7521	$44.64	$17.85	$8.93
73660	X		X-ray exam of toe(s)	0260	0.7521	$44.64	$17.85	$8.93
73700*	S		Ct lower extremity w/o dye	0332	3.2546	$193.16	$77.26	$38.63
73701*	S		Ct lower extremity w/dye	0283	4.4053	$261.45	$104.58	$52.29
73702*	S		Ct lwr extremity w/o&w/dye	0333	5.2596	$312.16	$124.86	$62.43
73706*	S		Ct angio lwr extr w/o&w/dye	0662	5.1387	$304.98	$121.99	$61.00
73718*	S		Mri lower extremity w/o dye	0336	6.0467	$358.87	$143.54	$71.77
73719*	S		Mri lower extremity w/dye	0284	6.3910	$379.31	$151.72	$75.86
73720*	S		Mri lwr extremity w/o&w/dye	0337	8.7547	$519.59	$207.83	$103.92
73721*	S		Mri jnt of lwr extre w/o dye	0336	6.0467	$358.87	$143.54	$71.77
73722*	S		Mri joint of lwr extr w/dye	0284	6.3910	$379.31	$151.72	$75.86
73723*	S		Mri joint lwr extr w/o&w/dye	0337	8.7547	$519.59	$207.83	$103.92
73725	B		Mr ang lwr ext w or w/o dye					
74000	X		X-ray exam of abdomen	0260	0.7521	$44.64	$17.85	$8.93
74010	X		X-ray exam of abdomen	0260	0.7521	$44.64	$17.85	$8.93
74020	X		X-ray exam of abdomen	0260	0.7521	$44.64	$17.85	$8.93
74022	X		X-ray exam series, abdomen	0261	1.2843	$76.22		$15.24
74150*	S		Ct abdomen w/o dye	0332	3.2546	$193.16	$77.26	$38.63
74160*	S		Ct abdomen w/dye	0283	4.4053	$261.45	$104.58	$52.29
74170*	S		Ct abdomen w/o &w /dye	0333	5.2596	$312.16	$124.86	$62.43
74175*	S		Ct angio abdom w/o & w/dye	0662	5.1387	$304.98	$121.99	$61.00
74181*	S		Mri abdomen w/o dye	0336	6.0467	$358.87	$143.54	$71.77
74182*	S		Mri abdomen w/dye	0284	6.3910	$379.31	$151.72	$75.86
74183*	S		Mri abdomen w/o & w/dye	0337	8.7547	$519.59	$207.83	$103.92
74185	B		Mri angio, abdom w orw/o dye					
74190	X		X-ray exam of peritoneum	0264	3.5080	$208.20	$79.41	$41.64
74210	S		Contrst x-ray exam of throat	0276	1.5250	$90.51	$36.20	$18.10
74220	S		Contrast x-ray, esophagus	0276	1.5250	$90.51	$36.20	$18.10
74230	S		Cine/vid x-ray, throat/esoph	0276	1.5250	$90.51	$36.20	$18.10
74235	S		Remove esophagus obstruction	0296	2.2350	$132.65	$53.06	$26.53
74240	S		X-ray exam, upper gi tract	0276	1.5250	$90.51	$36.20	$18.10
74241	S		X-ray exam, upper gi tract	0276	1.5250	$90.51	$36.20	$18.10
74245	S		X-ray exam, upper gi tract	0277	2.3744	$140.92	$56.36	$28.18
74246	S		Contrst x-ray uppr gi tract	0276	1.5250	$90.51	$36.20	$18.10
74247	S		Contrst x-ray uppr gi tract	0276	1.5250	$90.51	$36.20	$18.10
74249	S		Contrst x-ray uppr gi tract	0277	2.3744	$140.92	$56.36	$28.18

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
74250	S		X-ray exam of small bowel	0276	1.5250	$90.51	$36.20	$18.10
74251	S		X-ray exam of small bowel	0277	2.3744	$140.92	$56.36	$28.18
74260	S		X-ray exam of small bowel	0277	2.3744	$140.92	$56.36	$28.18
74270	S		Contrast x-ray exam of colon	0276	1.5250	$90.51	$36.20	$18.10
74280	S		Contrast x-ray exam of colon	0277	2.3744	$140.92	$56.36	$28.18
74283	S		Contrast x-ray exam of colon	0276	1.5250	$90.51	$36.20	$18.10
74290	S		Contrast x-ray, gallbladder	0276	1.5250	$90.51	$36.20	$18.10
74291	S		Contrast x-rays, gallbladder	0276	1.5250	$90.51	$36.20	$18.10
74300	X		X-ray bile ducts/pancreas	0263	1.7397	$103.25	$24.29	$20.65
74301	X		X-rays at surgery add-on	0263	1.7397	$103.25	$24.29	$20.65
74305	X		X-ray bile ducts/pancreas	0263	1.7397	$103.25	$24.29	$20.65
74320	X		Contrast x-ray of bile ducts	0264	3.5080	$208.20	$79.41	$41.64
74327	S		X-ray bile stone removal	0296	2.2350	$132.65	$53.06	$26.53
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	1.3738	$81.54	$32.61	$16.31
74350	X		X-ray guide, stomach tube	0263	1.7397	$103.25	$24.29	$20.65
74355	X		X-ray guide, intestinal tube	0263	1.7397	$103.25	$24.29	$20.65
74360	S		X-ray guide, GI dilation	0296	2.2350	$132.65	$53.06	$26.53
74363	S		X-ray, bile duct dilation	0297	5.2293	$310.36	$122.13	$62.07
74400	S		Contrst x-ray, urinary tract	0278	2.6314	$156.17	$62.46	$31.23
74410	S		Contrst x-ray, urinary tract	0278	2.6314	$156.17	$62.46	$31.23
74415	S		Contrst x-ray, urinary tract	0278	2.6314	$156.17	$62.46	$31.23
74420	S		Contrst x-ray, urinary tract	0278	2.6314	$156.17	$62.46	$31.23
74425	S		Contrst x-ray, urinary tract	0278	2.6314	$156.17	$62.46	$31.23
74430	S		Contrast x-ray, bladder	0278	2.6314	$156.17	$62.46	$31.23
74440	S		X-ray, male genital tract	0278	2.6314	$156.17	$62.46	$31.23
74445	S		X-ray exam of penis	0278	2.6314	$156.17	$62.46	$31.23
74450	S		X-ray, urethra/bladder	0278	2.6314	$156.17	$62.46	$31.23
74455	S		X-ray, urethra/bladder	0278	2.6314	$156.17	$62.46	$31.23
74470	X		X-ray exam of kidney lesion	0263	1.7397	$103.25	$24.29	$20.65
74475	S		X-ray control, cath insert	0297	5.2293	$310.36	$122.13	$62.07
74480	S		X-ray control, cath insert	0296	2.2350	$132.65	$53.06	$26.53
74485	S		X-ray guide, GU dilation	0296	2.2350	$132.65	$53.06	$26.53
74710	X		X-ray measurement of pelvis	0261	1.2843	$76.22		$15.24
74740	X		X-ray, female genital tract	0264	3.5080	$208.20	$79.41	$41.64
74742	X		X-ray, fallopian tube	0264	3.5080	$208.20	$79.41	$41.64
74775	S		X-ray exam of perineum	0278	2.6314	$156.17	$62.46	$31.23
75552	S		Heart mri for morph w/o dye	0336	6.0467	$358.87	$143.54	$71.77
75553	S		Heart mri for morph w/dye	0284	6.3910	$379.31	$151.72	$75.86
75554	S		Cardiac MRI/function	0336	6.0467	$358.87	$143.54	$71.77
75555	S		Cardiac MRI/limited study	0336	6.0467	$358.87	$143.54	$71.77
75556	E		Cardiac MRI/flow mapping					
75600	S		Contrast x-ray exam of aorta	0280	20.6960	$1,228.31	$353.85	$245.66
75605	S		Contrast x-ray exam of aorta	0280	20.6960	$1,228.31	$353.85	$245.66
75625	S		Contrast x-ray exam of aorta	0280	20.6960	$1,228.31	$353.85	$245.66
75630	S		X-ray aorta, leg arteries	0280	20.6960	$1,228.31	$353.85	$245.66
75635*	S		Ct angio abdominal arteries	0662	5.1387	$304.98	$121.99	$61.00
75650	S		Artery x-rays, head & neck	0280	20.6960	$1,228.31	$353.85	$245.66
75658	S		Artery x-rays, arm	0279	8.8914	$527.70	$150.03	$105.54
75660	S		Artery x-rays, head & neck	0668	6.4730	$384.17	$114.67	$76.83
75662	S		Artery x-rays, head & neck	0280	20.6960	$1,228.31	$353.85	$245.66
75665	S		Artery x-rays, head & neck	0280	20.6960	$1,228.31	$353.85	$245.66
75671	S		Artery x-rays, head & neck	0280	20.6960	$1,228.31	$353.85	$245.66
75676	S		Artery x-rays, neck	0280	20.6960	$1,228.31	$353.85	$245.66
75680	S		Artery x-rays, neck	0280	20.6960	$1,228.31	$353.85	$245.66
75685	S		Artery x-rays, spine	0280	20.6960	$1,228.31	$353.85	$245.66
75705	S		Artery x-rays, spine	0668	6.4730	$384.17	$114.67	$76.83
75710	S		Artery x-rays, arm/leg	0280	20.6960	$1,228.31	$353.85	$245.66
75716	S		Artery x-rays, arms/legs	0280	20.6960	$1,228.31	$353.85	$245.66
75722	S		Artery x-rays, kidney	0280	20.6960	$1,228.31	$353.85	$245.66
75724	S		Artery x-rays, kidneys	0280	20.6960	$1,228.31	$353.85	$245.66
75726	S		Artery x-rays, abdomen	0280	20.6960	$1,228.31	$353.85	$245.66
75731	S		Artery x-rays, adrenal gland	0280	20.6960	$1,228.31	$353.85	$245.66
75733	S		Artery x-rays, adrenals	0668	6.4730	$384.17	$114.67	$76.83

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
75736	S		Artery x-rays, pelvis	0280	20.6960	$1,228.31	$353.85	$245.66
75741	S		Artery x-rays, lung	0279	8.8914	$527.70	$150.03	$105.54
75743	S		Artery x-rays, lungs	0280	20.6960	$1,228.31	$353.85	$245.66
75746	S		Artery x-rays, lung	0279	8.8914	$527.70	$150.03	$105.54
75756	S		Artery x-rays, chest	0279	8.8914	$527.70	$150.03	$105.54
75774	S		Artery x-ray, each vessel	0279	8.8914	$527.70	$150.03	$105.54
75790	S		Visualize A-V shunt	0279	8.8914	$527.70	$150.03	$105.54
75801	X		Lymph vessel x-ray, arm/leg	0264	3.5080	$208.20	$79.41	$41.64
75803	X		Lymph vessel x-ray,arms/legs	0264	3.5080	$208.20	$79.41	$41.64
75805	X		Lymph vessel x-ray, trunk	0264	3.5080	$208.20	$79.41	$41.64
75807	X		Lymph vessel x-ray, trunk	0264	3.5080	$208.20	$79.41	$41.64
75809	X		Nonvascular shunt, x-ray	0263	1.7397	$103.25	$24.29	$20.65
75810	S		Vein x-ray, spleen/liver	0279	8.8914	$527.70	$150.03	$105.54
75820	S		Vein x-ray, arm/leg	0668	6.4730	$384.17	$114.67	$76.83
75822	S		Vein x-ray, arms/legs	0668	6.4730	$384.17	$114.67	$76.83
75825	S		Vein x-ray, trunk	0279	8.8914	$527.70	$150.03	$105.54
75827	S		Vein x-ray, chest	0279	8.8914	$527.70	$150.03	$105.54
75831	S		Vein x-ray, kidney	0279	8.8914	$527.70	$150.03	$105.54
75833	S		Vein x-ray, kidneys	0279	8.8914	$527.70	$150.03	$105.54
75840	S		Vein x-ray, adrenal gland	0280	20.6960	$1,228.31	$353.85	$245.66
75842	S		Vein x-ray, adrenal glands	0280	20.6960	$1,228.31	$353.85	$245.66
75860	S		Vein x-ray, neck	0668	6.4730	$384.17	$114.67	$76.83
75870	S		Vein x-ray, skull	0668	6.4730	$384.17	$114.67	$76.83
75872	S		Vein x-ray, skull	0279	8.8914	$527.70	$150.03	$105.54
75880	S		Vein x-ray, eye socket	0668	6.4730	$384.17	$114.67	$76.83
75885	S		Vein x-ray, liver	0280	20.6960	$1,228.31	$353.85	$245.66
75887	S		Vein x-ray, liver	0279	8.8914	$527.70	$150.03	$105.54
75889	S		Vein x-ray, liver	0280	20.6960	$1,228.31	$353.85	$245.66
75891	S		Vein x-ray, liver	0279	8.8914	$527.70	$150.03	$105.54
75893	N		Venous sampling by catheter					
75894	S		X-rays, transcath therapy	0297	5.2293	$310.36	$122.13	$62.07
75896	S		X-rays, transcath therapy	0297	5.2293	$310.36	$122.13	$62.07
75898	X		Follow-up angiography	0263	1.7397	$103.25	$24.29	$20.65
75900	C		Arterial catheter exchange					
75901	X		Remove cva device obstruct	0263	1.7397	$103.25	$24.29	$20.65
75902	X		Remove cva lumen obstruct	0263	1.7397	$103.25	$24.29	$20.65
75940	S		X-ray placement, vein filter	0297	5.2293	$310.36	$122.13	$62.07
75945	S		Intravascular us	0267	2.6208	$155.54	$62.18	$31.11
75946	S		Intravascular us add-on	0266	1.6319	$96.85	$38.74	$19.37
75952	C		Endovasc repair abdom aorta					
75953	C		Abdom aneurysm endovas rpr					
75954	C		Iliac aneurysm endovas rpr					
75960	S		Transcatheter intro, stent	0668	6.4730	$384.17	$114.67	$76.83
75961	S		Retrieval, broken catheter	0668	6.4730	$384.17	$114.67	$76.83
75962	S		Repair arterial blockage	0668	6.4730	$384.17	$114.67	$76.83
75964	S		Repair artery blockage, each	0668	6.4730	$384.17	$114.67	$76.83
75966	S		Repair arterial blockage	0668	6.4730	$384.17	$114.67	$76.83
75968	S		Repair artery blockage, each	0668	6.4730	$384.17	$114.67	$76.83
75970	S		Vascular biopsy	0668	6.4730	$384.17	$114.67	$76.83
75978	S		Repair venous blockage	0668	6.4730	$384.17	$114.67	$76.83
75980	S		Contrast xray exam bile duct	0297	5.2293	$310.36	$122.13	$62.07
75982	S		Contrast xray exam bile duct	0297	5.2293	$310.36	$122.13	$62.07
75984	X		Xray control catheter change	0263	1.7397	$103.25	$24.29	$20.65
75989	N		Abscess drainage under x-ray					
75992	S		Atherectomy, x-ray exam	0279	8.8914	$527.70	$150.03	$105.54
75993	S		Atherectomy, x-ray exam	0279	8.8914	$527.70	$150.03	$105.54
75994	S		Atherectomy, x-ray exam	0279	8.8914	$527.70	$150.03	$105.54
75995	S		Atherectomy, x-ray exam	0279	8.8914	$527.70	$150.03	$105.54
75996	S		Atherectomy, x-ray exam	0279	8.8914	$527.70	$150.03	$105.54
75998	N		Fluoroguide for vein device					
76000	X		Fluoroscope examination	0272	1.3738	$81.54	$32.61	$16.31
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	0.7521	$44.64	$17.85	$8.93
76010	X		X-ray, nose to rectum	0260	0.7521	$44.64	$17.85	$8.93

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76012	S		Percut vertebroplasty fluor	0274	3.0275	$179.68	$71.87	$35.94
76013	S		Percut vertebroplasty, ct	0274	3.0275	$179.68	$71.87	$35.94
76020	X		X-rays for bone age	0260	0.7521	$44.64	$17.85	$8.93
76040	X		X-rays, bone evaluation	0261	1.2843	$76.22		$15.24
76061	X		X-rays, bone survey	0261	1.2843	$76.22		$15.24
76062	X		X-rays, bone survey	0261	1.2843	$76.22		$15.24
76065	X		X-rays, bone evaluation	0261	1.2843	$76.22		$15.24
76066	X		Joint survey, single view	0260	0.7521	$44.64	$17.85	$8.93
76070	S		CT scan, bone density study	0288	1.2511	$74.25		$14.85
76071	S		Ct bone density, peripheral	0282	1.6467	$97.73	$39.09	$19.55
76075	S		Dexa, axial skeleton study	0288	1.2511	$74.25		$14.85
76076	S		Dexa, peripheral study	0665	0.6435	$38.19		$7.64
76077	X		Dxa bone density/v-fracture	0260	0.7521	$44.64	$17.85	$8.93
76078	X		Radiographic absorptiometry	0260	0.7521	$44.64	$17.85	$8.93
76080	X		X-ray exam of fistula	0263	1.7397	$103.25	$24.29	$20.65
76082	A		Computer mammogram add-on					
76083	A		Computer mammogram add-on					
76086	X		X-ray of mammary duct	0263	1.7397	$103.25	$24.29	$20.65
76088	X		X-ray of mammary ducts	0263	1.7397	$103.25	$24.29	$20.65
76090	A		Mammogram, one breast					
76091	A		Mammogram, both breasts					
76092	A		Mammogram, screening					
76093	E		Magnetic image, breast					
76094	E		Magnetic image, both breasts					
76095	X		Stereotactic breast biopsy	0264	3.5080	$208.20	$79.41	$41.64
76096	X		X-ray of needle wire, breast	0263	1.7397	$103.25	$24.29	$20.65
76098	X		X-ray exam, breast specimen	0260	0.7521	$44.64	$17.85	$8.93
76100	X		X-ray exam of body section	0261	1.2843	$76.22		$15.24
76101	X		Complex body section x-ray	0263	1.7397	$103.25	$24.29	$20.65
76102	X		Complex body section x-rays	0264	3.5080	$208.20	$79.41	$41.64
76120	X		Cine/video x-rays	0272	1.3738	$81.54	$32.61	$16.31
76125	X		Cine/video x-rays add-on	0260	0.7521	$44.64	$17.85	$8.93
76140	E		X-ray consultation					
76150	X		X-ray exam, dry process	0260	0.7521	$44.64	$17.85	$8.93
76350	N		Special x-ray contrast study					
76355	S		Ct scan for localization	0283	4.4053	$261.45	$104.58	$52.29
76360	S		Ct scan for needle biopsy	0283	4.4053	$261.45	$104.58	$52.29
76362	S		Ct guide for tissue ablation	0332	3.2546	$193.16	$77.26	$38.63
76370	S		Ct scan for therapy guide	0282	1.6467	$97.73	$39.09	$19.55
76375	S		3d/holograph reconstr add-on	0282	1.6467	$97.73	$39.09	$19.55
76380	S		CAT scan follow-up study	0282	1.6467	$97.73	$39.09	$19.55
76390	E		Mr spectroscopy					
76393	S		Mr guidance for needle place	0335	5.1347	$304.74	$121.89	$60.95
76394	S		Mri for tissue ablation	0335	5.1347	$304.74	$121.89	$60.95
76400	S		Magnetic image, bone marrow	0335	5.1347	$304.74	$121.89	$60.95
76496	X		Fluoroscopic procedure	0272	1.3738	$81.54	$32.61	$16.31
76497	S		Ct procedure	0282	1.6467	$97.73	$39.09	$19.55
76498	S		Mri procedure	0335	5.1347	$304.74	$121.89	$60.95
76499	X		Radiographic procedure	0260	0.7521	$44.64	$17.85	$8.93
76506	S		Echo exam of head	0265	1.0167	$60.34	$24.13	$12.07
76510	S		Ophth us, b & quant a	0266	1.6319	$96.85	$38.74	$19.37
76511	S		Echo exam of eye	0266	1.6319	$96.85	$38.74	$19.37
76512	S		Echo exam of eye	0266	1.6319	$96.85	$38.74	$19.37
76513	S		Echo exam of eye, water bath	0266	1.6319	$96.85	$38.74	$19.37
76514	X		Echo exam of eye, thickness	0340	0.6355	$37.72		$7.54
76516	S		Echo exam of eye	0265	1.0167	$60.34	$24.13	$12.07
76519	S		Echo exam of eye	0266	1.6319	$96.85	$38.74	$19.37
76529	S		Echo exam of eye	0265	1.0167	$60.34	$24.13	$12.07
76536	S		Us exam of head and neck	0266	1.6319	$96.85	$38.74	$19.37
76604*	S		Us exam, chest, b-scan	0266	1.6319	$96.85	$38.74	$19.37
76645*	S		Us exam, breast(s)	0265	1.0167	$60.34	$24.13	$12.07
76700*	S		Us exam, abdom, complete	0266	1.6319	$96.85	$38.74	$19.37
76705*	S		Echo exam of abdomen	0266	1.6319	$96.85	$38.74	$19.37
76770*	S		Us exam abdo back wall, comp	0266	1.6319	$96.85	$38.74	$19.37
76775*	S		Us exam abdo back wall, lim	0266	1.6319	$96.85	$38.74	$19.37
76778*	S		Us exam kidney transplant	0266	1.6319	$96.85	$38.74	$19.37

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
76800	S		Us exam, spinal canal	0266	1.6319	$96.85	$38.74	$19.37
76801	S		Ob us < 14 wks, single fetus	0266	1.6319	$96.85	$38.74	$19.37
76802	S		Ob us < 14 wks, add'l fetus	0265	1.0167	$60.34	$24.13	$12.07
76805	S		Us exam, pg uterus, compl	0266	1.6319	$96.85	$38.74	$19.37
76810	S		Us exam, pg uterus, mult	0266	1.6319	$96.85	$38.74	$19.37
76811	S		Ob us, detailed, sngl fetus	0267	2.6208	$155.54	$62.18	$31.11
76812	S		Ob us, detailed, addl fetus	0266	1.6319	$96.85	$38.74	$19.37
76815	S		Us exam, pg uterus limit	0265	1.0167	$60.34	$24.13	$12.07
76816	S		Us exam pg uterus repeat	0265	1.0167	$60.34	$24.13	$12.07
76817	S		Transvaginal us, obstetric	0266	1.6319	$96.85	$38.74	$19.37
76818	S		Fetal biophys profile w/nst	0266	1.6319	$96.85	$38.74	$19.37
76819	S		Fetal biophys profil w/o nst	0266	1.6319	$96.85	$38.74	$19.37
76820	S		Umbilical artery echo	0096	1.6233	$96.34	$38.53	$19.27
76821	S		Middle cerebral artery echo	0096	1.6233	$96.34	$38.53	$19.27
76825	S		Echo exam of fetal heart	0671	1.6951	$100.60	$40.24	$20.12
76826	S		Echo exam of fetal heart	0697	1.5288	$90.73	$36.29	$18.15
76827	S		Echo exam of fetal heart	0671	1.6951	$100.60	$40.24	$20.12
76828	S		Echo exam of fetal heart	0697	1.5288	$90.73	$36.29	$18.15
76830*	S		Transvaginal us, non-ob	0266	1.6319	$96.85	$38.74	$19.37
76831*	S		Echo exam, uterus	0267	2.6208	$155.54	$62.18	$31.11
76856*	S		Us exam, pelvic, complete	0266	1.6319	$96.85	$38.74	$19.37
76857*	S		Us exam, pelvic, limited	0265	1.0167	$60.34	$24.13	$12.07
76870	S		Us exam, scrotum	0266	1.6319	$96.85	$38.74	$19.37
76872	S		Us, transrectal	0266	1.6319	$96.85	$38.74	$19.37
76873	S		Echograp trans r, pros study	0266	1.6319	$96.85	$38.74	$19.37
76880	S		Us exam, extremity	0266	1.6319	$96.85	$38.74	$19.37
76885	S		Us exam infant hips, dynamic	0265	1.0167	$60.34	$24.13	$12.07
76886	S		Us exam infant hips, static	0266	1.6319	$96.85	$38.74	$19.37
76930	S		Echo guide, cardiocentesis	0268	1.0562	$62.69		$12.54
76932	S		Echo guide for heart biopsy	0268	1.0562	$62.69		$12.54
76936	S		Echo guide for artery repair	0268	1.0562	$62.69		$12.54
76937	N		Us guide, vascular access					
76940	S		Us guide, tissue ablation	0268	1.0562	$62.69		$12.54
76941	S		Echo guide for transfusion	0268	1.0562	$62.69		$12.54
76942	S		Echo guide for biopsy	0268	1.0562	$62.69		$12.54
76945	S		Echo guide, villus sampling	0268	1.0562	$62.69		$12.54
76946	S		Echo guide for amniocentesis	0268	1.0562	$62.69		$12.54
76948	S		Echo guide, ova aspiration	0268	1.0562	$62.69		$12.54
76950	S		Echo guidance radiotherapy	0268	1.0562	$62.69		$12.54
76965	S		Echo guidance radiotherapy	0268	1.0562	$62.69		$12.54
76970	S		Ultrasound exam follow-up	0265	1.0167	$60.34	$24.13	$12.07
76975	S		GI endoscopic ultrasound	0266	1.6319	$96.85	$38.74	$19.37
76977	X		Us bone density measure	0340	0.6355	$37.72		$7.54
76986	S		Ultrasound guide intraoper	0266	1.6319	$96.85	$38.74	$19.37
76999	S		Echo examination procedure	0265	1.0167	$60.34	$24.13	$12.07
77261	E		Radiation therapy planning					
77262	E		Radiation therapy planning					
77263	E		Radiation therapy planning					
77280	X		Set radiation therapy field	0304	1.7658	$104.80	$41.52	$20.96
77285	X		Set radiation therapy field	0305	3.9854	$236.53	$91.38	$47.31
77290	X		Set radiation therapy field	0305	3.9854	$236.53	$91.38	$47.31
77295	X		Set radiation therapy field	0310	13.8858	$824.12	$325.27	$164.82
77299	E		Radiation therapy planning					
77300	X		Radiation therapy dose plan	0304	1.7658	$104.80	$41.52	$20.96
77301	X		Radiotherapy dose plan, imrt	0310	13.8858	$824.12	$325.27	$164.82
77305	X		Teletx isodose plan simple	0304	1.7658	$104.80	$41.52	$20.96
77310	X		Teletx isodose plan intermed	0305	3.9854	$236.53	$91.38	$47.31
77315	X		Teletx isodose plan complex	0305	3.9854	$236.53	$91.38	$47.31
77321	X		Special teletx port plan	0305	3.9854	$236.53	$91.38	$47.31
77326	X		Radiation therapy dose plan	0304	1.7658	$104.80	$41.52	$20.96
77327	X		Brachytx isodose calc interm	0305	3.9854	$236.53	$91.38	$47.31
77328	X		Brachytx isodose plan compl	0305	3.9854	$236.53	$91.38	$47.31
77331	X		Special radiation dosimetry	0304	1.7658	$104.80	$41.52	$20.96
77332	X		Radiation treatment aid(s)	0303	2.8228	$167.53	$66.95	$33.51
77333	X		Radiation treatment aid(s)	0303	2.8228	$167.53	$66.95	$33.51
77334	X		Radiation treatment aid(s)	0303	2.8228	$167.53	$66.95	$33.51

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
77336	X		Radiation physics consult	0304	1.7658	$104.80	$41.52	$20.96
77370	X		Radiation physics consult	0304	1.7658	$104.80	$41.52	$20.96
77399	X		External radiation dosimetry	0304	1.7658	$104.80	$41.52	$20.96
77401	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77402	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77403	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77404	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77406	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77407	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77408	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77409	S		Radiation treatment delivery	0300	1.5129	$89.79		$17.96
77411	S		Radiation treatment delivery	0301	2.2094	$131.13		$26.23
77412	S		Radiation treatment delivery	0301	2.2094	$131.13		$26.23
77413	S		Radiation treatment delivery	0301	2.2094	$131.13		$26.23
77414	S		Radiation treatment delivery	0301	2.2094	$131.13		$26.23
77416	S		Radiation treatment delivery	0301	2.2094	$131.13		$26.23
77417	X		Radiology port film(s)	0260	0.7521	$44.64	$17.85	$8.93
77418	S		Radiation tx delivery, imrt	0412	5.3400	$316.93		$63.39
77427	E		Radiation tx management, x5					
77431	E		Radiation therapy management					
77432	E		Stereotactic radiation trmt					
77470	S		Special radiation treatment	0299	5.8217	$345.52		$69.10
77499	E		Radiation therapy management					
77520	S		Proton trmt, simple w/o comp	0664	12.8853	$764.74		$152.95
77522	S		Proton trmt, simple w/comp	0664	12.8853	$764.74		$152.95
77523	S		Proton trmt, intermediate	0667	15.4156	$914.92		$182.98
77525	S		Proton treatment, complex	0667	15.4156	$914.92		$182.98
77600	S		Hyperthermia treatment	0314	5.9674	$354.17	$98.36	$70.83
77605	S		Hyperthermia treatment	0314	5.9674	$354.17	$98.36	$70.83
77610	S		Hyperthermia treatment	0314	5.9674	$354.17	$98.36	$70.83
77615	S		Hyperthermia treatment	0314	5.9674	$354.17	$98.36	$70.83
77620	S		Hyperthermia treatment	0314	5.9674	$354.17	$98.36	$70.83
77750	S		Infuse radioactive materials	0301	2.2094	$131.13		$26.23
77761	S		Apply intrcav radiat simple	0312	4.9806	$295.60		$59.12
77762	S		Apply intrcav radiat interm	0312	4.9806	$295.60		$59.12
77763	S		Apply intrcav radiat compl	0312	4.9806	$295.60		$59.12
77776	S		Apply interstit radiat simpl	0312	4.9806	$295.60		$59.12
77777	S		Apply interstit radiat inter	0312	4.9806	$295.60		$59.12
77778	S		Apply interstit radiat compl	0651	12.0898	$717.53		$143.51
77781	S		High intensity brachytherapy	0313	12.8072	$760.11		$152.02
77782	S		High intensity brachytherapy	0313	12.8072	$760.11		$152.02
77783	S		High intensity brachytherapy	0313	12.8072	$760.11		$152.02
77784	S		High intensity brachytherapy	0313	12.8072	$760.11		$152.02
77789	S		Apply surface radiation	0300	1.5129	$89.79		$17.96
77790	N		Radiation handling					
77799	S		Radium/radioisotope therapy	0313	12.8072	$760.11		$152.02
78000	S		Thyroid, single uptake	0389	1.4908	$88.48	$35.39	$17.70
78001	S		Thyroid, multiple uptakes	0389	1.4908	$88.48	$35.39	$17.70
78003	S		Thyroid suppress/stimul	0389	1.4908	$88.48	$35.39	$17.70
78006	S		Thyroid imaging with uptake	0390	2.5446	$151.02	$60.40	$30.20
78007	S		Thyroid image, mult uptakes	0391	2.8643	$170.00	$68.00	$34.00
78010	S		Thyroid imaging	0390	2.5446	$151.02	$60.40	$30.20
78011	S		Thyroid imaging with flow	0390	2.5446	$151.02	$60.40	$30.20
78015	S		Thyroid met imaging	0406	4.2840	$254.26	$101.70	$50.85
78016	S		Thyroid met imaging/studies	0406	4.2840	$254.26	$101.70	$50.85
78018	S		Thyroid met imaging, body	0406	4.2840	$254.26	$101.70	$50.85
78020	S		Thyroid met uptake	0399	1.5123	$89.76	$35.90	$17.95
78070	S		Parathyroid nuclear imaging	0391	2.8643	$170.00	$68.00	$34.00
78075	S		Adrenal nuclear imaging	0391	2.8643	$170.00	$68.00	$34.00
78099	S		Endocrine nuclear procedure	0390	2.5446	$151.02	$60.40	$30.20
78102	S		Bone marrow imaging, ltd	0400	4.1147	$244.21	$97.68	$48.84
78103	S		Bone marrow imaging, mult	0400	4.1147	$244.21	$97.68	$48.84
78104	S		Bone marrow imaging, body	0400	4.1147	$244.21	$97.68	$48.84
78110	S		Plasma volume, single	0393	3.4282	$203.46	$81.38	$40.69
78111	S		Plasma volume, multiple	0393	3.4282	$203.46	$81.38	$40.69
78120	S		Red cell mass, single	0393	3.4282	$203.46	$81.38	$40.69

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78121	S		Red cell mass, multiple	0393	3.4282	$203.46	$81.38	$40.69
78122	S		Blood volume	0393	3.4282	$203.46	$81.38	$40.69
78130	S		Red cell survival study	0393	3.4282	$203.46	$81.38	$40.69
78135	S		Red cell survival kinetics	0393	3.4282	$203.46	$81.38	$40.69
78140	S		Red cell sequestration	0393	3.4282	$203.46	$81.38	$40.69
78160	S		Plasma iron turnover	0393	3.4282	$203.46	$81.38	$40.69
78162	S		Radioiron absorption exam	0393	3.4282	$203.46	$81.38	$40.69
78170	S		Red cell iron utilization	0393	3.4282	$203.46	$81.38	$40.69
78172	S		Total body iron estimation	0393	3.4282	$203.46	$81.38	$40.69
78185	S		Spleen imaging	0400	4.1147	$244.21	$97.68	$48.84
78190	S		Platelet survival, kinetics	0389	1.4908	$88.48	$35.39	$17.70
78191	S		Platelet survival	0389	1.4908	$88.48	$35.39	$17.70
78195	S		Lymph system imaging	0400	4.1147	$244.21	$97.68	$48.84
78199	S		Blood/lymph nuclear exam	0400	4.1147	$244.21	$97.68	$48.84
78201	S		Liver imaging	0394	4.4428	$263.68	$105.47	$52.74
78202	S		Liver imaging with flow	0394	4.4428	$263.68	$105.47	$52.74
78205	S		Liver imaging (3D)	0394	4.4428	$263.68	$105.47	$52.74
78206	S		Liver image (3d) with flow	0394	4.4428	$263.68	$105.47	$52.74
78215	S		Liver and spleen imaging	0394	4.4428	$263.68	$105.47	$52.74
78216	S		Liver & spleen image/flow	0394	4.4428	$263.68	$105.47	$52.74
78220	S		Liver function study	0394	4.4428	$263.68	$105.47	$52.74
78223	S		Hepatobiliary imaging	0394	4.4428	$263.68	$105.47	$52.74
78230	S		Salivary gland imaging	0395	3.8523	$228.63	$91.45	$45.73
78231	S		Serial salivary imaging	0395	3.8523	$228.63	$91.45	$45.73
78232	S		Salivary gland function exam	0395	3.8523	$228.63	$91.45	$45.73
78258	S		Esophageal motility study	0395	3.8523	$228.63	$91.45	$45.73
78261	S		Gastric mucosa imaging	0395	3.8523	$228.63	$91.45	$45.73
78262	S		Gastroesophageal reflux exam	0395	3.8523	$228.63	$91.45	$45.73
78264	S		Gastric emptying study	0395	3.8523	$228.63	$91.45	$45.73
78267	A		Breath tst attain/anal c-14					
78268	A		Breath test analysis, c-14					
78270	S		Vit B-12 absorption exam	0389	1.4908	$88.48	$35.39	$17.70
78271	S		Vit b-12 absrp exam, int fac	0389	1.4908	$88.48	$35.39	$17.70
78272	S		Vit B-12 absorp, combined	0389	1.4908	$88.48	$35.39	$17.70
78278	S		Acute GI blood loss imaging	0395	3.8523	$228.63	$91.45	$45.73
78282	S		GI protein loss exam	0395	3.8523	$228.63	$91.45	$45.73
78290	S		Meckel?s divert exam	0395	3.8523	$228.63	$91.45	$45.73
78291	S		Leveen/shunt patency exam	0395	3.8523	$228.63	$91.45	$45.73
78299	S		GI nuclear procedure	0395	3.8523	$228.63	$91.45	$45.73
78300	S		Bone imaging, limited area	0396	4.1238	$244.75	$97.90	$48.95
78305	S		Bone imaging, multiple areas	0396	4.1238	$244.75	$97.90	$48.95
78306	S		Bone imaging, whole body	0396	4.1238	$244.75	$97.90	$48.95
78315	S		Bone imaging, 3 phase	0396	4.1238	$244.75	$97.90	$48.95
78320	S		Bone imaging (3D)	0396	4.1238	$244.75	$97.90	$48.95
78350	X		Bone mineral, single photon	0260	0.7521	$44.64	$17.85	$8.93
78351	E		Bone mineral, dual photon					
78399	S		Musculoskeletal nuclear exam	0396	4.1238	$244.75	$97.90	$48.95
78414	S		Non-imaging heart function	0398	4.2898	$254.60	$101.84	$50.92
78428	S		Cardiac shunt imaging	0398	4.2898	$254.60	$101.84	$50.92
78445	S		Vascular flow imaging	0397	2.2543	$133.79	$53.51	$26.76
78455	S		Venous thrombosis study	0397	2.2543	$133.79	$53.51	$26.76
78456	S		Acute venous thrombus image	0397	2.2543	$133.79	$53.51	$26.76
78457	S		Venous thrombosis imaging	0397	2.2543	$133.79	$53.51	$26.76
78458	S		Ven thrombosis images, bilat	0397	2.2543	$133.79	$53.51	$26.76
78459	S		Heart muscle imaging (PET)	0285	17.1020	$1,015.00	$318.72	$203.00
78460	S		Heart muscle blood, single	0398	4.2898	$254.60	$101.84	$50.92
78461	S		Heart muscle blood, multiple	0377	6.8034	$403.78	$161.51	$80.76
78464	S		Heart image (3d), single	0398	4.2898	$254.60	$101.84	$50.92
78465	S		Heart image (3d), multiple	0377	6.8034	$403.78	$161.51	$80.76
78466	S		Heart infarct image	0398	4.2898	$254.60	$101.84	$50.92
78468	S		Heart infarct image (ef)	0398	4.2898	$254.60	$101.84	$50.92
78469	S		Heart infarct image (3D)	0398	4.2898	$254.60	$101.84	$50.92
78472	S		Gated heart, planar, single	0398	4.2898	$254.60	$101.84	$50.92
78473	S		Gated heart, multiple	0376	5.1740	$307.08	$121.42	$61.42
78478	S		Heart wall motion add-on	0399	1.5123	$89.76	$35.90	$17.95
78480	S		Heart function add-on	0399	1.5123	$89.76	$35.90	$17.95

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
78481	S		Heart first pass, single	0398	4.2898	$254.60	$101.84	$50.92
78483	S		Heart first pass, multiple	0376	5.1740	$307.08	$121.42	$61.42
78491	S		Heart image (pet), single	0285	17.1020	$1,015.00	$318.72	$203.00
78492	S		Heart image (pet), multiple	0285	17.1020	$1,015.00	$318.72	$203.00
78494	S		Heart image, spect	0398	4.2898	$254.60	$101.84	$50.92
78496	S		Heart first pass add-on	0399	1.5123	$89.76	$35.90	$17.95
78499	S		Cardiovascular nuclear exam	0398	4.2898	$254.60	$101.84	$50.92
78580	S		Lung perfusion imaging	0401	3.3995	$201.76	$80.70	$40.35
78584	S		Lung V/Q image single breath	0378	5.4748	$324.93	$129.97	$64.99
78585	S		Lung V/Q imaging	0378	5.4748	$324.93	$129.97	$64.99
78586	S		Aerosol lung image, single	0401	3.3995	$201.76	$80.70	$40.35
78587	S		Aerosol lung image, multiple	0401	3.3995	$201.76	$80.70	$40.35
78588	S		Perfusion lung image	0378	5.4748	$324.93	$129.97	$64.99
78591	S		Vent image, 1 breath, 1 proj	0401	3.3995	$201.76	$80.70	$40.35
78593	S		Vent image, 1 proj, gas	0401	3.3995	$201.76	$80.70	$40.35
78594	S		Vent image, mult proj, gas	0401	3.3995	$201.76	$80.70	$40.35
78596	S		Lung differential function	0378	5.4748	$324.93	$129.97	$64.99
78599	S		Respiratory nuclear exam	0401	3.3995	$201.76	$80.70	$40.35
78600	S		Brain imaging, ltd static	0402	5.1612	$306.32	$122.52	$61.26
78601	S		Brain imaging, ltd w/flow	0402	5.1612	$306.32	$122.52	$61.26
78605	S		Brain imaging, complete	0402	5.1612	$306.32	$122.52	$61.26
78606	S		Brain imaging, compl w/flow	0402	5.1612	$306.32	$122.52	$61.26
78607	S		Brain imaging (3D)	0402	5.1612	$306.32	$122.52	$61.26
78608	S		Brain imaging (PET)	1513		$1,150.00		$230.00
78609	S		Brain imaging (PET)	1513		$1,150.00		$230.00
78610	S		Brain flow imaging only	0402	5.1612	$306.32	$122.52	$61.26
78615	S		Cerebral vascular flow image	0402	5.1612	$306.32	$122.52	$61.26
78630	S		Cerebrospinal fluid scan	0403	3.5974	$213.51	$85.40	$42.70
78635	S		CSF ventriculography	0403	3.5974	$213.51	$85.40	$42.70
78645	S		CSF shunt evaluation	0403	3.5974	$213.51	$85.40	$42.70
78647	S		Cerebrospinal fluid scan	0403	3.5974	$213.51	$85.40	$42.70
78650	S		CSF leakage imaging	0403	3.5974	$213.51	$85.40	$42.70
78660	S		Nuclear exam of tear flow	0403	3.5974	$213.51	$85.40	$42.70
78699	S		Nervous system nuclear exam	0402	5.1612	$306.32	$122.52	$61.26
78700	S		Kidney imaging, static	0267	2.6208	$155.54	$62.18	$31.11
78701	S		Kidney imaging with flow	0404	3.8385	$227.81	$91.12	$45.56
78704	S		Imaging renogram	0404	3.8385	$227.81	$91.12	$45.56
78707	S		Kidney flow/function image	0404	3.8385	$227.81	$91.12	$45.56
78708	S		Kidney flow/function image	0405	4.2480	$252.12	$100.84	$50.42
78709	S		Kidney flow/function image	0405	4.2480	$252.12	$100.84	$50.42
78710	S		Kidney imaging (3D)	0404	3.8385	$227.81	$91.12	$45.56
78715	S		Renal vascular flow exam	0404	3.8385	$227.81	$91.12	$45.56
78725	S		Kidney function study	0389	1.4908	$88.48	$35.39	$17.70
78730	X		Urinary bladder retention	0340	0.6355	$37.72		$7.54
78740	S		Ureteral reflux study	0404	3.8385	$227.81	$91.12	$45.56
78760	S		Testicular imaging	0404	3.8385	$227.81	$91.12	$45.56
78761	S		Testicular imaging/flow	0404	3.8385	$227.81	$91.12	$45.56
78799	S		Genitourinary nuclear exam	0404	3.8385	$227.81	$91.12	$45.56
78800	S		Tumor imaging, limited area	0406	4.2840	$254.26	$101.70	$50.85
78801	S		Tumor imaging, mult areas	0406	4.2840	$254.26	$101.70	$50.85
78802	S		Tumor imaging, whole body	0406	4.2840	$254.26	$101.70	$50.85
78803	S		Tumor imaging (3D)	0406	4.2840	$254.26	$101.70	$50.85
78804	S		Tumor imaging, whole body	1508		$650.00		$130.00
78805	S		Abscess imaging, ltd area	0406	4.2840	$254.26	$101.70	$50.85
78806	S		Abscess imaging, whole body	0406	4.2840	$254.26	$101.70	$50.85
78807	S		Nuclear localization/abscess	0406	4.2840	$254.26	$101.70	$50.85
78811	S		Tumor imaging (pet), limited	1513		$1,150.00		$230.00
78812	S		Tumor image (pet)/skul-thigh	1513		$1,150.00		$230.00
78813	S		Tumor image (pet) full body	1513		$1,150.00		$230.00
78814	S		Tumor image pet/ct, limited	1513		$1,150.00		$230.00
78815	S		Tumorimage pet/ct skul-thigh	1513		$1,150.00		$230.00
78816	S		Tumor image pet/ct full body	1513		$1,150.00		$230.00
78890	N		Nuclear medicine data proc					
78891	N		Nuclear med data proc					
78999	S		Nuclear diagnostic exam	0389	1.4908	$88.48	$35.39	$17.70
79005	S		Nuclear rx, oral admin	0407	3.9659	$235.38	$94.15	$47.08

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
79101	S		Nuclear rx, iv admin	0407	3.9659	$235.38	$94.15	$47.08
79200	S		Intracavitary nuclear trmt	0407	3.9659	$235.38	$94.15	$47.08
79300	S		Interstitial nuclear therapy	0407	3.9659	$235.38	$94.15	$47.08
79403	S		Hematopoetic nuclear therapy	1507		$550.00		$110.00
79440	S		Nuclear joint therapy	0407	3.9659	$235.38	$94.15	$47.08
79445	S		Nuclear rx, intra-arterial	0407	3.9659	$235.38	$94.15	$47.08
79999	S		Nuclear medicine therapy	0407	3.9659	$235.38	$94.15	$47.08
80048	A		Basic metabolic panel					
80050	E		General health panel					
80051	A		Electrolyte panel					
80053	A		Comprehen metabolic panel					
80055	E		Obstetric panel					
80061	A		Lipid panel					
80069	A		Renal function panel					
80074	A		Acute hepatitis panel					
80076	A		Hepatic function panel					
80100	A		Drug screen, qualitate/multi					
80101	A		Drug screen, single					
80102	A		Drug confirmation					
80103	N		Drug analysis, tissue prep					
80150	A		Assay of amikacin					
80152	A		Assay of amitriptyline					
80154	A		Assay of benzodiazepines					
80156	A		Assay, carbamazepine, total					
80157	A		Assay, carbamazepine, free					
80158	A		Assay of cyclosporine					
80160	A		Assay of desipramine					
80162	A		Assay of digoxin					
80164	A		Assay, dipropylacetic acid					
80166	A		Assay of doxepin					
80168	A		Assay of ethosuximide					
80170	A		Assay of gentamicin					
80172	A		Assay of gold					
80173	A		Assay of haloperidol					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0433	0.2569	$15.25	$6.10	$3.05
80502	X		Lab pathology consultation	0342	0.1553	$9.22	$3.68	$1.84
81000	A		Urinalysis, nonauto w/scope					
81001	A		Urinalysis, auto w/scope					
81002	A		Urinalysis nonauto w/o scope					
81003	A		Urinalysis, auto, w/o scope					
81005	A		Urinalysis					
81007	A		Urine screen for bacteria					
81015	A		Microscopic exam of urine					
81020	A		Urinalysis, glass test					
81025	A		Urine pregnancy test					
81050	A		Urinalysis, volume measure					
81099	A		Urinalysis test procedure					
82000	A		Assay of blood acetaldehyde					
82003	A		Assay of acetaminophen					
82009	A		Test for acetone/ketones					
82010	A		Acetone assay					
82013	A		Acetylcholinesterase assay					
82016	A		Acylcarnitines, qual					
82017	A		Acylcarnitines, quant					
82024	A		Assay of acth					
82030	A		Assay of adp & amp					
82040	A		Assay of serum albumin					
82042	A		Assay of urine albumin					
82043	A		Microalbumin, quantitative					
82044	A		Microalbumin, semiquant					
82045	A		Albumin, ischemia modified					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
82190	A		Atomic absorption					
82205	A		Assay of barbiturates					
82232	A		Assay of beta-2 protein					
82239	A		Bile acids, total					
82240	A		Bile acids, cholylglycine					
82247	A		Bilirubin, total					
82248	A		Bilirubin, direct					
82252	A		Fecal bilirubin test					
82261	A		Assay of biotinidase					
82270	A		Test for blood, feces					
82273	A		Test for blood, other source					
82274	A		Assay test for blood, fecal					
82286	A		Assay of bradykinin					
82300	A		Assay of cadmium					
82306	A		Assay of vitamin D					
82307	A		Assay of vitamin D					
82308	A		Assay of calcitonin					
82310	A		Assay of calcium					
82330	A		Assay of calcium					
82331	A		Calcium infusion test					
82340	A		Assay of calcium in urine					
82355	A		Calculus analysis, qual					
82360	A		Calculus assay, quant					
82365	A		Calculus spectroscopy					
82370	A		X-ray assay, calculus					
82373	A		Assay, c-d transfer measure					
82374	A		Assay, blood carbon dioxide					
82375	A		Assay, blood carbon monoxide					
82376	A		Test for carbon monoxide					
82378	A		Carcinoembryonic antigen					
82379	A		Assay of carnitine					
82380	A		Assay of carotene					
82382	A		Assay, urine catecholamines					
82383	A		Assay, blood catecholamines					
82384	A		Assay, three catecholamines					
82387	A		Assay of cathepsin-d					
82390	A		Assay of ceruloplasmin					
82397	A		Chemiluminescent assay					
82415	A		Assay of chloramphenicol					
82435	A		Assay of blood chloride					
82436	A		Assay of urine chloride					
82438	A		Assay, other fluid chlorides					
82441	A		Test for chlorohydrocarbons					
82465	A		Assay, bld/serum cholesterol					
82480	A		Assay, serum cholinesterase					
82482	A		Assay, rbc cholinesterase					
82485	A		Assay, chondroitin sulfate					
82486	A		Gas/liquid chromatography					
82487	A		Paper chromatography					
82488	A		Paper chromatography					
82489	A		Thin layer chromatography					
82491	A		Chromotography, quant, sing					
82492	A		Chromotography, quant, mult					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
82656	A		Pancreatic elastase, fecal					
82657	A		Enzyme cell activity					
82658	A		Enzyme cell activity, ra					
82664	A		Electrophoretic test					
82666	A		Assay of epiandrosterone					
82668	A		Assay of erythropoietin					
82670	A		Assay of estradiol					
82671	A		Assay of estrogens					
82672	A		Assay of estrogen					
82677	A		Assay of estriol					
82679	A		Assay of estrone					
82690	A		Assay of ethchlorvynol					
82693	A		Assay of ethylene glycol					
82696	A		Assay of etiocholanolone					
82705	A		Fats/lipids, feces, qual					
82710	A		Fats/lipids, feces, quant					
82715	A		Assay of fecal fat					
82725	A		Assay of blood fatty acids					
82726	A		Long chain fatty acids					
82728	A		Assay of ferritin					
82731	A		Assay of fetal fibronectin					
82735	A		Assay of fluoride					
82742	A		Assay of flurazepam					
82746	A		Blood folic acid serum					
82747	A		Assay of folic acid, rbc					
82757	A		Assay of semen fructose					
82759	A		Assay of rbc galactokinase					
82760	A		Assay of galactose					
82775	A		Assay galactose transferase					
82776	A		Galactose transferase test					
82784	A		Assay of gammaglobulin igm					
82785	A		Assay of gammaglobulin ige					
82787	A		Igg 1, 2, 3 or 4, each					
82800	A		Blood pH					
82803	A		Blood gases pH, pO2 & pCO2					
82805	A		Blood gases W/02 saturation					
82810	A		Blood gases, O2 sat only					
82820	A		Hemoglobin-oxygen affinity					
82926	A		Assay of gastric acid					
82928	A		Assay of gastric acid					
82938	A		Gastrin test					
82941	A		Assay of gastrin					
82943	A		Assay of glucagon					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
83009	A		H pylori (c-13), blood					
83010	A		Assay of haptoglobin, quant					
83012	A		Assay of haptoglobins					
83013	A		H pylori analysis					
83014	A		H pylori drug admin/collect					
83015	A		Heavy metal screen					
83018	A		Quantitative screen, metals					
83020	A		Hemoglobin electrophoresis					
83021	A		Hemoglobin chromotography					
83026	A		Hemoglobin, copper sulfate					
83030	A		Fetal hemoglobin, chemical					
83033	A		Fetal hemoglobin assay, qual					
83036	A		Glycated hemoglobin test					
83045	A		Blood methemoglobin test					
83050	A		Blood methemoglobin assay					
83051	A		Assay of plasma hemoglobin					
83055	A		Blood sulfhemoglobin test					
83060	A		Blood sulfhemoglobin assay					
83065	A		Assay of hemoglobin heat					
83068	A		Hemoglobin stability screen					
83069	A		Assay of urine hemoglobin					
83070	A		Assay of hemosiderin, qual					
83071	A		Assay of hemosiderin, quant					
83080	A		Assay of b hexosaminidase					
83088	A		Assay of histamine					
83090	A		Assay of homocystine					
83150	A		Assay of for hva					
83491	A		Assay of corticosteroids					
83497	A		Assay of 5-hiaa					
83498	A		Assay of progesterone					
83499	A		Assay of progesterone					
83500	A		Assay, free hydroxyproline					
83505	A		Assay, total hydroxyproline					
83516	A		Immunoassay, nonantibody					
83518	A		Immunoassay, dipstick					
83519	A		Immunoassay, nonantibody					
83520	A		Immunoassay, RIA					
83525	A		Assay of insulin					
83527	A		Assay of insulin					
83528	A		Assay of intrinsic factor					
83540	A		Assay of iron					
83550	A		Iron binding test					
83570	A		Assay of idh enzyme					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
83630	A		Lactoferrin, fecal (qual)					
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					
83785	A		Assay of manganese					
83788	A		Mass spectrometry qual					
83789	A		Mass spectrometry quant					
83805	A		Assay of meprobamate					
83825	A		Assay of mercury					
83835	A		Assay of metanephrines					
83840	A		Assay of methadone					
83857	A		Assay of methemalbumin					
83858	A		Assay of methsuximide					
83864	A		Mucopolysaccharides					
83866	A		Mucopolysaccharides screen					
83872	A		Assay synovial fluid mucin					
83873	A		Assay of csf protein					
83874	A		Assay of myoglobin					
83880	A		Natriuretic peptide					
83883	A		Assay, nephelometry not spec					
83885	A		Assay of nickel					
83887	A		Assay of nicotine					
83890	A		Molecule isolate					
83891	A		Molecule isolate nucleic					
83892	A		Molecular diagnostics					
83893	A		Molecule dot/slot/blot					
83894	A		Molecule gel electrophor					
83896	A		Molecular diagnostics					
83897	A		Molecule nucleic transfer					
83898	A		Molecule nucleic ampli					
83901	A		Molecule nucleic ampli					
83902	A		Molecular diagnostics					
83903	A		Molecule mutation scan					
83904	A		Molecule mutation identify					
83905	A		Molecule mutation identify					
83906	A		Molecule mutation identify					
83912	A		Genetic examination					
83915	A		Assay of nucleotidase					
83916	A		Oligoclonal bands					
83918	A		Organic acids, total, quant					
83919	A		Organic acids, qual, each					
83921	A		Organic acid, single, quant					
83925	A		Assay of opiates					
83930	A		Assay of blood osmolality					
83935	A		Assay of urine osmolality					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
84126	A		Assay of feces porphyrins					
84127	A		Assay of feces porphyrins					
84132	A		Assay of serum potassium					
84133	A		Assay of urine potassium					
84134	A		Assay of prealbumin					
84135	A		Assay of pregnanediol					
84138	A		Assay of pregnanetriol					
84140	A		Assay of pregnenolone					
84143	A		Assay of 17-hydroxypregneno					
84144	A		Assay of progesterone					
84146	A		Assay of prolactin					
84150	A		Assay of prostaglandin					
84152	A		Assay of psa, complexed					
84153	A		Assay of psa, total					
84154	A		Assay of psa, free					
84155	A		Assay of protein, serum					
84156	A		Assay of protein, urine					
84157	A		Assay of protein, other					
84160	A		Assay of protein, any source					
84163	A		Pappa, serum					
84165	A		Electrophoreisis of proteins					
84166	A		Protein e-phoresis/urine/csf					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
84295	A		Assay of serum sodium					
84300	A		Assay of urine sodium					
84302	A		Assay of sweat sodium					
84305	A		Assay of somatomedin					
84307	A		Assay of somatostatin					
84311	A		Spectrophotometry					
84315	A		Body fluid specific gravity					
84375	A		Chromatogram assay, sugars					
84376	A		Sugars, single, qual					
84377	A		Sugars, multiple, qual					
84378	A		Sugars, single, quant					
84379	A		Sugars multiple quant					
84392	A		Assay of urine sulfate					
84402	A		Assay of testosterone					
84403	A		Assay of total testosterone					
84425	A		Assay of vitamin b-1					
84430	A		Assay of thiocyanate					
84432	A		Assay of thyroglobulin					
84436	A		Assay of total thyroxine					
84437	A		Assay of neonatal thyroxine					
84439	A		Assay of free thyroxine					
84442	A		Assay of thyroid activity					
84443	A		Assay thyroid stim hormone					
84445	A		Assay of tsi					
84446	A		Assay of vitamin e					
84449	A		Assay of transcortin					
84450	A		Transferase (AST) (SGOT)					
84460	A		Alanine amino (ALT) (SGPT)					
84466	A		Assay of transferrin					
84478	A		Assay of triglycerides					
84479	A		Assay of thyroid (t3 or t4)					
84480	A		Assay, triiodothyronine (t3)					
84481	A		Free assay (FT-3)					
84482	A		T3 reverse					
84484	A		Assay of troponin, quant					
84485	A		Assay duodenal fluid trypsin					
84488	A		Test feces for trypsin					
84490	A		Assay of feces for trypsin					
84510	A		Assay of tyrosine					
84512	A		Assay of troponin, qual					
84520	A		Assay of urea nitrogen					
84525	A		Urea nitrogen semi-quant					
84540	A		Assay of urine/urea-n					
84545	A		Urea-N clearance test					
84550	A		Assay of blood/uric acid					
84560	A		Assay of urine/uric acid					
84577	A		Assay of feces/urobilinogen					
84578	A		Test urine urobilinogen					
84580	A		Assay of urine urobilinogen					
84583	A		Assay of urine urobilinogen					
84585	A		Assay of urine vma					
84586	A		Assay of vip					
84588	A		Assay of vasopressin					
84590	A		Assay of vitamin a					
84591	A		Assay of nos vitamin					
84597	A		Assay of vitamin k					
84600	A		Assay of volatiles					
84620	A		Xylose tolerance test					
84630	A		Assay of zinc					
84681	A		Assay of c-peptide					
84702	A		Chorionic gonadotropin test					
84703	A		Chorionic gonadotropin assay					
84830	A		Ovulation tests					
84999	A		Clinical chemistry test					
85002	A		Bleeding time test					
85004	A		Automated diff wbc count					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85007	A		Differential WBC count					
85008	A		Nondifferential WBC count					
85009	A		Differential WBC count					
85013	A		Spun microhematocrit					
85014	A		Hematocrit					
85018	A		Hemoglobin					
85025	A		Automated hemogram					
85027	A		Automated hemogram					
85032	A		Manual cell count, each					
85041	A		Red blood cell (RBC) count					
85044	A		Reticulocyte count					
85045	A		Reticulocyte count					
85046	A		Reticyte/hgb concentrate					
85048	A		White blood cell (WBC) count					
85049	A		Automated platelet count					
85055	A		Reticulated platelet assay					
85060	B		Blood smear interpretation					
85097	X		Bone marrow interpretation	0343	0.4764	$28.27	$11.10	$5.65
85130	A		Chromogenic substrate assay					
85170	A		Blood clot retraction					
85175	A		Blood clot lysis time					
85210	A		Blood clot factor II test					
85220	A		Blood clot factor V test					
85230	A		Blood clot factor VII test					
85240	A		Blood clot factor VIII test					
85244	A		Blood clot factor VIII test					
85245	A		Blood clot factor VIII test					
85246	A		Blood clot factor VIII test					
85247	A		Blood clot factor VIII test					
85250	A		Blood clot factor IX test					
85260	A		Blood clot factor X test					
85270	A		Blood clot factor XI test					
85280	A		Blood clot factor XII test					
85290	A		Blood clot factor XIII test					
85291	A		Blood clot factor XIII test					
85292	A		Blood clot factor assay					
85293	A		Blood clot factor assay					
85300	A		Antithrombin III test					
85301	A		Antithrombin III test					
85302	A		Blood clot inhibitor antigen					
85303	A		Blood clot inhibitor test					
85305	A		Blood clot inhibitor assay					
85306	A		Blood clot inhibitor test					
85307	A		Assay activated protein c					
85335	A		Factor inhibitor test					
85337	A		Thrombomodulin					
85345	A		Coagulation time					
85347	A		Coagulation time					
85348	A		Coagulation time					
85360	A		Euglobulin lysis					
85362	A		Fibrin degradation products					
85366	A		Fibrinogen test					
85370	A		Fibrinogen test					
85378	A		Fibrin degradation					
85379	A		Fibrin degradation, quant					
85380	A		Fibrin degradation, vte					
85384	A		Fibrinogen					
85385	A		Fibrinogen					
85390	A		Fibrinolysins screen					
85396	N		Clotting assay, whole blood					
85400	A		Fibrinolytic plasmin					
85410	A		Fibrinolytic antiplasmin					
85415	A		Fibrinolytic plasminogen					
85420	A		Fibrinolytic plasminogen					
85421	A		Fibrinolytic plasminogen					
85441	A		Heinz bodies, direct					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
85445	A		Heinz bodies, induced					
85460	A		Hemoglobin, fetal					
85461	A		Hemoglobin, fetal					
85475	A		Hemolysin					
85520	A		Heparin assay					
85525	A		Heparin neutralization					
85530	A		Heparin-protamine tolerance					
85536	A		Iron stain peripheral blood					
85540	A		Wbc alkaline phosphatase					
85547	A		RBC mechanical fragility					
85549	A		Muramidase					
85555	A		RBC osmotic fragility					
85557	A		RBC osmotic fragility					
85576	A		Blood platelet aggregation					
85597	A		Platelet neutralization					
85610	A		Prothrombin time					
85611	A		Prothrombin test					
85612	A		Viper venom prothrombin time					
85613	A		Russell viper venom, diluted					
85635	A		Reptilase test					
85651	A		Rbc sed rate, nonautomated					
85652	A		Rbc sed rate, automated					
85660	A		RBC sickle cell test					
85670	A		Thrombin time, plasma					
85675	A		Thrombin time, titer					
85705	A		Thromboplastin inhibition					
85730	A		Thromboplastin time, partial					
85732	A		Thromboplastin time, partial					
85810	A		Blood viscosity examination					
85999	A		Hematology procedure					
86000	A		Agglutinins, febrile					
86001	A		Allergen specific igg					
86003	A		Allergen specific IgE					
86005	A		Allergen specific IgE					
86021	A		WBC antibody identification					
86022	A		Platelet antibodies					
86023	A		Immunoglobulin assay					
86038	A		Antinuclear antibodies					
86039	A		Antinuclear antibodies (ANA)					
86060	A		Antistreptolysin o, titer					
86063	A		Antistreptolysin o, screen					
86064	A		B cells, total count					
86077	X		Physician blood bank service	0433	0.2569	$15.25	$6.10	$3.05
86078	X		Physician blood bank service	0343	0.4764	$28.27	$11.10	$5.65
86079	X		Physician blood bank service	0433	0.2569	$15.25	$6.10	$3.05
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
86335	A		Immunfix e-phorsis/urine/csf					
86336	A		Inhibin A					
86337	A		Insulin antibodies					
86340	A		Intrinsic factor antibody					
86341	A		Islet cell antibody					
86343	A		Leukocyte histamine release					
86344	A		Leukocyte phagocytosis					
86353	A		Lymphocyte transformation					
86359	A		T cells, total count					
86360	A		T cell, absolute count/ratio					
86361	A		T cell, absolute count					
86376	A		Microsomal antibody					
86378	A		Migration inhibitory factor					
86379	A		Nk cells, total count					
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	0.1107	$6.57	$2.62	$1.31
86490	X		Coccidioidomycosis skin test	0341	0.1107	$6.57	$2.62	$1.31
86510	X		Histoplasmosis skin test	0341	0.1107	$6.57	$2.62	$1.31
86580	X		TB intradermal test	0341	0.1107	$6.57	$2.62	$1.31
86585	X		TB tine test	0341	0.1107	$6.57	$2.62	$1.31
86586	X		Skin test, unlisted	0341	0.1107	$6.57	$2.62	$1.31
86587	A		Stem cells, total count					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
86644	A		CMV antibody					
86645	A		CMV antibody, IgM					
86648	A		Diphtheria antibody					
86651	A		Encephalitis antibody					
86652	A		Encephalitis antibody					
86653	A		Encephalitis antibody					
86654	A		Encephalitis antibody					
86658	A		Enterovirus antibody					
86663	A		Epstein-barr antibody					
86664	A		Epstein-barr antibody					
86665	A		Epstein-barr antibody					
86666	A		Ehrlichia antibody					
86668	A		Francisella tularensis					
86671	A		Fungus antibody					
86674	A		Giardia lamblia antibody					
86677	A		Helicobacter pylori					
86682	A		Helminth antibody					
86684	A		Hemophilus influenza					
86687	A		Htlv-i antibody					
86688	A		Htlv-ii antibody					
86689	A		HTLV/HIV confirmatory test					
86692	A		Hepatitis, delta agent					
86694	A		Herpes simplex test					
86695	A		Herpes simplex test					
86696	A		Herpes simplex type 2					
86698	A		Histoplasma					
86701	A		HIV-1					
86702	A		HIV-2					
86703	A		HIV-1/HIV-2, single assay					
86704	A		Hep b core antibody, total					
86705	A		Hep b core antibody, igm					
86706	A		Hep b surface antibody					
86707	A		Hep be antibody					
86708	A		Hep a antibody, total					
86709	A		Hep a antibody, igm					
86710	A		Influenza virus antibody					
86713	A		Legionella antibody					
86717	A		Leishmania antibody					
86720	A		Leptospira antibody					
86723	A		Listeria monocytogenes ab					
86727	A		Lymph choriomeningitis ab					
86729	A		Lympho venereum antibody					
86732	A		Mucormycosis antibody					
86735	A		Mumps antibody					
86738	A		Mycoplasma antibody					
86741	A		Neisseria meningitidis					
86744	A		Nocardia antibody					
86747	A		Parvovirus antibody					
86750	A		Malaria antibody					
86753	A		Protozoa antibody nos					
86756	A		Respiratory virus antibody					
86757	A		Rickettsia antibody					
86759	A		Rotavirus antibody					
86762	A		Rubella antibody					
86765	A		Rubeola antibody					
86768	A		Salmonella antibody					
86771	A		Shigella antibody					
86774	A		Tetanus antibody					
86777	A		Toxoplasma antibody					
86778	A		Toxoplasma antibody, igm					
86781	A		Treponema pallidum, confirm					
86784	A		Trichinella antibody					
86787	A		Varicella-zoster antibody					
86790	A		Virus antibody nos					
86793	A		Yersinia antibody					
86800	A		Thyroglobulin antibody					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.2266	$13.45	$2.99	$2.69
86860	X		RBC antibody elution	0346	0.3418	$20.29	$4.52	$4.06
86870	X		RBC antibody identification	0346	0.3418	$20.29	$4.52	$4.06
86880	X		Coombs test, direct	0409	0.1252	$7.43	$2.22	$1.49
86885	X		Coombs test, indirect, qual	0409	0.1252	$7.43	$2.22	$1.49
86886	X		Coombs test, indirect, titer	0409	0.1252	$7.43	$2.22	$1.49
86890	X		Autologous blood process	0347	0.8395	$49.82	$12.30	$9.96
86891	X		Autologous blood, op salvage	0346	0.3418	$20.29	$4.52	$4.06
86900	X		Blood typing, ABO	0409	0.1252	$7.43	$2.22	$1.49
86901	X		Blood typing, Rh (D)	0409	0.1252	$7.43	$2.22	$1.49
86903	X		Blood typing, antigen screen	0345	0.2266	$13.45	$2.99	$2.69
86904	X		Blood typing, patient serum	0346	0.3418	$20.29	$4.52	$4.06
86905	X		Blood typing, RBC antigens	0345	0.2266	$13.45	$2.99	$2.69
86906	X		Blood typing, Rh phenotype	0345	0.2266	$13.45	$2.99	$2.69
86910	E		Blood typing, paternity test					
86911	E		Blood typing, antigen system					
86920	X		Compatibility test	0346	0.3418	$20.29	$4.52	$4.06
86921	X		Compatibility test	0345	0.2266	$13.45	$2.99	$2.69
86922	X		Compatibility test	0346	0.3418	$20.29	$4.52	$4.06
86927	X		Plasma, fresh frozen	0345	0.2266	$13.45	$2.99	$2.69
86930	X		Frozen blood prep	0347	0.8395	$49.82	$12.30	$9.96
86931	X		Frozen blood thaw	0347	0.8395	$49.82	$12.30	$9.96
86932	X		Frozen blood freeze/thaw	0347	0.8395	$49.82	$12.30	$9.96
86940	A		Hemolysins/agglutinins, auto					
86941	A		Hemolysins/agglutinins					
86945	X		Blood product/irradiation	0345	0.2266	$13.45	$2.99	$2.69
86950	X		Leukacyte transfusion	0345	0.2266	$13.45	$2.99	$2.69
86965	X		Pooling blood platelets	0345	0.2266	$13.45	$2.99	$2.69
86970	X		RBC pretreatment	0345	0.2266	$13.45	$2.99	$2.69
86971	X		RBC pretreatment	0345	0.2266	$13.45	$2.99	$2.69
86972	X		RBC pretreatment	0346	0.3418	$20.29	$4.52	$4.06
86975	X		RBC pretreatment, serum	0345	0.2266	$13.45	$2.99	$2.69
86976	X		RBC pretreatment, serum	0345	0.2266	$13.45	$2.99	$2.69
86977	X		RBC pretreatment, serum	0345	0.2266	$13.45	$2.99	$2.69
86978	X		RBC pretreatment, serum	0345	0.2266	$13.45	$2.99	$2.69
86985	X		Split blood or products	0345	0.2266	$13.45	$2.99	$2.69
86999	X		Transfusion procedure	0345	0.2266	$13.45	$2.99	$2.69
87001	A		Small animal inoculation					
87003	A		Small animal inoculation					
87015	A		Specimen concentration					
87040	A		Blood culture for bacteria					
87045	A		Feces culture, bacteria					
87046	A		Stool cultr, bacteria, each					
87070	A		Culture, bacteria, other					
87071	A		Culture bacteri aerobic othr					
87073	A		Culture bacteria anaerobic					
87075	A		Cultr bacteria, except blood					
87076	A		Culture anaerobe ident, each					
87077	A		Culture aerobic identify					
87081	A		Culture screen only					
87084	A		Culture of specimen by kit					
87086	A		Urine culture/colony count					
87088	A		Urine bacteria culture					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
87169	A		Macroscopic exam parasite					
87172	A		Pinworm exam					
87176	A		Tissue homogenization, cultr					
87177	A		Ova and parasites smears					
87181	A		Microbe susceptible, diffuse					
87184	A		Microbe susceptible, disk					
87185	A		Microbe susceptible, enzyme					
87186	A		Microbe susceptible, mic					
87187	A		Microbe susceptible, mlc					
87188	A		Microbe suscept, macrobroth					
87190	A		Microbe suscept, mycobacteri					
87197	A		Bactericidal level, serum					
87205	A		Smear, gram stain					
87206	A		Smear, fluorescent/acid stai					
87207	A		Smear, special stain					
87210	A		Smear, wet mount, saline/ink					
87220	A		Tissue exam for fungi					
87230	A		Assay, toxin or antitoxin					
87250	A		Virus inoculate, eggs/animal					
87252	A		Virus inoculation, tissue					
87253	A		Virus inoculate tissue, addl					
87254	A		Virus inoculation, shell via					
87255	A		Genet virus isolate, hsv					
87260	A		Adenovirus ag, if					
87265	A		Pertussis ag, if					
87267	A		Enterovirus antibody, dfa					
87269	A		Giardia ag, if					
87270	A		Chlamydia trachomatis ag, if					
87271	A		Cryptosporidum/gardia ag, if					
87272	A		Cryptosporidium ag, if					
87273	A		Herpes simplex 2, ag, if					
87274	A		Herpes simplex 1, ag, if					
87275	A		Influenza b, ag, if					
87276	A		Influenza a, ag, if					
87277	A		Legionella micdadei, ag, if					
87278	A		Legion pneumophilia ag, if					
87279	A		Parainfluenza, ag, if					
87280	A		Respiratory syncytial ag, if					
87281	A		Pneumocystis carinii, ag, if					
87283	A		Rubeola, ag, if					
87285	A		Treponema pallidum, ag, if					
87290	A		Varicella zoster, ag, if					
87299	A		Antibody detection, nos, if					
87300	A		Ag detection, polyval, if					
87301	A		Adenovirus ag, eia					
87320	A		Chylmd trach ag, eia					
87324	A		Clostridium ag, eia					
87327	A		Cryptococcus neoform ag, eia					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87328	A		Cryptosporidium ag, eia					
87329	A		Giardia ag, eia					
87332	A		Cytomegalovirus ag, eia					
87335	A		E coli 0157 ag, eia					
87336	A		Entamoeb hist dispr, ag, eia					
87337	A		Entamoeb hist group, ag, eia					
87338	A		Hpylori, stool, eia					
87339	A		H pylori ag, eia					
87340	A		Hepatitis b surface ag, eia					
87341	A		Hepatitis b surface, ag, eia					
87350	A		Hepatitis be ag, eia					
87380	A		Hepatitis delta ag, eia					
87385	A		Histoplasma capsul ag, eia					
87390	A		Hiv-1 ag, eia					
87391	A		Hiv-2 ag, eia					
87400	A		Influenza a/b, ag, eia					
87420	A		Resp syncytial ag, eia					
87425	A		Rotavirus ag, eia					
87427	A		Shiga-like toxin ag, eia					
87430	A		Strep a ag, eia					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
87541	A		Legion pneumo, dna, amp prob					
87542	A		Legion pneumo, dna, quant					
87550	A		Mycobacteria, dna, dir probe					
87551	A		Mycobacteria, dna, amp probe					
87552	A		Mycobacteria, dna, quant					
87555	A		M.tuberculo, dna, dir probe					
87556	A		M.tuberculo, dna, amp probe					
87557	A		M.tuberculo, dna, quant					
87560	A		M.avium-intra, dna, dir prob					
87561	A		M.avium-intra, dna, amp prob					
87562	A		M.avium-intra, dna, quant					
87580	A		M.pneumon, dna, dir probe					
87581	A		M.pneumon, dna, amp probe					
87582	A		M.pneumon, dna, quant					
87590	A		N.gonorrhoeae, dna, dir prob					
87591	A		N.gonorrhoeae, dna, amp prob					
87592	A		N.gonorrhoeae, dna, quant					
87620	A		Hpv, dna, dir probe					
87621	A		Hpv, dna, amp probe					
87622	A		Hpv, dna, quant					
87650	A		Strep a, dna, dir probe					
87651	A		Strep a, dna, amp probe					
87652	A		Strep a, dna, quant					
87660	A		Trichomonas vagin, dir probe					
87797	A		Detect agent nos, dna, dir					
87798	A		Detect agent nos, dna, amp					
87799	A		Detect agent nos, dna, quant					
87800	A		Detect agnt mult, dna, direc					
87801	A		Detect agnt mult, dna, ampli					
87802	A		Strep b assay w/optic					
87803	A		Clostridium toxin a w/optic					
87804	A		Influenza assay w/optic					
87807	A		Rsv 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	0433	0.2569	$15.25	$6.10	$3.05
88106	X		Cytopathology, fluids	0433	0.2569	$15.25	$6.10	$3.05
88107	X		Cytopathology, fluids	0433	0.2569	$15.25	$6.10	$3.05
88108	X		Cytopath, concentrate tech	0433	0.2569	$15.25	$6.10	$3.05
88112	X		Cytopath, cell enhance tech	0343	0.4764	$28.27	$11.10	$5.65
88125	X		Forensic cytopathology	0342	0.1553	$9.22	$3.68	$1.84
88130	A		Sex chromatin identification					
88140	A		Sex chromatin identification					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88141	N		Cytopath, c/v, interpret					
88142	A		Cytopath, c/v, thin layer					
88143	A		Cytopath c/v thin layer redo					
88147	A		Cytopath, c/v, automated					
88148	A		Cytopath, c/v, auto rescreen					
88150	A		Cytopath, c/v, manual					
88152	A		Cytopath, c/v, auto redo					
88153	A		Cytopath, c/v, redo					
88154	A		Cytopath, c/v, select					
88155	A		Cytopath, c/v, index add-on					
88160	X		Cytopath smear, other source	0433	0.2569	$15.25	$6.10	$3.05
88161	X		Cytopath smear, other source	0433	0.2569	$15.25	$6.10	$3.05
88162	X		Cytopath smear, other source	0433	0.2569	$15.25	$6.10	$3.05
88164	A		Cytopath tbs, c/v, manual					
88165	A		Cytopath tbs, c/v, redo					
88166	A		Cytopath tbs, c/v, auto redo					
88167	A		Cytopath tbs, c/v, select					
88172	X		Cytopathology eval of fna	0343	0.4764	$28.27	$11.10	$5.65
88173	X		Cytopath eval, fna, report	0343	0.4764	$28.27	$11.10	$5.65
88174	A		Cytopath, c/v auto, in fluid					
88175	A		Cytopath c/v auto fluid redo					
88182	X		Cell marker study	0344	0.7960	$47.24	$15.66	$9.45
88184	X		Flowcytometry/ tc, 1 marker	0344	0.7960	$47.24	$15.66	$9.45
88185	X		Flowcytometry/tc, add-on	0343	0.4764	$28.27	$11.10	$5.65
88187	X		Flowcytometry/read, 2-8	0433	0.2569	$15.25	$6.10	$3.05
88188	X		Flowcytometry/read, 9-15	0433	0.2569	$15.25	$6.10	$3.05
88189	X		Flowcytometry/read, 16 & >	0343	0.4764	$28.27	$11.10	$5.65
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	0.1553	$9.22	$3.68	$1.84
88300	X		Surgical path, gross	0433	0.2569	$15.25	$6.10	$3.05
88302	X		Tissue exam by pathologist	0433	0.2569	$15.25	$6.10	$3.05
88304	X		Tissue exam by pathologist	0343	0.4764	$28.27	$11.10	$5.65
88305	X		Tissue exam by pathologist	0343	0.4764	$28.27	$11.10	$5.65
88307	X		Tissue exam by pathologist	0344	0.7960	$47.24	$15.66	$9.45
88309	X		Tissue exam by pathologist	0344	0.7960	$47.24	$15.66	$9.45
88311	X		Decalcify tissue	0342	0.1553	$9.22	$3.68	$1.84
88312	X		Special stains	0433	0.2569	$15.25	$6.10	$3.05
88313	X		Special stains	0433	0.2569	$15.25	$6.10	$3.05
88314	X		Histochemical stain	0342	0.1553	$9.22	$3.68	$1.84
88318	X		Chemical histochemistry	0433	0.2569	$15.25	$6.10	$3.05

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
88319	X		Enzyme histochemistry	0343	0.4764	$28.27	$11.10	$5.65
88321	X		Microslide consultation	0433	0.2569	$15.25	$6.10	$3.05
88323	X		Microslide consultation	0343	0.4764	$28.27	$11.10	$5.65
88325	X		Comprehensive review of data	0344	0.7960	$47.24	$15.66	$9.45
88329	X		Path consult introp	0433	0.2569	$15.25	$6.10	$3.05
88331	X		Path consult intraop, 1 bloc	0343	0.4764	$28.27	$11.10	$5.65
88332	X		Path consult intraop, add'l	0433	0.2569	$15.25	$6.10	$3.05
88342	X		Immunohistochemistry	0343	0.4764	$28.27	$11.10	$5.65
88346	X		Immunofluorescent study	0343	0.4764	$28.27	$11.10	$5.65
88347	X		Immunofluorescent study	0343	0.4764	$28.27	$11.10	$5.65
88348	X		Electron microscopy	0661	3.3622	$199.55	$79.82	$39.91
88349	X		Scanning electron microscopy	0661	3.3622	$199.55	$79.82	$39.91
88355	X		Analysis, skeletal muscle	0343	0.4764	$28.27	$11.10	$5.65
88356	X		Analysis, nerve	0344	0.7960	$47.24	$15.66	$9.45
88358	X		Analysis, tumor	0344	0.7960	$47.24	$15.66	$9.45
88360	X		Tumor immunohistochem/manual	0344	0.7960	$47.24	$15.66	$9.45
88361	X		Immunohistochemistry, tumor	0344	0.7960	$47.24	$15.66	$9.45
88362	X		Nerve teasing preparations	0344	0.7960	$47.24	$15.66	$9.45
88365	X		Tissue hybridization	0344	0.7960	$47.24	$15.66	$9.45
88367	X		Insitu hybridization, auto	0344	0.7960	$47.24	$15.66	$9.45
88368	X		Insitu hybridization, manual	0344	0.7960	$47.24	$15.66	$9.45
88371	A		Protein, western blot tissue					
88372	A		Protein analysis w/probe					
88380	A		Microdissection					
88399	A		Surgical pathology procedure					
88400	A		Bilirubin total transcut					
89050	A		Body fluid cell count					
89051	A		Body fluid cell count					
89055	A		Leukocyte assessment, fecal					
89060	A		Exam,synovial fluid crystals					
89100	X		Sample intestinal contents	0360	1.4672	$87.08	$34.83	$17.42
89105	X		Sample intestinal contents	0360	1.4672	$87.08	$34.83	$17.42
89125	A		Specimen fat stain					
89130	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89132	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89135	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89136	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89140	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89141	X		Sample stomach contents	0360	1.4672	$87.08	$34.83	$17.42
89160	A		Exam feces for meat fibers					
89190	A		Nasal smear for eosinophils					
89220	X		Sputum specimen collection	0343	0.4764	$28.27	$11.10	$5.65
89225	A		Starch granules, feces					
89230	X		Collect sweat for test	0433	0.2569	$15.25	$6.10	$3.05
89235	A		Water load test					
89240	A		Pathology lab procedure					
89250	X		Cultr oocyte/embryo <4 days	0348	0.7891	$46.83		$9.37
89251	X		Cultr oocyte/embryo <4 days	0348	0.7891	$46.83		$9.37
89253	X		Embryo hatching	0348	0.7891	$46.83		$9.37
89254	X		Oocyte identification	0348	0.7891	$46.83		$9.37
89255	X		Prepare embryo for transfer	0348	0.7891	$46.83		$9.37
89257	X		Sperm identification	0348	0.7891	$46.83		$9.37
89258	X		Cryopreservation embryo(s)	0348	0.7891	$46.83		$9.37
89259	X		Cryopreservation, sperm	0348	0.7891	$46.83		$9.37
89260	X		Sperm isolation, simple	0348	0.7891	$46.83		$9.37
89261	X		Sperm isolation, complex	0348	0.7891	$46.83		$9.37
89264	X		Identify sperm tissue	0348	0.7891	$46.83		$9.37
89268	X		Insemination of oocytes	0348	0.7891	$46.83		$9.37
89272	X		Extended culture of oocytes	0348	0.7891	$46.83		$9.37
89280	X		Assist oocyte fertilization	0348	0.7891	$46.83		$9.37
89281	X		Assist oocyte fertilization	0348	0.7891	$46.83		$9.37
89290	X		Biopsy, oocyte polar body	0348	0.7891	$46.83		$9.37
89291	X		Biopsy, oocyte polar body	0348	0.7891	$46.83		$9.37
89300	A		Semen analysis w/huhner					
89310	A		Semen analysis					
89320	A		Semen analysis, complete					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
89321	A		Semen analysis & motility					
89325	A		Sperm antibody test					
89329	A		Sperm evaluation test					
89330	A		Evaluation, cervical mucus					
89335	X		Cryopreserve testicular tiss	0348	0.7891	$46.83		$9.37
89342	X		Storage/year embryo(s)	0348	0.7891	$46.83		$9.37
89343	X		Storage/year sperm/semen	0348	0.7891	$46.83		$9.37
89344	X		Storage/year reprod tissue	0348	0.7891	$46.83		$9.37
89346	X		Storage/year oocyte	0348	0.7891	$46.83		$9.37
89352	X		Thawing cryopresrved embryo	0348	0.7891	$46.83		$9.37
89353	X		Thawing cryopresrved sperm	0348	0.7891	$46.83		$9.37
89354	X		Thaw cryoprsvrd reprod tiss	0348	0.7891	$46.83		$9.37
89356	X		Thawing cryopresrved oocyte	0348	0.7891	$46.83		$9.37
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	N		Diphtheria antitoxin					
90371	E		Hep b ig, im					
90375	K		Rabies ig, im/sc	9133		$64.56		$12.91
90376	K		Rabies ig, heat treated	9134		$69.78		$13.96
90378	E		Rsv ig, im, 50mg					
90379	E		Rsv ig, iv					
90384	E		Rh ig, full-dose, im					
90385	N		Rh ig, minidose, im					
90386	E		Rh ig, iv					
90389	E		Tetanus ig, im					
90393	N		Vaccina ig, im					
90396	K		Varicella-zoster ig, im	9135		$96.57		$19.31
90399	E		Immune globulin					
90465	B		Immune admin 1 inj, < 8 yrs					
90466	B		Immune admin addl inj, < 8 y					
90467	B		Immune admin o or n, < 8 yrs					
90468	B		Immune admin o/n, addl < 8 y					
90471	X		Immunization admin	0353	0.3936	$23.36		$4.67
90472	X		Immunization admin, each add	0353	0.3936	$23.36		$4.67
90473	S		Immune admin oral/nasal	1491		$5.00		$1.00
90474	S		Immune admin oral/nasal addl	1491		$5.00		$1.00
90476	K		Adenovirus vaccine, type 4	9136	0.9498	$56.37		$11.27
90477	N		Adenovirus vaccine, type 7					
90581	K		Anthrax vaccine, sc	9169		$128.94		$25.79
90585	K		Bcg vaccine, percut	9137		$124.53		$24.91
90586	B		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	9138	0.9673	$57.41		$11.48
90645	N		Hib vaccine, hboc, im					
90646	N		Hib vaccine, prp-d, im					
90647	N		Hib vaccine, prp-omp, im					
90648	N		Hib vaccine, prp-t, im					
90655	L		Flu vaccine, 6-35 mo, im					
90656	L		Flu vaccine no preserv 3 & >					
90657	L		Flu vaccine, 6-35 mo, im					
90658	L		Flu vaccine, 3 yrs, im					
90660	E		Flu vaccine, nasal					
90665	N		Lyme disease vaccine, im					
90669	E		Pneumococcal vacc, ped <5					
90675	K		Rabies vaccine, im	9139		$128.03		$25.61
90676	K		Rabies vaccine, id	9140	1.4957	$88.77		$17.75
90680	N		Rotovirus vaccine, oral					
90690	N		Typhoid vaccine, oral					
90691	N		Typhoid vaccine, im					
90692	N		Typhoid vaccine, h-p, sc/id					
90693	N		Typhoid vaccine, akd, sc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90698	N		Dtap-hib-ip vaccine, im					
90700	N		Dtap vaccine, im					
90701	N		Dtp vaccine, im					
90702	N		Dt vaccine < 7, im					
90703	N		Tetanus vaccine, im					
90704	N		Mumps vaccine, sc					
90705	N		Measles vaccine, sc					
90706	N		Rubella vaccine, sc					
90707	N		Mmr vaccine, sc					
90708	K		Measles-rubella vaccine, sc	9141	0.9466	$56.18		$11.24
90710	N		Mmrv vaccine, sc					
90712	N		Oral poliovirus vaccine					
90713	N		Poliovirus, ipv, sc					
90715	N		Tdap vaccine >7 im					
90716	K		Chicken pox vaccine, sc	9142		$64.29		$12.86
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	E		Dtap-hep b-ipv vaccine, im					
90725	N		Cholera vaccine, injectable					
90727	N		Plague vaccine, im					
90732	L		Pneumococcal vaccine					
90733	K		Meningococcal vaccine, sc	9143		$56.74		$11.35
90734	K		Meningococcal vaccine, im	9145	0.8947	$53.10		$10.62
90735	K		Encephalitis vaccine, sc	9144		$67.72		$13.54
90740	F		Hepb vacc, ill pat 3 dose im					
90743	F		Hep b vacc, adol, 2 dose, im					
90744	F		Hepb vacc ped/adol 3 dose im					
90746	F		Hep b vaccine, adult, im					
90747	F		Hepb vacc, ill pat 4 dose im					
90748	E		Hep b/hib vaccine, im					
90749	N		Vaccine toxoid					
90780	S		IV infusion therapy, 1 hour	0120	2.0101	$119.30	$28.21	$23.86
90781	N		IV infusion, additional hour					
90782	X		Injection, sc/im	0353	0.3936	$23.36		$4.67
90783	X		Injection, ia	0359	0.8274	$49.11		$9.82
90784	X		Injection, iv	0359	0.8274	$49.11		$9.82
90788	X		Injection of antibiotic	0359	0.8274	$49.11		$9.82
90799	X		Ther/prophylactic/dx inject	0352	0.1407	$8.35		$1.67
90801	S		Psy dx interview	0323	1.6153	$95.87	$19.99	$19.17
90802	S		Intac psy dx interview	0323	1.6153	$95.87	$19.99	$19.17
90804	S		Psytx, office, 20-30 min	0322	1.2263	$72.78		$14.56
90805	S		Psytx, off, 20-30 min w/e&m	0322	1.2263	$72.78		$14.56
90806	S		Psytx, off, 45-50 min	0323	1.6153	$95.87	$19.99	$19.17
90807	S		Psytx, off, 45-50 min w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90808	S		Psytx, office, 75-80 min	0323	1.6153	$95.87	$19.99	$19.17
90809	S		Psytx, off, 75-80, w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90810	S		Intac psytx, off, 20-30 min	0322	1.2263	$72.78		$14.56
90811	S		Intac psytx, 20-30, w/e&m	0322	1.2263	$72.78		$14.56
90812	S		Intac psytx, off, 45-50 min	0323	1.6153	$95.87	$19.99	$19.17
90813	S		Intac psytx, 45-50 min w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90814	S		Intac psytx, off, 75-80 min	0323	1.6153	$95.87	$19.99	$19.17
90815	S		Intac psytx, 75-80 w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90816	S		Psytx, hosp, 20-30 min	0322	1.2263	$72.78		$14.56
90817	S		Psytx, hosp, 20-30 min w/e&m	0322	1.2263	$72.78		$14.56
90818	S		Psytx, hosp, 45-50 min	0323	1.6153	$95.87	$19.99	$19.17
90819	S		Psytx, hosp, 45-50 min w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90821	S		Psytx, hosp, 75-80 min	0323	1.6153	$95.87	$19.99	$19.17
90822	S		Psytx, hosp, 75-80 min w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90823	S		Intac psytx, hosp, 20-30 min	0322	1.2263	$72.78		$14.56
90824	S		Intac psytx, hsp 20-30 w/e&m	0322	1.2263	$72.78		$14.56
90826	S		Intac psytx, hosp, 45-50 min	0323	1.6153	$95.87	$19.99	$19.17
90827	S		Intac psytx, hsp 45-50 w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90828	S		Intac psytx, hosp, 75-80 min	0323	1.6153	$95.87	$19.99	$19.17

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
90829	S		Intac psytx, hsp 75-80 w/e&m	0323	1.6153	$95.87	$19.99	$19.17
90845	S		Psychoanalysis	0323	1.6153	$95.87	$19.99	$19.17
90846	S		Family psytx w/o patient	0324	2.0901	$124.05		$24.81
90847	S		Family psytx w/patient	0324	2.0901	$124.05		$24.81
90849	S		Multiple family group psytx	0325	1.3130	$77.93	$17.03	$15.59
90853	S		Group psychotherapy	0325	1.3130	$77.93	$17.03	$15.59
90857	S		Intac group psytx	0325	1.3130	$77.93	$17.03	$15.59
90862	X		Medication management	0374	1.0367	$61.53		$12.31
90865	S		Narcosynthesis	0323	1.6153	$95.87	$19.99	$19.17
90870	S		Electroconvulsive therapy	0320	5.3522	$317.65	$80.06	$63.53
90871	E		Electroconvulsive therapy					
90875	E		Psychophysiological therapy					
90876	E		Psychophysiological therapy					
90880	S		Hypnotherapy	0323	1.6153	$95.87	$19.99	$19.17
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	1.2263	$72.78		$14.56
90901	A		Biofeedback train, any meth					
90911	S		Biofeedback peri/uro/rectal	0321	1.3517	$80.22	$21.61	$16.04
90918	E		ESRD related services, month					
90919	E		ESRD related services, month					
90920	E		ESRD related services, month					
90921	E		ESRD related services, month					
90922	E		ESRD related services, day					
90923	E		Esrd related services, day					
90924	E		Esrd related services, day					
90925	E		Esrd related services, day					
90935	S		Hemodialysis, one evaluation	0170	5.8726	$348.54		$69.71
90937	E		Hemodialysis, repeated eval					
90939	N		Hemodialysis study, transcut					
90940	N		Hemodialysis access study					
90945	S		Dialysis, one evaluation	0170	5.8726	$348.54		$69.71
90947	E		Dialysis, repeated eval					
90989	B		Dialysis training, complete					
90993	B		Dialysis training, incompl					
90997	E		Hemoperfusion					
90999	B		Dialysis procedure					
91000	X		Esophageal intubation	0361	3.6052	$213.97	$83.23	$42.79
91010	X		Esophagus motility study	0361	3.6052	$213.97	$83.23	$42.79
91011	X		Esophagus motility study	0361	3.6052	$213.97	$83.23	$42.79
91012	X		Esophagus motility study	0361	3.6052	$213.97	$83.23	$42.79
91020	X		Gastric motility	0361	3.6052	$213.97	$83.23	$42.79
91030	X		Acid perfusion of esophagus	0361	3.6052	$213.97	$83.23	$42.79
91034	X		Gastroesophageal reflux test	0361	3.6052	$213.97	$83.23	$42.79
91035	X		G-esoph reflx tst w/electrod	0361	3.6052	$213.97	$83.23	$42.79
91037	X		Esoph imped function test	0361	3.6052	$213.97	$83.23	$42.79
91038	X		Esoph imped funct test > 1h	0361	3.6052	$213.97	$83.23	$42.79
91040	X		Esoph balloon distension tst	0360	1.4672	$87.08	$34.83	$17.42
91052	X		Gastric analysis test	0361	3.6052	$213.97	$83.23	$42.79
91055	X		Gastric intubation for smear	0360	1.4672	$87.08	$34.83	$17.42
91060	X		Gastric saline load test	0360	1.4672	$87.08	$34.83	$17.42
91065	X		Breath hydrogen test	0360	1.4672	$87.08	$34.83	$17.42
91100	X		Pass intestine bleeding tube	0360	1.4672	$87.08	$34.83	$17.42
91105	X		Gastric intubation treatment	0360	1.4672	$87.08	$34.83	$17.42
91110	T		Gi tract capsule endoscopy	0142	9.3063	$552.33	$152.78	$110.47
91120	T		Rectal sensation test	0156	2.5635	$152.14	$40.52	$30.43
91122	T		Anal pressure record	0156	2.5635	$152.14	$40.52	$30.43
91123	N		Irrigate fecal impaction					
91132	X		Electrogastrography	0360	1.4672	$87.08	$34.83	$17.42
91133	X		Electrogastrography w/test	0360	1.4672	$87.08	$34.83	$17.42
91299	X		Gastroenterology procedure	0360	1.4672	$87.08	$34.83	$17.42
92002	V		Eye exam, new patient	0601	0.9992	$59.30		$11.86
92004	V		Eye exam, new patient	0601	0.9992	$59.30		$11.86
92012	V		Eye exam established pat	0600	0.8649	$51.33		$10.27

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92014	V		Eye exam & treatment	0601	0.9992	$59.30		$11.86
92015	E		Refraction					
92018	T		New eye exam & treatment	0699	9.9723	$591.86		$118.37
92019	T		Eye exam & treatment	0699	9.9723	$591.86		$118.37
92020	S		Special eye evaluation	0230	0.7823	$46.43	$14.97	$9.29
92060	S		Special eye evaluation	0230	0.7823	$46.43	$14.97	$9.29
92065	S		Orthoptic/pleoptic training	0698	1.2381	$73.48	$16.48	$14.70
92070	N		Fitting of contact lens					
92081	S		Visual field examination(s)	0230	0.7823	$46.43	$14.97	$9.29
92082	S		Visual field examination(s)	0230	0.7823	$46.43	$14.97	$9.29
92083	S		Visual field examination(s)	0230	0.7823	$46.43	$14.97	$9.29
92100	N		Serial tonometry exam(s)					
92120	S		Tonography & eye evaluation	0230	0.7823	$46.43	$14.97	$9.29
92130	S		Water provocation tonography	0230	0.7823	$46.43	$14.97	$9.29
92135	S		Opthalmic dx imaging	0230	0.7823	$46.43	$14.97	$9.29
92136	S		Ophthalmic biometry	0698	1.2381	$73.48	$16.48	$14.70
92140	S		Glaucoma provocative tests	0698	1.2381	$73.48	$16.48	$14.70
92225	S		Special eye exam, initial	0230	0.7823	$46.43	$14.97	$9.29
92226	S		Special eye exam, subsequent	0230	0.7823	$46.43	$14.97	$9.29
92230	T		Eye exam with photos	0699	9.9723	$591.86		$118.37
92235	S		Eye exam with photos	0231	1.9191	$113.90		$22.78
92240	S		Icg angiography	0231	1.9191	$113.90		$22.78
92250	S		Eye exam with photos	0230	0.7823	$46.43	$14.97	$9.29
92260	S		Ophthalmoscopy/dynamometry	0698	1.2381	$73.48	$16.48	$14.70
92265	S		Eye muscle evaluation	0230	0.7823	$46.43	$14.97	$9.29
92270	S		Electro-oculography	0230	0.7823	$46.43	$14.97	$9.29
92275	S		Electroretinography	0231	1.9191	$113.90		$22.78
92283	S		Color vision examination	0230	0.7823	$46.43	$14.97	$9.29
92284	S		Dark adaptation eye exam	0698	1.2381	$73.48	$16.48	$14.70
92285	S		Eye photography	0230	0.7823	$46.43	$14.97	$9.29
92286	S		Internal eye photography	0698	1.2381	$73.48	$16.48	$14.70
92287	S		Internal eye photography	0698	1.2381	$73.48	$16.48	$14.70
92310	E		Contact lens fitting					
92311	X		Contact lens fitting	0362	2.6486	$157.19		$31.44
92312	X		Contact lens fitting	0362	2.6486	$157.19		$31.44
92313	X		Contact lens fitting	0362	2.6486	$157.19		$31.44
92314	E		Prescription of contact lens					
92315	X		Prescription of contact lens	0362	2.6486	$157.19		$31.44
92316	X		Prescription of contact lens	0362	2.6486	$157.19		$31.44
92317	X		Prescription of contact lens	0362	2.6486	$157.19		$31.44
92325	X		Modification of contact lens	0362	2.6486	$157.19		$31.44
92326	X		Replacement of contact lens	0362	2.6486	$157.19		$31.44
92330	S		Fitting of artificial eye	0230	0.7823	$46.43	$14.97	$9.29
92335	N		Fitting of artificial eye					
92340	E		Fitting of spectacles					
92341	E		Fitting of spectacles					
92342	E		Fitting of spectacles					
92352	X		Special spectacles fitting	0362	2.6486	$157.19		$31.44
92353	X		Special spectacles fitting	0362	2.6486	$157.19		$31.44
92354	X		Special spectacles fitting	0362	2.6486	$157.19		$31.44
92355	X		Special spectacles fitting	0362	2.6486	$157.19		$31.44
92358	X		Eye prosthesis service	0362	2.6486	$157.19		$31.44
92370	E		Repair & adjust spectacles					
92371	X		Repair & adjust spectacles	0362	2.6486	$157.19		$31.44
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	0.7823	$46.43	$14.97	$9.29
92502	T		Ear and throat examination	0251	2.0010	$118.76		$23.75
92504	N		Ear microscopy examination					
92506	A		Speech/hearing evaluation					
92507	A		Speech/hearing therapy					
92508	A		Speech/hearing therapy					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92510	E		Rehab for ear implant					
92511	T		Nasopharyngoscopy	0071	0.7879	$46.76	$11.31	$9.35
92512	X		Nasal function studies	0363	0.9087	$53.93	$17.44	$10.79
92516	X		Facial nerve function test	0660	1.6345	$97.01	$30.60	$19.40
92520	X		Laryngeal function studies	0660	1.6345	$97.01	$30.60	$19.40
92526	A		Oral function therapy					
92531	N		Spontaneous nystagmus study					
92532	N		Positional nystagmus test					
92533	N		Caloric vestibular test					
92534	N		Optokinetic nystagmus test					
92541	X		Spontaneous nystagmus test	0363	0.9087	$53.93	$17.44	$10.79
92542	X		Positional nystagmus test	0363	0.9087	$53.93	$17.44	$10.79
92543	X		Caloric vestibular test	0660	1.6345	$97.01	$30.60	$19.40
92544	X		Optokinetic nystagmus test	0363	0.9087	$53.93	$17.44	$10.79
92545	X		Oscillating tracking test	0363	0.9087	$53.93	$17.44	$10.79
92546	X		Sinusoidal rotational test	0660	1.6345	$97.01	$30.60	$19.40
92547	X		Supplemental electrical test	0363	0.9087	$53.93	$17.44	$10.79
92548	X		Posturography	0660	1.6345	$97.01	$30.60	$19.40
92551	E		Pure tone hearing test, air					
92552	X		Pure tone audiometry, air	0364	0.4686	$27.81	$9.06	$5.56
92553	X		Audiometry, air & bone	0365	1.2300	$73.00	$18.95	$14.60
92555	X		Speech threshold audiometry	0364	0.4686	$27.81	$9.06	$5.56
92556	X		Speech audiometry, complete	0364	0.4686	$27.81	$9.06	$5.56
92557	X		Comprehensive hearing test	0365	1.2300	$73.00	$18.95	$14.60
92559	E		Group audiometric testing					
92560	E		Bekesy audiometry, screen					
92561	X		Bekesy audiometry, diagnosis	0364	0.4686	$27.81	$9.06	$5.56
92562	X		Loudness balance test	0364	0.4686	$27.81	$9.06	$5.56
92563	X		Tone decay hearing test	0364	0.4686	$27.81	$9.06	$5.56
92564	X		Sisi hearing test	0364	0.4686	$27.81	$9.06	$5.56
92565	X		Stenger test, pure tone	0364	0.4686	$27.81	$9.06	$5.56
92567	X		Tympanometry	0364	0.4686	$27.81	$9.06	$5.56
92568	X		Acoustic reflex testing	0364	0.4686	$27.81	$9.06	$5.56
92569	X		Acoustic reflex decay test	0364	0.4686	$27.81	$9.06	$5.56
92571	X		Filtered speech hearing test	0364	0.4686	$27.81	$9.06	$5.56
92572	X		Staggered spondaic word test	0365	1.2300	$73.00	$18.95	$14.60
92573	X		Lombard test	0364	0.4686	$27.81	$9.06	$5.56
92575	X		Sensorineural acuity test	0364	0.4686	$27.81	$9.06	$5.56
92576	X		Synthetic sentence test	0364	0.4686	$27.81	$9.06	$5.56
92577	X		Stenger test, speech	0366	1.7663	$104.83	$27.36	$20.97
92579	X		Visual audiometry (vra)	0365	1.2300	$73.00	$18.95	$14.60
92582	X		Conditioning play audiometry	0365	1.2300	$73.00	$18.95	$14.60
92583	X		Select picture audiometry	0364	0.4686	$27.81	$9.06	$5.56
92584	X		Electrocochleography	0660	1.6345	$97.01	$30.60	$19.40
92585	S		Auditor evoke potent, compre	0216	2.6599	$157.87		$31.57
92586	S		Auditor evoke potent, limit	0218	1.1356	$67.40		$13.48
92587	X		Evoked auditory test	0363	0.9087	$53.93	$17.44	$10.79
92588	X		Evoked auditory test	0363	0.9087	$53.93	$17.44	$10.79
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	0364	0.4686	$27.81	$9.06	$5.56
92597	A		Voice Prosthetic Evaluation					
92601	X		Cochlear implt f/up exam < 7	0366	1.7663	$104.83	$27.36	$20.97
92602	X		Reprogram cochlear implt < 7	0366	1.7663	$104.83	$27.36	$20.97
92603	X		Cochlear implt f/up exam 7 >	0366	1.7663	$104.83	$27.36	$20.97
92604	X		Reprogram cochlear implt 7 >	0366	1.7663	$104.83	$27.36	$20.97
92605	A		Eval for nonspeech device rx					
92606	A		Non-speech device service					
92607	A		Ex for speech device rx, 1hr					
92608	A		Ex for speech device rx addl					
92609	A		Use of speech device service					
92610	A		Evaluate swallowing function					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
92611	A		Motion fluoroscopy/swallow					
92612	A		Endoscopy swallow tst (fees)					
92613	E		Endoscopy swallow tst (fees)					
92614	A		Laryngoscopic sensory test					
92615	E		Eval laryngoscopy sense tst					
92616	A		Fees w/laryngeal sense test					
92617	E		Interprt fees/laryngeal test					
92620	X		Auditory function, 60 min	0364	0.4686	$27.81	$9.06	$5.56
92621	N		Auditory function, + 15 min					
92625	X		Tinnitus assessment	0364	0.4686	$27.81	$9.06	$5.56
92700	X		Ent procedure/service	0364	0.4686	$27.81	$9.06	$5.56
92950	S		Heart/lung resuscitation cpr	0094	2.5248	$149.85	$47.41	$29.97
92953	S		Temporary external pacing	0094	2.5248	$149.85	$47.41	$29.97
92960	S		Cardioversion electric, ext	0679	5.5521	$329.52	$95.30	$65.90
92961	S		Cardioversion, electric, int	0679	5.5521	$329.52	$95.30	$65.90
92970	C		Cardioassist, internal					
92971	C		Cardioassist, external					
92973	T		Percut coronary thrombectomy	0676	2.3996	$142.42		$28.48
92974	T		Cath place, cardio brachytx	0103	14.6476	$869.34	$223.63	$173.87
92975	C		Dissolve clot, heart vessel					
92977	T		Dissolve clot, heart vessel	0676	2.3996	$142.42		$28.48
92978	S		Intravasc us, heart add-on	0670	25.2980	$1,501.44	$470.38	$300.29
92979	S		Intravasc us, heart add-on	0416	19.4657	$1,155.29		$231.06
92980	T		Insert intracoronary stent	0104	78.6515	$4,667.97		$933.59
92981	T		Insert intracoronary stent	0104	78.6515	$4,667.97		$933.59
92982	T		Coronary artery dilation	0083	50.6620	$3,006.79		$601.36
92984	T		Coronary artery dilation	0083	50.6620	$3,006.79		$601.36
92986	T		Revision of aortic valve	0083	50.6620	$3,006.79		$601.36
92987	T		Revision of mitral valve	0083	50.6620	$3,006.79		$601.36
92990	T		Revision of pulmonary valve	0083	50.6620	$3,006.79		$601.36
92992	C		Revision of heart chamber					
92993	C		Revision of heart chamber					
92995	T		Coronary atherectomy	0082	84.6276	$5,022.65	$1,080.41	$1,004.53
92996	T		Coronary atherectomy add-on	0082	84.6276	$5,022.65	$1,080.41	$1,004.53
92997	T		Pul art balloon repr, percut	0081	34.2913	$2,035.19		$407.04
92998	T		Pul art balloon repr, percut	0081	34.2913	$2,035.19		$407.04
93000	B		Electrocardiogram, complete					
93005	S		Electrocardiogram, tracing	0099	0.3804	$22.58		$4.52
93010	A		Electrocardiogram report					
93012	N		Transmission of ecg					
93014	B		Report on transmitted ecg					
93015	B		Cardiovascular stress test					
93016	B		Cardiovascular stress test					
93017	X		Cardiovascular stress test	0100	2.4855	$147.51	$41.44	$29.50
93018	B		Cardiovascular stress test					
93024	X		Cardiac drug stress test	0100	2.4855	$147.51	$41.44	$29.50
93025	X		Microvolt t-wave assess	0100	2.4855	$147.51	$41.44	$29.50
93040	B		Rhythm ECG with report					
93041	S		Rhythm ECG, tracing	0099	0.3804	$22.58		$4.52
93042	B		Rhythm ECG, report					
93224	B		ECG monitor/report, 24 hrs					
93225	X		ECG monitor/record, 24 hrs	0097	1.0177	$60.40	$23.79	$12.08
93226	X		ECG monitor/report, 24 hrs	0097	1.0177	$60.40	$23.79	$12.08
93227	B		ECG monitor/review, 24 hrs					
93230	B		ECG monitor/report, 24 hrs					
93231	X		Ecg monitor/record, 24 hrs	0097	1.0177	$60.40	$23.79	$12.08
93232	X		ECG monitor/report, 24 hrs	0097	1.0177	$60.40	$23.79	$12.08
93233	B		ECG monitor/review, 24 hrs					
93235	B		ECG monitor/report, 24 hrs					
93236	X		ECG monitor/report, 24 hrs	0097	1.0177	$60.40	$23.79	$12.08
93237	B		ECG monitor/review, 24 hrs					
93268	B		ECG record/review					
93270	X		ECG recording	0097	1.0177	$60.40	$23.79	$12.08
93271	X		Ecg/monitoring and analysis	0097	1.0177	$60.40	$23.79	$12.08
93272	B		Ecg/review, interpret only					
93278	S		ECG/signal-averaged	0099	0.3804	$22.58		$4.52

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93303	S		Echo transthoracic	0269	3.2290	$191.64	$76.65	$38.33
93304	S		Echo transthoracic	0697	1.5288	$90.73	$36.29	$18.15
93307	S		Echo exam of heart	0269	3.2290	$191.64	$76.65	$38.33
93308	S		Echo exam of heart	0697	1.5288	$90.73	$36.29	$18.15
93312	S		Echo transesophageal	0270	5.9919	$355.62	$142.24	$71.12
93313	S		Echo transesophageal	0270	5.9919	$355.62	$142.24	$71.12
93314	N		Echo transesophageal					
93315	S		Echo transesophageal	0270	5.9919	$355.62	$142.24	$71.12
93316	S		Echo transesophageal	0270	5.9919	$355.62	$142.24	$71.12
93317	N		Echo transesophageal					
93318	S		Echo transesophageal intraop	0270	5.9919	$355.62	$142.24	$71.12
93320	S		Doppler echo exam, heart	0671	1.6951	$100.60	$40.24	$20.12
93321	S		Doppler echo exam, heart	0697	1.5288	$90.73	$36.29	$18.15
93325	S		Doppler color flow add-on	0697	1.5288	$90.73	$36.29	$18.15
93350	S		Echo transthoracic	0269	3.2290	$191.64	$76.65	$38.33
93501	T		Right heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93503	T		Insert/place heart catheter	0103	14.6476	$869.34	$223.63	$173.87
93505	T		Biopsy of heart lining	0103	14.6476	$869.34	$223.63	$173.87
93508	T		Cath placement, angiography	0080	36.9679	$2,194.04	$838.92	$438.81
93510	T		Left heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93511	T		Left heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93514	T		Left heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93524	T		Left heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93526	T		Rt & Lt heart catheters	0080	36.9679	$2,194.04	$838.92	$438.81
93527	T		Rt & Lt heart catheters	0080	36.9679	$2,194.04	$838.92	$438.81
93528	T		Rt & Lt heart catheters	0080	36.9679	$2,194.04	$838.92	$438.81
93529	T		Rt, lt heart catheterization	0080	36.9679	$2,194.04	$838.92	$438.81
93530	T		Rt heart cath, congenital	0080	36.9679	$2,194.04	$838.92	$438.81
93531	T		R & l heart cath, congenital	0080	36.9679	$2,194.04	$838.92	$438.81
93532	T		R & l heart cath, congenital	0080	36.9679	$2,194.04	$838.92	$438.81
93533	T		R & l heart cath, congenital	0080	36.9679	$2,194.04	$838.92	$438.81
93539	N		Injection, cardiac cath					
93540	N		Injection, cardiac cath					
93541	N		Injection for lung angiogram					
93542	N		Injection for heart x-rays					
93543	N		Injection for heart x-rays					
93544	N		Injection for aortography					
93545	N		Inject for coronary x-rays					
93555	N		Imaging, cardiac cath					
93556	N		Imaging, cardiac cath					
93561	N		Cardiac output measurement					
93562	N		Cardiac output measurement					
93571	S		Heart flow reserve measure	0670	25.2980	$1,501.44	$470.38	$300.29
93572	S		Heart flow reserve measure	0416	19.4657	$1,155.29		$231.06
93580	T		Transcath closure of asd	0434	90.3765	$5,363.85		$1,072.77
93581	T		Transcath closure of vsd	0434	90.3765	$5,363.85		$1,072.77
93600	T		Bundle of His recording	0087	30.5711	$1,814.39		$362.88
93602	T		Intra-atrial recording	0087	30.5711	$1,814.39		$362.88
93603	T		Right ventricular recording	0087	30.5711	$1,814.39		$362.88
93609	T		Map tachycardia, add-on	0087	30.5711	$1,814.39		$362.88
93610	T		Intra-atrial pacing	0087	30.5711	$1,814.39		$362.88
93612	T		Intraventricular pacing	0087	30.5711	$1,814.39		$362.88
93613	T		Electrophys map 3d, add-on	0087	30.5711	$1,814.39		$362.88
93615	T		Esophageal recording	0087	30.5711	$1,814.39		$362.88
93616	T		Esophageal recording	0087	30.5711	$1,814.39		$362.88
93618	T		Heart rhythm pacing	0087	30.5711	$1,814.39		$362.88
93619	T		Electrophysiology evaluation	0085	35.0288	$2,078.96	$426.25	$415.79
93620	T		Electrophysiology evaluation	0085	35.0288	$2,078.96	$426.25	$415.79
93621	T		Electrophysiology evaluation	0085	35.0288	$2,078.96	$426.25	$415.79
93622	T		Electrophysiology evaluation	0085	35.0288	$2,078.96	$426.25	$415.79
93623	T		Stimulation, pacing heart	0087	30.5711	$1,814.39		$362.88
93624	T		Electrophysiologic study	0085	35.0288	$2,078.96	$426.25	$415.79
93631	T		Heart pacing, mapping	0087	30.5711	$1,814.39		$362.88
93640	S		Evaluation heart device	0084	9.9751	$592.02		$118.40
93641	S		Electrophysiology evaluation	0084	9.9751	$592.02		$118.40
93642	S		Electrophysiology evaluation	0084	9.9751	$592.02		$118.40

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
93650	T		Ablate heart dysrhythm focus	0086	44.0592	$2,614.91	$833.33	$522.98
93651	T		Ablate heart dysrhythm focus	0086	44.0592	$2,614.91	$833.33	$522.98
93652	T		Ablate heart dysrhythm focus	0086	44.0592	$2,614.91	$833.33	$522.98
93660	S		Tilt table evaluation	0101	4.2593	$252.79	$101.11	$50.56
93662	S		Intracardiac ecg (ice)	0670	25.2980	$1,501.44	$470.38	$300.29
93668	E		Peripheral vascular rehab					
93701	S		Bioimpedance, thoracic	0099	0.3804	$22.58		$4.52
93720	B		Total body plethysmography					
93721	X		Plethysmography tracing	0368	0.9716	$57.66	$23.06	$11.53
93722	B		Plethysmography report					
93724	S		Analyze pacemaker system	0690	0.3738	$22.19	$8.87	$4.44
93727	S		Analyze ilr system	0690	0.3738	$22.19	$8.87	$4.44
93731	S		Analyze pacemaker system	0690	0.3738	$22.19	$8.87	$4.44
93732	S		Analyze pacemaker system	0690	0.3738	$22.19	$8.87	$4.44
93733	S		Telephone analy, pacemaker	0690	0.3738	$22.19	$8.87	$4.44
93734	S		Analyze pacemaker system	0690	0.3738	$22.19	$8.87	$4.44
93735	S		Analyze pacemaker system	0690	0.3738	$22.19	$8.87	$4.44
93736	S		Telephonic analy, pacemaker	0690	0.3738	$22.19	$8.87	$4.44
93740	X		Temperature gradient studies	0368	0.9716	$57.66	$23.06	$11.53
93741	S		Analyze ht pace device sngl	0689	0.5709	$33.88		$6.78
93742	S		Analyze ht pace device sngl	0689	0.5709	$33.88		$6.78
93743	S		Analyze ht pace device dual	0689	0.5709	$33.88		$6.78
93744	S		Analyze ht pace device dual	0689	0.5709	$33.88		$6.78
93745	S		Set-up cardiovert-defibrill	0689	0.5709	$33.88		$6.78
93760	E		Cephalic thermogram					
93762	E		Peripheral thermogram					
93770	N		Measure venous pressure					
93784	E		Ambulatory BP monitoring					
93786	X		Ambulatory BP recording	0097	1.0177	$60.40	$23.79	$12.08
93788	X		Ambulatory BP analysis	0097	1.0177	$60.40	$23.79	$12.08
93790	B		Review/report BP recording					
93797	S		Cardiac rehab	0095	0.5858	$34.77	$13.90	$6.95
93798	S		Cardiac rehab/monitor	0095	0.5858	$34.77	$13.90	$6.95
93799	S		Cardiovascular procedure	0096	1.6233	$96.34	$38.53	$19.27
93875	S		Extracranial study	0096	1.6233	$96.34	$38.53	$19.27
93880	S		Extracranial study	0267	2.6208	$155.54	$62.18	$31.11
93882	S		Extracranial study	0267	2.6208	$155.54	$62.18	$31.11
93886	S		Intracranial study	0267	2.6208	$155.54	$62.18	$31.11
93888	S		Intracranial study	0266	1.6319	$96.85	$38.74	$19.37
93890	S		Tcd, vasoreactivity study	0266	1.6319	$96.85	$38.74	$19.37
93892	S		Tcd, emboli detect w/o inj	0266	1.6319	$96.85	$38.74	$19.37
93893	S		Tcd, emboli detect w/inj	0266	1.6319	$96.85	$38.74	$19.37
93922	S		Extremity study	0096	1.6233	$96.34	$38.53	$19.27
93923	S		Extremity study	0096	1.6233	$96.34	$38.53	$19.27
93924	S		Extremity study	0096	1.6233	$96.34	$38.53	$19.27
93925	S		Lower extremity study	0267	2.6208	$155.54	$62.18	$31.11
93926	S		Lower extremity study	0266	1.6319	$96.85	$38.74	$19.37
93930	S		Upper extremity study	0267	2.6208	$155.54	$62.18	$31.11
93931	S		Upper extremity study	0266	1.6319	$96.85	$38.74	$19.37
93965	S		Extremity study	0096	1.6233	$96.34	$38.53	$19.27
93970	S		Extremity study	0267	2.6208	$155.54	$62.18	$31.11
93971	S		Extremity study	0266	1.6319	$96.85	$38.74	$19.37
93975	S		Vascular study	0267	2.6208	$155.54	$62.18	$31.11
93976	S		Vascular study	0267	2.6208	$155.54	$62.18	$31.11
93978	S		Vascular study	0266	1.6319	$96.85	$38.74	$19.37
93979	S		Vascular study	0266	1.6319	$96.85	$38.74	$19.37
93980	S		Penile vascular study	0267	2.6208	$155.54	$62.18	$31.11
93981	S		Penile vascular study	0266	1.6319	$96.85	$38.74	$19.37
93990	S		Doppler flow testing	0266	1.6319	$96.85	$38.74	$19.37
94010	X		Breathing capacity test	0368	0.9716	$57.66	$23.06	$11.53
94014	X		Patient recorded spirometry	0367	0.6629	$39.34	$14.80	$7.87
94015	X		Patient recorded spirometry	0367	0.6629	$39.34	$14.80	$7.87
94016	A		Review patient spirometry					
94060	X		Evaluation of wheezing	0368	0.9716	$57.66	$23.06	$11.53
94070	X		Evaluation of wheezing	0369	2.7394	$162.58	$44.18	$32.52
94150	X		Vital capacity test	0367	0.6629	$39.34	$14.80	$7.87

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
94200	X		Lung function test (MBC/MVV)	0367	0.6629	$39.34	$14.80	$7.87
94240	X		Residual lung capacity	0368	0.9716	$57.66	$23.06	$11.53
94250	X		Expired gas collection	0367	0.6629	$39.34	$14.80	$7.87
94260	X		Thoracic gas volume	0367	0.6629	$39.34	$14.80	$7.87
94350	X		Lung nitrogen washout curve	0367	0.6629	$39.34	$14.80	$7.87
94360	X		Measure airflow resistance	0367	0.6629	$39.34	$14.80	$7.87
94370	X		Breath airway closing volume	0367	0.6629	$39.34	$14.80	$7.87
94375	X		Respiratory flow volume loop	0367	0.6629	$39.34	$14.80	$7.87
94400	X		CO2 breathing response curve	0367	0.6629	$39.34	$14.80	$7.87
94450	X		Hypoxia response curve	0368	0.9716	$57.66	$23.06	$11.53
94452	X		Hast w/report	0368	0.9716	$57.66	$23.06	$11.53
94453	X		Hast w/oxygen titrate	0368	0.9716	$57.66	$23.06	$11.53
94620	X		Pulmonary stress test/simple	0368	0.9716	$57.66	$23.06	$11.53
94621	X		Pulm stress test/complex	0369	2.7394	$162.58	$44.18	$32.52
94640	S		Airway inhalation treatment	0077	0.3428	$20.35	$7.74	$4.07
94642	S		Aerosol inhalation treatment	0078	1.0190	$60.48	$14.55	$12.10
94656	S		Initial ventilator mgmt	0079	2.3375	$138.73		$27.75
94657	S		Continued ventilator mgmt	0079	2.3375	$138.73		$27.75
94660	S		Pos airway pressure, CPAP	0068	1.2237	$72.63	$29.05	$14.53
94662	S		Neg press ventilation, cnp	0079	2.3375	$138.73		$27.75
94664	S		Aerosol or vapor inhalations	0077	0.3428	$20.35	$7.74	$4.07
94667	S		Chest wall manipulation	0077	0.3428	$20.35	$7.74	$4.07
94668	S		Chest wall manipulation	0077	0.3428	$20.35	$7.74	$4.07
94680	X		Exhaled air analysis, o2	0367	0.6629	$39.34	$14.80	$7.87
94681	X		Exhaled air analysis, o2/co2	0368	0.9716	$57.66	$23.06	$11.53
94690	X		Exhaled air analysis	0368	0.9716	$57.66	$23.06	$11.53
94720	X		Monoxide diffusing capacity	0368	0.9716	$57.66	$23.06	$11.53
94725	X		Membrane diffusion capacity	0368	0.9716	$57.66	$23.06	$11.53
94750	X		Pulmonary compliance study	0368	0.9716	$57.66	$23.06	$11.53
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	0.6629	$39.34	$14.80	$7.87
94772	X		Breath recording, infant	0369	2.7394	$162.58	$44.18	$32.52
94799	X		Pulmonary service/procedure	0367	0.6629	$39.34	$14.80	$7.87
95004	X		Percut allergy skin tests	0381	0.1876	$11.13	$2.34	$2.23
95010	X		Percut allergy titrate test	0381	0.1876	$11.13	$2.34	$2.23
95015	X		Id allergy titrate-drug/bug	0381	0.1876	$11.13	$2.34	$2.23
95024	X		Id allergy test, drug/bug	0381	0.1876	$11.13	$2.34	$2.23
95027	X		Skin end point titration	0381	0.1876	$11.13	$2.34	$2.23
95028	X		Id allergy test-delayed type	0381	0.1876	$11.13	$2.34	$2.23
95044	X		Allergy patch tests	0381	0.1876	$11.13	$2.34	$2.23
95052	X		Photo patch test	0381	0.1876	$11.13	$2.34	$2.23
95056	X		Photosensitivity tests	0370	1.1181	$66.36		$13.27
95060	X		Eye allergy tests	0370	1.1181	$66.36		$13.27
95065	X		Nose allergy test	0381	0.1876	$11.13	$2.34	$2.23
95070	X		Bronchial allergy tests	0369	2.7394	$162.58	$44.18	$32.52
95071	X		Bronchial allergy tests	0369	2.7394	$162.58	$44.18	$32.52
95075	X		Ingestion challenge test	0361	3.6052	$213.97	$83.23	$42.79
95078	X		Provocative testing	0370	1.1181	$66.36		$13.27
95115	X		Immunotherapy, one injection	0352	0.1407	$8.35		$1.67
95117	X		Immunotherapy injections	0353	0.3936	$23.36		$4.67
95120	B		Immunotherapy, one injection					
95125	B		Immunotherapy, many antigens					
95130	B		Immunotherapy, insect venom					
95131	B		Immunotherapy, insect venoms					
95132	B		Immunotherapy, insect venoms					
95133	B		Immunotherapy, insect venoms					
95134	B		Immunotherapy, insect venoms					
95144	X		Antigen therapy services	0353	0.3936	$23.36		$4.67
95145	X		Antigen therapy services	0353	0.3936	$23.36		$4.67
95146	X		Antigen therapy services	0359	0.8274	$49.11		$9.82
95147	X		Antigen therapy services	0359	0.8274	$49.11		$9.82
95148	X		Antigen therapy services	0353	0.3936	$23.36		$4.67
95149	X		Antigen therapy services	0352	0.1407	$8.35		$1.67
95165	X		Antigen therapy services	0353	0.3936	$23.36		$4.67

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95170	X		Antigen therapy services	0352	0.1407	$8.35		$1.67
95180	X		Rapid desensitization	0370	1.1181	$66.36		$13.27
95199	X		Allergy immunology services	0370	1.1181	$66.36		$13.27
95250	X		Glucose monitoring, cont	0421	1.6525	$98.08		$19.62
95805	S		Multiple sleep latency test	0209	11.5189	$683.65	$273.46	$136.73
95806	S		Sleep study, unattended	0213	2.2828	$135.48	$54.19	$27.10
95807	S		Sleep study, attended	0209	11.5189	$683.65	$273.46	$136.73
95808	S		Polysomnography, 1-3	0209	11.5189	$683.65	$273.46	$136.73
95810	S		Polysomnography, 4 or more	0209	11.5189	$683.65	$273.46	$136.73
95811	S		Polysomnography w/cpap	0209	11.5189	$683.65	$273.46	$136.73
95812	S		Electroencephalogram (EEG)	0213	2.2828	$135.48	$54.19	$27.10
95813	S		Eeg, over 1 hour	0213	2.2828	$135.48	$54.19	$27.10
95816	S		Electroencephalogram (EEG)	0213	2.2828	$135.48	$54.19	$27.10
95819	S		Electroencephalogram (EEG)	0213	2.2828	$135.48	$54.19	$27.10
95822	S		Sleep electroencephalogram	0213	2.2828	$135.48	$54.19	$27.10
95824	S		Eeg, cerebral death only	0214	1.1302	$67.08	$26.83	$13.42
95827	S		night electroencephalogram	0213	2.2828	$135.48	$54.19	$27.10
95829	S		Surgery electrocorticogram	0214	1.1302	$67.08	$26.83	$13.42
95830	B		Insert electrodes for EEG					
95831	A		Limb muscle testing, manual					
95832	A		Hand muscle testing, manual					
95833	A		Body muscle testing, manual					
95834	A		Body muscle testing, manual					
95851	A		Range of motion measurements					
95852	A		Range of motion measurements					
95857	S		Tensilon test	0218	1.1356	$67.40		$13.48
95858	S		Tensilon test & myogram	0215	0.6087	$36.13	$14.45	$7.23
95860	S		Muscle test, one limb	0218	1.1356	$67.40		$13.48
95861	S		Muscle test, 2 limbs	0218	1.1356	$67.40		$13.48
95863	S		Muscle test, 3 limbs	0218	1.1356	$67.40		$13.48
95864	S		Muscle test, 4 limbs	0218	1.1356	$67.40		$13.48
95867	S		Muscle test, head or neck	0218	1.1356	$67.40		$13.48
95868	S		Muscle test cran nerve bilat	0218	1.1356	$67.40		$13.48
95869	S		Muscle test, thor paraspinal	0215	0.6087	$36.13	$14.45	$7.23
95870	S		Muscle test, nonparaspinal	0215	0.6087	$36.13	$14.45	$7.23
95872	S		Muscle test, one fiber	0218	1.1356	$67.40		$13.48
95875	S		Limb exercise test	0215	0.6087	$36.13	$14.45	$7.23
95900	S		Motor nerve conduction test	0215	0.6087	$36.13	$14.45	$7.23
95903	S		Motor nerve conduction test	0215	0.6087	$36.13	$14.45	$7.23
95904	S		Sense nerve conduction test	0215	0.6087	$36.13	$14.45	$7.23
95920	S		Intraop nerve test add-on	0216	2.6599	$157.87		$31.57
95921	S		Autonomic nerv function test	0218	1.1356	$67.40		$13.48
95922	S		Autonomic nerv function test	0218	1.1356	$67.40		$13.48
95923	S		Autonomic nerv function test	0218	1.1356	$67.40		$13.48
95925	S		Somatosensory testing	0216	2.6599	$157.87		$31.57
95926	S		Somatosensory testing	0216	2.6599	$157.87		$31.57
95927	S		Somatosensory testing	0216	2.6599	$157.87		$31.57
95928	S		C motor evoked, uppr limbs	0218	1.1356	$67.40		$13.48
95929	S		C motor evoked, lwr limbs	0218	1.1356	$67.40		$13.48
95930	S		Visual evoked potential test	0216	2.6599	$157.87		$31.57
95933	S		Blink reflex test	0215	0.6087	$36.13	$14.45	$7.23
95934	S		H-reflex test	0215	0.6087	$36.13	$14.45	$7.23
95936	S		H-reflex test	0215	0.6087	$36.13	$14.45	$7.23
95937	S		Neuromuscular junction test	0218	1.1356	$67.40		$13.48
95950	S		Ambulatory eeg monitoring	0213	2.2828	$135.48	$54.19	$27.10
95951	S		EEG monitoring/videorecord	0209	11.5189	$683.65	$273.46	$136.73
95953	S		EEG monitoring/computer	0209	11.5189	$683.65	$273.46	$136.73
95954	S		EEG monitoring/giving drugs	0214	1.1302	$67.08	$26.83	$13.42
95955	S		EEG during surgery	0213	2.2828	$135.48	$54.19	$27.10
95956	S		Eeg monitoring, cable/radio	0209	11.5189	$683.65	$273.46	$136.73
95957	S		EEG digital analysis	0214	1.1302	$67.08	$26.83	$13.42
95958	S		EEG monitoring/function test	0213	2.2828	$135.48	$54.19	$27.10
95961	S		Electrode stimulation, brain	0216	2.6599	$157.87		$31.57
95962	S		Electrode stim, brain add-on	0216	2.6599	$157.87		$31.57
95965	T		Meg, spontaneous	0430	11.3524	$673.76		$134.75
95966	T		Meg, evoked, single	0430	11.3524	$673.76		$134.75

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
95967	T		Meg, evoked, each add'l	0430	11.3524	$673.76		$134.75
95970	S		Analyze neurostim, no prog	0218	1.1356	$67.40		$13.48
95971	S		Analyze neurostim, simple	0692	2.0020	$118.82	$30.16	$23.76
95972	S		Analyze neurostim, complex	0692	2.0020	$118.82	$30.16	$23.76
95973	S		Analyze neurostim, complex	0692	2.0020	$118.82	$30.16	$23.76
95974	S		Cranial neurostim, complex	0692	2.0020	$118.82	$30.16	$23.76
95975	S		Cranial neurostim, complex	0692	2.0020	$118.82	$30.16	$23.76
95978	S		Analyze neurostim brain/1h	0692	2.0020	$118.82	$30.16	$23.76
95979	S		Analyz neurostim brain addon	0692	2.0020	$118.82	$30.16	$23.76
95990	T		Spin/brain pump refil & main	0125	1.9244	$114.21		$22.84
95991	T		Spin/brain pump refil & main	0125	1.9244	$114.21		$22.84
95999	S		Neurological procedure	0215	0.6087	$36.13	$14.45	$7.23
96000	S		Motion analysis, video/3d	0216	2.6599	$157.87		$31.57
96001	S		Motion test w/ft press meas	0216	2.6599	$157.87		$31.57
96002	S		Dynamic surface emg	0218	1.1356	$67.40		$13.48
96003	S		Dynamic fine wire emg	0215	0.6087	$36.13	$14.45	$7.23
96004	E		Phys review of motion tests					
96100	X		Psychological testing	0373	2.1827	$129.54		$25.91
96105	A		Assessment of aphasia					
96110	X		Developmental test, lim	0373	2.1827	$129.54		$25.91
96111	X		Developmental test, extend	0373	2.1827	$129.54		$25.91
96115	X		Neurobehavior status exam	0373	2.1827	$129.54		$25.91
96117	X		Neuropsych test battery	0373	2.1827	$129.54		$25.91
96150	S		Assess lth/behave, init	0432	0.6918	$41.06		$8.21
96151	S		Assess hlth/behave, subseq	0432	0.6918	$41.06		$8.21
96152	S		Intervene hlth/behave, indiv	0432	0.6918	$41.06		$8.21
96153	S		Intervene hlth/behave, group	0432	0.6918	$41.06		$8.21
96154	S		Interv hlth/behav, fam w/pt	0432	0.6918	$41.06		$8.21
96155	E		Interv hlth/behav fam no pt					
96400	S		Chemotherapy, sc/im	0116	1.1401	$67.66		$13.53
96405	S		Intralesional chemo admin	0116	1.1401	$67.66		$13.53
96406	S		Intralesional chemo admin	0116	1.1401	$67.66		$13.53
96408	S		Chemotherapy, push technique	0116	1.1401	$67.66		$13.53
96410	S		Chemotherapy,infusion method	0117	3.2231	$191.29	$42.54	$38.26
96412	N		Chemo, infuse method add-on					
96414	S		Chemo, infuse method add-on	0117	3.2231	$191.29	$42.54	$38.26
96420	S		Chemotherapy, push technique	0116	1.1401	$67.66		$13.53
96422	S		Chemotherapy,infusion method	0117	3.2231	$191.29	$42.54	$38.26
96423	N		Chemo, infuse method add-on					
96425	S		Chemotherapy,infusion method	0117	3.2231	$191.29	$42.54	$38.26
96440	S		Chemotherapy, intracavitary	0116	1.1401	$67.66		$13.53
96445	S		Chemotherapy, intracavitary	0116	1.1401	$67.66		$13.53
96450	S		Chemotherapy, into CNS	0116	1.1401	$67.66		$13.53
96520	T		Port pump refill & main	0125	1.9244	$114.21		$22.84
96530	T		Pump refilling, maintenance	0125	1.9244	$114.21		$22.84
96542	S		Chemotherapy injection	0116	1.1401	$67.66		$13.53
96545	N		Provide chemotherapy agent					
96549	S		Chemotherapy, unspecified	0116	1.1401	$67.66		$13.53
96567	T		Photodynamic tx, skin	0016	2.5717	$152.63	$33.42	$30.53
96570	T		Photodynamic tx, 30 min	0015	1.6439	$97.57	$20.20	$19.51
96571	T		Photodynamic tx, addl 15 min	0015	1.6439	$97.57	$20.20	$19.51
96900	S		Ultraviolet light therapy	0001	0.4194	$24.89	$7.00	$4.98
96902	N		Trichogram					
96910	S		Photochemotherapy with UV-B	0001	0.4194	$24.89	$7.00	$4.98
96912	S		Photochemotherapy with UV-A	0001	0.4194	$24.89	$7.00	$4.98
96913	S		Photochemotherapy, UV-A or B	0683	1.8920	$112.29	$25.23	$22.46
96920	T		Laser tx, skin < 250 sq cm	0013	1.1028	$65.45	$14.20	$13.09
96921	T		Laser tx, skin 250-500 sq cm	0013	1.1028	$65.45	$14.20	$13.09
96922	T		Laser tx, skin > 500 sq cm	0013	1.1028	$65.45	$14.20	$13.09
96999	T		Dermatological procedure	0010	0.5693	$33.79	$9.63	$6.76
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
97010	A		Hot or cold packs therapy					
97012	A		Mechanical traction therapy					
97014	E		Electric stimulation therapy					
97016	A		Vasopneumatic device therapy					
97018	A		Paraffin bath therapy					
97020	A		Microwave therapy					
97022	A		Whirlpool therapy					
97024	A		Diathermy treatment					
97026	A		Infrared therapy					
97028	A		Ultraviolet therapy					
97032	A		Electrical stimulation					
97033	A		Electric current therapy					
97034	A		Contrast bath therapy					
97035	A		Ultrasound therapy					
97036	A		Hydrotherapy					
97039	A		Physical therapy treatment					
97110	A		Therapeutic exercises					
97112	A		Neuromuscular reeducation					
97113	A		Aquatic therapy/exercises					
97116	A		Gait training therapy					
97124	A		Massage therapy					
97139	A		Physical medicine procedure					
97140	A		Manual therapy					
97150	A		Group therapeutic procedures					
97504	A		Orthotic training					
97520	A		Prosthetic training					
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					
97597	A		Active wound care/20 cm or <					
97598	A		Active wound care > 20 cm					
97602	A		Wound(s) care non-selective					
97605	A		Neg press wound tx, < 50 cm					
97606	A		Neg press wound tx, > 50 cm					
97703	A		Prosthetic checkout					
97750	A		Physical performance test					
97755	A		Assistive technology assess					
97799	A		Physical medicine procedure					
97802	A		Medical nutrition, indiv, in					
97803	A		Med nutrition, indiv, subseq					
97804	A		Medical nutrition, group					
97810	E		Acupunct w/o stimul 15 min					
97811	E		Acupunct w/o stimul addl 15m					
97813	E		Acupunct w/stimul 15 min					
97814	E		Acupunct w/stimul addl 15m					
98925	S		Osteopathic manipulation	0060	0.4913	$29.16		$5.83
98926	S		Osteopathic manipulation	0060	0.4913	$29.16		$5.83
98927	S		Osteopathic manipulation	0060	0.4913	$29.16		$5.83
98928	S		Osteopathic manipulation	0060	0.4913	$29.16		$5.83
98929	S		Osteopathic manipulation	0060	0.4913	$29.16		$5.83
98940	S		Chiropractic manipulation	0060	0.4913	$29.16		$5.83
98941	S		Chiropractic manipulation	0060	0.4913	$29.16		$5.83
98942	S		Chiropractic manipulation	0060	0.4913	$29.16		$5.83
98943	E		Chiropractic manipulation					
99000	B		Specimen handling					
99001	B		Specimen handling					
99002	B		Device handling					
99024	B		Postop follow-up visit					
99026	E		In-hospital on call service					
99027	E		Out-of-hosp on call service					
99050	B		Medical services after hrs					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99052	B		Medical services at night					
99054	B		Medical servcs, unusual hrs					
99056	B		Non-office medical services					
99058	B		Office emergency care					
99070	B		Special supplies					
99071	B		Patient education materials					
99075	E		Medical testimony					
99078	N		Group health education					
99080	B		Special reports or forms					
99082	B		Unusual physician travel					
99090	B		Computer data analysis					
99091	E		Collect/review data from pt					
99100	B		Special anesthesia service					
99116	B		Anesthesia with hypothermia					
99135	B		Special anesthesia procedure					
99140	B		Emergency anesthesia					
99141	N		Sedation, iv/im or inhalant					
99142	N		Sedation, oral/rectal/nasal					
99170	T		Anogenital exam, child	0191	0.1663	$9.87	$2.77	$1.97
99172	E		Ocular function screen					
99173	E		Visual acuity screen					
99175	N		Induction of vomiting					
99183	B		Hyperbaric oxygen therapy					
99185	N		Regional hypothermia					
99186	N		Total body hypothermia					
99190	C		Special pump services					
99191	C		Special pump services					
99192	C		Special pump services					
99195	X		Phlebotomy	0372	0.5675	$33.68	$10.09	$6.74
99199	B		Special service/proc/report					
99201	V		Office/outpatient visit, new	0600	0.8649	$51.33		$10.27
99202	V		Office/outpatient visit, new	0600	0.8649	$51.33		$10.27
99203	V		Office/outpatient visit, new	0601	0.9992	$59.30		$11.86
99204	V		Office/outpatient visit, new	0602	1.4220	$84.40		$16.88
99205	V		Office/outpatient visit, new	0602	1.4220	$84.40		$16.88
99211	V		Office/outpatient visit, est	0600	0.8649	$51.33		$10.27
99212	V		Office/outpatient visit, est	0600	0.8649	$51.33		$10.27
99213	V		Office/outpatient visit, est	0601	0.9992	$59.30		$11.86
99214	V		Office/outpatient visit, est	0602	1.4220	$84.40		$16.88
99215	V		Office/outpatient visit, est	0602	1.4220	$84.40		$16.88
99217	B		Observation care discharge					
99218	B		Observation care					
99219	B		Observation care					
99220	B		Observation care					
99221	E		Initial hospital care					
99222	E		Initial hospital care					
99223	E		Initial hospital care					
99231	E		Subsequent hospital care					
99232	E		Subsequent hospital care					
99233	E		Subsequent hospital care					
99234	B		Observ/hosp same date					
99235	B		Observ/hosp same date					
99236	B		Observ/hosp same date					
99238	E		Hospital discharge day					
99239	E		Hospital discharge day					
99241	V		Office consultation	0600	0.8649	$51.33		$10.27
99242	V		Office consultation	0600	0.8649	$51.33		$10.27
99243	V		Office consultation	0601	0.9992	$59.30		$11.86
99244	V		Office consultation	0602	1.4220	$84.40		$16.88
99245	V		Office consultation	0602	1.4220	$84.40		$16.88
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
99262	C		Follow-up inpatient consult					
99263	C		Follow-up inpatient consult					
99271	V		Confirmatory consultation	0600	0.8649	$51.33		$10.27
99272	V		Confirmatory consultation	0600	0.8649	$51.33		$10.27
99273	V		Confirmatory consultation	0601	0.9992	$59.30		$11.86
99274	V		Confirmatory consultation	0602	1.4220	$84.40		$16.88
99275	V		Confirmatory consultation	0602	1.4220	$84.40		$16.88
99281	V		Emergency dept visit	0610	1.2889	$76.50	$19.40	$15.30
99282	V		Emergency dept visit	0610	1.2889	$76.50	$19.40	$15.30
99283	V		Emergency dept visit	0611	2.2615	$134.22	$35.60	$26.84
99284	V		Emergency dept visit	0612	3.9673	$235.46	$54.12	$47.09
99285	V		Emergency dept visit	0612	3.9673	$235.46	$54.12	$47.09
99288	B		Direct advanced life support					
99289	N		Pt transport, 30-74 min					
99290	N		Pt transport, addl 30 min					
99291	S		Critical care, first hour	0620	8.2620	$490.35	$135.08	$98.07
99292	N		Critical care, add'l 30 min					
99293	C		Ped critical care, initial					
99294	C		Ped critical care, subseq					
99295	C		Neonatal critical care					
99296	C		Neonatal critical care					
99298	C		Neonatal critical care					
99299	C		Ic, lbw infant 1500-2500 gm					
99301	B		Nursing facility care					
99302	B		Nursing facility care					
99303	B		Nursing facility care					
99311	B		Nursing fac care, subseq					
99312	B		Nursing fac care, subseq					
99313	B		Nursing fac care, subseq					
99315	B		Nursing fac discharge day					
99316	B		Nursing fac discharge day					
99321	B		Rest home visit, new patient					
99322	B		Rest home visit, new patient					
99323	B		Rest home visit, new patient					
99331	B		Rest home visit, est pat					
99332	B		Rest home visit, est pat					
99333	B		Rest home visit, est pat					
99341	B		Home visit, new patient					
99342	B		Home visit, new patient					
99343	B		Home visit, new patient					
99344	B		Home visit, new patient					
99345	B		Home visit, new patient					
99347	B		Home visit, est patient					
99348	B		Home visit, est patient					
99349	B		Home visit, est patient					
99350	B		Home visit, est patient					
99354	N		Prolonged service, office					
99355	N		Prolonged service, office					
99356	C		Prolonged service, inpatient					
99357	C		Prolonged service, inpatient					
99358	N		Prolonged serv, w/o contact					
99359	N		Prolonged serv, w/o contact					
99360	B		Physician standby services					
99361	E		Physician/team conference					
99362	E		Physician/team conference					
99371	B		Physician phone consultation					
99372	B		Physician phone consultation					
99373	B		Physician phone consultation					
99374	B		Home health care supervision					
99375	E		Home health care supervision					
99377	B		Hospice care supervision					
99378	E		Hospice care supervision					
99379	B		Nursing fac care supervision					
99380	B		Nursing fac care supervision					
99381	E		Prev visit, new, infant					
99382	E		Prev visit, new, age 1-4					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	0.8649	$51.33		$10.27
99432	N		Newborn care, not in hosp					
99433	C		Normal newborn care/hospital					
99435	E		Newborn discharge day hosp					
99436	N		Attendance, birth					
99440	S		Newborn resuscitation	0094	2.5248	$149.85	$47.41	$29.97
99450	E		Life/disability evaluation					
99455	B		Disability examination					
99456	B		Disability examination					
99499	B		Unlisted e&m service					
99500	E		Home visit, prenatal					
99501	E		Home visit, postnatal					
99502	E		Home visit, nb care					
99503	E		Home visit, resp therapy					
99504	E		Home visit mech ventilator					
99505	E		Home visit, stoma care					
99506	E		Home visit, im injection					
99507	E		Home visit, cath maintain					
99509	E		Home visit day life activity					
99510	E		Home visit, sing/m/fam couns					
99511	E		Home visit, fecal/enema mgmt					
99512	E		Home visit for hemodialysis					
99600	E		Home visit nos					
99601	E		Home infusion/visit, 2 hrs					
99602	E		Home infusion, each addtl hr					
A0021	E		Outside state ambulance serv					
A0080	E		Noninterest escort in non er					
A0090	E		Interest escort in non er					
A0100	E		Nonemergency transport taxi					
A0110	E		Nonemergency transport bus					
A0120	E		Noner transport mini-bus					
A0130	E		Noner transport wheelch van					
A0140	E		Nonemergency transport air					
A0160	E		Noner transport case worker					
A0170	E		Noner transport parking fees					
A0180	E		Noner transport lodgng recip					
A0190	E		Noner transport meals recip					
A0200	E		Noner transport lodgng escrt					
A0210	E		Noner transport meals escort					
A0225	A		Neonatal emergency transport					
A0380	A		Basic life support mileage					
A0382	A		Basic support routine suppls					
A0384	A		Bls defibrillation supplies					
A0390	A		Advanced life support mileag					
A0392	A		Als defibrillation supplies					
A0394	A		Als IV drug therapy supplies					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A0396	A		Als esophageal intub suppls					
A0398	A		Als routine disposble suppls					
A0420	A		Ambulance waiting 1/2 hr					
A0422	A		Ambulance 02 life sustaining					
A0424	A		Extra ambulance attendant					
A0425	A		Ground mileage					
A0426	A		Als 1					
A0427	A		ALS1-emergency					
A0428	A		bls					
A0429	A		BLS-emergency					
A0430	A		Fixed wing air transport					
A0431	A		Rotary wing air transport					
A0432	A		PI volunteer ambulance co					
A0433	A		als 2					
A0434	A		Specialty care transport					
A0435	A		Fixed wing air mileage					
A0436	A		Rotary wing air mileage					
A0800	B		Amb trans 7pm-7am					
A0888	E		Noncovered ambulance mileage					
A0999	A		Unlisted ambulance service					
A4206	E		1 CC sterile syringe&needle					
A4207	E		2 CC sterile syringe&needle					
A4208	E		3 CC sterile syringe&needle					
A4209	E		5+ CC sterile syringe&needle					
A4210	E		Nonneedle injection device					
A4211	B		Supp for self-adm injections					
A4212	B		Non coring needle or stylet					
A4213	E		20+ CC syringe only					
A4215	E		Sterile needle					
A4216	A		Sterile water/saline, 10 ml					
A4217	A		Sterile water/saline, 500 ml					
A4220	N		Infusion pump refill kit					
A4221	Y		Maint drug infus cath per wk					
A4222	Y		Drug infusion pump supplies					
A4223	E		Infusion supplies w/o pump					
A4230	Y		Infus insulin pump non needl					
A4231	Y		Infusion insulin pump needle					
A4232	Y		Syringe w/needle insulin 3cc					
A4244	E		Alcohol or peroxide per pint					
A4245	E		Alcohol wipes per box					
A4246	E		Betadine/phisohex solution					
A4247	E		Betadine/iodine swabs/wipes					
A4248	N		Chlorhexidine antisept					
A4250	E		Urine reagent strips/tablets					
A4253	Y		Blood glucose/reagent strips					
A4254	Y		Battery for glucose monitor					
A4255	Y		Glucose monitor platforms					
A4256	Y		Calibrator solution/chips					
A4257	Y		Replace Lensshield Cartridge					
A4258	Y		Lancet device each					
A4259	Y		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	Y		Paraffin					
A4266	E		Diaphragm					
A4267	E		Male condom					
A4268	E		Female condom					
A4269	E		Spermicide					
A4270	A		Disposable endoscope sheath					
A4280	A		Brst prsths adhsv attchmnt					
A4281	E		Replacement breastpump tube					
A4282	E		Replacement breastpump adpt					
A4283	E		Replacement breastpump cap					
A4284	E		Replcmnt breast pump shield					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4285	E		Replcmnt breast pump bottle					
A4286	E		Replcmnt breastpump lok ring					
A4290	B		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					
A4320	A		Irrigation tray					
A4321	A		Cath therapeutic irrig agent					
A4322	A		Irrigation syringe					
A4326	A		Male external catheter					
A4327	A		Fem urinary collect dev cup					
A4328	A		Fem urinary collect pouch					
A4330	A		Stool collection pouch					
A4331	A		Extension drainage tubing					
A4332	A		Lubricant for cath insertion					
A4333	A		Urinary cath anchor device					
A4334	A		Urinary cath leg strap					
A4335	A		Incontinence supply					
A4338	A		Indwelling catheter latex					
A4340	A		Indwelling catheter special					
A4344	A		Cath indw foley 2 way silicn					
A4346	A		Cath indw foley 3 way					
A4348	A		Male ext cath extended wear					
A4349	A		Disposable male external cat					
A4351	A		Straight tip urine catheter					
A4352	A		Coude tip urinary catheter					
A4353	A		Intermittent urinary cath					
A4354	A		Cath insertion tray w/bag					
A4355	A		Bladder irrigation tubing					
A4356	A		Ext ureth clmp or compr dvc					
A4357	A		Bedside drainage bag					
A4358	A		Urinary leg or abdomen bag					
A4359	A		Urinary suspensory w/o leg b					
A4361	A		Ostomy face plate					
A4362	A		Solid skin barrier					
A4364	A		Adhesive, liquid or equal					
A4365	A		Adhesive remover wipes					
A4366	A		Ostomy vent					
A4367	A		Ostomy belt					
A4368	A		Ostomy filter					
A4369	A		Skin barrier liquid per oz					
A4371	A		Skin barrier powder per oz					
A4372	A		Skin barrier solid 4x4 equiv					
A4373	A		Skin barrier with flange					
A4375	A		Drainable plastic pch w fcpl					
A4376	A		Drainable rubber pch w fcplt					
A4377	A		Drainable plstic pch w/o fp					
A4378	A		Drainable rubber pch w/o fp					
A4379	A		Urinary plastic pouch w fcpl					
A4380	A		Urinary rubber pouch w fcplt					
A4381	A		Urinary plastic pouch w/o fp					
A4382	A		Urinary hvy plstc pch w/o fp					
A4383	A		Urinary rubber pouch w/o fp					
A4384	A		Ostomy faceplt/silicone ring					
A4385	A		Ost skn barrier sld ext wear					
A4387	A		Ost clsd pouch w att st barr					
A4388	A		Drainable pch w ex wear barr					
A4389	A		Drainable pch w st wear barr					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4390	A		Drainable pch ex wear convex					
A4391	A		Urinary pouch w ex wear barr					
A4392	A		Urinary pouch w st wear barr					
A4393	A		Urine pch w ex wear bar conv					
A4394	A		Ostomy pouch liq deodorant					
A4395	A		Ostomy pouch solid deodorant					
A4396	A		Peristomal hernia supprt blt					
A4397	A		Irrigation supply sleeve					
A4398	A		Ostomy irrigation bag					
A4399	A		Ostomy irrig cone/cath w brs					
A4400	A		Ostomy irrigation set					
A4402	A		Lubricant per ounce					
A4404	A		Ostomy ring each					
A4405	A		Nonpectin based ostomy paste					
A4406	A		Pectin based ostomy paste					
A4407	A		Ext wear ost skn barr <=4sq″					
A4408	A		Ext wear ost skn barr >4sq″					
A4409	A		Ost skn barr w flng <=4 sq″					
A4410	A		Ost skn barr w flng >4sq″					
A4413	A		2 pc drainable ost pouch					
A4414	A		Ostomy sknbarr w flng <=4sq″					
A4415	A		Ostomy skn barr w flng >4sq″					
A4416	A		Ost pch clsd w barrier/filtr					
A4417	A		Ost pch w bar/bltinconv/fltr					
A4418	A		Ost pch clsd w/o bar w filtr					
A4419	A		Ost pch for bar w flange/flt					
A4420	A		Ost pch clsd for bar w lk fl					
A4421	E		Ostomy supply misc					
A4422	A		Ost pouch absorbent material					
A4423	A		Ost pch for bar w lk fl/fltr					
A4424	A		Ost pch drain w bar & filter					
A4425	A		Ost pch drain for barrier fl					
A4426	A		Ost pch drain 2 piece system					
A4427	A		Ost pch drain/barr lk flng/f					
A4428	A		Urine ost pouch w faucet/tap					
A4429	A		Urine ost pch bar w lock fln					
A4430	A		Ost pch urine w lock flng/ft					
A4431	A		Urine ost pch bar w lock fln					
A4432	A		Ost pch urine w lock flng/ft					
A4433	A		Urine ost pch bar w lock fln					
A4434	A		Ost pch urine w lock flng/ft					
A4450	A		Non-waterproof tape					
A4452	A		Waterproof tape					
A4455	A		Adhesive remover per ounce					
A4458	E		Reusable enema bag					
A4462	A		Abdmnl drssng holder/binder					
A4465	A		Non-elastic extremity binder					
A4470	A		Gravlee jet washer					
A4480	A		Vabra aspirator					
A4481	A		Tracheostoma filter					
A4483	A		Moisture exchanger					
A4490	E		Above knee surgical stocking					
A4495	E		Thigh length surg stocking					
A4500	E		Below knee surgical stocking					
A4510	E		Full length surg stocking					
A4520	E		Incontinence garment anytype					
A4550	B		Surgical trays					
A4554	E		Disposable underpads					
A4555	E		Disposable underpad small					
A4556	Y		Electrodes, pair					
A4557	Y		Lead wires, pair					
A4558	Y		Conductive paste or gel					
A4561	N		Pessary rubber, any type					
A4562	N		Pessary, non rubber,any type					
A4565	A		Slings					
A4570	E		Splint					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4575	E		Hyperbaric o2 chamber disps					
A4580	E		Cast supplies (plaster)					
A4590	E		Special casting material					
A4595	Y		TENS suppl 2 lead per month					
A4605	Y		Trach suction cath close sys					
A4606	A		Oxygen probe used w oximeter					
A4608	Y		Transtracheal oxygen cath					
A4611	Y		Heavy duty battery					
A4612	Y		Battery cables					
A4613	Y		Battery charger					
A4614	A		Hand-held PEFR meter					
A4615	Y		Cannula nasal					
A4616	Y		Tubing (oxygen) per foot					
A4617	Y		Mouth piece					
A4618	Y		Breathing circuits					
A4619	Y		Face tent					
A4620	Y		Variable concentration mask					
A4623	A		Tracheostomy inner cannula					
A4624	Y		Tracheal suction tube					
A4625	A		Trach care kit for new trach					
A4626	A		Tracheostomy cleaning brush					
A4627	E		Spacer bag/reservoir					
A4628	Y		Oropharyngeal suction cath					
A4629	A		Tracheostomy care kit					
A4630	Y		Repl bat t.e.n.s. own by pt					
A4632	Y		Infus pump rplcemnt battery					
A4633	Y		Uvl replacement bulb					
A4634	A		Replacement bulb th lightbox					
A4635	Y		Underarm crutch pad					
A4636	Y		Handgrip for cane etc					
A4637	Y		Repl tip cane/crutch/walker					
A4638	Y		Repl batt pulse gen sys					
A4639	Y		Infrared ht sys replcmnt pad					
A4640	Y		Alternating pressure pad					
A4641	N		Diagnostic imaging agent					
A4642	H		Satumomab pendetide per dose	0704				
A4643	B		High dose contrast MRI					
A4644	B		Contrast 100-199 MGs iodine					
A4645	B		Contrast 200-299 MGs iodine					
A4646	B		Contrast 300-399 MGs iodine					
A4647	B		Supp- paramagnetic contr mat					
A4649	A		Surgical supplies					
A4651	A		Calibrated microcap tube					
A4652	A		Microcapillary tube sealant					
A4653	A		PD catheter anchor belt					
A4656	A		Dialysis needle					
A4657	A		Dialysis syringe w/wo needle					
A4660	A		Sphyg/bp app w cuff and stet					
A4663	A		Dialysis blood pressure cuff					
A4670	E		Automatic bp monitor, dial					
A4671	B		Disposable cycler set					
A4672	B		Drainage ext line, dialysis					
A4673	B		Ext line w easy lock connect					
A4674	B		Chem/antisept solution, 8oz					
A4680	A		Activated carbon filter, ea					
A4690	A		Dialyzer, each					
A4706	A		Bicarbonate conc sol per gal					
A4707	A		Bicarbonate conc pow per pac					
A4708	A		Acetate conc sol per gallon					
A4709	A		Acid conc sol per gallon					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A4724	A		Dialys sol fld vol > 3999cc					
A4725	A		Dialys sol fld vol > 4999cc					
A4726	A		Dialys sol fld vol > 5999cc					
A4728	B		Dialysate solution, non-dex					
A4730	A		Fistula cannulation set, ea					
A4736	A		Topical anesthetic, per gram					
A4737	A		Inj anesthetic per 10 ml					
A4740	A		Shunt accessory					
A4750	A		Art or venous blood tubing					
A4755	A		Comb art/venous blood tubing					
A4760	A		Dialysate sol test kit, each					
A4765	A		Dialysate conc pow per pack					
A4766	A		Dialysate conc sol add 10 ml					
A4770	A		Blood collection tube/vacuum					
A4771	A		Serum clotting time tube					
A4772	A		Blood glucose test strips					
A4773	A		Occult blood test strips					
A4774	A		Ammonia test strips					
A4802	A		Protamine sulfate per 50 mg					
A4860	A		Disposable catheter tips					
A4870	A		Plumb/elec wk hm hemo equip					
A4890	A		Repair/maint cont hemo equip					
A4911	A		Drain bag/bottle					
A4913	A		Misc dialysis supplies noc					
A4918	A		Venous pressure clamp					
A4927	A		Non-sterile gloves					
A4928	A		Surgical mask					
A4929	A		Tourniquet for dialysis, ea					
A4930	A		Sterile, gloves per pair					
A4931	A		Reusable oral thermometer					
A4932	E		Reusable rectal thermometer					
A5051	A		Pouch clsd w barr attached					
A5052	A		Clsd ostomy pouch w/o barr					
A5053	A		Clsd ostomy pouch faceplate					
A5054	A		Clsd ostomy pouch w/flange					
A5055	A		Stoma cap					
A5061	A		Pouch drainable w barrier at					
A5062	A		Drnble ostomy pouch w/o barr					
A5063	A		Drain ostomy pouch w/flange					
A5071	A		Urinary pouch w/barrier					
A5072	A		Urinary pouch w/o barrier					
A5073	A		Urinary pouch on barr w/flng					
A5081	A		Continent stoma plug					
A5082	A		Continent stoma catheter					
A5093	A		Ostomy accessory convex inse					
A5102	A		Bedside drain btl w/wo tube					
A5105	A		Urinary suspensory					
A5112	A		Urinary leg bag					
A5113	A		Latex leg strap					
A5114	A		Foam/fabric leg strap					
A5119	A		Skin barrier wipes box pr 50					
A5121	A		Solid skin barrier 6x6					
A5122	A		Solid skin barrier 8x8					
A5126	A		Disk/foam pad +or- adhesive					
A5131	A		Appliance cleaner					
A5200	A		Percutaneous catheter anchor					
A5500	Y		Diab shoe for density insert					
A5501	Y		Diabetic custom molded shoe					
A5503	Y		Diabetic shoe w/roller/rockr					
A5504	Y		Diabetic shoe with wedge					
A5505	Y		Diab shoe w/metatarsal bar					
A5506	Y		Diabetic shoe w/off set heel					
A5507	Y		Modification diabetic shoe					
A5508	Y		Diabetic deluxe shoe					
A5509	E		Direct heat form shoe insert					
A5510	E		Compression form shoe insert					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A5511	E		Custom fab molded shoe inser					
A6000	E		Wound warming wound cover					
A6010	A		Collagen based wound filler					
A6011	A		Collagen gel/paste wound fil					
A6021	A		Collagen dressing <=16 sq in					
A6022	A		Collagen drsg>6<=48 sq in					
A6023	A		Collagen dressing >48 sq in					
A6024	A		Collagen dsg wound filler					
A6025	E		Silicone gel sheet, each					
A6154	A		Wound pouch each					
A6196	A		Alginate dressing <=16 sq in					
A6197	A		Alginate drsg >16 <=48 sq in					
A6198	A		alginate dressing > 48 sq in					
A6199	A		Alginate drsg wound filler					
A6200	A		Compos drsg <=16 no border					
A6201	A		Compos drsg >16<=48 no bdr					
A6202	A		Compos drsg >48 no border					
A6203	A		Composite drsg <= 16 sq in					
A6204	A		Composite drsg >16<=48 sq in					
A6205	A		Composite drsg > 48 sq in					
A6206	A		Contact layer <= 16 sq in					
A6207	A		Contact layer >16<= 48 sq in					
A6208	A		Contact layer > 48 sq in					
A6209	A		Foam drsg <=16 sq in w/o bdr					
A6210	A		Foam drg >16<=48 sq in w/o b					
A6211	A		Foam drg > 48 sq in w/o brdr					
A6212	A		Foam drg <=16 sq in w/border					
A6213	A		Foam drg >16<=48 sq in w/bdr					
A6214	A		Foam drg > 48 sq in w/border					
A6215	A		Foam dressing wound filler					
A6216	A		Non-sterile gauze<=16 sq in					
A6217	A		Non-sterile gauze>16<=48 sq					
A6218	A		Non-sterile gauze > 48 sq in					
A6219	A		Gauze <= 16 sq in w/border					
A6220	A		Gauze >16 <=48 sq in w/bordr					
A6221	A		Gauze > 48 sq in w/border					
A6222	A		Gauze <=16 in no w/sal w/o b					
A6223	A		Gauze >16<=48 no w/sal w/o b					
A6224	A		Gauze > 48 in no w/sal w/o b					
A6228	A		Gauze <= 16 sq in water/sal					
A6229	A		Gauze >16<=48 sq in watr/sal					
A6230	A		Gauze > 48 sq in water/salne					
A6231	A		Hydrogel dsg<=16 sq in					
A6232	A		Hydrogel dsg>16<=48 sq in					
A6233	A		Hydrogel dressing >48 sq in					
A6234	A		Hydrocolld drg <=16 w/o bdr					
A6235	A		Hydrocolld drg >16<=48 w/o b					
A6236	A		Hydrocolld drg > 48 in w/o b					
A6237	A		Hydrocolld drg <=16 in w/bdr					
A6238	A		Hydrocolld drg >16<=48 w/bdr					
A6239	A		Hydrocolld drg > 48 in w/bdr					
A6240	A		Hydrocolld drg filler paste					
A6241	A		Hydrocolloid drg filler dry					
A6242	A		Hydrogel drg <=16 in w/o bdr					
A6243	A		Hydrogel drg >16<=48 w/o bdr					
A6244	A		Hydrogel drg >48 in w/o bdr					
A6245	A		Hydrogel drg <= 16 in w/bdr					
A6246	A		Hydrogel drg >16<=48 in w/b					
A6247	A		Hydrogel drg > 48 sq in w/b					
A6248	A		Hydrogel drsg gel filler					
A6250	A		Skin seal protect moisturizr					
A6251	A		Absorpt drg <=16 sq in w/o b					
A6252	A		Absorpt drg >16 <=48 w/o bdr					
A6253	A		Absorpt drg > 48 sq in w/o b					
A6254	A		Absorpt drg <=16 sq in w/bdr					
A6255	A		Absorpt drg >16<=48 in w/bdr					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
A6266	A		Impreg gauze no h20/sal/yard					
A6402	A		Sterile gauze <= 16 sq in					
A6403	A		Sterile gauze>16 <= 48 sq in					
A6404	A		Sterile gauze > 48 sq in					
A6407	A		Packing strips, non-impreg					
A6410	A		Sterile eye pad					
A6411	A		Non-sterile eye pad					
A6412	E		Occlusive eye patch					
A6441	A		Pad band w>=3″ <5″/yd					
A6442	A		Conform band n/s w<3″/yd					
A6443	A		Conform band n/s w>=3″<5″/yd					
A6444	A		Conform band n/s w>=5″/yd					
A6445	A		Conform band s w <3″/yd					
A6446	A		Conform band s w>=3″ <5″/yd					
A6447	A		Conform band s w >=5″/yd					
A6448	A		Lt compres band <3″/yd					
A6449	A		Lt compres band >=3″ <5″/yd					
A6450	A		Lt compres band >=5″/yd					
A6451	A		Mod compres band w>=3″<5″/yd					
A6452	A		High compres band w>=3″<5″yd					
A6453	A		Self-adher band w <3″/yd					
A6454	A		Self-adher band w>=3″ <5″/yd					
A6455	A		Self-adher band >=5″/yd					
A6456	A		Zinc paste band w >=3″<5″/yd					
A6501	A		Compres burngarment bodysuit					
A6502	A		Compres burngarment chinstrp					
A6503	A		Compres burngarment facehood					
A6504	A		Cmprsburngarment glove-wrist					
A6505	A		Cmprsburngarment glove-elbow					
A6506	A		Cmprsburngrmnt glove-axilla					
A6507	A		Cmprs burngarment foot-knee					
A6508	A		Cmprs burngarment foot-thigh					
A6509	A		Compres burn garment jacket					
A6510	A		Compres burn garment leotard					
A6511	A		Compres burn garment panty					
A6512	A		Compres burn garment, noc					
A6550	Y		Neg pres wound ther drsg set					
A6551	Y		Neg press wound ther canistr					
A7000	Y		Disposable canister for pump					
A7001	Y		Nondisposable pump canister					
A7002	Y		Tubing used w suction pump					
A7003	Y		Nebulizer administration set					
A7004	Y		Disposable nebulizer sml vol					
A7005	Y		Nondisposable nebulizer set					
A7006	Y		Filtered nebulizer admin set					
A7007	Y		Lg vol nebulizer disposable					
A7008	Y		Disposable nebulizer prefill					
A7009	Y		Nebulizer reservoir bottle					
A7010	Y		Disposable corrugated tubing					
A7011	Y		Nondispos corrugated tubing					
A7012	Y		Nebulizer water collec devic					
A7013	Y		Disposable compressor filter					
A7014	Y		Compressor nondispos filter					
A7015	Y		Aerosol mask used w nebulize					
A7016	Y		Nebulizer dome & mouthpiece					
A7017	Y		Nebulizer not used w oxygen					
A7018	Y		Water distilled w/nebulizer					
A7025	Y		Replace chest compress vest					
A7026	Y		Replace chst cmprss sys hose					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A7030	Y		CPAP full face mask					
A7031	Y		Replacement facemask interfa					
A7032	Y		Replacement nasal cushion					
A7033	Y		Replacement nasal pillows					
A7034	Y		Nasal application device					
A7035	Y		Pos airway press headgear					
A7036	Y		Pos airway press chinstrap					
A7037	Y		Pos airway pressure tubing					
A7038	Y		Pos airway pressure filter					
A7039	Y		Filter, non disposable w pap					
A7040	A		One way chest drain valve					
A7041	A		Water seal drain container					
A7042	A		Implanted pleural catheter					
A7043	A		Vacuum drainagebottle/tubing					
A7044	Y		PAP oral interface					
A7045	Y		Repl exhalation port for PAP					
A7046	Y		Repl water chamber, PAP dev					
A7501	A		Tracheostoma valve w diaphra					
A7502	A		Replacement diaphragm/fplate					
A7503	A		HMES filter holder or cap					
A7504	A		Tracheostoma HMES filter					
A7505	A		HMES or trach valve housing					
A7506	A		HMES/trachvalve adhesivedisk					
A7507	A		Integrated filter & holder					
A7508	A		Housing & Integrated Adhesiv					
A7509	A		Heat & moisture exchange sys					
A7520	A		Trach/laryn tube non-cuffed					
A7521	A		Trach/laryn tube cuffed					
A7522	A		Trach/laryn tube stainless					
A7523	A		Tracheostomy shower protect					
A7524	A		Tracheostoma stent/stud/bttn					
A7525	A		Tracheostomy mask					
A7526	A		Tracheostomy tube collar					
A7527	A		Trach/laryn tube plug/stop					
A9150	B		Misc/exper non-prescript dru					
A9152	E		Single vitamin nos					
A9153	E		Multi-vitamin nos					
A9180	E		Lice treatment, topical					
A9270	E		Non-covered item or service					
A9280	E		Alert device, noc					
A9300	E		Exercise equipment					
A9500	H		Technetium TC 99m sestamibi	1600				
A9502	H		Technetium TC99M tetrofosmin	0705				
A9503	N		Technetium TC 99m medronate					
A9504	N		Technetium tc 99m apcitide					
A9505	H		Thallous chloride TL 201/mci	1603				
A9507	H		Indium/111 capromab pendetid	1604				
A9508	H		Iobenguane sulfate I-131, pe	1045				
A9510	H		Technetium TC99m Disofenin	9146				
A9511	H		Technetium TC 99m depreotide	9147				
A9512	N		Technetiumtc99mpertechnetate					
A9513	N		Technetium tc-99m mebrofenin					
A9514	N		Technetiumtc99mpyrophosphate					
A9515	N		Technetium tc-99m pentetate					
A9516	H		I-123 sodium iodide capsule	9148				
A9517	H		Th I131 so iodide cap millic	1064				
A9519	N		Technetiumtc-99mmacroag albu					
A9520	N		Technetiumtc-99m sulfur clld					
A9521	H		Technetiumtc-99m exametazine	1096				
A9522	B		Indium111ibritumomabtiuxetan					
A9523	B		Yttrium90ibritumomabtiuxetan					
A9524	H		Iodinated I-131 serumalbumin	9100				
A9525	E		Low/iso-osmolar contrast mat					
A9526	H		Ammonia N-13, per dose	0737				
A9528	H		Dx I131 so iodide cap millic	1088				
A9529	H		Dx I131 so iodide sol millic	1065				

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
A9530	H		Th I131 so iodide sol millic	1150				
A9531	H		Dx I131 so iodide microcurie	9149				
A9532	H		I-125 serum albumin micro	9150				
A9533	B		I-131 tositumomab diagnostic					
A9534	B		I-131 tositumomab therapeut					
A9600	H		Strontium-89 chloride	0701				
A9605	H		Samarium sm153 lexidronamm	0702				
A9699	N		Noc therapeutic radiopharm					
A9700	B		Echocardiography Contrast					
A9900	A		Supply/accessory/service					
A9901	A		Delivery/set up/dispensing					
A9999	Y		DME supply or accessory, nos					
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		Food thickener oral					
B4102	Y		EF adult fluids and electro					
B4103	Y		EF ped fluid and electrolyte					
B4104	E		Additive for enteral formula					
B4149	Y		EF blenderized foods					
B4150	A		Enteral formulae category i					
B4152	A		Enteral formulae category ii					
B4153	A		Enteral formulae categoryIII					
B4154	A		Enteral formulae category IV					
B4155	A		Enteral formulae category v					
B4157	Y		EF special metabolic inherit					
B4158	Y		EF ped complete intact nut					
B4159	Y		EF ped complete soy based					
B4160	Y		EF ped calorie dense>/=0.7kc					
B4161	Y		EF ped hydrolyzed/amino acid					
B4162	Y		EF ped specmetabolic inherit					
B4164	A		Parenteral 50% dextrose solu					
B4168	A		Parenteral sol amino acid 3.					
B4172	A		Parenteral sol amino acid 5.					
B4176	A		Parenteral sol amino acid 7-					
B4178	A		Parenteral sol amino acid >					
B4180	A		Parenteral sol carb > 50%					
B4184	A		Parenteral sol lipids 10%					
B4186	A		Parenteral sol lipids 20%					
B4189	A		Parenteral sol amino acid &					
B4193	A		Parenteral sol 52-73 gm prot					
B4197	A		Parenteral sol 74-100 gm pro					
B4199	A		Parenteral sol > 100gm prote					
B4216	A		Parenteral nutrition additiv					
B4220	A		Parenteral supply kit premix					
B4222	A		Parenteral supply kit homemi					
B4224	A		Parenteral administration ki					
B5000	A		Parenteral sol renal-amirosy					
B5100	A		Parenteral sol hepatic-fream					
B5200	A		Parenteral sol stres-brnch c					
B9000	A		Enter infusion pump w/o alrm					
B9002	A		Enteral infusion pump w/ ala					
B9004	A		Parenteral infus pump portab					
B9006	A		Parenteral infus pump statio					
B9998	A		Enteral supp not otherwise c					
B9999	A		Parenteral supp not othrws c					
C1079	N		CO 57/58 per 0.5 uCi					
C1080	H		I-131 tositumomab, dx	1080				
C1081	H		I-131 tositumomab, tx	1081				
C1082	H		In-111 ibritumomab tiuxetan	9118				
C1083	H		Yttrium 90 ibritumomab tiuxe	9117				
C1091	H		IN111 oxyquinoline,per0.5mCi	1091				

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1092	H		IN 111 pentetate per 0.5 mCi	1092				
C1093	H		TC99M fanolesomab	1093				
C1122	H		Tc 99M ARCITUMOMAB PER VIAL	9151				
C1178	K		BUSULFAN IV, 6 Mg	1178	0.2851	$16.92		$3.38
C1200	N		TC 99M Sodium Glucoheptonat					
C1201	H		TC 99M SUCCIMER, PER Vial	1201				
C1300	S		HYPERBARIC Oxygen	0659	1.5403	$91.42		$18.28
C1305	K		Apligraf, 44cm2	1305	12.9206	$766.84		$153.37
C1713	N		Anchor/screw bn/bn,tis/bn					
C1714	N		Cath, trans atherectomy, dir					
C1715	N		Brachytherapy needle					
C1716	H		Brachytx source, Gold 198	1716				
C1717	H		Brachytx source, HDR Ir-192	1717				
C1718	H		Brachytx source, Iodine 125	1718				
C1719	H		Brachytx sour,Non-HDR Ir-192	1719				
C1720	H		Brachytx sour, Palladium 103	1720				
C1721	N		AICD, dual chamber					
C1722	N		AICD, single chamber					
C1724	N		Cath, trans atherec,rotation					
C1725	N		Cath, translumin non-laser					
C1726	N		Cath, bal dil, non-vascular					
C1727	N		Cath, bal tis dis, non-vas					
C1728	N		Cath, brachytx seed adm					
C1729	N		Cath, drainage					
C1730	N		Cath, EP, 19 or few elect					
C1731	N		Cath, EP, 20 or more elec					
C1732	N		Cath, EP, diag/abl, 3D/vect					
C1733	N		Cath, EP, othr than cool-tip					
C1750	N		Cath, hemodialysis,long-term					
C1751	N		Cath, inf, per/cent/midline					
C1752	N		Cath,hemodialysis,short-term					
C1753	N		Cath, intravas ultrasound					
C1754	N		Catheter, intradiscal					
C1755	N		Catheter, intraspinal					
C1756	N		Cath, pacing, transesoph					
C1757	N		Cath, thrombectomy/embolect					
C1758	N		Catheter, ureteral					
C1759	N		Cath, intra echocardiography					
C1760	N		Closure dev, vasc					
C1762	N		Conn tiss, human(inc fascia)					
C1763	N		Conn tiss, non-human					
C1764	N		Event recorder, cardiac					
C1765	N		Adhesion barrier					
C1766	N		Intro/sheath,strble,non-peel					
C1767	N		Generator, neurostim, imp					
C1768	N		Graft, vascular					
C1769	N		Guide wire					
C1770	N		Imaging coil, MR, insertable					
C1771	N		Rep dev, urinary, w/sling					
C1772	N		Infusion pump, programmable					
C1773	N		Ret dev, insertable					
C1775	H		FDG, per dose (4-40 mCi/ml)	1775				
C1776	N		Joint device (implantable)					
C1777	N		Lead, AICD, endo single coil					
C1778	N		Lead, neurostimulator					
C1779	N		Lead, pmkr, transvenous VDD					
C1780	N		Lens, intraocular (new tech)					
C1781	N		Mesh (implantable)					
C1782	N		Morcellator					
C1783	N		Ocular imp, aqueous drain de					
C1784	N		Ocular dev, intraop, det ret					
C1785	N		Pmkr, dual, rate-resp					
C1786	N		Pmkr, single, rate-resp					
C1787	N		Patient progr, neurostim					
C1788	N		Port, indwelling, imp					
C1789	N		Prosthesis, breast, imp					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C1813	N		Prosthesis, penile, inflatab					
C1814	N		Retinal tamp, silicone oil					
C1815	N		Pros, urinary sph, imp					
C1816	N		Receiver/transmitter, neuro					
C1817	N		Septal defect imp sys					
C1818	N		Integrated keratoprosthesis					
C1819	N		Tissue local excision					
C1874	N		Stent, coated/cov w/del sys					
C1875	N		Stent, coated/cov w/o del sy					
C1876	N		Stent, non-coa/non-cov w/del					
C1877	N		Stent, non-coat/cov w/o del					
C1878	N		Matrl for vocal cord					
C1879	N		Tissue marker, implantable					
C1880	N		Vena cava filter					
C1881	N		Dialysis access system					
C1882	N		AICD, other than sing/dual					
C1883	N		Adapt/ext, pacing/neuro lead					
C1884	N		Embolization Protect syst					
C1885	N		Cath, translumin angio laser					
C1887	N		Catheter, guiding					
C1888	N		Endovas non-cardiac abl cath					
C1891	N		Infusion pump,non-prog, perm					
C1892	N		Intro/sheath,fixed,peel-away					
C1893	N		Intro/sheath, fixed,non-peel					
C1894	N		Intro/sheath, non-laser					
C1895	N		Lead, AICD, endo dual coil					
C1896	N		Lead, AICD, non sing/dual					
C1897	N		Lead, neurostim test kit					
C1898	N		Lead, pmkr, other than trans					
C1899	N		Lead, pmkr/AICD combination					
C1900	N		Lead coronary venous					
C2614	N		Probe, perc lumb disc					
C2615	N		Sealant, pulmonary, liquid					
C2616	H		Brachytx source, Yttrium-90	2616				
C2617	N		Stent, non-cor, tem w/o del					
C2618	N		Probe, cryoablation					
C2619	N		Pmkr, dual, non rate-resp					
C2620	N		Pmkr, single, non rate-resp					
C2621	N		Pmkr, other than sing/dual					
C2622	N		Prosthesis, penile, non-inf					
C2625	N		Stent, non-cor, tem w/del sy					
C2626	N		Infusion pump, non-prog,temp					
C2627	N		Cath, suprapubic/cystoscopic					
C2628	N		Catheter, occlusion					
C2629	N		Intro/sheath, laser					
C2630	N		Cath, EP, cool-tip					
C2631	N		Rep dev, urinary, w/o sling					
C2632	H		Brachytx sol, I-125, per mCi	2632				
C2633	H		Brachytx source, Cesium-131	2633				
C2634	H		Brachytx source, HA, I-125	2634				
C2635	H		Brachytx source, HA, P-103	2635				
C2636	H		Brachytx linear source, P-10	2636				
C8900*	S		MRA w/cont, abd	0284	6.3910	$379.31	$151.72	$75.86
C8901*	S		MRA w/o cont, abd	0336	6.0467	$358.87	$143.54	$71.77
C8902*	S		MRA w/o fol w/cont, abd	0337	8.7547	$519.59	$207.83	$103.92
C8903*	S		MRI w/cont, breast, uni	0284	6.3910	$379.31	$151.72	$75.86
C8904*	S		MRI w/o cont, breast, uni	0336	6.0467	$358.87	$143.54	$71.77
C8905*	S		MRI w/o fol w/cont, brst, un	0337	8.7547	$519.59	$207.83	$103.92
C8906*	S		MRI w/cont, breast, bi	0284	6.3910	$379.31	$151.72	$75.86
C8907*	S		MRI w/o cont, breast, bi	0336	6.0467	$358.87	$143.54	$71.77
C8908*	S		MRI w/o fol w/cont, breast,	0337	8.7547	$519.59	$207.83	$103.92
C8909*	S		MRA w/cont, chest	0284	6.3910	$379.31	$151.72	$75.86
C8910*	S		MRA w/o cont, chest	0336	6.0467	$358.87	$143.54	$71.77
C8911*	S		MRA w/o fol w/cont, chest	0337	8.7547	$519.59	$207.83	$103.92
C8912*	S		MRA w/cont, lwr ext	0284	6.3910	$379.31	$151.72	$75.86
C8913*	S		MRA w/o cont, lwr ext	0336	6.0467	$358.87	$143.54	$71.77

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C8914*	S		MRA w/o fol w/cont, lwr ext	0337	8.7547	$519.59	$207.83	$103.92
C8918*	S		MRA w/cont, pelvis	0284	6.3910	$379.31	$151.72	$75.86
C8919*	S		MRA w/o cont, pelvis	0336	6.0467	$358.87	$143.54	$71.77
C8920*	S		MRA w/o fol w/cont, pelvis	0337	8.7547	$519.59	$207.83	$103.92
C9000	H		Na chromateCr51, per 0.25mCi	9130				
C9003	K		Palivizumab, per 50 mg	9003	4.1486	$246.22		$49.24
C9007	K		Baclofen Intrathecal kit-1am	9152	0.8561	$50.81		$10.16
C9008	K		Baclofen Refill Kit-500mcg	9008	0.2447	$14.52		$2.90
C9009	K		Baclofen Refill Kit-2000mcg	9009	0.7208	$42.78		$8.56
C9013	N		Co 57 cobaltous chloride					
C9102	H		51 Na Chromate, 50mCi	9132				
C9103	H		Na Iothalamate I-125, 10 uCi	9153				
C9105	K		Hep B imm glob, per 1 ml	9105	1.8810	$111.64		$22.33
C9112	D		Perflutren lipid micro, 2ml					
C9113	N		Inj pantoprazole sodium, via					
C9121	K		Injection, argatroban	9121	0.1897	$11.26		$2.25
C9123	K		Transcyte, 247cm2	9123		$719.36		$143.87
C9127	K		Paclitaxel protein pr	9127		$8.59		$1.72
C9128	K		Inj pegaptanib sodium	9128		$1,074.18		$214.84
C9200	K		Orcel, 36 cm2	9200	2.6890	$159.59		$31.92
C9201	K		Dermagraft, 37.5cm2	9201	6.2059	$368.32		$73.66
C9202	D		Octafluoropropane					
C9203	D		Perflexane lipid micro					
C9205	K		Oxaliplatin	9205		$84.05		$16.81
C9206	K		Integra, per cm2	9206		$9.23		$1.85
C9211	K		Inj, alefacept, IV	9211		$570.97		$114.19
C9212	K		Inj, alefacept, IM	9212		$401.97		$80.39
C9218	K		Injection, Azacitidine	9218		$4.03		$.81
C9220	G		Sodium hyaluronate	9220		$203.82		$40.76
C9221	G		Graftjacket Reg Matrix	9221		$1,234.26		$246.85
C9222	G		Graftjacket SftTis	9222		$890.67		$178.13
C9223	D		Inj adenosine, tx dx					
C9399	A		Unclass drugs/biologicals					
C9400	D		Thallous chloride, brand					
C9401	D		Strontium-89 chloride, brand					
C9402	D		Th I131 so iodide cap, brand					
C9403	D		Dx I131 so iodide cap, brand					
C9404	D		Dx I131 so iodide sol, brand					
C9405	D		Th I131 so iodide sol, brand					
C9410	D		Dexrazoxane HCl inj, brand					
C9411	D		Pamidronate disodium, brand					
C9413	D		Na hyaluronate bran					
C9414	D		Etoposide oral, brand					
C9415	D		Doxorubic hcl chemo, brand					
C9417	D		Bleomycin sulfate inj, brand					
C9418	D		Cisplatin inj, brand					
C9419	D		Inj cladribine, brand					
C9420	D		Cyclophosphamide inj, brand					
C9421	D		Cyclophosphamide lyo, brand					
C9422	D		Cytarabine hcl inj, brand					
C9423	D		Dacarbazine inj, brand					
C9424	D		Daunorubicin, brand					
C9425	D		Etoposide inj, brand					
C9426	D		Floxuridine inj, brand					
C9427	D		Ifosfomide inj, brand					
C9428	D		Mesna injection, brand					
C9429	D		Idarubicin hcl inj, brand					
C9430	D		Leuprolide acetate bran					
C9431	D		Paclitaxel inj, brand					
C9432	D		Mitomycin inj, brand					
C9433	D		Thiotepa inj, brand					
C9435	D		Gonadorelin hydroch, brand					
C9436	D		Azathioprine parenteral,brnd					
C9437	D		Carmus bischl nitro inj					
C9438	D		Cyclosporine oral, brand					
C9439	D		Diethylstilbestrol injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
C9440	D		Vinorelbine tar,brand					
C9704	T		Inj inert subs upper GI	1556		$1,750.00		$350.00
C9713	T		Non-contact laser vap prosta	0429	42.1231	$2,500.01		$500.00
C9716	S		RF Energy to Anus	1519		$1,750.00		$350.00
C9718	T		Kyphoplasty, first vertebra	0051	36.3617	$2,158.07		$431.61
C9719	T		Kyphoplasty, each addl	0051	36.3617	$2,158.07		$431.61
C9720	T		HE ESW tx, tennis elbow	1547		$850.00		$170.00
C9721	T		HE ESW tx, plantar fasciitis	1547		$850.00		$170.00
C9722	S		KV imaging w/IR tracking	1502		$75.00		$15.00
C9723	S		Dyn IR Perf Img	1502		$75.00		$15.00
C9724	T		EPS gast cardia plic	0422	22.8607	$1,356.78	$448.81	$271.36
D0120	E		Periodic oral evaluation					
D0140	E		Limit oral eval problm focus					
D0150	S		Comprehensve oral evaluation	0330	7.1431	$423.94		$84.79
D0160	E		Extensv oral eval prob focus					
D0170	E		Re-eval,est pt,problem focus					
D0180	E		Comp periodontal evaluation					
D0210	E		Intraor complete film series					
D0220	E		Intraoral periapical first f					
D0230	E		Intraoral periapical ea add					
D0240	S		Intraoral occlusal film	0330	7.1431	$423.94		$84.79
D0250	S		Extraoral first film	0330	7.1431	$423.94		$84.79
D0260	S		Extraoral ea additional film	0330	7.1431	$423.94		$84.79
D0270	S		Dental bitewing single film	0330	7.1431	$423.94		$84.79
D0272	S		Dental bitewings two films	0330	7.1431	$423.94		$84.79
D0274	S		Dental bitewings four films	0330	7.1431	$423.94		$84.79
D0277	S		Vert bitewings-sev to eight	0330	7.1431	$423.94		$84.79
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					
D0416	B		Viral culture					
D0421	B		Gen tst suscept oral disease					
D0425	E		Caries susceptibility test					
D0431	B		Diag tst detect mucos abnorm					
D0460	S		Pulp vitality test	0330	7.1431	$423.94		$84.79
D0470	E		Diagnostic casts					
D0472	B		Gross exam, prep & report					
D0473	B		Micro exam, prep & report					
D0474	B		Micro w exam of surg margins					
D0475	B		Decalcification procedure					
D0476	B		Spec stains for microorganis					
D0477	B		Spec stains not for microorg					
D0478	B		Immunohistochemical stains					
D0479	B		Tissue in-situ hybridization					
D0480	B		Cytopath smear prep & report					
D0481	B		Electron microscopy diagnost					
D0482	B		Direct immunofluorescence					
D0483	B		Indirect immunofluorescence					
D0484	B		Consult slides prep elsewher					
D0485	B		Consult inc prep of slides					
D0502	B		Other oral pathology procedu					
D0999	B		Unspecified diagnostic proce					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D1330	E		Oral hygiene instruction					
D1351	E		Dental sealant per tooth					
D1510	S		Space maintainer fxd unilat	0330	7.1431	$423.94		$84.79
D1515	S		Fixed bilat space maintainer	0330	7.1431	$423.94		$84.79
D1520	S		Remove unilat space maintain	0330	7.1431	$423.94		$84.79
D1525	S		Remove bilat space maintain	0330	7.1431	$423.94		$84.79
D1550	S		Recement space maintainer	0330	7.1431	$423.94		$84.79
D2140	E		Amalgam one surface permanen					
D2150	E		Amalgam two surfaces permane					
D2160	E		Amalgam three surfaces perma					
D2161	E		Amalgam 4 or > surfaces perm					
D2330	E		Resin one surface-anterior					
D2331	E		Resin two surfaces-anterior					
D2332	E		Resin three surfaces-anterio					
D2335	E		Resin 4/> surf or w incis an					
D2390	E		Ant resin-based cmpst crown					
D2391	E		Post 1 srfc resinbased cmpst					
D2392	E		Post 2 srfc resinbased cmpst					
D2393	E		Post 3 srfc resinbased cmpst					
D2394	E		Post >=4srfc resinbase cmpst					
D2410	E		Dental gold foil one surface					
D2420	E		Dental gold foil two surface					
D2430	E		Dental gold foil three surfa					
D2510	E		Dental inlay metalic 1 surf					
D2520	E		Dental inlay metallic 2 surf					
D2530	E		Dental inlay metl 3/more sur					
D2542	E		Dental onlay metallic 2 surf					
D2543	E		Dental onlay metallic 3 surf					
D2544	E		Dental onlay metl 4/more sur					
D2610	E		Inlay porcelain/ceramic 1 su					
D2620	E		Inlay porcelain/ceramic 2 su					
D2630	E		Dental onlay porc 3/more sur					
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					
D2712	E		Crown 3/4 resin-based compos					
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					
D2794	E		Crown-titanium					
D2799	E		Provisional crown					
D2910	E		Dental recement inlay					
D2915	E		Recement cast or prefab post					
D2920	E		Dental recement crown					
D2930	E		Prefab stnlss steel crwn pri					
D2931	E		Prefab stnlss steel crown pe					
D2932	E		Prefabricated resin crown					
D2933	E		Prefab stainless steel crown					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D2934	E		Prefab steel crown primary					
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					
D2971	E		Add proc construct new crown					
D2975	E		Coping					
D2980	E		Crown repair					
D2999	S		Dental unspec restorative pr	0330	7.1431	$423.94		$84.79
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	7.1431	$423.94		$84.79
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	7.1431	$423.94		$84.79
D4210	E		Gingivectomy/plasty per quad					
D4211	E		Gingivectomy/plasty per toot					
D4240	E		Gingival flap proc w/ planin					
D4241	E		Gngvl flap w rootplan 1-3 th					
D4245	E		Apically positioned flap					
D4249	E		Crown lengthen hard tissue					
D4260	S		Osseous surgery per quadrant	0330	7.1431	$423.94		$84.79
D4261	E		Osseous surgl-3teethperquad					
D4263	S		Bone replce graft first site	0330	7.1431	$423.94		$84.79
D4264	S		Bone replce graft each add	0330	7.1431	$423.94		$84.79
D4265	E		Bio mtrls to aid soft/os reg					
D4266	E		Guided tiss regen resorble					
D4267	E		Guided tiss regen nonresorb					
D4268	S		Surgical revision procedure	0330	7.1431	$423.94		$84.79
D4270	S		Pedicle soft tissue graft pr	0330	7.1431	$423.94		$84.79
D4271	S		Free soft tissue graft proc	0330	7.1431	$423.94		$84.79
D4273	S		Subepithelial tissue graft	0330	7.1431	$423.94		$84.79
D4274	E		Distal/proximal wedge proc					
D4275	E		Soft tissue allograft					
D4276	E		Con tissue w dble ped graft					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D4320	E		Provision splnt intracoronal					
D4321	E		Provisional splint extracoro					
D4341	E		Periodontal scaling & root					
D4342	E		Periodontal scaling 1-3teeth					
D4355	S		Full mouth debridement	0330	7.1431	$423.94		$84.79
D4381	S		Localized chemo delivery	0330	7.1431	$423.94		$84.79
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					
D5225	E		Maxillary part denture flex					
D5226	E		Mandibular part denture flex					
D5281	E		Removable partial denture					
D5410	E		Dentures adjust cmplt maxil					
D5411	E		Dentures adjust cmplt mand					
D5421	E		Dentures adjust part maxill					
D5422	E		Dentures adjust part mandbl					
D5510	E		Dentur repr broken compl bas					
D5520	E		Replace denture teeth complt					
D5610	E		Dentures repair resin base					
D5620	E		Rep part denture cast frame					
D5630	E		Rep partial denture clasp					
D5640	E		Replace part denture teeth					
D5650	E		Add tooth to partial denture					
D5660	E		Add clasp to partial denture					
D5670	E		Replc tth&acrlc on mtl frmwk					
D5671	E		Replc tth&acrlc mandibular					
D5710	E		Dentures rebase cmplt maxil					
D5711	E		Dentures rebase cmplt mand					
D5720	E		Dentures rebase part maxill					
D5721	E		Dentures rebase part mandbl					
D5730	E		Denture reln cmplt maxil ch					
D5731	E		Denture reln cmplt mand chr					
D5740	E		Denture reln part maxil chr					
D5741	E		Denture reln part mand chr					
D5750	E		Denture reln cmplt max lab					
D5751	E		Denture reln cmplt mand lab					
D5760	E		Denture reln part maxil lab					
D5761	E		Denture reln part mand lab					
D5810	E		Denture interm cmplt maxill					
D5811	E		Denture interm cmplt mandbl					
D5820	E		Denture interm part maxill					
D5821	E		Denture interm part mandbl					
D5850	E		Denture tiss conditn maxill					
D5851	E		Denture tiss condtin mandbl					
D5860	E		Overdenture complete					
D5861	E		Overdenture partial					
D5862	E		Precision attachment					
D5867	E		Replacement of precision att					
D5875	E		Prosthesis modification					
D5899	E		Removable prosthodontic proc					
D5911	S		Facial moulage sectional	0330	7.1431	$423.94		$84.79
D5912	S		Facial moulage complete	0330	7.1431	$423.94		$84.79
D5913	E		Nasal prosthesis					
D5914	E		Auricular prosthesis					
D5915	E		Orbital prosthesis					
D5916	E		Ocular prosthesis					
D5919	E		Facial prosthesis					
D5922	E		Nasal septal prosthesis					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	7.1431	$423.94		$84.79
D5984	S		Radiation shield	0330	7.1431	$423.94		$84.79
D5985	S		Radiation cone locator	0330	7.1431	$423.94		$84.79
D5986	E		Fluoride applicator					
D5987	S		Commissure splint	0330	7.1431	$423.94		$84.79
D5988	E		Surgical splint					
D5999	E		Maxillofacial prosthesis					
D6010	E		Odontics endosteal implant					
D6040	E		Odontics eposteal implant					
D6050	E		Odontics transosteal implnt					
D6053	E		Implnt/abtmnt spprt remv dnt					
D6054	E		Implnt/abtmnt spprt remvprtl					
D6055	E		Implant connecting bar					
D6056	E		Prefabricated abutment					
D6057	E		Custom abutment					
D6058	E		Abutment supported crown					
D6059	E		Abutment supported mtl crown					
D6060	E		Abutment supported mtl crown					
D6061	E		Abutment supported mtl crown					
D6062	E		Abutment supported mtl crown					
D6063	E		Abutment supported mtl crown					
D6064	E		Abutment supported mtl crown					
D6065	E		Implant supported crown					
D6066	E		Implant supported mtl crown					
D6067	E		Implant supported mtl crown					
D6068	E		Abutment supported retainer					
D6069	E		Abutment supported retainer					
D6070	E		Abutment supported retainer					
D6071	E		Abutment supported retainer					
D6072	E		Abutment supported retainer					
D6073	E		Abutment supported retainer					
D6074	E		Abutment supported retainer					
D6075	E		Implant supported retainer					
D6076	E		Implant supported retainer					
D6077	E		Implant supported retainer					
D6078	E		Implnt/abut suprtd fixd dent					
D6079	E		Implnt/abut suprtd fixd dent					
D6080	E		Implant maintenance					
D6090	E		Repair implant					
D6094	E		Abut support crown titanium					
D6095	E		Odontics repr abutment					
D6100	E		Removal of implant					
D6190	E		Radio/surgical implant index					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D6194	E		Abut support retainer titani					
D6199	E		Implant procedure					
D6205	E		Pontic-indirect resin based					
D6210	E		Prosthodont high noble metal					
D6211	E		Bridge base metal cast					
D6212	E		Bridge noble metal cast					
D6214	E		Pontic titanium					
D6240	E		Bridge porcelain high noble					
D6241	E		Bridge porcelain base metal					
D6242	E		Bridge porcelain nobel metal					
D6245	E		Bridge porcelain/ceramic					
D6250	E		Bridge resin w/high noble					
D6251	E		Bridge resin base metal					
D6252	E		Bridge resin w/noble metal					
D6253	E		Provisional pontic					
D6545	E		Dental retainr cast metl					
D6548	E		Porcelain/ceramic retainer					
D6600	E		Porcelain/ceramic inlay 2srf					
D6601	E		Porc/ceram inlay >= 3 surfac					
D6602	E		Cst hgh nble mtl inlay 2 srf					
D6603	E		Cst hgh nble mtl inlay >=3sr					
D6604	E		Cst bse mtl inlay 2 surfaces					
D6605	E		Cst bse mtl inlay >= 3 surfa					
D6606	E		Cast noble metal inlay 2 sur					
D6607	E		Cst noble mtl inlay >=3 surf					
D6608	E		Onlay porc/crmc 2 surfaces					
D6609	E		Onlay porc/crmc >=3 surfaces					
D6610	E		Onlay cst hgh nbl mtl 2 srfc					
D6611	E		Onlay cst hgh nbl mtl >=3srf					
D6612	E		Onlay cst base mtl 2 surface					
D6613	E		Onlay cst base mtl >=3 surfa					
D6614	E		Onlay cst nbl mtl 2 surfaces					
D6615	E		Onlay cst nbl mtl >=3 surfac					
D6624	E		Inlay titanium					
D6634	E		Onlay titanium					
D6710	E		Crown-indirect resin based					
D6720	E		Retain crown resin w hi nble					
D6721	E		Crown resin w/base metal					
D6722	E		Crown resin w/noble metal					
D6740	E		Crown porcelain/ceramic					
D6750	E		Crown porcelain high noble					
D6751	E		Crown porcelain base metal					
D6752	E		Crown porcelain noble metal					
D6780	E		Crown 3/4 high noble metal					
D6781	E		Crown 3/4 cast based metal					
D6782	E		Crown 3/4 cast noble metal					
D6783	E		Crown 3/4 porcelain/ceramic					
D6790	E		Crown full high noble metal					
D6791	E		Crown full base metal cast					
D6792	E		Crown full noble metal cast					
D6793	E		Provisional retainer crown					
D6794	E		Crown titanium					
D6920	S		Dental connector bar	0330	7.1431	$423.94		$84.79
D6930	E		Dental recement bridge					
D6940	E		Stress breaker					
D6950	E		Precision attachment					
D6970	E		Post & core plus retainer					
D6971	E		Cast post bridge retainer					
D6972	E		Prefab post & core plus reta					
D6973	E		Core build up for retainer					
D6975	E		Coping metal					
D6976	E		Each addtnl cast post					
D6977	E		Each addtl prefab post					
D6980	E		Bridge repair					
D6985	E		Pediatric partial denture fx					
D6999	E		Fixed prosthodontic proc					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7111	S		Coronal remnants deciduous t	0330	7.1431	$423.94		$84.79
D7140	S		Extraction erupted tooth/exr	0330	7.1431	$423.94		$84.79
D7210	S		Rem imp tooth w mucoper flp	0330	7.1431	$423.94		$84.79
D7220	S		Impact tooth remov soft tiss	0330	7.1431	$423.94		$84.79
D7230	S		Impact tooth remov part bony	0330	7.1431	$423.94		$84.79
D7240	S		Impact tooth remov comp bony	0330	7.1431	$423.94		$84.79
D7241	S		Impact tooth rem bony w/comp	0330	7.1431	$423.94		$84.79
D7250	S		Tooth root removal	0330	7.1431	$423.94		$84.79
D7260	S		Oral antral fistula closure	0330	7.1431	$423.94		$84.79
D7261	S		Primary closure sinus perf	0330	7.1431	$423.94		$84.79
D7270	E		Tooth reimplantation					
D7272	E		Tooth transplantation					
D7280	E		Exposure impact tooth orthod					
D7282	E		Mobilize erupted/malpos toot					
D7283	B		Place device impacted tooth					
D7285	E		Biopsy of oral tissue hard					
D7286	E		Biopsy of oral tissue soft					
D7287	E		Cytology sample collection					
D7288	B		Brush biopsy					
D7290	E		Repositioning of teeth					
D7291	S		Transseptal fiberotomy	0330	7.1431	$423.94		$84.79
D7310	E		Alveoplasty w/ extraction					
D7311	E		Alveoloplasty w/extract 1-3					
D7320	E		Alveoplasty w/o extraction					
D7321	B		Alveoloplasty not w/extracts					
D7340	E		Vestibuloplasty ridge extens					
D7350	E		Vestibuloplasty exten graft					
D7410	E		Rad exc lesion up to 1.25 cm					
D7411	E		Excision benign lesion>1.25c					
D7412	E		Excision benign lesion compl					
D7413	E		Excision malig lesion<=1.25c					
D7414	E		Excision malig lesion>1.25cm					
D7415	E		Excision malig les complicat					
D7440	E		Malig tumor exc to 1.25 cm					
D7441	E		Malig tumor > 1.25 cm					
D7450	E		Rem odontogen cyst to 1.25cm					
D7451	E		Rem odontogen cyst > 1.25 cm					
D7460	E		Rem nonodonto cyst to 1.25cm					
D7461	E		Rem nonodonto cyst > 1.25 cm					
D7465	E		Lesion destruction					
D7471	E		Rem exostosis any site					
D7472	E		Removal of torus palatinus					
D7473	E		Remove torus mandibularis					
D7485	E		Surg reduct osseoustuberosit					
D7490	E		Mandible resection					
D7510	E		I&d absc intraoral soft tiss					
D7511	B		Incision/drain abscess intra					
D7520	E		I&d abscess extraoral					
D7521	B		Incision/drain abscess extra					
D7530	E		Removal fb skin/areolar tiss					
D7540	E		Removal of fb reaction					
D7550	E		Removal of sloughed off bone					
D7560	E		Maxillary sinusotomy					
D7610	E		Maxilla open reduct simple					
D7620	E		Clsd reduct simpl maxilla fx					
D7630	E		Open red simpl mandible fx					
D7640	E		Clsd red simpl mandible fx					
D7650	E		Open red simp malar/zygom fx					
D7660	E		Clsd red simp malar/zygom fx					
D7670	E		Closd rductn splint alveolus					
D7671	E		Alveolus open reduction					
D7680	E		Reduct simple facial bone fx					
D7710	E		Maxilla open reduct compound					
D7720	E		Clsd reduct compd maxilla fx					
D7730	E		Open reduct compd mandble fx					
D7740	E		Clsd reduct compd mandble fx					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D7750	E		Open red comp malar/zygma fx					
D7760	E		Clsd red comp malar/zygma fx					
D7770	E		Open reduc compd alveolus fx					
D7771	E		Alveolus clsd reduc stblz te					
D7780	E		Reduct compnd facial bone fx					
D7810	E		Tmj open reduct-dislocation					
D7820	E		Closed tmp manipulation					
D7830	E		Tmj manipulation under anest					
D7840	E		Removal of tmj condyle					
D7850	E		Tmj meniscectomy					
D7852	E		Tmj repair of joint disc					
D7854	E		Tmj excisn of joint membrane					
D7856	E		Tmj cutting of a muscle					
D7858	E		Tmj reconstruction					
D7860	E		Tmj cutting into joint					
D7865	E		Tmj reshaping components					
D7870	E		Tmj aspiration joint fluid					
D7871	E		Lysis + lavage w catheters					
D7872	E		Tmj diagnostic arthroscopy					
D7873	E		Tmj arthroscopy lysis adhesn					
D7874	E		Tmj arthroscopy disc reposit					
D7875	E		Tmj arthroscopy synovectomy					
D7876	E		Tmj arthroscopy discectomy					
D7877	E		Tmj arthroscopy debridement					
D7880	E		Occlusal orthotic appliance					
D7899	E		Tmj unspecified therapy					
D7910	E		Dent sutur recent wnd to 5cm					
D7911	E		Dental suture wound to 5 cm					
D7912	E		Suture complicate wnd > 5 cm					
D7920	E		Dental skin graft					
D7940	S		Reshaping bone orthognathic	0330	7.1431	$423.94		$84.79
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					
D7953	E		Bone replacement graft					
D7955	E		Repair maxillofacial defects					
D7960	E		Frenulectomy/frenulotomy					
D7963	E		Frenuloplasty					
D7970	E		Excision hyperplastic tissue					
D7971	E		Excision pericoronal gingiva					
D7972	E		Surg redct fibrous tuberosit					
D7980	E		Sialolithotomy					
D7981	E		Excision of salivary gland					
D7982	E		Sialodochoplasty					
D7983	E		Closure of salivary fistula					
D7990	E		Emergency tracheotomy					
D7991	E		Dental coronoidectomy					
D7995	E		Synthetic graft facial bones					
D7996	E		Implant mandible for augment					
D7997	E		Appliance removal					
D7999	E		Oral surgery procedure					
D8010	E		Limited dental tx primary					
D8020	E		Limited dental tx transition					
D8030	E		Limited dental tx adolescent					
D8040	E		Limited dental tx adult					
D8050	E		Intercep dental tx primary					
D8060	E		Intercep dental tx transitn					
D8070	E		Compre dental tx transition					
D8080	E		Compre dental tx adolescent					
D8090	E		Compre dental tx adult					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
D8210	E		Orthodontic rem appliance tx					
D8220	E		Fixed appliance therapy habt					
D8660	E		Preorthodontic tx visit					
D8670	E		Periodic orthodontc tx visit					
D8680	E		Orthodontic retention					
D8690	E		Orthodontic treatment					
D8691	E		Repair ortho appliance					
D8692	E		Replacement retainer					
D8999	E		Orthodontic procedure					
D9110	N		Tx dental pain minor proc					
D9210	E		Dent anesthesia w/o surgery					
D9211	E		Regional block anesthesia					
D9212	E		Trigeminal block anesthesia					
D9215	E		Local anesthesia					
D9220	E		General anesthesia					
D9221	E		General anesthesia ea ad 15m					
D9230	N		Analgesia					
D9241	E		Intravenous sedation					
D9242	E		IV sedation ea ad 30 m					
D9248	N		Sedation (non-iv)					
D9310	E		Dental consultation					
D9410	E		Dental house call					
D9420	E		Hospital call					
D9430	E		Office visit during hours					
D9440	E		Office visit after hours					
D9450	E		Case presentation tx plan					
D9610	E		Dent therapeutic drug inject					
D9630	S		Other drugs/medicaments	0330	7.1431	$423.94		$84.79
D9910	E		Dent appl desensitizing med					
D9911	E		Appl desensitizing resin					
D9920	E		Behavior management					
D9930	S		Treatment of complications	0330	7.1431	$423.94		$84.79
D9940	S		Dental occlusal guard	0330	7.1431	$423.94		$84.79
D9941	E		Fabrication athletic guard					
D9942	E		Repair/reline occlusal guard					
D9950	S		Occlusion analysis	0330	7.1431	$423.94		$84.79
D9951	S		Limited occlusal adjustment	0330	7.1431	$423.94		$84.79
D9952	S		Complete occlusal adjustment	0330	7.1431	$423.94		$84.79
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	Y		Cane adjust/fixed with tip					
E0105	Y		Cane adjust/fixed quad/3 pro					
E0110	Y		Crutch forearm pair					
E0111	Y		Crutch forearm each					
E0112	Y		Crutch underarm pair wood					
E0113	Y		Crutch underarm each wood					
E0114	Y		Crutch underarm pair no wood					
E0116	Y		Crutch underarm each no wood					
E0117	Y		Underarm springassist crutch					
E0118	E		Crutch substitute					
E0130	Y		Walker rigid adjust/fixed ht					
E0135	Y		Walker folding adjust/fixed					
E0140	Y		Walker w trunk support					
E0141	Y		Rigid wheeled walker adj/fix					
E0143	Y		Walker folding wheeled w/o s					
E0144	Y		Enclosed walker w rear seat					
E0147	Y		Walker variable wheel resist					
E0148	Y		Heavyduty walker no wheels					
E0149	Y		Heavy duty wheeled walker					
E0153	Y		Forearm crutch platform atta					
E0154	Y		Walker platform attachment					
E0155	Y		Walker wheel attachment,pair					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0156	Y		Walker seat attachment					
E0157	Y		Walker crutch attachment					
E0158	Y		Walker leg extenders set of4					
E0159	Y		Brake for wheeled walker					
E0160	Y		Sitz type bath or equipment					
E0161	Y		Sitz bath/equipment w/faucet					
E0162	Y		Sitz bath chair					
E0163	Y		Commode chair stationry fxd					
E0164	Y		Commode chair mobile fixed a					
E0166	Y		Commode chair mobile detach					
E0167	Y		Commode chair pail or pan					
E0168	Y		Heavyduty/wide commode chair					
E0169	Y		Seatlift incorp commodechair					
E0175	Y		Commode chair foot rest					
E0180	Y		Press pad alternating w pump					
E0181	Y		Press pad alternating w/ pum					
E0182	Y		Pressure pad alternating pum					
E0184	Y		Dry pressure mattress					
E0185	Y		Gel pressure mattress pad					
E0186	Y		Air pressure mattress					
E0187	Y		Water pressure mattress					
E0188	Y		Synthetic sheepskin pad					
E0189	Y		Lambswool sheepskin pad					
E0190	E		Positioning cushion					
E0191	Y		Protector heel or elbow					
E0193	Y		Powered air flotation bed					
E0194	Y		Air fluidized bed					
E0196	Y		Gel pressure mattress					
E0197	Y		Air pressure pad for mattres					
E0198	Y		Water pressure pad for mattr					
E0199	Y		Dry pressure pad for mattres					
E0200	Y		Heat lamp without stand					
E0202	Y		Phototherapy light w/ photom					
E0203	E		Therapeutic lightbox tabletp					
E0205	Y		Heat lamp with stand					
E0210	Y		Electric heat pad standard					
E0215	Y		Electric heat pad moist					
E0217	Y		Water circ heat pad w pump					
E0218	Y		Water circ cold pad w pump					
E0220	Y		Hot water bottle					
E0221	E		Infrared heating pad system					
E0225	Y		Hydrocollator unit					
E0230	Y		Ice cap or collar					
E0231	E		Wound warming device					
E0232	E		Warming card for NWT					
E0235	Y		Paraffin bath unit portable					
E0236	Y		Pump for water circulating p					
E0238	Y		Heat pad non-electric moist					
E0239	Y		Hydrocollator unit portable					
E0240	E		Bath/shower chair					
E0241	E		Bath tub wall rail					
E0242	E		Bath tub rail floor					
E0243	E		Toilet rail					
E0244	E		Toilet seat raised					
E0245	E		Tub stool or bench					
E0246	E		Transfer tub rail attachment					
E0247	E		Trans bench w/wo comm open					
E0248	E		HDtrans bench w/wo comm open					
E0249	Y		Pad water circulating heat u					
E0250	Y		Hosp bed fixed ht w/ mattres					
E0251	Y		Hosp bed fixd ht w/o mattres					
E0255	Y		Hospital bed var ht w/ mattr					
E0256	Y		Hospital bed var ht w/o matt					
E0260	Y		Hosp bed semi-electr w/ matt					
E0261	Y		Hosp bed semi-electr w/o mat					
E0265	Y		Hosp bed total electr w/ mat					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0266	Y		Hosp bed total elec w/o matt					
E0270	E		Hospital bed institutional t					
E0271	Y		Mattress innerspring					
E0272	Y		Mattress foam rubber					
E0273	E		Bed board					
E0274	E		Over-bed table					
E0275	Y		Bed pan standard					
E0276	Y		Bed pan fracture					
E0277	Y		Powered pres-redu air mattrs					
E0280	Y		Bed cradle					
E0290	Y		Hosp bed fx ht w/o rails w/m					
E0291	Y		Hosp bed fx ht w/o rail w/o					
E0292	Y		Hosp bed var ht w/o rail w/o					
E0293	Y		Hosp bed var ht w/o rail w/					
E0294	Y		Hosp bed semi-elect w/ mattr					
E0295	Y		Hosp bed semi-elect w/o matt					
E0296	Y		Hosp bed total elect w/ matt					
E0297	Y		Hosp bed total elect w/o mat					
E0300	Y		Enclosed ped crib hosp grade					
E0301	Y		HD hosp bed, 350-600 lbs					
E0302	Y		Ex hd hosp bed > 600 lbs					
E0303	Y		Hosp bed hvy dty xtra wide					
E0304	Y		Hosp bed xtra hvy dty x wide					
E0305	Y		Rails bed side half length					
E0310	Y		Rails bed side full length					
E0315	E		Bed accessory brd/tbl/supprt					
E0316	Y		Bed safety enclosure					
E0325	Y		Urinal male jug-type					
E0326	Y		Urinal female jug-type					
E0350	E		Control unit bowel system					
E0352	E		Disposable pack w/bowel syst					
E0370	E		Air elevator for heel					
E0371	Y		Nonpower mattress overlay					
E0372	Y		Powered air mattress overlay					
E0373	Y		Nonpowered pressure mattress					
E0424	Y		Stationary compressed gas 02					
E0425	E		Gas system stationary compre					
E0430	E		Oxygen system gas portable					
E0431	Y		Portable gaseous 02					
E0434	Y		Portable liquid 02					
E0435	E		Oxygen system liquid portabl					
E0439	Y		Stationary liquid 02					
E0440	E		Oxygen system liquid station					
E0441	Y		Oxygen contents, gaseous					
E0442	Y		Oxygen contents, liquid					
E0443	Y		Portable 02 contents, gas					
E0444	Y		Portable 02 contents, liquid					
E0445	A		Oximeter non-invasive					
E0450	Y		Volume vent stationary/porta					
E0455	Y		Oxygen tent excl croup/ped t					
E0457	Y		Chest shell					
E0459	Y		Chest wrap					
E0460	Y		Neg press vent portabl/statn					
E0461	Y		Vol vent noninvasive interfa					
E0462	Y		Rocking bed w/ or w/o side r					
E0463	Y		Press supp vent invasive int					
E0464	Y		Press supp vent noninv int					
E0470	Y		RAD w/o backup non-inv intfc					
E0471	Y		RAD w/backup non inv intrfc					
E0472	Y		RAD w backup invasive intrfc					
E0480	Y		Percussor elect/pneum home m					
E0481	E		Intrpulmnry percuss vent sys					
E0482	Y		Cough stimulating device					
E0483	Y		Chest compression gen system					
E0484	Y		Non-elec oscillatory pep dvc					
E0500	Y		Ippb all types					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0550	Y		Humidif extens supple w ippb					
E0555	Y		Humidifier for use w/ regula					
E0560	Y		Humidifier supplemental w/ i					
E0561	Y		Humidifier nonheated w PAP					
E0562	Y		Humidifier heated used w PAP					
E0565	Y		Compressor air power source					
E0570	Y		Nebulizer with compression					
E0571	Y		Aerosol compressor for svneb					
E0572	Y		Aerosol compressor adjust pr					
E0574	Y		Ultrasonic generator w svneb					
E0575	Y		Nebulizer ultrasonic					
E0580	Y		Nebulizer for use w/ regulat					
E0585	Y		Nebulizer w/ compressor & he					
E0590	Y		Dispensing fee dme neb drug					
E0600	Y		Suction pump portab hom modl					
E0601	Y		Cont airway pressure device					
E0602	Y		Manual breast pump					
E0603	A		Electric breast pump					
E0604	A		Hosp grade elec breast pump					
E0605	Y		Vaporizer room type					
E0606	Y		Drainage board postural					
E0607	Y		Blood glucose monitor home					
E0610	Y		Pacemaker monitr audible/vis					
E0615	Y		Pacemaker monitr digital/vis					
E0616	N		Cardiac event recorder					
E0617	Y		Automatic ext defibrillator					
E0618	A		Apnea monitor					
E0619	A		Apnea monitor w recorder					
E0620	Y		Cap bld skin piercing laser					
E0621	Y		Patient lift sling or seat					
E0625	E		Patient lift bathroom or toi					
E0627	Y		Seat lift incorp lift-chair					
E0628	Y		Seat lift for pt furn-electr					
E0629	Y		Seat lift for pt furn-non-el					
E0630	Y		Patient lift hydraulic					
E0635	Y		Patient lift electric					
E0636	Y		PT support & positioning sys					
E0637	E		Sit-stand w seatlift wheeled					
E0638	E		Standing frame sys wheeled					
E0639	E		Moveable patient lift system					
E0640	E		Fixed patient lift system					
E0650	Y		Pneuma compresor non-segment					
E0651	Y		Pneum compressor segmental					
E0652	Y		Pneum compres w/cal pressure					
E0655	Y		Pneumatic appliance half arm					
E0660	Y		Pneumatic appliance full leg					
E0665	Y		Pneumatic appliance full arm					
E0666	Y		Pneumatic appliance half leg					
E0667	Y		Seg pneumatic appl full leg					
E0668	Y		Seg pneumatic appl full arm					
E0669	Y		Seg pneumatic appli half leg					
E0671	Y		Pressure pneum appl full leg					
E0672	Y		Pressure pneum appl full arm					
E0673	Y		Pressure pneum appl half leg					
E0675	Y		Pneumatic compression device					
E0691	Y		Uvl pnl 2 sq ft or less					
E0692	Y		Uvl sys panel 4 ft					
E0693	Y		Uvl sys panel 6 ft					
E0694	Y		Uvl md cabinet sys 6 ft					
E0700	E		Safety equipment					
E0701	Y		Helmet w face guard prefab					
E0710	E		Restraints any type					
E0720	Y		Tens two lead					
E0730	Y		Tens four lead					
E0731	Y		Conductive garment for tens/					
E0740	Y		Incontinence treatment systm					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0744	Y		Neuromuscular stim for scoli					
E0745	Y		Neuromuscular stim for shock					
E0746	E		Electromyograph biofeedback					
E0747	Y		Elec osteogen stim not spine					
E0748	Y		Elec osteogen stim spinal					
E0749	N		Elec osteogen stim implanted					
E0752	B		Neurostimulator electrode					
E0754	A		Pulsegenerator pt programmer					
E0755	E		Electronic salivary reflex s					
E0756	B		Implantable pulse generator					
E0757	N		Implantable RF receiver					
E0758	A		External RF transmitter					
E0759	A		Replace rdfrquncy transmittr					
E0760	Y		Osteogen ultrasound stimltor					
E0761	E		Nontherm electromgntc device					
E0765	Y		Nerve stimulator for tx n&v					
E0769	B		Electric wound treatment dev					
E0776	Y		Iv pole					
E0779	Y		Amb infusion pump mechanical					
E0780	Y		Mech amb infusion pump <8hrs					
E0781	Y		External ambulatory infus pu					
E0782	N		Non-programble infusion pump					
E0783	N		Programmable infusion pump					
E0784	Y		Ext amb infusn pump insulin					
E0785	N		Replacement impl pump cathet					
E0786	N		Implantable pump replacement					
E0791	Y		Parenteral infusion pump sta					
E0830	N		Ambulatory traction device					
E0840	Y		Tract frame attach headboard					
E0849	Y		Cervical pneum trac equip					
E0850	Y		Traction stand free standing					
E0855	Y		Cervical traction equipment					
E0860	Y		Tract equip cervical tract					
E0870	Y		Tract frame attach footboard					
E0880	Y		Trac stand free stand extrem					
E0890	Y		Traction frame attach pelvic					
E0900	Y		Trac stand free stand pelvic					
E0910	Y		Trapeze bar attached to bed					
E0920	Y		Fracture frame attached to b					
E0930	Y		Fracture frame free standing					
E0935	Y		Exercise device passive moti					
E0940	Y		Trapeze bar free standing					
E0941	Y		Gravity assisted traction de					
E0942	Y		Cervical head harness/halter					
E0944	Y		Pelvic belt/harness/boot					
E0945	Y		Belt/harness extremity					
E0946	Y		Fracture frame dual w cross					
E0947	Y		Fracture frame attachmnts pe					
E0948	Y		Fracture frame attachmnts ce					
E0950	E		Tray					
E0951	E		Loop heel					
E0952	E		Toe loop/holder, each					
E0953	E		Pneumatic tire					
E0954	E		Wheelchair semi-pneumatic ca					
E0955	Y		Cushioned headrest					
E0956	Y		W/c lateral trunk/hip suppor					
E0957	Y		W/c medial thigh support					
E0958	A		Whlchr att- conv 1 arm drive					
E0959	B		Amputee adapter					
E0960	Y		W/c shoulder harness/straps					
E0961	B		Wheelchair brake extension					
E0966	B		Wheelchair head rest extensi					
E0967	Y		Wheelchair hand rims					
E0968	Y		Wheelchair commode seat					
E0969	Y		Wheelchair narrowing device					
E0970	B		Wheelchair no. 2 footplates					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E0971	B		Wheelchair anti-tipping devi					
E0972	A		Transfer board or device					
E0973	B		W/Ch access det adj armrest					
E0974	B		W/Ch access anti-rollback					
E0977	Y		Wheelchair wedge cushion					
E0978	B		W/C acc,saf belt pelv strap					
E0980	Y		Wheelchair safety vest					
E0981	Y		Seat upholstery, replacement					
E0982	Y		Back upholstery, replacement					
E0983	Y		Add pwr joystick					
E0984	Y		Add pwr tiller					
E0985	Y		W/c seat lift mechanism					
E0986	Y		Man w/c push-rim pow assist					
E0990	B		Whellchair elevating leg res					
E0992	B		Wheelchair solid seat insert					
E0994	Y		Wheelchair arm rest					
E0995	B		Wheelchair calf rest					
E0996	B		Wheelchair tire solid					
E0997	Y		Wheelchair caster w/ a fork					
E0998	Y		Wheelchair caster w/o a fork					
E0999	Y		Wheelchr pneumatic tire w/wh					
E1000	B		Wheelchair tire pneumatic ca					
E1001	Y		Wheelchair wheel					
E1002	Y		Pwr seat tilt					
E1003	Y		Pwr seat recline					
E1004	Y		Pwr seat recline mech					
E1005	Y		Pwr seat recline pwr					
E1006	Y		Pwr seat combo w/o shear					
E1007	Y		Pwr seat combo w/shear					
E1008	Y		Pwr seat combo pwr shear					
E1009	Y		Add mech leg elevation					
E1010	Y		Add pwr leg elevation					
E1011	Y		Ped wc modify width adjustm					
E1014	Y		Reclining back add ped w/c					
E1015	Y		Shock absorber for man w/c					
E1016	Y		Shock absorber for power w/c					
E1017	Y		HD shck absrbr for hd man wc					
E1018	Y		HD shck absrber for hd powwc					
E1019	E		HD feature power seat					
E1020	Y		Residual limb support system					
E1021	E		Ex hd feature power seat					
E1025	E		Pedwc lat/thor sup nocontour					
E1026	E		Pedwc contoured lat/thor sup					
E1027	E		Ped wc lat/ant support					
E1028	Y		W/c manual swingaway					
E1029	Y		W/c vent tray fixed					
E1030	Y		W/c vent tray gimbaled					
E1031	Y		Rollabout chair with casters					
E1035	Y		Patient transfer system					
E1037	Y		Transport chair, ped size					
E1038	Y		Transport chair, adult size					
E1039	Y		Transport chair pt wt>=250lb					
E1050	A		Whelchr fxd full length arms					
E1060	A		Wheelchair detachable arms					
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					
E1092	A		Wheelchair wide w/ leg rests					
E1093	A		Wheelchair wide w/ foot rest					
E1100	A		Whchr s-recl fxd arm leg res					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1110	A		Wheelchair semi-recl detach					
E1130	A		Whlchr stand fxd arm ft rest					
E1140	A		Wheelchair standard detach a					
E1150	Y		Wheelchair standard w/ leg r					
E1160	A		Wheelchair fixed arms					
E1161	A		Manual adult wc w tiltinspac					
E1170	A		Whlchr ampu fxd arm leg rest					
E1171	A		Wheelchair amputee w/o leg r					
E1172	A		Wheelchair amputee detach ar					
E1180	A		Wheelchair amputee w/ foot r					
E1190	A		Wheelchair amputee w/ leg re					
E1195	A		Wheelchair amputee heavy dut					
E1200	A		Wheelchair amputee fixed arm					
E1210	Y		Whlchr moto ful arm leg rest					
E1211	Y		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	Y		Wheelchair spec sz semi-recl					
E1226	B		W/C access fully reclineback					
E1227	Y		Wheelchair spec sz spec ht a					
E1228	Y		Wheelchair spec sz spec ht b					
E1229	Y		Pediatric wheelchair NOS					
E1230	Y		Power operated vehicle					
E1231	Y		Rigid ped w/c tilt-in-space					
E1232	Y		Folding ped wc tilt-in-space					
E1233	Y		Rig ped wc tltnspc w/o seat					
E1234	Y		Fld ped wc tltnspc w/o seat					
E1235	Y		Rigid ped wc adjustable					
E1236	Y		Folding ped wc adjustable					
E1237	Y		Rgd ped wc adjstabl w/o seat					
E1238	Y		Fld ped wc adjstabl w/o seat					
E1239	Y		Ped power wheelchair NOS					
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	Y		Wheelchair special seat heig					
E1297	Y		Wheelchair special seat dept					
E1298	Y		Wheelchair spec seat depth/w					
E1300	E		Whirlpool portable					
E1310	Y		Whirlpool non-portable					
E1340	Y		Repair for DME, per 15 min					
E1353	Y		Oxygen supplies regulator					
E1355	Y		Oxygen supplies stand/rack					
E1372	Y		Oxy suppl heater for nebuliz					
E1390	Y		Oxygen concentrator					
E1391	Y		Oxygen concentrator, dual					
E1399	N		Durable medical equipment mi					
E1405	Y		O2/water vapor enrich w/heat					
E1406	Y		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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E1570	A		Adjustable chair for esrd pt					
E1575	A		Transducer protect/fld bar					
E1580	A		Unipuncture control system					
E1590	A		Hemodialysis machine					
E1592	A		Auto interm peritoneal dialy					
E1594	A		Cycler dialysis machine					
E1600	A		Deli/install chrg hemo equip					
E1610	A		Reverse osmosis h2o puri sys					
E1615	A		Deionizer H2O puri system					
E1620	A		Replacement blood pump					
E1625	A		Water softening system					
E1630	A		Reciprocating peritoneal dia					
E1632	A		Wearable artificial kidney					
E1634	B		Peritoneal dialysis clamp					
E1635	A		Compact travel hemodialyzer					
E1636	A		Sorbent cartridges per 10					
E1637	A		Hemostats for dialysis, each					
E1639	A		Dialysis scale					
E1699	A		Dialysis equipment noc					
E1700	Y		Jaw motion rehab system					
E1701	Y		Repl cushions for jaw motion					
E1702	Y		Repl measr scales jaw motion					
E1800	Y		Adjust elbow ext/flex device					
E1801	Y		SPS elbow device					
E1802	Y		Adjst forearm pro/sup device					
E1805	Y		Adjust wrist ext/flex device					
E1806	Y		SPS wrist device					
E1810	Y		Adjust knee ext/flex device					
E1811	Y		SPS knee device					
E1815	Y		Adjust ankle ext/flex device					
E1816	Y		SPS ankle device					
E1818	Y		SPS forearm device					
E1820	Y		Soft interface material					
E1821	Y		Replacement interface SPSD					
E1825	Y		Adjust finger ext/flex devc					
E1830	Y		Adjust toe ext/flex device					
E1840	Y		Adj shoulder ext/flex device					
E1841	Y		Static str shldr dev rom adj					
E1902	A		AAC non-electronic board					
E2000	Y		Gastric suction pump hme mdl					
E2100	Y		Bld glucose monitor w voice					
E2101	Y		Bld glucose monitor w lance					
E2120	Y		Pulse gen sys tx endolymp fl					
E2201	Y		Man w/ch acc seat w>=20″<24″					
E2202	Y		Seat width 24-27 in					
E2203	Y		Frame depth less than 22 in					
E2204	Y		Frame depth 22 to 25 in					
E2205	Y		Manual wc accessory, handrim					
E2206	Y		Complete wheel lock assembly					
E2291	E		Planar back for ped size wc					
E2292	E		Planar seat for ped size wc					
E2293	E		Contour back for ped size wc					
E2294	E		Contour seat for ped size wc					
E2300	Y		Pwr seat elevation sys					
E2301	Y		Pwr standing					
E2310	Y		Electro connect btw control					
E2311	Y		Electro connect btw 2 sys					
E2320	Y		Hand chin control					
E2321	Y		Hand interface joystick					
E2322	Y		Mult mech switches					
E2323	Y		Special joystick handle					
E2324	Y		Chin cup interface					
E2325	Y		Sip and puff interface					
E2326	Y		Breath tube kit					
E2327	Y		Head control interface mech					
E2328	Y		Head/extremity control inter					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
E2329	Y		Head control nonproportional					
E2330	Y		Head control proximity switc					
E2331	Y		Attendant control					
E2340	Y		W/c wdth 20-23 in seat frame					
E2341	Y		W/c wdth 24-27 in seat frame					
E2342	Y		W/c dpth 20-21 in seat frame					
E2343	Y		W/c dpth 22-25 in seat frame					
E2351	Y		Electronic SGD interface					
E2360	Y		22nf nonsealed leadacid					
E2361	Y		22nf sealed leadacid battery					
E2362	Y		Gr24 nonsealed leadacid					
E2363	Y		Gr24 sealed leadacid battery					
E2364	Y		U1nonsealed leadacid battery					
E2365	Y		U1 sealed leadacid battery					
E2366	Y		Battery charger, single mode					
E2367	Y		Battery charger, dual mode					
E2368	Y		Power wc motor replacement					
E2369	Y		Pwr wc gear box replacement					
E2370	Y		Pwr wc motor/gear box combo					
E2399	Y		Noc interface					
E2402	Y		Neg press wound therapy pump					
E2500	Y		SGD digitized pre-rec <=8min					
E2502	Y		SGD prerec msg >8min <=20min					
E2504	Y		SGD prerec msg>20min <=40min					
E2506	Y		SGD prerec msg > 40 min					
E2508	Y		SGD spelling phys contact					
E2510	Y		SGD w multi methods msg/accs					
E2511	Y		SGD sftwre prgrm for PC/PDA					
E2512	Y		SGD accessory, mounting sys					
E2599	Y		SGD accessory noc					
E2601	Y		Gen w/c cushion wdth < 22 in					
E2602	Y		Gen w/c cushion wdth >=22 in					
E2603	Y		Skin protect wc cus wd <22in					
E2604	Y		Skin protect wc cus wd>=22in					
E2605	Y		Position wc cush wdth <22 in					
E2606	Y		Position wc cush wdth>=22 in					
E2607	Y		Skin pro/pos wc cus wd <22in					
E2608	Y		Skin pro/pos wc cus wd>=22in					
E2609	Y		Custom fabricate w/c cushion					
E2610	B		Powered w/c cushion					
E2611	Y		Gen use back cush wdth <22in					
E2612	Y		Gen use back cush wdth>=22in					
E2613	Y		Position back cush wd <22in					
E2614	Y		Position back cush wd>=22in					
E2615	Y		Pos back post/lat wdth <22in					
E2616	Y		Pos back post/lat wdth>=22in					
E2617	Y		Custom fab w/c back cushion					
E2618	Y		Wc acc solid seat supp base					
E2619	Y		Replace cover w/c seat cush					
E2620	Y		WC planar back cush wd <22in					
E2621	Y		WC planar back cush wd>=22in					
E8000	E		Posterior gait trainer					
E8001	E		Upright gait trainer					
E8002	E		Anterior gait trainer					
G0008	X		Admin influenza virus vac	0350	0.3936	$23.36	$.00	$.00
G0009	X		Admin pneumococcal vaccine	0350	0.3936	$23.36	$.00	$.00
G0010	B		Admin hepatitis b vaccine					
G0027	A		Semen analysis					
G0101	V		CA screen pelvic/breast exam	0600	0.8649	$51.33		$10.27
G0102	N		Prostate ca screening dre					
G0103	A		Psa, total screening					
G0104	S		CA screen flexi sigmoidscope	0159	3.1312	$185.84		$46.46
G0105	T		Colorectal scrn hi risk ind	0158	7.6242	$452.50		$113.13
G0106	S		Colon CA screen barium enema	0157	2.2800	$135.32		$27.06
G0107	A		CA screen fecal blood test					
G0108	A		Diab manage trn per indiv					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	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	0.7823	$46.43	$14.97	$9.29
G0118	S		Glaucoma scrn hgh risk direc	0230	0.7823	$46.43	$14.97	$9.29
G0120	S		Colon ca scrn barium enema	0157	2.2800	$135.32		$27.06
G0121	T		Colon ca scrn not hi rsk ind	0158	7.6242	$452.50		$113.13
G0122	E		Colon ca scrn barium enema					
G0123	A		Screen cerv/vag thin layer					
G0124	A		Screen c/v thin layer by MD					
G0127	T		Trim nail(s)	0009	0.6650	$39.47	$8.34	$7.89
G0128	B		CORF skilled nursing service					
G0129	P		Partial hosp prog service	0033	4.0524	$240.51		$48.10
G0130	X		Single energy x-ray study	0260	0.7521	$44.64	$17.85	$8.93
G0141	E		Scr c/v cyto,autosys and md					
G0143	A		Scr c/v cyto,thinlayer,rescr					
G0144	A		Scr c/v cyto,thinlayer,rescr					
G0145	A		Scr c/v cyto,thinlayer,rescr					
G0147	A		Scr c/v cyto, automated sys					
G0148	A		Scr c/v cyto, autosys, rescr					
G0151	B		HHCP-serv of pt,ea 15 min					
G0152	B		HHCP-serv of ot,ea 15 min					
G0153	B		HHCP-svs of s/l path,ea 15mn					
G0154	B		HHCP-svs of rn,ea 15 min					
G0155	B		HHCP-svs of csw,ea 15 min					
G0156	B		HHCP-svs of aide,ea 15 min					
G0166	T		Extrnl counterpulse, per tx	0678	1.7197	$102.06		$20.41
G0168	N		Wound closure by adhesive					
G0173	S		Linear acc stereo radsur com	1528		$5,250.00		$1,050.00
G0175	V		OPPS Service,sched team conf	0602	1.4220	$84.40		$16.88
G0176	P		OPPS/PHP activity therapy	0033	4.0524	$240.51		$48.10
G0177	P		OPPS/PHP train & educ serv	0033	4.0524	$240.51		$48.10
G0179	E		MD recertification HHA PT					
G0180	E		MD certification HHA patient					
G0181	E		Home health care supervision					
G0182	E		Hospice care supervision					
G0186	T		Dstry eye lesn,fdr vssl tech	0235	4.6382	$275.28	$67.10	$55.06
G0202	A		Screeningmammographydigital					
G0204	A		Diagnosticmammographydigital					
G0206	A		Diagnosticmammographydigital					
G0219	E		PET img whbd ring noncov ind					
G0235	E		PET not otherwise specified					
G0237	S		Therapeutic procd strg endur	0411	0.3852	$22.86		$4.57
G0238	S		Oth resp proc, indiv	0411	0.3852	$22.86		$4.57
G0239	S		Oth resp proc, group	0411	0.3852	$22.86		$4.57
G0243	S		Multisour photon stero treat	1528		$5,250.00		$1,050.00
G0244	B		Observ care by facility topt					
G0245	V		Initial Foot Exam PTLOPS	0600	0.8649	$51.33		$10.27
G0246	V		Followup eval of foot pt lop	0600	0.8649	$51.33		$10.27
G0247	T		Routine footcare pt w lops	0009	0.6650	$39.47	$8.34	$7.89
G0248	S		Demonstrate use home inr mon	1503		$150.00		$30.00
G0249	S		Provide test material,equipm	1503		$150.00		$30.00
G0250	E		MD review interpret of test					
G0251	S		Linear acc based stero radio	1513		$1,150.00		$230.00
G0252	E		PET imaging initial dx					
G0255	E		Current percep threshold tst					
G0257	S		Unsched dialysis ESRD pt hos	0170	5.8726	$348.54		$69.71
G0258	X		IV infusion during obs stay	0340	0.6355	$37.72		$7.54
G0259	N		Inject for sacroiliac joint					
G0260	T		Inj for sacroiliac jt anesth	0206	5.4672	$324.48	$75.55	$64.90
G0263	B		Adm with CHF, CP, asthma					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0264	B		Assmt otr CHF, CP, asthma					
G0265	A		Cryopresevation Freeze+stora					
G0266	A		Thawing + expansion froz cel					
G0267	S		Bone marrow or psc harvest	0110	3.6428	$216.20		$43.24
G0268	X		Removal of impacted wax md	0340	0.6355	$37.72		$7.54
G0269	N		Occlusive device in vein art					
G0270	A		MNT subs tx for change dx					
G0271	A		Group MNT 2 or more 30 mins					
G0275	N		Renal angio, cardiac cath					
G0278	N		Iliac art angio,cardiac cath					
G0279	A		Excorp shock tx, elbow epi					
G0280	A		Excorp shock tx other than					
G0281	A		Elec stim unattend for press					
G0282	E		Elect stim wound care not pd					
G0283	A		Elec stim other than wound					
G0288	S		Recon, CTA for pre & post su	0417	4.0566	$240.76		$48.15
G0289	N		Arthro, loose body + chondro					
G0290	T		Drug-eluting stents, single	0656	109.4258	$6,494.42		$1,298.88
G0291	T		Drug-eluting stents,each add	0656	109.4258	$6,494.42		$1,298.88
G0293	S		Non-cov surg proc,clin trial	1505		$350.00		$70.00
G0294	S		Non-cov proc, clinical trial	1502		$75.00		$15.00
G0295	E		Electromagnetic therapy onc					
G0297	T		Insert single chamber/cd	0107	258.8517	$15,362.85	$3,089.53	$3,072.57
G0298	T		Insert dual chamber/cd	0107	258.8517	$15,362.85	$3,089.53	$3,072.57
G0299	T		Inser/repos single icd+leads	0108	347.5867	$20,629.27		$4,125.85
G0300	T		Insert reposit lead dual+gen	0108	347.5867	$20,629.27		$4,125.85
G0302	S		Pre-op service LVRS complete	1509		$750.00		$150.00
G0303	S		Pre-op service LVRS 10-15dos	1507		$550.00		$110.00
G0304	S		Pre-op service LVRS 1-9 dos	1504		$250.00		$50.00
G0305	S		Post op service LVRS min 6	1504		$250.00		$50.00
G0306	A		CBC/diffwbc w/o platelet					
G0307	A		CBC without platelet					
G0308	A		ESRD related svc 4+mo<2yrs					
G0309	A		ESRD related svc 2-3mo<2yrs					
G0310	A		ESRD related svc 1vst<2yr					
G0311	A		ESRD related svs 4+mo 2-11yr					
G0312	A		ESRD relate svs 2-3 mo 2-11y					
G0313	A		ESRD related svs 1 mon 2-11y					
G0314	A		ESRD relate svs 4+mo 12-19					
G0315	A		ESRD related svs 2-3 mo 12-1					
G0316	A		ESRD related svs 1 vis/12-19					
G0317	A		ESRD related svs 4+mo 20+yrs					
G0318	A		ESRD related svs 2-3 mo 20+y					
G0319	A		ESRD related svs 1visit 20+y					
G0320	A		ESRD related svs home under					
G0321	A		ESRDrelatedsvs home mo 2-11y					
G0322	A		ESRD related svs home mo12-1					
G0323	A		ESRD related svs home mo 20+					
G0324	A		ESRD related svs home/dy/2y					
G0325	A		ESRD relate home/dy 2-11yr					
G0326	A		ESRD relate home/dy 12-19y					
G0327	A		ESRD relate home/dy 20+yrs					
G0328	A		Fecal blood scrn immunoassay					
G0329	A		Electromagntic tx for ulcers					
G0337	A		Hospice evaluation preelecti					
G0339	S		Robot lin-radsurg com, first	1528		$5,250.00		$1,050.00
G0340	S		Robt lin-radsurg fractx 2-5	1525		$3,750.00		$750.00
G0341	C		Percutaneous islet celltrans					
G0342	C		Laparoscopy Islet cell Trans					
G0343	C		Laparotomy Islet cell tranp					
G0344	V		Initial preventive exam	0601	0.9992	$59.30		$11.86
G0345	M		IV infuse hydration initial					
G0346	M		Each additional infuse hours					
G0347	M		IV infusion therapy/diagnost					
G0348	M		each additional hr up to 8hr					
G0349	M		additional sequential infuse					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
G0350	M		concurrent infusion					
G0351	M		therapeutic/diagnostic injec					
G0353	M		IV push,single orinitial dru					
G0354	M		each addition sequential IV					
G0355	M		chemo administrate subcut/IM					
G0356	M		hormonal anti-neoplastic					
G0357	M		IV push single/initial subst					
G0358	M		IV push each additional drug					
G0359	M		chemotherapy IV one hr initi					
G0360	M		each additional hr 1-8 hrs					
G0361	M		prolong chemo Infuse>8hrs pu					
G0362	M		each add sequential infusion					
G0363	M		irrigate implanted venous de					
G0364	X		Bone marrow aspirate & biops	0342	0.1553	$9.22	$3.68	$1.84
G0365	S		Vessel mapping hemo access	0267	2.6208	$155.54	$62.18	$31.11
G0366	B		EKG for initial prevent exam					
G0367	S		EKG tracing for initial prev	0099	0.3804	$22.58		$4.52
G0368	M		EKG interpret & report preve					
G0369	M		Pharm fee 1st month transpla					
G0370	M		Pharmacy fee oral cancer etc					
G0371	M		Pharm dispense inhalation 30					
G0374	M		Pharm dispense inhalation 90					
G0375	S		Smoke/Tobacco counseling 3-1	1491		$5.00		$1.00
G0376	S		Smoke/Tobacco counseling >10	1491		$5.00		$1.00
G3001	S		Admin + supply, tositumomab	1522		$2,250.00		$450.00
G9001	B		MCCD, initial rate					
G9002	B		MCCD,maintenance rate					
G9003	B		MCCD, risk adj hi, initial					
G9004	B		MCCD, risk adj lo, initial					
G9005	B		MCCD, risk adj, maintenance					
G9006	B		MCCD, Home monitoring					
G9007	B		MCCD, sch team conf					
G9008	B		Mccd,phys coor-care ovrsght					
G9009	E		MCCD, risk adj, level 3					
G9010	E		MCCD, risk adj, level 4					
G9011	E		MCCD, risk adj, level 5					
G9012	E		Other Specified Case Mgmt					
G9013	E		ESRD demo bundle level I					
G9014	E		ESRD demo bundle-level II					
G9016	E		Demo-smoking cessation coun					
G9017	A		Amantadine HCL,oral					
G9018	A		Zanamivir, inh pwdr					
G9019	A		Oseltamivir phosp					
G9020	A		Rimantadine HCL					
G9021	M		Chemo assess nausea vomit L1					
G9022	M		Chemo assess nausea vomit L2					
G9023	M		Chemo assess nausea vomit L3					
G9024	M		Chemo assess nausea vomit L4					
G9025	M		Chemo assessment pain level1					
G9026	M		Chemo assessment pain level2					
G9027	M		Chemo assessment pain level3					
G9028	M		Chemo assessment pain level4					
G9029	M		Chemo assess for fatigue L1					
G9030	M		Chemo assess for fatigue L2					
G9031	M		Chemo assess for fatigue L3					
G9032	M		Chemo assess for fatigue L4					
G9033	A		Amantadine HCL, oral, brand					
G9034	A		Zanamivir, inh pwdr, brand					
G9035	A		Oseltamivir phosp, brand					
G9036	A		Rimantadine HCL, brand					
G9041	A		Low vision serv occupational					
G9042	A		Low vision orient/mobility					
G9043	A		Low vision rehab therapist					
G9044	A		Low vision rehab teacher					
J0120	N		Tetracyclin injection					
J0128	G		Abarelix injection	9216		$66.96		$13.39

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J0130	K		Abciximab injection	1605		$450.56		$90.11
J0135	K		Adalimumab injection	1083		$300.07		$60.01
J0150	K		Injection adenosine 6 MG	0379		$33.44		$6.69
J0152	K		Adenosine injection	0917		$71.52		$14.30
J0170	N		Adrenalin epinephrin inject					
J0180	K		Agalsidase beta injection	9208		$123.35		$24.67
J0190	N		Inj biperiden lactate/5 mg					
J0200	N		Alatrofloxacin mesylate					
J0205	K		Alglucerase injection	0900		$39.94		$7.99
J0207	K		Amifostine	7000		$435.98		$87.20
J0210	K		Methyldopate hcl injection	2210		$9.58		$1.92
J0215	B		Alefacept					
J0256	K		Alpha 1 proteinase inhibitor	0901		$3.30		$.66
J0270	B		Alprostadil for injection					
J0275	B		Alprostadil urethral suppos					
J0280	N		Aminophyllin 250 MG inj					
J0282	N		Amiodarone HCl					
J0285	K		Amphotericin B	9030		$30.70		$6.14
J0287	K		Amphotericin b lipid complex	9024		$11.95		$2.39
J0288	K		Ampho b cholesteryl sulfate	0735		$12.24		$2.45
J0289	K		Amphotericin b liposome inj	0736		$21.91		$4.38
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	K		Arbutamine HCl injection	9031		$163.13		$32.63
J0456	N		Azithromycin					
J0460	N		Atropine sulfate injection					
J0470	N		Dimecaprol injection					
J0475	K		Baclofen 10 MG injection	9032		$188.00		$37.60
J0476	B		Baclofen intrathecal trial					
J0500	N		Dicyclomine injection					
J0515	N		Inj benztropine mesylate					
J0520	N		Bethanechol chloride inject					
J0530	N		Penicillin g benzathine inj					
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	K		Penicillin g benzathine inj	0880		$72.25		$14.45
J0583	N		Bivalirudin					
J0585	K		Botulinum toxin a per unit	0902		$4.80		$.96
J0587	K		Botulinum toxin type B	9018		$7.89		$1.58
J0592	N		Buprenorphine hydrochloride					
J0595	N		Butorphanol tartrate 1 mg					
J0600	K		Edetate calcium disodium inj	0892		$40.34		$8.07
J0610	N		Calcium gluconate injection					
J0620	N		Calcium glycer & lact/10 ML					
J0630	K		Calcitonin salmon injection	0893		$35.68		$7.14
J0636	N		Inj calcitriol per 0.1 mcg					
J0637	K		Caspofungin acetate	9019		$32.35		$6.47
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	K		Caffeine citrate injection	0876		$3.34		$.67

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	K		Clonidine hydrochloride	0935		$57.46		$11.49
J0740	K		Cidofovir injection	9033		$782.91		$156.58
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	K		Corticotropin injection	1280		$95.43		$19.09
J0835	K		Inj cosyntropin per 0.25 MG	0835		$69.27		$13.85
J0850	K		Cytomegalovirus imm IV /vial	0903		$683.02		$136.60
J0878	G		Daptomycin injection	9124		$.30		$.06
J0880	E		Darbepoetin alfa injection					
J0895	K		Deferoxamine mesylate inj	0895		$14.91		$2.98
J0900	N		Testosterone enanthate inj					
J0945	N		Brompheniramine maleate inj					
J0970	N		Estradiol valerate injection					
J1000	N		Depo-estradiol cypionate inj					
J1020	N		Methylprednisolone 20 MG inj					
J1030	N		Methylprednisolone 40 MG inj					
J1040	N		Methylprednisolone 80 MG inj					
J1051	N		Medroxyprogesterone inj					
J1055	E		Medrxyprogester acetate inj					
J1056	E		MA/EC contraceptiveinjection					
J1060	N		Testosterone cypionate 1 ML					
J1070	N		Testosterone cypionat 100 MG					
J1080	N		Testosterone cypionat 200 MG					
J1094	N		Inj dexamethasone acetate					
J1100	N		Dexamethasone sodium phos					
J1110	K		Inj dihydroergotamine mesylt	1210		$27.82		$5.56
J1120	N		Acetazolamid sodium injectio					
J1160	N		Digoxin injection					
J1165	N		Phenytoin sodium injection					
J1170	N		Hydromorphone injection					
J1180	K		Dyphylline injection	9166		$7.74		$1.55
J1190	K		Dexrazoxane HCl injection	0726		$216.38		$43.28
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	K		Dolasetron mesylate	0750		$6.55		$1.31
J1270	N		Injection, doxercalciferol					
J1320	N		Amitriptyline injection					
J1325	N		Epoprostenol injection					
J1327	K		Eptifibatide injection	1607		$12.73		$2.55
J1330	K		Ergonovine maleate injection	1330	0.5262	$31.23		$6.25
J1335	N		Ertapenem injection					
J1364	N		Erythro lactobionate /500 MG					
J1380	N		Estradiol valerate 10 MG inj					
J1390	N		Estradiol valerate 20 MG inj					
J1410	K		Inj estrogen conjugate 25 MG	9038		$57.76		$11.55
J1435	N		Injection estrone per 1 MG					
J1436	K		Etidronate disodium inj	1436		$68.69		$13.74
J1438	K		Etanercept injection	1608		$152.10		$30.42
J1440	K		Filgrastim 300 mcg injection	0728		$178.38		$35.68
J1441	K		Filgrastim 480 mcg injection	7049		$282.27		$56.45
J1450	N		Fluconazole					
J1452	K		Intraocular Fomivirsen na	9040		$203.91		$40.78

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J1455	N		Foscarnet sodium injection					
J1457	K		Gallium nitrate injection	1085		$1.30		$.26
J1460	N		Gamma globulin 1 CC inj					
J1470	B		Gamma globulin 2 CC inj					
J1480	B		Gamma globulin 3 CC inj					
J1490	B		Gamma globulin 4 CC inj					
J1500	B		Gamma globulin 5 CC inj					
J1510	B		Gamma globulin 6 CC inj					
J1520	B		Gamma globulin 7 CC inj					
J1530	B		Gamma globulin 8 CC inj					
J1540	B		Gamma globulin 9 CC inj					
J1550	B		Gamma globulin 10 CC inj					
J1560	B		Gamma globulin > 10 CC inj					
J1563	E		IV immune globulin					
J1564	E		Immune globulin 10 mg					
J1565	K		RSV-ivig	0906		$15.56		$3.11
J1570	N		Ganciclovir sodium injection					
J1580	N		Garamycin gentamicin inj					
J1590	N		Gatifloxacin injection					
J1595	N		Injection glatiramer acetate					
J1600	N		Gold sodium thiomaleate inj					
J1610	K		Glucagon hydrochloride/1 MG	9042		$62.16		$12.43
J1620	K		Gonadorelin hydroch/ 100 mcg	7005		$173.42		$34.68
J1626	K		Granisetron HCl injection	0764		$7.24		$1.45
J1630	N		Haloperidol injection					
J1631	N		Haloperidol decanoate inj					
J1642	N		Inj heparin sodium per 10 u					
J1644	N		Inj heparin sodium per 1000u					
J1645	N		Dalteparin sodium					
J1650	N		Inj enoxaparin sodium					
J1652	N		Fondaparinux sodium					
J1655	K		Tinzaparin sodium injection	1655		$2.53		$.51
J1670	K		Tetanus immune globulin inj	1670		$76.89		$15.38
J1700	N		Hydrocortisone acetate inj					
J1710	N		Hydrocortisone sodium ph inj					
J1720	N		Hydrocortisone sodium succ i					
J1730	K		Diazoxide injection	1740		$113.85		$22.77
J1742	K		Ibutilide fumarate injection	9044		$243.32		$48.66
J1745	K		Infliximab injection	7043		$54.19		$10.84
J1750	K		Iron dextran	9045		$11.43		$2.29
J1756	K		Iron sucrose injection	9046		$.38		$.08
J1785	K		Injection imiglucerase /unit	0916		$3.98		$.80
J1790	N		Droperidol injection					
J1800	N		Propranolol injection					
J1810	E		Droperidol/fentanyl inj					
J1815	N		Insulin injection					
J1817	N		Insulin for insulin pump use					
J1825	E		Interferon beta-1a					
J1830	K		Interferon beta-1b / .25 MG	0910		$81.94		$16.39
J1835	K		Itraconazole injection	9047		$36.93		$7.39
J1840	N		Kanamycin sulfate 500 MG inj					
J1850	N		Kanamycin sulfate 75 MG inj					
J1885	N		Ketorolac tromethamine inj					
J1890	N		Cephalothin sodium injection					
J1931	K		Laronidase injection	9209		$23.16		$4.63
J1940	N		Furosemide injection					
J1950	K		Leuprolide acetate /3.75 MG	0800		$441.74		$88.35
J1955	B		Inj levocarnitine per 1 gm					
J1956	N		Levofloxacin injection					
J1960	N		Levorphanol tartrate inj					
J1980	N		Hyoscyamine sulfate inj					
J1990	N		Chlordiazepoxide injection					
J2001	N		Lidocaine injection					
J2010	N		Lincomycin injection					
J2020	K		Linezolid injection	9001		$24.15		$4.83
J2060	N		Lorazepam injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2150	N		Mannitol injection					
J2175	N		Meperidine hydrochl /100 MG					
J2180	N		Meperidine/promethazine inj					
J2185	N		Meropenem					
J2210	N		Methylergonovin maleate inj					
J2250	N		Inj midazolam hydrochloride					
J2260	N		Inj milrinone lactate / 5 MG					
J2270	N		Morphine sulfate injection					
J2271	N		Morphine so4 injection 100mg					
J2275	N		Morphine sulfate injection					
J2280	N		Inj, moxifloxacin 100 mg					
J2300	N		Inj nalbuphine hydrochloride					
J2310	N		Inj naloxone hydrochloride					
J2320	N		Nandrolone decanoate 50 MG					
J2321	N		Nandrolone decanoate 100 MG					
J2322	N		Nandrolone decanoate 200 MG					
J2324	K		Nesiritide	9114		$75.18		$15.04
J2353	K		Octreotide injection, depot	1207		$87.39		$17.48
J2354	N		Octreotide inj, non-depot					
J2355	K		Oprelvekin injection	7011		$249.04		$49.81
J2357	G		Omalizumab injection	9300		$15.98		$3.20
J2360	N		Orphenadrine injection					
J2370	N		Phenylephrine hcl injection					
J2400	N		Chloroprocaine hcl injection					
J2405	K		Ondansetron hcl injection	0768		$3.80		$.76
J2410	N		Oxymorphone hcl injection					
J2430	K		Pamidronate disodium /30 MG	0730		$58.41		$11.68
J2440	N		Papaverin hcl injection					
J2460	N		Oxytetracycline injection					
J2469	K		Palonosetron HCl	9210		$18.42		$3.68
J2501	N		Paricalcitol					
J2505	K		Injection, pegfilgrastim 6mg	9119		$2,178.11		$435.62
J2510	N		Penicillin g procaine inj					
J2515	N		Pentobarbital sodium inj					
J2540	N		Penicillin g potassium inj					
J2543	N		Piperacillin/tazobactam					
J2545	Y		Pentamidine isethionte/300mg					
J2550	N		Promethazine hcl injection					
J2560	N		Phenobarbital sodium inj					
J2590	N		Oxytocin injection					
J2597	N		Inj desmopressin acetate					
J2650	N		Prednisolone acetate inj					
J2670	N		Totazoline hcl injection					
J2675	N		Inj progesterone per 50 MG					
J2680	N		Fluphenazine decanoate 25 MG					
J2690	N		Procainamide hcl injection					
J2700	N		Oxacillin sodium injeciton					
J2710	N		Neostigmine methylslfte inj					
J2720	N		Inj protamine sulfate/10 MG					
J2725	N		Inj protirelin per 250 mcg					
J2730	K		Pralidoxime chloride inj	2730		$76.67		$15.33
J2760	N		Phentolaine mesylate inj					
J2765	N		Metoclopramide hcl injection					
J2770	K		Quinupristin/dalfopristin	2770		$105.48		$21.10
J2780	N		Ranitidine hydrochloride inj					
J2783	G		Rasburicase	0738		$109.17		$21.83
J2788	K		Rho d immune globulin 50 mcg	9023		$25.08		$5.02
J2790	K		Rho d immune globulin inj	0884		$113.90		$22.78
J2792	K		Rho(D) immune globulin h, sd	1609		$12.04		$2.41
J2794	G		Risperidone, long acting	9125		$4.71		$.94
J2795	N		Ropivacaine HCl injection					
J2800	N		Methocarbamol injection					
J2810	N		Inj theophylline per 40 MG					
J2820	K		Sargramostim injection	0731		$21.11		$4.22
J2910	N		Aurothioglucose injeciton					
J2912	N		Sodium chloride injection					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J2916	N		Na ferric gluconate complex					
J2920	N		Methylprednisolone injection					
J2930	N		Methylprednisolone injection					
J2940	K		Somatrem injection	2940		$43.13		$8.63
J2941	K		Somatropin injection	7034		$42.93		$8.59
J2950	N		Promazine hcl injection					
J2993	K		Reteplase injection	9005		$898.74		$179.75
J2995	K		Inj streptokinase /250000 IU	0911		$83.35		$16.67
J2997	K		Alteplase recombinant	7048		$30.65		$6.13
J3000	N		Streptomycin injection					
J3010	N		Fentanyl citrate injeciton					
J3030	K		Sumatriptan succinate / 6 MG	3030		$51.03		$10.21
J3070	N		Pentazocine hcl injection					
J3100	K		Tenecteplase injection	9002		$2,052.60		$410.52
J3105	N		Terbutaline sulfate inj					
J3110	B		Teriparatide injection					
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		$712.52		$142.50
J3246	K		Tirofiban HCl	7041		$7.89		$1.58
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		$139.84		$27.97
J3310	N		Perphenazine injeciton					
J3315	K		Triptorelin pamoate	9122		$369.95		$73.99
J3320	N		Spectinomycn di-hcl inj					
J3350	K		Urea injection	9051	1.0453	$62.04		$12.41
J3360	N		Diazepam injection					
J3364	N		Urokinase 5000 IU injection					
J3365	K		Urokinase 250,000 IU inj	7036		$415.66		$83.13
J3370	N		Vancomycin hcl injection					
J3396	K		Verteporfin injection	1203		$9.16		$1.83
J3400	N		Triflupromazine hcl inj					
J3410	N		Hydroxyzine hcl injection					
J3411	N		Thiamine hcl 100 mg					
J3415	N		Pyridoxine hcl 100 mg					
J3420	N		Vitamin b12 injection					
J3430	N		Vitamin k phytonadione inj					
J3465	K		Injection, voriconazole	1052		$4.63		$.93
J3470	N		Hyaluronidase injection					
J3475	N		Inj magnesium sulfate					
J3480	N		Inj potassium chloride					
J3485	N		Zidovudine					
J3486	N		Ziprasidone mesylate					
J3487	K		Zoledronic acid	9115		$202.39		$40.48
J3490	N		Drugs unclassified injection					
J3520	E		Edetate disodium per 150 mg					
J3530	N		Nasal vaccine inhalation					
J3535	E		Metered dose inhaler drug					
J3570	E		Laetrile amygdalin vit B17					
J3590	N		Unclassified biologics					
J7030	N		Normal saline solution infus					
J7040	N		Normal saline solution infus					
J7042	N		5% dextrose/normal saline					
J7050	N		Normal saline solution infus					
J7051	N		Sterile saline/water					
J7060	N		5% dextrose/water					
J7070	N		D5w infusion					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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		$.51		$.10
J7191	K		Factor VIII (porcine)	0926		$1.75		$.35
J7192	K		Factor viii recombinant	0927		$.94		$.19
J7193	K		Factor IX non-recombinant	0931		$.75		$.15
J7194	K		Factor ix complex	0928		$.52		$.10
J7195	K		Factor IX recombinant	0932		$.86		$.17
J7197	N		Antithrombin iii injection					
J7198	K		Anti-inhibitor	0929		$1.12		$.22
J7199	B		Hemophilia clot factor noc					
J7300	E		Intraut copper contraceptive					
J7302	E		Levonorgestrel iu contracept					
J7303	E		Contraceptive vaginal ring					
J7304	E		Contraceptive hormone patch					
J7308	K		Aminolevulinic acid hcl top	7308		$96.79		$19.36
J7310	K		Ganciclovir long act implant	0913		$4,318.33		$863.67
J7317	K		Sodium hyaluronate injection	7316		$110.64		$22.13
J7320	K		Hylan G-F 20 injection	1611		$203.13		$40.63
J7330	B		Cultured chondrocytes implnt					
J7340	E		Metabolic active D/E tissue					
J7342	K		Metabolically active tissue	9054		$15.69		$3.14
J7343	B		Nonmetabolic act d/e tissue					
J7344	K		Nonmetabolic active tissue	9156		$53.75		$10.75
J7350	K		Injectable human tissue	9055		$3.54		$.71
J7500	N		Azathioprine oral 50mg					
J7501	K		Azathioprine parenteral	0887		$47.39		$9.48
J7502	K		Cyclosporine oral 100 mg	0888		$3.94		$.79
J7504	K		Lymphocyte immune globulin	0890		$290.28		$58.06
J7505	K		Monoclonal antibodies	7038		$885.29		$177.06
J7506	N		Prednisone oral					
J7507	K		Tacrolimus oral per 1 MG	0891		$3.37		$.67
J7509	N		Methylprednisolone oral					
J7510	N		Prednisolone oral per 5 mg					
J7511	K		Antithymocyte globuln rabbit	9104		$299.45		$59.89
J7513	K		Daclizumab, parenteral	1612		$381.45		$76.29
J7515	K		Cyclosporine oral 25 mg	7515		$1.00		$.20
J7516	N		Cyclosporin parenteral 250mg					
J7517	K		Mycophenolate mofetil oral	9015		$2.50		$.50
J7518	G		Mycophenolic acid	9219		$2.47		$.49
J7520	K		Sirolimus, oral	9020		$6.85		$1.37
J7525	K		Tacrolimus injection	9006		$126.61		$25.32
J7599	N		Immunosuppressive drug noc					
J7608	Y		Acetylcysteine inh sol u d					
J7611	Y		Albuterol concentrated form					
J7612	Y		Levalbuterol concentrated					
J7613	Y		Albuterol unit dose					
J7614	Y		Levalbuterol unit dose					
J7616	Y		Albuterol compound solution					
J7617	Y		Levalbuterol compounded sol					
J7622	A		Beclomethasone inhalatn sol					
J7624	A		Betamethasone inhalation sol					
J7626	A		Budesonide inhalation sol					
J7628	Y		Bitolterol mes inhal sol con					
J7629	Y		Bitolterol mes inh sol u d					
J7631	Y		Cromolyn sodium inh sol u d					
J7633	N		Budesonide concentrated sol					
J7635	Y		Atropine inhal sol con					
J7636	Y		Atropine inhal sol unit dose					
J7637	Y		Dexamethasone inhal sol con					
J7638	Y		Dexamethasone inhal sol u d					
J7639	Y		Dornase alpha inhal sol u d					
J7641	A		Flunisolide, inhalation sol					
J7642	Y		Glycopyrrolate inhal sol con					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J7643	Y		Glycopyrrolate inhal sol u d					
J7644	Y		Ipratropium brom inh sol u d					
J7648	Y		Isoetharine hcl inh sol con					
J7649	Y		Isoetharine hcl inh sol u d					
J7658	Y		Isoproterenolhcl inh sol con					
J7659	Y		Isoproterenol hcl inh sol ud					
J7668	Y		Metaproterenol inh sol con					
J7669	Y		Metaproterenol inh sol u d					
J7674	N		Methacholine chloride, neb					
J7680	Y		Terbutaline so4 inh sol con					
J7681	Y		Terbutaline so4 inh sol u d					
J7682	Y		Tobramycin inhalation sol					
J7683	Y		Triamcinolone inh sol con					
J7684	Y		Triamcinolone inh sol u d					
J7699	Y		Inhalation solution for DME					
J7799	Y		Non-inhalation drug for DME					
J8499	E		Oral prescrip drug non chemo					
J8501	G		Oral aprepitant	0868		$4.75		$.95
J8510	K		Oral busulfan	7015		$1.98		$.40
J8520	K		Capecitabine, oral, 150 mg	7042		$3.30		$.66
J8521	E		Capecitabine, oral, 500 mg					
J8530	N		Cyclophosphamide oral 25 MG					
J8560	K		Etoposide oral 50 MG	0802		$41.12		$8.22
J8565	E		Gefitinib oral					
J8600	N		Melphalan oral 2 MG					
J8610	N		Methotrexate oral 2.5 MG					
J8700	K		Temozolomide	1086		$7.28		$1.46
J8999	B		Oral prescription drug chemo					
J9000	N		Doxorubic hcl 10 MG vl chemo					
J9001	K		Doxorubicin hcl liposome inj	7046		$365.61		$73.12
J9010	K		Alemtuzumab injection	9110		$516.83		$103.37
J9015	K		Aldesleukin/single use vial	0807		$701.71		$140.34
J9017	K		Arsenic trioxide	9012		$33.76		$6.75
J9020	K		Asparaginase injection	0814		$55.41		$11.08
J9031	K		Bcg live intravesical vac	0809		$121.74		$24.35
J9035	G		Bevacizumab injection	9214		$58.17		$11.63
J9040	K		Bleomycin sulfate injection	0857		$54.17		$10.83
J9041	K		Bortezomib injection	9207		$28.90		$5.78
J9045	K		Carboplatin injection	0811		$77.15		$15.43
J9050	K		Carmus bischl nitro inj	0812		$141.27		$28.25
J9055	G		Cetuximab injection	9215		$50.58		$10.12
J9060	N		Cisplatin 10 MG injection					
J9062	B		Cisplatin 50 MG injection					
J9065	K		Inj cladribine per 1 MG	0858		$39.37		$7.87
J9070	N		Cyclophosphamide 100 MG inj					
J9080	B		Cyclophosphamide 200 MG inj					
J9090	B		Cyclophosphamide 500 MG inj					
J9091	B		Cyclophosphamide 1.0 grm inj					
J9092	B		Cyclophosphamide 2.0 grm inj					
J9093	N		Cyclophosphamide lyophilized					
J9094	B		Cyclophosphamide lyophilized					
J9095	B		Cyclophosphamide lyophilized					
J9096	B		Cyclophosphamide lyophilized					
J9097	B		Cyclophosphamide lyophilized					
J9098	K		Cytarabine liposome	1166		$366.40		$73.28
J9100	N		Cytarabine hcl 100 MG inj					
J9110	B		Cytarabine hcl 500 MG inj					
J9120	N		Dactinomycin actinomycin d					
J9130	K		Dacarbazine 100 mg inj	0819		$6.20		$1.24
J9140	B		Dacarbazine 200 MG inj					
J9150	K		Daunorubicin	0820		$35.28		$7.06
J9151	K		Daunorubicin citrate liposom	0821		$57.55		$11.51
J9160	K		Denileukin diftitox, 300 mcg	1084		$1,235.23		$247.05
J9165	N		Diethylstilbestrol injection					
J9170	K		Docetaxel	0823		$301.15		$60.23
J9178	K		Inj, epirubicin hcl, 2 mg	1167		$25.15		$5.03

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
J9181	N		Etoposide 10 MG inj					
J9182	B		Etoposide 100 MG inj					
J9185	K		Fludarabine phosphate inj	0842		$262.39		$52.48
J9190	N		Fluorouracil injection					
J9200	K		Floxuridine injection	0827		$60.16		$12.03
J9201	K		Gemcitabine HCl	0828		$117.44		$23.49
J9202	K		Goserelin acetate implant	0810		$196.24		$39.25
J9206	K		Irinotecan injection	0830		$129.07		$25.81
J9208	K		Ifosfomide injection	0831		$53.53		$10.71
J9209	K		Mesna injection	0732		$13.68		$2.74
J9211	K		Idarubicin hcl injection	0832		$313.97		$62.79
J9212	K		Interferon alfacon-1	0912		$3.91		$.78
J9213	K		Interferon alfa-2a inj	0834		$31.75		$6.35
J9214	K		Interferon alfa-2b inj	0836		$13.22		$2.64
J9215	K		Interferon alfa-n3 inj	0865		$8.77		$1.75
J9216	K		Interferon gamma 1-b inj	0838		$277.77		$55.55
J9217	K		Leuprolide acetate suspnsion	9217		$230.85		$46.17
J9218	K		Leuprolide acetate injeciton	0861		$10.96		$2.19
J9219	K		Leuprolide acetate implant	7051		$2,262.01		$452.40
J9230	N		Mechlorethamine hcl inj					
J9245	K		Inj melphalan hydrochl 50 MG	0840		$523.18		$104.64
J9250	N		Methotrexate sodium inj					
J9260	B		Methotrexate sodium inj					
J9263	B		Oxaliplatin					
J9265	K		Paclitaxel injection	0863		$19.11		$3.82
J9266	K		Pegaspargase/singl dose vial	0843		$1,528.67		$305.73
J9268	K		Pentostatin injection	0844		$1,868.76		$373.75
J9270	K		Plicamycin (mithramycin) inj	0860		$80.54		$16.11
J9280	K		Mitomycin 5 MG inj	0862		$26.36		$5.27
J9290	B		Mitomycin 20 MG inj					
J9291	B		Mitomycin 40 MG inj					
J9293	K		Mitoxantrone hydrochl / 5 MG	0864		$329.66		$65.93
J9300	K		Gemtuzumab ozogamicin	9004		$2,244.86		$448.97
J9305	G		Pemetrexed injection	9213		$41.29		$8.26
J9310	K		Rituximab cancer treatment	0849		$447.93		$89.59
J9320	K		Streptozocin injection	0850		$153.31		$30.66
J9340	K		Thiotepa injection	0851		$44.55		$8.91
J9350	K		Topotecan	0852		$755.44		$151.09
J9355	K		Trastuzumab	1613		$53.97		$10.79
J9357	K		Valrubicin, 200 mg	9167		$376.83		$75.37
J9360	N		Vinblastine sulfate inj					
J9370	N		Vincristine sulfate 1 MG inj					
J9375	B		Vincristine sulfate 2 MG inj					
J9380	B		Vincristine sulfate 5 MG inj					
J9390	K		Vinorelbine tartrate/10 mg	0855		$62.84		$12.57
J9395	K		Injection, Fulvestrant	9120		$82.90		$16.58
J9600	K		Porfimer sodium	0856		$2,457.78		$491.56
J9999	N		Chemotherapy drug					
K0001	Y		Standard wheelchair					
K0002	Y		Stnd hemi (low seat) whlchr					
K0003	Y		Lightweight wheelchair					
K0004	Y		High strength ltwt whlchr					
K0005	Y		Ultralightweight wheelchair					
K0006	Y		Heavy duty wheelchair					
K0007	Y		Extra heavy duty wheelchair					
K0009	Y		Other manual wheelchair/base					
K0010	Y		Stnd wt frame power whlchr					
K0011	Y		Stnd wt pwr whlchr w control					
K0012	Y		Ltwt portbl power whlchr					
K0014	Y		Other power whlchr base					
K0015	Y		Detach non-adjus hght armrst					
K0017	Y		Detach adjust armrest base					
K0018	Y		Detach adjust armrst upper					
K0019	Y		Arm pad each					
K0020	Y		Fixed adjust armrest pair					
K0037	Y		High mount flip-up footrest					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0038	Y		Leg strap each					
K0039	Y		Leg strap h style each					
K0040	Y		Adjustable angle footplate					
K0041	Y		Large size footplate each					
K0042	Y		Standard size footplate each					
K0043	Y		Ftrst lower extension tube					
K0044	Y		Ftrst upper hanger bracket					
K0045	Y		Footrest complete assembly					
K0046	Y		Elevat legrst low extension					
K0047	Y		Elevat legrst up hangr brack					
K0050	Y		Ratchet assembly					
K0051	Y		Cam relese assem ftrst/lgrst					
K0052	Y		Swingaway detach footrest					
K0053	Y		Elevate footrest articulate					
K0056	Y		Seat ht >17 or <=21 ltwt wc					
K0064	Y		Zero pressure tube flat free					
K0065	Y		Spoke protectors					
K0066	Y		Solid tire any size each					
K0067	Y		Pneumatic tire any size each					
K0068	Y		Pneumatic tire tube each					
K0069	Y		Rear whl complete solid tire					
K0070	Y		Rear whl compl pneum tire					
K0071	Y		Front castr compl pneum tire					
K0072	Y		Frnt cstr cmpl sem-pneum tir					
K0073	Y		Caster pin lock each					
K0074	Y		Pneumatic caster tire each					
K0075	Y		Semi-pneumatic caster tire					
K0076	Y		Solid caster tire each					
K0077	Y		Front caster assem complete					
K0078	Y		Pneumatic caster tire tube					
K0090	Y		Rear tire power wheelchair					
K0091	Y		Rear tire tube power whlchr					
K0092	Y		Rear assem cmplt powr whlchr					
K0093	Y		Rear zero pressure tire tube					
K0094	Y		Wheel tire for power base					
K0095	Y		Wheel tire tube each base					
K0096	Y		Wheel assem powr base complt					
K0097	Y		Wheel zero presure tire tube					
K0098	Y		Drive belt power wheelchair					
K0099	Y		Pwr wheelchair front caster					
K0102	Y		Crutch and cane holder					
K0104	Y		Cylinder tank carrier					
K0105	Y		Iv hanger					
K0106	Y		Arm trough each					
K0108	Y		W/c component-accessory NOS					
K0195	Y		Elevating whlchair leg rests					
K0415	B		RX antiemetic drg, oral NOS					
K0416	B		Rx antiemetic drg,rectal NOS					
K0452	Y		Wheelchair bearings					
K0455	Y		Pump uninterrupted infusion					
K0462	Y		Temporary replacement eqpmnt					
K0552	Y		Supply/Ext inf pump syr type					
K0600	Y		Functional neuromuscularstim					
K0601	Y		Repl batt silver oxide 1.5 v					
K0602	Y		Repl batt silver oxide 3 v					
K0603	Y		Repl batt alkaline 1.5 v					
K0604	Y		Repl batt lithium 3.6 v					
K0605	Y		Repl batt lithium 4.5 v					
K0606	Y		AED garment w/elec analysis					
K0607	Y		Repl batt for AED					
K0608	Y		Repl garment for AED					
K0609	Y		Repl electrode for AED					
K0618	A		TLSO 2 piece rigid shell					
K0619	A		TLSO 3 piece rigid shell					
K0620	A		Tubular elastic dressing					
K0628	Y		Mult dens insert direct form					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
K0629	Y		Mult dens insert custom mold					
K0630	Y		SIO flex pelvisacral prefab					
K0631	Y		SIO flex pelvisacral custom					
K0632	Y		SIO panel prefab					
K0633	Y		SIO panel custom					
K0634	Y		LO flexibl L1 - below L5 pre					
K0635	Y		LO sag stays/panels pre-fab					
K0636	Y		LO sagitt rigid panel prefab					
K0637	Y		LO flex w/o rigid stays pre					
K0638	Y		LSO flex w/rigid stays cust					
K0639	Y		LSO post rigid panel pre					
K0640	Y		LSO sag-coro rigid frame pre					
K0641	Y		LSO sag-cor rigid frame cust					
K0642	Y		LSO flexion control prefab					
K0643	Y		LSO flexion control custom					
K0644	Y		LSO sagit rigid panel prefab					
K0645	Y		LSO sagittal rigid panel cus					
K0646	Y		LSO sag-coronal panel prefab					
K0647	Y		LSO sag-coronal panel custom					
K0648	Y		LSO s/c shell/panel prefab					
K0649	Y		LSO s/c shell/panel custom					
K0669	Y		W/c seat/back no CVR SADMERC					
K0670	A		Stance phase only					
K0671	Y		Portable oxygen concentrator					
L0100	A		Cranial orthosis/helmet mold					
L0110	A		Cranial orthosis/helmet nonm					
L0112	A		Cranial cervical orthosis					
L0120	A		Cerv flexible non-adjustable					
L0130	A		Flex thermoplastic collar mo					
L0140	A		Cervical semi-rigid adjustab					
L0150	A		Cerv semi-rig adj molded chn					
L0160	A		Cerv semi-rig wire occ/mand					
L0170	A		Cervical collar molded to pt					
L0172	A		Cerv col thermplas foam 2 pi					
L0174	A		Cerv col foam 2 piece w thor					
L0180	A		Cer post col occ/man sup adj					
L0190	A		Cerv collar supp adj cerv ba					
L0200	A		Cerv col supp adj bar & thor					
L0210	A		Thoracic rib belt					
L0220	A		Thor rib belt custom fabrica					
L0430	A		Dewall posture protector					
L0450	A		TLSO flex prefab thoracic					
L0452	A		tlso flex custom fab thoraci					
L0454	A		TLSO flex prefab sacrococ-T9					
L0456	A		TLSO flex prefab					
L0458	A		TLSO 2Mod symphis-xipho pre					
L0460	A		TLSO2Mod symphysis-stern pre					
L0462	A		TLSO 3Mod sacro-scap pre					
L0464	A		TLSO 4Mod sacro-scap pre					
L0466	A		TLSO rigid frame pre soft ap					
L0468	A		TLSO rigid frame prefab pelv					
L0470	A		TLSO rigid frame pre subclav					
L0472	A		TLSO rigid frame hyperex pre					
L0480	A		TLSO rigid plastic custom fa					
L0482	A		TLSO rigid lined custom fab					
L0484	A		TLSO rigid plastic cust fab					
L0486	A		TLSO rigidlined cust fab two					
L0488	A		TLSO rigid lined pre one pie					
L0490	A		TLSO rigid plastic pre one					
L0700	A		Ctlso a-p-l control molded					
L0710	A		Ctlso a-p-l control w/ inter					
L0810	A		Halo cervical into jckt vest					
L0820	A		Halo cervical into body jack					
L0830	A		Halo cerv into milwaukee typ					
L0860	A		Magnetic resonanc image comp					
L0861	A		Halo repl liner/interface					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L0960	E		Post surgical support pads					
L0970	A		Tlso corset front					
L0972	A		Lso corset front					
L0974	A		Tlso full corset					
L0976	A		Lso full corset					
L0978	A		Axillary crutch extension					
L0980	A		Peroneal straps pair					
L0982	A		Stocking supp grips set of f					
L0984	A		Protective body sock each					
L0999	A		Add to spinal orthosis NOS					
L1000	A		Ctlso milwauke initial model					
L1005	A		Tension based scoliosis orth					
L1010	A		Ctlso axilla sling					
L1020	A		Kyphosis pad					
L1025	A		Kyphosis pad floating					
L1030	A		Lumbar bolster pad					
L1040	A		Lumbar or lumbar rib pad					
L1050	A		Sternal pad					
L1060	A		Thoracic pad					
L1070	A		Trapezius sling					
L1080	A		Outrigger					
L1085	A		Outrigger bil w/ vert extens					
L1090	A		Lumbar sling					
L1100	A		Ring flange plastic/leather					
L1110	A		Ring flange plas/leather mol					
L1120	A		Covers for upright each					
L1200	A		Furnsh initial orthosis only					
L1210	A		Lateral thoracic extension					
L1220	A		Anterior thoracic extension					
L1230	A		Milwaukee type superstructur					
L1240	A		Lumbar derotation pad					
L1250	A		Anterior asis pad					
L1260	A		Anterior thoracic derotation					
L1270	A		Abdominal pad					
L1280	A		Rib gusset (elastic) each					
L1290	A		Lateral trochanteric pad					
L1300	A		Body jacket mold to patient					
L1310	A		Post-operative body jacket					
L1499	A		Spinal orthosis NOS					
L1500	A		Thkao mobility frame					
L1510	A		Thkao standing frame					
L1520	A		Thkao swivel walker					
L1600	A		Abduct hip flex frejka w cvr					
L1610	A		Abduct hip flex frejka covr					
L1620	A		Abduct hip flex pavlik harne					
L1630	A		Abduct control hip semi-flex					
L1640	A		Pelv band/spread bar thigh c					
L1650	A		HO abduction hip adjustable					
L1652	A		HO bi thighcuffs w sprdr bar					
L1660	A		HO abduction static plastic					
L1680	A		Pelvic & hip control thigh c					
L1685	A		Post-op hip abduct custom fa					
L1686	A		HO post-op hip abduction					
L1690	A		Combination bilateral HO					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L1831	A		Knee orth pos locking joint					
L1832	A		KO adj jnt pos rigid support					
L1834	A		Ko w/0 joint rigid molded to					
L1836	A		Rigid KO wo joints					
L1840	A		Ko derot ant cruciate custom					
L1843	A		KO single upright custom fit					
L1844	A		Ko w/adj jt rot cntrl molded					
L1845	A		Ko w/ adj flex/ext rotat cus					
L1846	A		Ko w adj flex/ext rotat mold					
L1847	A		KO adjustable w air chambers					
L1850	A		Ko swedish type					
L1855	A		Ko plas doub upright jnt mol					
L1858	A		Ko polycentric pneumatic pad					
L1860	A		Ko supracondylar socket mold					
L1870	A		Ko doub upright lacers molde					
L1880	A		Ko doub upright cuffs/lacers					
L1900	A		Afo sprng wir drsflx calf bd					
L1901	A		Prefab ankle orthosis					
L1902	A		Afo ankle gauntlet					
L1904	A		Afo molded ankle gauntlet					
L1906	A		Afo multiligamentus ankle su					
L1907	A		AFO supramalleolar custom					
L1910	A		Afo sing bar clasp attach sh					
L1920	A		Afo sing upright w/ adjust s					
L1930	A		Afo plastic					
L1932	A		Afo rig ant tib prefab TCF/=					
L1940	A		Afo molded to patient plasti					
L1945	A		Afo molded plas rig ant tib					
L1950	A		Afo spiral molded to pt plas					
L1951	A		AFO spiral prefabricated					
L1960	A		Afo pos solid ank plastic mo					
L1970	A		Afo plastic molded w/ankle j					
L1971	A		AFO w/ankle joint, prefab					
L1980	A		Afo sing solid stirrup calf					
L1990	A		Afo doub solid stirrup calf					
L2000	A		Kafo sing fre stirr thi/calf					
L2005	A		KAFO sng/dbl mechanical act					
L2010	A		Kafo sng solid stirrup w/o j					
L2020	A		Kafo dbl solid stirrup band/					
L2030	A		Kafo dbl solid stirrup w/o j					
L2035	A		KAFO plastic pediatric size					
L2036	A		Kafo plas doub free knee mol					
L2037	A		Kafo plas sing free knee mol					
L2038	A		Kafo w/o joint multi-axis an					
L2039	A		KAFO,plstic,medlat rotat con					
L2040	A		Hkafo torsion bil rot straps					
L2050	A		Hkafo torsion cable hip pelv					
L2060	A		Hkafo torsion ball bearing j					
L2070	A		Hkafo torsion unilat rot str					
L2080	A		Hkafo unilat torsion cable					
L2090	A		Hkafo unilat torsion ball br					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L2232	A		Rocker bottom, contact AFO					
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					
L2492	A		Knee lift loop drop lock rin					
L2500	A		Thi/glut/ischia wgt bearing					
L2510	A		Th/wght bear quad-lat brim m					
L2520	A		Th/wght bear quad-lat brim c					
L2525	A		Th/wght bear nar m-l brim mo					
L2526	A		Th/wght bear nar m-l brim cu					
L2530	A		Thigh/wght bear lacer non-mo					
L2540	A		Thigh/wght bear lacer molded					
L2550	A		Thigh/wght bear high roll cu					
L2570	A		Hip clevis type 2 posit jnt					
L2580	A		Pelvic control pelvic sling					
L2600	A		Hip clevis/thrust bearing fr					
L2610	A		Hip clevis/thrust bearing lo					
L2620	A		Pelvic control hip heavy dut					
L2622	A		Hip joint adjustable flexion					
L2624	A		Hip adj flex ext abduct cont					
L2627	A		Plastic mold recipro hip & c					
L2628	A		Metal frame recipro hip & ca					
L2630	A		Pelvic control band & belt u					
L2640	A		Pelvic control band & belt b					
L2650	A		Pelv & thor control gluteal					
L2660	A		Thoracic control thoracic ba					
L2670	A		Thorac cont paraspinal uprig					
L2680	A		Thorac cont lat support upri					
L2750	A		Plating chrome/nickel pr bar					
L2755	A		Carbon graphite lamination					
L2760	A		Extension per extension per					
L2768	A		Ortho sidebar disconnect					
L2770	A		Low ext orthosis per bar/jnt					
L2780	A		Non-corrosive finish					
L2785	A		Drop lock retainer each					
L2795	A		Knee control full kneecap					
L2800	A		Knee cap medial or lateral p					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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	B		Ft insert ucb berkeley shell					
L3001	B		Foot insert remov molded spe					
L3002	B		Foot insert plastazote or eq					
L3003	B		Foot insert silicone gel eac					
L3010	B		Foot longitudinal arch suppo					
L3020	B		Foot longitud/metatarsal sup					
L3030	B		Foot arch support remov prem					
L3031	E		Foot lamin/prepreg composite					
L3040	B		Ft arch suprt premold longit					
L3050	B		Foot arch supp premold metat					
L3060	B		Foot arch supp longitud/meta					
L3070	B		Arch suprt att to sho longit					
L3080	B		Arch supp att to shoe metata					
L3090	B		Arch supp att to shoe long/m					
L3100	B		Hallus-valgus nght dynamic s					
L3140	B		Abduction rotation bar shoe					
L3150	B		Abduct rotation bar w/o shoe					
L3160	B		Shoe styled positioning dev					
L3170	B		Foot plastic heel stabilizer					
L3201	B		Oxford w supinat/pronat inf					
L3202	B		Oxford w/ supinat/pronator c					
L3203	B		Oxford w/ supinator/pronator					
L3204	B		Hightop w/ supp/pronator inf					
L3206	B		Hightop w/ supp/pronator chi					
L3207	B		Hightop w/ supp/pronator jun					
L3208	B		Surgical boot each infant					
L3209	B		Surgical boot each child					
L3211	B		Surgical boot each junior					
L3212	B		Benesch boot pair infant					
L3213	B		Benesch boot pair child					
L3214	B		Benesch boot pair junior					
L3215	B		Orthopedic ftwear ladies oxf					
L3216	B		Orthoped ladies shoes dpth i					
L3217	B		Ladies shoes hightop depth i					
L3219	B		Orthopedic mens shoes oxford					
L3221	B		Orthopedic mens shoes dpth i					
L3222	B		Mens shoes hightop depth inl					
L3224	A		Womans shoe oxford brace					
L3225	A		Mans shoe oxford brace					
L3230	B		Custom shoes depth inlay					
L3250	B		Custom mold shoe remov prost					
L3251	B		Shoe molded to pt silicone s					
L3252	B		Shoe molded plastazote cust					
L3253	B		Shoe molded plastazote cust					
L3254	B		Orth foot non-stndard size/w					
L3255	B		Orth foot non-standard size/					
L3257	B		Orth foot add charge split s					
L3260	B		Ambulatory surgical boot eac					
L3265	B		Plastazote sandal each					
L3300	B		Sho lift taper to metatarsal					
L3310	B		Shoe lift elev heel/sole neo					
L3320	B		Shoe lift elev heel/sole cor					
L3330	B		Lifts elevation metal extens					
L3332	B		Shoe lifts tapered to one-ha					
L3334	B		Shoe lifts elevation heel /i					
L3340	B		Shoe wedge sach					
L3350	B		Shoe heel wedge					
L3360	B		Shoe sole wedge outside sole					
L3370	B		Shoe sole wedge between sole					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3380	B		Shoe clubfoot wedge					
L3390	B		Shoe outflare wedge					
L3400	B		Shoe metatarsal bar wedge ro					
L3410	B		Shoe metatarsal bar between					
L3420	B		Full sole/heel wedge btween					
L3430	B		Sho heel count plast reinfor					
L3440	B		Heel leather reinforced					
L3450	B		Shoe heel sach cushion type					
L3455	B		Shoe heel new leather standa					
L3460	B		Shoe heel new rubber standar					
L3465	B		Shoe heel thomas with wedge					
L3470	B		Shoe heel thomas extend to b					
L3480	B		Shoe heel pad & depress for					
L3485	B		Shoe heel pad removable for					
L3500	B		Ortho shoe add leather insol					
L3510	B		Orthopedic shoe add rub insl					
L3520	B		O shoe add felt w leath insl					
L3530	B		Ortho shoe add half sole					
L3540	B		Ortho shoe add full sole					
L3550	B		O shoe add standard toe tap					
L3560	B		O shoe add horseshoe toe tap					
L3570	B		O shoe add instep extension					
L3580	B		O shoe add instep velcro clo					
L3590	B		O shoe convert to sof counte					
L3595	B		Ortho shoe add march bar					
L3600	B		Trans shoe calip plate exist					
L3610	B		Trans shoe caliper plate new					
L3620	B		Trans shoe solid stirrup exi					
L3630	B		Trans shoe solid stirrup new					
L3640	B		Shoe dennis browne splint bo					
L3649	B		Orthopedic shoe modifica NOS					
L3650	A		Shlder fig 8 abduct restrain					
L3651	A		Prefab shoulder orthosis					
L3652	A		Prefab dbl shoulder orthosis					
L3660	A		Abduct restrainer canvas&web					
L3670	A		Acromio/clavicular canvas&we					
L3675	A		Canvas vest SO					
L3677	E		SO hard plastic stabilizer					
L3700	A		Elbow orthoses elas w stays					
L3701	A		Prefab elbow orthosis					
L3710	A		Elbow elastic with metal joi					
L3720	A		Forearm/arm cuffs free motio					
L3730	A		Forearm/arm cuffs ext/flex a					
L3740	A		Cuffs adj lock w/ active con					
L3760	A		EO withjoint, Prefabricated					
L3762	A		Rigid EO wo joints					
L3800	A		Whfo short opponen no attach					
L3805	A		Whfo long opponens no attach					
L3807	A		WHFO,no joint, prefabricated					
L3810	A		Whfo thumb abduction bar					
L3815	A		Whfo second m.p. abduction a					
L3820	A		Whfo ip ext asst w/ mp ext s					
L3825	A		Whfo m.p. extension stop					
L3830	A		Whfo m.p. extension assist					
L3835	A		Whfo m.p. spring extension a					
L3840	A		Whfo spring swivel thumb					
L3845	A		Whfo thumb ip ext ass w/ mp					
L3850	A		Action wrist w/ dorsiflex as					
L3855	A		Whfo adj m.p. flexion contro					
L3860	A		Whfo adj m.p. flex ctrl & i.					
L3890	B		Torsion mechanism wrist/elbo					
L3900	A		Hinge extension/flex wrist/f					
L3901	A		Hinge ext/flex wrist finger					
L3902	E		Whfo ext power compress gas					
L3904	A		Whfo electric custom fitted					
L3906	A		Wrist gauntlet molded to pt					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L3907	A		Whfo wrst gauntlt thmb spica					
L3908	A		Wrist cock-up non-molded					
L3909	A		Prefab wrist orthosis					
L3910	A		Whfo swanson design					
L3911	A		Prefab hand finger orthosis					
L3912	A		Flex glove w/elastic finger					
L3914	A		WHO wrist extension cock-up					
L3916	A		Whfo wrist extens w/ outrigg					
L3917	A		Prefab metacarpl fx orthosis					
L3918	A		HFO knuckle bender					
L3920	A		Knuckle bender with outrigge					
L3922	A		Knuckle bend 2 seg to flex j					
L3923	A		HFO, no joint, prefabricated					
L3924	A		Oppenheimer					
L3926	A		Thomas suspension					
L3928	A		Finger extension w/ clock sp					
L3930	A		Finger extension with wrist					
L3932	A		Safety pin spring wire					
L3934	A		Safety pin modified					
L3936	A		Palmer					
L3938	A		Dorsal wrist					
L3940	A		Dorsal wrist w/ outrigger at					
L3942	A		Reverse knuckle bender					
L3944	A		Reverse knuckle bend w/ outr					
L3946	A		HFO composite elastic					
L3948	A		Finger knuckle bender					
L3950	A		Oppenheimer w/ knuckle bend					
L3952	A		Oppenheimer w/ rev knuckle 2					
L3954	A		Spreading hand					
L3956	A		Add joint upper ext orthosis					
L3960	A		Sewho airplan desig abdu pos					
L3962	A		Sewho erbs palsey design abd					
L3963	A		Molded w/ articulating elbow					
L3964	Y		Seo mobile arm sup att to wc					
L3965	Y		Arm supp att to wc rancho ty					
L3966	Y		Mobile arm supports reclinin					
L3968	Y		Friction dampening arm supp					
L3969	Y		Monosuspension arm/hand supp					
L3970	Y		Elevat proximal arm support					
L3972	Y		Offset/lat rocker arm w/ ela					
L3974	Y		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					
L4002	A		Replace strap, any orthosis					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L4350	A		Ankle control orthosi prefab					
L4360	A		Pneumati walking boot prefab					
L4370	A		Pneumatic full leg splint					
L4380	A		Pneumatic knee splint					
L4386	A		Non-pneum walk boot prefab					
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					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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 cushion socket					
L5647	A		Below knee suction socket					
L5648	A		Above knee cushion socket					
L5649	A		Isch containmt/narrow m-l so					
L5650	A		Tot contact ak/knee disart s					
L5651	A		Ak flex inner socket ext fra					
L5652	A		Suction susp ak/knee disart					
L5653	A		Knee disart expand wall sock					
L5654	A		Socket insert symes					
L5655	A		Socket insert below knee					
L5656	A		Socket insert knee articulat					
L5658	A		Socket insert above knee					
L5661	A		Multi-durometer symes					
L5665	A		Multi-durometer below knee					
L5666	A		Below knee cuff suspension					
L5668	A		Socket insert w/o lock lower					
L5670	A		Bk molded supracondylar susp					
L5671	A		BK/AK locking mechanism					
L5672	A		Bk removable medial brim sus					
L5673	A		Socket insert w lock mech					
L5676	A		Bk knee joints single axis p					
L5677	A		Bk knee joints polycentric p					
L5678	A		Bk joint covers pair					
L5679	A		Socket insert w/o lock mech					
L5680	A		Bk thigh lacer non-molded					
L5681	A		Intl custm cong/latyp insert					
L5682	A		Bk thigh lacer glut/ischia m					
L5683	A		Initial custom socket insert					
L5684	A		Bk fork strap					
L5685	A		Below knee sus/seal sleeve					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L5728	A		Knee-shin fluid swg & stance					
L5780	A		Knee-shin pneum/hydra pneum					
L5781	A		Lower limb pros vacuum pump					
L5782	A		HD low limb pros vacuum pump					
L5785	A		Exoskeletal bk ultralt mater					
L5790	A		Exoskeletal ak ultra-light m					
L5795	A		Exoskel hip ultra-light mate					
L5810	A		Endoskel knee-shin mnl lock					
L5811	A		Endo knee-shin mnl lck ultra					
L5812	A		Endo knee-shin frct swg & st					
L5814	A		Endo knee-shin hydral swg ph					
L5816	A		Endo knee-shin polyc mch sta					
L5818	A		Endo knee-shin frct swg & st					
L5822	A		Endo knee-shin pneum swg frc					
L5824	A		Endo knee-shin fluid swing p					
L5826	A		Miniature knee joint					
L5828	A		Endo knee-shin fluid swg/sta					
L5830	A		Endo knee-shin pneum/swg pha					
L5840	A		Multi-axial knee/shin system					
L5845	A		Knee-shin sys stance flexion					
L5848	A		Knee-shin sys hydraul stance					
L5850	A		Endo ak/hip knee extens assi					
L5855	A		Mech hip extension assist					
L5856	A		Elec knee-shin swing/stance					
L5857	A		Elec knee-shin swing only					
L5910	A		Endo below knee alignable sy					
L5920	A		Endo ak/hip alignable system					
L5925	A		Above knee manual lock					
L5930	A		High activity knee frame					
L5940	A		Endo bk ultra-light material					
L5950	A		Endo ak ultra-light material					
L5960	A		Endo hip ultra-light materia					
L5962	A		Below knee flex cover system					
L5964	A		Above knee flex cover system					
L5966	A		Hip flexible cover system					
L5968	A		Multiaxial ankle w dorsiflex					
L5970	A		Foot external keel sach foot					
L5972	A		Flexible keel foot					
L5974	A		Foot single axis ankle/foot					
L5975	A		Combo ankle/foot prosthesis					
L5976	A		Energy storing foot					
L5978	A		Ft prosth multiaxial ankl/ft					
L5979	A		Multi-axial ankle/ft prosth					
L5980	A		Flex foot system					
L5981	A		Flex-walk sys low ext prosth					
L5982	A		Exoskeletal axial rotation u					
L5984	A		Endoskeletal axial rotation					
L5985	A		Lwr ext dynamic prosth pylon					
L5986	A		Multi-axial rotation unit					
L5987	A		Shank ft w vert load pylon					
L5988	A		Vertical shock reducing pylo					
L5990	A		User adjustable heel height					
L5995	A		Lower ext pros heavyduty fea					
L5999	A		Lowr extremity prosthes NOS					
L6000	A		Par hand robin-aids thum rem					
L6010	A		Hand robin-aids little/ring					
L6020	A		Part hand robin-aids no fing					
L6025	A		Part hand disart myoelectric					
L6050	A		Wrst MLd sck flx hng tri pad					
L6055	A		Wrst mold sock w/exp interfa					
L6100	A		Elb mold sock flex hinge pad					
L6110	A		Elbow mold sock suspension t					
L6120	A		Elbow mold doub splt soc ste					
L6130	A		Elbow stump activated lock h					
L6200	A		Elbow mold outsid lock hinge					
L6205	A		Elbow molded w/ expand inter					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6250	A		Elbow inter loc elbow forarm					
L6300	A		Shlder disart int lock elbow					
L6310	A		Shoulder passive restor comp					
L6320	A		Shoulder passive restor cap					
L6350	A		Thoracic intern lock elbow					
L6360	A		Thoracic passive restor comp					
L6370	A		Thoracic passive restor cap					
L6380	A		Postop dsg cast chg wrst/elb					
L6382	A		Postop dsg cast chg elb dis/					
L6384	A		Postop dsg cast chg shlder/t					
L6386	A		Postop ea cast chg & realign					
L6388	A		Postop applicat rigid dsg on					
L6400	A		Below elbow prosth tiss shap					
L6450	A		Elb disart prosth tiss shap					
L6500	A		Above elbow prosth tiss shap					
L6550	A		Shldr disar prosth tiss shap					
L6570	A		Scap thorac prosth tiss shap					
L6580	A		Wrist/elbow bowden cable mol					
L6582	A		Wrist/elbow bowden cbl dir f					
L6584	A		Elbow fair lead cable molded					
L6586	A		Elbow fair lead cable dir fo					
L6588	A		Shdr fair lead cable molded					
L6590	A		Shdr fair lead cable direct					
L6600	A		Polycentric hinge pair					
L6605	A		Single pivot hinge pair					
L6610	A		Flexible metal hinge pair					
L6615	A		Disconnect locking wrist uni					
L6616	A		Disconnect insert locking wr					
L6620	A		Flexion/extension wrist unit					
L6623	A		Spring-ass rot wrst w/ latch					
L6625	A		Rotation wrst w/ cable lock					
L6628	A		Quick disconn hook adapter o					
L6629	A		Lamination collar w/ couplin					
L6630	A		Stainless steel any wrist					
L6632	A		Latex suspension sleeve each					
L6635	A		Lift assist for elbow					
L6637	A		Nudge control elbow lock					
L6638	A		Elec lock on manual pw elbow					
L6640	A		Shoulder abduction joint pai					
L6641	A		Excursion amplifier pulley t					
L6642	A		Excursion amplifier lever ty					
L6645	A		Shoulder flexion-abduction j					
L6646	A		Multipo locking shoulder jnt					
L6647	A		Shoulder lock actuator					
L6648	A		Ext pwrd shlder lock/unlock					
L6650	A		Shoulder universal joint					
L6655	A		Standard control cable extra					
L6660	A		Heavy duty control cable					
L6665	A		Teflon or equal cable lining					
L6670	A		Hook to hand cable adapter					
L6672	A		Harness chest/shlder saddle					
L6675	A		Harness figure of 8 sing con					
L6676	A		Harness figure of 8 dual con					
L6680	A		Test sock wrist disart/bel e					
L6682	A		Test sock elbw disart/above					
L6684	A		Test socket shldr disart/tho					
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					
L6694	A		Elbow socket ins use w/lock					
L6695	A		Elbow socket ins use w/o lck					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
L6696	A		Cus elbo skt in for con/atyp					
L6697	A		Cus elbo skt in not con/atyp					
L6698	A		Below/above elbow lock mech					
L6700	A		Terminal device model #3					
L6705	A		Terminal device model #5					
L6710	A		Terminal device model #5x					
L6715	A		Terminal device model #5xa					
L6720	A		Terminal device model #6					
L6725	A		Terminal device model #7					
L6730	A		Terminal device model #7lo					
L6735	A		Terminal device model #8					
L6740	A		Terminal device model #8x					
L6745	A		Terminal device model #88x					
L6750	A		Terminal device model #10p					
L6755	A		Terminal device model #10x					
L6765	A		Terminal device model #12p					
L6770	A		Terminal device model #99x					
L6775	A		Terminal device model #555					
L6780	A		Terminal device model #ss555					
L6790	A		Hooks-accu hook or equal					
L6795	A		Hooks-2 load or equal					
L6800	A		Hooks-aprl vc or equal					
L6805	A		Modifier wrist flexion unit					
L6806	A		Trs grip vc or equal					
L6807	A		Term device grip1/2 or equal					
L6808	A		Term device infant or child					
L6809	A		Trs super sport passive					
L6810	A		Pincher tool otto bock or eq					
L6825	A		Hands dorrance vo					
L6830	A		Hand aprl vc					
L6835	A		Hand sierra vo					
L6840	A		Hand becker imperial					
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					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L7181	A		Electronic elbo simultaneous					
L7185	A		Electron elbow adolescent sw					
L7186	A		Electron elbow child switch					
L7190	A		Elbow adolescent myoelectron					
L7191	A		Elbow child myoelectronic ct					
L7260	A		Electron wrist rotator otto					
L7261	A		Electron wrist rotator utah					
L7266	A		Servo control steeper or equ					
L7272	A		Analogue control unb or equa					
L7274	A		Proportional ctl 12 volt uta					
L7360	A		Six volt bat otto bock/eq ea					
L7362	A		Battery chrgr six volt otto					
L7364	A		Twelve volt battery utah/equ					
L7366	A		Battery chrgr 12 volt utah/e					
L7367	A		Replacemnt lithium ionbatter					
L7368	A		Lithium ion battery charger					
L7499	A		Upper extremity prosthes NOS					
L7500	A		Prosthetic dvc repair hourly					
L7510	A		Prosthetic device repair rep					
L7520	A		Repair prosthesis per 15 min					
L7900	A		Male vacuum erection system					
L8000	A		Mastectomy bra					
L8001	A		Breast prosthesis bra & form					
L8002	A		Brst prsth bra & bilat form					
L8010	A		Mastectomy sleeve					
L8015	A		Ext breastprosthesis garment					
L8020	A		Mastectomy form					
L8030	A		Breast prosthesis silicone/e					
L8035	A		Custom breast prosthesis					
L8039	A		Breast prosthesis NOS					
L8040	A		Nasal prosthesis					
L8041	A		Midfacial prosthesis					
L8042	A		Orbital prosthesis					
L8043	A		Upper facial prosthesis					
L8044	A		Hemi-facial prosthesis					
L8045	A		Auricular prosthesis					
L8046	A		Partial facial prosthesis					
L8047	A		Nasal septal prosthesis					
L8048	A		Unspec maxillofacial prosth					
L8049	A		Repair maxillofacial prosth					
L8100	E		Compression stocking BK18-30					
L8110	A		Compression stocking BK30-40					
L8120	A		Compression stocking BK40-50					
L8130	E		Gc stocking thighlngth 18-30					
L8140	E		Gc stocking thighlngth 30-40					
L8150	E		Gc stocking thighlngth 40-50					
L8160	E		Gc stocking full lngth 18-30					
L8170	E		Gc stocking full lngth 30-40					
L8180	E		Gc stocking full lngth 40-50					
L8190	E		Gc stocking waistlngth 18-30					
L8195	E		Gc stocking waistlngth 30-40					
L8200	E		Gc stocking waistlngth 40-50					
L8210	E		Gc stocking custom made					
L8220	E		Gc stocking lymphedema					
L8230	E		Gc stocking garter belt					
L8239	E		G compression stocking NOS					
L8300	A		Truss single w/ standard pad					
L8310	A		Truss double w/ standard pad					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
L8499	A		Unlisted misc prosthetic ser					
L8500	A		Artificial larynx					
L8501	A		Tracheostomy speaking valve					
L8505	A		Artificial larynx, accessory					
L8507	A		Trach-esoph voice pros pt in					
L8509	A		Trach-esoph voice pros md in					
L8510	A		Voice amplifier					
L8511	A		Indwelling trach insert					
L8512	A		Gel cap for trach voice pros					
L8513	A		Trach pros cleaning device					
L8514	A		Repl trach puncture dilator					
L8515	A		Gel cap app device for trach					
L8600	N		Implant breast silicone/eq					
L8603	N		Collagen imp urinary 2.5 ml					
L8606	N		Synthetic implnt urinary 1ml					
L8610	N		Ocular implant					
L8612	N		Aqueous shunt prosthesis					
L8613	N		Ossicular implant					
L8614	N		Cochlear device/system					
L8615	A		Coch implant headset replace					
L8616	A		Coch implant microphone repl					
L8617	A		Coch implant trans coil repl					
L8618	A		Coch implant tran cable repl					
L8619	A		Replace cochlear processor					
L8620	A		Repl lithium ion battery					
L8621	A		Repl zinc air battery					
L8622	A		Repl alkaline battery					
L8630	N		Metacarpophalangeal implant					
L8631	N		MCP joint repl 2 pc or more					
L8641	N		Metatarsal joint implant					
L8642	N		Hallux implant					
L8658	N		Interphalangeal joint spacer					
L8659	N		Interphalangeal joint repl					
L8670	N		Vascular graft, synthetic					
L8699	N		Prosthetic implant NOS					
L9900	A		O&P supply/accessory/service					
M0064	X		Visit for drug monitoring	0374	1.0367	$61.53		$12.31
M0075	E		Cellular therapy					
M0076	E		Prolotherapy					
M0100	E		Intragastric hypothermia					
M0300	E		IV chelationtherapy					
M0301	E		Fabric wrapping of aneurysm					
P2028	A		Cephalin floculation test					
P2029	A		Congo red blood test					
P2031	E		Hair analysis					
P2033	A		Blood thymol turbidity					
P2038	A		Blood mucoprotein					
P3000	A		Screen pap by tech w md supv					
P3001	B		Screening pap smear by phys					
P7001	E		Culture bacterial urine					
P9010	K		Whole blood for transfusion	0950	2.0032	$118.89		$23.78

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
P9011	K		Blood split unit	0967	1.2641	$75.02		$15.00
P9012	K		Cryoprecipitate each unit	0952	0.7361	$43.69		$8.74
P9016	K		RBC leukocytes reduced	0954	2.7246	$161.71		$32.34
P9017	K		Plasma 1 donor frz w/in 8 hr	9508	1.1983	$71.12		$14.22
P9019	K		Platelets, each unit	0957	0.8279	$49.14		$9.83
P9020	K		Plaelet rich plasma unit	0958	5.1580	$306.13		$61.23
P9021	K		Red blood cells unit	0959	2.0209	$119.94		$23.99
P9022	K		Washed red blood cells unit	0960	2.9573	$175.52		$35.10
P9023	K		Frozen plasma, pooled, sd	0949	1.1902	$70.64		$14.13
P9031	K		Platelets leukocytes reduced	1013	1.5950	$94.66		$18.93
P9032	K		Platelets, irradiated	9500	1.3527	$80.28		$16.06
P9033	K		Platelets leukoreduced irrad	0968	2.3532	$139.66		$27.93
P9034	K		Platelets, pheresis	9507	6.8676	$407.59		$81.52
P9035	K		Platelet pheres leukoreduced	9501	8.1126	$481.48		$96.30
P9036	K		Platelet pheresis irradiated	9502	5.1660	$306.60		$61.32
P9037	K		Plate pheres leukoredu irrad	1019	9.4700	$562.04		$112.41
P9038	K		RBC irradiated	9505	2.3768	$141.06		$28.21
P9039	K		RBC deglycerolized	9504	6.4022	$379.97		$75.99
P9040	K		RBC leukoreduced irradiated	0969	3.6286	$215.36		$43.07
P9041	K		Albumin (human),5%, 50ml	0961	0.5119	$30.38		$6.08
P9043	K		Plasma protein fract,5%,50ml	0956	1.1175	$66.32		$13.26
P9044	K		Cryoprecipitatereducedplasma	1009	1.3003	$77.17		$15.43
P9045	K		Albumin (human), 5%, 250 ml	0963	1.3867	$82.30		$16.46
P9046	K		Albumin (human), 25%, 20 ml	0964	0.4878	$28.95		$5.79
P9047	K		Albumin (human), 25%, 50ml	0965	1.1115	$65.97		$13.19
P9048	K		Plasmaprotein fract,5%,250ml	0966	4.9340	$292.83		$58.57
P9050	K		Granulocytes, pheresis unit	9506	15.5448	$922.58		$184.52
P9051	K		Blood, l/r, cmv-neg	1010	2.9558	$175.43		$35.09
P9052	K		Platelets, hla-m, l/r, unit	1011	10.9193	$648.06		$129.61
P9053	K		Plt, pher, l/r cmv-neg, irr	1020	10.1091	$599.98		$120.00
P9054	K		Blood, l/r, froz/degly/wash	1016	5.2392	$310.95		$62.19
P9055	K		Plt, aph/pher, l/r, cmv-neg	1017	8.5608	$508.08		$101.62
P9056	K		Blood, l/r, irradiated	1018	2.7877	$165.45		$33.09
P9057	K		RBC, frz/deg/wsh, l/r, irrad	1021	4.8566	$288.24		$57.65
P9058	K		RBC, l/r, cmv-neg, irrad	1022	4.2707	$253.47		$50.69
P9059	K		Plasma, frz between 8-24hour	0955	1.2876	$76.42		$15.28
P9060	K		Fr frz plasma donor retested	9503	1.6167	$95.95		$19.19
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	2.4855	$147.51	$41.44	$29.50
Q0081	B		Infusion ther other than che					
Q0083	B		Chemo by other than infusion					
Q0084	B		Chemotherapy by infusion					
Q0085	B		Chemo by both infusion and o					
Q0091	T		Obtaining screen pap smear	0191	0.1663	$9.87	$2.77	$1.97
Q0092	N		Set up port xray equipment					
Q0111	A		Wet mounts/ w preparations					
Q0112	A		Potassium hydroxide preps					
Q0113	A		Pinworm examinations					
Q0114	A		Fern test					
Q0115	A		Post-coital mucous exam					
Q0136	K		Non esrd epoetin alpha inj	0733		$9.99		$2.00
Q0137	K		Darbepoetin alfa, non esrd	0734		$3.28		$.66
Q0144	E		Azithromycin dihydrate, oral					
Q0163	N		Diphenhydramine HCl 50mg					
Q0164	N		Prochlorperazine maleate 5mg					
Q0165	B		Prochlorperazine maleate10mg					
Q0166	K		Granisetron HCl 1 mg oral	0765		$33.50		$6.70
Q0167	N		Dronabinol 2.5mg oral					
Q0168	B		Dronabinol 5mg oral					
Q0169	N		Promethazine HCl 12.5mg oral					
Q0170	B		Promethazine HCl 25 mg oral					
Q0171	N		Chlorpromazine HCl 10mg oral					
Q0172	B		Chlorpromazine HCl 25mg oral					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q0173	N		Trimethobenzamide HCl 250mg					
Q0174	N		Thiethylperazine maleate10mg					
Q0175	N		Perphenazine 4mg oral					
Q0176	B		Perphenazine 8mg oral					
Q0177	N		Hydroxyzine pamoate 25mg					
Q0178	B		Hydroxyzine pamoate 50mg					
Q0179	K		Ondansetron HCl 8mg oral	0769		$32.02		$6.40
Q0180	K		Dolasetron mesylate oral	0763		$48.54		$9.71
Q0181	E		Unspecified oral anti-emetic					
Q0187	K		Factor viia recombinant	1409		$1,080.03		$216.01
Q1001	N		Ntiol category 1					
Q1002	N		Ntiol category 2					
Q1003	N		Ntiol category 3					
Q1004	N		Ntiol category 4					
Q1005	N		Ntiol category 5					
Q2001	E		Oral cabergoline 0.5 mg					
Q2002	N		Elliotts b solution per ml					
Q2003	K		Aprotinin, 10,000 kiu	7019		$2.20		$.44
Q2004	N		Bladder calculi irrig sol					
Q2005	K		Corticorelin ovine triflutat	7024		$386.49		$77.30
Q2006	K		Digoxin immune fab (ovine)	7025		$552.14		$110.43
Q2007	K		Ethanolamine oleate 100 mg	7026		$64.53		$12.91
Q2008	K		Fomepizole, 15 mg	7027		$12.31		$2.46
Q2009	K		Fosphenytoin, 50 mg	7028		$5.19		$1.04
Q2011	K		Hemin, per 1 mg	7030		$6.51		$1.30
Q2012	K		Pegademase bovine, 25 iu	9168		$161.15		$32.23
Q2013	K		Pentastarch 10% solution	7040		$12.45		$2.49
Q2014	N		Sermorelin acetate, 0.5 mg					
Q2017	K		Teniposide, 50 mg	7035		$266.21		$53.24
Q2018	K		Urofollitropin, 75 iu	7037		$44.73		$8.95
Q2019	K		Basiliximab	1615		$1,473.45		$294.69
Q2020	E		Histrelin acetate					
Q2021	K		Lepirudin	9057		$128.16		$25.63
Q2022	K		VonWillebrandFactrCmplxperIU	1618		$.74		$.15
Q3000	H		Rubidium-Rb-82	9025				
Q3001	B		Brachytherapy Radioelements					
Q3002	H		Gallium ga 67	1619				
Q3003	H		Technetium tc99m bicisate	1620				
Q3004	N		Xenon xe 133					
Q3005	H		Technetium tc99m ertiatide	1622				
Q3006	H		Technetium tc99m glucepatate	9154				
Q3007	H		Sodium phosphate p32	1624				
Q3008	H		Indium 111-in pentetreotide	1625				
Q3009	N		Technetium tc99m oxidronate					
Q3010	H		Technetium tc99mlabeledrbcs	9155				
Q3011	H		Chromic phosphate p32	1628				
Q3012	N		Cyanocobalamin cobalt co57					
Q3014	A		Telehealth facility fee					
Q3019	A		ALS emer trans no ALS serv					
Q3020	A		ALS nonemer trans no ALS se					
Q3025	K		IM inj interferon beta 1-a	9022		$89.09		$17.82
Q3026	E		Subc inj interferon beta-1a					
Q3031	N		Collagen skin test					
Q4001	B		Cast sup body cast plaster					
Q4002	B		Cast sup body cast fiberglas					
Q4003	B		Cast sup shoulder cast plstr					
Q4004	B		Cast sup shoulder cast fbrgl					
Q4005	B		Cast sup long arm adult plst					
Q4006	B		Cast sup long arm adult fbrg					
Q4007	B		Cast sup long arm ped plster					
Q4008	B		Cast sup long arm ped fbrgls					
Q4009	B		Cast sup sht arm adult plstr					
Q4010	B		Cast sup sht arm adult fbrgl					
Q4011	B		Cast sup sht arm ped plaster					
Q4012	B		Cast sup sht arm ped fbrglas					
Q4013	B		Cast sup gauntlet plaster					

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ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
Q4014	B		Cast sup gauntlet fiberglass					
Q4015	B		Cast sup gauntlet ped plster					
Q4016	B		Cast sup gauntlet ped fbrgls					
Q4017	B		Cast sup lng arm splint plst					
Q4018	B		Cast sup lng arm splint fbrg					
Q4019	B		Cast sup lng arm splnt ped p					
Q4020	B		Cast sup lng arm splnt ped f					
Q4021	B		Cast sup sht arm splint plst					
Q4022	B		Cast sup sht arm splint fbrg					
Q4023	B		Cast sup sht arm splnt ped p					
Q4024	B		Cast sup sht arm splnt ped f					
Q4025	B		Cast sup hip spica plaster					
Q4026	B		Cast sup hip spica fiberglas					
Q4027	B		Cast sup hip spica ped plstr					
Q4028	B		Cast sup hip spica ped fbrgl					
Q4029	B		Cast sup long leg plaster					
Q4030	B		Cast sup long leg fiberglass					
Q4031	B		Cast sup lng leg ped plaster					
Q4032	B		Cast sup lng leg ped fbrgls					
Q4033	B		Cast sup lng leg cylinder pl					
Q4034	B		Cast sup lng leg cylinder fb					
Q4035	B		Cast sup lngleg cylndr ped p					
Q4036	B		Cast sup lngleg cylndr ped f					
Q4037	B		Cast sup shrt leg plaster					
Q4038	B		Cast sup shrt leg fiberglass					
Q4039	B		Cast sup shrt leg ped plster					
Q4040	B		Cast sup shrt leg ped fbrgls					
Q4041	B		Cast sup lng leg splnt plstr					
Q4042	B		Cast sup lng leg splnt fbrgl					
Q4043	B		Cast sup lng leg splnt ped p					
Q4044	B		Cast sup lng leg splnt ped f					
Q4045	B		Cast sup sht leg splnt plstr					
Q4046	B		Cast sup sht leg splnt fbrgl					
Q4047	B		Cast sup sht leg splnt ped p					
Q4048	B		Cast sup sht leg splnt ped f					
Q4049	B		Finger splint, static					
Q4050	B		Cast supplies unlisted					
Q4051	B		Splint supplies misc					
Q4054	A		Darbepoetin alfa, esrd use					
Q4055	A		Epoetin alfa, esrd use					
Q4075	N		Acyclovir, 5 mg					
Q4076	N		Dopamine hcl, 40 mg					
Q4077	K		Treprostinil, 1 mg	1082		$55.02		$11.00
Q4079	G		Injection, natalizumab	9126		$6.51		$1.30
Q9941	K		IVIG lyophil 1g	0869		$39.46		$7.89
Q9942	K		IVIG lyophil 10 mg	0870		$.40		$.08
Q9943	K		IVIG non-lyophil 1g	0871		$57.26		$11.45
Q9944	K		IVIG non-lyophil 10 mg	0872		$.57		$.11
Q9945	K		LOCM <=149 mg/ml iodine, 1ml	9157		$.51		$.10
Q9946	K		LOCM 150-199mg/ml iodine,1ml	9158		$2.00		$.40
Q9947	K		LOCM 200-249mg/ml iodine,1ml	9159		$.78		$.16
Q9948	K		LOCM 250-299mg/ml iodine,1ml	9160		$.66		$.13
Q9949	K		LOCM 300-349mg/ml iodine,1ml	9161		$.41		$.08
Q9950	K		LOCM 350-399mg/ml iodine,1ml	9162		$.27		$.05
Q9951	K		LOCM >= 400 mg/ml iodine,1ml	9163		$.20		$.04
Q9952	K		Inj Gad-base MR contrast, ml	9164		$3.01		$.60
Q9953	N		Inj Fe-based MR contrast, ml					
Q9954	K		Oral MR contrast, 100 ml	9165		$9.01		$1.80
Q9955	K		Inj perflexane lip micros, m	9203		$13.49		$2.70
Q9956	K		Inj octafluoropropane mic,ml	9202		$41.42		$8.28
Q9957	K		Inj perflutren lip micros, m	9112		$63.50		$12.70
R0070	N		Transport portable x-ray					
R0075	N		Transport port x-ray multipl					
R0076	N		Transport portable EKG					
V2020	A		Vision svcs frames purchases					
V2025	E		Eyeglasses delux frames					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
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					
V2118	A		Lens aniseikonic single					
V2121	A		Lenticular lens, single					
V2199	A		Lens single vision not oth c					
V2200	A		Lens spher bifoc plano 4.00d					
V2201	A		Lens sphere bifocal 4.12-7.0					
V2202	A		Lens sphere bifocal 7.12-20.					
V2203	A		Lens sphcyl bifocal 4.00d/.1					
V2204	A		Lens sphcy bifocal 4.00d/2.1					
V2205	A		Lens sphcy bifocal 4.00d/4.2					
V2206	A		Lens sphcy bifocal 4.00d/ove					
V2207	A		Lens sphcy bifocal 4.25-7d/.					
V2208	A		Lens sphcy bifocal 4.25-7/2.					
V2209	A		Lens sphcy bifocal 4.25-7/4.					
V2210	A		Lens sphcy bifocal 4.25-7/ov					
V2211	A		Lens sphcy bifo 7.25-12/.25-					
V2212	A		Lens sphcyl bifo 7.25-12/2.2					
V2213	A		Lens sphcyl bifo 7.25-12/4.2					
V2214	A		Lens sphcyl bifocal over 12.					
V2215	A		Lens lenticular bifocal					
V2218	A		Lens aniseikonic bifocal					
V2219	A		Lens bifocal seg width over					
V2220	A		Lens bifocal add over 3.25d					
V2221	A		Lenticular lens, bifocal					
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					
V2318	A		Lens aniseikonic trifocal					
V2319	A		Lens trifocal seg width > 28					
V2320	A		Lens trifocal add over 3.25d					
V2321	A		Lenticular lens, trifocal					
V2399	A		Lens trifocal speciality					
V2410	A		Lens variab asphericity sing					
V2430	A		Lens variable asphericity bi					
V2499	A		Variable asphericity lens					
V2500	A		Contact lens pmma spherical					
V2501	A		Cntct lens pmma-toric/prism					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V2502	A		Contact lens pmma bifocal					
V2503	A		Cntct lens pmma color vision					
V2510	A		Cntct gas permeable sphericl					
V2511	A		Cntct toric prism ballast					
V2512	A		Cntct lens gas permbl bifocl					
V2513	A		Contact lens extended wear					
V2520	A		Contact lens hydrophilic					
V2521	A		Cntct lens hydrophilic toric					
V2522	A		Cntct lens hydrophil bifocl					
V2523	A		Cntct lens hydrophil extend					
V2530	A		Contact lens gas impermeable					
V2531	A		Contact lens gas permeable					
V2599	A		Contact lens/es other type					
V2600	A		Hand held low vision aids					
V2610	A		Single lens spectacle mount					
V2615	A		Telescop/othr compound lens					
V2623	A		Plastic eye prosth custom					
V2624	A		Polishing artifical eye					
V2625	A		Enlargemnt of eye prosthesis					
V2626	A		Reduction of eye prosthesis					
V2627	A		Scleral cover shell					
V2628	A		Fabrication & fitting					
V2629	A		Prosthetic eye other type					
V2630	N		Anter chamber intraocul lens					
V2631	N		Iris support intraoclr lens					
V2632	N		Post chmbr intraocular lens					
V2700	A		Balance lens					
V2702	E		Deluxe lens feature					
V2710	A		Glass/plastic slab off prism					
V2715	A		Prism lens/es					
V2718	A		Fresnell prism press-on lens					
V2730	A		Special base curve					
V2744	A		Tint photochromatic lens/es					
V2745	A		Tint, any color/solid/grad					
V2750	A		Anti-reflective coating					
V2755	A		UV lens/es					
V2756	E		Eye glass case					
V2760	A		Scratch resistant coating					
V2761	B		Mirror coating					
V2762	A		Polarization, any lens					
V2770	A		Occluder lens/es					
V2780	A		Oversize lens/es					
V2781	B		Progressive lens per lens					
V2782	A		Lens, 1.54-1.65 p/1.60-1.79g					
V2783	A		Lens, >= 1.66 p/>=1.80 g					
V2784	A		Lens polycarb or equal					
V2785	F		Corneal tissue processing					
V2786	A		Occupational multifocal lens					
V2790	N		Amniotic membrane					
V2797	A		Vis item/svc in other code					
V2799	A		Miscellaneous vision service					
V5008	E		Hearing screening					
V5010	E		Assessment for hearing aid					
V5011	E		Hearing aid fitting/checking					
V5014	E		Hearing aid repair/modifying					
V5020	E		Conformity evaluation					
V5030	E		Body-worn hearing aid air					
V5040	E		Body-worn hearing aid bone					
V5050	E		Hearing aid monaural in ear					
V5060	E		Behind ear hearing aid					
V5070	E		Glasses air conduction					
V5080	E		Glasses bone conduction					
V5090	E		Hearing aid dispensing fee					
V5095	E		Implant mid ear hearing pros					
V5100	E		Body-worn bilat hearing aid					
V5110	E		Hearing aid dispensing fee					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

ADDENDUM B.—PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION CALENDAR YEAR 2006—Continued

CPT/ HCPCS	SI	CI	Description	APC	Relative weight	Payment rate	National unadjusted copayment	Minimum unadjusted copayment
V5120	E		Body-worn binaur hearing aid					
V5130	E		In ear binaural hearing aid					
V5140	E		Behind ear binaur hearing ai					
V5150	E		Glasses binaural hearing aid					
V5160	E		Dispensing fee binaural					
V5170	E		Within ear cros hearing aid					
V5180	E		Behind ear cros hearing aid					
V5190	E		Glasses cros hearing aid					
V5200	E		Cros hearing aid dispens fee					
V5210	E		In ear bicros hearing aid					
V5220	E		Behind ear bicros hearing ai					
V5230	E		Glasses bicros hearing aid					
V5240	E		Dispensing fee bicros					
V5241	E		Dispensing fee, monaural					
V5242	E		Hearing aid, monaural, cic					
V5243	E		Hearing aid, monaural, itc					
V5244	E		Hearing aid, prog, mon, cic					
V5245	E		Hearing aid, prog, mon, itc					
V5246	E		Hearing aid, prog, mon, ite					
V5247	E		Hearing aid, prog, mon, bte					
V5248	E		Hearing aid, binaural, cic					
V5249	E		Hearing aid, binaural, itc					
V5250	E		Hearing aid, prog, bin, cic					
V5251	E		Hearing aid, prog, bin, itc					
V5252	E		Hearing aid, prog, bin, ite					
V5253	E		Hearing aid, prog, bin, bte					
V5254	E		Hearing id, digit, mon, cic					
V5255	E		Hearing aid, digit, mon, itc					
V5256	E		Hearing aid, digit, mon, ite					
V5257	E		Hearing aid, digit, mon, bte					
V5258	E		Hearing aid, digit, bin, cic					
V5259	E		Hearing aid, digit, bin, itc					
V5260	E		Hearing aid, digit, bin, ite					
V5261	E		Hearing aid, digit, bin, bte					
V5262	E		Hearing aid, disp, monaural					
V5263	E		Hearing aid, disp, binaural					
V5264	E		Ear mold/insert					
V5265	E		Ear mold/insert, disp					
V5266	E		Battery for hearing device					
V5267	E		Hearing aid supply/accessory					
V5268	E		ALD Telephone Amplifier					
V5269	E		Alerting device, any type					
V5270	E		ALD, TV amplifier, any type					
V5271	E		ALD, TV caption decoder					
V5272	E		Tdd					
V5273	E		ALD for cochlear implant					
V5274	E		ALD unspecified					
V5275	E		Ear impression					
V5298	E		Hearing aid noc					
V5299	B		Hearing service					
V5336	E		Repair communication device					
V5362	E		Speech screening					
V5363	E		Language screening					
V5364	E		Dysphagia screening					

*Code is subject to contiguous body area imaging discount policy discussed in Section XIV of this proposed rule.

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

Indicator	Item/code/service	OPPS payment status
A	Services furnished to a hospital outpatient that are paid under a fee schedule or payment system other than OPPS, for example: • Ambulance Services. • Clinical Diagnostic Laboratory Services. • Non-Implantable Prosthetic and Orthotic Devices. • EPO for ESRD Patients. • Physical, Occupational, and Speech Therapy. • Routine Dialysis Services for ESRD Patients Provided in a Certified Dialysis Unit of a Hospital. • Diagnostic Mammography. • Screening Mammography.	Not paid under OPPS. Paid by fiscal intermediaries under a fee schedule or payment system other than OPPS.
B	Codes that are not recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x,13x, and 14x).	Not paid under OPPS • May be paid by intermediaries when submitted on a different bill type, for example, 75x (CORF), but not paid under OPPS. • An alternate code that is recognized by OPPS when submitted on an outpatient hospital Part B bill type (12x, 13x, and 14x) may be available.
C	Inpatient Procedures	Not paid under OPPS. Admit patient. Bill as inpatient.
D	Discontinued Codes	Not paid under OPPS.
E	Items, Codes, and Services: • That are not covered by Medicare based on statutory exclusion. • That are not covered by Medicare for reasons other than statutory exclusion. • That are not recognized by Medicare but for which an alternate code for the same item or service may be available. • For which separate payment is not provided by Medicare.	Not paid under OPPS.
F	Corneal Tissue Acquisition; Certain CRNA Services and Hepatitis B Vaccines.	Not paid under OPPS. Paid at reasonable cost.
G	Pass-Through Drugs and Biologicals	Paid under OPPS; Separate APC payment includes passπthrough amount.
H	(1) Pass-Through Device Categories (2) Brachytherapy Sources (3) Radiopharmaceutical Agents	Paid under OPPS; (1) Separate cost-based pass-through payment. (2) Separate cost-based non-pass-through payment. (3) Separate cost-based non-pass-through payment.
K	Non-Pass-Through Drugs, Biologicals, and Radiopharmaceuticals Agents.	Paid under OPPS; Separate APC payment.
L	Influenza Vaccine; Pneumococcal Pneumonia Vaccine	Not paid under OPPS. Paid at reasonable cost; Not subject to deductible or coinsurance.
M	Items and Services Not Billable to the Fiscal Intermediary	Not paid under OPPS.
N	Items and Services Packaged into APC Rates	Paid under OPPS; Payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
P	Partial Hospitalization	Paid under OPPS; Per diem APC payment.
Q	Packaged Services Subject to Separate Payment Based on Criteria.	Paid under OPPS; (1) Separate APC payment based on criteria. (2) If criteria are not met, payment is packaged into payment for other services, including outliers. Therefore, there is no separate APC payment.
S	Significant Service, Separately Payable	Paid under OPPS; Separate APC payment.
T	Significant Procedure, Multiple Reduction Applies	Paid under OPPS; Separate APC payment.
V	Clinic or Emergency Department Visit	Paid under OPPS; Separate APC payment.
Y	Non-Implantable Durable Medical Equipment	Not paid under OPPS. All institutional providers other than home health agencies bill to DMERC.
X	Ancillary Services	Paid under OPPS; Separate APC payment.

ADDENDUM D2.—COMMENT INDICATORS

Comment indicator	Descriptor
NF	New code, final APC assignment; Comments were accepted on a proposed APC assignment in the proposed rule; APC assignment is no longer open to comment.
NI	New code, interim APC assignment; Comments will be accepted on the interim APC assignment for the new code.

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
00176 ..	C	Anesth, pharyngeal surgery
00192 ..	C	Anesth, facial bone surgery
00214 ..	C	Anesth, skull drainage
00215 ..	C	Anesth, skull repair/ fract
0021T ..	C	Fetal oximetry, trnsvag/cerv
0024T ..	C	Transcath cardiac reduction
0033T ..	C	Endovasc taa repr incl subcl
0034T ..	C	Endovasc taa repr w/o subcl
0035T ..	C	Insert endovasc prosth, taa
0036T ..	C	Endovasc prosth, taa, add-on
0037T ..	C	Artery transpose/ endovas taa
0038T ..	C	Rad endovasc taa rpr w/cover
0039T ..	C	Rad s/i, endovasc taa repair
00404 ..	C	Anesth, surgery of breast
00406 ..	C	Anesth, surgery of breast
0040T ..	C	Rad s/i, endovasc taa prosth
00452 ..	C	Anesth, surgery of shoulder
00474 ..	C	Anesth, surgery of rib(s)
0048T ..	C	Implant ventricular device
0049T ..	C	External circulation assist
0050T ..	C	Removal circulation assist
0051T ..	C	Implant total heart system
00524 ..	C	Anesth, chest drainage
0052T ..	C	Replace component heart syst
0053T ..	C	Replace component heart syst
00540 ..	C	Anesth, chest surgery
00542 ..	C	Anesth, release of lung
00546 ..	C	Anesth, lung,chest wall surg
00560 ..	C	Anesth, open heart surgery
00561 ..	C	Anesth, heart surg < age 1
00562 ..	C	Anesth, open heart surgery
00580 ..	C	Anesth, heart/lung transplnt
00604 ..	C	Anesth, sitting procedure
00622 ..	C	Anesth, removal of nerves
00632 ..	C	Anesth, removal of nerves

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
00670 ..	C	Anesth, spine, cord surgery
0075T ..	C	Perq stent/chest vert art
0076T ..	C	S&i stent/chest vert art
0077T ..	C	Cereb therm perfusion probe
0078T ..	C	Endovasc aort repr w/ device
0079T ..	C	Endovasc visc extnsn repr
00792 ..	C	Anesth, hemorr/excise liver
00794 ..	C	Anesth, pancreas removal
00796 ..	C	Anesth, for liver transplant
0080T ..	C	Endovasc aort repr rad s&i
00802 ..	C	Anesth, fat layer removal
0081T ..	C	Endovasc visc extnsn s&i
00844 ..	C	Anesth, pelvis surgery
00846 ..	C	Anesth, hysterectomy
00848 ..	C	Anesth, pelvic organ surg
00864 ..	C	Anesth, removal of bladder
00865 ..	C	Anesth, removal of prostate
00866 ..	C	Anesth, removal of adrenal
00868 ..	C	Anesth, kidney transplant
00882 ..	C	Anesth, major vein ligation
00904 ..	C	Anesth, perineal surgery
00908 ..	C	Anesth, removal of prostate
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
11004 ..	C	Debride genitalia & perineum
11005 ..	C	Debride abdom wall
11006 ..	C	Debride genit/per/ abdom wall
11008 ..	C	Remove mesh from abd wall
15756 ..	C	Free muscle flap, microvasc
15757 ..	C	Free skin flap, microvasc
15758 ..	C	Free fascial flap, microvasc
16035 ..	C	Incision of burn scab, initi
16036 ..	C	Escharotomy addl incision
19200 ..	C	Removal of breast
19220 ..	C	Removal of breast
19271 ..	C	Revision of chest wall
19272 ..	C	Extensive chest wall surgery
19361 ..	C	Breast reconstruction
19364 ..	C	Breast reconstruction
19367 ..	C	Breast reconstruction
19368 ..	C	Breast reconstruction
19369 ..	C	Breast reconstruction
20660 ..	C	Apply, rem fixation device
20661 ..	C	Application of head brace
20664 ..	C	Halo brace application
20802 ..	C	Replantation, arm, complete
20805 ..	C	Replant forearm, complete
20808 ..	C	Replantation hand, complete

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
20816 ..	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
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
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
21196 ..	C	Reconst lwr jaw w/fixation
21247 ..	C	Reconstruct lower jaw bone
21255 ..	C	Reconstruct lower jaw bone
21256 ..	C	Reconstruction of orbit
21268 ..	C	Revise eye sockets
21343 ..	C	Treatment of sinus fracture
21344 ..	C	Treatment of sinus fracture
21346 ..	C	Treat nose/jaw fracture
21347 ..	C	Treat nose/jaw fracture
21348 ..	C	Treat nose/jaw fracture
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
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
21510 ..	C	Drainage of bone lesion
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
22532 ..	C	Lat thorax spine fusion
22533 ..	C	Lat lumbar spine fusion
22534 ..	C	Lat thor/lumb, add'l seg
22548 ..	C	Neck spine fusion
22554 ..	C	Neck spine fusion
22556 ..	C	Thorax spine fusion
22558 ..	C	Lumbar spine fusion
22585 ..	C	Additional spinal fusion
22590 ..	C	Spine & skull spinal fusion
22595 ..	C	Neck spinal fusion
22600 ..	C	Neck spine fusion
22610 ..	C	Thorax spine fusion
22630 ..	C	Lumbar spine fusion
22632 ..	C	Spine fusion, extra segment
22800 ..	C	Fusion of spine
22802 ..	C	Fusion of spine
22804 ..	C	Fusion of spine
22808 ..	C	Fusion of spine
22810 ..	C	Fusion of spine
22812 ..	C	Fusion of spine
22818 ..	C	Kyphectomy, 1-2 segments
22819 ..	C	Kyphectomy, 3 or more
22830 ..	C	Exploration of spinal fusion
22840 ..	C	Insert spine fixation device
22841 ..	C	Insert spine fixation device
22842 ..	C	Insert spine fixation device
22843 ..	C	Insert spine fixation device

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
31766 ..	C	Reconstruction of windpipe

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
32855 ..	C	Prepare donor lung, single
32856 ..	C	Prepare donor lung, double
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
33470 ..	C	Revision of pulmonary valve
33471 ..	C	Valvotomy, pulmonary valve
33472 ..	C	Revision of pulmonary valve
33474 ..	C	Revision of pulmonary valve
33475 ..	C	Replacement, pulmonary valve
33476 ..	C	Revision of heart chamber
33478 ..	C	Revision of heart chamber
33496 ..	C	Repair, prosth valve clot
33500 ..	C	Repair heart vessel fistula
33501 ..	C	Repair heart vessel fistula
33502 ..	C	Coronary artery correction
33503 ..	C	Coronary artery graft
33504 ..	C	Coronary artery graft
33505 ..	C	Repair artery w/tunnel
33506 ..	C	Repair artery, translocation
33510 ..	C	CABG, vein, single
33511 ..	C	CABG, vein, two
33512 ..	C	CABG, vein, three
33513 ..	C	CABG, vein, four
33514 ..	C	CABG, vein, five
33516 ..	C	Cabg, vein, six or more
33517 ..	C	CABG, artery-vein, single
33518 ..	C	CABG, artery-vein, two
33519 ..	C	CABG, artery-vein, three
33521 ..	C	CABG, artery-vein, four
33522 ..	C	CABG, artery-vein, five
33523 ..	C	Cabg, art-vein, six or more
33530 ..	C	Coronary artery, bypass/reop
33533 ..	C	CABG, arterial, single
33534 ..	C	CABG, arterial, two
33535 ..	C	CABG, arterial, three
33536 ..	C	Cabg, arterial, four or more
33542 ..	C	Removal of heart lesion
33545 ..	C	Repair of heart damage
33572 ..	C	Open coronary endarterectomy
33600 ..	C	Closure of valve
33602 ..	C	Closure of valve
33606 ..	C	Anastomosis/artery-aorta
33608 ..	C	Repair anomaly w/conduit
33610 ..	C	Repair by enlargement
33611 ..	C	Repair double ventricle
33612 ..	C	Repair double ventricle

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
33615 ..	C	Repair, modified fontan
33617 ..	C	Repair single ventricle
33619 ..	C	Repair single ventricle
33641 ..	C	Repair heart septum defect
33645 ..	C	Revision of heart veins
33647 ..	C	Repair heart septum defects
33660 ..	C	Repair of heart defects
33665 ..	C	Repair of heart defects
33670 ..	C	Repair of heart chambers
33681 ..	C	Repair heart septum defect
33684 ..	C	Repair heart septum defect
33688 ..	C	Repair heart septum defect
33690 ..	C	Reinforce pulmonary artery
33692 ..	C	Repair of heart defects
33694 ..	C	Repair of heart defects
33697 ..	C	Repair of heart defects
33702 ..	C	Repair of heart defects
33710 ..	C	Repair of heart defects
33720 ..	C	Repair of heart defect
33722 ..	C	Repair of heart defect
33730 ..	C	Repair heart-vein defect(s)
33732 ..	C	Repair heart-vein defect
33735 ..	C	Revision of heart chamber
33736 ..	C	Revision of heart chamber
33737 ..	C	Revision of heart chamber
33750 ..	C	Major vessel shunt
33755 ..	C	Major vessel shunt
33762 ..	C	Major vessel shunt
33764 ..	C	Major vessel shunt & graft
33766 ..	C	Major vessel shunt
33767 ..	C	Major vessel shunt
33770 ..	C	Repair great vessels defect
33771 ..	C	Repair great vessels defect
33774 ..	C	Repair great vessels defect
33775 ..	C	Repair great vessels defect
33776 ..	C	Repair great vessels defect
33777 ..	C	Repair great vessels defect
33778 ..	C	Repair great vessels defect
33779 ..	C	Repair great vessels defect
33780 ..	C	Repair great vessels defect
33781 ..	C	Repair great vessels defect
33786 ..	C	Repair arterial trunk

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
33933 ..	C	Prepare donor heart/ lung
33935 ..	C	Transplantation, heart/ lung
33940 ..	C	Removal of donor heart
33944 ..	C	Prepare 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
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
34803 ..	C	Endovas aaa repr w/3-p part
34804 ..	C	Endovasc abdo repr w/ device
34805 ..	C	Endovasc abdo repair w/pros
34808 ..	C	Endovasc abdo occlud device
34812 ..	C	Xpose for endoprosth, aortic
34813 ..	C	Femoral endovas graft add-on
34820 ..	C	Xpose for endoprosth, iliac
34825 ..	C	Endovasc extend prosth, init
34826 ..	C	Endovasc exten prosth, add'l
34830 ..	C	Open aortic tube prosth repr
34831 ..	C	Open aortoiliac prosth repr
34832 ..	C	Open aortofemor prosth repr
34833 ..	C	Xpose for endoprosth, iliac
34834 ..	C	Xpose, endoprosth, brachial
34900 ..	C	Endovasc iliac repr w/ graft
35001 ..	C	Repair defect of artery
35002 ..	C	Repair artery rupture, neck
35005 ..	C	Repair defect of artery
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
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
35483 ..	C	Atherectomy, open
35501 ..	C	Artery bypass graft
35506 ..	C	Artery bypass graft
35507 ..	C	Artery bypass graft
35508 ..	C	Artery bypass graft
35509 ..	C	Artery bypass graft
35510 ..	C	Artery bypass graft
35511 ..	C	Artery bypass graft
35512 ..	C	Artery bypass graft
35515 ..	C	Artery bypass graft
35516 ..	C	Artery bypass graft
35518 ..	C	Artery bypass graft
35521 ..	C	Artery bypass graft
35522 ..	C	Artery bypass graft
35525 ..	C	Artery bypass graft
35526 ..	C	Artery bypass graft
35531 ..	C	Artery bypass graft
35533 ..	C	Artery bypass graft
35536 ..	C	Artery bypass graft
35541 ..	C	Artery bypass graft
35546 ..	C	Artery bypass graft
35548 ..	C	Artery bypass graft
35549 ..	C	Artery bypass graft
35551 ..	C	Artery bypass graft
35556 ..	C	Artery bypass graft
35558 ..	C	Artery bypass graft
35560 ..	C	Artery bypass graft
35563 ..	C	Artery bypass graft
35565 ..	C	Artery bypass graft
35566 ..	C	Artery bypass graft
35571 ..	C	Artery bypass graft
35583 ..	C	Vein bypass graft
35585 ..	C	Vein bypass graft
35587 ..	C	Vein bypass graft
35600 ..	C	Harvest artery for cabg
35601 ..	C	Artery bypass graft
35606 ..	C	Artery bypass graft
35612 ..	C	Artery bypass graft
35616 ..	C	Artery bypass graft
35621 ..	C	Artery bypass graft
35623 ..	C	Bypass graft, not vein
35626 ..	C	Artery bypass graft
35631 ..	C	Artery bypass graft
35636 ..	C	Artery bypass graft
35641 ..	C	Artery bypass graft
35642 ..	C	Artery bypass graft
35645 ..	C	Artery bypass graft
35646 ..	C	Artery bypass graft
35647 ..	C	Artery bypass graft
35650 ..	C	Artery bypass graft
35651 ..	C	Artery bypass graft
35654 ..	C	Artery bypass graft
35656 ..	C	Artery bypass graft
35661 ..	C	Artery bypass graft
35663 ..	C	Artery bypass graft
35665 ..	C	Artery bypass graft
35666 ..	C	Artery bypass graft
35671 ..	C	Artery bypass graft
35681 ..	C	Composite bypass graft
35682 ..	C	Composite bypass graft
35683 ..	C	Composite bypass graft
35691 ..	C	Arterial transposition
35693 ..	C	Arterial transposition
35694 ..	C	Arterial transposition

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
35695 ..	C	Arterial transposition
35697 ..	C	Reimplant artery each
35700 ..	C	Reoperation, bypass graft
35701 ..	C	Exploration, carotid artery
35721 ..	C	Exploration, femoral artery
35741 ..	C	Exploration popliteal artery
35800 ..	C	Explore neck vessels
35820 ..	C	Explore chest vessels
35840 ..	C	Explore abdominal vessels
35870 ..	C	Repair vessel graft defect
35901 ..	C	Excision, graft, neck
35905 ..	C	Excision, graft, thorax
35907 ..	C	Excision, graft, abdomen
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)
37215 ..	C	Transcath stent, cca w/eps
37216 ..	C	Transcath stent, cca w/o eps
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
43108 ..	C	Removal of esophagus
43112 ..	C	Removal of esophagus
43113 ..	C	Removal of esophagus
43116 ..	C	Partial removal of esophagus
43117 ..	C	Partial removal of esophagus
43118 ..	C	Partial removal of esophagus
43121 ..	C	Partial removal of esophagus
43122 ..	C	Partial removal of esophagus
43123 ..	C	Partial removal of esophagus
43124 ..	C	Removal of esophagus
43135 ..	C	Removal of esophagus pouch
43300 ..	C	Repair of esophagus
43305 ..	C	Repair esophagus and fistula
43310 ..	C	Repair of esophagus
43312 ..	C	Repair esophagus and fistula
43313 ..	C	Esophagoplasty congenital
43314 ..	C	Tracheo-esophagoplasty cong
43320 ..	C	Fuse esophagus & stomach
43324 ..	C	Revise esophagus & stomach
43325 ..	C	Revise esophagus & stomach
43326 ..	C	Revise esophagus & stomach
43330 ..	C	Repair of esophagus
43331 ..	C	Repair of esophagus
43340 ..	C	Fuse esophagus & intestine
43341 ..	C	Fuse esophagus & intestine
43350 ..	C	Surgical opening, esophagus
43351 ..	C	Surgical opening, esophagus
43352 ..	C	Surgical opening, esophagus
43360 ..	C	Gastrointestinal repair
43361 ..	C	Gastrointestinal repair
43400 ..	C	Ligate esophagus veins
43401 ..	C	Esophagus surgery for veins
43405 ..	C	Ligate/staple esophagus
43410 ..	C	Repair esophagus wound
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
43520 ..	C	Incision of pyloric muscle
43605 ..	C	Biopsy of stomach
43610 ..	C	Excision of stomach lesion
43611 ..	C	Excision of stomach lesion
43620 ..	C	Removal of stomach
43621 ..	C	Removal of stomach
43622 ..	C	Removal of stomach
43631 ..	C	Removal of stomach, partial
43632 ..	C	Removal of stomach, partial
43633 ..	C	Removal of stomach, partial
43634 ..	C	Removal of stomach, partial
43635 ..	C	Removal of stomach, partial
43638 ..	C	Removal of stomach, partial
43639 ..	C	Removal of stomach, partial
43640 ..	C	Vagotomy & pylorus repair
43641 ..	C	Vagotomy & pylorus repair
43644 ..	C	Lap gastric bypass/ roux-en-y
43645 ..	C	Lap gastr bypass incl smll i
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
43845 ..	C	Gastroplasty duodenal switch
43846 ..	C	Gastric bypass for obesity
43847 ..	C	Gastric bypass for obesity
43848 ..	C	Revision gastroplasty
43850 ..	C	Revise stomach-bowel fusion
43855 ..	C	Revise stomach-bowel fusion
43860 ..	C	Revise stomach-bowel fusion
43865 ..	C	Revise stomach-bowel fusion
43880 ..	C	Repair stomach-bowel fistula
44005 ..	C	Freeing of bowel adhesion
44010 ..	C	Incision of small bowel
44015 ..	C	Insert needle cath bowel
44020 ..	C	Explore small intestine
44021 ..	C	Decompress small bowel
44025 ..	C	Incision of large bowel
44050 ..	C	Reduce bowel obstruction
44055 ..	C	Correct malrotation of bowel
44110 ..	C	Excise intestine lesion(s)
44111 ..	C	Excision of bowel lesion(s)
44120 ..	C	Removal of small intestine
44121 ..	C	Removal of small intestine
44125 ..	C	Removal of small intestine
44126 ..	C	Enterectomy w/o taper, cong
44127 ..	C	Enterectomy w/taper, cong
44128 ..	C	Enterectomy cong, add-on
44130 ..	C	Bowel to bowel fusion
44132 ..	C	Enterectomy, cadaver donor
44133 ..	C	Enterectomy, live donor
44135 ..	C	Intestine transplnt, cadaver
44136 ..	C	Intestine transplant, live
44137 ..	C	Remove intestinal allograft
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
44153 ..	C	Removal of colon/ileostomy
44155 ..	C	Removal of colon/ileostomy
44156 ..	C	Removal of colon/ileostomy
44160 ..	C	Removal of colon
44202 ..	C	Lap resect s/intestine singl
44203 ..	C	Lap resect s/intestine, addl
44204 ..	C	Laparo partial colectomy
44205 ..	C	Lap colectomy part w/ileum
44210 ..	C	Laparo total proctocolectomy
44211 ..	C	Laparo total proctocolectomy
44212 ..	C	Laparo total proctocolectomy
44300 ..	C	Open bowel to skin
44310 ..	C	Ileostomy/jejunostomy
44314 ..	C	Revision of ileostomy
44316 ..	C	Devise bowel pouch
44320 ..	C	Colostomy
44322 ..	C	Colostomy with biopsies
44345 ..	C	Revision of colostomy
44346 ..	C	Revision of colostomy
44602 ..	C	Suture, small intestine
44603 ..	C	Suture, small intestine
44604 ..	C	Suture, large intestine
44605 ..	C	Repair of bowel lesion
44615 ..	C	Intestinal stricturoplasty
44620 ..	C	Repair bowel opening
44625 ..	C	Repair bowel opening
44626 ..	C	Repair bowel opening
44640 ..	C	Repair bowel-skin fistula
44650 ..	C	Repair bowel fistula
44660 ..	C	Repair bowel-bladder fistula
44661 ..	C	Repair bowel-bladder fistula
44680 ..	C	Surgical revision, intestine
44700 ..	C	Suspend bowel w/prosthesis
44715 ..	C	Prepare donor intestine
44720 ..	C	Prep donor intestine/venous
44721 ..	C	Prep donor intestine/artery
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
44950 ..	C	Appendectomy
44955 ..	C	Appendectomy add-on

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
44960 ..	C	Appendectomy
45110 ..	C	Removal of rectum
45111 ..	C	Partial removal of rectum
45112 ..	C	Removal of rectum
45113 ..	C	Partial proctectomy
45114 ..	C	Partial removal of rectum
45116 ..	C	Partial removal of rectum
45119 ..	C	Remove rectum w/reservoir
45120 ..	C	Removal of rectum
45121 ..	C	Removal of rectum and colon
45123 ..	C	Partial proctectomy
45126 ..	C	Pelvic exenteration
45130 ..	C	Excision of rectal prolapse
45135 ..	C	Excision of rectal prolapse
45136 ..	C	Excise ileoanal reservior
45540 ..	C	Correct rectal prolapse
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
47125 ..	C	Partial removal of liver
47130 ..	C	Partial removal of liver
47133 ..	C	Removal of donor liver
47135 ..	C	Transplantation of liver
47136 ..	C	Transplantation of liver
47140 ..	C	Partial removal, donor liver
47141 ..	C	Partial removal, donor liver
47142 ..	C	Partial removal, donor liver
47143 ..	C	Prep donor liver, whole
47144 ..	C	Prep donor liver, 3-segment
47145 ..	C	Prep donor liver, lobe split
47146 ..	C	Prep donor liver/venous
47147 ..	C	Prep donor liver/arterial
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
48551 ..	C	Prep donor pancreas
48552 ..	C	Prep donor pancreas/ venous
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
49040 ..	C	Drain, open, abdom abscess
49060 ..	C	Drain, open, retrop abscess
49062 ..	C	Drain to peritoneal cavity
49201 ..	C	Remove abdom lesion, complex
49215 ..	C	Excise sacral spine tumor
49220 ..	C	Multiple surgery, abdomen
49255 ..	C	Removal of omentum
49425 ..	C	Insert abdomen-venous drain
49428 ..	C	Ligation of shunt
49605 ..	C	Repair umbilical lesion
49606 ..	C	Repair umbilical lesion
49610 ..	C	Repair umbilical lesion
49611 ..	C	Repair umbilical lesion
49900 ..	C	Repair of abdominal wall
49904 ..	C	Omental flap, extra-abdom
49905 ..	C	Omental flap
49906 ..	C	Free omental flap, microvasc
50010 ..	C	Exploration of kidney
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
50323 ..	C	Prep cadaver renal allograft
50325 ..	C	Prep donor renal graft
50327 ..	C	Prep renal graft/venous
50328 ..	C	Prep renal graft/arterial
50329 ..	C	Prep renal graft/ ureteral
50340 ..	C	Removal of kidney
50360 ..	C	Transplantation of kidney
50365 ..	C	Transplantation of kidney
50370 ..	C	Remove transplanted kidney
50380 ..	C	Reimplantation of kidney
50400 ..	C	Revision of kidney/ureter
50405 ..	C	Revision of kidney/ureter
50500 ..	C	Repair of kidney wound
50520 ..	C	Close kidney-skin fistula
50525 ..	C	Repair renal-abdomen fistula
50526 ..	C	Repair renal-abdomen fistula
50540 ..	C	Revision of horseshoe kidney
50545 ..	C	Laparo radical nephrectomy
50546 ..	C	Laparoscopic nephrectomy
50547 ..	C	Laparo removal donor kidney
50548 ..	C	Laparo remove w/ ureter
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
53415 ..	C	Reconstruction of urethra
53448 ..	C	Remov/replc ur sphinctr comp
54125 ..	C	Removal of penis
54130 ..	C	Remove penis & nodes
54135 ..	C	Remove penis & nodes
54332 ..	C	Revise penis/urethra
54336 ..	C	Revise penis/urethra
54390 ..	C	Repair penis and bladder
54411 ..	C	Remov/replc penis pros, comp
54417 ..	C	Remv/replc penis pros, compl
54430 ..	C	Revision of penis
54535 ..	C	Extensive testis surgery
54650 ..	C	Orchiopexy (Fowler-Stephens)
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
57283 ..	C	Colpopexy, intraperitoneal
57292 ..	C	Construct vagina with graft
57305 ..	C	Repair rectum-vagina fistula
57307 ..	C	Fistula repair & colostomy
57308 ..	C	Fistula repair, transperine
57311 ..	C	Repair urethrovaginal lesion
57335 ..	C	Repair vagina
57531 ..	C	Removal of cervix, radical
57540 ..	C	Removal of residual cervix
57545 ..	C	Remove cervix/repair pelvis
58140 ..	C	Removal of uterus lesion
58146 ..	C	Myomectomy abdom complex
58150 ..	C	Total hysterectomy
58152 ..	C	Total hysterectomy
58180 ..	C	Partial hysterectomy
58200 ..	C	Extensive hysterectomy
58210 ..	C	Extensive hysterectomy
58240 ..	C	Removal of pelvis contents
58260 ..	C	Vaginal hysterectomy
58262 ..	C	Vag hyst including t/o
58263 ..	C	Vag hyst w/t/o & vag repair
58267 ..	C	Vag hyst w/urinary repair
58270 ..	C	Vag hyst w/enterocele repair
58275 ..	C	Hysterectomy/revise vagina
58280 ..	C	Hysterectomy/revise vagina
58285 ..	C	Extensive hysterectomy
58290 ..	C	Vag hyst complex
58291 ..	C	Vag hyst incl t/o, complex
58292 ..	C	Vag hyst t/o & repair, compl
58293 ..	C	Vag hyst w/uro repair, compl
58294 ..	C	Vag hyst w/enterocele, compl
58400 ..	C	Suspension of uterus
58410 ..	C	Suspension of uterus
58520 ..	C	Repair of ruptured uterus

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
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
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
58956 ..	C	Bso, omentectomy w/ tah
58960 ..	C	Exploration of abdomen
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
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

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
60502 ..	C	Re-explore parathyroids
60505 ..	C	Explore parathyroid glands
60520 ..	C	Removal of thymus gland
60521 ..	C	Removal of thymus gland
60522 ..	C	Removal of thymus gland
60540 ..	C	Explore adrenal gland
60545 ..	C	Explore adrenal gland
60600 ..	C	Remove carotid body lesion
60605 ..	C	Remove carotid body lesion
60650 ..	C	Laparoscopy adrenalectomy
61105 ..	C	Twist drill hole
61107 ..	C	Drill skull for implantation
61108 ..	C	Drill skull for drainage
61120 ..	C	Burr hole for puncture
61140 ..	C	Pierce skull for biopsy
61150 ..	C	Pierce skull for drainage
61151 ..	C	Pierce skull for drainage
61154 ..	C	Pierce skull & remove clot
61156 ..	C	Pierce skull for drainage
61210 ..	C	Pierce skull, implant device
61250 ..	C	Pierce skull & explore
61253 ..	C	Pierce skull & explore
61304 ..	C	Open skull for exploration
61305 ..	C	Open skull for exploration
61312 ..	C	Open skull for drainage
61313 ..	C	Open skull for drainage
61314 ..	C	Open skull for drainage
61315 ..	C	Open skull for drainage
61316 ..	C	Implt cran bone flap to abdo
61320 ..	C	Open skull for drainage
61321 ..	C	Open skull for drainage
61322 ..	C	Decompressive craniotomy
61323 ..	C	Decompressive lobectomy
61332 ..	C	Explore/biopsy eye socket
61333 ..	C	Explore orbit/remove lesion
61340 ..	C	Relieve cranial pressure
61343 ..	C	Incise skull (press relief)

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
61345 ..	C	Relieve cranial pressure
61440 ..	C	Incise skull for surgery
61450 ..	C	Incise skull for surgery
61458 ..	C	Incise skull for brain wound
61460 ..	C	Incise skull for surgery
61470 ..	C	Incise skull for surgery
61480 ..	C	Incise skull for surgery
61490 ..	C	Incise skull for surgery
61500 ..	C	Removal of skull lesion
61501 ..	C	Remove infected skull bone
61510 ..	C	Removal of brain lesion
61512 ..	C	Remove brain lining lesion
61514 ..	C	Removal of brain abscess
61516 ..	C	Removal of brain lesion
61517 ..	C	Implt brain chemotx add-on
61518 ..	C	Removal of brain lesion
61519 ..	C	Remove brain lining lesion
61520 ..	C	Removal of brain lesion
61521 ..	C	Removal of brain lesion
61522 ..	C	Removal of brain abscess
61524 ..	C	Removal of brain lesion
61526 ..	C	Removal of brain lesion
61530 ..	C	Removal of brain lesion
61531 ..	C	Implant brain electrodes
61533 ..	C	Implant brain electrodes
61534 ..	C	Removal of brain lesion
61535 ..	C	Remove brain electrodes
61536 ..	C	Removal of brain lesion
61537 ..	C	Removal of brain tissue
61538 ..	C	Removal of brain tissue
61539 ..	C	Removal of brain tissue
61540 ..	C	Removal of brain tissue
61541 ..	C	Incision of brain tissue
61542 ..	C	Removal of brain tissue
61543 ..	C	Removal of brain tissue
61544 ..	C	Remove & treat brain lesion
61545 ..	C	Excision of brain tumor
61546 ..	C	Removal of pituitary gland

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
61548 ..	C	Removal of pituitary gland
61550 ..	C	Release of skull seams
61552 ..	C	Release of skull seams
61556 ..	C	Incise skull/sutures
61557 ..	C	Incise skull/sutures
61558 ..	C	Excision of skull/sutures
61559 ..	C	Excision of skull/sutures
61563 ..	C	Excision of skull tumor
61564 ..	C	Excision of skull tumor
61566 ..	C	Removal of brain tissue
61567 ..	C	Incision of brain tissue
61570 ..	C	Remove foreign body, brain
61571 ..	C	Incise skull for brain wound
61575 ..	C	Skull base/brainstem surgery
61576 ..	C	Skull base/brainstem surgery
61580 ..	C	Craniofacial approach, skull
61581 ..	C	Craniofacial approach, skull
61582 ..	C	Craniofacial approach, skull
61583 ..	C	Craniofacial approach, skull
61584 ..	C	Orbitocranial approach/skull
61585 ..	C	Orbitocranial approach/skull
61586 ..	C	Resect nasopharynx, skull
61590 ..	C	Infratemporal approach/skull
61591 ..	C	Infratemporal approach/skull
61592 ..	C	Orbitocranial approach/skull
61595 ..	C	Transtemporal approach/skull
61596 ..	C	Transcochlear approach/skull
61597 ..	C	Transcondylar approach/skull
61598 ..	C	Transpetrosal approach/skull
61600 ..	C	Resect/excise cranial lesion
61601 ..	C	Resect/excise cranial lesion
61605 ..	C	Resect/excise cranial lesion
61606 ..	C	Resect/excise cranial lesion
61607 ..	C	Resect/excise cranial lesion
61608 ..	C	Resect/excise cranial lesion
61609 ..	C	Transect artery, sinus
61610 ..	C	Transect artery, sinus
61611 ..	C	Transect artery, sinus
61612 ..	C	Transect artery, sinus
61613 ..	C	Remove aneurysm, sinus
61615 ..	C	Resect/excise lesion, skull
61616 ..	C	Resect/excise lesion, skull
61618 ..	C	Repair dura
61619 ..	C	Repair dura
61624 ..	C	Occlusion/embolization cath
61680 ..	C	Intracranial vessel surgery
61682 ..	C	Intracranial vessel surgery
61684 ..	C	Intracranial vessel surgery
61686 ..	C	Intracranial vessel surgery
61690 ..	C	Intracranial vessel surgery
61692 ..	C	Intracranial vessel surgery
61697 ..	C	Brain aneurysm repr, complx
61698 ..	C	Brain aneurysm repr, complx
61700 ..	C	Brain aneurysm repr, simple
61702 ..	C	Inner skull vessel surgery
61703 ..	C	Clamp neck artery
61705 ..	C	Revise circulation to head
61708 ..	C	Revise circulation to head
61710 ..	C	Revise circulation to head
61711 ..	C	Fusion of skull arteries
61720 ..	C	Incise skull/brain surgery
61735 ..	C	Incise skull/brain surgery
61750 ..	C	Incise skull/brain biopsy
61751 ..	C	Brain biopsy w/ ct/mr guide
61760 ..	C	Implant brain electrodes
61770 ..	C	Incise skull for treatment
61850 ..	C	Implant neuroelectrodes
61860 ..	C	Implant neuroelectrodes
61863 ..	C	Implant neuroelectrode
61864 ..	C	Implant neuroelectrde, add'l
61867 ..	C	Implant neuroelectrode
61868 ..	C	Implant neuroelectrde, add'l
61870 ..	C	Implant neuroelectrodes
61875 ..	C	Implant neuroelectrodes
62000 ..	C	Treat skull fracture
62005 ..	C	Treat skull fracture
62010 ..	C	Treatment of head injury
62100 ..	C	Repair brain fluid leakage
62115 ..	C	Reduction of skull defect
62116 ..	C	Reduction of skull defect
62117 ..	C	Reduction of skull defect
62120 ..	C	Repair skull cavity lesion
62121 ..	C	Incise skull repair
62140 ..	C	Repair of skull defect
62141 ..	C	Repair of skull defect
62142 ..	C	Remove skull plate/flap
62143 ..	C	Replace skull plate/flap
62145 ..	C	Repair of skull & brain
62146 ..	C	Repair of skull with graft
62147 ..	C	Repair of skull with graft
62148 ..	C	Retr bone flap to fix skull
62161 ..	C	Dissect brain w/scope
62162 ..	C	Remove colloid cyst w/scope
62163 ..	C	Neuroendoscopy w/fb removal
62164 ..	C	Remove brain tumor w/scope
62165 ..	C	Remove pituit tumor w/scope
62180 ..	C	Establish brain cavity shunt
62190 ..	C	Establish brain cavity shunt
62192 ..	C	Establish brain cavity shunt
62200 ..	C	Establish brain cavity shunt
62201 ..	C	Establish brain cavity shunt
62220 ..	C	Establish brain cavity shunt
62223 ..	C	Establish brain cavity shunt
62256 ..	C	Remove brain cavity shunt
62258 ..	C	Replace brain cavity shunt
63043 ..	C	Laminotomy, add'l cervical
63044 ..	C	Laminotomy, add'l lumbar
63050 ..	C	Cervical laminoplasty
63051 ..	C	C-laminoplasty w/graft/plate
63075 ..	C	Neck spine disk surgery
63076 ..	C	Neck spine disk surgery
63077 ..	C	Spine disk surgery, thorax

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
63078 ..	C	Spine disk surgery, thorax
63081 ..	C	Removal of vertebral body
63082 ..	C	Remove vertebral body add-on
63085 ..	C	Removal of vertebral body
63086 ..	C	Remove vertebral body add-on
63087 ..	C	Removal of vertebral body
63088 ..	C	Remove vertebral body add-on
63090 ..	C	Removal of vertebral body
63091 ..	C	Remove vertebral body add-on
63101 ..	C	Removal of vertebral body
63102 ..	C	Removal of vertebral body
63103 ..	C	Remove vertebral body add-on
63170 ..	C	Incise spinal cord tract(s)
63172 ..	C	Drainage of spinal cyst
63173 ..	C	Drainage of spinal cyst
63180 ..	C	Revise spinal cord ligaments
63182 ..	C	Revise spinal cord ligaments
63185 ..	C	Incise spinal column/ nerves
63190 ..	C	Incise spinal column/ nerves
63191 ..	C	Incise spinal column/ nerves
63194 ..	C	Incise spinal column & cord
63195 ..	C	Incise spinal column & cord
63196 ..	C	Incise spinal column & cord
63197 ..	C	Incise spinal column & cord
63198 ..	C	Incise spinal column & cord
63199 ..	C	Incise spinal column & cord
63200 ..	C	Release of spinal cord
63250 ..	C	Revise spinal cord vessels
63251 ..	C	Revise spinal cord vessels
63252 ..	C	Revise spinal cord vessels
63265 ..	C	Excise intraspinal lesion
63266 ..	C	Excise intraspinal lesion
63267 ..	C	Excise intraspinal lesion
63268 ..	C	Excise intraspinal lesion
63270 ..	C	Excise intraspinal lesion
63271 ..	C	Excise intraspinal lesion
63272 ..	C	Excise intraspinal lesion
63273 ..	C	Excise intraspinal lesion
63275 ..	C	Biopsy/excise spinal tumor
63276 ..	C	Biopsy/excise spinal tumor
63277 ..	C	Biopsy/excise spinal tumor
63278 ..	C	Biopsy/excise spinal tumor
63280 ..	C	Biopsy/excise spinal tumor
63281 ..	C	Biopsy/excise spinal tumor
63282 ..	C	Biopsy/excise spinal tumor
63283 ..	C	Biopsy/excise spinal tumor
63285 ..	C	Biopsy/excise spinal tumor
63286 ..	C	Biopsy/excise spinal tumor
63287 ..	C	Biopsy/excise spinal tumor
63290 ..	C	Biopsy/excise spinal tumor
63295 ..	C	Repair of laminectomy defect
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
64804 ..	C	Remove sympathetic nerves
64809 ..	C	Remove sympathetic nerves
64818 ..	C	Remove sympathetic nerves
64866 ..	C	Fusion of facial/other nerve
64868 ..	C	Fusion of facial/other nerve
65273 ..	C	Repair of eye wound
69155 ..	C	Extensive ear/neck surgery
69535 ..	C	Remove part of temporal bone
69554 ..	C	Remove ear lesion
69950 ..	C	Incise inner ear nerve
69970 ..	C	Remove inner ear lesion
75900 ..	C	Arterial catheter exchange
75952 ..	C	Endovasc repair abdom aorta
75953 ..	C	Abdom aneurysm endovas rpr
75954 ..	C	Iliac aneurysm endovas rpr
92970 ..	C	Cardioassist, internal
92971 ..	C	Cardioassist, external
92975 ..	C	Dissolve clot, heart vessel
92992 ..	C	Revision of heart chamber
92993 ..	C	Revision of heart chamber
99190 ..	C	Special pump services
99191 ..	C	Special pump services
99192 ..	C	Special pump services
99251 ..	C	Initial inpatient consult
99252 ..	C	Initial inpatient consult
99253 ..	C	Initial inpatient consult
99254 ..	C	Initial inpatient consult
99255 ..	C	Initial inpatient consult
99261 ..	C	Follow-up inpatient consult
99262 ..	C	Follow-up inpatient consult
99263 ..	C	Follow-up inpatient consult
99293 ..	C	Ped critical care, initial
99294 ..	C	Ped critical care, subseq
99295 ..	C	Neonatal critical care
99296 ..	C	Neonatal critical care
99298 ..	C	Neonatal critical care
99299 ..	C	Ic, lbw infant 1500-2500 gm
99356 ..	C	Prolonged service, inpatient
99357 ..	C	Prolonged service, inpatient
99433 ..	C	Normal newborn care/ hospital

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
G0341	C	Percutaneous islet cell trans

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
G0342	C	Laparoscopy Islet cell Trans

ADDENDUM E.—CPT CODES THAT ARE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	Proposed CY 2006 status indicator	Description
G0343	C	Laparotomy Islet cell tranp

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA

CBSA code	Urban area (constituent counties)	Wage index
10180	[2] Abilene, TX	0.8038
	Callahan County, TX	
	Jones County, TX	
	Taylor County, TX	
10380	Aguadilla-Isabela-San Sebastián, PR	0.4736
	Aguada Municipio, PR	
	Aguadilla Municipio, PR	
	Añasco Municipio, PR	
	Isabela Municipio, PR	
	Lares Municipio, PR	
	Moca Municipio, PR	
	Rincón Municipio, PR	
	San Sebastián Municipio, PR	
10420	Akron, OH	0.8979
	Portage County, OH	
	Summit County, OH	
10500	Albany, GA	0.8645
	Baker County, GA	
	Dougherty County, GA	
	Lee County, GA	
	Terrell County, GA	
	Worth County, GA	
10580	Albany-Schenectady-Troy, NY	0.8565
	Albany County, NY	
	Rensselaer County, NY	
	Saratoga County, NY	
	Schenectady County, NY	
	Schoharie County, NY	
10740	Albuquerque, NM	0.9696
	Bernalillo County, NM	
	Sandoval County, NM	
	Torrance County, NM	
	Valencia County, NM	
10780	Alexandria, LA	0.8048
	Grant Parish, LA	
	Rapides Parish, LA	
10900	Allentown-Bethlehem-Easton, PA-NJ (PA Hospitals)	0.9844
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
10900	[2] Allentown-Bethlehem-Easton, PA-NJ (NJ Hospitals)	1.1253
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.8942
	Blair County, PA	
11100	Amarillo, TX	0.9165
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	0.9546
	Story County, IA	
11260	Anchorage, AK	1.2110
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
11300	Anderson, IN	0.8634
	Madison County, IN	
11340	Anderson, SC	0.8887
	Anderson County, SC	
11460	Ann Arbor, MI	1.0885
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.7702
	Calhoun County, AL	
11540	[2] Appleton, WI	0.9478
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9312
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	0.9813
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	[1] Atlanta-Sandy Springs-Marietta, GA	0.9637
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City, NJ	1.1618
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8113
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9567
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	
12420	[1] Austin-Round Rock, TX	0.9451
	Bastrop County, TX	
	Caldwell County, TX	
	Hays County, TX	
	Travis County, TX	
	Williamson County, TX	
12540	[1] Bakersfield, CA	1.0848
	Kern County, CA	
12580	[1] Baltimore-Towson, MD	0.9892
	Anne Arundel County, MD	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	
12620	Bangor, ME Penobscot County, ME	0.9985
12700	Barnstable Town, MA Barnstable County, MA	1.2518
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8605
12980	Battle Creek, MI Calhoun County, MI	0.9492
13020	Bay City, MI Bay County, MI	0.9535
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8422
13380	Bellingham, WA Whatcom County, WA	1.1705
13460	Bend, OR Deschutes County, OR	1.0783
13644	[1] Bethesda-Gaithersburg-Frederick, MD Frederick County, MD Montgomery County, MD	1.1471
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.8855
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.8588
13820	[1] Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.8979
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.7519
13980	[2] Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8024
14020	[2] Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.8632
14060	Bloomington-Normal, IL McLean County, IL	0.9083
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9048
14484	[1] Boston-Quincy, MA Norfolk County, MA	1.1537

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Plymouth County, MA Suffolk County, MA	
14500	Boulder, CO Boulder County, CO	0.9743
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8222
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.0681
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.2607
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9853
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9341
15380	[1] Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	0.8888
15500	Burlington, NC Alamance County, NC	0.8902
15540	[2] Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0199
15764	[1] Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1078
15804	[1, 2] Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.1253
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.8957
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9333
16180	Carson City, NV Carson City, NV	1.0229
16220	[2] Casper, WY Natrona County, WY	0.9207
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.8605
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	0.9591
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8429
16700	Charleston-North Charleston, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9433
16740	[1] Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	0.9717
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA	1.0230

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Charlottesville City, VA	
16860	Chattanooga, TN-GA	0.9099
	Catoosa County, GA	
	Dade County, GA	
	Walker County, GA	
	Hamilton County, TN	
	Marion County, TN	
	Sequatchie County, TN	
16940	[2] Cheyenne, WY	0.9207
	Laramie County, WY	
16974	[1] Chicago-Naperville-Joliet, IL	1.0846
	Cook County, IL	
	DeKalb County, IL	
	DuPage County, IL	
	Grundy County, IL	
	Kane County, IL	
	Kendall County, IL	
	McHenry County, IL	
	Will County, IL	
17020	[2] Chico, CA	1.0848
	Butte County, CA	
17140	[1] Cincinnati-Middletown, OH-KY-IN	0.9604
	Dearborn County, IN	
	Franklin County, IN	
	Ohio County, IN	
	Boone County, KY	
	Bracken County, KY	
	Campbell County, KY	
	Gallatin County, KY	
	Grant County, KY	
	Kenton County, KY	
	Pendleton County, KY	
	Brown County, OH	
	Butler County, OH	
	Clermont County, OH	
	Hamilton County, OH	
	Warren County, OH	
17300	Clarksville, TN-KY	0.8272
	Christian County, KY	
	Trigg County, KY	
	Montgomery County, TN	
	Stewart County, TN	
17420	Cleveland, TN	0.8160
	Bradley County, TN	
	Polk County, TN	
17460	[1] Cleveland-Elyria-Mentor, OH	0.9197
	Cuyahoga County, OH	
	Geauga County, OH	
	Lake County, OH	
	Lorain County, OH	
	Medina County, OH	
17660	Coeur d'Alene, ID	0.9642
	Kootenai County, ID	
17780	College Station-Bryan, TX	0.8911
	Brazos County, TX	
	Burleson County, TX	
	Robertson County, TX	
17820	Colorado Springs, CO	0.9457
	El Paso County, CO	
	Teller County, CO	
17860	Columbia, MO	0.8346
	Boone County, MO	
	Howard County, MO	
17900	Columbia, SC	0.9057
	Calhoun County, SC	
	Fairfield County, SC	
	Kershaw County, SC	
	Lexington County, SC	
	Richland County, SC	
	Saluda County, SC	
17980	Columbus, GA-AL	0.8570

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Russell County, AL	
	Chattahoochee County, GA	
	Harris County, GA	
	Marion County, GA	
	Muscogee County, GA	
18020	Columbus, IN	0.9596
	Bartholomew County, IN	
18140	[1] Columbus, OH	0.9848
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.8557
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.0711
	Benton County, OR	
19060	Cumberland, MD-WV	0.9310
	Allegany County, MD	
	Mineral County, WV	
19124	[1] Dallas-Plano-Irving, TX	1.0226
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9033
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9048
	Vermilion County, IL	
19260	Danville, VA	0.8514
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8716
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9069
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8517
	Lawrence County, AL	
	Morgan County, AL	
19500	[2] Decatur, IL	0.8285
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9307
	Volusia County, FL	
19740	[1] Denver-Aurora, CO	1.0710
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines, IA	0.9650

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	[1] Detroit-Livonia-Dearborn, MI	1.0453
	Wayne County, MI	
20020	Dothan, AL	0.7743
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	0.9821
	Kent County, DE	
20220	Dubuque, IA	0.9116
	Dubuque County, IA	
20260	Duluth, MN-WI	1.0224
	Carlton County, MN	
	St. Louis County, MN	
	Douglas County, WI	
20500	Durham, NC	1.0260
	Chatham County, NC	
	Durham County, NC	
	Orange County, NC	
	Person County, NC	
20740	[2] Eau Claire, WI	0.9478
	Chippewa County, WI	
	Eau Claire County, WI	
20764	[1] Edison, NJ	1.1301
	Middlesex County, NJ	
	Monmouth County, NJ	
	Ocean County, NJ	
	Somerset County, NJ	
20940	[2] El Centro, CA	1.0848
	Imperial County, CA	
21060	Elizabethtown, KY	0.8816
	Hardin County, KY	
	Larue County, KY	
21140	Elkhart-Goshen, IN	0.9616
	Elkhart County, IN	
21300	Elmira, NY	0.8276
	Chemung County, NY	
21340	El Paso, TX	0.8954
	El Paso County, TX	
21500	Erie, PA	0.8746
	Erie County, PA	
21604	Essex County, MA	1.0679
	Essex County, MA	
21660	Eugene-Springfield, OR	1.0810
	Lane County, OR	
21780	Evansville, IN-KY	0.8735
	Gibson County, IN	
	Posey County, IN	
	Vanderburgh County, IN	
	Warrick County, IN	
	Henderson County, KY	
	Webster County, KY	
21820	[2] Fairbanks, AK	1.1977
	Fairbanks North Star Borough, AK	
21940	Fajardo, PR	0.4160
	Ceiba Municipio, PR	
	Fajardo Municipio, PR	
	Luquillo Municipio, PR	
22020	Fargo, ND-MN (ND Hospitals)	0.8778
	Clay County, MN	
	Cass County, ND	
22020	[2] Fargo, ND-MN (MN Hospitals)	0.9183
	Clay County, MN	
	Cass County, ND	
22140	[2] Farmington, NM	0.8649
	San Juan County, NM	
22180	Fayetteville, NC	0.9426

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Cumberland County, NC	
	Hoke County, NC	
22220	Fayetteville-Springdale-Rogers, AR-MO	0.8615
	Benton County, AR	
	Madison County, AR	
	Washington County, AR	
	McDonald County, MO	
22380	Flagstaff, AZ	1.2094
	Coconino County, AZ	
22420	Flint, MI.	
	Genesee County, MI	1.0654
22500	Florence, SC	0.8988
	Darlington County, SC	
	Florence County, SC	
22520	Florence-Muscle Shoals, AL	0.8305
	Colbert County, AL	
	Lauderdale County, AL	
22540	Fond du Lac, WI	0.9649
	Fond du Lac County, WI	
22660	Fort Collins-Loveland, CO	1.0146
	Larimer County, CO	
22744	[1] Fort Lauderdale-Pompano Beach-Deerfield Beach, FL	1.0508
	Broward County, FL	
22900	Fort Smith, AR-OK	0.8231
	Crawford County, AR	
	Franklin County, AR	
	Sebastian County, AR	
	Le Flore County, OK	
	Sequoyah County, OK	
23020	Fort Walton Beach-Crestview-Destin, FL	0.8877
	Okaloosa County, FL	
23060	Fort Wayne, IN	0.9797
	Allen County, IN	
	Wells County, IN	
	Whitley County, IN	
23104	[1] Fort Worth-Arlington, TX	0.9514
	Johnson County, TX	
	Parker County, TX	
	Tarrant County, TX	
	Wise County, TX	
23420	[2] Fresno, CA	1.0848
	Fresno County, CA	
23460	Gadsden, AL	0.7974
	Etowah County, AL	
23540	Gainesville, FL	0.9461
	Alachua County, FL	
	Gilchrist County, FL	
23580	Gainesville, GA	0.8897
	Hall County, GA	
23844	Gary, IN	0.9366
	Jasper County, IN	
	Lake County, IN	
	Newton County, IN	
	Porter County, IN	
24020	Glens Falls, NY	0.8587
	Warren County, NY	
	Washington County, NY	
24140	Goldsboro, NC	0.8781
	Wayne County, NC	
24220	Grand Forks, ND-MN	1.1521
	Polk County, MN	
	Grand Forks County, ND	
24300	Grand Junction, CO	0.9590
	Mesa County, CO	
24340	Grand Rapids-Wyoming, MI	0.9398
	Barry County, MI	
	Ionia County, MI	
	Kent County, MI	
	Newaygo County, MI	
24500	Great Falls, MT	0.9074
	Cascade County, MT	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
24540	Greeley, CO Weld County, CO	0.9597
24580	[2] Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	0.9478
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9133
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9414
24860	Greenville, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0138
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.3186
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.8922
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9528
25260	[2] Hanford-Corcoran, CA Kings County, CA	1.0848
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9317
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9101
25540	[1, 2] Hartford-West Hartford-East Hartford, CT Hartford County, CT Litchfield County, CT Middlesex County, CT Tolland County, CT	1.1790
25620	[2] Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.7685
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.8931
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.7684
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9133
26180	Honolulu, HI Honolulu County, HI	1.1206
26300	Hot Springs, AR Garland County, AR	0.9066
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.7903
26420	[1] Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX	1.0008

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Liberty County, TX	
	Montgomery County, TX	
	San Jacinto County, TX	
	Waller County, TX	
26580	Huntington-Ashland, WV-KY-OH	0.9482
	Boyd County, KY	
	Greenup County, KY	
	Lawrence County, OH	
	Cabell County, WV	
	Wayne County, WV	
26620	Huntsville, AL	0.9124
	Limestone County, AL	
	Madison County, AL	
26820	Idaho Falls, ID	0.9409
	Bonneville County, ID	
	Jefferson County, ID	
26900	[1] Indianapolis, IN	0.9922
	Boone County, IN	
	Brown County, IN	
	Hamilton County, IN	
	Hancock County, IN	
	Hendricks County, IN	
	Johnson County, IN	
	Marion County, IN	
	Morgan County, IN	
	Putnam County, IN	
	Shelby County, IN	
26980	Iowa City, IA	0.9751
	Johnson County, IA	
	Washington County, IA	
27060	Ithaca, NY	0.9855
	Tompkins County, NY	
27100	Jackson, MI	0.9300
	Jackson County, MI	
27140	Jackson, MS	0.8313
	Copiah County, MS	
	Hinds County, MS	
	Madison County, MS	
	Rankin County, MS	
	Simpson County, MS	
27180	Jackson, TN	0.8964
	Chester County, TN	
	Madison County, TN	
27260	[1] Jacksonville, FL	0.9303
	Baker County, FL	
	Clay County, FL	
	Duval County, FL	
	Nassau County, FL	
	St. Johns County, FL	
27340	[2] Jacksonville, NC	0.8570
	Onslow County, NC	
27500	Janesville, WI	0.9561
	Rock County, WI	
27620	Jefferson City, MO	0.8389
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.7958
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8348
	Cambria County, PA	
27860	Jonesboro, AR	0.7968
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.8594
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI.	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Kalamazoo County, MI	
	Van Buren County, MI	1.0403
28100	Kankakee-Bradley, IL	1.0991
	Kankakee County, IL	
28140	[1]Kansas City, MO-KS	0.9454
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Richland-Pasco, WA	1.0619
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.8566
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8095
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9260
	Ulster County, NY	
28940	Knoxville, TN	0.8470
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	0.9555
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	0.9557
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.8730
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.8429
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.7847
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.0444
	Lake County, IL	
	Kenosha County, WI	
29460	Lakeland, FL	0.8934
	Polk County, FL	
29540	Lancaster, PA	0.9716
	Lancaster County, PA	
29620	Lansing-East Lansing, MI	0.9786
	Clinton County, MI	
	Eaton County, MI	
	Ingham County, MI	
29700	Laredo, TX	0.8101
	Webb County, TX	
29740	[2] Las Cruces, NM	0.8649

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Dona Ana County, NM	
29820	[1] Las Vegas-Paradise, NV	1.1416
	Clark County, NV	
29940	Lawrence, KS	0.8538
	Douglas County, KS	
30020	Lawton, OK	0.7916
	Comanche County, OK	
30140	Lebanon, PA	0.8654
	Lebanon County, PA	
30300	Lewiston, ID-WA (ID Hospitals)	0.9878
	Nez Perce County, ID	
	Asotin County, WA	
30300	[2] Lewiston, ID-WA (WA Hospitals)	1.0459
	Nez Perce County, ID	
	Asotin County, WA	
30340	Lewiston-Auburn, ME	0.9332
	Androscoggin County, ME	
30460	Lexington-Fayette, KY	0.9060
	Bourbon County, KY	
	Clark County, KY	
	Fayette County, KY	
	Jessamine County, KY	
	Scott County, KY	
	Woodford County, KY	
30620	Lima, OH	0.9263
	Allen County, OH	
30700	Lincoln, NE	1.0197
	Lancaster County, NE	
	Seward County, NE	
30780	Little Rock-North Little Rock, AR	0.8768
	Faulkner County, AR	
	Grant County, AR	
	Lonoke County, AR	
	Perry County, AR	
	Pulaski County, AR	
	Saline County, AR	
30860	Logan, UT-ID	0.9183
	Franklin County, ID	
	Cache County, UT	
30980	Longview, TX	0.8741
	Gregg County, TX	
	Rusk County, TX	
	Upshur County, TX	
31020	[2] Longview, WA	1.0459
	Cowlitz County, WA	
31084	[1] Los Angeles-Long Beach-Glendale, CA	1.1762
	Los Angeles County, CA	
31140	[1] Louisville, KY-IN	0.9264
	Clark County, IN	
	Floyd County, IN	
	Harrison County, IN	
	Washington County, IN	
	Bullitt County, KY	
	Henry County, KY	
	Jefferson County, KY	
	Meade County, KY	
	Nelson County, KY	
	Oldham County, KY	
	Shelby County, KY	
	Spencer County, KY	
	Trimble County, KY	
31180	Lubbock, TX	0.8790
	Crosby County, TX	
	Lubbock County, TX	
31340	Lynchburg, VA	0.8706
	Amherst County, VA	
	Appomattox County, VA	
	Bedford County, VA	
	Campbell County, VA	
	Bedford City, VA	
	Lynchburg City, VA	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
31420	Macon, GA	0.9485
	Bibb County, GA	
	Crawford County, GA	
	Jones County, GA	
	Monroe County, GA	
	Twiggs County, GA	
31460	[2] Madera, CA	1.0848
	Madera County, CA	
31540	Madison, WI	1.0629
	Columbia County, WI	
	Dane County, WI	
	Iowa County, WI	
31700	[2] Manchester-Nashua, NH	1.0668
	Hillsborough County, NH	
	Merrimack County, NH	
31900	Mansfield, OH	0.8788
	Richland County, OH	
32420	Mayagüez, PR	0.4016
	Hormigueros Municipio, PR	
	Mayagüez Municipio, PR	
32580	McAllen-Edinburg-Mission, TX	0.8945
	Hidalgo County, TX	
32780	[2] Medford, OR	1.0284
	Jackson County, OR	
32820	[1] Memphis, TN-MS-AR	0.9346
	Crittenden County, AR	
	DeSoto County, MS	
	Marshall County, MS	
	Tate County, MS	
	Tunica County, MS	
	Fayette County, TN	
	Shelby County, TN	
	Tipton County, TN	
32900	Merced, CA	1.1123
	Merced County, CA	
33124	[1] Miami-Miami Beach-Kendall, FL	0.9757
	Miami-Dade County, FL	
33140	Michigan City-La Porte, IN	0.9409
	LaPorte County, IN	
33260	Midland, TX	0.9522
	Midland County, TX	
33340	[1] Milwaukee-Waukesha-West Allis, WI	1.0111
	Milwaukee County, WI	
	Ozaukee County, WI	
	Washington County, WI	
	Waukesha County, WI	
33460	[1] Minneapolis-St. Paul-Bloomington, MN-WI	1.1055
	Anoka County, MN	
	Carver County, MN	
	Chisago County, MN	
	Dakota County, MN	
	Hennepin County, MN	
	Isanti County, MN	
	Ramsey County, MN	
	Scott County, MN	
	Sherburne County, MN	
	Washington County, MN	
	Wright County, MN	
	Pierce County, WI	
	St. Croix County, WI	
33540	Missoula, MT	0.9535
	Missoula County, MT	
33660	Mobile, AL	0.7902
	Mobile County, AL	
33700	Modesto, CA	1.1885
	Stanislaus County, CA	
33740	Monroe, LA	0.8044
	Ouachita Parish, LA	
	Union Parish, LA	
33780	Monroe, MI	0.9468
	Monroe County, MI	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
33860	Montgomery, AL	0.8600
	Autauga County, AL	
	Elmore County, AL	
	Lowndes County, AL	
	Montgomery County, AL	
34060	Morgantown, WV	0.8439
	Monongalia County, WV	
	Preston County, WV	
34100	Morristown, TN	0.8758
	Grainger County, TN	
	Hamblen County, TN	
	Jefferson County, TN	
34580	[2] Mount Vernon-Anacortes, WA	1.0459
	Skagit County, WA	
34620	Muncie, IN	0.8952
	Delaware County, IN	
34740	Muskegon-Norton Shores, MI	0.9677
	Muskegon County, MI	
34820	Myrtle Beach-Conway-North Myrtle Beach, SC	0.8869
	Horry County, SC	
34900	Napa, CA	1.2643
	Napa County, CA	
34940	Naples-Marco Island, FL	1.0115
	Collier County, FL	
34980	[1] Nashville-Davidson--Murfreesboro, TN	0.9757
	Cannon County, TN	
	Cheatham County, TN	
	Davidson County, TN	
	Dickson County, TN	
	Hickman County, TN	
	Macon County, TN	
	Robertson County, TN	
	Rutherford County, TN	
	Smith County, TN	
	Sumner County, TN	
	Trousdale County, TN	
	Williamson County, TN	
	Wilson County, TN	
35004	[1] Nassau-Suffolk, NY	1.2781
	Nassau County, NY	
	Suffolk County, NY	
35084	[1] Newark-Union, NJ-PA	1.2192
	Essex County, NJ	
	Hunterdon County, NJ	
	Morris County, NJ	
	Sussex County, NJ	
	Union County, NJ	
	Pike County, PA	
35300	[2] New Haven-Milford, CT	1.1790
	New Haven County, CT	
35380	[1] New Orleans-Metairie-Kenner, LA	0.9003
	Jefferson Parish, LA	
	Orleans Parish, LA	
	Plaquemines Parish, LA	
	St. Bernard Parish, LA	
	St. Charles Parish, LA	
	St. John the Baptist Parish, LA	
	St. Tammany Parish, LA	
35644	[1] New York-White Plains-Wayne, NY-NJ	1.3191
	Bergen County, NJ	
	Hudson County, NJ	
	Passaic County, NJ	
	Bronx County, NY	
	Kings County, NY	
	New York County, NY	
	Putnam County, NY	
	Queens County, NY	
	Richmond County, NY	
	Rockland County, NY	
	Westchester County, NY	
35660	[2] Niles-Benton Harbor, MI	0.8923

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Berrien County, MI	
35980	[2] Norwich-New London, CT	1.1790
	New London County, CT	
36084	[1] Oakland-Fremont-Hayward, CA	1.5474
	Alameda County, CA	
	Contra Costa County, CA	
36100	Ocala, FL	0.8955
	Marion County, FL	
36140	Ocean City, NJ	1.1253
	Cape May County, NJ	
36220	Odessa, TX	0.9893
	Ector County, TX	
36260	Ogden-Clearfield, UT	0.9048
	Davis County, UT	
	Morgan County, UT	
	Weber County, UT	
36420	[1] Oklahoma City, OK	0.9043
	Canadian County, OK	
	Cleveland County, OK	
	Grady County, OK	
	Lincoln County, OK	
	Logan County, OK	
	McClain County, OK	
	Oklahoma County, OK	
36500	Olympia, WA	1.0970
	Thurston County, WA	
36540	Omaha-Council Bluffs, NE-IA	0.9555
	Harrison County, IA	
	Mills County, IA	
	Pottawattamie County, IA	
	Cass County, NE	
	Douglas County, NE	
	Sarpy County, NE	
	Saunders County, NE	
	Washington County, NE	
36740	[1] Orlando-Kissimmee, FL	0.9446
	Lake County, FL	
	Orange County, FL	
	Osceola County, FL	
	Seminole County, FL	
36780	[2] Oshkosh-Neenah, WI	0.9478
	Winnebago County, WI	
36980	Owensboro, KY	0.8806
	Daviess County, KY	
	Hancock County, KY	
	McLean County, KY	
37100	Oxnard-Thousand Oaks-Ventura, CA	1.1604
	Ventura County, CA	
37340	Palm Bay-Melbourne-Titusville, FL	0.9826
	Brevard County, FL	
37460	[2] Panama City-Lynn Haven, FL	0.8613
	Bay County, FL	
37620	Parkersburg-Marietta-Vienna, WV-OH (WV Hospitals)	0.8303
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37620	[2] Parkersburg-Marietta-Vienna, WV-OH (OH Hospitals)	0.8788
	Washington County, OH	
	Pleasants County, WV	
	Wirt County, WV	
	Wood County, WV	
37700	Pascagoula, MS	0.8164
	George County, MS	
	Jackson County, MS	
37860	[2] Pensacola-Ferry Pass-Brent, FL	0.8613
	Escambia County, FL	
	Santa Rosa County, FL	
37900	Peoria, IL	0.8844
	Marshall County, IL	
	Peoria County, IL	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Stark County, IL	
	Tazewell County, IL	
	Woodford County, IL	
37964	[1] Philadelphia, PA	1.1030
	Bucks County, PA	
	Chester County, PA	
	Delaware County, PA	
	Montgomery County, PA	
	Philadelphia County, PA	
38060	[1] Phoenix-Mesa-Scottsdale, AZ	1.0139
	Maricopa County, AZ	
	Pinal County, AZ	
38220	Pine Bluff, AR	0.8716
	Cleveland County, AR	
	Jefferson County, AR	
	Lincoln County, AR	
38300	[1] Pittsburgh, PA	0.8840
	Allegheny County, PA	
	Armstrong County, PA	
	Beaver County, PA	
	Butler County, PA	
	Fayette County, PA	
	Washington County, PA	
	Westmoreland County, PA	
38340	Pittsfield, MA	1.0679
	Berkshire County, MA	
38540	Pocatello, ID	0.9348
	Bannock County, ID	
	Power County, ID	
38660	Ponce, PR	0.5178
	Juana Díaz Municipio, PR	
	Ponce Municipio, PR	
	Villalba Municipio, PR	
38860	Portland-South Portland-Biddeford, ME	1.0382
	Cumberland County, ME	
	Sagadahoc County, ME	
	York County, ME	
38900	[1] Portland-Vancouver-Beaverton, OR-WA	1.1229
	Clackamas County, OR	
	Columbia County, OR	
	Multnomah County, OR	
	Washington County, OR	
	Yamhill County, OR	
	Clark County, WA	
	Skamania County, WA	
38940	Port St. Lucie-Fort Pierce, FL	1.0162
	Martin County, FL	
	St. Lucie County, FL	
39100	Poughkeepsie-Newburgh-Middletown, NY	1.0767
	Dutchess County, NY	
	Orange County, NY	
39140	Prescott, AZ	0.9884
	Yavapai County, AZ	
39300	[1] Providence-New Bedford-Fall River, RI-MA	1.0952
	Bristol County, MA	
	Bristol County, RI	
	Kent County, RI	
	Newport County, RI	
	Providence County, RI	
	Washington County, RI	
39340	Provo-Orem, UT	0.9578
	Juab County, UT	
	Utah County, UT	
39380	[2] Pueblo, CO	0.9379
	Pueblo County, CO	
39460	Punta Gorda, FL	0.9274
	Charlotte County, FL	
39540	[2] Racine, WI	0.9478
	Racine County, WI	
39580	Raleigh-Cary, NC	0.9709
	Franklin County, NC	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Johnston County, NC	
	Wake County, NC	
39660	Rapid City, SD	0.9027
	Meade County, SD	
	Pennington County, SD	
39740	Reading, PA	0.9698
	Berks County, PA	
39820	Redding, CA	1.2207
	Shasta County, CA	
39900	Reno-Sparks, NV	1.0984
	Storey County, NV	
	Washoe County, NV	
40060	[1] Richmond, VA	0.9319
	Amelia County, VA	
	Caroline County, VA	
	Charles City County, VA	
	Chesterfield County, VA	
	Cumberland County, VA	
	Dinwiddie County, VA	
	Goochland County, VA	
	Hanover County, VA	
	Henrico County, VA	
	King and Queen County, VA	
	King William County, VA	
	Louisa County, VA	
	New Kent County, VA	
	Powhatan County, VA	
	Prince George County, VA	
	Sussex County, VA	
	Colonial Heights City, VA	
	Hopewell City, VA	
	Petersburg City, VA	
	Richmond City, VA	
40140	[1] Riverside-San Bernardino-Ontario, CA	1.1021
	Riverside County, CA	
	San Bernardino County, CA	
40220	Roanoke, VA	0.8450
	Botetourt County, VA	
	Craig County, VA	
	Franklin County, VA	
	Roanoke County, VA	
	Roanoke City, VA	
	Salem City, VA	
40340	Rochester, MN	1.1128
	Dodge County, MN	
	Olmsted County, MN	
	Wabasha County, MN	
40380	[1] Rochester, NY	0.9117
	Livingston County, NY	
	Monroe County, NY	
	Ontario County, NY	
	Orleans County, NY	
	Wayne County, NY	
40420	Rockford, IL	0.9975
	Boone County, IL	
	Winnebago County, IL	
40484	[2] Rockingham County-Strafford County, NH	1.0668
	Rockingham County, NH	
	Strafford County, NH	
40580	Rocky Mount, NC	0.8924
	Edgecombe County, NC	
	Nash County, NC	
40660	Rome, GA	0.9414
	Floyd County, GA	
40900	[1] Sacramento--Arden-Arcade--Roseville, CA	1.2953
	El Dorado County, CA	
	Placer County, CA	
	Sacramento County, CA	
	Yolo County, CA	
40980	Saginaw-Saginaw Township North, MI	0.9474
	Saginaw County, MI	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
41060	St. Cloud, MN	1.0030
	Benton County, MN	
	Stearns County, MN	
41100	St. George, UT	0.9416
	Washington County, UT	
41140	St. Joseph, MO-KS	0.9565
	Doniphan County, KS	
	Andrew County, MO	
	Buchanan County, MO	
	DeKalb County, MO	
41180	St. Louis, MO-IL	0.8953
	Bond County, IL	
	Calhoun County, IL	
	Clinton County, IL	
	Jersey County, IL	
	Macoupin County, IL	
	Madison County, IL	
	Monroe County, IL	
	St. Clair County, IL	
	Crawford County, MO	
	Franklin County, MO	
	Jefferson County, MO	
	Lincoln County, MO	
	St. Charles County, MO	
	St. Louis County, MO	
	Warren County, MO	
	Washington County, MO	
	St. Louis City, MO	
41420	Salem, OR	1.0445
	Marion County, OR	
	Polk County, OR	
41500	Salinas, CA	1.4140
	Monterey County, CA	
41540	[2] Salisbury, MD	0.9099
	Somerset County, MD	
	Wicomico County, MD	
41620	Salt Lake City, UT	0.9436
	Salt Lake County, UT	
	Summit County, UT	
	Tooele County, UT	
41660	San Angelo, TX	0.8287
	Irion County, TX	
	Tom Green County, TX	
41700	[1] San Antonio, TX	0.8987
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	[1] San Diego-Carlsbad-San Marcos, CA	1.1417
	San Diego County, CA	
41780	Sandusky, OH	0.9033
	Erie County, OH	
41884	[1] San Francisco-San Mateo-Redwood City, CA	1.4970
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.4646
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	[1] San Jose-Sunnyvale-Santa Clara, CA	1.5114
	San Benito County, CA	
	Santa Clara County, CA	
41980	[1] San Juan-Caguas-Guaynabo, PR	0.4686
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Arecibo Municipio, PR Barceloneta Municipio, PR Barranquitas Municipio, PR Bayamón Municipio, PR Caguas Municipio, PR Camuy Municipio, PR Canóvanas Municipio, PR Carolina Municipio, PR Cataño Municipio, PR Cayey Municipio, PR Ciales Municipio, PR Cidra Municipio, PR Comerío Municipio, PR Corozal Municipio, PR Dorado Municipio, PR Florida Municipio, PR Guaynabo Municipio, PR Gurabo Municipio, PR Hatillo Municipio, PR Humacao Municipio, PR Juncos Municipio, PR Las Piedras Municipio, PR Loíza Municipio, PR Manatí Municipio, PR Maunabo Municipio, PR Morovis Municipio, PR Naguabo Municipio, PR Naranjito Municipio, PR Orocovis Municipio, PR Quebradillas Municipio, PR Río Grande Municipio, PR San Juan Municipio, PR San Lorenzo Municipio, PR Toa Alta Municipio, PR Toa Baja Municipio, PR Trujillo Alto Municipio, PR Vega Alta Municipio, PR Vega Baja Municipio, PR Yabucoa Municipio, PR	
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.1357
42044	[1] Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.1564
42060	Santa Barbara-Santa Maria, CA Santa Barbara County, CA	1.1525
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.5159
42140	Santa Fe, NM Santa Fe County, NM	1.0908
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.3480
42260	Sarasota-Bradenton-Venice, FL Manatee County, FL Sarasota County, FL	0.9554
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9483
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8530
42644	[1] Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.1573
43100	[2] Sheboygan, WI Sheboygan County, WI	0.9478
43300	Sherman-Denison, TX Grayson County, TX	0.9518
43340	Shreveport-Bossier City, LA Bossier Parish, LA	0.8767

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Caddo Parish, LA	
	De Soto Parish, LA	
43580	Sioux City, IA-NE-SD	0.9360
	Woodbury County, IA	
	Dakota County, NE	
	Dixon County, NE	
	Union County, SD	
43620	Sioux Falls, SD	0.9616
	Lincoln County, SD	
	McCook County, SD	
	Minnehaha County, SD	
	Turner County, SD	
43780	South Bend-Mishawaka, IN-MI	0.9785
	St. Joseph County, IN	
	Cass County, MI	
43900	Spartanburg, SC	0.9183
	Spartanburg County, SC	
44060	Spokane, WA	1.0898
	Spokane County, WA	
44100	Springfield, IL	0.8879
	Menard County, IL	
	Sangamon County, IL	
44140	Springfield, MA	1.0679
	Franklin County, MA	
	Hampden County, MA	
	Hampshire County, MA	
44180	Springfield, MO	0.8251
	Christian County, MO	
	Dallas County, MO	
	Greene County, MO	
	Polk County, MO	
	Webster County, MO	
44220	[2] Springfield, OH	0.8788
	Clark County, OH	
44300	State College, PA	0.8368
	Centre County, PA	
44700	Stockton, CA	1.1333
	San Joaquin County, CA	
44940	[2] Sumter, SC	0.8663
	Sumter County, SC	
45060	Syracuse, NY	0.9595
	Madison County, NY	
	Onondaga County, NY	
	Oswego County, NY	
45104	Tacoma, WA	1.0794
	Pierce County, WA	
45220	Tallahassee, FL	0.8712
	Gadsden County, FL	
	Jefferson County, FL	
	Leon County, FL	
	Wakulla County, FL	
45300	[1] Tampa-St. Petersburg-Clearwater, FL	0.9292
	Hernando County, FL	
	Hillsborough County, FL	
	Pasco County, FL	
	Pinellas County, FL	
45460	[2] Terre Haute, IN	0.8632
	Clay County, IN	
	Sullivan County, IN	
	Vermillion County, IN	
	Vigo County, IN	
45500	Texarkana, TX-Texarkana, AR	0.8293
	Miller County, AR	
	Bowie County, TX	
45780	Toledo, OH	0.9573
	Fulton County, OH	
	Lucas County, OH	
	Ottawa County, OH	
	Wood County, OH	
45820	Topeka, KS	0.8921
	Jackson County, KS	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Jefferson County, KS	
	Osage County, KS	
	Shawnee County, KS	
	Wabaunsee County, KS	
45940	Trenton-Ewing, NJ	1.1253
	Mercer County, NJ	
46060	Tucson, AZ	0.9007
	Pima County, AZ	
46140	Tulsa, OK	0.8313
	Creek County, OK	
	Okmulgee County, OK	
	Osage County, OK	
	Pawnee County, OK	
	Rogers County, OK	
	Tulsa County, OK	
	Wagoner County, OK	
46220	Tuscaloosa, AL	0.8724
	Greene County, AL	
	Hale County, AL	
	Tuscaloosa County, AL	
46340	Tyler, TX	0.9322
	Smith County, TX	
46540	Utica-Rome, NY	0.8313
	Herkimer County, NY	
	Oneida County, NY	
46660	Valdosta, GA	0.8873
	Brooks County, GA	
	Echols County, GA	
	Lanier County, GA	
	Lowndes County, GA	
46700	Vallejo-Fairfield, CA	1.4888
	Solano County, CA	
46940	Vero Beach, FL	0.9458
	Indian River County, FL	
47020	Victoria, TX	0.8148
	Calhoun County, TX	
	Goliad County, TX	
	Victoria County, TX	
47220	[2] Vineland-Millville-Bridgeton, NJ	1.1253
	Cumberland County, NJ	
47260	[1] Virginia Beach-Norfolk-Newport News, VA-NC	0.8841
	Currituck County, NC	
	Gloucester County, VA	
	Isle of Wight County, VA	
	James City County, VA	
	Mathews County, VA	
	Surry County, VA	
	York County, VA	
	Chesapeake City, VA	
	Hampton City, VA	
	Newport News City, VA	
	Norfolk City, VA	
	Poquoson City, VA	
	Portsmouth City, VA	
	Suffolk City, VA	
	Virginia Beach City, VA	
	Williamsburg City, VA	
47300	[2] Visalia-Porterville, CA	1.0848
	Tulare County, CA	
47380	Waco, TX	0.8532
	McLennan County, TX	
47580	Warner Robins, GA	0.8662
	Houston County, GA	
47644	[1] Warren-Farmington Hills-Troy, MI	0.9858
	Lapeer County, MI	
	Livingston County, MI	
	Macomb County, MI	
	Oakland County, MI	
	St. Clair County, MI	
47894	[1] Washington-Arlington-Alexandria, DC-VA-MD-WV	1.0935
	District of Columbia, DC	

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.8564
48140	Wausau, WI Marathon County, WI	0.9964
48260	Weirton-Steubenville, WV-OH (WV Hospitals) Jefferson County, OH Brooke County, WV Hancock County, WV	0.7821
48260	[2] Weirton-Steubenville, WV-OH (OH Hospitals) Jefferson County, OH Brooke County, WV Hancock County, WV	0.8788
48300	[2] Wenatchee, WA Chelan County, WA Douglas County, WA	1.0459
48424	[1] West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0061
48540	[2] Wheeling, WV-OH (WV Hospitals) Belmont County, OH Marshall County, WV Ohio County, WV	0.7742
48540	[2] Wheeling, WV-OH (OH Hospitals) Belmont County, OH Marshall County, WV Ohio County, WV	0.8788
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9156
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.8327
48700	Williamsport, PA Lycoming County, PA	0.8368
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.0652
48864	Wilmington, DE-MD-NJ (NJ Hospitals)	1.1253
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9580
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0214
49180	Winston-Salem, NC	0.9020

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS BY CBSA—Continued

CBSA code	Urban area (constituent counties)	Wage index
	Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	
49340	Worcester, MA Worcester County, MA	1.1044
49420	[2] Yakima, WA Yakima County, WA	1.0459
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.4413
49620	York-Hanover, PA York County, PA	0.9422
49660	[2] Youngstown-Warren-Boardman, OH-PA (OH Hospitals) Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8788
49660	Youngstown-Warren-Boardman, OH-PA (PA Hospitals) Mahoning County, OH Trumbull County, OH Mercer County, PA	0.8609
49700	Yuba City, CA Sutter County, CA Yuba County, CA	1.0951
49740	Yuma, AZ Yuma County, AZ	0.9188

[1] Large urban area.
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2006.

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS BY CBSA

CBSA code	Rural area	Wage index
01	Alabama	0.7495
02	Alaska	1.1977
03	Arizona	0.8991
04	Arkansas	0.7478
05	California	1.0848
06	Colorado	0.9379
07	Connecticut	1.1790
08	Delaware	0.9606
10	Florida	0.8613
11	Georgia	0.7684
12	Hawaii	1.0598
13	Idaho	0.8810
14	Illinois	0.8285
15	Indiana	0.8632
16	Iowa	0.8563
17	Kansas	0.8032
18	Kentucky	0.7788
19	Louisiana	0.7445
20	Maine	0.8840
21	Maryland	0.9099
22	Massachusetts[1]	1.0679
23	Michigan	0.8923
24	Minnesota	0.9183
25	Mississippi	0.7685
26	Missouri	0.7927
27	Montana	0.8822
28	Nebraska	0.8666
29	Nevada	0.9079
30	New Hampshire	1.0668
31	New Jersey[1]	1.1253
32	New Mexico	0.8649
33	New York	0.8220
34	North Carolina	0.8570

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS BY CBSA—Continued

CBSA code	Rural area	Wage index
35	North Dakota	0.7278
36	Ohio	0.8788
37	Oklahoma	0.7615
38	Oregon	1.0284
39	Pennsylvania	0.8300
40	Puerto Rico[1]	
41	Rhode Island[1]	1.0952
42	South Carolina	0.8663
43	South Dakota	0.8475
44	Tennessee	0.7915
45	Texas	0.8038
46	Utah	0.8134
47	Vermont	1.0199
49	Virginia	0.8024
50	Washington	1.0459
51	West Virginia	0.7742
52	Wisconsin	0.9478
53	Wyoming	0.9207

[1] All counties within the State are classified as urban, with the exception of Massachusetts. Massachusetts has area(s) designated as rural. However, no short-term, acute care hospitals are located in the area(s) for FY 2006. Massachusetts, New Jersey, and Rhode Island rural floors are imputed.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA

CBSA code	Area	Wage index
10180	Abilene, TX	0.8038
10420	Akron, OH	0.8979
10580	Albany-Schenectady-Troy, NY.	0.8565
10740	Albuquerque, NM	0.9558
10780	Alexandria, LA	0.8048
10900	Allentown-Bethlehem-Easton, PA-NJ.	0.9844
11020	Altoona, PA	0.8942
11100	Amarillo, TX	0.9165
11180	Ames, IA	0.9231
11460	Ann Arbor, MI	1.0628
11500	Anniston-Oxford, AL	0.7702
11700	Asheville, NC	0.9312
12020	Athens-Clarke County, GA.	0.9684
12060	Atlanta-Sandy Springs-Marietta, GA.	0.9637
12420	Austin-Round Rock, TX	0.9451
12620	Bangor, ME	0.9985
12700	Barnstable Town, MA	1.2254
12940	Baton Rouge, LA	0.8470
13020	Bay City, MI	0.9535
13780	Binghamton, NY	0.8471
13820	Birmingham-Hoover, AL	0.8872
14260	Boise City-Nampa, ID	0.9048
14484	Boston-Quincy, MA	1.1233
14540	Bowling Green, KY	0.8222
15380	Buffalo-Niagara Falls, NY	0.8888
15540	Burlington-South Burlington, VT.	0.9306

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
15764 ..	Cambridge-Newton-Framingham, MA.	1.0903
16180 ..	Carson City, NV	0.9786
16220 ..	Casper, WY	0.9207
16580 ..	Champaign-Urbana, IL	0.9335
16620 ..	Charleston, WV (WV Hospitals).	0.8274
16620 ..	Charleston, WV(OH Hospitals).	0.8788
16700 ..	Charleston-North Charleston, SC.	0.9317
16740 ..	Charlotte-Gastonia-Concord, NC-SC.	0.9585
16820 ..	Charlottesville, VA	0.9806
16860 ..	Chattanooga, TN-GA	0.9099
16974 ..	Chicago-Naperville-Joliet, IL.	1.0698
17140 ..	Cincinnati-Middletown, OH-KY-IN.	0.9604
17300 ..	Clarksville, TN-KY	0.8092
17460 ..	Cleveland-Elyria-Mentor, OH.	0.9197
17780 ..	College Station-Bryan, TX.	0.8911
17860 ..	Columbia, MO	0.8346
17900 ..	Columbia, SC	0.9057
17980 ..	Columbus, GA-AL	0.8402
18140 ..	Columbus, OH	0.9848
18700 ..	Corvallis, OR	1.0328
19124 ..	Dallas-Plano-Irving, TX	0.9955
19380 ..	Dayton, OH	0.9069
19460 ..	Decatur, AL	0.8517
19740 ..	Denver-Aurora, CO	1.0517
19780 ..	Des Moines, IA	0.9413
19804 ..	Detroit-Livonia-Dearborn, MI.	1.0453
20260 ..	Duluth, MN-WI	1.0224
20500 ..	Durham, NC	0.9993
20764 ..	Edison, NJ	1.1301
20940 ..	El Centro, CA	0.9102
21060 ..	Elizabethtown, KY	0.8286
21500 ..	Erie, PA	0.8424
21604 ..	Essex County, MA	1.0668
21660 ..	Eugene-Springfield, OR	1.0492
21780 ..	Evansville, IN-KY	0.8508
22020 ..	Fargo, ND-MN (ND, SD Hospitals).	0.8778
22020 ..	Fargo, ND-MN (MN Hospitals).	0.9183
22180 ..	Fayetteville, NC	0.9193
22220 ..	Fayetteville-Springdale-Rogers, AR-MO.	0.8615
22380 ..	Flagstaff, AZ	1.1713
22420 ..	Flint, MI	1.0654
22540 ..	Fond du Lac, WI	0.9478
22660 ..	Fort Collins-Loveland, CO.	1.0146
22744 ..	Ft Lauderdale-Pompano Beach-Deerfield Beach, FL.	1.0508
22900 ..	Fort Smith, AR-OK	0.7986
23020 ..	Fort Walton Beach-Crestview-Destin, FL.	0.8672
23060 ..	Fort Wayne, IN	0.9797
23104 ..	Fort Worth-Arlington, TX	0.9514
23540 ..	Gainesville, FL	0.9461
23844 ..	Gary, IN	0.9366
24340 ..	Grand Rapids-Wyoming, MI.	0.9398

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
24500 ..	Great Falls, MT	0.9074
24540 ..	Greeley, CO	0.9597
24580 ..	Green Bay, WI (MI Hospitals).	0.9439
24580 ..	Green Bay, WI (WI Hospitals).	0.9478
24780 ..	Greenville, NC	0.9414
24860 ..	Greenville, SC	0.9807
25060 ..	Gulfport-Biloxi, MS	0.8612
25420 ..	Harrisburg-Carlisle, PA	0.9145
25500 ..	Harrisonburg, VA	0.8998
25540 ..	Hartford-West Hartford-East Hartford, CT (MA Hospitals).	1.1085
25540 ..	Hartford-West Hartford-East Hartford, CT (CT Hospitals).	1.1790
25860 ..	Hickory-Lenoir-Morganton, NC.	0.8931
26100 ..	Holland-Grand Haven, MI	0.9133
26180 ..	Honolulu, HI	1.1206
26420 ..	Houston-Sugar Land-Baytown, TX.	1.0008
26580 ..	Huntington-Ashland, WV-KY-OH.	0.9119
26620 ..	Huntsville, AL	0.9124
26900 ..	Indianapolis, IN	0.9776
26980 ..	Iowa City, IA	0.9574
27060 ..	Ithaca, NY	0.9204
27140 ..	Jackson, MS	0.8182
27180 ..	Jackson, TN	0.8799
27260 ..	Jacksonville, FL	0.9303
27860 ..	Jonesboro, AR	0.7793
27900 ..	Joplin, MO	0.8458
28020 ..	Kalamazoo-Portage, MI	1.0403
28100 ..	Kankakee-Bradley, IL	1.0991
28140 ..	Kansas City, MO-KS	0.9454
28420 ..	Kennewick-Richland-Pasco, WA.	1.0459
28700 ..	Kingsport-Bristol-Bristol, TN-VA.	0.8095
28740 ..	Kingston, NY	0.8904
28940 ..	Knoxville, TN	0.8470
29180 ..	Lafayette, LA	0.8429
29404 ..	Lake County-Kenosha County, IL-WI.	1.0444
29460 ..	Lakeland, FL	0.8934
29620 ..	Lansing-East Lansing, MI	0.9786
29740 ..	Las Cruces, NM	0.8649
29820 ..	Las Vegas-Paradise, NV	1.1249
30020 ..	Lawton, OK	0.7673
30460 ..	Lexington-Fayette, KY	0.8830
30620 ..	Lima, OH	0.9263
30700 ..	Lincoln, NE	0.9666
30780 ..	Little Rock-North Little Rock, AR.	0.8552
30980 ..	Longview, TX	0.8621
31084 ..	Los Angeles-Long Beach-Santa Ana, CA.	1.1660
31140 ..	Louisville, KY-IN	0.9264
31180 ..	Lubbock, TX	0.8790
31340 ..	Lynchburg, VA	0.8596
31420 ..	Macon, GA	0.9087
31540 ..	Madison, WI	1.0416
31700 ..	Manchester-Nashua, NH	1.0668
32780 ..	Medford, OR	1.0284
32820 ..	Memphis, TN-MS-AR	0.9108
33124 ..	Miami-Miami Beach-Kendall, FL.	0.9757

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
33260 ..	Midland, TX	0.9317
33340 ..	Milwaukee-Waukesha-West Allis, WI.	0.9957
33460 ..	Minneapolis-St. Paul-Bloomington, MN-WI.	1.0905
33540 ..	Missoula, MT	0.9535
33660 ..	Mobile, AL	0.7902
33700 ..	Modesto, CA	1.1885
33860 ..	Montgomery, AL	0.8276
34060 ..	Morgantown, WV	0.8332
34980 ..	Nashville-Davidson--Murfreesboro, TN.	0.9492
35084 ..	Newark-Union, NJ-PA	1.2192
35380 ..	New Orleans-Metairie-Kenner, LA.	0.9003
35644 ..	New York-White Plains-Wayne, NY-NJ.	1.3191
36084 ..	Oakland-Fremont-Hayward, CA.	1.5474
36100 ..	Ocala, FL	0.8955
36140 ..	Ocean City, NJ	1.0289
36220 ..	Odessa, TX	0.9593
36260 ..	Ogden-Clearfield, UT	0.9048
36420 ..	Oklahoma City, OK	0.9043
36500 ..	Olympia, WA	1.0970
36540 ..	Omaha-Council Bluffs, NE-IA.	0.9555
36740 ..	Orlando-Kissimmee, FL	0.9446
37860 ..	Pensacola-Ferry Pass-Brent, FL.	0.8089
37900 ..	Peoria, IL	0.8844
37964 ..	Philadelphia, PA	1.1030
38220 ..	Pine Bluff, AR	0.8099
38300 ..	Pittsburgh, PA	0.8840
38340 ..	Pittsfield, MA	1.0199
38860 ..	Portland-South Portland-Biddeford, ME.	0.9884
38900 ..	Portland-Vancouver-Beaverton, OR-WA.	1.1229
38940 ..	Port St. Lucie-Fort Pierce, FL.	1.0162
39100 ..	Poughkeepsie-Newburgh-Middletown, NY.	1.0576
39340 ..	Provo-Orem, UT	0.9578
39580 ..	Raleigh-Cary, NC	0.9476
39740 ..	Reading, PA	0.9500
39820 ..	Redding, CA	1.1909
39900 ..	Reno-Sparks, NV (NV Hospitals).	1.0805
39900 ..	Reno-Sparks, NV (CA Hospitals).	1.0848
40060 ..	Richmond, VA	0.9319
40220 ..	Roanoke, VA	0.8450
40340 ..	Rochester, MN	1.1128
40380 ..	Rochester, NY	0.9117
40420 ..	Rockford, IL	0.9667
40484 ..	Rockingham County, NH	1.0503
40660 ..	Rome, GA	0.9414
40900 ..	Sacramento—Arden-Arcade—Roseville, CA.	1.2953
40980 ..	Saginaw-Saginaw Township North, MI.	0.9090
41060 ..	St. Cloud, MN	0.9785
41100 ..	St. George, UT	0.9416
41180 ..	St. Louis, MO-IL	0.8953
41620 ..	Salt Lake City, UT	0.9436
41700 ..	San Antonio, TX	0.8987

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
41884 ..	San Francisco-San Mateo-Redwood City,CA.	1.4739
41980 ..	San Juan-Caguas-Guaynabo, PR.	0.4686
42044 ..	Santa Ana-Anaheim-Irvine, CA.	1.1297
42140 ..	Santa Fe, NM	1.0163
42220 ..	Santa Rosa-Petaluma, CA.	1.3480
42260 ..	Sarasota-Bradenton-Venice, FL.	0.9554
42340 ..	Savannah, GA	0.9316
42644 ..	Seattle-Bellevue-Everett, WA.	1.1573
43300 ..	Sherman-Denison, TX	0.8971
43340 ..	Shreveport-Bossier City, LA.	0.8767
43620 ..	Sioux Falls, SD	0.9616
43780 ..	South Bend-Mishawaka, IN-MI.	0.9785
43900 ..	Spartanburg, SC	0.9183
44060 ..	Spokane, WA	1.0722
44180 ..	Springfield, MO	0.8251
44300 ..	State College, PA	0.8300]
44940 ..	Sumter, SC	0.8663
45060 ..	Syracuse, NY	0.9315
45104 ..	Tacoma, WA	1.0794

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
45220 ..	Tallahassee, FL	0.8420
45300 ..	Tampa-St. Petersburg-Clearwater, FL.	0.9292
45500 ..	Texarkana, TX-Texarkana, AR.	0.8293
45820 ..	Topeka, KS	0.8785
46140 ..	Tulsa, OK	0.8313
46220 ..	Tuscaloosa, AL	0.8614
46340 ..	Tyler, TX	0.9164
46660 ..	Valdosta, GA	0.8710
46700 ..	Vallejo-Fairfield, CA	1.3955
47260 ..	Virginia Beach-Norfolk-Newport News, VA.	0.8841
47380 ..	Waco, TX	0.8532
47894 ..	Washington-Arlington-Alexandria DC-VA.	1.0813
48140 ..	Wausau, WI	0.9964
48620 ..	Wichita, KS	0.8946
48700 ..	Williamsport, PA	0.8300
48864 ..	Wilmington, DE-MD-NJ	1.0652
48864 ..	Wilmington, DE-MD-NJ (NJ Hospitals).	1.1253
48900 ..	Wilmington, NC	0.9394
49020 ..	Winchester, VA-WV	1.0214
49180 ..	Winston-Salem, NC	0.9020
49660 ..	Youngstown-Warren-Boardman, OH-PA (PA Hospitals).	0.8446

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED BY CBSA—Continued

CBSA code	Area	Wage index
49660 ..	Youngstown-Warren-Boardman, OH-PA (OH Hospitals).	0.8788
03	Rural Arizona	0.8991
04	Rural Arkansas	0.7478
05	Rural California	1.0848
07	Rural Connecticut	1.0448
10	Rural Florida	0.8613
13	Rural Idaho	0.8810
14	Rural Illinois	0.8285
15	Rural Indiana	0.8632
16	Rural Iowa	0.8563
17	Rural Kansas	0.8032
19	Rural Louisiana	0.7445
23	Rural Michigan	0.8923
24	Rural Minnesota	0.9183
26	Rural Missouri	0.7927
30	Rural New Hampshire	1.0668
37	Rural Oklahoma	0.7615
38	Rural Oregon	1.0284
45	Rural Texas	0.8038
50	Rural Washington (ID Hospitals).	1.0061
50	Rural Washington (WA Hospitals).	1.0459
53	Rural Wyoming	0.9207

ADDENDUM K.—PUERTO RICO WAGE INDEX BY CBSA

CBSA code	Area	Wage index	Wage index–reclassified hospitals
10380	Aguadilla-Isabela-San Sebastián, PR	1.0196	
21940	Fajardo, PR	0.8956	
25020	Guayama, PR	0.6858	
32420	Mayagüez, PR	0.8647	
38660	Ponce, PR	1.1147	
41900	San Germán-Cabo Rojo, PR	1.0002	
41980	San JuanCaguasGuaynabo, PR	1.0087	1.0087
49500	Yauco, PR	0.9500	

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]

Provider No.	Out-migration adjustment	Qualifying county name
010009	0.0092	MORGAN
010010	0.0259	MARSHALL
010038	0.0062	CALHOUN
010047	0.0155	BUTLER
010054	0.0092	MORGAN
010061	0.0506	JACKSON
010078	0.0062	CALHOUN
010085	0.0092	MORGAN
010109	0.0464	PICKENS
010115	0.0093	FRANKLIN
010129	0.0121	BALDWIN
010146	0.0062	CALHOUN
040066	0.0382	CLARK
040070	0.0140	MISSISSIPPI
040143	0.0026	JEFFERSON
050008	0.0028	SAN FRANCISCO

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050016	0.0087	SAN LUIS OBISPO
050047	0.0028	SAN FRANCISCO
050055	0.0028	SAN FRANCISCO
050084	0.0555	SAN JOAQUIN
050088	0.0087	SAN LUIS OBISPO
050101	0.0269	SOLANO
050117	0.0463	MERCED
050122	0.0555	SAN JOAQUIN
050133	0.0170	YUBA
050152	0.0028	SAN FRANCISCO
050167	0.0555	SAN JOAQUIN

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050232	0.0087	SAN LUIS OBISPO
050253	0.0029	ORANGE
050313	0.0555	SAN JOAQUIN
050325	0.0176	TUOLUMNE
050335	0.0176	TUOLUMNE
050336	0.0555	SAN JOAQUIN
050367	0.0269	SOLANO
050407	0.0028	SAN FRANCISCO
050444	0.0463	MERCED
050454	0.0028	SAN FRANCISCO
050457	0.0028	SAN FRANCISCO
050476	0.0257	LAKE
050491	0.0029	ORANGE

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
050506	0.0087	SAN LUIS OBISPO
050539	0.0257	LAKE
050568	0.0062	MADERA
050633	0.0087	SAN LUIS OBISPO
050680	0.0269	SOLANO
050695	0.0555	SAN JOAQUIN
070020	0.0073	MIDDLESEX
080001	0.0062	NEW CASTLE
080003	0.0062	NEW CASTLE
100014	0.0118	VOLUSIA
100017	0.0118	VOLUSIA
100047	0.0021	CHARLOTTE
100062	0.0060	MARION
100068	0.0118	VOLUSIA
100072	0.0118	VOLUSIA
100077	0.0021	CHARLOTTE
100102	0.0133	COLUMBIA
100156	0.0133	COLUMBIA
100175	0.0231	DE SOTO
100212	0.0060	MARION
100236	0.0021	CHARLOTTE
100290	0.0558	SUMTER
110027	0.0387	FRANKLIN
110063	0.0290	LIBERTY
110120	0.0873	POLK
110124	0.0428	WAYNE
110136	0.0261	BALDWIN
110190	0.0182	MACON
130011	0.0218	LATAH
130024	0.0275	BONNER
140026	0.0346	LA SALLE
140033	0.0147	LAKE
140084	0.0147	LAKE
140100	0.0147	LAKE
140129	0.0096	WABASH
140130	0.0147	LAKE
140173	0.0046	WHITESIDE
140202	0.0147	LAKE
140205	0.0163	BOONE
150022	0.0249	MONTGOMERY
150035	0.0083	PORTER
150045	0.0416	DE KALB
150060	0.0052	VERMILLION
150062	0.0153	DECATUR
150091	0.0573	HUNTINGTON
150122	0.0199	RIPLEY
160013	0.0218	MUSCATINE
160030	0.0032	STORY
160032	0.0272	JASPER
160140	0.0364	PLYMOUTH
180128	0.0282	LAWRENCE
190010	0.0401	TANGIPAHOA
190017	0.0235	ST. LANDRY
190049	0.0645	WASHINGTON
190054	0.0107	IBERIA
190078	0.0235	ST. LANDRY
190088	0.0705	WEBSTER
190133	0.0238	ALLEN
190144	0.0705	WEBSTER
190147	0.0401	TANGIPAHOA
190148	0.0390	AVOYELLES
190184	0.0161	CALDWELL
190190	0.0161	CALDWELL
190246	0.0161	CALDWELL
200013	0.0186	WALDO
200032	0.0460	OXFORD
210001	0.0129	WASHINGTON

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
210004	0.0040	MONTGOMERY
210016	0.0040	MONTGOMERY
210018	0.0040	MONTGOMERY
210022	0.0040	MONTGOMERY
210023	0.0209	ANNE ARUNDEL
210028	0.0512	ST. MARYS
210043	0.0209	ANNE ARUNDEL
210048	0.0287	HOWARD
210057	0.0040	MONTGOMERY
220006	0.0306	ESSEX
220076	0.0249	MIDDLESEX
230015	0.0359	ST. JOSEPH
230021	0.0136	BERRIEN
230041	0.0099	BAY
230075	0.0145	CALHOUN
230184	0.0389	JACKSON
230222	0.0228	MIDLAND
240011	0.0506	MC LEOD
240014	0.0454	RICE
240021	0.0897	LE SUEUR
240044	0.0868	WINONA
240089	0.1196	GOODHUE
240133	0.0319	MEEKER
240154	0.0138	ITASCA
240205	0.0138	ITASCA
250030	0.0318	LEAKE
250045	0.0042	HANCOCK
250088	0.0122	WILKINSON
250154	0.0318	LEAKE
260097	0.0425	JOHNSON
260127	0.0158	PIKE
280054	0.0137	GAGE
280123	0.0137	GAGE
310010	0.0097	MERCER
310011	0.0113	CAPE MAY
310039	0.0350	MIDDLESEX
310044	0.0097	MERCER
310092	0.0097	MERCER
310108	0.0350	MIDDLESEX
310110	0.0097	MERCER
320003	0.0630	SAN MIGUEL
320011	0.0442	RIO ARRIBA
320018	0.0063	DONA ANA
320085	0.0063	DONA ANA
330167	0.0137	NASSAU
330198	0.0137	NASSAU
330209	0.0560	ORANGE
330222	0.0003	SARATOGA
330224	0.0959	ULSTER
330225	0.0137	NASSAU
330259	0.0137	NASSAU
330276	0.0063	FULTON
330331	0.0137	NASSAU
330332	0.0137	NASSAU
330333	0.0137	NASSAU
330372	0.0137	NASSAU
330402	0.0959	ULSTER
340015	0.0267	ROWAN
340020	0.0207	LEE
340037	0.0216	CLEVELAND
340070	0.0448	ALAMANCE
340085	0.0377	DAVIDSON
340088	0.0115	TRANSYLVANIA
340096	0.0377	DAVIDSON
340104	0.0216	CLEVELAND
340126	0.0161	WILSON
340133	0.0302	MARTIN
360034	0.0263	WAYNE
360070	0.0028	STARK

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
360084	0.0028	STARK
360093	0.0120	DEFIANCE
360095	0.0087	HANCOCK
360099	0.0087	HANCOCK
360100	0.0028	STARK
360131	0.0028	STARK
360151	0.0028	STARK
360156	0.0213	SANDUSKY
370023	0.0084	STEPHENS
370043	0.0294	MARSHALL
370065	0.0121	CRAIG
370149	0.0356	POTTAWATOMIE
380002	0.0130	JOSEPHINE
380029	0.0073	MARION
380051	0.0073	MARION
380056	0.0073	MARION
390011	0.0012	CAMBRIA
390044	0.0200	BERKS
390046	0.0098	YORK
390056	0.0042	HUNTINGDON
390096	0.0200	BERKS
390101	0.0098	YORK
390130	0.0012	CAMBRIA
390146	0.0053	WARREN
390162	0.0207	NORTHAMPTON
390233	0.0098	YORK
420007	0.0001	SPARTANBURG
420027	0.0210	ANDERSON
420043	0.0177	CHEROKEE
420083	0.0001	SPARTANBURG
420093	0.0001	SPARTANBURG
420098	0.0035	GEORGETOWN
440024	0.0387	BRADLEY
440047	0.0499	GIBSON
440056	0.0321	JEFFERSON
440063	0.0011	WASHINGTON
440105	0.0011	WASHINGTON
440114	0.0523	LAUDERDALE
440115	0.0499	GIBSON
440143	0.0448	MARSHALL
440153	0.0145	COCKE
440174	0.0372	HAYWOOD
440181	0.0407	HARDEMAN
440184	0.0011	WASHINGTON
450050	0.0750	WARD
450113	0.0195	ANDERSON
450163	0.0134	KLEBERG
450362	0.0486	BURNET
450370	0.0258	COLORADO
450395	0.0484	POLK
450465	0.0435	MATAGORDA
450596	0.0808	HOOD
450597	0.0077	DE WITT
450626	0.0294	JACKSON
450763	0.0236	HUTCHINSON
450813	0.0195	ANDERSON
460017	0.0392	BOX ELDER
470018	0.0287	WINDSOR
470023	0.0118	CALEDONIA
490019	0.1240	CULPEPER
490038	0.0022	SMYTH
490084	0.0167	ESSEX
490110	0.0082	MONTGOMERY
500007	0.0208	SKAGIT
500019	0.0213	LEWIS
500021	0.0055	PIERCE
500079	0.0055	PIERCE
500108	0.0055	PIERCE
500118	0.0548	MASON

ADDENDUM L.—OUT-MIGRATION WAGE ADJUSTMENT—FY 2006 [1]—Continued

Provider No.	Out-migration adjustment	Qualifying county name
500129	0.0055	PIERCE
510039	0.0112	OHIO
510050	0.0112	OHIO
510088	0.0141	FAYETTE
520035	0.0077	SHEBOYGAN
520042	0.0118	SAUK
520044	0.0077	SHEBOYGAN
520057	0.0118	SAUK
520132	0.0077	SHEBOYGAN

[1] The above table lists all hospitals that we anticipate will have their wage index increased by the out-migration adjustment. This list includes hospitals designated in Table 4J of FY 2006 hospital IPPS proposed rule (May 5, 2005) as NOT reclassified under section 1886(d)(10) of the Act or redesignated under section 1886(d)(8)(B) of the Act, as well as TEFRA hospitals falling in a designated out-migration county. In the IPPS proposed rule we asked hospitals to notify us if they wish to withdraw their reclassification/redesignation request and receive the out-migration adjustment. Because we are proposing to adopt the final IPPS wage indices for OPPS, we will adopt any changes in eligibility for the out-migration adjustment resulting from requests to waive reclassification

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
010005	01	13820	
010008	01	33860	
010012	01	16860	
010022	01	40660	LUGAR
010025	01	17980	
010029	12220	17980	
010035	01	13820	
010044	01	13820	
010045	01	13820	
010065	01	33860	
010072	01	11500	LUGAR
010083	01	37860	
010100	01	37860	
010101	01	11500	LUGAR
010118	01	33860	
010120	01	33660	
010126	01	33860	
010143	01	13820	
010158	01	19460	
030013	49740	20940	
030033	03	22380	
040014	04	30780	
040017	04	44180	
040019	04	32820	
040020	27860	32820	
040027	04	44180	
040039	04	27860	
040041	04	30780	
040047	04	27860	
040069	04	32820	
040071	38220	30780	
040072	04	30780	
040076	04	30780	
040078	26300	30780	
040080	04	27860	
040088	04	43340	
040091	04	45500	
040100	04	30780	
040119	04	30780	
050006	05	39820	
050009	34900	46700	
050013	34900	46700	
050014	05	40900	
050022	40140	42044	
050042	05	39820	
050046	37100	31084	
050054	40140	42044	
050065	42044	31084	
050069	42044	31084	
050071	41940	36084	
050073	46700	36084	
050076	41884	36084	
050082	37100	31084	
050089	40140	31084	
050090	42220	41884	
050099	40140	31084	
050102	40140	42044	
050118	44700	33700	
050129	40140	31084	
050136	42220	41884	
050140	40140	31084	
050150	05	40900	
050159	37100	31084	
050168	42044	31084	
050173	42044	31084	
050174	42220	41884	
050177	37100	31084	
050193	42044	31084	
050224	42044	31084	
050226	42044	31084	
050228	41884	36084	
050230	42044	31084	
050236	37100	31084	
050243	40140	42044	
050245	40140	31084	
050251	05	39900	
050272	40140	31084	
050279	40140	31084	
050291	42220	41884	
050292	40140	42044	
050298	40140	31084	
050300	40140	31084	
050327	40140	31084	
050329	40140	42044	
050331	42220	41884	
050348	42044	31084	
050385	42220	41884	
050390	40140	42044	
050394	37100	31084	
050419	05	39820	
050423	40140	42044	
050426	42044	31084	
050430	05	39900	
050510	41884	36084	
050517	40140	31084	
050526	42044	31084	
050534	40140	42044	
050535	42044	31084	
050541	41884	36084	
050543	42044	31084	
050547	42220	41884	
050548	42044	31084	
050550	42044	31084	
050551	42044	31084	
050567	42044	31084	
050569	05	42220	
050570	42044	31084	
050573	40140	42044	
050580	42044	31084	
050584	40140	31084	
050585	42044	31084	
050586	40140	31084	
050589	42044	31084	
050592	42044	31084	
050594	42044	31084	
050603	42044	31084	
050609	42044	31084	
050616	37100	31084	
050667	34900	46700	
050668	41884	36084	
050678	42044	31084	
050684	40140	42044	
050686	40140	42044	
050690	42220	41884	
050693	42044	31084	
050694	40140	42044	
050701	40140	42044	
050709	40140	31084	
050718	40140	42044	
050720	42044	31084	
050728	42220	41884	
060001	24540	19740	
060003	14500	19740	
060023	24300	39340	
060027	14500	19740	
060044	06	19740	
060049	06	22660	
060096	06	19740	
060103	14500	19740	
070003	07	25540	LUGAR
070021	07	25540	LUGAR
070033	14860	35644	
080004	20100	48864	
080007	08	36140	
100022	33124	22744	
100023	10	36740	
100024	10	33124	
100045	19660	36740	
100049	10	29460	
100081	10	23020	LUGAR
100109	10	36740	
100118	10	27260	
100139	10	23540	LUGAR
100150	10	33124	
100157	29460	45300	
100176	48424	38940	
100217	46940	38940	
100232	10	27260	
100239	45300	42260	
100249	10	36100	
100252	10	38940	
100292	10	23020	LUGAR
110001	19140	12060	
110002	11	12060	
110003	11	27260	
110023	11	12060	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
110025	15260	27260	
110029	23580	12060	
110038	11	45220	
110040	11	12060	LUGAR
110041	11	12020	
110052	11	16860	LUGAR
110054	40660	12060	
110069	47580	31420	
110075	11	42340	
110088	11	12060	LUGAR
110095	11	46660	
110117	11	12060	LUGAR
110122	46660	45220	
110125	11	31420	
110128	11	42340	
110150	11	31420	
110153	47580	31420	
110168	40660	12060	
110187	11	12060	LUGAR
110189	11	12060	
110205	11	12060	
120028	12	26180	
130002	13	14260	
130003	30300	50	
130049	17660	44060	
140012	14	16974	
140015	14	41180	
140032	14	41180	
140034	14	41180	
140040	14	37900	
140043	14	40420	
140046	14	41180	
140058	14	41180	
140061	14	41180	
140064	14	37900	
140110	14	16974	
140143	14	37900	
140160	14	40420	
140161	14	16974	
140164	14	41180	
140189	14	16580	
140233	40420	16974	
140234	14	37900	
140236	14	28100	LUGAR
140291	29404	16974	
150002	23844	16974	
150004	23844	16974	
150006	33140	43780	
150008	23844	16974	
150011	15	26900	
150015	33140	16974	
150030	15	26900	LUGAR
150048	15	17140	
150065	15	26900	
150069	15	17140	
150076	15	43780	
150088	11300	26900	
150090	23844	16974	
150102	15	23844	LUGAR
150112	18020	26900	
150113	11300	26900	
150125	23844	16974	
150126	23844	16974	
150132	23844	16974	
150133	15	23060	
150146	15	23060	
150147	23844	16974	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
160001	16	11180	
160016	16	19780	
160026	16	11180	LUGAR
160057	16	26980	
160080	16	40420	
160089	16	19780	
160147	16	11180	
170006	17	27900	
170010	17	46140	
170012	17	48620	
170013	17	48620	
170020	17	48620	
170022	17	28140	
170023	17	48620	
170033	17	48620	
170058	17	28140	
170068	17	11100	
170120	17	27900	
170142	17	45820	
170175	17	48620	
180005	18	26580	
180011	18	30460	
180012	21060	31140	
180013	14540	34980	
180017	18	21060	
180018	18	30460	
180019	18	17140	
180024	18	31140	
180027	18	17300	
180028	18	26580	
180029	18	28700	
180044	18	26580	
180048	18	31140	
180066	18	34980	
180069	18	26580	
180075	18	14540	LUGAR
180078	18	26580	
180080	18	28940	
180093	18	21780	
180102	18	17300	
180104	18	17300	
180116	18	14	
180124	14540	34980	
180127	18	31140	
180132	18	30460	
180139	18	30460	
190001	19	35380	
190003	19	29180	
190015	19	35380	
190086	19	43340	
190099	19	12940	
190106	19	10780	
190131	12940	35380	
190155	19	12940	LUGAR
190164	19	10780	
190191	19	12940	
190223	19	12940	LUGAR
200002	20	38860	
200020	38860	40484	
200024	30340	38860	
200034	30340	38860	
200039	20	38860	
200050	20	12620	
200063	20	38860	
220001	49340	14484	
220002	15764	14484	
220003	49340	14484	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
220010	21604	14484	
220011	15764	14484	
220019	49340	14484	
220025	49340	14484	
220028	49340	14484	
220029	21604	14484	
220033	21604	14484	
220035	21604	14484	
220049	15764	14484	
220058	49340	14484	
220060	14484	12700	
220062	49340	14484	
220063	15764	14484	
220070	15764	14484	
220077	44140	25540	
220080	21604	14484	
220082	15764	14484	
220084	15764	14484	
220089	15764	14484	
220090	49340	14484	
220095	49340	14484	
220098	15764	14484	
220101	15764	14484	
220105	15764	14484	
220133	15764	14484	
220163	49340	14484	
220171	15764	14484	
220174	21604	14484	
230022	23	11460	
230030	23	40980	
230035	23	24340	LUGAR
230037	23	11460	
230042	23	26100	LUGAR
230047	47644	19804	
230054	23	24580	
230069	47644	22420	
230077	40980	22420	
230080	23	40980	
230093	23	24340	
230096	23	28020	
230099	33780	11460	
230105	23	13020	
230121	23	29620	LUGAR
230134	23	26100	LUGAR
230195	47644	19804	
230204	47644	19804	
230208	23	24340	LUGAR
230217	12980	29620	
230227	47644	19804	
230235	23	40980	LUGAR
230257	47644	19804	
230264	47644	19804	
230279	47644	22420	
230295	23	26100	LUGAR
240013	24	33460	
240018	24	33460	
240030	24	41060	
240031	41060	33460	
240036	41060	33460	
240052	24	22020	
240064	24	20260	
240069	24	40340	
240071	24	40340	
240075	24	41060	
240088	24	41060	
240093	24	33460	
240105	24	40340	LUGAR

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
240150	24	40340	LUGAR
240152	24	33460	
240187	24	33460	
240211	24	33460	
250004	25	32820	
250006	25	32820	
250009	25	27180	
250023	25	25060	LUGAR
250031	25	27140	
250034	25	32820	
250040	37700	25060	
250042	25	32820	
250069	25	46220	
250079	25	27140	
250081	25	27140	
250082	25	38220	
250094	25620	25060	
250097	25	12940	
250099	25	27140	
250100	25	46220	
250104	25	27140	
250117	25	25060	LUGAR
260009	26	28140	
260011	27620	17860	
260017	26	41180	
260022	26	16	
260025	26	41180	
260047	27620	17860	
260049	26	44180	LUGAR
260064	26	17860	
260074	26	17860	
260094	26	44180	
260110	26	41180	
260113	26	14	
260116	26	14	
260183	26	41180	
260186	26	17860	
270003	27	24500	
270011	27	24500	
270017	27	33540	
270051	27	33540	
280009	28	30700	
280023	28	30700	
280032	28	30700	
280057	28	30700	
280061	28	53	
280065	28	24540	
280077	28	36540	
290002	29	16180	LUGAR
290006	29	39900	
290008	29	29820	
290019	16180	39900	
300003	30	31700	
300005	30	31700	
300007	31700	15764	
300011	31700	15764	
300012	31700	15764	
300014	40484	31700	
300017	40484	21604	
300018	40484	31700	
300019	30	15764	
300020	31700	15764	
300023	40484	21604	
300029	40484	21604	
300034	31700	15764	
310002	35084	35644	
310009	35084	35644	
310013	35084	35644	
310015	35084	35644	
310018	35084	35644	
310031	15804	20764	
310032	47220	48864	
310038	20764	35644	
310048	20764	35084	
310054	35084	35644	
310070	20764	35644	
310076	35084	35644	
310078	35084	35644	
310083	35084	35644	
310093	35084	35644	
310096	35084	35644	
310119	35084	35644	
320005	22140	10740	
320006	32	42140	
320013	32	42140	
320014	32	29740	
320033	32	42140	LUGAR
320063	32	36220	
320065	32	36220	
330001	39100	35644	
330004	28740	39100	
330008	33	15380	LUGAR
330027	35004	35644	
330038	33	40380	LUGAR
330062	33	27060	LUGAR
330073	33	40380	LUGAR
330085	33	45060	
330094	33	28740	
330136	33	45060	
330157	33	45060	
330181	35004	35644	
330182	35004	35644	
330191	24020	10580	
330229	27460	21500	
330235	33	45060	LUGAR
330239	27460	21500	
330250	33	15540	
330277	33	27060	
330359	33	39100	LUGAR
330386	33	39100	LUGAR
340004	24660	49180	
340008	34	16740	
340010	24140	39580	
340013	34	16740	
340018	34	43900	LUGAR
340021	34	16740	
340023	11700	24860	
340027	34	24780	
340039	34	16740	
340050	34	22180	
340051	34	25860	
340068	34	48900	
340069	39580	20500	
340071	34	39580	LUGAR
340073	39580	20500	
340091	24660	49180	
340109	34	47260	
340114	39580	20500	
340115	34	20500	
340124	34	39580	LUGAR
340127	34	20500	LUGAR
340129	34	16740	
340131	34	24780	
340136	34	20500	LUGAR
340138	39580	20500	
340144	34	16740	
340145	34	16740	LUGAR
340147	40580	39580	
340173	39580	20500	
350009	35	22020	
360008	36	26580	
360010	36	10420	
360011	36	18140	
360013	36	30620	
360014	36	18140	
360019	10420	17460	
360020	10420	17460	
360025	41780	17460	
360027	10420	17460	
360036	36	17460	
360039	36	18140	
360054	36	16620	
360065	36	17460	
360078	10420	17460	
360079	19380	17140	
360086	44220	19380	
360096	36	49660	LUGAR
360107	36	17460	
360112	45780	11460	
360125	36	17460	LUGAR
360150	10420	17460	
360159	36	18140	
360175	36	18140	
360185	36	49660	LUGAR
360187	44220	19380	
360197	36	18140	
360211	48260	38300	
360238	36	49660	LUGAR
360241	10420	17460	
360245	36	17460	LUGAR
370004	37	27900	
370014	37	43300	
370015	37	46140	
370018	37	46140	
370022	37	30020	
370025	37	46140	
370034	37	22900	
370047	37	43300	
370049	37	36420	
370099	37	46140	
370103	37	45	
370113	37	22220	
370179	37	46140	
380001	38	38900	
380008	38	18700	LUGAR
380022	38	18700	LUGAR
380027	38	21660	
380047	13460	21660	
380050	38	32780	
380070	38	38900	
390006	39	25420	
390013	39	25420	
390016	39	49660	
390030	39	10900	
390031	39	39740	LUGAR
390048	39	25420	
390052	39	11020	
390065	39	47894	
390066	30140	25420	
390071	39	48700	LUGAR
390079	39	13780	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
390081	37964	48864	
390086	39	44300	
390091	39	49660	
390093	39	49660	
390110	27780	38300	
390113	39	49660	
390133	10900	37964	
390138	39	47894	
390150	39	38300	LUGAR
390151	39	47894	
390156	37964	48864	
390180	37964	48864	
390222	37964	48864	
390224	39	13780	LUGAR
390244	39	48700	LUGAR
390246	39	48700	
390249	39	13780	LUGAR
400048	25020	41980	
410001	39300	14484	
410004	39300	14484	
410005	39300	14484	
410006	39300	14484	
410007	39300	14484	
410008	39300	14484	
410009	39300	14484	
410011	39300	14484	
410012	39300	14484	
410013	39300	14484	
420009	42	24860	LUGAR
420020	42	16700	
420028	42	44940	LUGAR
420030	42	16700	
420036	42	16740	
420039	42	43900	LUGAR
420067	42	42340	
420068	42	16700	
420069	42	44940	LUGAR
420070	44940	17900	
420071	42	24860	
420080	42	42340	
420085	34820	48900	
430012	43	43620	
430014	43	22020	
430094	43	53	
440008	44	21780	
440020	44	26620	
440035	17300	34980	
440050	44	11700	
440058	44	16860	
440059	44	34980	
440060	44	27180	
440067	34100	28940	
440068	44	16860	
440072	44	32820	
440073	44	34980	
440148	44	34980	
440151	44	34980	
440175	44	34980	
440180	44	28940	
440185	17420	16860	
440192	44	34980	
450007	45	41700	
450032	45	43340	
450039	23104	19124	
450059	41700	12420	
450064	23104	19124	
450073	45	10180	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
450080	45	30980	
450087	23104	19124	
450098	45	30980	
450099	45	11100	
450121	23104	19124	
450135	23104	19124	
450137	23104	19124	
450144	45	36220	
450148	23104	19124	
450187	45	26420	
450192	45	19124	
450194	45	19124	
450196	45	19124	
450211	45	26420	
450214	45	26420	
450224	45	46340	
450283	45	19124	LUGAR
450286	45	17780	LUGAR
450347	45	26420	
450351	45	23104	
450389	45	19124	LUGAR
450400	45	47380	
450419	23104	19124	
450438	45	26420	
450447	45	19124	
450451	45	23104	
450484	45	26420	
450508	45	46340	
450547	45	19124	
450563	23104	19124	
450623	45	19124	LUGAR
450639	23104	19124	
450653	45	33260	
450656	45	46340	
450672	23104	19124	
450675	23104	19124	
450677	23104	19124	
450694	45	26420	
450747	45	19124	
450755	45	31180	
450770	45	12420	LUGAR
450779	23104	19124	
450830	45	36220	
450839	45	43340	
450858	23104	19124	
450872	23104	19124	
450880	23104	19124	
460004	36260	41620	
460005	36260	41620	
460007	46	41100	
460011	46	39340	
460021	41100	29820	
460036	46	39340	
460039	46	36260	
460041	36260	41620	
460042	36260	41620	
470001	47	30	
470011	47	15764	
470012	47	38340	
490004	25500	16820	
490005	49020	47894	
490006	49	49020	LUGAR
490013	49	31340	
490018	49	16820	
490047	49	25500	LUGAR
490079	49	49180	
490092	49	40060	

ADDENDUM M.—HOSPITALS RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITALS AND CBSA—CY 2006—Continued

Provider No.	Geographic CBSA	Reclassified CBSA	Lugar
490105	49	28700	
490106	49	16820	
490109	47260	40060	
500002	50	28420	
500003	34580	42644	
500016	48300	42644	
500024	36500	45104	
500031	50	36500	
500039	14740	42644	
500041	31020	38900	
500072	50	42644	
500139	36500	45104	
500143	36500	45104	
510001	34060	38300	
510002	51	40220	
510006	51	38300	
510018	51	16620	LUGAR
510024	34060	38300	
510028	51	16620	
510030	51	34060	
510046	51	16620	
510047	51	38300	
510070	51	16620	
510071	51	16620	
510077	51	26580	
520002	52	48140	
520021	29404	16974	
520028	52	31540	LUGAR
520037	52	48140	
520059	39540	29404	
520060	52	22540	LUGAR
520066	27500	31540	
520071	52	33340	LUGAR
520076	52	31540	
520088	22540	33340	
520094	39540	33340	
520095	52	31540	
520096	39540	33340	
520102	52	33340	LUGAR
520107	52	24580	
520113	52	24580	
520116	52	33340	LUGAR
520152	52	24580	
520173	52	20260	
520189	29404	16974	
530002	53	16220	
530025	53	22660	

ADDENDUM N.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173

Provider No.	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
010150	01	17980	.....
020008	02	.....	1.2841
050494	05	42220	.....
050549	37100	42220	.....
060057	06	19740	.....
060075	06	.....	1.1709

ADDENDUM N.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173—Continued

Provider No.	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
070001	35300	35004	.....
070005	35300	35004	.....
070010	14860	35644	.....
070016	35300	35004	.....
070017	35300	35004	.....
070019	35300	35004	.....
070022	35300	35004	.....
070028	14860	35644	.....
070031	35300	35004	.....
070036	25540	.....	1.2926
070039	35300	35004	.....
120025	12	26180	.....
150034	23844	16974	.....
160040	47940	16300	.....
160064	16	.....	1.0228
160067	47940	16300	.....
160110	47940	16300	.....
190218	19	43340	.....
220046	38340	14484	.....
230003	26100	28020	.....
230004	34740	28020	.....
230013	47644	22420	.....
230019	47644	22420	.....
230020	19804	11460	.....
230024	19804	11460	.....
230029	47644	22420	.....
230036	23	22420	.....
230038	24340	28020	.....
230053	19804	11460	.....
230059	24340	28020	.....
230066	34740	28020	.....
230071	47644	22420	.....
230072	26100	28020	.....
230089	19804	11460	.....
230092	27100	24340	.....
230097	23	28020	.....
230104	19804	11460	.....
230106	24340	28020	.....
230119	19804	11460	.....
230130	47644	22420	.....
230135	19804	11460	.....
230146	19804	11460	.....
230151	47644	22420	.....
230165	19804	11460	.....
230174	26100	28020	.....
230176	19804	11460	.....
230207	47644	22420	.....
230223	47644	22420	.....
230236	24340	28020	.....
230254	47644	22420	.....
230269	47644	22420	.....
230270	19804	11460	.....
230273	19804	11460	.....
230277	47644	22420	.....
250002	25	25060	.....
250122	25	25060	.....
270021	27	13740	.....
270023	33540	13740	.....
270032	27	13740	.....
270050	27	13740	.....
270057	27	13740	.....

ADDENDUM N.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173—Continued

Provider No.	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
310021	45940	35644	.....
310028	35084	35644	.....
310050	35084	35644	.....
310051	35084	35644	.....
310060	10900	35644	.....
310115	10900	35644	.....
310120	35084	35644	.....
330049	39100	35644	.....
330067	39100	35300	.....
330106	35004	.....	1.4734
330126	39100	35644	.....
330135	39100	35644	.....
330205	39100	35644	.....
330264	39100	35004	.....
340002	11700	16740	.....
350002	13900	22020	.....
350003	35	22020	.....
350006	35	22020	.....
350010	35	22020	.....
350014	35	22020	.....
350015	13900	22020	.....
350017	35	22020	.....
350030	35	22020	.....
350061	35	22020	.....
380090	38	.....	1.2316
390001	42540	10900	.....
390003	39	10900	.....
390054	42540	29540	.....
390072	39	10900	.....
390095	42540	10900	.....
390109	42540	10900	.....
390119	42540	10900	.....
390137	42540	10900	.....
390169	42540	10900	.....
390185	42540	29540	.....
390192	42540	10900	.....
390237	42540	10900	.....
390270	42540	29540	.....
410010	39300	.....	1.1746
430005	43	39660	.....
430015	43	43620	.....
430048	43	43620	.....
430060	43	43620	.....
430064	43	43620	.....
430077	39660	43620	.....
430091	39660	43620	.....
450010	48660	32580	.....
450072	26420	26420	.....
450591	26420	26420	.....
470003	15540	14484	.....
490001	49	31340	.....
490024	40220	19260	.....
530015	53	.....	0.9897
070006*	14860	35644	.....
070018*	14860	35644	.....
070034*	14860	35644	.....
140155*	28100	16974	.....
140186*	28100	16974	.....
250078*	25620	25060	.....
270002*	27	33540	.....
270012*	24500	33540	.....

ADDENDUM N.—HOSPITAL RECLASSIFICATIONS AND REDESIGNATIONS BY INDIVIDUAL HOSPITAL UNDER SECTION 508 OF PUB. L. 108-173—Continued

Provider No.	Geographic CBSA	Wage index CBSA 508 reclassification	Own wage index
270084*	27	33540	.....
330023*	39100	35644	.....
330067*	39100	35644	.....
350019*	24220	22020	.....
430008*	43	43620	.....
430013*	43	43620	.....
430031*	43	43620	.....
530008*	53	16220	.....
530010*	53	16220	.....

*These hospitals are assigned a wage index value under a special exceptions policy (FY 2005 IPPS final rule, 69 FR 49105).

ADDENDUM O.—HOSPITALS REDESIGNATED AS RURAL UNDER SECTION 1886(d)(8)(E) OF THE ACT

Provider No.	Geographic CBSA	Redesignated rural area
030007	39140	03
040075	22220	04
050192	23420	05
050469	40140	05
050528	32900	05
050618	40140	05
070004	25540	07
100048	37860	10
100134	27260	10
130018	26820	13
140167	14	14
150051	14020	15
150078	23844	15
170137	29940	17
190048	26380	19
230078	35660	23
240037	33460	24
260006	41140	26
300009	31700	30
370054	36420	37
380040	13460	38
380084	41420	38
390181	39	39
390183	39	39
390201	39	39
450052	45	45
450078	10180	45
450243	10180	45
450276	48660	45
450348	45	45
500023	28420	50
500037	49420	50
500122	50	50
500147	42644	50
500148	48300	50

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