DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 405, 410, 411, 414, 418, 424, 484, and 486

[CMS–1429–FC]

RIN 0938–AM90

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

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

ACTION: Final rule with comment period.

SUMMARY: This final rule refines the resource-based practice expense relative value units (RVUs) and makes other changes to Medicare Part B payment policy. These policy changes concern: supplemental survey data for practice expense; updated geographic practice cost indices for physician work and practice expense; updated malpractice RVUs; revised requirements for supervision of therapy assistants; revised payment rules for low osmolar contrast media; changes to payment policies for physicians and practitioners managing dialysis patients; clarification of care plan oversight requirements; revised requirements for supervision of diagnostic psychological testing services; clarifications to the policies affecting therapy services; revised requirements for assignment of Medicare claims; addition to the list of telehealth services; and, several coding issues. We are making these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

This final rule also addresses the following provisions of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–17) (MMA): coverage of an initial preventive physical examination; coverage of cardiovascular (CV) screening blood tests; coverage of diabetes screening tests; incentive payment improvements for physicians in shortage areas; payment for covered outpatient drugs and biologicals; payment for renal dialysis services; coverage of routine costs associated with certain clinical trials of category A devices as defined by the Food and Drug Administration; hospice consultation service; indexing the Part B deductible to inflation; extension of coverage of intravenous immune globulin (IVIG) for the treatment in the home of primary immune deficiency diseases; revisions to reassignment provisions; and, payment for diagnostic mammograms, physicians' services associated with drug administration services and coverage of religious nonmedical health care institution items and services to the beneficiary's home.

In addition, this rule updates the codes subject to the physician self-referral prohibition, discusses payment for set-up of portable x-ray equipment, discusses the third five-year refinement of work RVUs, and solicits comments on potentially misvalued work RVUs.

We are also finalizing the calendar year (CY) 2004 interim RVUs and are issuing interim RVUs for new and revised procedure codes for CY 2005.

As required by the statute, we are announcing that the physician fee schedule update for CY 2005 is 1.5 percent, the initial estimate for the sustainable growth rate for CY 2005 is 4.3, and the conversion factor for CY 2005 is $37.8975.

DATES: *Effective Date:* These regulations are effective on January 1, 2005.

Applicability Date: Section 623 of the MMA, that is, the case-mix portion of the revised composite payment methodology and the budget neutrality adjustment required by the MMA, is applicable on April 1, 2005.

Comment Date: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on January 3, 2005.

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

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

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

2. *By mail.* You may mail written comments (one original and two copies) to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1429–FC, P.O. Box 8012, Baltimore, MD 21244–8012.

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

3. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments (one original and two copies) before the close of the comment period to one of the following addresses. If you intend to deliver your comments to the Baltimore address, please call telephone number 800–743–3951 in advance to schedule your arrival with one of our staff members. Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201; or 7500 Security Boulevard, Baltimore, MD 21244–1850.

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

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

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

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

FOR FURTHER INFORMATION CONTACT:

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

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

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

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

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

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

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

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

David Worgo (410) 786–5919, (for issues related to incentive payment

improvements for physicians practicing in shortage areas).

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

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

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

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

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

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

Dorothy Shannon (410) 786–3396 (for issues related to outpatient therapy services performed ''incident to'' physicians' services).

Roberta Epps (410) 786–5919 (for issues related to low osmolar contrast media or supervision of diagnostic psychological testing services).

Gail Addis (410) 786–4522 (for issues related to care plan oversight).

Jean-Marie Moore (410) 786–3508 (for issues related to religious nonmedical health care institution services).

Diane Milstead (410) 786–3355 or Gaysha Brooks (410) 786–9649 (for all other issues).

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on the following issues: interim RVUs for selected procedure codes identified in Addendum C; zip code areas for Health Professional Shortage Areas (HPSAs); the coverage of religious nonmedical health care institution items and services to the beneficiary's home; the physician self referral designated health services listed in tables 20 and 21; the third five-year refinement of work RVUs for services furnished beginning January 1, 2007; and, potentially misvalued work RVUs for all services in the CY 2005 physician fee schedule. You can assist us by referencing the file code CMS–1429–FC and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: Comments received timely will be available for public inspection as they are processed, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 800–743–3951.

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

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

1. Go to the CMS homepage (*http://www.cms.hhs.gov*).

2. Place your cursor over the word ''Professionals'' in the blue area near the top of the page. Select ''physicians'' from the drop-down menu.

3. Under ''Policies/Regulations'' select ''Physician Fee Schedule.''

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

Table of Contents

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

AAA Abdominal aortic aneurysm
AAFP American Academy of Family Physicians
AAKP American Association of Kidney Patients
AANA American Association of Nurse Anesthetists
ABI Ankle brachial index
ABN Advanced beneficiary notice
ACC American College of Cardiology
ACLA American Clinical Laboratory Association
ACP American College of Physicians
ACPM American College of Preventative Medicine
ACR American College of Radiology
ADLs Activities of daily living
AFROC Association of Freestanding Radiation Oncology Centers
AGS American Geriatric Society
AHA American Heart Association
AMA American Medical Association
AOA American Osteopathic Association
APA Administrative Procedures Act
APTA American Physical Therapy Association
ASA American Society of Anesthesiologists
ASCP American Society for Clinical Pathology
ASN American Society of Nephrology
ASP Average sales price
ASTRO American Society for Therapeutic Radiation Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997
BBRA Balanced Budget Refinement Act of 1999
BIPA Benefits Improvement and Protection Act of 2000
BLS Bureau of Labor Statistics
BMI Body mass index
BSA Body surface area
CAH Critical access hospital
CAP College of American Pathologists
CAPD Continuous ambulatory peritoneal dialysis
CCPD Continuous cycling peritoneal dialysis
CDC Centers for Disease Control and Prevention
CF Conversion factor
CFR Code of Federal Regulations
CLIA Clinical Laboratory Improvement Amendment
CMA California Medical Association
CMS Centers for Medicare & Medicaid Services
CNMs Certified nurse midwives
CNS Clinical nurse specialist
COPD Chronic obstructive pulmonary disease
CORF Comprehensive outpatient rehabilitation facilities
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPO Care Plan Oversight
CPT [Physicians'] Current Procedural Terminology [4th Edition, 2002, copyrighted by the American Medical Association]
CRNAs Certified Registered Nurse Anesthetists
CT Computed tomography
CV Cardiovascular
CY Calendar year
DEXA Dual energy x-ray absorptiometry
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DMERC Durable medical equipment regional carrier
DOI Departments of Insurance
DRE Digital rectal exam
DRG Diagnosis-related groups
DVT Deep venous thrombosis
EKG Electrocardiogram
E/M Evaluation and management
EPO Erythropoeitin
ESRD End-stage renal disease
FAX Facsimile
FMR Fair market rental
FQHC Federally qualified healthcare center
FR Federal Register
FY Fiscal year
GAF Geographic adjustment factor
GPCI Geographic practice cost index
GTT Glucose tolerance test
HBO Hyperbaric oxygen
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HHA Home health agency
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996
HOCM High osmolar contrast media
HPSA Health professional shortage area
HRSA Health Resources and Services Administration
HsCRP high sensitivity C-reactive protein
HUD Housing and Urban Development
IDTFs Independent diagnostic testing facilities
IMRT Intensity modulated radiation therapy
IOM Internet Only Manual
IPD Intermittent peritoneal dialysis
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
ISO Insurance Services Office
IVIG Intravenous immune globulin
JUAs Joint underwriting associations
KCP Kidney Care Partners
KECC Kidney Epidemiology and Cost Center
LCD Local coverage determination
LMRP Local medical review policies
LOCM Low osmolar contrast media
LUPA Low utilization payment adjustment
MCM Medicare Carrier Manual
MCP Monthly capitation payment
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MGMA Medical Group Management Association
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003
MPFS Medicare physician fee schedule
MSA Metropolitan statistical area
NAMCS National Ambulatory Medical Care Survey
NCD National coverage determination
NCIPC National Center for Injury Prevention and Control
NDC National drug code
NIH National Institutes of Health
NP Nurse practitioner
NPP Nonphysician practitioners
OASIS Outcome and Assessment Information Set
OBRA Omnibus Budget Reconciliation Act
OIG Office of Inspector General
OMB Office of Management and Budget
OPPS Outpatient prospective payment system
OT Occupational therapy
OTA Occupational therapist assistant
OTPP Occupational therapists in private practice
PA Physician assistant
PAD Peripheral arterial disease
PC Professional component
PCF Patient compensation fund
PD Peritoneal dialysis
PEAC Practice Expense Advisory Committee
PET Positron emission tomography
PFS Physician Fee Schedule
PHSA Public Health Services Act
PIAA Physician Insurers Association of America
PIN Provider identification number
PLI Professional liability insurance
POS Prosthetics, orthotics and supplies
PPI Producer price index
PPS Prospective payment system
PRA Paperwork Reduction Act
PSA Physician scarcity area
PT Physical therapy
PTA Physical therapist assistant
PTPP Physical therapists in private practice
PVD Peripheral vascular disease
RFA Regulatory Flexibility Act

RHC Rural health clinic
RHHI Regional home health intermediary
RIA Regulatory impact analysis
RN Registered nurse
RNHCI Religious nonmedical health care institution
RPA Renal Physicians Association
RT Respiratory therapy
RTs Respiratory therapists
RUC [AMA's Specialty Society] Relative [Value] Update Committee
RUCA Rural-Urban commuting area
RVU Relative value unit
SAF Standard analytic file
SCHIP State Child Health Insurance Program
SGR Sustainable growth rate
SHIPs State Health Insurance Assistance Programs
SIR Society for Interventional Radiology
SLP Speech language pathology
SMR Standardized mortality ratio
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
TC Technical component
UAF Update adjustment factor
URR Urea reduction ratios
USPSTF U.S. Preventive Services Task Force

I. Background

A. Legislative History

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

B. Published Changes to the Fee Schedule

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

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

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

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

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

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

C. Components of the Fee Schedule Payment Amounts

Under the formula set forth in section 1848(b)(1) of the Act, the payment amount for each service paid under the physician fee schedule is the product of three factors: (1) A nationally uniform relative value unit (RVU) for the service; (2) a geographic adjustment factor (GAF) for each physician fee schedule area; and (3) a nationally uniform conversion factor (CF) for the service. The CF converts the relative values into payment amounts.

For each physician fee schedule service, there are three relative values: (1) An RVU for physician work; (2) an RVU for practice expense; and (3) an RVU for malpractice expense. For each of these components of the fee schedule, there is a geographic practice cost index (GPCI) for each fee schedule area. The GPCIs reflect the relative costs of practice expenses, malpractice insurance, and physician work in an area compared to the national average for each component.

The general formula for calculating the Medicare fee schedule amount for a given service in a given fee schedule area can be expressed as:

Payment = [(RVU work × GPCI work) + (RVU practice expense × GPCI practice expense) + (RVU malpractice x GPCI malpractice)] × CF

The CF for calendar year (CY) 2005 appears in section X. The RVUs for CY 2005 are in Addendum B. The GPCIs for CY 2005 can be found in Addendum D.

Section 1848(e) of the Act requires us to develop GAFs for all physician fee schedule areas. The total GAF for a fee schedule area is equal to a weighted average of the individual GPCIs for each of the three components of the service. In accordance with the statute, however, the GAF for the physician's work reflects one-quarter of the relative cost of physician's work compared to the national average.

D. Development of the Relative Value System

1. Work Relative Value Units

Approximately 7,500 codes represent services included in the physician fee schedule. The work RVUs established for the implementation of the fee schedule in January 1992 were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original work RVUs for most codes in a cooperative agreement with us. In constructing the vignettes for the original RVUs, Harvard worked with expert panels of physicians and obtained input from physicians from numerous specialties.

The RVUs for radiology services were based on the American College of Radiology (ACR) relative value scale, which we integrated into the overall physician fee schedule. The RVUs for anesthesia services were based on RVUs from a uniform relative value guide. We established a separate CF for anesthesia services, and we continue to recognize

time as a factor in determining payment for these services. As a result, there is a separate payment system for anesthesia services.

2. Practice Expense and Malpractice Expense Relative Value Units

Section 1848(c)(2)(C) of the Act requires that the practice expense and malpractice expense RVUs equal the product of the base allowed charges and the practice expense and malpractice percentages for the service. Base allowed charges are defined as the national average allowed charges for the service furnished during 1991, as estimated using the most recent data available. For most services, we used 1989 charge data aged to reflect the 1991 payment rules, because those were the most recent data available for the 1992 fee schedule.

Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required us to develop a methodology for a resource-based system for determining practice expense RVUs for each physician's service. As amended by the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), enacted on August 5, 1997, section 1848(c) required the new payment methodology to be phased in over 4 years, effective for services furnished in 1999, with resource-based practice expense RVUs becoming fully effective in 2002. The BBA also required us to implement resource-based malpractice RVUs for services furnished beginning in 2000.

II. Provisions of the Proposed Rule Related to the Physician Fee Schedule

In response to the publication of the August 5, 2004 proposed rule (69 FR 47488), we received approximately 9,302 comments. We received comments from individual physicians, health care workers, professional associations and societies, and beneficiaries. The majority of the comments addressed the proposals related to ''incident to'' therapy services, GPCI, diagnostic psychological testing, and drug issues including average sales price (ASP).

The proposed rule discussed policies that affected the number of RVUs on which payment for certain services would be based. The proposed rule also discussed policies related to implementation of the MMA. RVU changes implemented through this final rule are subject to the $20 million limitation on annual adjustments contained in section 1848(c)(2)(B)(ii)(II) of the Act.

After reviewing the comments and determining the policies we would implement, we have estimated the costs and savings of these policies and discuss in detail the effects of these changes in the Regulatory Impact Analysis in section XIV.

For the convenience of the reader, the headings for the policy issues correspond to the headings used in the August 5, 2004 proposed rule. More detailed background information for each issue can be found in the August 5, 2004 proposed rule.

A. Resource-Based Practice Expense Relative Value Units

1. Resource-Based Practice Expense Legislation

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

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

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

Further legislation affecting resource-based practice expense RVUs was included in the Medicare, Medicaid and State Child Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) enacted on November 29, 1999. Section 212 of the BBRA amended section 1848(c)(2)(C)(ii) of the Act by directing us to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations. These data would supplement the data we normally collect in determining the practice expense component of the physician fee schedule for payments in CY 2001 and CY 2002. (The 1999 and 2003 final rules (64 FR 59380 and 68 FR 63196, respectively, extended the period during which we would accept supplemental data.)

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

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

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

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

a. Major Steps

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

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

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

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

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

b. Other Methodological Issues

i. Nonphysician Work Pool

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

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

ii. Crosswalks for Specialties Without Practice Expense Survey Data

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

iii. Physical Therapy Services

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

3. Practice Expense Proposals for Calendar Year 2005

a. Supplemental Practice Expense Surveys

i. Survey Criteria and Submission Dates

As required by the BBRA, we established criteria to evaluate survey data collected by organizations to supplement the SMS survey data used in the calculation of the practice expense component of the physician fee schedule. The deadline for submission of supplemental data to be considered in CY 2006 is March 1, 2005.

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

In the August 5, 2004 rule, we proposed to incorporate the CAP survey data into the practice expense methodology and to implement a change to the practice expense methodology to calculate the technical component RVUs for pathology services as the difference between the global and professional component RVUs. (This technical change was proposed in the June 28, 2002 **Federal Register** (67 FR 43849), but, at the specialty's request, we delayed implementation of this change for pathology services to permit evaluation of the combined effects of the use of the new survey data along with this technical change to the methodology.) We proposed to use the following practice expense per hour figures for specialty 69—Independent Laboratory.

TABLE 1: Practice Expense Per Hour Figures for Specialty 69--Independent Laboratory

Specialty	Clinical Staff	Admin. Staff	Office Expense	Medical Supplies	Medical Equipment	Other	Total
Independent Laboratory	$66.5	$20.2	$15.0	$15.8	$6.9	$16.9	$141.1

Comment: Specialty organizations representing clinical laboratories and pathologists expressed support for the use of the CAP supplemental survey data and urged us to finalize this proposal.

Response: We will incorporate the CAP survey data into the practice expense methodology and implement the proposed change to the practice expense methodology to calculate the technical component RVUs for pathology services as the difference between the global and professional component RVUs.

iii. Submission of Supplemental Surveys

We received surveys from the American College of Cardiology (ACC), the American College of Radiology (ACR), and the American Society for Therapeutic Radiation Oncology (ASTRO). Our contractor, The Lewin Group, evaluated the data and recommended that we accept the data from the ACC and the ACR, but indicated that the survey from ASTRO did not meet the precision criteria established for supplemental surveys and, thus, did not recommend using the ASTRO survey results at this time. We agreed with these recommendations. However, as explained in the August 5, 2004 proposed rule, the ACR and the ACC requested that we not use the data until we have a stable and global solution that is workable for all specialties that are currently paid using the nonphysician work pool. We agreed with these requests and proposed delaying use of these supplemental surveys until issues related to the nonphysician work pool can be addressed.

Comment: The ACR expressed appreciation for our acceptance of the supplemental data and for our proposal to delay implementation until next year, as they had requested, to allow further time to examine the issue of the nonphysician work pool. The Society for Interventional Radiology (SIR) also expressed support for the use of the ACR data and the delay in implementation.

Response: We look forward to working with these and other specialties as we seek a permanent solution to practice expense issues associated with the nonphysician work pool.

Comment: ASTRO stated that they appreciate the opportunity to submit data and, that they understand we will not be using the data in 2005. ASTRO further commented that, due to the specific practice patterns and practice environment of radiation oncology, new data, regardless of the response rate, may not meet the criteria. ASTRO further stated that they will continue to work with CMS and with the Lewin Group as this issue is analyzed. The Association of Freestanding Radiation Oncology Centers (AFROC) expressed concern that freestanding centers that have higher costs than hospital-based centers were underrepresented by the ASTRO survey. They also expressed concern about the reference in the Lewin Group report to crosswalking radiation oncology costs from another specialty. In addition, AFROC argued that we should not average costs associated with freestanding centers with those that are hospital-based, because the costs would be understated. They urged us to ensure that any assumption regarding representativeness of any survey data is justified.

Response: We will take these comments into consideration as we continue to work with these groups concerning the supplemental survey data. We currently have no plans to propose a practice expense crosswalk for radiation oncology.

Comment: The ACC expressed appreciation that we are not eliminating the nonphysician workpool until methodologic issues are addressed. While they support the delay in implementing their supplemental survey data, they believe that the contractor's suggestion that the ACC survey data could be blended with the existing SMS survey data is invalid for two reasons: (1) The suggestion that similar changes to physician practice (for example, increased use of technology) may have occurred throughout all physician services is an unfounded speculation because few other specialties are as technologically driven as cardiology; and (2) other supplemental data has not been blended and all specialties must be treated consistently.

Response: We will take these comments into consideration as part of the evaluation and discussion of the cardiology survey data in next year's proposed rule.

Comment: The American Urological Association requested that, as we explore alternate sources of data and consider how to incorporate new practice expense data into the methodology, we find a way to incorporate recently collected specialty supplemental data into the new efforts. They also requested that we clarify whether we would apply the budget neutrality exemption to any increases in drug administration PE RVUs that result from the use of urology survey data that will be submitted under the supplemental survey process.

Response: We anticipate that we would incorporate all accepted supplemental survey data into any comprehensive changes to the nonphysician work pool.

As we explained in the January 7, 2004 **Federal Register** (69 FR 1093 through 1094), section 303(a)(1) of the MMA modifies section 1848(c)(2)(B) of the Act to provide an exemption from the budget neutrality requirements in 2006 for further increases in the practice expense RVUs for drug administration that may result from using survey data from specialties meeting certain criteria. The survey must include expenses for the administration of drugs and biologicals and be submitted by a specialty that receives more than 40 percent of its 2002 Medicare revenues from drugs. Urology received more than 40 percent of its 2002 Medicare revenues from drugs. Therefore, if we were to receive a practice expense survey of urologists by March 1, 2005

that included expenses for the administration of drugs and biologicals and the survey met the criteria we have established (and those of section 1848(c)(2)(I)(ii) of the Act), we would exempt the change in the practice expense RVUs for drug administration services from the budget neutrality requirements of section 1848(c)(2)(B) of the Act.

b. Practice Expense Advisory Committee (PEAC)

Recommendations on CPEP Inputs for 2005

- CPEP Refinement Process.

In the August 5, 2004 proposed rule, we included the PEAC recommendations from meetings held in March and August 2003 and January and March 2004, which accounted for over 2,200 codes from many specialties. We also stated that future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC.

Comment: We received comments from the AMA that future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC with the help of a new ad hoc committee, now termed the Practice Expense Review Committee (PERC), comprised of former PEAC members. The RUC also noted that their Practice Expense Subcommittee remains committed to reviewing improvements to the practice expense methodology.

The AMA and the RUC, as well as the specialty society representing neurological surgeons, noted their appreciation of our continued efforts to improve the direct practice expense data and to establish a reasonable methodology for determining practice expense relative values.

Response: We look forward to our continuing work with the AMA, the RUC and all the specialty societies on the refinement of the remaining codes and with ongoing practice expense issues.

Comment: The National Association for the Support of Long Term Care expressed concern about the dissolution of the PEAC and requested that we require the RUC to expand its membership to include a broad array of providers who are reimbursed under the physician fee schedule.

Response: Because the RUC is an independent committee, we are not in a position to set the requirements for RUC membership. However, we are confident that the RUC and the Health Care Professional Advisory Committee, which also sends practice expense recommendations directly to us, together represent two broad ranges of practitioners, both physician and nonphysician.

Comment: A specialty society suggested that there should be a process for fixing minor errors that are identified outside of the refinement process. The commenter also suggested that there should be a system to address individual exceptions to PEAC standard packages.

Response: If we have made errors, major or minor, in any part of our calculation of practice expense RVUs in this final rule, inform us as soon as possible so that we are able to correct them in the physician fee schedule correction notice. Any other revisions would have to be made in the next physician fee schedule rule. If a specialty society believes that a RUC decision is not appropriate, the society can always request that the decision be revisited or can discuss the issue with us at any time. For the concern with the standard packages adopted by the PEAC, it is our understanding that all presenters at the RUC have the opportunity to demonstrate that something other than the standard would be more appropriate.

- PEAC Recommendations.

We proposed to adopt nearly all of the PEAC recommendations. However, we disagreed with the PEAC recommendation for clinical labor time for CPT code 99183, Physician attendance and supervision of hyperbaric oxygen therapy, per session, and proposed a total clinical labor time of 112 minutes for this service.

Comment: Specialty societies representing interventional radiology and neurological surgeons, as well as the AMA, expressed appreciation for our acceptance of well over 2,000 PEAC refinements in this rule. However, the specialty society representing orthopaedic surgeons commented that some of our proposals appeared to be circumventing the PEAC process, in that we changed the PEAC recommendation for hyperbaric oxygen (HBO) therapy and proposed in-office inputs for two services rather than referring these to the RUC.

Response: We appreciate the hard work and perseverance on the part of the PEAC and the specialty societies that produced the recommended refinements for so many services. In addition, we do not believe that we circumvented the PEAC process in any way. We have the greatest respect for the PEAC and RUC recommendations that we received. However, we do have the final responsibility for all payments made under the physician fee schedule, and this can lead to disagreement with a specific recommendation. The RUC itself has always demonstrated its understanding and respect for our responsibility in this regard. With regard to the two services that we priced in the office, we stated explicitly in the proposed rule that we were requesting that the RUC review the practice expense inputs.

Comment: The specialty society representing family physicians disagreed with our proposed changes to the PEAC recommendations for the clinical labor time for CPT code 99183, *Physician attendance and supervision of hyperbaric oxygen therapy, per session.* The commenter contended that a physician providing this service would probably have multiple hyperbaric oxygen chambers; therefore, staff would not be in constant attendance. However, the specialty society representing podiatrists supported this change in clinical staff time.

Response: Based on our concern that the PEAC recommendation of 20 minutes of clinical staff time during the intra-service period undervalued the clinical staff time, we proposed increasing this time to 90 minutes in the proposed rule. This was, of course, subject to comment. We believe there is some merit to the claim that the clinical staff may be monitoring more than one chamber at a time. Therefore, we are adjusting the time for the intra-service period from the proposed 90 minutes to 60 minutes in recognition of this point. We will continue our examination of this issue and entertain ongoing dialog with all interested organizations and individuals familiar with this service to assure the accuracy of the intra-service time.

Comment: The Cardiac Event Monitoring Provider Group Coalition expressed concern about the PEAC recommendations that would substantially reduce the clinical staff time associated with cardiac monitoring services. Of particular concern to the Coalition was the 70 percent reduction in time for CPT code 93271, the code for cardiac event monitoring, receipt of transmissions, and analysis. Although all these services are currently priced in the nonphysician work pool and this decrease in the staff times has no immediate impact, the commenter was concerned that, when the nonphysician work pool is eliminated, these services will be undervalued. The commenter also believed that the PEAC recommendations may not have reflected all the supplies and equipment utilized in these services and included a complete list of necessary supplies

and equipment. The American College of Cardiology (ACC) presented these services at the PEAC meeting and commented they had been unable to collect sufficient data so that the PEAC could make an appropriate recommendation.

Response: It is clear from the Coalition and ACC comments that more information is needed in order to ensure that the appropriate practice expense inputs are assigned to these services in the event that they are removed from the nonphysician work pool. We would be glad to work with the Coalition and the specialty society so that they can make a new presentation to the RUC this coming year.

• Adjustments To Conform With PEAC Standards

We also reviewed those codes that are currently unrefined or that were refined early in the PEAC process to apply some of the major PEAC-agreed standards. For the unrefined 10-day global services, we proposed to substitute for the original CPEP times the PEAC-agreed standard post-service office visit clinical staff times used for all 90-day and refined 10-day global services. We also proposed to eliminate the discharge day management clinical staff time from all but the 10 and 90-day global codes, substituting one post-service phone call if not already in the earlier data. Lastly, we proposed to delete any extra clinical staff time for post-visit phone calls for 10 and 90-day global service because that time is already included in the time allotted for the visits.

Comment: A specialty society representing family physicians supported the elimination of the discharge day management time assigned in the facility setting for all 0-day global services, as well as all the other adjustments we made to apply PEAC standards. However, several specialty societies representing gastroenterology and orthopaedics, as well as the American College of Physicians, did not agree with the deletion of the discharge day management time. These groups requested restoration of the six minutes allocated to the discharge day management for 0-day global services and argued that most 0-day services require as much staff time as do many 10-day global services performed in the outpatient setting. One of these commenters did not believe a rationale was provided for this change. Another commenter, although recommending that any future refinements take into account all of the PEAC standards, expressed concern regarding all of the above changes, suggesting that this could lead to additional anomalies and recommending that the revisions should be reviewed by the RUC.

Response: The PEAC recommended that the discharge day management time apply only to 10-day and 90-day global services and we were complying with this recommendation. We also believe that this PEAC recommendation is reasonable; it is hard to imagine what tasks a physician's clinical staff back in the office is performing for a patient during the period that the patient is undergoing a same-day procedure in the hospital outpatient department. However, the point made about 10-day global procedures is pertinent. We would suggest that the RUC reconsider whether the discharge day management clinical staff time should apply only to services that are typically performed in the inpatient setting. We also believe that it was appropriate to apply the PEAC standards to codes that were not refined or that were refined before the standards were developed. The application of these standards is not only fair, but can also help to avoid the possible rank order anomalies cited by the commenter.

Methacholine Chloride

The PEAC recommendations for CPT codes 91011 and 91052 included a supply input for methacholine chloride as the injected stimulant for these two services. In discussions with representatives from the gastroenterology specialty society subsequent to receipt of the PEAC recommendations, we learned this is incorrect. For the esophageal motility study, CPT code 91011, we proposed to include edrophonium as the drug typically used in this procedure. For the gastric analysis study, CPT code 91052, we were unable to identify the single drug that is most typically used with this procedure. We requested that commenters provide us with information on the drug that is most typically used for CPT code 91052, including drug dosage and price, so that it could be included in the practice expense database.

Comment: Several specialty societies representing allergists, pulmonologists and chest physicians, as well as the AMA, requested that the additional cost of methacholine be reflected in the RVUS for the bronchial challenge test, CPT code 95070. As an alternative, the specialty society representing allergists suggested that a HCPCS code could be created so that methacholine could be billed separately.

In response to our request for information about the supply inputs for CPT codes 91011 and 91052, the American Gastroenterological Association (AGA) indicated that edrophonium may be an appropriate supply proxy for CPT code 91011, but, in practice, other agents are more commonly used. However, they provided no additional information regarding these other agents. AGA also stated that the most commonly used drug for CPT code 91052 is pentagastrin, but betazole or histamine may also be used. Again, they did not provide further specific information.

Response: Because CPT code 95070 is valued in the nonphysician work pool, the PEAC's addition of methacholine to this procedure could not be captured by the practice expense RVUs. However, a J-code was established, J7674, *Methacholine chloride administered as inhalation solution through nebulizer, per 1mg,* so that this drug can be billed separately. Accordingly, we have deleted methacholine from the practice expense database.

For CPT code 91011, we have retained the drug edrophonium, and our proposed price of $4.67 per ml, as a supply in the practice expense database. However, we were not able to include a price for pentagastrin in the supply practice expense database for CPT code 91052. We will be happy to work with the specialty societies involved with both of these procedures to obtain accurate drug pricing for the 2006 fee schedule.

• Nursing Facility and Home Visits.

We proposed to adopt the direct practice expense input recommendations from the March 2003 PEAC meeting for CPT codes 99348 and 99350, two E/M codes for home visits, as well as the March 2004 PEAC recommendations for E/M codes for nursing home services (CPT codes 99301 through 99316).

Comment: A specialty group representing family physicians supported the acceptance of the PEAC recommendations for nursing facility visits, even though this resulted in a decrease for these services. The commenter stated that the decrease occurred because the original CPEP data was flawed and the clinical staff times were too high. The commenter also stated that the payments in the facility setting will increase for these services and that setting has the higher volume of visits. Other commenters representing long term care physicians, geriatricians and podiatrists expressed disappointment in these PEAC recommendations and stated that, while the PEAC did consider the views of long term care physicians, the PEAC failed to accept these views even though they were supported by data. These commenters believe the PEAC did not

recommend an appropriate increase based on a false assumption that the nursing home provides the staff. Another commenter contended that the new values do not adequately account for work performed by the physician's clinical staff. The commenter stated that the pre- and post-times for these codes are less than for the comparable office visit codes, even though it is clear that more clinical staff time is required for the nursing facility resident. One commenter suggested that these concerns would need to be addressed within the framework of the 5-year review. The specialty society representing homecare physicians also commented that, rather than challenging a flawed system, they will use the 5-year review process to have work and practice expense re-valuated for the home visit codes.

Response: While sympathetic to the concerns expressed by the long-term care physicians regarding the overall decrease in clinical staff time in the nursing facility E/M procedures, we believe the PEAC recommendations for these services to be reasonable. We also agree with commenters regarding the upcoming 5-year review process as a means to address the physician work component of these codes. To the extent that there is overlap between the physician time and the clinical labor practice expenses involved in a particular procedure, the 5-year review process can be utilized to address these issues. We encourage the home care physicians and the long-term care physicians to consider using the 5-year review process for these codes.

• Suggested Corrections to the CPEP Data.

Comment: The RUC and American Podiatric Medical Association identified a number of PEAC refinements from the August 2003 meeting that were not reflected in the practice expense database and asked that these be implemented. The RUC also asked us to correct the equipment times for all of the 90-day global services to correspond with the PEAC-refined clinical staff times for these codes.

Response: We have made the recommended corrections to our practice expense database.

Comment: The specialty society representing hematology noted the supply items missing from the practice expense database for CPT codes 36514 through 36516 that had been included in the CMS-accepted PEAC refinements.

Response: We regret the error. These items are incorporated into the practice expense database.

Comment: The specialty society representing pediatrics as well as the RUC commented that the PEAC recommendations also included a recommendation for a change in the global period for CPT code 54150, *Circumcision, using clamp or other device; newborn,* from a 10-day global to an ''xxx'' designation, which would mean the global period does not apply. This issue was not discussed in the proposed rule and the commenters requested that this change be reflected in the final rule.

Response: As stated by the commenters, this request was included in the PEAC recommendations but was inadvertently omitted from the proposed rule. We agree that the 10-day global period currently assigned to this procedure may not be appropriate because the physician performing the procedure most likely does not see the infant for a post-procedure visit. However, we believe that a 0-day global period rather than ''xxx'' should be assigned to this procedure. We generally use the ''xxx'' designation for diagnostic tests and no surgical procedure currently is designated as an ''xxx'' global service. We believe this will accomplish the same end because most any other service performed at the same time as the circumcision could be billed with the appropriate modifier. We are adjusting the practice expense database to delete any staff time, supplies and equipment associated with the post-procedure office visit.

Comment: Specialty societies representing dermatology stated that there was an error in the nonfacility practice expense RVUS for the Mohs micrographic surgery service, CPT code 17307, due to the omission of clinical staff time from the practice expense database.

Response: We have corrected the practice expense database to reflect the appropriate clinical staff time.

Comment: We received comments from the American College of Radiology (ACR) and Society of Nuclear Medicine noting that some of the codes used by their specialty were omitted from the listing of PEAC-refined codes that appeared in Addendum C in our proposed rule. They submitted a complete list of the codes that had gone through PEAC refinement, beginning at the first PEAC meeting in April 1999, and asked that we include these codes on the Addendum.

Response: We appreciate the specialty societies bringing to our attention that some of their codes were omitted from Addendum C and we have reviewed the codes on their submitted list. Addendum C was meant to list only those codes that were refined in this year's rule, and thus, only listed those refined by the PEAC from March and August 2003 and January and March 2004. However, it does appear that there is some confusion regarding what codes were refined during this period, particularly from the March 2004 meeting. We will work with all medical societies and the RUC to clarify the status of all the codes in question.

• Other Issues.

Comment: The RUC requested that we publish practice expense RVUs for all Medicare noncovered services for which the RUC has recommended direct inputs. We also received a request from the American Academy of Pediatrics to publish work and practice expense RVUs for the noncovered nasal or oral immunization services (CPT codes 90473 and 90474) and the visual acuity test (CPT code 99173).

Response: In the past, we have published the practice expense RVUs for only a small number of noncovered codes which are listed in our national payment files that can be accessed via our physician web page under ''Medicare Payment Systems'' as part of the public use files at *www.cms.hhs.gov/physicians/.* Because we have not yet established a consistent policy regarding the publication of RVUs for noncovered services, we will need to examine this issue further to carefully weigh the pros and cons of publishing these RVUs for noncovered services.

Comment: The American Speech-Language Hearing Association (ASHA) and the American Academy of Audiology (AAA), expressed concern about the reduction of practice expense RVUs for CPT code 92547, *Use of vertical electrodes (List separately in addition to code for primary procedure),* which resulted after the PEAC refinement. The commenters asked for our assistance to clarify a CPT instruction regarding this procedure because they believe it prevents the multiple billings of CPT 92547 in a given patient encounter.

Response: While we are sympathetic to the concerns expressed by ASHA and AAA, we also want to note that CPT code descriptors and accompanying coding instructions are proprietary to CPT. We would encourage these organizations to discuss this issue directly with the CPT editorial committee.

Comment: A specialty society representing vascular surgery expressed concern about the wide variations in practice expense RVUs that are sometimes derived under the current methodology. The commenter suggested that some outliers require additional focus to determine whether these are errors in the direct inputs or if they

reflect problems inherent in the methodology. According to the commenter, it would appear that some of the extreme variation is due to the high costs of certain disposable supplies in the office setting as well as high scaling factors. A few examples of outlier codes were provided. The commenter suggested that we consider an alternative methodology for payment of high-priced single-use items in the nonfacility setting.

Response: We agree with the commenter that the issue raised is one worth study and analysis. Unfortunately, this is not a task that can be accomplished in time for discussion in this final rule. We will be very willing to work with the specialty society and with the Practice Expense Subcommittee of the RUC, as well as any other interested parties, to work further on this issue that will only be magnified as more complex procedures are moved into the office setting.

Comment: A provider of radiology services questioned the reductions in practice expense for CPT code 77370, *Special medical radiation physics consultation.*

Response: The practice expense RVUs for CPT code 77370 decreased by 0.02 RVUs between last year's final rule and this year's proposed rule. This small decrease is due to the normal fluctuations resulting from updating our practice expense data.

c. Repricing of Clinical Practice Expense Inputs—Equipment

We use the practice expense inputs (the clinical staff, supplies, and equipment assigned to each procedure) to allocate the specialty-specific practice expense cost pools to the procedures performed by each specialty. The costs of the original equipment inputs assigned by the CPEP panels were determined in 1997 by our contractor, Abt Associates, based primarily on list prices from equipment suppliers. Subsequent to the CPEP panels, equipment has also been added to the CPEP data, with the costs of the inputs provided by the relevant specialty society. We only include equipment with costs equal to or exceeding $500 in our practice expense database because the cost per use for equipment costing less than $500 would be negligible. We also consider the useful life of the equipment in establishing an equipment cost per minute of use.

We contracted with a consultant to assist in obtaining the current price for each equipment item in our CPEP database. The consultant was able to determine the current prices for most of the equipment inputs and clarified the specific composition of each of the various packaged and standardized rooms or ophthalmology ''lanes'' currently identified in the equipment practice expense database (for example, mammography room or exam lane). We proposed to delete the current ''room'' designation for the radiopharmaceutical receiving area and, in its place, list separately the equipment necessary for each procedure as individual line items.

Also, we proposed to replace all surgical packs and trays in the practice expense database with the appropriate standardized packs that were recommended by the PEAC, either the basic instrument pack or the medium pack.

The useful life for each equipment item was also updated as necessary, primarily based on the AHA's ''Estimated Useful Lives of Depreciable Hospital Assets'' (1998 edition). We noted in the August 5, 2004 proposed rule that AHA would be publishing updated guidelines this summer and that we would reflect any updates in our final rule.

In addition, we proposed the following database revisions:

Assignment of Equipment Categories

We proposed that equipment be assigned to one of the following six categories: documentation, laboratory, scopes, radiology, furniture, rooms-lanes, and other equipment. These categories would also be used to establish a new numbering system for equipment that would more clearly identify them for practice expense purposes.

Consolidation and Standardization of Item Descriptions

We proposed combining items that appeared to be duplicative. For example, for two cervical endoscopy procedures, our contractor identified that the price of the LEEP system includes a smoke evacuation system but that system is also listed separately. We proposed to merge these two line items and reflect both prices in the price of the LEEP system.

These changes were reflected in Addendum D of the proposed rule.

Additionally, there were specific equipment items for which a source was not identified or for which pricing information was not found that were included in Table 2 of the August 5 proposed rule. Items that we proposed to delete from the database were also identified in this table. We requested that commenters, particularly the relevant specialty groups, provide us with the needed pricing information, including appropriate documentation. Also, we stated that if we were not able to obtain any verified pricing information for an item, we might eliminate it from the database.

Comment: The Society of Nuclear Medicine agreed with the deletion of the current room designation for radiopharmaceutical area and designation of categories for equipment. However, the society recommended that the category designation of ''radiology'' be changed to ''imaging equipment'' and ''other equipment'' be changed to ''non-imaging equipment'' to be inclusive of these modalities. The American College of Radiology also concurred with the elimination of the current room designation for radiopharmaceutical area.

Response: We agree that the term ''imaging equipment'' rather than the term ''radiology'' more accurately reflects current practice and have changed the practice expense database accordingly. However, it would be inappropriate to change the ''other equipment'' category to ''non-imaging equipment'' because there are items in other categories that would not be encompassed in the proposed title change.

Comment: The Society of Nuclear Medicine supplied information on the equipment item E51076 with the requested documentation.

Response: We have revised the practice expense database to reflect the information provided.

Comment: The American Society for Therapeutic Radiology and Oncology (ASTRO) submitted information and the requested documentation for fifteen items, often supplying two or more pricing sources.

Response: We greatly appreciate the information and have revised the practice expense database to reflect the information provided.

Comment: Commenters representing manufacturers and providers expressed concern about the reduction in payment (9 percent) for external counterpulsation (ECP), G0166. The commenters questioned the proposed change made to the life of the ECP equipment, from seven to five years, used for this service. Commenters did not believe this was supported by the AHA information (which indicated that similar diagnostic cardiovascular equipment has an equipment life of five years) and requested that this timeframe be applied to the ECP equipment for this service. The American College of Cardiology also questioned the change to the ECP equipment life. The commenters also questioned the allocation for maintenance and indirect costs applied under the practice expense methodology

as well as the time allocated for this service. As a final point, some of the commenters requested that we adjust the work RVUs assigned to this G-code to that of an echocardiogram (CPT code 93307) and include it in the nonphysician work pool.

Response: Based upon review of the information provided we have revised the equipment life to five years. The methodology used for the allocation for maintenance and indirect costs is consistent with our methodology. For the request to adjust the work RVUs for this service, we refer the commenters to section VI of this final rule where we are soliciting comments on services where the physician work may be misvalued.

Comment: The College of American Pathologists provided information on items listed in table 2: the DNA image analyzer (ACIS), and image analyzer (CAS system) code E13652. They noted that the CAS system is no longer marketed and that the ACIS system would be used in its place. Thus, they provided documentation on the price for the ACIS system.

Response: We appreciate the information and have made the necessary changes to the database.

Comment: The American College of Cardiology (ACC) agreed with the pricing for the ambulatory blood pressure monitor, provided prices for the ECG signal averaging system (E55035), but provided no documentation for these prices. They stated that the echocardiography digital acquisition ultrasound referenced in table 2 was no longer in the marketplace and that a digital workstation was now typically used. They requested that an appropriate equipment code be available for this item and provided a price range for this item (although without the supporting documentation). ACC also recommended that the pacemaker programmer (E55013) be removed from the equipment list because it is provided at no cost to the physician. Removal of this item from the PE database was also supported by a manufacturer that commented on the rule.

Response: We have removed the pacemaker programmer from the practice expense database. We will temporarily retain other items and prices for the 2005 physician fee schedule and request that ACC forward the documentation as soon as possible.

Comment: The American College of Radiology (ACR) provided partial information for the CAD processor unit and software. ACR also submitted information regarding the computer workstation for MRA and the mammography reporting software, but with insufficient documentation. For the various equipment items ACR listed for the mammography room, updated information was provided for a few of the items. ACR noted that they would submit documentation for all outstanding pieces of equipment when it is available. ACR did not agree with the room price for MRI and CT that was referenced in Addendum D and requested an extension so that they can work with us to accurately price these items.

Response: We will maintain current pricing for all equipment items and the mammography room on an interim basis, until sufficient documentation is provided.

Comment: The American Ophthalmology Association (AOA) and American Optometric Association both supplied pricing information along with the requested documentation for the computer, VDT, and software (E71013) listed in table 2. AOA also provided pricing information for the ophthalmology drill listed in this table, indicating a cost of $57. They expressed their appreciation for the recategorization and standardization of descriptions for equipment and supplies.

Response: We appreciate the documentation forwarded by these two organizations and have incorporated into the practice expense database the pricing information provided for the computer, VDT, and software. Because the ophthalmology drill is less than $500 (the standard established for equipment), we are removing it from the equipment list for the practice expense database.

Comment: The American Gastroenterological Association (AGA) expressed concern about the reduction in RVUs for CPT code 91065, a breath hydrogen test. They believe that the newer equipment listed in the practice expense database does not reflect the analyzer that is typically used, which is more expensive, and noted that the costs for the reagents have also increased.

Response: We are sympathetic to the concerns of the AGA regarding the typical equipment used for CPT code 91065 and would like to work with them to ascertain updated pricing information about the equipment most physicians utilize for this service. However, the majority of the decrease (76 percent) in practice expense RVUs for this procedure is due to the PEAC refinement for the clinical labor time that was reduced by nearly 50 percent.

Comment: The American Academy of Sleep Medicine indicated that most typical CPAP/BiPAP remote unit is a bilevel positive airway pressure unit and provided documentation for the price of this item.

Response: This price is reflected in the practice expense database.

Comment: The Society for Vascular Surgery (SVS), Society for Vascular Ultrasound and Society of Diagnostic Medical Sonography all expressed appreciation for the refinement to the inputs that apply to vascular ultrasound services. However, the commenters requested that we incorporate the requested refinements for the other ancillary equipment present in a vascular ultrasound room into other similar procedures. SVS specifically listed the following CPT codes: 93875–9 and 93990.

Response: In addition to the three new CPT codes for cerebrovascular arterial studies CPT 93890, 93892 and 93893, we have added the vascular ultrasound room to the codes indicated in the SVS comment noted above.

Comment: The American Psychiatric Association provided documentation for the cost of the ECT machine and the American Psychological Association provided information on the neurobehavioral status exam and testing, as well as the biofeedback equipment listed in table 2, along with the requested documentation.

Response: We appreciate this information. The practice expense database was revised to reflect this cost information.

Comment: The American Society of Clinical Oncology requested that the biohazard hood be substituted for the ventilator and hood blower as a practice expense input for the chemotherapy codes.

Response: We revised the database to reflect this change.

Comment: American Academy of Neurology supplied information and the necessary documentation on several equipment items listed in table 2 associated with neurology services.

Response: We have made the revisions to the prices for the ambulatory EEG recorder (E54008), ambulatory review station (E54009), and portable digital EEG monitor based on the documentation provided. Based on the documentation provided, we note that the price for the ambulatory review station was substantially reduced ($44,950 to $7,950).

Comment: The American Clinical Neurophysiology Society (ACNS) stated that the payment for CPT code 95819, an EEG service, was substantially reduced. The Society believes it is due to a price reduction for the EEG equipment (E54006) used in this service that was listed in Addendum D of the

proposed rule. The commenter indicated that the proposed price does not include the review station and software which is needed for this service and provided documentation for appropriately pricing this item.

Response: Based on the documentation provided, we have changed, on an interim basis for the 2005 fee schedule, the price for this item and note that this equipment price is associated only with CPT code 95819. We would be happy to work with ACNS in order to resolve any issues surrounding the RVUs for CPT code 95819. Reviewing the direct inputs for this code, we note that the largest contributor to the reduction of practice expense RVUs is the PEAC's refinement of this code's supply items.

Comment: The National Association for Medical Direction of Respiratory Care and the American College of Chest Physicians were in agreement with the proposed prices for equipment except for the pulse oximeter (including printer), E55003. The commenters referenced a price that is $83 more than that listed in the table, but provided no documentation.

Response: We appreciate the comments from these organizations regarding the repricing of the equipment items in the practice expense database. We have retained our price of $1,207 for the pulse oximeter and note that it is an average from two different available sources.

Comment: We received a comment from a consumer regarding the price of the electromagnetic therapy machine for HCPCS code G0329 with concerns about the low payment for this modality. While no documentation was submitted, the commenter noted that the cost for this equipment ranged from $25,000 to $35,000.

Response: We appreciate the commenter's remarks about the price of the electromagnetic therapy equipment, Diapulse. We have retained our price of $25,000 in the practice expense database because we do not have documentation that any higher-priced equipment is typically used. Similar to other modalities used in rehabilitation, including those used in wound care, we note that this procedure reflects comparable practice expense values.

Comment: Several specialty organizations questioned our substitution of the two standardized packs for previously PEAC-approved packs and trays, as discussed in our proposed rule. One specialty society suggested we consult with the AMA before proceeding on this point.

Response: We uniformly applied the PEAC-approved values for the packs and trays to all packs and trays, regardless of whether the codes had previously been refined by the PEAC. To the extent that a specialty society feels that it was disadvantaged by this policy, we would encourage them to bring the specific codes that should be excluded from this policy to the newly formed PERC (formerly PEAC) at the next RUC meeting in February 2005.

Comment: Several specialty organizations indicated that they were in the process of obtaining pricing information on equipment items and would provide it as soon as possible. One commenter also asked that we retain the items proposed for deletion as they are necessary in providing their services, but provided no documentation.

Response: In the proposed rule, we noted that we might eliminate those items from the database for which documented pricing information was not received. Due to the number of outstanding equipment prices, and the number of societies that are underway in their search for this data, we have decided to extend the submission deadline. We would encourage specialty societies to submit price information soon to help ensure that it can be used to establish practice expense RVUs in next year's proposed rule.

BILLING CODE 4120–01–P

Table 2

Equipment Items Needing Specialty Input for Pricing and Proposed Deletions

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
ambulatory blood pressure monitor	3,000.00	cardiology	93784, 93786, 93788	See Note A	No/Insufficient documentation received	See Note D.
biofeedback equipment		psychology	90875	See Note A	Submitted price of $9,925	See Note F.
CAD processor unit (mammography)	210,000.00	radiology	76082, 76083, 76085	See Note A (Need system components)	No/Insufficient documentation received	See Note D.
camera system, cardiac, nuclear	675,000.00	anesthesia, IM, cardiology	78414	See Note A	Submitted price of $406,817	See Note F.
collimator, cardiofocal set	29,990.00	radiology	78206, 78607, 78647, 78803, 78807	See Note A	No/Insufficient documentation received	See Note D.
computer and VDT and software	9,000.00	ophthalmology, optometry	92060, 92065	See Notes A and C	Submitted price of $7,100	See Note F.
computer software, MR/PET/CT fusion	60,000.00	radiation oncology	77301	See Note A	Sumitted price of $60,000	See Note F.
computer system, record and verify	60,000.00	radiation oncology	77418	See Note A	Submitted prices from 2 sources, average of $163,593	See Note F.
computer workstation, 3D teletherapy treatment planning	221,500.00	radiation oncology	77300, 77305, 77310, 77315, 77321, 77331	See Note A	Submitted prices from 4 sources, average of $256,224	See Note F.
computer workstation, MRA post processing		radiology	71555, 72159, 72198, 73225, 73725, 74185	See Note A	No/Insufficient documentation received	See Note E.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
computer, server		radiation oncology	77301	See Note A (Need system components)	Submitted prices from 3 sources, average of $22,567	See Note F.
cortical bipolar-biphasic stimulating equipment		neurosurgery, neurology	95961, 95962	See Note A	No/Insufficient documentation received	See Note E.
CPAP/BiPAP remote clinical unit		pulmonary disease, neurology	95811	See Note A	Submitted price of $3,100	See Note F.
cryo-thermal unit		anesthesia	64620	See Notes A and C	No/Insufficient documentation received	See Note E.
densitometry unit, whole body, DPA	65,000.00	radiology	78351	See Notes A and C	No/Insufficient documentation received	See Note D.
densitometry unit, whole body, SPA	22,500.00	radiology	78350	See Notes A and C	No/Insufficient documentation received	See Note D.
Detector (Probe)	14,000.00	radiology, cardiology	78455	See Notes A and C	No/Insufficient documentation received	See Note D.
dialysis access flow monitor	10,000.00	nephrology	90940	See Note A	No/Insufficient documentation received	See Note D.
diathermy, microwave		anesthesia, GP, podiatry	97020	See Notes A and C	No/Insufficient documentation received	See Note D.
DNA image analyzer (ACIS)	200,000.00	lab, pathology	88358, 88361	See Note A	Submitted price of $195,000	See Note F.
drill, ophthalmology		ophthalmology	65125	See Note A	Submitted price of $57, less than $500	See Note G.
ECG signal averaging system	8,250.00	cardiology, IM	93278	See Note A	No/Insufficient documentation received	See Note D.
EEG monitor, digital, portable		neurology	95953	See Note A	Submitted price of $17,500	See Note F.
EEG recorder, ambulatory	6,940.00	neurology	95950	See Note A	Submitted price of $12,500	See Note F.
EEG review station, ambulatory	44,950.00	neurology	95950	See Note A	Submitted price of $7,950	See Note F.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
electroconvulsive therapy machine		psychiatry	90870	See Note A	Submitted price of $13,995	See Note F.
Electromagnetic therapy machine	25,000.00	physical therapy	G0329	See Note A	No/Insufficient documentation received	See Note D.
EMG botox	1,500.00	critical care, pulmonary, ophthalmology	92265	See Note A	No/Insufficient documentation received	See Note D.
fetal monitor software	35,000.00	ob-gyn, radiology	76818, 76819	See Note A	No/Insufficient documentation received	See Note D.
film alternator (motorized film viewbox)	27,500.00	radiology	329 codes	See Note B	No/Insufficient documentation received	See Note D.
generator, constant current	950.00	neurology, NP	95923	See Note A	No/Insufficient documentation received	See Note D.
HDR Afterload System, Nucletron - Oldelft	375,000.00	radiation oncology	77781-84	See Note A	Submitted prices from 2 sources, average of $375,9665	See Note F.
hyperbaric chamber	125,000.00	FP, IM, EM	99183	See Note A	No/Insufficient documentation received	See Note D.
hyperthermia system, ultrasound, external	360,000.00	radiation oncology	77600	See Note A	Submitted price of $360,000	See Note F.
hyperthermia system, ultrasound, intracavitary	250,000.00	radiation oncology	77620	See Note A	No/Insufficient documentation received	See Note D.
hysteroscopy ablation system	19,500.00	ob-gyn	58563	See Note A	No/Insufficient documentation received	See Note D.
image analyzer (CAS system)	92,000.00	pathology, neurology	88355, 88356	See Note A	No longer available	See Note H.
IMRT physics tools	55,485.00	radiation oncology	77301, 77418	See Note A	Submitted prices from 3 sources, average of $78,600	See Note F.
IVAC Injection Automatic Pump	2,500.00	radiology	78206, 78607, 78647, 78803, 78807	See Note A	No/Insufficient documentation received	See Note D.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
mammography reporting software		radiology	76090, 76091, 76092	See Note A	No/Insufficient documentation received	See Note E.
neurobehavioral status instrument-average	717.00	psychology, IM	96115, 96117	See Note A	Submitted price of $1,136.25	See Note F.
orthovoltage radiotherapy system	140,000.00	radiation oncology	77401	See Note A	No/Insufficient documentation received	See Note D.
OSHA ventilated hood	5,000.00	radiation oncology	77334	See Note B	No/Insufficient documentation received	See Note D.
plasma pheresis machine w/UV light source	37,900.00	radiology, dermatology	36481, 36510, 36522	See Note A	No/Insufficient documentation received	See Note D.
programmer, pacemaker	10,000.00	cardiology, cardiothoracic surgery, general surgery	33200-01, 33206-08, 33212-18, 33220, 33222, 33240, 33245-46, 33249, 33282	See Note A	Supplied without cost to physician offices, IDTFs, etc	See Note G.
pulse oxymetry recording software (prolonged monitoring)	3,660.00	pulmonary disease, IM	94762	See Note A	No/Insufficient documentation received	See Note D.
radiation treatment vault	550,670.00	radiation oncology	774XX	See Note B	Submitted prices from 3 sources, average $773,104	See Note F.
radiation virtual simulation system		radiation oncology	77280, 77285, 77290, 77402-16	See Note A	Submitted price of $967,000	See Note F.
remote monitoring service (neurodiagnostics)	9,500.00	neurology	95955	See Note A	No/Insufficient documentation received	See Note D.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
review master	23,500.00	pulmonary disease, neurology	95805, 95807-11, 95816, 95822, 95955-56	See Note A	No/Insufficient documentation received	See Note D.
room, basic radiology	150,000.00	radiology	103 codes	See Note A	No/Insufficient documentation received	See Note D.
room, mammography	130,000.00	radiology	19030, 19290-91, 19295, 76086-92, 76096	See Note A	No/Insufficient documentation received	See Note D.
room, radiographic-fluoroscopic	475,000.00		123 codes	See Note A	No/Insufficient documentation received	See Note D.
room, ultrasound, vascular		vascular		New-Added 10/04	Submitted price of $466,492	See Note F.
source, 10 Ci Ir 192	22,000.00	radiation oncology	77781-84	See Note A	Submitted prices from 2 sources, average $45,326	See Note F.
strontium-90 applicator	8,599.00	radiation oncology	77789	See Note A	Submitted prices from 3 sources, average $6,705	See Note F.
table, cystoscopy		urology	52204-24, 52265-75, 52310-17, 52327-32	See Note A	No/Insufficient documentation received	See Note E.
ultrasound color doppler, transducers and vaginal probe	155,000.00	ob-gyn	59070, 59074, 76818-19	See Note A	No/Insufficient documentation received	See Note D.
ultrasound, echocardiography digital acquisition (Novo Microsonics, TomTec)	29,900.00	ob-gyn, cardiology, pediatrics	76825-28, 93303-12, 93314, 93320, 93325, 93350	See Note A	No/Insufficient documentation received	See Note D.
vacuum cart		anesthesia	64620	See Notes A and C	No/Insufficient documentation received	See Note E.

2005 Description	2004 Price	Primary specialties associated with item	*CPT code(s) associated with item	Prior status of equipment item	Commenter response	CMS action taken
video camera	1,000.00	radiation oncology	77418	See Note A	Submitted price of $1,000	See Note F.
water chiller (radiation treatment)	28,000.00	radiation oncology	77402-16	See Note B	Submitted prices from 2 sources, average $25,565	See Note F.
well counter		radiology	78160-72, 78282	See Note A	Submitted price of $3,450	See Note F.

Notes:
A. Additional information required. Need detailed description, source, and current pricing information.
B. Proposed deletion as indirect expense.
C. Item may no longer be available.
D. No/Insufficient documentation. Current price retained on an interim basis. Forward documentation promptly.
E. No/Insufficient documentation. No price in database. Forward documentation promptly.
F. Submitted price accepted.
G. Equipment deleted, per comment.
H. No longer available/marketed. Item deleted.

BILLING CODE 4120–01–C

d. Miscellaneous Practice Expense Issues

- Pricing for Seldinger Needle.

We proposed to average two prices of this supply item to reflect a cost of $5.175. We requested that, if commenters disagreed with this change in price, the comment should provide documentation to support the recommended price, as well as the specific type of needle that is most commonly used.

Comment: Commenters were in agreement with the proposed pricing of the seldinger needle.

Response: We will use the proposed price of $5.175 for this supply item in the practice expense database.

• Hysteroscopic Endometrial Ablation.

We proposed to assign, on an interim basis, the following direct practice expense inputs in the nonfacility setting for CPT code 58563, *Hysteroscopy, surgical; with endometrial ablation.* (**Note:** In the August 5, 2004 proposed rule this code was erroneously identified as 56853, which does not exist.) We also stated we would request that the RUC review these inputs as part of the practice expense refinement process.

+ *Clinical Staff:* RN/LPN/MTA—72 minutes (18 pre-service and 54 service)

+ *Supplies:* PEAC multispecialty visit supply package, pelvic exam package, irrigation tubing, sterile impervious gown, surgical cap, shoe cover, surgical mask with face shield, 3x3 sterile gauze (20), cotton tip applicator, cotton balls (4), irrigation 0.9 percent sodium chloride 500–1000 ml (3), maxi-pad, mini-pad, 3-pack betadine swab (4), Monsel's solution (10 ml), lidocaine jelly (1000 ml), disposable speculum, spinal needle, 18–24 g needle, 20 ml syringe, bupivicaine 0.25 percent (10 ml), 1 percent xylocaine (20 ml), cidex (10 ml), Polaroid film-type 667 (2), endosheath, and hysteroscopic ablation device kit.

+ *Equipment:* power table, fiberoptic exam light, endoscopic-rigid hysteroscope, endoscopy video system, and hysteroscopic ablation system.

Comment: Commenters, including many individual practitioners, were supportive of this proposed change. The specialty society also stated that they plan to present the inputs for this service at the RUC meeting in February 2005

Response: With the exception of the post incision care kit that we deleted because this procedure does not require an incision, we will finalize these inputs as proposed.

• Photopheresis.

We proposed to assign, on an interim basis, the following nonfacility practice expense inputs for the photopheresis service, CPT code 36522:

+ *Clinical Staff:* RN—223 minutes (treatment is for approximately 4 hours)

+ *Supplies:* multispecialty visit supply package, photopheresis procedural kit, blood filter (filter iv set), IV blood administration set, 0.9 percent irrigation sodium chloride 500–1000 ml (2), heparin 1,000 units-ml (10), povidone solution-betadine, methoxsalen (UVADEX) sterile solution-10 ml vial, 1 percent-2 percent lidocaine-xylocaine, paper surgical tape (12), 2x3 underpad (chux), nonsterile drapesheet 40 inches x 60 inches, nonsterile Kling bandage, bandage strip, 3x3 sterile gauze, 4x4 sterile gauze, alcohol swab pad (3), impervious staff gown, 19–25 g butterfly needle, 14–24g angiocatheter, 18–27 g needle, 20 ml syringe, 10–12 ml syringe, 1 ml syringe, 22–26 g syringe needle-3 ml.

+ *Equipment:* plasma pheresis machine with ultraviolet light source, medical recliner.

We also stated we would request that the RUC review these inputs.

Comment: One commenter supplied information on practice expense inputs for this code and indicated that an oncology nurse should be used, instead of an RN, to perform the procedure. A specialty society also stated that they would be providing information on this service at the September RUC meeting.

Response: We appreciate the information submitted by the commenters. This code was discussed at the September RUC meeting and recommended practice expense inputs for this service were provided to us. We do not agree with the RUC recommended clinical staff procedure (intra) time of 90 minutes. We believe that this time, which is half of the proposed intra time, does not accurately reflect the total time involved in performing this procedure. Our understanding is that the filtration rate and the procedures performed by the nurse for photopheresis are similar to those that are reflected in the selective apheresis services, CPT code 36516, with a PEAC-approved intra time of 240 minutes. Based on this, and the absence of specialty representation at the RUC familiar with the process, we are assigning 180 minutes for the intra time, as proposed. We are also assigning the RN/LPN staff type to this procedure, because we believe it is similar to other apheresis procedures. We will continue our examination of this issue and entertain ongoing dialog with all interested organizations and individuals, including the AMA and the RUC, the industry, and those physicians and individuals familiar with the photopheresis procedure in order to assure the accuracy of the intra time.

• Pricing of New Supply Items.

As part of last year's rulemaking process, we reviewed and updated the prices for supply items in our practice expense database. During subsequent meetings of both the PEAC and the RUC, supply items were added that were not included in the supply pricing update. The August 5, 2004 proposed rule included Table 3 Proposed Practice Expense Supply Item Additions for 2005, which listed supply items added as a result of PEAC or RUC recommendations subsequent to last year's update of the supply items and the proposed associated prices that we will use in the practice expense calculation.

We also identified certain supply items for which we were unable to verify the pricing information (*see* Table 4, Supply Items Needing Specialty Input for Pricing, in the August 5, 2004 proposed rule). We requested that commenters provide pricing information on these items along with documentation to support the recommended price. In addition, we also requested information on the specific contents of the listed kits, so that we do not duplicate any supply items.

Comment: Several commenters representing providers of these services stated that table 3 incorrectly associated ''gold markers'' with the brachtherapy intracavity codes. They were all in agreement that these markers are typically used in external beam treatments and payment is associated with unlisted procedure codes and should be paid for at cost.

Response: We have deleted the gold markers from CPT codes 77761–77763 and removed this supply from the practice expense database.

Comment: The American Urology Association noted that we should exclude the vasotomy kit from CPT codes 55200 and 55250.

Response: We have deleted the vasotomy kit from CPT codes 55200 and 55250.

Comment: The American College of Chest Physicians agreed with pricing of items used in their practices in table 3 and stated that the bronchogram tray does not need to be included in the practice expense database, as the procedure is seldom performed and, when it is, the procedure is performed in a facility.

Response: We have deleted the bronchogram tray from the practice expense database and corrected the direct inputs for CPT code 31708 accordingly.

Comment: We received comments from the American College of Cardiology (ACC) that included price quotes and names of sources for supply items listed on table 3.

Response: Unfortunately, ACC did not include the requested sufficient documentation, such as invoices or catalog web page links. We have asked ACC to forward this pricing documentation to us as soon as possible because it will be required for supplies to remain valued in the practice expense database. In the interim, for the 2005 fee schedule, we will maintain the prices currently in the practice expense database for the following supplies:

blood pressure recording form at $0.31, pressure bag (infuser) 500cc or 1000cc at $8.925, sterile, non-vented, tubing at $1.99.

Comment: Noting that a $15 supply item, needle-wire for localization of lesions in the breast (used preoperatively in CPT codes 19290 and 19291) was no longer used, a manufacturer requested that we replace this supply with an anchor-guide device valued at $245. The commenters also stated that this device is used in over 70 offices and imaging centers.

Response: We appreciate the comments from the manufacturer. However, during last year's rulemaking process we repriced all of our supplies, and the needle-wire price of $15 was an average of prices from two different sources ($17 and $13). This price was proposed and accepted by the medical specialty societies that we depend on to verify typical items in our practice expense database. We have retained the $15 needle-wire for localization because we believe it is typically used for this procedure.

The following table lists the items on which we requested input, the comments received, and the action taken.

BILLING CODE 4120–01–P

Table 3: Supplies Needing Specialty Input

2005 Description	Unit	Unit Price	Primary specialties associated with item	Prior status of item	Commenter response	CMS action taken
antibodies - detection	slide	30.90	lab, pathology	See Note A.	Deleted, CPEP refinement	See Note D.
blood pressure recording form, average	item	0.31	cardiology	See Note A.	No/Insufficient documentaion received	See Note B.
catheter, hyperthermia, closed-end	item		radiation oncology	See Note A.	Submitted price of $20	See Note C.
catheter, hyperthermia, open-end	item		radiation oncology	See Note A.	Submitted price of $20	See Note C.
Edrophonium	ml	4.67	gastroenterology	See Note A	No/Insufficient documentaion received	See Note B.
hysteroscope, ablation device	item	1,146.00	ob-gyn	See Note A	No/Insufficient documentaion received	See Note B.
kit, BCR/ABL DNA probe	kit	42.65	pathology	See Note A.	Submitted price of $42.65	See Note C.
kit, Her-2/Neu DNA probe	kit		pathology	New-Added 10/04	Submitted price of $105	See Note C.
kit, detection	slide	8.50	pathology, neurology	See Note A.	Refinement scheduled 2/05	See Note B.
kit, photopheresis procedure	kit	809.00	dermatology, ob-gyn	See Note A.	Submitted price of $858	See Note C.
kit, vasotomy	kit		urology	See Note A.	Delete, per comment	See Note D.
methoxsalen, sterile solution (UVADEX) 10 ml vial	ml	49.50	dermatology, radiation oncology	See Note A.	Submitted price of $49.50	See Note C.
pressure bag	item		cardiology	See Note A.	No/Insufficient documentaion received	See Note E.

2005 Description	Unit	Unit Price	Primary specialties associated with item	Prior status of item	Commenter response	CMS action taken
primary antibodies	slide	3.52	pathology, neurology	See Note A.	Refinement scheduled 2/05	See Note B.
tray, bronchogram	tray		pulmonary disease	See Note A.	Delete, per comment	See Note D.
tubing, sterile, non-vented (fluid administration)	item		cardiology	See Note A.	No/Insufficient documentaion received	See Note E.

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Notes:
A. Additional information required. Need detailed description (including kit contents), source, and current pricing information.
B. No/Insufficient documentation. Retained price in database, on interim basis. Forward documentation promptly.
C. Submitted price accepted.
D. Deleted per comment.
E. 2004 price retained on an interim basis. Forward documentation promptly.

BILLING CODE 4120–01–C

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

We proposed to add, on an interim basis, a DNA probe to the CPEP database for CPT 88365, tissue in situ hybridization, with the understanding that the inclusion of the item would be subject to forthcoming RUC review.

Comment: Commenters were supportive of this proposal. The College of American Pathologists also encouraged us to include updated information on practice expense inputs from the September RUC meeting, while another commenter suggested that we run the information by the specialty society.

Response: The direct practice expense inputs for this code and two other codes in the same family were discussed at the September RUC after a presentation made by the specialty society. We have reviewed and accepted the RUC recommendations, and these practice expense inputs will be included in the practice expense database.

• Ophthalmology Equipment.

In cases where both the screening and exam lanes are included in the equipment list for the same ophthalmology service, we proposed to include only one lane because the patient could only be in one lane at a time. We proposed defaulting to the exam lane and, thus, we proposed deleting the screening lane from the practice expense inputs for these procedures. For the services where a lane change was made, time values were assigned to the exam lane in accordance with our established standard procedure.

Comment: The American Academy of Ophthalmology requested that we specifically identify the codes for which we deleted the screening lane, so that they can ensure that the correct lane was deleted.

Response: This information can be obtained by comparing the direct inputs in the practice expense database files for the 2004 and 2005 fee schedules that are posted on our Web site (*http://www.cms.hhs.gov/physicians/pfs*). However, we would be happy to work with the specialty organization to verify the accuracy of the information.

• Parathyroid Imaging, CPT code 78070.

Based on comments received from the RUC and the specialty society representing nuclear medicine, we proposed to crosswalk the charge-based RVUs from CPT 78306, *Bone and/or joint imaging; whole body,* to CPT 78070, *Parathyroid imaging.*

Comment: Several specialty societies expressed appreciation for this proposed change.

Response: We will finalize our proposal and crosswalk the charge-based RVUs from CPT code 78306 to CPT code 78070.

• Additional PE concerns.

Comment: We received information from the American Academy of Ophthalmology that two biometry devices (a-scan ultrasonic biometry unit and an optical coherence biometer) were listed as equipment for the ophthalmic biometry service, CPT code 92136. Only the optical coherence biometer should be included for this code.

Response: As requested by the specialty society, we have deleted the a-scan biometry unit from the equipment list for CPT code 92136.

Comment: We received comments from manufacturers, specialty societies representing renal physicians and vascular surgeons, and individual providers questioning the decrease in nonfacility practice expense RVUS for CPT code 36870, *Percutaneous thrombectomy, arteriovenous fistula, autogenous or nonautogenous graft (includes mechanical thrombus extraction and intra-graft thrombolysis.* Some commenters believe this reduction occurred because the supplies listed in the database for this service reflect only one method of providing this service. While commenters acknowledged that the database includes the supplies used in approximately 50 percent of the instances this procedure is performed, the commenters claimed that other supplies may be used in the remaining occasions. Commenters requested that we add these other specific supplies to the database.

Response: Because there are a variety of supplies and equipment that can be used in performing a service, under the practice expense methodology, the supplies and equipment that are used in determining payment are those that are most typical for the procedure. Although there may be alternative supplies used, the inputs in the database reflect what is typically used (which is acknowledged by the commenters) and thus we are not adding the requested supplies to the practice expense database. However, we did note that the list of equipment did not reflect the cost of the angiography room that is used during the procedure, and this has been added to our database for this code.

Comment: Societies representing dermatologic specialties expressed concern about the reduction in practice expense RVUs for a photodynamic therapy service, CPT code 96567. The commenters believe that this reduction is due to the application of the dermatology scaling factor based on updated practice expense utilization and requested that this be reconsidered. These commenters also expressed appreciation that there is now a separate HCPCS code to bill for levulan that is needed for this procedure, but stated that there are two medical supplies that need to be included in the practice expense database: bacitracin, and a topical anesthetic cream.

Response: The practice expense RVUs for photodynamic therapy decreased only slightly in this year's proposed rule due to the proposed repricing of equipment. The decrease referred to by the commenter occurred after the first year that the code was established. At that time we obtained the utilization data that demonstrated that dermatologists performed the service and we then applied the same scaling factors to the code that we do for all dermatology services. Therefore, the scaling factor we now apply is correct. We will add the requested amount of bacitracin to the supply list for the code. Unfortunately, the topical anesthetic requested is not in our database and the commenters did not include pricing information so we are not able to include the item in our practice expense calculation.

Comment: A society representing interventional pain physicians expressed concern that the practice expense RVUs for CPT code 95990, *Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular)*, are understated when compared to the RVUs for CPT code 95991, the same service administered by a physician. According to the commenter, CPT code 95991 includes a total of 47 minutes of nonphysician labor and 37 minutes of physician labor or total professional time of 84 minutes. This is the total time spent with the patient before, during and after the refill. The commenter requested that the number of minutes of direct labor for CPT code 95990 should be a minimum of 84 minutes, since the nonphysician practitioner would be performing all the services associated with CPT code 95991 that are performed by both the physician and clinical staff. In addition, the commenter stated that CPT code 95990 should also be assigned physician work RVUs because there is physician oversight of the service even when performed by clinical staff. Two other commenters stated that both CPT codes 95990 and 95991 should be valued the same as the chemotherapy implanted pump refill service, CPT code 96530. The commenters state that this was the code originally used to report the above services, that CPT codes 95990 and 95991 originally were assigned higher RVUs than CPT code 96530 and that the MMA adjustments that increased the payment for CPT code 96530 should be applied to CPT codes 95990 and 95991.

Response: The commenter is correct that the clinical staff times for CPT codes 95990 and 95991 are the same (50 minutes of clinical staff time), although the clinical staff is performing the procedure in one case and assisting the physician in the other. However, the assumption underlying these times is that, in the cases where it is necessary for the physician to personally perform the procedure, the nurse is assisting for the entire time. If this assumption is not correct, then the clinical staff time for CPT code 95991 is overstated. Because CPT codes 95990 and 95991 are not considered drug administration codes under section 303 of the MMA, we will not apply the adjustments made for CPT code 96530 to these services. Therefore, we will not be revising the staff time for either code at this time, but would suggest that the RUC look further at this issue. We would also suggest that the society bring CPT code 95990 to the 5-year review, if they wish to make the case that work RVUs should be assigned.

Comment: The society representing interventional pain physicians questioned the ''professional component only'' designation we assigned to the codes for the analysis of an implanted intrathecal pump, CPT codes 62367 and 62368, and the subsequent low RVUs for these services. The commenter stated that if the payment is left as proposed, more physicians would stop offering intrathecal pumps to patients.

Response: This was an inadvertent error on our part that we have corrected for the final rule. These services are physicians' services that do not have separate professional and technical components. We thank the commenter for pointing out this error.

Comment: The Joint Council of Allergy, Asthma and Immunology expressed concern about the reduction in the proposed rule in practice expense RVUs for a number of allergy codes, in particular the venom therapy CPT codes, 95145 through 95149. The commenter stated that Medicare reimbursement for these services does not cover the physician's supply expense, due to the expensive venom antigens that are part of the service, and believes this is a result of the scaling factor being used.

Response: We are sympathetic to the commenter's concern about the high cost of the venom antigens and the specialty's low scaling factor. We would be happy to work with JCAAI further to see if a remedy can be identified regarding this subset of the allergy codes.

Comment: Two commenters stated that the practice expense RVUs for HCPCS code G0329, Electromagnetic Therapy for ulcers, were too low and supplied information on the supplies, equipment and clinical staff time for this service.

Response: Based on the information provided by the commenters, we added diapulse asetips and chux to the supplies in the practice expense database for this service. We also increased the equipment time to 30 minutes.

Comment: We received comments from the North American Spine Society (NASS) stating that the specific needle used for CPT codes 22520 and 22522, which was originally recommended by NASS, is the most expensive needle and may not be the most typical. The specialty noted that available needles range from $26 to $1,295, which represent the needle (termed vertebroplasty kit) in the practice expense database. NASS indicated that the specialties involved in performing these procedures are conducting a survey to determine the most commonly used needles and their costs.

Response: We appreciate the comments from NASS and look forward to receiving the survey results. In the interim, we have averaged the needle costs for the range indicated above by the specialty and have entered this figure, $660.50, as a placeholder for the 2005 fee schedule. Because of the large disparity between the lowest and highest needle costs, it is not reasonable to consider $660.50 as a true average cost for this supply item. We will continue to work with the specialty organizations in order to ensure that the 2006 fee schedule practice expense database reflects the value for the most typical needle used in these procedures.

Comment: We received comments from two medical societies with concerns about a decrease in practice expense RVUs for CPT code 95819, which is part of the EEG sleep study series of codes. These two organizations noted their willingness to bring this code to the February 2005 RUC meeting in order to rectify the direct practice expense inputs for this procedure.

Response: We have reviewed the family of EEG sleep-study codes and believe that a rank order anomaly exists relating primarily to the 2004 PEAC recommendation to delete the 25 reusable electrodes from CPT code 95819. We support and encourage these organizations to bring the entire EEG family of codes to the February 2005 RUC to ensure that this rank order anomaly can be resolved and the correct direct inputs can be identified for these procedures.

Comment: The Coalition for Advancement of Prosthetic Urology expressed concern about the continuing decline in practice expense RVUs for prosthetic urology procedures. They believe that this is due in part to the number of post service visits assigned to these services. They stated that information from a survey they conducted shows there are typically four to five post service visits rather than three as reflected in the database. The commenter also provided a copy of the survey information.

Response: The number of post service visits for these services was established based on recommendations from the RUC or by using the Harvard data. If they believe that the information regarding the number of post service visits for specific procedures is incorrect, the Coalition must request that the codes be examined as part of the 5-year refinement of work RVUs. An explanation of this process and the information that must be provided is found in section VI. of this rule.

B. Geographic Practice Cost Indices (GPCIs)

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

Section 1848(e)(1)(C) of the Act requires us to review and, if necessary, to adjust the GPCIs at least every 3 years. This section of the Act also requires us to phase-in the adjustment over 2 years and to implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. The GPCIs were first implemented in 1992. The first review and revision was implemented in 1995, the second review was implemented in 1998, and the third review was implemented in 2001. We reviewed and revised the malpractice GPCIs as part of the November 7, 2003 (68 FR 63196) physician fee schedule final rule. We were unable to revise the work and practice expense GPCIs at the time of the publication of the November 2003 final rule because the U.S. Census data, upon which the work and practice expense GPCIs are based, were not yet available.

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

In the August 5, 2004 proposed rule, we proposed to revise the work and practice expense GPCIs for 2005 through 2007 based on updated U.S. Census data and Department of Housing and Urban Development (HUD) fair market rental (FMR) data. The same data sources and methodology used for the development of the 2001 through 2003 GPCIs were used for the proposed 2005 through 2007 work and practice expense GPCIs.

The relative respective weights for the 2004 work, practice expense and malpractice GPCIs, as well as the proposed 2005 through 2007 GPCI revisions, were derived using the same weights that were used in the Medicare Economic Index (MEI) revision discussed in the November 2003 physician fee schedule final rule (68 FR 63245).

1. Work Geographic Practice Cost Indices

As explained in the August 5, 2004 proposed rule, we used data from the 2000 decennial U.S. Census, by county, of seven professional occupations (architecture and engineering; computer, mathematical, and natural sciences; social scientists, social workers, lawyers; education, library, training; registered nurses; pharmacists; writers, artists, editors) in the development of the proposed work GPCIs. Physicians' wages are not included because Medicare payments are determinant of the physicians' earnings. Including physician wages in the physician work GPCI would, in effect, make the index dependent upon Medicare payments. Based on analysis performed by Health Economics Research, we believe that, in the majority of instances, the earnings of physicians will vary among areas to the same degree that the earnings of other professionals vary.

The U.S. Census Bureau has very specific criteria that tabulations must meet in order to be released to the public. To maximize the accuracy and availability of the data collection, the nonphysician professional wage data were aggregated by county and a median wage by county was calculated for each occupational category. These median wages were then weighted by the total RVUs associated with a given county to ultimately arrive at locality-specific work GPCIs. This geographic aggregation of Census data is the same methodology that was used in previous updates to the GPCIs.

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

2. Practice Expense GPCIs

As in the past, we proposed that the practice expense GPCI would be comprised of several factors that represent the major expenses incurred in operating a physician practice. The impact of each individual factor on the calculation of the practice expense GPCI is based on the relative weight for that factor consistent with the calculation of the MEI. The specific factors included:

- *Employee Wage Indices*—The employee wage index is based on special tabulations of 2000 Census data and is designed to capture the median wage by county of the professional labor force. The employee wage index uses the median wages of four labor categories that are most commonly present in a physician's private practice (administrative support, registered nurses, licensed practical nurses, and health technicians). Median wages for these occupations were aggregated by county in the same manner as the data for the work GPCI.
- *Office Rent Indices*—The HUD FMR data for the residential rents were again used as the proxy for physician office rents as they are in the current practice expense GPCIs. The proposed 2005 through 2007 practice expense GPCIs reflect the final fiscal year 2004 HUD FMR data. We believe that the FMR data remain the best available source for constructing the office rent index. The FMR data are available for all areas, are updated annually, and retain consistency from area-to-area and from year-to-year. A reduction in an area's rent index does not necessarily mean that rents have gone down in that area since the last GPCI update. Since the GPCIs measure area costs compared to the national average, a decrease in an area's rent index means that that area's rental costs are lower relative to the national average rental costs. Addendum X illustrates the changes in the rental index based upon the new FMR data.
- *Medical Equipment, Supplies, and other Miscellaneous Expenses*—The GPCIs assume that items such as medical equipment and supplies have a national market and that input prices do not vary among geographic areas. We were again unable to find any data sources that demonstrated price differences by geographic areas. As mentioned in previous updates, some price differences may exist, but these differences are more likely to be based on volume discounts rather than on geographic areas. The medical equipment, supplies, and miscellaneous expense portion of the practice expense geographic index will continue to be 1.000 for all areas in the proposed GPCIs, except for Alaska which will have an overall practice expense GPCI set at 1.67 for 2005 and 2006.

3. Fee Schedule Payments

All three of the indices for a specific fee schedule locality are based on the indices for the individual counties within the respective fee schedule localities. As in the past, fee schedule RVUs are again used to weight the county indices (to reflect volumes of services within counties) when mapping to fee schedule areas and in constructing the national average indices.

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

- Decreased the proposed work GPCI by 0.9965;

• Decreased the proposed practice expense GPCI by 0.9930; and

• Increased the malpractice GPCIs that were published in the November 7, 2003 final rule by 1.0021.

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

Comment: A specialty society representing family physicians recommended that we work with the Congress to eliminate the GPCIs or set them all at 1.00. The society stated that they understand the statutory requirement to apply the GPCIs, but that all geographic adjustment factors should be eliminated from the physician fee schedule, except for those designed to achieve a specific policy good, such as adjustment to encourage physicians to practice in underserved areas. The commenter contended that elimination of the GPCIs would have a positive effect on the availability of medical care to rural beneficiaries. Other commenters suggested that we should no longer apply the work GPCI to the work RVUs.

We also received numerous comments on the subject of the source of the data we use in the development of the GPCIs. Commenters suggested that we find data sources other than Census Bureau data. They believe the census data become obsolete very quickly and want us to use data that reflect up-to-date prices for inputs. This would, they argue, make the GPCI values more realistic.

A medical specialty group commented that the index is flawed because—

• It is based on the tenuous assumption that the relative differences in the prices of the input proxies accurately reflect relative changes in prices of corresponding physician practice cost components; and,

• It applies uniform weights to practice cost components, despite evidence of geographic variation in component shares.

Several commenters had specific concerns about the proxies used for the work and practice expense GPCIs, for example—

• Using data for four employee classes to measure relative compensation differences for all physicians' office staff which does not reflect the changes in medical practice that have occurred since the index was developed;

• Using residential real estate prices to reflect relative differences in physicians' office costs; and

• Using nationally uniform prices for supplies, equipment, and other expenses.

Another particular concern among commenters is the use of HUD apartment rental data as the source of costs for physicians' rents. Instead, they argue, we should find, or carry out, a national study of retail and business rents.

Another commenter asserts that these indices have not been verified by peer-reviewed published research since they were instituted and that we should replace the indices with data from nationwide studies that validate and update actual cost of practice data.

Response: As noted by a commenter, we are required by the Congress to adjust for geographic differences in the operational cost of physicians' practices by applying geographic price indices to each component of the Physician Fee Schedule. However, we also believe it appropriate in our resource based payment system to account for real differences in physicians' costs in different geographical areas. We share the concern about access to care for our rural beneficiaries and, in this rule, we are finalizing our proposals on payment adjustments to physicians in underserved areas through the HPSA Incentive Payment Program. For the commenters who object to the GPCI adjustment to the work RVUs, we would note that for 2005 and 2006 the floor for the work GPCI will be 1.00.

With reference to the issue of the GPCI data source, we are always open to suggestions about possible data sources; however, we believe the most reliable source of national, comparable data at the county level is the Census Bureau. Other data sources that we have examined either fail to produce the data at the county level, cannot be compared nationally, or offer no means of comparability over time.

We believe that the proxies, while not perfect, are the best tools available for the development of the GPCIs. For example, if we were to eliminate all proxies, we would have to collect actual physicians' office data from a sufficiently large sample in each locality to calculate the GPCIs. This would place a substantial burden on the office staff and would be prohibitively expensive. Also, the benefits from that approach would be uncertain.

The question of applying uniform weights to practice components is an area where more research could lead to better information about the variation attributable to case mix and the availability of other health resources, input prices, and practice styles. However, it is important to note that much of the variation associated with case and specialty mix is accounted for by the varying RVUs for different services. However, we are open to exploring this issue.

On the issue of which employee categories are included in the employee wage index component of the practice expense GPCI calculation, we included those that have been determined in the past to be most commonly present in a physician's private practice. We are considering the suggestion that we include a broader group of employment categories in the future.

While we recognize that apartment rents are not a perfect proxy for physician office rents, there are no existing national studies that present reliable retail and business rentals data. We would welcome any nationally consistent data that could be used for this purpose.

We noted in the proposed rule that we were unable to find any data sources that demonstrate price differences by geographic areas for medical equipment and supplies. Once again, however, we welcome any nationally consistent data for this purpose.

We appreciate the concern expressed by the commenter who suggested our GPCI methodology has not been subjected to peer-review validation since its inception, but we are not aware of any currently available data that could replace our methodology. Furthermore, we believe the process of updating the GPCIs periodically through notice and comment rulemaking affords an opportunity for a thorough review of the GPCI calculation methodology.

Comment: A member of a medical society suggested that we make the floor of 1.00 permanent for the work GPCI and incrementally increase both the practice expense GPCI and the professional liability insurance GPCI to 1.00 over the next ten years.

Response: We have no authority to extend the floor of the work GPCI, or to create a 1.00 floor for the practice expense and professional liability insurance GPCIs. Section 1848(c)(1)(A) of the Act requires that the index reflect resource costs relative to the national average, indicating that, aside from the MMA provision establishing a floor on the work GPCI through 2006, localities with costs below the national average have GPCIs below 1.00.

Comment: A specialty organization representing the long term care industry suggested that we phase in the new

GPCI values over a three-year period to minimize the impact of the changes.

Response: We are required by section 1848(e)(1)(C) of the Act to review and adjust the GPCIs every 3 years. This section of the Act also requires us to phase in the adjustment over 2 years and implement only one-half of any adjustment if more than 1 year has elapsed since the last GPCI revision. We believe this phase-in appropriately balances any negative impacts of the changes with the positive impacts on those localities where the GPCIs increase.

4. Payment Localities

As discussed in the August 5, 2004 proposed rule, we have considered, and are continuing to examine, alternatives to the composition of the current 89 Medicare physician payment localities to which the GPCIs are applied.

While we have considered alternatives, we have been unable to establish a policy and criteria that would satisfactorily apply to all situations. Any policy that we would propose would have to apply to all States and payment localities. If, for example, we were to establish a policy that when adjacent county geographic indices exceeded a threshold amount the lower county could be moved to the higher county or that a separate locality could be created, redistributions would be caused within a State.

Because there will be both winners and losers in any locality reconfiguration, the State medical associations should be the impetus behind these changes. The support of State medical associations has been the basis for previous changes to statewide areas, and continues to be equally important in our consideration of other future locality changes.

Comment: We received numerous comments from physicians and individuals, including members of the Congress, living in and around Santa Cruz County, California. Their comments uniformly expressed the opinion that Santa Cruz be taken out of the ''Rest of California'' payment locality and placed in a separate payment locality.

Additionally, the California Medical Association (CMA) submitted a ''placeholder'' proposal to move any county with a county-specific geographic adjustment factor (GAF) that is 5 percent greater than its locality GAF to its own individual county payment locality. Under their proposal, any reductions in payments to maintain budget neutrality in light of the higher payments to physicians in the counties that are moved into the new independent county localities would be divided equally among all payment localities within the State of California. Additionally, for 2005 and 2006, the GAFs in localities from which the high-cost counties are removed would not be reduced as a result of removing the counties.

Response: We greatly appreciate the efforts of the CMA and many others toward addressing this difficult issue. We also recognize the concerns expressed by the residents of Santa Cruz County about the impact of the current payment disparities upon physicians in their community. Our consistent position has been that we will be responsive to requests for locality changes when there is a demonstrated consensus within the State medical association for the change. Due to the re-distributive impacts of these types of changes, we believe this approach helps ensure the appropriateness of any such change.

We are required, however, to publish the final 2005 GPCIs and GAFs in this rule, and we have applied the current definitions for all California localities.

On October 21, 2004, the CMA Board of Trustees voted without objection to support the placeholder proposal submitted in the CMA's comment with the amendment to limit the time period to the years 2005 through 2006. However, we have determined that we do not have the authority under section 1848(e) of the Act to reduce the GPCIs of some localities in a State to offset higher payments to other localities. Nonetheless, we are eager to work with CMA and its Congressional Representatives to resolve this difficult problem as quickly and fairly as possible.

Comment: We received comments from physicians, individuals and the Texas Medical Association regarding locality payments. These commenters request that we regard all counties in a metropolitan statistical area (MSA) as being in a single payment locality. This would, they argue, equalize payments in those areas where growth has expanded city boundaries across county lines.

Response: As noted above, we will be responsive to requests for locality changes when there is a demonstrated consensus within the State medical association for the change.

Result of Evaluation of Comments

We will finalize the GPCIs as proposed.

C. Malpractice Relative Value Units (RVUs)

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

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

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

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

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

We were unable to obtain a nationally representative sample of 2003 malpractice premium data for the following two reasons:

- The premium data that we collected from the private insurance companies had to ''match'' the market share data that were provided by the respective State Departments of Insurance (DOI). Because none of the State DOI had 2003 market share information at the time of this data collection, 2003 premium data were not usable; and
- The majority of private insurers were not amenable to releasing premium data to us. In the majority of instances, the private insurance companies would release their premium data only to the State Department of Insurance.

Discussions with the industry led us to conclude that the primary determinants of malpractice liability costs remain physician specialty, level

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

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

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

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

Malpractice insurers generally use five-digit codes developed by the Insurance Services Office (ISO), an advisory body serving property and casualty insurers, to classify physician specialties into different risk classes for premium rating purposes. ISO codes classify physicians not only by specialty, but in many cases also by whether or not the specialty performs surgical procedures. A given specialty could thus have two ISO codes, one for use in rating a member of that specialty who performs surgical procedures and another for rating a member who does not perform surgery. We use our own system of specialty classification for payment and data purposes. It was therefore necessary to map Medicare specialties to ISO codes and insurer risk classes. Different insurers, while using ISO codes, have their own risk class categories. To ensure consistency, we used the risk classes of St. Paul Companies, one of the oldest and largest malpractice insurers. Although St. Paul Companies have recently terminated writing professional liability insurance policies at the time of this data collection they were still the largest and most nationally representative writer of professional liability insurance policies in the nation. The crosswalks for Medicare specialties to ISO codes and to the St. Paul risk classes used are reflected in Table 4.

Some physician specialties, nonphysician practitioners, and other entities (for example, independent diagnostic testing facilities) paid under the physician fee schedule could not be assigned an ISO code. We crosswalked these specialties to similar physician specialties and assigned an ISO code and a risk class. These crosswalks are reflected in Table 5.

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

Dominant Specialty Approach

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

The dominant specialty approach produces modest increases for some specialties and modest decreases for other specialties. The largest increase for any given specialty, over the specialty-weighted approach, is less than 1.5 percent of total RVUs, while the largest decrease for any given specialty is less than 0.5 percent of total RVUs. The dominant specialty approach also fails to account for as much as 49 percent of the utilization associated with a given procedure.

Specialty-Weighted Approach

The approach that we adopted in the November 1999 final rule and proposed

to use for 2005 bases the final malpractice RVUs upon a weighted average of the risk factors of all specialties performing a given service. The specialty-weighted approach ensures that all specialties performing a given service are accounted for in the calculation of the final malpractice RVU. Under the proposed methodology, we—

• *Compute a national average premium for each specialty.* Insurance rating area malpractice premiums for each specialty are mapped to the county level. The specialty premium for each county is then multiplied by the total county RVUs (as defined by Medicare claims data), which were divided by the malpractice GPCI applicable to each county to standardize the relative values for geographic variations. If the malpractice RVUs were not normalized for geographic variation, the locality cost differences (as reflected by the GPCIs) would be counted twice. The product of the malpractice premiums and standardized RVUs is then summed across specialties for each county. This calculation is then divided by the total RVUs for all counties, for each specialty, to yield a national average premium for each specialty. As stated previously, we used an average of the 3 most current years, 2001 to projected 2003 malpractice premiums, in our calculation of the proposed malpractice RVUs. See Table 6 for a display of the average premiums for the top 20 Medicare specialties;

• *Calculate a risk factor for each specialty.* Differences among specialties in malpractice premiums are a direct reflection of the malpractice risk associated with the services performed by a given specialty. The relative differences in national average premiums between various specialties can be expressed as a specialty risk factor. These risk factors are an index calculated by dividing the national average premium for each specialty by the national average premium for the specialty with the lowest average premium, nephrology. The risk factors used in the development of the resource-based malpractice RVUs are displayed in Table 7;

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

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

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

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

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

The proposed resource-based malpractice RVUs were shown in Addendum B of the August 5, 2004 proposed rule. The values did not reflect any final budget-neutrality adjustment, which we stated would be made in the final rule based upon the more current Medicare claims data. The malpractice RVUs identified in this final rule did not require the application of a scaling factor to retain budget neutrality.

Because of the differences in the sizes of the three fee schedule components, the implementation of the updated resource-based malpractice RVUs has a smaller payment effect than the previous implementation of resource-based practice expense RVUs. On average, work represents about 52.5 percent of the total payment for a procedure, practice expense about 43.6 percent of the total payment, and malpractice expense about 3.9 percent of the total payment. Thus, a 20 percent change in practice expense or work RVUs would yield a change in payment of about 8 to 11 percent. In contrast, a corresponding 20 percent change in malpractice values would yield a change in payment of only about 0.6 percent.

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TABLE 4:

Medicare Code	Medicare Description	ISO code		Risk Class		St. Paul's Description
		Surgery	Other	Surgery	Other	
1	General practice	80117	80420	4	1	Family/Gen. Practitioners - No Obstetrical
2	General surgery	80143	80143	5	5	Surgery General
3	Allergy/Immunology	80254	80254	1A	1A	Allergy
4	Otolaryngology	80159	80265	3	1	Otarhinolaryngology
5	Anesthesiology	80151	80151	5A	5A	Anesthesiology
6	Cardiology	80281	80255	2	1	Cardiovascular Disease
7	Dermatology	80472	80256	5	1A	Dermatology
8	Family practice	80117	80420	4	1	Family/Gen. Practitioners - No Obstetrical
10	Gastroenterology	80104	80241	3	1	Gastroenterology
11	Internal medicine	80284	80257	2	1	Internal medicine
13	Neurology	80288	80261	2	2	Neurology
14	Neurosurgery	80152	80152	8	8	Surgery Neurology
16	Obstetrics/Gynecology	80167	80244	4	1	Gynecology
18	Ophthalmology	80114	80263	2	1	Ophthalmology
20	Orthopedic surgery	80501	80501	5	5	Surgery Orthopedic - excluding Spinal Surgery
20	Orthopedic surgery	80154	80154	6	6	Surgery Orthopedic - including Spinal Surgery
22	Pathology	80292	80266	2	1A	Pathology
24	Plastic and reconstructive surgery	80156	80156	5	5	Surgery Plastic
25	Physical medicine and rehab	80235	80235	1	1	Physical medicine and rehab
26	Psychiatry *	80492, 80431	80249	2	1A	Psychiatry
28	Colorectal surgery	80115	80115	3	3	Surgery Colon and Rectal
29	Pulmonary Disease	80269	80269	1	1	Pulmonary Disease
30	Diagnostic radiology **	80280	80253	2	2	Radiology
33	Thoracic surgery	80144	80144	6	6	Surgery Thoracic
34	Urology	80145	80145	2	2	Surgery Urological
36	Nuclear medicine	80262	80262	1	1	Nuclear medicine

Medicare Code	Medicare Description	ISO code		Risk Class		St. Paul's Description
		Surgery	Other	Surgery	Other	
37	Pediatric medicine	80293	80267	2	1	Pediatrics
38	Geriatric medicine ***	80276	80243	2	1	Geriatrics
39	Nephrology ***	80287	80260	2	1	Nephrology
40	Hand surgery	80169	80169	5	5	Surgery Hand
44	Infectious disease	80279	80246	2	1	Infectious disease
46	Endocrinology ***	80272	80238	2	1	Endocrinology
65	Physical therapist (independent)	80235	80235	1	1	Physical medicine and rehab
66	Rheumatology	80252	80252	1	1	Rheumatology
67	Occupational therapist (independent)	80235	80235	1	1	Occupational Medicine
77	Vascular surgery	80146	80146	6	6	Surgery Vascular
78	Cardiac surgery	80141	80141	6	6	Surgery Cardiac
82	Hematology	80278	80245	2	1	Hematology
83	Hematology/oncology	80473	80473	1	1	Oncology
84	Preventive medicine	80231	80231	1	1	General Preventive Medicine
92	Radiation Oncology ****	80425	80425	2	2	Radiation Therapy
93	Emergency medicine	80157	80102	5	4	Emergency Medicine
98	Gynecologist/oncologist	80167	80244	4	1	Gynecology

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

Note: If a specialty has only one risk classification the same classification was used for both surgery and nonsurgery..*The ISO codes for surgery for Psychiatry represents Psychiatry - shock therapy.

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

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

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

TABLE 5:

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

TABLE 6:

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

[1] A simple average of figures for 2001, 2002, and 2003.
[2] Annualized average growth rate between 1996 - 1998 and 2001 - 2003.

[3] An average of locality malpractice GPCIs using specialty-specific malpractice RVUs as weights.
[4] 2001 - 2003 premium divided by specialty MGPCI.
[5] (Normalized 2001 - 2003 Premium, .9289) x 1.51.
[6] Nephrology is set to 1.51 to be consistent with the risk factor taken from the rating manuals.
n/a siginifies that the premium data was not available.

TABLE 7:

Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
01	General practice	1.79	4.26
02	General surgery	6.13	6.13
03	Allergy/Immunology	1.00	1.00
04	Otolaryngology	1.45	3.78
05	Anesthesiology	2.84	2.84
06	Cardiology	1.45	2.53
07	Dermatology	1.00	1.86
08	Family practice	1.79	4.26
10	Gastroenterology	2.05	3.49
11	Internal medicine	2.05	2.48
12	Osteopathic Manipulative Therapy	1.79	4.26
13	Neurology	2.52	2.74
14	Neurosurgery	12.00	12.00
16	Obstretics/Gynecology	2.15	5.63
18	Ophthalmology	1.24	2.31
20	Orthopedic surgery w/o Spinal	8.06	8.06
20	Orthopedic surgery with Spinal	8.89	8.89
22	Pathology	1.72	2.09
24	Plastic Surgery	6.92	6.92

Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
25	Physical Med & Rehab	1.26	1.26
26	Psychiatry	1.11	3.08
28	Colorectal surgery	4.08	4.08
29	Pulmonary disease	2.14	2.14
30	Diagnostic radiology	2.07	2.75
32	Anesthesiologist Assistant	2.84	2.84
33	Thoracic surgery	6.91	6.91
34	Urology	3.30	3.30
35	Chiropractic	1.26	1.26
36	Nuclear medicine	1.66	1.66
37	Pediatric medicine	1.76	2.42
38	Geriatric medicine	1.35	2.17
39	Nephrology	1.51	1.96
40	Hand surgery	4.71	4.71
41	Optometry	1.24	2.31
43	Certified Registered Nurse Assistant	3.04	3.71
44	Infectious disease	1.55	2.09
46	Endocrinology	2.03	2.09
47	Physiological Laboratory (independent)	3.04	3.71
48	Podiatry	3.04	3.71
50	Nurse Practitioner	3.04	3.71
62	Psychologist	1.11	3.08
65	Physical therapist (independent)	1.26	1.26
66	Rheumatology	2.11	2.11
67	Occupational therapist	1.11	1.11
68	Clinical Psychologist	1.11	3.08

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Medicare Code	Medicare Description	Nonsurgical Risk Factor	Surgical Risk Factor
69	Clinical Laboratory	3.04	3.71
70	Multi-Specialty Clinic or Group Practice	3.04	3.71
74	Radiation Therapy Center	2.43	2.43
76	Peripheral Vascular Disease	6.85	6.85
77	Vascular surgery	6.85	6.85
78	Cardiac surgery	7.18	7.18
79	Addiction Medicine	1.11	3.08
80	Licensed Clinical Social Worker	1.11	3.08
81	Critical Care (Intensivists)	3.04	3.71
82	Hematology	1.77	2.26
83	Hematology/oncology	2.05	2.11
84	Preventive medicine	1.26	1.26
85	Maxillofacial Surgery	6.92	6.92
86	Neuropsychiatry	1.11	3.08
89	Certified Clinical Nurse Specialist	3.04	3.71
90	Medical Oncology	2.05	2.48
91	Surgical Oncology	6.13	6.13
92	*Radiation oncology/therapy	2.43	2.43
93	Emergency medicine	3.79	4.55
94	Interventional Radiology	2.07	2.75
96	Optician	1.24	2.31
97	Physician Assistant	3.04	3.71
98	Gynecologist/oncologist	2.15	5.63

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

Note: For specialties with multiple risk classifications depending on the level of surgical involvement, the highest level of surgery was selected for surgery risk factor and the lowest level of surgery was selected for nonsurgery risk factor.

Note: CPT codes 59000-59899 were assigned the obstetrics risk factor (11.30) while all other OB/GYN procedures were assigned the gynecology surgical risk factor.

Comments and Responses

We received public comments on several malpractice issues. The comments and our responses are stated below.

Comment: Several comments were received that requested revisions to the data sources utilized in the development of resource-based malpractice RVUs. Specifically, commenters requested that we remove utilization for assistant-at-surgery claims from the calculation of resource-based malpractice RVUs because the utilization of assistant-at-surgery services artificially lowers the average risk associated with surgical services. Additionally, we also received comments that raised questions related to the ISO crosswalks and resulting risk factors that we used.

Response: We agree that assistants at surgery should not be reflected in the malpractice RVUs because they are not primarily responsible for performing the surgical procedures, and we are removing the assistant-at-surgery utilization, and associated risk factors, from the data that are used to calculate the resource-based malpractice RVUs. The inclusion of the lower assistant-at-surgery risk factors into the overall determination of some complex surgical services artificially lowers the average risk factor and resulting resource-based malpractice RVUs of these services.

Regarding the ISO Classifications and resulting risk factors that were applied to specialties, the majority of comments received did not offer substantive reasons or alternative methodologies for the proposed ISO crosswalks. We derived the ISO crosswalks, and resulting risk factors, based upon the review by both our contractor and CMS medical officers. Due to the lack of substantive alternatives in the comments received, we will retain the crosswalks that were proposed in the August 4, 2004 proposed rule (see Table 7) with the exception of orthopedic surgery and dermatology.

Comment: Several commenters believed that the August 2004 proposed rule that established risk factors of 7.46 for orthopedic surgery with spinal and 8.06 for orthopedic surgery without spinal were counterintuitive and needed revision.

Response: We agree with these comments and have revised the orthopedic surgery with spinal risk factor to reflect the risk factor identified in the rating manuals (8.89). In the proposed rule, the risk factors for orthopedic surgery with spinal and without spinal were taken from two separate sources (premium data and rating manuals, respectively) thus causing the anomalous result. See Table 7 for the revised orthopedic surgery risk factors.

Comment: Two commenters, including the American College of Dermatology believe that the use of the higher risk class of major surgery is inappropriate for dermatological services as the typical dermatological practice does not encompass major surgery but instead focuses on minor surgery in the office setting.

Response: We agree with these comments and will use the minor surgery and no-surgery risk classifications for dermatological services. See Table 7 for the revised dermatology risk factors. The impact of removing the assistant at surgery claims and revising the risk factor associated with orthopedic surgery with spinal is a 0.9 percent increase for neurosurgery and a 0.4 percent increase for orthopedic surgery over the malpractice RVUs shown in proposed rule. The effect of replacing the major surgery risk factor with the minor surgery risk factor for dermatology is a 0.9 percent decrease in total payments relative to the proposed rule.

Comment: One commenter states that the resource-based malpractice RVU methodology underestimates the cost of PLI for physicians who perform obstetric and gynecologic services. According to the commenter, eighty percent of OB/GYNs perform both obstetric and gynecologic services yet the risk factor for most services these physicians provide to Medicare beneficiaries is based on the much lower premiums paid by physicians who offer only gynecologic services.

Response: Although obstetricians and gynecologists' malpractice premiums can be appreciably different, most Medicare OB/GYN services are gynecological. Therefore, all Medicare OB/GYN procedures will be assigned a gynecology risk factor except in those instances where the service provided is clearly obstetrical in nature. CPT codes in the range of 59000–59899 are clearly obstetrical services and use the obstetrics risk factor (11.30).

Comment: One commenter felt that it was inappropriate to assign 0.00 malpractice RVUs to services that have physician work and have historically had a small amount of malpractice RVUs associated with them.

Response: We agree with this comment and will adjust these services in the final rule. All payable fee schedule services have some amount of PLI associated with their performance.

Comment: One commenter requested that we consider the implementation of the resource-based malpractice expense RVUs interim until the agency has worked with the medical community to ensure that the data and methodology utilized to calculate the malpractice RVUs are appropriate.

Response: We are continuing to work with the medical community to ensure that the methodology and data used to calculate the malpractice RVUs appropriately reflect the actual resource costs associated with professional liability insurance for physicians. Section 1848(c)(2)(B)(i) of the Act states that the Secretary is required to review the relative values not less often than every 5 years. If substantive information becomes available subsequent to the publication of the final malpractice RVUs, the statute allows us flexibility to review that information for possible inclusion in future malpractice RVU updates.

Comment: Several commenters requested that we use a methodology that would only account for the dominant specialty in the calculation of the service-specific resource-based malpractice RVUs. Commenters stated that a dominant specialty approach would be consistent with the ''typical'' service approach that we use throughout the resource-based physician payment system. Commenters also feel that a dominant specialty approach would more appropriately reflect the actual premium resource costs associated with the performance of individual services.

Response: We continue to believe that accounting for all specialties that perform a given service is the more appropriate and equitable methodology in establishing resource-based malpractice RVUs. Basing payment upon all specialties that perform a given service ensures that the actual professional liability insurance resource costs of all specialties are included in the calculation of the final malpractice RVUs. Using only the dominant specialty does not capture the true resource costs associated with a given service and under a relative value based system, results in the redistribution of RVUs based upon only partial data.

The dominant specialty approach is particularly vulnerable for calculating resource-based malpractice RVUs in services that are multi-disciplinary in nature. An example that illustrates the potentially distorting effect of the dominant specialty approach on multi-disciplinary services is the specialty utilization associated with a level III established office visit. Although over 35 different specialties perform a significant number of these services, a dominant specialty approach would base the malpractice RVUs on

approximately 2 specialties. High risk specialties such as neurosurgery, thoracic surgery, general surgery, and obstetrics and gynecology, which account for a small percentage of the total utilization but a large amount of total dollars, would no longer factor into the calculation of the malpractice RVU for this service. These four specialties alone account for nearly $300 million of the total dollars associated with a level III established office visit. The effect of removing these four high-cost, high-risk specialties from the calculation of the malpractice RVUs for this service would be an overall decrease in the malpractice RVUs, because the calculation would be based upon lower-cost, lower-risk specialties.

We disagree that a dominant specialty approach is consistent with the typical service approach used in the RUC survey process. Irrespective of the specialty performing a given service, we require that the typical service be the measurement tool for the calculation of final payments. The typical service approach utilized in the RUC survey process has never referred to the typical specialty performing a service, but instead to the typical type of service furnished. This typical service would encompass such things as the condition of the patient, the extent of the work, the staff needed to accomplish the service, and the respective resource inputs associated with the typical service.

We will continue to work with the RUC PLI Workgroup to identify alternatives to the dominant specialty approach. One alternative that we are currently exploring with the RUC PLI Workgroup is removing aberrant data from low utilization services.

Comment: One commenter suggested that we determine the exponential rate of growth in the PLI premium data from 2001 through 2003 to predict the 2004 premium data. This commenter believes that we should use only this predicted 2004 premium data in the calculation of resource-based malpractice RVUs.

Response: We disagree with the commenter's recommendation that predicted 2004 professional liability insurance premium data be utilized in the calculation of resource-based malpractice RVUs. The data sources that are currently used in the calculation of the 2005 resource-based malpractice RVUs consist of actual 2001 and 2002 premium data (when available) and projected 2003 premium data. Professional liability insurance has proven to be the most volatile data source that is used in the calculation of resource-based physician fee schedule RVUs. For this reason, we believe that it is inappropriate to use only one year of projected premium data.

Comment: Various specialty organizations request that we work with the RUC's Professional Liability Insurance (PLI) Workgroup to ensure that the medical community has input into the refinement of the malpractice RVUs.

Response: Over the course of the past year, we have been working with the RUC PLI Workgroup to solicit input on the methodology and data sources utilized to calculate resource-based malpractice RVUs. We continue to actively participate in the PLI Workgroup to keep both the workgroup and the various specialty organizations aware of our progress in the development and refinement of resource-based malpractice RVUs. We have forwarded all requested contractor reports, which outline both our methodology and data sources, to the RUC for review and comment. We agree with these comments and plan to continue our cooperative relationship with the RUC PLI Workgroup and various specialty organizations to ensure that the necessary specialty organizations are involved with both the premium collection efforts and the development and refinement of resource-based malpractice RVUs.

Comment: Tail coverage is designed to cover any claims that may be made against a new employee for services furnished on behalf of his or her old employer during the time that he or she is employed by the new employer. Several commenters suggested that we incorporate the cost of tail coverage in the determination of PLI annual premium data.

Response: Although we agree with the commenters that it might be desirable to use tail coverage premium data in addition to the annual premium data that are currently used in the revisions to resource-based malpractice RVUs, we have been unable to identify a nationally representative source of tail coverage premium data. We are continuing to work with the RUC PLI Workgroup, the AMA, and the various specialty organizations to identify a nationally representative source of tail coverage premium data for future rulemaking.

Comment: One commenter recommended that professional liability insurance data for all specialties should be used rather than the data from the top 20 Medicare specialties.

Response: Although it might be desirable to obtain premium data from every conceivable specialty in the practice of medicine, it is not possible to obtain this scope of data under the time constraints associated with collecting the most current premium data. In order to conduct surveys that collect the maximum amount of premium data from all geographic areas without being too intrusive to the State Departments of Insurance and private insurance companies, we chose to limit the scope of the data collection to the top 20 Medicare specialties. Further, utilizing PLI data from the top 20 Medicare specialties encompasses 80 percent of fee schedule services.

Comment: Several commenters requested that we use data from the Physician Insurers Association of America (PIAA) in the development of resource-based malpractice RVUs. This commenter further requested that we provide concise requirements for those data collection efforts.

Response: We did explore the use of data from PIAA in the development of resource-based malpractice RVUs. Unfortunately, the PIAA does not include actual physician claims-made premium data by insurer and specialty classification. The information that was available from PIAA ranged from insured demographics information to medical malpractice claims trends.

Regarding our criteria for premium data collection efforts, we have shared the criteria for those premium data collection efforts with the RUC PLI Workgroup.

Comment: Several commenters recommended that the malpractice RVUs should remain stable. Commenters suggested that any budget neutrality adjustments, positive or negative, that might occur due to the 5-year review of malpractice RVUs should be made to the conversion factor and not to the malpractice RVUs.

Response: We acknowledge the comments that suggest that any adjustments for budget neutrality not be performed on the RVUs, but we note that any budget neutrality adjustments to the RVUs do not change the relative relationship among the values for the services but instead uniformly change all relative values. Regarding malpractice RVUs specifically, malpractice RVUs are by nature not ''stable.'' When the malpractice RVUs are reviewed and updated, the malpractice RVUs associated with all services could potentially change. Additionally, for 2005, we are mandated by statute to apply at least a 1.5 percent increase to the conversion factor. Thus, if the budget neutrality associated with updated malpractice RVUs were negative, it would not be possible to ensure budget neutrality and comply with the statutory 1.5 percent update.

Comment: One commenter recommended that the exceptions to the surgical risk factor be modified to include coding changes since the initiation of the resource-based malpractice RVUs in 2000. The previous update to the malpractice RVUs made service-specific exceptions, whereby certain codes were assigned the higher surgical risk factor in the calculation of their final malpractice RVU. The commenter specifically requested that due to CPT coding modifications, the following codes should also receive this same coding modification and receive the greater of their actual average risk factor or the risk factor for cardiac catheterization: 92973–92974, 93501–93533, 93580–93581, 93600–93613, and 93650–93652.

Response: In order to retain the exceptions that were identified in the previous malpractice RVU update for this new series of services, we will assign the greater of the actual average risk factors or the risk factor for cardiac catheterization services.

Comment: Several commenters agreed with our use of the work RVUs as the best available data source for adjusting the malpractice RVUs for risk of service. These commenters noted, as we did, that the work RVUs are not a perfect proxy for risk of service, but are the best available source at this time. Commenters requested that we continue our use of work RVUs as the adjuster to malpractice RVUs for risk of service, but also requested that we be responsive to potential anomalies that may be identified.

Response: We agree with these comments and look forward to continuing our work with the various organizations to identify all potential anomalies in the malpractice RVUs.

Comment: One commenter expressed concern that, although malpractice premiums have increased for all specialty practices, some specialty practices will experience a decline in payments as a result of the 5-Year Review of malpractice RVUs. This commenter suggested that additional dollars need to be added to the system to account for rising PLI costs.

Response: The impact of the malpractice RVU revisions on an individual specialty organization is not a direct reflection of the increases or decreases in their malpractice premiums but instead reflects increases or decreases in a specific state's premiums as compared to the national average. In some instances, specialty organizations might have experienced slight increases in their respective malpractice premiums since the last malpractice RVU update, but these increases have occurred at a slower rate than the national average increase for all specialty organizations. The result is a negative impact on these specialties. Specialty organizations that have increased at a rate higher than the national average will experience positive impacts.

Comment: One commenter believes that additional dollars should be added to the Medicare physician fee schedule to account for escalating professional liability insurance premiums.

Response: The Medicare Economic Index (MEI) is the device by which additional dollars are added to the physician fee schedule. For 2005, the cost category associated with professional liability insurance has increased by 23.9 percent. However, for 2004 and 2005, section 601 of the MMA established an update of 1.5 percent.

Comment: The American College of Radiology (ACR) commented that there is an imbalance between the distribution of malpractice RVUs to the professional component and technical component of a service. The ACR requested that we work with ACR staff to identify alternative methodologies for the more appropriate valuation of technical component services.

Response: Physician work RVUs are used to adjust for risk of service. Because technical component services do not have physician work RVUs, they are still valued using charge-based RVUs instead of the resource-based malpractice RVU methodology. We look forward to working with the ACR and other interested specialty organizations to examine alternative methodologies that would allow technical component services to also reflect resource-based malpractice RVUs.

Final Decision

We are implementing the revised 2005 malpractice RVUs as proposed with the modifications noted in the discussions above. Additionally, we are continuing to work with the AMA's RUC to—

- Consider the appropriateness of a dominant specialty approach;
- Identify the most current nationally representative professional liability insurance premium data;
- Review the current ISO crosswalks; and
- Review aberrant data patterns in low-utilization services for possible inclusion in a future rulemaking cycle.

D. Coding Issues

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

This code was included in the November 2, 1999 physician fee schedule final rule (64 FR 59380) and was effective for services beginning January 1, 2000. In that rule, and subsequent rules, we have applied a global indicator of ''xxx'' to this code, meaning that the global concept does not apply. It was brought to our attention that this global indicator is incorrect and that the code should be assigned a 90-day global period because the RUC valuation of this service reflected a global period of 90 days which we had accepted. Therefore, we proposed to correct the global indicator for this service to reflect a global period of 90 days (090).

Comment: Specialty organizations representing radiation oncology and radiology as well as individual physicians and providers, and the AMA, all expressed concern about this proposal to change the global period for CPT code 77427. The commenters stated that this code is universally recognized as a recurring service that can be provided multiple times during a course of radiation. This code is usually submitted once for each group of five treatments (or fractions) and represents substantial services furnished during that group (typically 1 week) of five treatments. Commenters believe this proposed change would—

- Contradict the current CPT definitions;
- Not reflect the process of care for radiation;
- Countervene the essence of the RUC valuations; and
- Negate the guidelines that we previously issued.

Because a change in the global period could have a significant impact on the process of care for radiation oncology, commenters urged us to withdraw this proposal or to delay implementation until there is further discussion with the specialty organizations and the RUC, and clarification of billing matters related to this proposed change are provided.

Response: Based on the concerns raised by the commenters, we are not changing the global period for this service as proposed.

Result of Evaluation of Comments

We are retaining the global period of ''xxx'' for CPT code 77427.

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

As discussed in the proposed rule (69 FR 47510), section 1834(m) of the Act defines telehealth services as professional consultations, office and other outpatient visits, and office psychiatry services defined as of July 1, 2000 by CPT codes 99241 through 99275, 99201 through 99215, 90804 through 90809, and 90862. In addition, the statute requires us to establish a process for adding services to, or deleting services from, the list of telehealth services on an annual basis. In the CY 2003 final rule, we established a process for adding to or deleting services from the list of Medicare telehealth services (67 FR 79988). This process provides the public an opportunity on an ongoing basis to submit requests for adding a service. We assign any request to add a service to the list of Medicare telehealth services to one of the following categories:

• *Category 1:* Services that are similar to office and other outpatient visits, consultation, and office psychiatry services. In reviewing these requests, we look for similarities between the proposed and existing telehealth services in terms of the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. We also look for similarities in the telecommunications system used to deliver the proposed service, for example, the use of interactive audio and video equipment.

• *Category 2:* Services that are not similar to the current list of telehealth services. Our review of these requests includes an assessment of whether the use of a telecommunications system to deliver the service produces similar diagnostic findings or therapeutic interventions as compared with the face-to-face ''hands on'' delivery of the same service. Requestors should submit evidence showing that the use of a telecommunications system does not affect the diagnosis or treatment plan as compared to a face-to-face delivery of the requested service.

Requests for adding services to the list of Medicare telehealth services must be submitted and received no later than December 31st of each calendar year to be considered for the next proposed rule. For example, requests submitted in CY 2003 are considered for the CY 2005 proposed rule. For more information on submitting a request for addition to the list of Medicare telehealth services, visit our Web site at *http://www.cms.hhs.gov/physicians/telehealth*.

We received the following public requests for addition in CY 2003:

• Inpatient hospital care (as represented by CPT codes 99221 through 99223 and 99231 through 99233).

• Emergency department visits (as defined by CPT codes 99281 through 99285).

• Hospital observation services (as represented by CPT codes 99217, 99218 through 99220).

• Inpatient psychotherapy (as defined by CPT codes 90816 through 90822).

• Monthly management of patients with end-stage renal disease (ESRD), (as represented by HCPCS codes G0308 through G0319).

• Speech and audiologist services (as defined by CPT code range 92541 through 92596).

• Case management (as identified by CPT codes 99361 and 99362)

• Care plan oversight services (as represented by CPT codes 99374 and 99375).

After reviewing the public requests for addition, we proposed to add ESRD–related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 to the list of Medicare telehealth services. However, we specified that the required clinical examination of the vascular access site must be furnished face-to-face ''hands on'' (without the use of an interactive telecommunications system) by a physician, certified nurse specialist (CNS), nurse practitioner (NP), or physician's assistant (PA). An interactive telecommunications system may be used for providing additional visits required under the 2 to 3 visit Monthly Capitation Payment (MCP) code and the 4 or more visit MCP code.

Moreover, we proposed to add the term ''ESRD–related visits'' to the definition of Medicare telehealth services at § 410.78 and § 414.65 as appropriate.

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

For further information on the addition to the list of telehealth services, see the **Federal Register** dated August 5, 2004 (69 FR 47510).

Inpatient Hospital Care, Hospital Observation Services, Inpatient Psychotherapy, and Emergency Department Services

Comment: We received conflicting comments on our proposal not to add inpatient hospital care, hospital observation services, inpatient psychotherapy, and emergency department services to the list of approved telehealth services. For example, one professional society supported our proposal not to add inpatient hospital care, hospital observation services, inpatient psychotherapy, and emergency department services to the list. That commenter believes conclusive efficacy data is necessary before adding the aforementioned services. Likewise, an association representing emergency department management agreed that emergency department visits should not be added to the list of Medicare telehealth services. That commenter believes that hospitals in rural areas have physicians with sufficient experience to handle the complexities of emergent care.

An association representing family physicians agreed with our proposal not to add inpatient hospital care and hospital observation services. However, they disagreed with our proposal not to add emergency department visits to the list of Medicare telehealth services. The commenter stated that emergency department visits should not be assigned to category 2 based on the acuity of the patient. The commenter believes that the range of potential acuity is the same in the emergency room as it is in the office setting and noted that office and other outpatient visits are currently on the list of Medicare telehealth services. A professional society encouraged us to reexamine the request to add inpatient hospital care, observation services, and inpatient psychotherapy to the list of Medicare telehealth services in the future.

Response: We agree that the acuity for some patients may be the same in the emergency department as in a physician's office. However, we also believe that more acutely ill patients are more likely to be seen in the emergency department. Although telehealth is an acceptable alternative to face-to-face ''hands on'' patient care in certain settings, the potential for misdiagnosis and/or mismanagement, with more serious consequences, exists in high acuity environments like the emergency department when telehealth is used as a replacement for an onsite physician or practitioner. The practice of emergency medicine often requires frequent patient reassessments, rapid physician interventions, and sometimes the continuous physician interaction with ancillary staff and consultants. We do not have evidence suggesting the use of telehealth could be a reasonable surrogate service for this type of care. In the absence of sufficient evidence that illustrates that the use of a telecommunications system produces

similar diagnoses or therapeutic interventions as would the face-to-face delivery of inpatient hospital care, emergency department visits, hospital observation services, and inpatient psychotherapy, we do not plan to add these services to the list of approved telehealth services. As discussed in the proposed rule, we believe that the current list of Medicare telehealth services is appropriate for hospital inpatients, emergency room cases, and patients designated as observation status. If guidance or advice is needed in these settings, a consultation may be requested from an appropriate source.

Comment: A telehealth association and a telehealth network requested that we clarify what consultation codes could be used for hospital inpatients, emergency room cases, and patients designated as observation status.

Response: The appropriate consultation code depends on the admission status of the beneficiary. When the beneficiary is an inpatient of a hospital, the physician or practitioner at the distant site bills an initial or follow-up inpatient consultation as described by CPT codes 99251 through 99263. For the hospital observation setting and emergency department, the appropriate office or other outpatient consultation code is CPT codes 99241 through 99245.

Comment: Some commenters believe that hospital inpatient care, inpatient psychotherapy, observation services, and emergency department visits should all be assigned to category 1 because they are clinically the same as a consultation. Moreover, the commenters expressed their opinion that a telecommunications system would not substitute for an in-person practitioner for the requested hospital services.

Response: We agree that the key components of a consultation are similar to inpatient hospital care, observation services, and emergency department visits. However, a consultation service is distinguished from the requested hospital services because it is provided by a physician or practitioner whose opinion or advice regarding evaluation and management of a specific problem is requested by another physician or appropriate source. The ongoing management of the patient's condition remains the responsibility of the practitioner who requested the consultation. As discussed in our response to another comment, a consultation may be provided as a Medicare telehealth service for hospital inpatients, emergency room cases, and patients designated in observation status.

In furnishing a consultation as a telehealth service, the physician at the distant site provides additional expertise, to ensure optimal patient outcomes. For consultation services, a practitioner is available to manage the patient at the originating site. However, adding the requested hospital services would permit a telecommunications system to be used as a substitute for an onsite practitioner because the physician or practitioner at the distant site assumes responsibility for the ongoing management of the patient's condition.

End Stage Renal Disease—Monthly Management of Patients on Dialysis

Comment: Many commenters, including a telehealth association, a nephrology nurses association, a renal physicians association, a health system, a community hospital, a telemedicine law group, and others applauded our proposal to add the ESRD-related services with 2 or 3 visits per month and ESRD-related services with 4 or more visits per month to the list of Medicare telehealth services. For example, two commenters believe that adding these services will help provide dialysis patients living in rural areas sufficient access to nephrology specialists and will save both patients and practitioners a significant amount of travel time. Additionally, many commenters expressed strong support for not permitting the visit that includes a clinical examination of the vascular access site to be added to the list of Medicare telehealth services and agreed that this exam should be furnished in person.

Response: We agree with the comments.

Comment: With regard to furnishing ESRD-related visits under the MCP, a nephrology association suggested that we permit the use of e-mail and telephone conferencing for one year. The commenter believes this grace period would enable physicians and originating sites to acquire the necessary technology and execute their implementation plans. Additionally, an association of kidney patients questioned whether telehealth services would be available to ESRD patients in non-rural areas.

Response: Services added to the list of Medicare telehealth services are subject to the requirements and conditions of payment in the law and regulations. Under the Medicare telehealth provision, the use of an interactive audio and video telecommunications system that permits real-time interaction between the patient, physician or practitioner at the distant site, and telepresenter (if necessary) is a substitution for the face-to-face requirements under Medicare. Electronic mail systems and telephone calls are specifically excluded from the definition of an interactive telecommunications system. Moreover, we do not have the legislative authority to expand the geographic areas where telehealth services may be furnished. Telehealth services may only be furnished in non-Metropolitan Statistical Area counties or rural health professional shortage areas.

Comment: An association representing kidney patients questioned whether we plan to evaluate the provision of telehealth services to ESRD patients to determine best practices.

Response: We believe that most physicians and practitioners will use telehealth services for providing additional visits required under the MCP as appropriate to manage their patients on dialysis. However, we would welcome specific data on best practice methods for furnishing ESRD-related services as telehealth services.

Comment: Some commenters indicated a belief that the ESRD-related services were assigned to category 2 for review. For example, one telehealth group believed that a discrepancy exists between the rationale we used to add ESRD-related services to the list of telehealth services and our decision not to add inpatient hospital care, observation services, inpatient psychotherapy, and emergency department visits. The commenter stated that ESRD-related services were added in the absence of randomized clinical trials or comparison studies and mentioned that the same level of evidence was submitted for ESRD-related services as for other requests (for example, inpatient hospital services). The commenter requested clarification on the method used to assign services to category 1 or category 2.

Response: As discussed in the proposed rule, the MCP represents a range of services provided during the month, including various physician and practitioner services, such as the establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visit(s), telephone calls, and patient management as well as clinically appropriate physician or practitioner visit(s) during the month. At least one of the visits must include a clinical examination of the vascular access site furnished face-to-face, ''hands-on'' by a physician, CNS, NP, or PA.

We considered the outpatient evaluation and management of the dialysis visits to be similar to an office

visit and other outpatient visits currently on the list of Medicare telehealth services. However, we believe that the clinical examination of the vascular access site is not similar to the existing telehealth services, and, therefore, it meets the criteria for a category 2 request. We did not propose to add a comprehensive visit including a clinical examination of the vascular access site, to the list of Medicare telehealth services because the requestor did not provide comparative analyses illustrating that the use of a telecommunications system is an adequate substitute for a face-to-face clinical examination of the vascular access site. However, as discussed in the proposed rule, we do believe that the subsequent visits to monitor the patient's condition met our criteria for approving a category 1 request. For category 1 services, we look for similarities between the proposed and existing telehealth services in terms of the roles of, and interactions among, the beneficiary, the physician or practitioner at the distant site, and, if necessary, the telepresenter.

Therefore, we proposed that the MCP physician, that is, the physician or practitioner responsible for the evaluation and management of the patient's ESRD, and other practitioners within the same group practice or employed by the same employer or entity, may furnish additional ESRD-related visits as telehealth services using an interactive audio and video telecommunications system. However, for purposes of billing the MCP, at least one visit must include a clinical examination of the vascular access site, and must be furnished face-to-face, ''hands on'' by a physician, CNS, NP, or PA each month.

Comment: One commenter requested that we allow a physician or surgeon located at the originating site (who is not the MCP physician) to furnish ESRD-related visits involving the clinical examination of the vascular access site. The commenter stated that having a physician or surgeon skilled in vascular access management available to work in coordination with the MCP physician is necessary for geographically remote areas such as Alaska and in severe weather conditions. The commenter believes that this type of arrangement is well suited for telehealth.

Response: The MCP physician may use another physician to provide some of the visits during the month however, the non-MCP physician must have a relationship with the billing physician such as a partner, employees of the same group practice or an employee of the MCP physician, for example, the physician at the originating site is either a W–2 employee or 1099 independent contractor.

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

A telehealth association and a network of clinics requested clarification on—

- The scope of authority relating to the addition of services that do not require a face-to-face encounter with the patient; and
- Whether our policy for care plan oversight is similar to the interpretation of an x-ray and other services that do not require a face-to-face encounter.

Additionally, a neurological society urged us to reconsider our decision not to add medical team conferences to the list of telehealth services. The commenter argued that adding medical team conferences as a telehealth service would improve the quality of the care plan and save time for all physicians involved in the patient's care.

Response: We add services to the list of Medicare telehealth services that traditionally require a face-to-face physician or practitioner encounter. The use of an interactive audio and video telecommunications system, permitting real time interaction between the beneficiary, physician or practitioner at the distant site, and telepresenter (if necessary) is a substitute for face-to-face requirements under Medicare. Services not requiring a face-to-face encounter with the patient that may be furnished through the use of a telecommunications system are already covered under Medicare. As discussed in chapter 15, section 30 of the Medicare Benefit Policy Manual, payment may be made for physicians' services delivered via a telecommunications system for services that do not require a face-to-face patient encounter. The interpretation of an x-ray, electrocardiogram, electroencephalogram and tissue samples are listed as examples of these services. The Medicare Benefit Policy Manual may be found on our Web site at *http://www.cms.hhs.gov/manuals/* by selecting the internet-only manuals link.

Medical team conferences and monthly physician supervision do not require a face-to-face encounter with the patient, and, thus, a telecommunications system may be used to accomplish them. However, Medicare payment for CPT codes 99361, 99362, and 99374 are bundled; no separate payment is made under the Medicare program for these services, and CPT code 99375 (physician supervision; 30 minutes or more) is invalid for Medicare payment purposes. We pay for monthly physician supervision as described by HCPCS codes G0181 and G0182.

Process for Adding Services to the List of Medicare Telehealth Services

Comment: We received conflicting comments on our process for adding services to the list of Medicare telehealth services. For example, a surgeons' association supported the evidence-based approach for adding category 2 services. However, a school of medicine and a telemedicine and electronic health group believe that we should consider changing our categorical system for adding a service to the list of Medicare telehealth services, specifically, in relation to the requested hospital services for hospital inpatients, emergency room cases, and patients designated as observation status.

One of the commenters believes that the decision to use a telehealth system should be up to the physician or practitioner at the distant site. The commenter argues that, if the physician or practitioner at the distant site is not comfortable in making a clinical judgment, the patient may be asked to travel to the physician's office for further examination.

Moreover, the commenter contends that the nature of telehealth services is not well suited for clinical trials and that the evidence that we require under category 2 may never be obtained because of the lack of reimbursement. As an alternative, the commenters recommended a method of review that considers—

- Clinical utilization of the requested telehealth service;
- The opinions of physicians and practitioners furnishing the telehealth service; and
- The opportunity for the physicians and practitioners to prove the service is being delivered appropriately via telecommunications system.

Response: We believe that the current method for reviewing requests for addition already considers the criteria mentioned by the commenter. The process for adding services to the list of Medicare telehealth services provides the public an ongoing opportunity to propose services that they believe are appropriate for Medicare payment. Requestors may submit data showing that patients who receive the requested service via telecommunications system are satisfied with the service delivered and that the use of a telecommunications system does not change the diagnosis or therapeutic

interventions for the requested service. Additionally, we believe that having different categories of review allows us to add requested services that are most like the current telehealth services (for example, office visits, consultation, and office psychiatry) without subjecting these requests to a comparative analysis.

Since establishing the process to add services to the list of Medicare telehealth services, we have added the psychiatric diagnostic interview examination and have proposed specific ESRD-related services for the CY 2005 rule.

Comment: One commenter recommended that we replace the term face-to-face with ''in-person''. The commenter believes that the term ''in-person'' is a better description of an encounter where the practitioner is in the same physical location as the beneficiary.

Response: The commenter's suggestion to use the term ''in-person'' to describe an encounter where the physician or practitioner and the beneficiary are physically in the same room has been noted. We will consider the commenter's suggestion as we discuss Medicare telehealth payment policy in the future.

Report to Congress

Comment: An audiology society and a language and hearing association strongly believe that most audiology services and speech therapy can be furnished remotely as telehealth services. To that end, many commenting groups and associations requested that we complete the report to Congress (as required by section 223(d) of the BIPA) and urged us to recommend adding speech language pathologists and audiologists as medical professionals that may provide and receive payment for Medicare telehealth services.

Moreover, in light of the proposed addition of ESRD-related services to the list of telehealth services, many of these same commenters along with a nephrology society requested that we recommend adding dialysis facilities to the list of originating sites. One commenter requested that we add the patient's home to the definition of an originating site.

Response: The report to Congress on additional sites and settings, practitioners, and geographic areas that may be appropriate for Medicare telehealth payment is under development. We are considering the suggestions raised by the commenters as we formulate our recommendations to the Congress.

Result of Evaluation of Comments

We are adding ESRD-related services as described by G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318 to the list of Medicare telehealth services. However, we will require that the complete assessment must include a face-to-face clinical examination of the vascular access site furnished ''hands on'' (without the use of an interactive telecommunications system) by a physician, clinical nurse specialist, nurse practitioner, or physician's assistant. An interactive telecommunications system may be used for providing additional visits required under the 2 to 3 visit MCP code and the 4 or more visit MCP code. Additionally, we are adding the term ''ESRD–related visits'' to the definition of Medicare telehealth services at § 410.78 and § 414.65, as appropriate.

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

In the 2001 final rule, we created the following three G codes for respiratory therapy services:

- G0237 Therapeutic procedures to increase strength or endurance of respiratory muscles, face-to-face, one-on-one, each 15 minutes (includes monitoring).
- G0238 Therapeutic procedures to improve respiratory function, other than ones described by G0237, one-on-one, face-to-face, per 15 minutes (includes monitoring).
- G0239 Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring).

We assigned RVUs to one of the codes (G0237), and indicated that the other two codes (G0238 and G0239) would be carrier-priced. Since the services represented by these codes are frequently being performed in comprehensive outpatient rehabilitation facilities (CORFs), paid under the physician fee schedule through fiscal intermediaries, there has been some uncertainty surrounding the payment for the carrier-priced services. We believe assigning RVUs to G0238 and G0239 will provide needed clarity. Since these services are typically performed by respiratory therapists, we did not assign physician work to G0237, and we did not propose work RVUs for either G0238 or G0239.

Therefore, we proposed to value nationally the practice expense for these services using the nonphysician work pool. We proposed to crosswalk practice expense RVUs for G0238 to those for G0237 based on our belief that the practice expense for the activities involved is substantially the same for both services.

For G0239, we believe a typical group session to be 30 minutes in length and to consist of 3 patients. Therefore, for the practice expense RVUs for G0239, we proposed using the practice expense RVUs of G0237 reduced by one-third to account for the fact that the service is being provided to more than one patient simultaneously and each patient in a group can be billed for the services of G0329.

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

Comment: Commenters supported the national pricing for these 2 G–codes, G0238 and G0239. However, these organizations disagree with our RVU assignment. Specifically, most commenters disagreed with the lack of physician work RVUs and also believed that the malpractice RVU is inadequate to reflect the costs associated with the delivery of the services. These organizations contend that pulmonary rehabilitation services ''include a physician-directed individualized plan of care using multidisciplinary qualified health professionals to enhance the effective management of pulmonary diseases and resultant functional deficits.'' They believe that beneficiaries may receive pulmonary rehabilitation services at physician offices, outpatient departments of acute care hospitals, CORFs and rehabilitation clinics. The commenters noted that physicians and qualified nurse practitioners (NPs) and PAs order, supervise, and approve the plans of care for patients receiving respiratory therapy services, irrespective of the delivery setting.

Because respiratory rehabilitation is often furnished in a physician office, these organizations believe the malpractice RVU assigned is inadequate to account for the physician involvement and requested that a more appropriate risk factor be used.

Response: Because we believe that respiratory therapists (RTs) typically deliver these services, it would be inappropriate to assign a physician work RVU to these services. The malpractice RVU of 0.02 is similar to RVUs of therapeutic procedures delivered by physical and occupational therapists for similar services, including procedures performed one-on-one and in groups. We believe that the 0.02 malpractice RVU fairly represents the risk value inherent in the provision of these procedures. However, because the commenters expressed concerns about work and malpractice RVUs, we are assigning these RVUs on an interim

basis, and we are requesting that the RUC or HCPAC consider this series of three G–codes at an upcoming meeting.

Because RTs cannot directly bill Medicare for their services, these G-codes can only be billed as incident to services in physician offices and outpatient hospital departments or as CORF services. When performed in the CORF setting, these services must be delivered by qualified personnel, that is, RTs and respiratory therapy technicians, as defined at § 485.70. The CORF benefit requires the physician to establish the respiratory therapy plan of care and mandates a 60-day recertification for therapy plans of care, including physical therapy (PT), occupational therapy (OT), speech language pathology (SLP), and respiratory therapy. As we stated in the December 31, 2002 final rule, we believe that specially trained professionals (that is, registered nurses, physical therapists and occupational therapists) can also provide these services.

These respiratory therapy G-codes were designed to provide more specific information about the medically necessary services being provided to improve respiratory function and to substitute for the physical medicine series of CPT codes 97000 through 97799, except when services are furnished and meet all the requirements for physical and occupational therapy services.

Comment: While three commenters voiced concerns about the significant undervaluing of these codes, one commenter noted that the practice expense RVUs fail to recognize the intensity of services and the cost of monitoring and other equipment associated with providing these services.

Response: We agree that the practice expenses, particularly the equipment, for G0237 and G0238 are not equivalent and that there are more resources required to provide the medically necessary services of G0238. The necessary monitoring equipment referenced by commenters were considered at the time G0327 was originally valued. The appropriate direct inputs will be added to the practice expense database. However, we identified the omission of therapeutic exercise equipment for G0238 and G0239 and we will also add this to the practice expense database.

Result of Evaluation of Comments

We are assigning practice expense and malpractice RVUs to G0238 and G0239 and will add the additional items to the practice expense database. These codes are being valued in the nonphysician work pool as proposed. We will also ask the RUC or HCPAC to consider these codes.

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

In the August 5, 2004 rule, we proposed a new add-on G-code, G0364 (proposed as G0XX1): Bone marrow aspiration performed with bone marrow biopsy through same incision on same date of service. The physician would use the CPT code for bone marrow biopsy (38221) and G0364 for the second procedure (bone marrow aspiration).

We believe that there is minimal incremental work associated with performing the second procedure through the same incision during a single encounter. We estimated that the time associated with this G-code is approximately 5 minutes based on a comparison to CPT code 38220 bone marrow aspiration which has 34 minutes of intraservice time and a work RVU of 1.08 work when performed on its own. We proposed 0.16 work RVUs for this new add-on G-code and malpractice RVUs of 0.04 (current malpractice RVUs assigned to CPT code 38220). For practice expense, we proposed the following practice expense inputs:

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

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

In the August 5, 2004 proposed rule, we also stated that if the two procedures, aspiration and biopsy, are performed at different sites (for example, contralateral iliac crests, sternum/iliac crest or two separate incisions on the same iliac crest), the −59 modifier, which denotes a distinct procedural service, is appropriate to use and Medicare's multiple procedure rule will apply. In this instance, the CPT codes for aspiration and biopsy are each being used.

Comment: Many commenters supported creation of this G-code; however, all commenters stated that the time for this procedure (5 minutes) was substantially underestimated. Commenters recommended increasing the added incremental time associated with the aspiration to 15 minutes. One commenter noted that this time is needed for the actual aspiration procedure, approving the quality of the aspiration, collecting flow cytometry and chromosome studies, preparing additional slides, ordering appropriate lab tests on the slides, and performing the added recordkeeping and documentation. Another commenter provided a detailed description of the activities involved in this procedure. Commenters also recommended that the practice expense input for the nurse assisting with the procedure should be increased to 15 minutes.

Response: We continue to believe that the proposed 5 minutes of physician time, 5 minutes of registered nurse time, and 2 minutes of lab technician time reflect the additional effort involved when a bone marrow aspiration is performed in conjunction with a bone marrow biopsy through the same incision during a single encounter. It is our understanding that some of the activities attributed to the additional 15 minutes of physician work generally are performed by ancillary staff, for example, preparing slides. While we appreciate the information provided, we believe that the majority of the effort and specific tasks discussed are accounted for in the CPT code for bone marrow biopsy (38221) which is the primary code being billed.

Comment: Two physician specialty societies, representing radiologists and interventional radiologists, questioned the need for the proposed code, because the multiple surgical discount rule that reduces payment for a subsequent lower valued service applies, thereby taking into account any savings in physician work. If we choose to proceed with the proposal, the commenter recommended the RVUs be consistent with those determined using the current values for CPT codes 38220 and 38221 and the multiple surgical discount rule.

Response: One of the primary reasons for our proposal for this G-code was that we believe that, even with the application of the multiple procedure reduction, we would be overpaying for these services when they are performed on the same day, at the same encounter and using the same incision.

Result Of Evaluation of Comments

We are finalizing our proposal and using new G-code G0364, Bone marrow aspiration performed with bone marrow biopsy through the same incision on the same date of service. Payment is based on the work and malpractice RVUs and practice expense inputs proposed and the global period for this service is ''ZZZ''.

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

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

As discussed in the August 5, 2004 proposed rule, the Conference Report accompanying the Consolidated Appropriations Bill, H.R. 2673, (Pub. L. 108–199, enacted January 23, 2004) urged the Secretary to review payment for this code, and the portable x-ray industry has also requested that we reexamine payments for this code.

Q0092 is currently priced in the nonphysician work pool. At the time we modeled this change for the proposed rule, removing this code from the nonphysician work pool had an overall negative impact on payments to portable x-ray suppliers (as a result of decreases to radiology codes that remain in the nonphysician work pool) and a negative impact on many of the codes remaining in the nonphysician work pool. An alternative to national pricing of portable x-ray set-up would be to require Medicare carriers to develop local pricing as they do currently for portable x-ray transportation. We requested comments on whether we should pursue national pricing for portable x-ray set-up outside of the nonphysician work pool or local carrier pricing for 2005, or whether we should continue to price the service in the nonphysician work pool.

Comment: Most commenters recommended removing portable x-ray from the nonphysician work pool, using the ''existing data'' from the American College of Radiology (ACR) supplemental practice expense survey as the practice expense per hour proxy. However, the National Association of Portable X-Ray Suppliers (NAPXP) requested additional time to review information they received from us just 3 days before the close of the comment period. This association requested that they be allowed to submit supplemental comments.

Response: ACR requested that we delay incorporating their survey data for 1 year. Using the data for one code, as proposed by commenters, would be inconsistent with that request. We believe it is inappropriate to use the new survey data for this code but no other code. Even if we removed the set-up code from the nonphysician work pool and calculated its practice expense RVU using the ACR data, the increase in payment for the portable x-ray set-up code would be largely offset by lower payment for x-ray services. Payments for other services in the nonphysician work pool would also decline affecting other specialties, such as radiology, radiation oncology, cardiology, allergy, audiology and others. Further, the portable x-ray set-up code is yet to be refined, and we believe that the 45 minutes of staff time that is used to determine its value is likely overstated. We believe it is preferable to address refinement of the code and pricing the service outside of the nonphysician work pool together. Therefore, in 2005, we are continuing to price this service within the nonphysician work pool.

The NAPXP requested more time to review the data we supplied them. NAPXP's comment implying that we withheld ''data'' from them is simply wrong. In an effort to explain the theoretical reasons for our statements that removing this service from the nonphysician work pool could lower overall payments to portable x-ray suppliers, we prepared an illustration for another association as a follow-up request after a meeting, where we were asked to explain our proposed rule analysis. The explanation contained no new data. Moreover, we provided the explanatory information to NAPXP as soon as they requested it. Since the information NAPXP complains about was illustrative only, we do not believe NAPXP has been prejudiced in any way. Moreover, we are willing to explain the information to NAPXP and to consider any comments they may have as we consider changes to the practice expense methodology for 2006.

6. Venous Mapping for Hemodialysis

In the August 5, 2004 rule, we proposed a new G-code (G0XX3: Venous mapping for hemodialysis access placement (Service to be performed by operating surgeon for preoperative venous mapping prior to creation of a hemodialysis access conduit using an autogenous graft). Autogenous grafts have longer patency rates, a lower incidence of infection and greater durability than prosthetic grafts. Use of autogenous grafts can also result in a decrease in hospitalizations and morbidity related to vascular access complications. We stated that creation of this G-code will enable us to distinguish between CPT code 93971 (Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study) and G0XX3 in order to allow us to track use of venous mapping for quality improvement purposes.

We also proposed that this G-code be billed only by the operating surgeon in conjunction with CPT codes 36819, 36821, 36825, and 36832 and that we would not permit payment for CPT code 93971 when this G-code is billed, unless code CPT 93971 was being performed for a separately identifiable clinical indication in a different anatomic region.

We proposed to crosswalk the RVUs for the new G-code from those of CPT code 93971 and also assigned this new G-code a global period of ''XXX,'' which means that the global concept does not apply.

Comment: Commenters representing specialty societies and individual providers were generally supportive of the proposal for this new code, but expressed the following three primary concerns:

- Commenters did not agree with restricting this code to the operating surgeon, stating that such a restriction could limit access and serve as a barrier in providing this service. They also stated that this proposed restriction is not reflective of current practice, since nonsurgeons often perform this procedure.
- Commenters did not agree with the proposed descriptor. They indicated that the proposed descriptor did not reflect the procedure as it is now performed and suggested (a) alternate wording, such as ''vascular mapping,'' ''autogenous AV fistula,'' and ''prosthetic graft,'' ''vessel mapping;'' (b) that two G-codes should be created to distinguish between a complete bilateral and unilateral or limited studies. Other commenters noted that the proposal did not distinguish between mapping by venography or ultrasound (duplex), and some commenters suggested creating an additional G-code to distinguish between these procedures.
- Commenters stated that the comparison to CPT code 93971 in the proposed rule undervalues the service. While there are differences, the closer analogue in terms of time and resources required is CPT code 93990, Duplex scans of hemodialysis access.

Response: We proposed the G-code to create the opportunity for us to analyze

the relationship between venous mapping utilization and fistula formation.

Based on the comments we received, we are revising the code descriptor to enable clinicians, other than the operating surgeon, who provide care to ESRD patients the opportunity to bill for this service.

We believe that vessel mapping requires the assessment of the arterial and venous vessels in order to provide the information necessary for the creation of an autogenous conduit. Therefore, we are also revising payment for this code and will crosswalk it to CPT code 93990 for work, malpractice, and practice expense RVUs because these RVUs more appropriately reflect the work and resources of this new G-code. The G-code and descriptor for this service will be G0365, Vessel mapping of vessels for hemodialysis access (Services for preoperative vessel mapping prior to creation of hemodialysis access using an autogenous hemodialysis conduit, including arterial inflow and venous outflow). This code can only be used in patients who have not had a prior hemodialysis access prosthetic graft or autogenous fistula and is limited to two times per year.

We will not permit separate payment for CPT code 93971 when this G-code is billed, unless CPT code 93971 is being performed for a separately identifiable indication in a different anatomic region. We also note that other imaging studies may not be billed for the same site on the same date of service unless an appropriate ''KO'' modifier indicating the reason or need for the second imaging study is provided on the claim form.

We will follow the utilization closely this year to better understand whether this code is used as intended.

III. Provisions Related to the Medicare Modernization Act of 2003

A. Section 611—Preventive Physical Examination

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

In the August 5, 2004 proposed rule, we described a new § 410.16 (Initial preventive physical examination: conditions for and limitations on coverage) that would provide for coverage of the various IPPE services specified in the statute. As provided in the statute, this new coverage allows payment for one IPPE within the first 6 months after the effective date of the beneficiary's first Part B coverage period, but only if that coverage period begins on or after January 1, 2005. To implement the statutory provisions, we proposed definitions of the following terms:

- Eligible beneficiary;
- An initial preventive physical examination;
- Medical history;
- Physician;
- Qualified NPP;
- Social History, and
- Review of the individual's functional ability and level of safety.

In keeping with the language of section 611 of the MMA, we defined the term ''eligible beneficiary'' to mean individuals who receive their IPPEs within 6 months after the date of their first Medicare Part B coverage period, but only if their first Part B coverage period begins on or after January 1, 2005. This section also defines the term ''Initial Preventive Physical Examination'' to mean services provided by a physician or a qualified NPP consisting of: (1) A physical examination (including measurement of height, weight, blood pressure, and an electrocardiogram, but excluding clinical laboratory tests) with the goal of health promotion and disease detection; and (2) education, counseling, and referral for screening and other covered preventive benefits separately authorized under Medicare Part B.

Specifically, section 611(b) of the MMA provides that the education, counseling, and referral of the individual by the physician or other qualified NPP are for the following statutory screening and other preventive services authorized under Medicare Part B:

- Pneumococcal, influenza, and hepatitis B vaccine and their administration;
- Screening mammography;
- Screening pap smear and screening pelvic exam services;
- Prostate cancer screening services;
- Colorectal cancer screening tests;
- Diabetes outpatient self-management training services;
- Bone mass measurements;
- Screening for glaucoma;
- Medical nutrition therapy services for individuals with diabetes or renal disease;
- Cardiovascular screening blood tests; and
- Diabetes screening tests.

Based on the language of the statute, our review of the medical literature, current clinical practice guidelines, and United States Preventive Services Task Force (USPSTF) recommendations, we interpreted the term ''initial preventive physical examination'' for purposes of this benefit to include all of the following service elements:

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

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

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

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

5. Performance and interpretation of an electrocardiogram;

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

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

The proposed ''medical history'' definition includes the following elements:

- Past medical history and surgical history, including experience with illnesses, hospital stays, operations, allergies, injuries, and treatment.
- Current medications and supplements, including calcium and vitamins.
- Family history, including a review of medical events in the patient's family, including diseases that may be hereditary or place the individual at risk.

The proposed ''physician'' definition means for purposes of this provision a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

The proposed ''qualified nonphysician practitioner'' for purposes of this provision means a PA, NP, or clinical nurse specialist (CNS) (as authorized under sections 1861(s)(2)(K)(i) and 1861(s)(2)(K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in regulations at § 410.74, § 410.75, and § 410.76).

The proposed ''social history'' definition includes, at a minimum, the following elements:

- History of alcohol, tobacco, and illicit drug use.
- Work and travel history.
- Diet.
- Social activities.
- Physical activities.

The proposed definition of ''Review of the individual's functional ability and level of safety'' includes, at a minimum, a review of the following areas:

- Hearing impairment.
- Activities of daily living.
- Falls risk.
- Home safety.

We also proposed conforming changes to specify an exception to the list of examples of routine physical examinations excluded from coverage in § 411.15(a)(1) and § 411.15(k)(11) for IPPEs that meet the eligibility limitation and the conditions for coverage that we are specifying under § 410.16, Initial preventive physical examinations.

With regards to the issue of payment for the IPPE, in the August 5, 2004 proposed rule we stated that there is no current CPT code that contains the specific elements included in the IPPE and proposed to establish a new HCPCS code to be used for billing for the initial preventive examination. As required by the statute, we indicated that this code includes an electrocardiogram, but does not include the other previously mentioned preventive services that are currently separately covered and paid under the Medicare Part B screening benefits. When these other preventive services are performed, they must be identified using the existing appropriate codes.

Proposed payment for this code was based on the following:

- *Work RVUs:* We proposed a work value of 1.51 RVUs for G0344 (G0XX2 in proposed rule) based on our determination that this new service has equivalent resources and work intensity to those contained in CPT E/M code 99203, *new patient, office or other outpatient visit* (1.34 RVUs), and CPT code 93000 *electrocardiogram, complete* (0.17 RVUs), which is for a routine ECG with the interpretation and report.

- *Malpractice RVUs:* For the malpractice component of G0344, we proposed malpractice RVUs of 0.13 in the nonfacility setting based on the malpractice RVUs currently assigned to CPT code 99203 (0.10) and CPT code 93000 (0.03). In the facility setting, we proposed malpractice RVUs of 0.11 based on the current malpractice RVUs assigned to CPT code 99203 (0.10) and 93010 (an EKG interpretation with a value of 0.01).

- *Practice Expense RVUs:* For the practice expense component of G0344, we proposed practice expense RVUs of 1.65 in the nonfacility setting based on the practice RVUs assigned to CPT code 99203 (1.14) and CPT code 93000 (0.51). In the facility setting, we proposed practice expense RVUs of 0.54 based on the practice expense RVUs assigned to CPT code 99203 (0.48) and 93010 (0.06).

Because some of the components for a medically necessary Evaluation and Management (E/M) visit are reflected in this new G code, we also proposed, when it is appropriate, to allow a medically necessary E/M service no greater than a level 2 to be reported at the same visit as the IPPE. That portion of the visit must be medically necessary to treat the patient's illness or injury or to improve the function of a malformed body member and should be reported with modifier—25. We also stated the physician or qualified NPP could also bill for the screening and other preventive services currently covered and paid by Medicare Part B under separate provisions of section 1861 of the Act, if provided during this IPPE.

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

Analysis of and Response to Comments

We specifically solicited public comments on the definition of the term ''initial preventive physical examination,'' with supporting documentation. For example, we indicated that we chose not to define the term, ''appropriate screening instrument,'' for screening individuals for depression, functional ability, and level of safety, as specified in the rule, because we anticipated that the examining physician or qualified NPP may want to use the test of his or her choice, based on current clinical practice guidelines. We believe that any standardized screening test for depression, functional ability, and level of safety recognized by the American Academy of Family Physicians, the American College of Physicians-American Society of Internal Medicine, the American College of Preventive Medicine, the American Geriatrics Society, the American Psychiatric Association, or the USPSTF, or other recognized medical professional group, would be acceptable for purposes of meeting the ''appropriate screening instrument'' provision. We asked that commenters making specific recommendations on this or any related issue provide documentation from the medical literature, current clinical practice guidelines, or the USPSTF recommendations.

We received 71 public comments on the proposed rule regarding IPPE. Commenters included national and State professional associations, medical societies and medical advocacy groups, hospital associations, hospitals, managed care plans, physicians, senior advocacy groups, health care manufacturers, and others. Although a number of commenters expressed concern that the proposed rule was too prescriptive and not sufficiently targeted to prevention, a large majority of the commenters enthusiastically supported most of the coverage provisions of the proposed rule. Many of the commenters, however, suggested clarification and revision of the rule in a number of different areas, including the proposed definitions of ''initial preventive physical examination,'' ''physician,'' and ''qualified nonphysician practitioner.'' Commenters also raised questions regarding other issues, such as those relating to the need for us to educate Medicare beneficiaries and providers with respect to the new benefit, and to monitor the implementation of the new benefit. Finally, commenters offered suggestions and questions with regards to payment issues, evaluation and

management services (E/M) and coinsurance and Part B deductible issues.

A summary of the comments and our responses are presented below.

Comment: A number of commenters expressed concern that in the proposed rule, we had gone beyond the coverage criteria that were specified in the statute for the new benefit. They noted that the additional criteria was too prescriptive and would only add confusion and an additional burden for physicians in determining what medical services are necessary for each beneficiary they evaluate. Several commenters indicated that while the proposed definition for the scope of the benefit was well-intentioned, the beneficiary's physician or other provider was the best person to determine what medical services are necessary in providing a thorough physical and to be responsive to the individual's age, gender, and particular health risks. In general, they suggested that we not interfere in a physician's judgment by attempting to standardize by Federal regulations the specific medical services to be included under the new benefit.

Response: Section 611 of the MMA defines the scope of the IPPE benefit as physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure and an electrocardiogram) with the goal of health promotion and disease detection, as well as certain education, counseling, and referral services with respect to other statutory screening and preventive services also covered under the Medicare statute. We believe that the statutory parenthetical language, (including measurement of height, weight, and blood pressure and an electrocardiogram) recognizes that other services could be contained within the IPPE benefit. We are using the authority under section 1871(a) of the Act through the rulemaking process to provide clarity as to the specific services that are to be included under the new benefit.

We believe that adding these additional services will help to ensure that a full and complete IPPE is provided to each beneficiary who chooses to take advantage of the service and that all beneficiaries who decide to do this are treated in a relatively uniform manner throughout the country. With an estimated 200,000 individuals expected to enroll in Medicare Part B each month starting in January 2005, who will be eligible to receive the IPPE benefit, we believe that it is paramount that we promulgate a minimum list of required services important to the goals of health promotion and disease detection that must be included in the new benefit, and we are specifying those service elements in the final rule.

The ''Initial Preventive Physical Examination'' Definition (IPPE) (§ 410.16(a))

Comment: Three commenters indicated that this new benefit presents a unique opportunity to offer Medicare beneficiaries with a visit focused on prevention at the start of their Part B enrollment. They suggested, that we shift our focus in service element 1 of the definition of the new IPPE from a comprehensive to a more targeted priority list of modifiable risk factors, screening tests, and immunizations that are supported by the strongest evidence of effectiveness, and have been proven to improve the health of beneficiaries.

Response: We agree that the intent of the new benefit is to deliver clinical preventive services that are accepted and effective in helping to keep people healthy and reduce the burden of disease whenever possible. Therefore, we agree to revise the language in service element 1 to read as follows: ''Review of the individual's medical and social history with particular attention to modifiable risk factors for disease.''

Comment: Three commenters indicated that the collection of information on a beneficiary's social history such as social activities, work and travel history, is a distraction and is not needed by the physician or other qualified NPP who is performing the preventive physical examination. The commenters suggest that we eliminate the proposed definition and not require the collection of this information.

Response: We agree that information on work and travel history, and social activities may not be necessary for purposes of the new preventive physical examination and thus we are removing those elements from the minimum requirements for the ''social history'' definition. However, we believe it is important to retain three elements of the Social history definition in the final rule and they will be reflected in that document as follows:

- History of alcohol, tobacco, and illicit drug use.
- Diet.
- Physical activities.

Comment: Several commenters requested that we add language to service element 1 to allow practitioners to ascertain information from individuals about additional disease or other diagnoses such as including questions regarding past diagnoses or treatment of cancer, diabetes, elevated blood sugar, height loss, previous fractures, and medical conditions that may increase a person's risk of coagulopathic disorders such as deep venous thrombosis (DVT).

Response: In applying our definition of ''past medical history'' we expect that physicians and qualified NPPs performing the IPPE will be able to ask about an array of medical illnesses, including prior diagnoses and treatment of conditions such as cancer, diabetes, risk factors for osteoporosis such as height loss or previous fractures, and history of coagulopathic disorders such as DVT. Therefore, we do not see a need to expand the proposed definition as the commenters have suggested, and we have decided to leave it unchanged in the final rule.

Comment: Three commenters asked us to add language to either service element 1 or 3 to allow practitioners to screen individuals for memory impairment.

Response: Currently, the USPSTF has found insufficient evidence to recommend for or against routine screening for dementia with standardized instruments in asymptomatic persons. However, the USPSTF notes that patients with problems in performing daily activities should have their mental status evaluated and clinicians should remain alert for possible signs of declining cognitive function. We included as part of the definition for service element 3, ''Review of the individual's functional ability and level of safety,'' a review of the patient's activities of daily living. While not exhaustive, this review will primarily aid physicians in identifying a patient's problems with regard to performing these activities and the role cognitive impairment may play in these deficits.

Comment: One commenter proposed that we not use the NCD process to revise the content of the IPPE in the future. The NCD process would be too slow or cumbersome to allow us to keep the content of the examination consistent with current clinical practice.

Response: For service elements 2 and 3, which discuss the future use of the NCD process in determining appropriate screening instruments we will delete the following: ''unless the appropriate instrument is defined through the NCD process.'' We will add language that states available standardized screening tests must be recognized by national medical professional organizations.

Comment: Several commenters requested that we clarify our intent as to whether the depression screening assessment in service element 2 will include consideration of the potential for depression as well as an assessment

of an individual's current depression status. Another commenter asked us to clarify our intent with respect to the use of a screening instrument for persons with a current diagnosis of depression.

Response: We agree with the commenters that the regulation language on depression screening needs to be clarified. We are revising service element 2 to read ''review of the individual's potential (risk factors) for depression, including current or past experience with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations.''

Comment: Three commenters expressed the view that the proposed screening tests for falls risk and home safety in service element 3 were not supported by direct scientific evidence, and should be dropped from the IPPE benefit in the final rule.

Response: Falls are among the most common and serious problems facing elderly persons. They are associated with considerable morbidity such as hip fractures and overall reduced level of functioning. The USPSTF also notes that falls are the second leading cause of unintentional injury deaths in the United States. The death rate due to falls increases as a person ages. According to the National Center for Injury Prevention and Control, approximately one-half to two-thirds of all falls occur in and around a person's home. Therefore, discussing with patients home safety tips may reduce some home hazards. In addition, the USPSTF recommends counseling patients on specific measures to reduce the risk of falling, although direct evidence of effectiveness has not yet been established. Therefore, we believe that questioning and counseling patients to determine their risk of falling and home safety is warranted as part of the IPPE benefit.

Comment: Several commenters from the audiology community have asked us to clarify the meaning of the proposed requirement in service element 3, which includes (among other things) a review of any hearing impairment. In addition, several commenters have requested that we clarify whether a hearing assessment is required as part of service element 3, or whether questions (or a questionnaire) advanced to an individual about any possible hearing problems would suffice for purposes of this part of the new benefit. The commenters ask for provider flexibility in meeting this requirement.

Response: The regulatory intent of service element 3 is that we expect that the physician or qualified NPP will engage in a dialogue with patients concerning these issues by asking the individual appropriate questions or using a written questionnaire to address hearing impairment, activities of daily living, falls risk, and home safety. We do not intend for actual screening instruments such as audiometric screening tests to be used. After questioning the individual, if abnormalities are identified, additional follow-up services may be warranted and may include education, counseling, and referral (if appropriate.)

Therefore, we are revising the language of service element 3 to read ''review of the individual's functional ability and level of safety, based on the use of appropriate screening questions or a screening questionnaire which the physician or qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national medical professional organizations.''

Medically necessary diagnostic hearing tests, including hearing and balance assessment services, performed by a qualified audiologist are covered as other diagnostic tests under section 1861(s)(3) of the Act and would be separate from the new IPPE benefit. These services may be appropriate when a physician or other qualified NPP orders a diagnostic hearing test for the purpose of obtaining information necessary for the physician's diagnostic evaluation or to determine the appropriate medical or surgical treatment of a hearing deficit or related medical problem. However, coverage of this testing is excluded by virtue of section 1862 (a)(7) of the Act when the diagnostic information required to determine the appropriate medical or surgical arrangement is already known to the physician, or the diagnostic services are performed only to determine the need for the appropriate type of hearing aid. For further information about the application of the hearing test exclusion to diagnostic hearing tests and payment for these services, we suggest review of section 80.3 to 80.3.1 of the Medicare Benefit Policy Manual.

Comment: Several commenters suggested that we expand the services to be included as part of service element 4 that was proposed for coverage under the IPPE benefit to include: (1) Palpitation/auscultation of carotid arteries; (2) palpitation/auscultation of abdominal aorta; and (3) the ankle-brachial index (ABI) test for peripheral arterial disease (PAD).

Response: Currently, routine screening of asymptomatic persons for carotid artery stenosis via palpation/auscultation of the carotid arteries or carotid ultrasound is not recommended by organizations such as the USPSTF, which provides guidelines on this issue. Therefore, we are not adding routine screening of asymptomatic individuals for carotid artery stenosis to service element 4 in the absence of evidence of the effectiveness of the screening. In addition, the USPSTF has determined that there is insufficient evidence to recommend for or against routine screening of asymptomatic adults for abdominal aortic aneurysm (AAA) by palpation/auscultation or ultrasound of the abdominal aorta so we are not adding that type of screening to service element 4.

Finally, the USPSTF does not recommend routine screening for PAD in asymptomatic persons. However, they also state that clinicians, should be aware of symptoms and risk factors for PAD and evaluate patients accordingly. Therefore, routine screening for PAD with the use of the ABI will not be required as part of the initial preventive physical examination.

Comment: One commenter asked for clarification on whether the proposed regulatory language ''and other factors deemed appropriate by the physician or qualified nonphysician practitioner,'' as specified in service element 4, would permit inclusion of coverage of a screening for chronic obstructive pulmonary disease (COPD) through spirometric testing under the IPPE benefit.

Response: The intent of this language for the actual physical examination portion of the IPPE benefit is to leave to the discretion of the physician or other qualified NPP whether to perform commonly utilized physical examination measures such as auscultation of the heart or lungs on a particular patient, if needed. Spirometry as a screening test for COPD, however, would not be considered to fall within the scope of the physical examination element of the IPPE benefit.

Comment: A number of commenters suggested that we add an assessment of abdominal obesity or alternatively the calculation of the body mass index (BMI) to the vital signs part of service element 4 to help in determining if an individual is at risk for a heart attack, diabetes, or other medical problems.

Response: By requiring measurement of height and weight as part of the IPPE in element 4 (an examination to include

measurement of an individual's height, weight, blood pressure), we believe that the physician or other qualified NPP performing the IPPE will use that information to determine an individual's BMI if necessary.

Comment: Three commenters expressed concern about the wide latitude given to physicians and other qualified NPPs providing the IPPE benefit to select whichever screening test they prefer to use in connection with the assessment of visual acuity. The commenters believe that setting vague boundaries around what constitutes an appropriate screening instrument could open the door for inappropriate use of preventive services. To avoid this, the commenters recommend narrowly defining the appropriate screening instrument for visual acuity in service element 4 by specifying the use of the Snellen test for that purpose.

Response: We agree that the Snellen test is a widely available test used to assess a person's visual acuity. Other similarly available tests for visual acuity also exist, however, and may convey similar results for individual physicians and other clinicians. While we expect that many physicians will utilize the Snellen test in assessing a beneficiary's visual acuity for the purpose of this new benefit, we are not mandating the use of the Snellen test or any other specific visual acuity test in order to meet the requirements of element 4 in the final rule.

Comment: One commenter noted that the proposed rule allows for coverage of the assessment in service element 4 of ''other factors as deemed appropriate based on the individual's comprehensive medical and social history.'' The commenter expressed the view that the quoted language might result in the possibility that virtually any patient's abnormality identified during the preventive physical examination might lead to further evaluation of the patient and a cascade of diagnostic workup of questionable health benefit to the patient and potentially of great cost to the Medicare program. In view of these concerns, the commenter recommended using more restrictive language that would allow for additional assessment of other factors only when they are supported by evidence-based clinical practice guidelines.

Response: Our purpose in proposing the specific quoted language referenced in service element 4 was to allow for the physician or other qualified NPP to perform a limited physical examination of those key elements such as height, weight, blood pressure, and a visual acuity screen that may be important in detecting disease. However, we have specified that additional physical examination measures may be performed if deemed appropriate based on the issues identified by the physician or other clinician in the review of service elements 1 to 3. While we will not specify in the final rule that these additional measures must be supported by evidence-based practice guidelines, we will state that the practitioner performing the preventive examination follow current clinical standards and those guidelines, of course, may include the evidence-based guidelines referenced by the commenter.

Comment: One commenter recommends that we include in our guidelines for the IPPE benefit information that informs the physician or other qualified NPP of: (1) The need to refer patients to occupational therapists when a more extensive evaluation of activities of daily living, falls risk, and home safety is warranted; and, (2) when, such referrals would be medically appropriate.

Response: As part of the final rule, service element 6 of the IPPE benefit will require, education, counseling, and referral, as appropriate, based on the individual's results of the previous 5 elements of the IPPE benefit. However, appropriate referral of a patient to an occupational therapist is left to the discretion of the physician or other qualified NPP who is treating the patient for the medical problem that is identified, subject to contractors' medical necessity review. We do not believe there is a need for us to issue guidelines to our contractors on this point.

Comment: Several commenters indicated that they were concerned about use of the term ''counseling'' in service elements 6 and 7 of the definition of the IPPE because it lacked sufficient clarity. The commenters indicated that counseling may include varying amounts of time depending upon the intensity of the type of service provided, the ability of the individual receiving the counseling to understand the information that is being communicated, etc. The commenters suggested that either we not use the term counseling or clarify its meaning in the final rule.

Response: Use of the term counseling in connection with service element 7 is mandated by section 611 of the MMA, and thus, it is appropriate to use the term in the final rule. However, we would like to clarify this issue in connection with both service elements 6 and 7 of the new benefit. In most cases, we do not expect that the physician or other qualified NPP performing the service should need to spend more than a few minutes of brief education and counseling with a new beneficiary on appropriate topics as required by element 7. Nonetheless, it is possible that it may be necessary to spend more than a few minutes on the education and counseling required by element 6. As the commenters have indicated, the education and counseling required may involve varying amounts of time depending upon the medical problem or problems that are being considered, based on the results of elements 1 to 5, and the intensity of the service that is believed to be medically necessary at that time.

Comment: Three commenters indicated that they support proposed service element 6 on ''education, referral, and counseling deemed appropriate based on the results of the review and evaluation of services,'' in service elements 1 to 5 because it offers an unprecedented opportunity to counsel beneficiaries about health behaviors (for example, stopping smoking, losing weight). Nonetheless, they were concerned about possible over-utilization of services that might result from that provision, and suggest that we clarify that these education, counseling and referral efforts be concordant with evidence-based practice guidelines.

Response: We will not specify in the final rule that education, counseling, and referral efforts must be consistent with evidence-based practice guidelines. We expect that physicians and other qualified NPPs will provide appropriate education, counseling, and referral that utilizes evidence-based practice guidelines and current clinical standards. In addition, follow-up care obtained outside of the IPPE Benefit must be reasonable and necessary based on Section 1862(a)(1)(A) of the Act.

Comment: A number of commenters requested that we clarify the written plan provision of service element 7 that was included in the proposed rule. Several commenters indicated that two problems they see with this requirement are: (1) It is not clearly defined and thus could impose a significant burden on physicians and other clinicians, if it is not more carefully written; and, (2) it does not acknowledge that alternative mechanisms may already be in place that could better facilitate coordination of care for these beneficiaries than the proposed written plan requirement. For example, one commenter suggests that some physicians and other clinicians may currently be using electronic technology to track the delivery of preventive services and should not be

required to file written plans. Instead, the commenter recommends that we craft language to require physicians to demonstrate a system for ensuring that beneficiaries receive recommended screening and preventive services and allow physicians flexibility to determine the design and medium that such a system would employ.

Response: We agree that the term written plan may not offer a sufficiently clear description of our intentions in requiring the physician or other qualified NPP who also performs the IPPE to carry out the statutory mandate that eligible beneficiaries be provided with education, counseling, and referral for screening and other preventive services described in section 1861(ww)(2) of the Act. Our intent in the proposed rule was that each physician or other qualified NPP provide their eligible beneficiaries at the time of the examination with appropriate education, counseling, and referral(s), including a brief written plan such as a checklist, which is provided to the beneficiary for obtaining the appropriate screening and/or other preventive services that are covered as separate Medicare Part B benefits to which he or she is entitled. We acknowledge that physicians or qualified NPPs may have an alternative mechanism in place to ensure that beneficiaries receive recommended screening and other preventive services that does not provide for a written plan to be provided to the beneficiary. However, the intent of the written plan requirement is to promote and encourage beneficiary participation in the health care process by making them aware, briefly in writing of the screening and prevention services for which they are entitled under the Medicare Part B program.

In conclusion, we will revise service element 7 to read ''education, counseling, and referral, including a brief written plan such as a checklist, be provided to the individual for obtaining appropriate screening and other preventive services, which are separately covered under Medicare Part B benefits.''

The ''Physician'' Definition (§ 410.16(a))

Comment: One commenter expressed concerns regarding the definition of a physician. The commenter expressed concern that the proposed rule limits the type of practitioner who is considered qualified to perform the new preventive physical examination. The commenter states that this restriction was not specified by the Congress in section 611 of the MMA or its accompanying conference committee report, and suggests that it should be revised to allow all practitioners, including doctors of podiatric medicine, who are defined as a physician under section 1861(r) of the Act, to be considered qualified to perform the preventive physical examination.

Response: Section 611 of the MMA amended the statute to provide that payment for the IPPE must be made under the Medicare physician fee schedule, as provided in section 1848(j)(3) of the Act, but it did not specifically define what type of physician is eligible for performing this examination. In developing the proposed rule on which physicians are considered qualified to perform the IPPE, we considered the various types of physicians that are identified in section 1861(r)(2), (r)(3), (r)(4), and (r)(5) of the Act. These include doctors of dental surgery, doctors of podiatric medicine, doctors of optometry, and chiropractors, whose scope of medical practice is generally limited by State law to a particular part (or parts) of the human anatomy.

These state licensing restrictions would likely make it difficult for those practitioners to perform all of the services required. Based on this information, we are leaving the definition of a physician unchanged in the final rule.

The ''Qualified Nonphysician Practitioner'' Definition (§ 410.16(a))

Comment: One commenter indicated concern that in the proposed rule certified nurse-midwives (CNMs) are not eligible to furnish the new preventive physical examinations, but physicians and certain other NPPs are eligible to provide those services to Medicare beneficiaries. The commenter indicates that CNMs are fully qualified to provide physical examination and checkups covered by the statute and that they do so on a daily basis as a basic component of the care they provide their clients. The commenter states that we may be constrained by the statute as enacted by Congress on this subject, but suggests that we should review the issue and if possible revise the proposed rule to include CNMs among those who are considered to be eligible to provide the new service in the final rule.

Response: Section 611 of the MMA amended the statute to provide that in addition to physicians certain NPPs, that is, PAs, NPs, and CNS (as authorized under section 1861(s)(2)(K)(i) and (ii) of the Act, and defined in section 1861(aa)(5) of the Act, or in regulations at § 410.74, § 410.75, and § 410.76) will be able to furnish the new preventive physical examination to eligible beneficiaries effective January 1, 2005. Thus, Congress did not specifically authorize CNMs to perform the IPPE. Unless CNMs are able to qualify as one of these other types of NPPs designated by the statute for purposes of the new IPPE benefit, they will not be eligible to provide this service to beneficiaries for Medicare Part B coverage purposes.

Other Issues

Comment: One commenter requested that we clarify application of the proposed IPPE definition to managed care plans where preventive physical examinations are available to Medicare enrollees on an annual basis and they are not limited to a one-time benefit. Generally in the case of managed care plans, it is indicated that the extent of their typical annual preventive examination is determined by the enrollee's physician or other treating physician, depending upon the patient's history and clinical indications. The commenter asks that we allow managed care plans greater flexibility in providing their Medicare enrollees with the various service elements described in the proposed rule. Alternatively, the commenter requests that we clarify in the final rule that managed care plans will need to provide their Medicare enrollees with all elements of the new benefit only if requested to do so by a particular Medicare enrollee.

Response: Section 611 of the MMA requires that IPPEs be made available to all Medicare beneficiaries who first enroll in Medicare Part B on or after January 1, 2005, and who receive that benefit within 6 months of the effective date of their initial Part B coverage period. The new statute does not allow for any exceptions to be made to the coverage of IPPEs for beneficiaries who are members of managed care plans. In fact, section 1852(a) of the Act provides that generally each managed care plan must, at a minimum, provide to its Medicare members all of those items and services (other than hospice care) for which benefits are available under Parts A and B for individuals residing in the area served by the plan. Nonetheless, if a particular Part B member of the plan chooses not to take advantage of the IPPE benefit, for example, because it would duplicate an annual preventive physical exam that has already been provided to that member, the plan would not be obligated to provide the IPPE to that member.

Comment: One commenter noted that while the screening benefits listed in paragraph (A)(1) on **Federal Register**

page 47514 (vol. 69, No. 150) includes ''(5) colorectal cancer screening test,'' the list of screening benefits described in the same section, paragraph (7) on page 47515 does not include that type of cancer screening test. The commenter requests that we include colorectal cancer screening in the list of screening services described on page 47515 of the Physician Fee Schedule Proposed Rule and any other sections of any proposed rule in which covered screening benefits are listed to ensure there is no confusion regarding what services should discussed with patients during the IPPE.

Response: We agree with the commenter that there was an error of omission relative to colorectal cancer screening in the language in the preamble to the proposed rule in the list of screening benefits described on page 47515 of the Physicians Fee Schedule, and we have corrected that oversight in this final rule.

Comment: One commenter requests that we clarify the part of the definition of the IPPE (service element 7) that refers to the provision of education, counseling, and referral of the individual for coverage of bone mass measurements by adding the term ''Dual Energy X–Ray Absorptiometry'' (DEXA) to that provision. The commenter states that DEXA testing is the most accurate method available for diagnosis of osteoporosis and that early detection of this condition paramount for preventing further bone loss and eventual fractures. The commenter is concerned that unless this is clarified in the final rule, local Medicare contractors may exclude coverage for the DEXA test as part of the IPPE benefit.

Response: Our existing regulations governing bone mass measurements are published in § 410.31. While we agree that the DEXA scan is a very commonly used method for the initial diagnosis of osteoporosis, we do not believe that it would be appropriate to add any specific reference to the DEXA test in the IPPE definition because it may be perceived as endorsing one test over another. We do not believe this would be appropriate. Physicians and other qualified NPPs who perform IPPE services may provide appropriate education, counseling, and referral of their Medicare patients for the bone density tests. The counseling and referral may include choosing the appropriateness of the diagnostic modalities for the particular patient.

Comment: A number of commenters have asked us to provide information to Medicare physicians and qualified NPPs performing the IPPE for appropriate referral of their patients when treatment or a more extensive evaluation of patients is needed as part of service element 6.

Response: As part of the final rule, under service element 6, providers are required to furnish their patients with education, counseling, and referral, as appropriate, based on the individual's results of service elements 1–5 of the IPPE service. However, appropriate referral of a patient, of course, is left to the discretion of the physician or other qualified NPP who is treating the patient for the medical problem that is identified.

Comment: One commenter asked us how we plan to monitor the effectiveness of the IPPE benefit over the next several years.

Response: As indicated in the final rule, we have established unique billing codes for the IPPE service which physicians and other qualified NPPs must use in billing Medicare Part B for the new service. Establishing those codes will allow us to monitor over time the extent to which the eligible Medicare Part B population is utilizing the new service, which will be of interest to our program administrators, members of the Congress, and the general public.

Comment: One commenter asked how providers of IPPE services will know if a particular beneficiary is eligible to receive the new benefit due to the statutory time and coverage frequency (one-time benefit) limitations.

Response: The statute provides for coverage of a one-time IPPE benefit that must be performed for new beneficiaries by qualified physicians or certain specified NPPs within the first 6 months period following the effective date of the beneficiary's first Part B coverage. Since physicians or other qualified NPPs may not have the complete medical history for a particular new beneficiary, including information on possible use of the one-time benefit, these clinicians are largely relying on their own medical records and the information the beneficiary provides to them in establishing whether or not the IPPE benefit is still available to a particular individual and was not performed by another qualified practitioner. Since a second IPPE will always fall outside the definition of the new Medicare benefit, an advance beneficiary notice (ABN) need not be issued in those instances where there is doubt regarding whether the beneficiary has previously received an IPPE. The beneficiary will always be liable for a second IPPE no matter when it is conducted. However, for those instances where there is sufficient doubt as to whether the statutory 6-month period has lapsed, the physician or other qualified NPP should issue an ABN indicating that Medicare may not cover and pay for the service. If the physician or other qualified NPP does not issue an ABN and Medicare denies payment because the statutory time limitation for conducting the initial IPPE has expired, then the physician or other qualified NPP may be held financially liable.

Comment: Several commenters asked that we provide explicit instructions and guidelines, respectively, to providers and beneficiaries regarding the details of what will be included in the new benefit, the eligibility requirements, and how providers must bill Medicare for the new service.

Response: Medicare will release appropriate manual and transmittal instructions and information from our educational components for the medical community, including a MedLearn Matters article and fact sheets like the ''2005 Payment Changes for Physicians and Other Providers: Key News From Medicare for 2005''. The medical community can join this effort in educating physicians, qualified NPPs, and beneficiaries by distributing their own communications, bulletins or other publications.

In addition, we have specifically included information on the new IPPE benefit in the 2005 version of the *Medicare and You Handbook* and the revised booklet, *Medicare's Preventive Services.* A new 2-page fact sheet on all of the new preventive services, including the IPPE benefit, is currently under development, and a bilingual brochure for Hispanic beneficiaries will also be available in the new future. This information will be disseminated by our regional offices, State Health Insurance Assistance Programs (SHIPs), and various partners at the national, State, and local levels. Information on the new benefit will also be made available to the public through medicare.gov, the cms.gov partner Web site, 1–800–MEDICARE, numerous forums hosted by CMS, and conference exhibits and presentations.

Comment: Many of the major physician specialty societies believe the payment, as proposed, is undervalued for what is believed to be a labor-intensive IPPE. They request that we use the existing CPT preventive medicine services code series rather than creating a new G-code. These codes have higher RVUs than the office or other outpatient visit code 99203. For example, preventive medicine services visit code 99387 has total nonfacility RVUs of 4.00 while the corresponding value for 99203 is 2.58.

Response: The existing CPT preventive medicine services codes

(99381–99397) are not covered by Medicare. In accordance with section 1862(a)(1)(A) of the Act that requires us to pay only for services that are reasonable and necessary for the treatment of an illness or injury or to improve the function of a malformed body member, we have not covered E/M visits for screening purposes.

The IPPE is intended to target selected modifiable risk factors and secondary prevention opportunities shown by evidence to improve the health and welfare of the beneficiary, and is less focused on a comprehensive physical examination compared to the typical service provided in accordance with CPT code 99397. We equated the resources anticipated with this service to the existing new office or other outpatient visit. For CPT code 99203 the RUC survey data shows 53 physician minutes (including pre-service time, intra-service time and post-service time) with 51 minutes of staff time. We believe the IPPE will reflect these time approximations. We will be looking at the data and consulting with the medical community after initial experience with this new benefit to determine if this payment has been valued appropriately.

Comment: Two commenters suggested that we allow the IPPE either on a yearly basis or every decade after the initial evaluation.

Response: The IPPE was specifically legislated as a one time only benefit for the beneficiary newly enrolled in the Medicare program. This visit familiarizes the beneficiary with a physician or qualified NPP who will highlight the assessments available to help prevent and detect disease and also make available the educational, counseling and referral opportunities to the new Medicare recipient. Our policy anticipates physicians will make appropriate and individualized referrals for the beneficiary. Expanding the number of routine physicals would require additional legislation (See section 1862(a)(7) of the Act).

Comment: Many commenters asked if the IPPE may be provided without performing the EKG at the same visit. They asked to have the EKG component unbundled from the evaluation and management component that had been specified in the proposed rule for the IPPE service since a physician may not have the equipment and capability of providing EKG services to their patients in the office suite or clinic. Additionally, others asked if a physician would be denied payment for the IPPE if the screening EKG was not performed because a diagnostic EKG was performed in a recent visit or if a diagnostic EKG was warranted at the IPPE visit.

Response: Section 611 of the MMA does require a screening EKG to be performed as part of the IPPE visit. We recognize that there are a number of primary care physicians or other clinicians furnishing the service who may want to refer their beneficiaries to outside practitioners or entities for performance and interpretation of the EKG service rather than performing it themselves. Therefore, if an individual physician or other qualified NPP does not have the capacity to perform the EKG in the office suite, then alternative arrangements will need to be made with an outside physician or other entity in order to make certain that the EKG is performed. In circumstances where the primary care physician or qualified NPP refers the beneficiary to an outside physician or entity for the EKG service, we expect that the primary care physician or qualified NPP will incorporate the results of the EKG into the beneficiary's medical record to complete the IPPE. Both components of the IPPE, the examination portion and the EKG, must be performed for either of the components to be paid. Billing instructions for physicians, qualified NPPs and providers will be issued. In order to address these potentially occurring scenarios to complete the IPPE and EKG we have created the following HCPCS codes:

- G0344: *Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first six months of Medicare enrollment*
- G0366: *Electrocardiogram, routine ECG with at least 12 leads with interpretation and report, performed as a component of the initial preventive physical examination*

A physician or qualified NPP performing the complete service would report both G0344 and G0366.

- G0367: *tracing only, without interpretation and report, performed as a component of the initial preventive physical examination*
- G0368: *interpretation and report only, performed as a component of the IPPE*

RVUs for payment for these new HCPCS codes will be crosswalked from the following CPT codes:

- G0344 will crosswalk from CPT code 99203 *(Office or other outpatient visit)*
- G0366 will crosswalk from CPT code 93000 *(Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report)*
- G0367 will crosswalk from CPT code 93005 *(Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report)*
- G0368 will crosswalk from CPT code 93010 *(Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only)*

Note that HCPCS codes G0366 and G0367 are not payable under the physician fee schedule in the facility setting.

To comply with MMA the IPPE must include the EKG regardless of whether a diagnostic EKG was recently performed. An EKG performed by the physician or qualified NPP during the IPPE visit must be reported with HCPCS code G0366. Medicare does not cover a screening EKG alone.

Comment: One commenter asked if physicians and qualified NPP who see patients in Federally Qualified Healthcare Centers (FQHCs) will be able to provide and bill under the FQHC all-inclusive rate.

Response: Physicians and other qualified NPPs in RHCs and FQHCs may provide this new benefit and follow normal procedures for billing for RHCs and FQHC services. Payment for the professional services will be made under the all-inclusive rate.

Comment: Many physician specialty societies did not agree with our proposal to limit the level of a medically necessary E/M visit when performed and billed with the IPPE. They contend that most Medicare patients, even if known to their physician, come to the IPPE visit with multiple chronic problems often necessitating immediate evaluation and treatment at a level of care equal to a level 4/5 E/M visit code. They also state that current Medicare policy does permit a medically necessary E/M visit at whatever level is appropriate when the noncovered preventive medicine services (CPT codes 99381–99397) are performed. They ask that we eliminate the restriction for the level of service for a medically necessary E/M visit performed at the same visit as the IPPE visit.

Response: The physician will need to schedule time with the beneficiary identifying the available preventive and educational opportunities. A level 2 new or established patient office or other outpatient visit code was proposed because we believe there is a substantial overlap of practice expense, malpractice expense and physician work in both history taking and examination of the patient with the IPPE and another E/M service. We do not want to prohibit the use of an appropriate level of service when it is necessary to evaluate and treat the beneficiary for acute and chronic

conditions. At the same time, we believe the physician is better able to discuss health promotion, disease prevention and the educational opportunities available with the beneficiary when the health status is stabilized and the beneficiary is physically receptive.

We will remove the restriction limiting the medically necessary E/M service to a level 2 visit code. CPT codes 99201 through 99215 may be used depending on the circumstances and appended with CPT modifier ''25 identifying the E/M visit as a separately identifiable service from the IPPE code G0344 reported.

We do not believe this scenario will be the typical occurrence and, therefore, we will monitor utilization patterns for the level 4/5 new or established office or other outpatient visit codes being reported with the IPPE. If there are consistent data that demonstrate high usage of level 4/5 E/M codes we may need to revise the policy.

Comment: Two commenters asked if we would permit separate payment for a digital rectal exam (DRE) when performed on the same day as the initial preventive physical examination.

Response: Currently Medicare does not make separate payment for DRE (code G0102) when performed on the same day as an E/M service. We will maintain the current policy and not pay separately for a DRE performed during the IPPE visit. A DRE is usually furnished as part of an E/M service and is bundled into the payment for an E/M service when a covered E/M service is furnished on the same day as a DRE. It is a relatively quick and simple procedure and if it is the only service furnished or is provided as part of an otherwise noncovered service it would be payable if coverage requirements are met.

Comment: Several commenters requested guidance on documentation.

Response: It is expected that the physician will use the appropriate screening tools. As for all E/M services, the 1995 and 1997 E/M documentation guidelines must be followed for recording information in the patient's medical record. The screening tools used, EKG documentation, referrals and a written plan for the patient also must be included in the patient's medical record. These forms and methods of documentation mirror those that would be used in typical physician practice with patient visits and do not add an additional burden to the physician.

Comment: Several commenters expressed concern that the non-waived deductible and coinsurance will be a disincentive to the beneficiary having the IPPE. They are concerned that some beneficiaries will not avail themselves of the opportunity of the IPPE visit because of the beneficiary's cost share.

Response: The MMA did not waive the deductible and coinsurance, therefore, we must implement the provision as written.

Result of Evaluation of Comments

In view of the comments, we have decided to make several revisions in § 410.16(a) relative to service elements 1, 2, and 3. We are revising § 410.16(a)(1)(i) language in service element 1 to read as follows: ''Review of the individual's medical and social history with particular attention to modifiable risk factors for disease.''

We are clarifying the regulation language on depression screening (service element 2) by revising § 410.16(a)(1)(ii) to specify that review of the individual's potential (risk factors) for depression, including current or past experience with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified NPP may select from various available standardized screening tests designed for this purpose and recognized by national medical professional organizations. To allow for a certain amount of provider flexibility in meeting the requirements of the regulatory intent of service component 3 we are revising § 410.16(a)(1)(iii) to specify that review of the individual's functional ability and level of safety, based on the use of appropriate screening questions or a screening questionnaire, which the physician or qualified NPP may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national medical professional organizations.

To clarify the requirements of the regulatory intent of service component 7 we are revising § 410.16(a)(1)(vii) to specify that education, counseling, and referral, including a brief written plan such as a checklist be provided to the individual for obtaining the screening and other preventive services for the individual that are covered as separate Medicare Part B benefits.

The ''social history'' definition in the final rule will be revised to include 3 elements:

- History of alcohol, tobacco, and illicit drug use.
- Diet.
- Physical activities.

With regard to payment of the IPPE, we will use the new HCPCS codes and payment will be based on the RVUs of the CPT codes crosswalked as stated above. We will not finalize our proposal to allow a medically necessary E/M service no greater than a level 2 to be reported at the same visit as the IPPE.

B. Section 613—Diabetes Screening

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

The term ''diabetes screening tests'' is defined in section 613 of the MMA as testing furnished to an individual at risk for diabetes and includes a fasting blood glucose test and other tests. The Secretary may modify these tests, when appropriate, as the result of consultations with the appropriate organizations. In compliance with this directive, we consulted with the American Diabetes Association, the American Association of Clinical Endocrinologists, and the National Institute for Diabetes and Digestive and Kidney Diseases.

1. Coverage

We proposed in § 410.18 that Medicare cover—

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

We would not include a random serum or plasma glucose for persons with symptoms of uncontrolled diabetes such as excessive thirst or frequent urination in this benefit because it is already covered as a diagnostic service. This language is not intended to exclude other post-glucose challenge tests that may be developed in the future, including panels that may be created to include new diabetes and lipid screening tests. We also would include language that would allow Medicare to cover other diabetes screening tests, subject to a NCD process.

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

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

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

+ A family history of diabetes.

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

+ 65 years of age or older.

For individuals previously diagnosed as diabetic, there is no coverage under this statute.

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

We proposed that Medicare beneficiaries diagnosed with pre-diabetes be eligible for the maximum frequency allowed by the statute, that is, 2 screening tests per 12 month period. We defined ''pre-diabetes'' as a previous fasting glucose level of 100–125 mg/dL, or a 2-hour post-glucose challenge of 140–199 mg/dL. This definition of pre-diabetes was developed with the assistance of the American Association of Clinical Endocrinologists, concurs with the Centers for Disease Control and Prevention (CDC) definition, and complements the definition of diabetes that we published November 7, 2003 (68 FR 63195).

2. Payment

We proposed to pay for diabetes screening tests at the same amounts paid for these tests when performed to diagnose an individual with signs and symptoms of diabetes. We would pay for these tests under the clinical laboratory fee schedule. We proposed to pay for these tests under CPT code 82947 Glucose; quantitative, blood (except reagent strip), CPT code 82950, post glucose dose (includes glucose), and CPT code 82951 Glucose; tolerance test (GTT), three specimens (includes glucose). To indicate that the purpose of the test is for diabetes screening, we would require that the laboratory include a screening diagnosis code in the diagnosis section of the claim. We proposed V77.1 special screening for diabetes mellitus as the applicable ICD–9–CM code for this purpose. Because laboratories are required and accustomed to submitting diagnosis codes when requesting payment for testing, we believe including a screening diagnosis code is appropriate for this benefit.

Comment: One commenter questioned whether there is statutory authority to expand eligibility for individuals. Adding that, section 613 of the MMA gives authority for additional test and frequency, not additional individuals.

Response: There is no statutory authority to expand eligibility for individuals. Section 613 of the MMA establishes coverage for beneficiaries who are at risk for developing diabetes. Beneficiaries who are pre-diabetic fall within 1861(yy)(2)(D) or (E) and are at an increased risk for developing diabetes. This increased risk separates them from the general at-risk population and requires the course of their care to be managed closer and more frequently.

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

Comment: Several comments were received that recommended we provide physicians with clear guidance about Medicare's covered services to help patients control their diabetes. The commenters also asked that we inform providers about other covered services, such as Hgb1AC tests, that will help patients avoid painful diabetes-related complications.

Response: We will be releasing two publications. The *Dear Doctor Package* publication, which includes the ''2005 FACT SHEET'', will be sent to the contractors on a CD on or about October 15, 2005 and distributed to the providers by November 15, 2005. The *Medicare Coverage of Diabetes Services and Supplies* publication was originally written in 2002. It was revised in 2003 to update the Part B premium amount and is being revised again this year to update the premium amount and to include any information relevant to the MMA. This document will be available on the CMS Web site and at 1–800–MEDICARE.

Comment: We received several comments suggesting that screening should not require a physician's prescription or referral in order to be covered under Medicare Part B. This approach would follow the successful precedent established by us with other screening tests such as mammograms.

Response: The legislative history on mammography did result in us allowing self-referral for mammograms. However, Medicare rules have required that laboratory tests for screening or other diagnoses must be ordered by licensed health care practitioners, specifically physicians, PAs, NPs, or CNSs.

Comment: Comments were received recommending that the final rule include coverage of one annual diabetes screening for all Medicare beneficiaries.

Response: The benefit of screening all Medicare beneficiaries is not supported by current evidence. We plan risk-based frequency limitations of coverage for diabetes screening based upon the statute requirements. Furthermore, we believe beneficiaries with pre-diabetes may warrant a more frequent follow-up and this is permitted at the professional judgment of the health care practitioner.

Comment: We received a few comments suggesting the addition of the C-peptide test, as it is sometimes useful in Type 1 or Type 2 diabetes.

Response: We believe that C-peptide testing is appropriate for diagnostic evaluation, but not for screening. It is currently covered under the general lab benefit as a diagnostic test when it is medically necessary.

Comment: The American Society for Clinical Pathology (ASCP) has urged us to add CPT 82950 glucose; post glucose dose (includes glucose). This test is more frequently used to screen for diabetes. GTT is a more definitive test usually requested when questionable results from random, fasting or postprandial glucose levels are obtained. As written, the proposed rule appears to exclude 82950 as a screening test.

Response: We appreciate attention being drawn to the apparent exclusion of CPT code 82950, which was not our intention and we have corrected that omission.

Comment: A commenter suggested that due to increased incidence of obesity in recent years that family history of diabetes be defined as persons with Type 2 Diabetes in one or more first or second-degree relatives.

Response: The comments received did not provide a clear consensus on the definition of family history of diabetes. Thus the definition of family history of diabetes will be left to the professional judgment of the treating physician or qualified non-physician practitioner based on the beneficiary's medical history and best practice standards.

Comment: The American Clinical Laboratory Association (ACLA) believes that the other codes on the NCD routine screening list that currently result in a diabetes denial on the basis of routine screening should be covered under the new diabetes screening benefit.

Response: We believe the majority of individuals who will seek care under this benefit will conform to the V77.1 code. We are willing to review a sample of claims and determine if other specific codes are appropriate code for this benefit. Codes that need to be considered for this new benefit can be brought to our attention through the national coverage determination process for laboratories.

Comment: A comment was received recommending that the proposed rule be clarified to refer to a ''fasting blood glucose test'' rather than a ''fasting plasma glucose test'' since the CPT code

does not differentiate between blood and plasma.

Response: We agree with the recommendation to change the term ''fasting plasma glucose test'' to ''fasting blood glucose test''.

Comment: A comment was received recommending additional diabetes screening tests be added through a less formal process of consultation with manufacturers, health care providers, patients, and other stakeholders, as contemplated by Congress. The commenter further stated that the NCD process is complex and time consuming, delaying the coverage of new tests.

Response: We believe the evidence-based NCD process is an effective process to review and analyze items and services as potential benefits for Medicare beneficiaries. Because the NCD process allows for public comment before we make any changes, we believe this is the appropriate process for any future changes. Further, we may not be able to accept every stakeholder's recommendation because of instructional, coding, or claims issues which must be resolved before any benefit can be implemented.

Result of Evaluation of Comments

Our review of the comments has led to the elimination of the word ''plasma'' from the term ''fasting plasma glucose test.'' The word ''plasma'' will be replaced with the term ''blood''. We have corrected the unintentional omission of CPT code 82950, post glucose dose (includes glucose) as a diabetes screening test. The providers and beneficiaries are reassured that there will be clear guidance on covered services by way of two publications: The *Dear Doctor Package*, which includes the ''2005 Fact Sheet'' and *Medicare Coverage of Diabetes Services and Supplies*. We continue to promote healthcare practitioner autonomy with our policy of risk-based frequency limitations on items and services provided to our beneficiaries. We recognize the differing opinions with regard to the usage of the NCD process to review potential new items and services such as new diabetes screening tests for our beneficiaries. To provide transparency, timeliness and fairness, a formal process is necessary. Historically, the NCD process has been open to all interested parties and has proven to be an effective process.

Based on reasoning from the responses to the comments we received, at this time we will not be accepting the following suggestions.

- Reversing policy requiring a physician's or a qualified non-physician's prescription or referral for diabetes screening tests.
- Providing coverage of one annual diabetes screening test for all Medicare beneficiaries.
- Adding coverage of C-peptide test as a screening test.
- Bypassing the current NCD process for a less formal process to add additional diabetes screening tests.

C. Section 612—Cardiovascular Screening

Section 612 of the MMA adds section 1861(xx) to the Act and provides for Medicare coverage of cardiovascular (CV) screening blood tests for the early detection of CV disease or abnormalities associated with an elevated risk for that disease effective on or after January 1, 2005.

Upon reviewing the USPSTF reports, the scientific literature and comments of professional societies, trade associations, the industry, and the public, we proposed in the August 5, 2004 **Federal Register**, that the benefit for CV screening would include the use of three clinical laboratory tests to detect early risk for CV disease. Since the three tests, a total cholesterol, a HDL-cholesterol, and a triglycerides test, could be ordered as a lipid panel or individually, the frequency was limited to one of each individual test or combination as a panel every 5 years.

When we researched the benefit, some scientific experts proposed that the use of only the total cholesterol test as a single test every 2 years was adequate. After reviewing the literature and comments, we concluded that each test in the lipid panel is important since each test predicts the risk for CV disease independently. It would be prudent, therefore, to promote the benefit as three separate tests every 5 years. The decision to limit the frequency to 5 years, rather than more frequent testing every 2 years was due to information found in the Clinical Considerations of the USPSTF which indicate that the cholesterol values of elderly persons, who are the majority of the Medicare population, change slowly as they age. We also proposed that any changes to the list of tests could be made after a review of recommendations by the USPSTF and the use of the NCD process.

We proposed that for the claims processing and payment system, the coding of the tests would be made using the CPT codes available for the lipid panel or the three tests individually coded with the use of V codes to identify the tests were ordered for screening purposes. We also stated that we would pay for these CV screening tests at the same amounts paid for these tests to diagnose an individual with signs of CV disease and that these would be paid under the clinical laboratory fee schedule. The proposed coverage requirements were set forth in new § 410.17.

In response to the proposed rule, we received letters and e-mails from 28 commenters representing professional societies, trade groups, the industry, and individuals, who wrote on 26 different issues. One commenter represented 14 medical societies. Each commenter had many concerns and the comments were grouped into 26 areas of concern.

Comment: Three commenters expressed concern that many laboratories perform direct measurement LDL reflexively when triglycerides exceed certain parameters. The commenters are concerned that if screening direct measurement LDL is statutorily excluded then the Medicare beneficiaries would be liable for these tests without prior notice.

Response: Section 410.32 requires that tests be ordered by a treating physician and used in the management of the patient. We have interpreted this provision to restrict the furnishing of reflex testing to situations where it is clear that the physician is ordering reflex testing at specific parameters and where the physician has an option to order the test without the reflex portion. Thus, laboratories must offer physicians the ability to order a lipid panel without the option to perform the direct measurement LDL. We strongly encourage physicians to order lipid panels without the direct measurement LDL reflex option to protect Medicare beneficiaries from incurring a charge for this service without advanced notice.

If the screening lipid panel results indicate a triglyceride level that indicates the need for a direct measurement LDL, the physician may order this test once the results of screening lipid panel are reported. The NCD for lipid testing includes coverage of direct measurement LDL for patients with hyperglyceridemia. *[http://www.cms.hhs.gov/ mcd/viewncd.asp ?ncd_id=190.23&ncd_ version=1&show=all]*

We do not require the patient to physically return to the treating physician for an office visit and ordering of subsequent testing. Physicians may order such tests based on the results of the CV screening. The Medicare law and regulations do not prohibit the use of the same sample of blood to be used for direct measurement LDL following a lipid panel with very high triglycerides. Laboratories may archive the initial specimen and use it

for subsequently ordered medically necessary direct measurement LDL.

Comment: One commenter suggested that if the direct LDL cholesterol is included in the CV risk screening benefit, we must provide guidance to laboratories regarding whether or not the direct LDL must be billed with the −59 modifier for the charge to be reimbursed.

Response: Since the direct LDL cholesterol is not being added to the CV screening benefit, there is no change to the billing.

Comment: One commenter requested that the V codes (V81.0, V81.1, and V81.2) be added to the Lipid NCD and that the NCD Edit Software be modified to accept these V codes (V81.0, 81.1, and 81.2) on a frequency basis.

Response: The Laboratory NCD Edit Module will be modified to accept the V codes for matching the CPT codes with the ICD–9–CM code for those tests within the lipid NCD that are part of this statutory benefit. The entire lipid NCD is not open for modification. The frequency is determined by the NCD process and implemented through changes to the claims processing system to edit the patient history and coding.

Comment: One commenter asked that Medicare contractors provide explicit instructions to physicians to provide the necessary V codes (or their corresponding narratives) since screening is normally non-covered.

Response: We will release the appropriate manual, transmittal instructions and information from our educational components for the medical community including a MedLearn Matters article and fact sheets such as the ''2005 Payment Changes for Physicians and Other Providers: Key News From Medicare for 2005.'' Laboratories can join this effort to educate physicians and beneficiaries by distributing their own communication, bulletins or other publications. Some of this information will also be part of the ''Welcome to Medicare Preventive Services Package.''

Comment: Three commenters recommended that high sensitivity C-reactive protein (hsCRP) be considered as a test for this benefit since the AHA and CDC issued a Class IIa recommendation stating that hsCRP measurements for risk stratification add important information to the ''classic'' cholesterol and HDL measurement. They cited that given Congressional intent, we should include this measure in its list of ''approved'' screening tests and, if not, that we immediately request that USPSTF conduct a formal review of hsCRP as a screening test. Four commenters recommended the addition of the ABI test. Another requested the inclusion of the 12-lead ECG, the echocardiogram, and tests for carotid artery disease. Another requested the coverage of blood pressure screening. Finally, another commenter suggested that we allow the broadest access and maximize the potential for tests.

Response: We appreciate the commenters' suggestions to include hsCRP and the other tests. In our efforts to develop the proposed rule, many tests were considered for inclusion in the list of screening tests for this benefit. There was insufficient evidence to include any additional tests beyond the lipid panel tests. The information we received in the development of the proposed rule did not support the inclusion of these additional tests but we invite the public to submit scientific literature for our consideration. Other new types of CV screening blood tests may be added under this new screening benefit if we determine them appropriate through a subsequent NCD. 68 FR 55634 (Sept 26, 2003) or *http://www.cms.hhs.gov/coverage/8a.asp].*

Comment: Two commenters recommended that we add HCPCS codes for the Lipid Panel and components as waived tests since they are performed in physician offices and other sites with Clinical Laboratory Improvement Amendments (CLIA) Certificates of Waiver.

Responses: Under CLIA, a facility with a CLIA certificate of waiver can only perform those tests that are approved by the FDA as waived tests. We update the list of waived tests and their appropriate CPT codes on a quarterly basis through our program transmittal process. When we program the claims system to look for the AMA CPT codes for Lipid Panel or any of the three tests which make up the panel, the system will recognize those waived tests performed using the same code plus the QW modifier that are medically necessary.

Comment: Two commenters requested clarification of the frequency limits for the three tests considered for this benefit. They asked if we would cover: (1) A lipid panel; (2) one or more component tests making up the lipid panel once every 5 years; or (3) each of the 4 HCPCS codes listed every 5 years.

Response: The intent of the benefit is to screen for CV disease. Since we believe most physicians would order the Lipid Panel as a single test, our intention was to cover the panel. We recognize that physicians may have different approaches to reaching their decision to treat, and therefore, we have to make available the possibility that physicians could order the individual tests which make up the panel. No matter how the physician(s) order the tests, our intention is to cover each of the 3 component tests (that is, a total cholesterol, a triglycerides test, and an HDL cholesterol) once every 5 years.

Comment: Two commenters asked that we clarify the reasons for having V codes for screening tests added from the MMA rather than the past practice of developing G codes (unique HCPCS codes; temporary codes). This commenter believed that the change to V codes would cause confusion to the databases like the Physician/Supplier Procedure Summary Master File. This confusion would result in improperly filed provider claims and this would lead to a different and confusing method of processing claims.

Response: The decision to use ICD–9–CM codes rather than continue to add G codes was made because we try to utilize existing coding structures where possible and create G codes if there is a specific programmatic need. The laboratory community has lobbied against the use of G codes for a few years. Also the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Standardization Requirements are working toward phasing out G codes, which are CMS only codes. The claims processing and editing systems are expected to be adjusted to manage this change.

Comment: Five commenters questioned the reasons for establishing limits on the frequency of this benefit since this places great legal, administrative, and financial burden for providers to manage this type of information. One commenter suggested the use of a chit that beneficiaries would receive and redeem for testing so laboratories would not need to keep records.

Response: The statute requires a frequency limit. Since laboratories may not have the complete medical history for individuals, including their history of CV screening tests, they are largely relying on the physician's order in establishing whether the test is medically necessary and covered by Medicare. However, relying on the physician's order does not provide the laboratory with proof that the CV screening test is medically necessary since the beneficiary may be treated by multiple physicians who may have ordered these tests independently within the 5 year coverage window. If the laboratory has sufficient doubt, the laboratory may issue an Advanced Beneficiary Notice (ABN) to the beneficiary indicating that Medicare may not cover the CV screening test. If the laboratory does not issue an ABN to

the beneficiary who has received more that one CV screening test during the previous five years, the laboratory may be financially liable for the cost of the test. Laboratories are not required to issue an ABN if the physician has already issued one.

In addition, section 40.3.6.4(C) titled ''Frequency Limited Items and Services'' of Chapter 30 of Pub 100–4 of the ''Internet Only Manual'' provides additional guidance for those instances where Medicare has imposed frequency limitations on items or services. This section instructs providers that the provider may routinely give ABNs to beneficiaries and that whenever such a routine ABN is provided to a beneficiary, the ABN must include the frequency limitation as the reason for which Medicare will deny coverage.

Comment: Several commenters, including the ACR and the SIR, offered their assistance to us when we determine whether noninvasive testing for CV disease is necessary.

Response: Since the organizations that suggested noninvasive tests for inclusion in this benefit provided the materials for our review, it is not necessary for us to seek outside assistance. We appreciate the commenters' offer of assistance.

Comment: Four commenters suggested that the CV screening benefit stipulate an age for the population to be tested. We reviewed the USPSTF recommendation that promoted testing for men 35 years and older and women 45 years and older. The commenters believe this age range should be lowered to include those aged 20 years and older and asked us to consider including younger people in this benefit.

Response: The statutory change for this benefit did not include an age for the person to be tested. While some of the USPSTF recommendations included an age or an age range, none was selected for the proposed rule. Since the majority of the individuals in Medicare are generally 65 and older, the belief was that we are looking at an older population rather than concentrating our resources on the younger beneficiaries who may also be disabled and Medicaid eligible or could be eligible for other services due to other complications of CV disease. While there may be individuals younger than 65 years of age that could benefit from this testing, this benefit is intended for those entitled to Medicare. Therefore, any patient entitled to Medicare would be covered for this benefit as specified in this rule.

Comment: One commenter noted that if the patient did not fast for the screening test (fasting may be difficult for some patients), the calculation of LDL cholesterol may be inaccurate. This commenter recommended that for screening purposes, an alternative to repeating the full lipoprotein profile in the fasting state would be a follow-up direct measurement of LDL cholesterol.

Response: If a patient cannot fast and the physician believes the patient's medical history and circumstances suggest the beneficiary is at risk of CV disease, then any additional testing beyond an initial screening would need to be done under the diagnostic clinical laboratory benefit. Under the screening benefit, a repeated full lipoprotein profile (fasting) or a second LDL cholesterol (fasting) would not be covered for anyone who failed to fast when they had their first set of tests.

Comment: Several commenters suggested that the tests that the USPSTF approves for CV screening blood tests be automatically adopted and covered by Medicare for the purposes of this benefit. We would not need to use the NCD process to add tests to this benefit. Immediate adoption of USPSTF recommendations will remove us from our own lengthy review.

Response: While the USPSTF process is well established, we believe it is prudent to review any recommendations from the USPSTF before implementing them. In the proposed rule, we asked the public how we should make changes for this benefit. Because the national coverage determination process allows for public comment before we make any changes, we believe this is the most appropriate basis for any future changes. Further, we may not be able to accept every USPSTF recommendation because of instructional, coding or claims issues that must be resolved before any benefit can be implemented.

Comment: Several commenters questioned whether the screening benefit for CV disease included noninvasive tests or whether it was limited only to blood tests. Further, they recommended that the adoption of noninvasive tests be tied to recommendations of the USPSTF or to an NCD.

Response: We interpreted this portion of the screening benefit to permit noninvasive tests for which there was a blood test recommended by the USPSTF (for example, there is a blood test for cholesterol and if a noninvasive test was developed that detected characteristics of cholesterol, could provide a meaningful (comparison) result and accurate reading) then the noninvasive test could be considered for inclusion in the screening benefit. Noninvasive tests would not be immediately included but would be subject to a review before adoption. When it is time to consider the addition of tests or changes to the list of tests, we will consider any changes through an NCD. This benefit is not limited only to blood tests.

Comment: One commenter recommended that we include a fasting blood glucose test as part of the CV screening blood benefit and that we cover this test every 2 years for beneficiaries over 45 and for younger beneficiaries who are obese or have a family history of diabetes. Fasting blood glucose is inherently a CV screening test because diabetes carries increased risk of CV disease.

Response: While some people who have diabetes exhibit other factors associated with CV disease, we do not see the necessity to adjust the CV screening benefit to include a fasting blood glucose test. The diabetes screening benefit should be able to identify these individuals. Medicare does not plan to duplicate tests when they are available through other screening programs.

Comment: One commenter requested the inclusion of V70.0 for routine examination to be added as one of the ICD–9-CM codes to be covered for screening for CV screening blood tests. They asked that the NCD on lipid panel be reviewed for any codes that were previously denied as routine screening in the past, and that these codes be considered for inclusion under this new benefit.

Response: We believe the majority of individuals who will seek care under this benefit will fit the V81.0, V81.1, or V 81.2 codes. We are willing to review a sample of claims and determine if V70.0 is an appropriate code for this benefit. At this time, we are unable to add V70.0 to the instructions being cleared. Codes that are to be considered for this new benefit must be brought to our attention through the national coverage determination process for laboratories.

Comment: One commenter suggested that the proposed § 410.17 include reference to whether beneficiaries will incur out-of-pocket costs for CV screening blood tests.

Response: Section § 410.17 is specific to coverage instructions for screening tests for the early detection of CV disease. We do not believe it is necessary to revise § 410.17 to include payment instructions. We have indicated that Medicare would pay for the tests under the clinical laboratory fee schedule. Currently under this payment system, beneficiaries do not incur copayments and deductibles in accordance with section 1833(a)(1)(D)(i) of the Act, and is included in

instructions at Medicare Claims Processing Manual, Pub. 100–04, chapter 16, § 30.2.

Comment: Two commenters asked us to clarify why we chose 5 years as the timeframe for the benefit, rather than the 2 years allowed by the statute.

Response: Our primary goal was to allow testing for the population that needed to be screened. In the preamble to the proposed rule, we stipulated that the Clinical Considerations of the USPSTF indicate, while screening may be appropriate in older people, repeated screening is less important because lipid levels are less likely to increase after age 65. Screening individuals more often than necessary might lead to unnecessary expenses and treatment. The scientific literature indicates that lipid levels in the elderly are fairly stable. Therefore, we proposed screening once every 5 years and have not received sufficient evidence to change this position.

Comment: Two commenters suggested that a two-tiered benefit be developed that would allow lipid profile screening tests at least every 5 years for beneficiaries when risk factors are not evident and a second group be screened at least every 2 years. The second group would include individuals who have modifiable risk factors (for example, tobacco smoking, high blood pressure, physical inactivity, obesity, and diabetes mellitus) and non-modifiable risk factors (such as age, gender, race, and family history).

Response: While the CV screening benefit could be expanded to include individuals other than those mentioned in the proposed rule, preventive benefits were added to the Medicare Program on a limited basis as science and technology permit them. Since some of the individuals in the second group already would be screened through the IPPE and the Diabetes Screening Benefit, we are not developing a second tier at this time. We believe expanding this to a second tier would waste precious resources of time and money and not contribute to lowering the risk factors for individuals with CV disease.

Comment: One commenter questioned why we proposed to use the NCD process as the method of making changes to the list of tests covered by the CV screening blood test benefit. The commenter wrote that the MMA does not require that the NCD process be utilized. They indicated that there is no need for us to conduct our own assessment since a thorough evaluation of the test was to be done by the USPSTF in determining that the test is one that it recommends. The commenter objected to the use of the NCD process for consideration of new tests because of the significant delays that mark this process. The commenter also stated that all that would be needed for us to approve the coverage of additional CV screening tests is the recommendation of the USPSTF.

Response: In establishing the benefit for CV screening blood tests, the Congress gave the Secretary the authority to determine which tests would be covered by this benefit. We do not believe it would be proper to delegate this function to USPSTF or any other entity. In the proposed rule, we proposed the tests to be covered for the new benefit when it becomes effective January 1, 2005 and at the same time, we offered the NCD process for changes to this benefit. We proposed that future tests would be added after reviewing the recommendations of the USPSTF and the use of the NCD process. The NCD process actually has several methods for evaluating which tests we may eventually cover. The NCD process includes an application for a new coverage issue, a reconsideration of an existing policy, or a coding change for laboratory tests. We believe the use of the NCD process is a worthwhile endeavor since it is a public process and less time consuming than rulemaking. The use of an NCD is authorized by Section 1871 of the Act.

Comment: One commenter suggested that we include triglycerides as a test for the CV screening blood test benefit since the 2001 USPSTF recommendations for screening for lipid disorders associated with CV disease only includes measurement of total cholesterol and high-density lipoprotein cholesterol (HDL–C).

Response: We have included the triglycerides test as one of the tests for screening for CV disease. For some individuals, triglycerides may detect a risk factor for CV disease. That is why it was more prudent to select a lipid profile that includes the three tests (total cholesterol, HDL-C, and the triglycerides) rather than to indicate the use of individual tests with different test intervals and different ordering patterns.

Comment: One commenter requested that the frequency limit for lipid testing of 5 years be waived if the patient develops a risk factor, such as diabetes, a marked weight gain, etc. in the interval.

Response: A patient screened for lipid testing could also meet the requirements for screening under the diabetes screening benefit. If a patient developed further risk factors which negate the need for continued screening under the CV screening blood test benefit, their additional signs or symptoms would probably cause the person to need to seek treatment which would be covered under other benefits including diagnostic clinical laboratory testing.

Comment: One commenter questioned whether § 410.16 that permits qualified nurse practitioners and others to order CV screening tests under the physical examination (section 611 of the MMA) is inconsistent with § 410.17 that requires that the laboratory tests be ordered by the treating physician (§ 410.32(a)).

Response: Section 410.16 addresses services by NPs because of conforming changes made in section 611(d) of the MMA. Section 410.32(a)(3) permits certain NPPs to furnish services that would be physicians' services if furnished by a physician and who are operating within the scope of their authority under State law and within the scope of their Medicare statutory benefit. We believe that the statute permits the use of NPPs to order tests described under § 410.17 without a change in the statute. The general rule for laboratory tests is that the tests must be ordered by the treating physician and in the instance of screening tests, the treating NPP may be regarded as a physician for this purpose.

Comment: One commenter believed that screening every 5 years was too long a period between tests and that the data we collect be used to allow more frequent testing.

Response: We have heard from commenters that the frequency limitation of keeping records for the 5 years is difficult because of storage, access and retrieval, and orders from multiple physicians. Change in the frequency (that is, the number of times a patient can be tested during a given timeframe) will be considered if the scientific literature supports it. We do not believe we are permitted to change the frequency based solely upon the logistical difficulties in collecting, consolidating, and maintaining administrative data. Modifying the benefit to permit more frequent testing will not resolve these administrative difficulties. However, we will take this recommendation under advisement as we continue to consider the associated clinical data, but will not make any changes for the final rule.

Comment: One commenter requested that blood be removed from the title of this benefit for the final rule. The commenter believed the narrow focus on blood would restrict the types of tests that would be administered for detecting CV disease.

Response: In developing the proposed rule, we included blood in the title of this benefit to be consistent with the

history of this benefit and to distinguish the tests in the benefit. We believe that noninvasive tests could be covered and this benefit is not limited only to blood tests.

Comment: One commenter suggested that the CV screening benefit include an appropriate screening instrument. As with depression, the examining physician has a test based on clinical practice guidelines to use as a tool for assessing the patient. Since the American Heart Association (AHA) and the ACC Guidelines for PAD are expected to be published in 2005, the commenter is requesting that we adapt the patient assessment and include these guidelines under the CV screening benefit.

Response: Since the publication of the AHA and ACC Guidelines has not taken place, it would be difficult to evaluate this document and how physicians would use this in the course of examining a patient. Physicians may use their best judgment for how they assess an individual patient and whether additional specific tests from the AHA and ACC guidelines would be more helpful than what is already included in the screening benefit for CV disease is not something we can conclude at this time. The NCD process is available when additional tests should be considered.

Result of Evaluation of Comments

After reviewing all the comments, we have plans to include the V codes (V81.0, V81.1 and V81.2) in the Laboratory Edit Module, and to release manual and transmittal instructions and information to smooth the transition for the new benefit. Providers who routinely give ABNs to beneficiaries must include in the ABN that the frequency limitation is the reason for which Medicare will deny coverage. A patient who has an ABN and exceeds the frequency limitation may incur out-of-pocket charges. We will finalize the changes to § 410.17 as proposed.

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

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

Section 413(a) of the MMA provides a new 5 percent incentive payment to physicians furnishing services in physician scarcity areas (PSAs). The MMA added a new section 1833(u) of the Act that provides for paying primary care physicians furnishing services in a primary care scarcity county and specialty physicians furnishing services in a specialist care scarcity county an additional amount equal to 5 percent of the amount paid for these services.

Section 1833(u) of the Act defines the two measures of physician scarcity as follows:

1. Primary care scarcity areas—determined by the ratio of primary care physicians to Medicare beneficiaries. A primary care physician is a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist.

2. Specialist care scarcity areas—determined by the ratio of specialty care physicians to Medicare beneficiaries. The specialist care PSA ratio includes all physicians other than primary care physicians as defined in the definition of primary care scarcity areas.

To identify eligible primary care and specialist care scarcity areas, we ranked each county by its ratio of physicians to Medicare beneficiaries. In accordance with the statute, in the list of primary care and specialist care scarcity counties, only those counties with the lowest ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties were considered eligible for the 5 percent incentive payment. In accordance with the section 1833(u) of the Act, we also treated a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification) as an equivalent area (that is, equal to a full county).

Consistent with section 1833(u)(4)(C) of the Act, all PSAs were assigned their 5-digit zip code area so that we may automatically provide the 5 percent incentive payment to eligible physicians. For zip codes that cross county boundaries, we used the dominant county of the postal zip code (as determined by the U.S. Postal Service) to identify areas eligible to receive the 5 percent payment. Section 1833(u)(4)(C) of the Act also requires us to publish a list of eligible areas as part of the proposed and final physician fee schedule rules for the years for which PSAs are identified or revised and to post a list of PSAs on our Web site. *See* Addenda J and H for the zip codes of primary care and specialist care PSAs. The PSA lists by zip code and county are also available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* Since we are publishing these lists for the first time in this final rule with comment period, we are accepting comments for 60 days after the date of publication of this regulation on the zip codes and counties qualifying as physician scarcity areas and will address the comments in next year's fee schedule.

In addition to creating of the 5 percent PSA incentive payment, section 413 of the MMA amended section 1833(m) of the Act to mandate that we pay the 10 percent health professional shortage areas (HPSA) incentive payment to eligible physicians in full county HPSAs without any requirement that the physician identify the HPSA area. We can only achieve this result by assigning zip codes to eligible areas. *See* Addenda I and K for the lists of eligible primary care and mental health HPSAs by zip code. Consistent with the Act, we have also posted a list of links on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment* to assist those physicians located in eligible areas where automation is not feasible, that is, the eligible area could not be assigned a zip code.

In the August 5, 2004 proposed rule, we proposed conforming changes to our regulations to add § 414.66 to provide a 5 percent incentive payment to eligible physicians furnishing covered services in eligible PSAs. We also proposed conforming changes to our regulations to add § 414.67 to codify the 10 percent incentive payment to eligible physicians furnishing covered services in eligible HPSAs, established under the Omnibus Budget Reconciliation Act of 1987 (OBRA) (Pub. L. 100–203), previously implemented through manual issuance.

We received 23 letter comments on the bonus payment provisions of section 413 of the MMA. A summary of those comments and our responses follows:

Comment: One commenter questioned the rationale behind using zip codes for the purpose of identifying eligible areas for physician bonuses. The commenter believes that zip codes are less accurate than political boundaries (counties, census civil divisions, and census tracts).

Response: The statute requires the identification of PSAs on a county basis, except for rural areas (using the Goldsmith Modification). At this time, we can only determine physician scarcity for Goldsmith areas at the zip code level since the Medicare beneficiary data is currently unavailable at the census tract level.

Automation of physician bonus payments can only be achieved by assigning zip codes to eligible areas. That is, the zip code place of service is the only data element reported on the Medicare claim form that would allow automation.

Comment: A commenter believes that our proposal to identify qualified PSAs and HPSAs by zip code for automatic payment purposes is problematic

because zip codes cross county lines. The commenter suggested that a more user-friendly option would be to add a county identifier to the claim form.

Response: The addition of a county code would not resolve the issue of identifying the claims that would have a bonus because not all designated HPSAs and PSAs are full counties. We cannot identify, for an automated payment, services furnished in counties that are only partially designated and Goldsmith areas that are not full counties. In addition, there currently is no place on the standard electronic claims form to accommodate the entry of a county code.

Comment: A commenter requested clarification regarding circumstances when automation of bonus payments is not feasible.

Response: When the boundaries of zip code areas precisely overlay with the boundaries of eligible HPSAs and PSAs, automation of bonus payments is feasible. In other words, eligible physicians furnishing services to Medicare patients within these zip code areas will automatically receive their bonus payments. We can also automate bonus payments within zip code areas that cross outside of qualified county boundaries as long as the zip code, as determined by the U.S. Postal Service, is dominant to the qualified scarcity county. We cannot automate bonus payments when boundaries of zip code areas only partially coincide with the boundaries of HPSAs and PSAs.

Comment: One commenter requested clarification regarding the application of the billing modifier in determining physician eligibility. The commenter inferred from the proposed rule that, if the zip code is not posted as a qualified area, an eligible physician could still receive a bonus payment if a modifier is used.

Response: Eligible physicians furnishing covered services in a portion of an eligible PSA, which cannot be properly assigned a zip code to permit automation of the bonus payment, would need to include the new physician scarcity modifier on the Medicare claim in order to receive the bonus payment. Lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus are available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* If a service is provided in a zip code area that is not listed on the automated payment files, but is within a designated physician scarcity county, the physician must submit the ''AR'' billing modifier with the service in order to receive the bonus payment. Separate lists for the primary care PSAs and the specialty care PSAs are provided on our Web site for both the automated zip codes and the counties.

Comment: A commenter requested clarification on what ratios would be used to identify PSAs. The Health Resources and Services Administration (HRSA) uses a national ratio of 3,500:1, or 3,000:1 if high needs are shown. The commenter requested information on which ratios would be used to determine PSAs for specialty providers, and whether the ratios would be different for different specialty care providers.

Response: Only those counties with the lowest primary care ratios that represent 20 percent of the total number of Medicare beneficiaries residing in the counties will be considered eligible for the 5 percent incentive payment. In other words, we ranked each county by its ratio of physicians to beneficiaries and then designated counties as scarcity areas with the lowest ratios until 20 percent of the Medicare population was reached. A separate specialist physician ratio was calculated to identify specialist care PSAs using the same methods stated. The statutory mandate precludes us from adopting a national physician-to-patient ratio similar to the HPSA designations. By statute, the 20 percent population threshold must serve as the qualifying condition for all counties/rural areas.

For calculating the ratios, section 1833(u)(6) of the Act, as added by the MMA, defines a primary care physician as a general practitioner, family practice practitioner, general internist, obstetrician, or gynecologist. In accordance with the statute, all other physicians were grouped together as specialists for purposes of determining the specialist care PSA list.

Comment: A commenter requested clarification regarding the frequency of updating the eligible zip code list for automatic HPSA bonus payments and its impact on otherwise eligible physicians.

Response: Determination of zip codes eligible for automatic HPSA bonus payment will be made on an annual basis, and there will not be any mid-year updates. We will effectuate revisions made to designations by HRSA the following year for purposes of automatic bonus payments. Consequently, if HRSA changes to the HPSA designations remove physicians in those areas from receiving automatic payment, the zip code areas will remain eligible until the next year when we remove the zip code from our approved list.

Eligible physicians furnishing covered services in newly-designated HPSAs are permitted to add a modifier to their Medicare claims to collect the HPSA incentive payment until our next annual posting of eligible zip codes for automation of bonus payments. In cases where a zip code cannot be properly assigned to the newly-qualified HPSA, physicians furnishing services in the area must continue to bill for the incentive payments using the appropriate modifier.

Comment: A commenter requested that we provide FQHCs with the 5 percent PSA incentive payment. Since the statute does not explicitly exclude other physicians' services (that are billed on an all-inclusive basis), such as those provided in FQHCs or RHCs, the commenter stated that we should extend the new 5 percent bonus payment to FQHC physicians.

Response: As defined in section 1861(aa) of the Act, FQHC and RHC services are not physicians' services, even though physicians' services are frequently a component of the services furnished in these facilities. The services are rather identified as FQHC services. Therefore, services furnished by these providers are not eligible for the incentive payment.

Comment: A commenter has questioned our proposal not to apply the new 5 percent physician incentive payment to the technical component of physicians' services. The commenter stated that extending the new bonus payment to both the professional and technical component of the physicians' services is consistent with Congressional intent and would simplify claims processing.

Response: Section 1833(u) of the Act provides for incentive payments for physicians' services furnished in PSAs. We note that the statute contains two definitions of physicians' services. The first, which appears at section 1861(q) of the Act, defines physicians' services as ''professional services performed by physicians including surgery, consultation, and home, office, and institutional calls.'' The second, which refers to services paid under the physician fee schedule, is found at section 1848(j)(3) of the Act and contains a broader definition of physician services. However, that definition applies only for purposes of section 1848 of the Act.

Since the incentive payment is not included in section 1848 of the Act, the definition of physicians' services specified in section 1861(q) of the Act is the definition that applies. Thus, we believe the best reading of the statute is that only *professional* services furnished

by physicians are eligible for incentive payments.

Comment: A commenter recommended that we extend the HPSA bonus payment to all physicians, regardless of their specialty, when their services are furnished within a mental health HPSA. The commenter believes there is no statutory basis to limit incentive payments just to psychiatrists within mental health HPSAs.

Response: We provide HPSA bonus payments in primary medical care HPSAs to all physicians regardless of specialty (including psychiatrists) in light of the fact that there is significant overlap between primary medical care HPSAs and mental health HPSAs. Furthermore, most primary medical HPSAs, especially in rural areas, also have shortages of specialists. Consequently, there is no apparent need to distinguish between physician specialties within primary medical care HPSAs for determining physician eligibility for bonus payment purposes. However, in the situation where the mental health HPSA does not overlap with a primary medical care HPSA, we allow only psychiatrists to collect the incentive payment. Within these stand-alone mental health HPSAs, there is an adequate supply of physicians for the provision of medical services and a shortage only of those providing mental health services. Therefore, it would be inconsistent with the HPSA incentive payment provisions, as well as an inappropriate use of the Medicare Trust Fund, to pay bonuses to physicians who furnish medical services in service areas without shortages of primary medical services.

Comment: A commenter requested that we count only those practicing physicians who treat Medicare patients when determining the ratio of beneficiaries to practicing physicians. To count all practicing physicians, including those who do not treat Medicare patients would undermine the intent of the provision.

Response: The statute does not permit us to count only Medicare participating physicians to determine PSAs. The statute explicitly requires that we calculate the primary and specialist care ratio by the number of physicians in the active practice of medicine or osteopathy within the county or rural area. Therefore, we must include in the physician tally all actively practicing physicians when determining PSAs.

Comment: A commenter asked that we clarify our methods for determining the number of primary care and specialty care physicians to calculate the physician-to-beneficiary ratio for identifying PSAs. The commenter suggested that we use only the number of practicing physicians when determining the beneficiary to physician ratio, that is, distinguish between licensed physicians and practicing physicians when determining ratios of primary care and specialty care since some physicians continue to be licensed after they retire.

Response: As required by section 413 of the MMA, the determination of eligible PSAs is based on the ratio of ''active practice'' physicians to Medicare beneficiaries within a county or rural area (using the Goldsmith Modification). The physician data source used in calculating scarcity areas is contained in the following:

- The 2001 Physician Characteristics file; and
- The 2001 Physician Address file.

These data are a compilation of:

- The December 2001 AMA Master file;
- The December 2001 American Osteopathic Association (AOA) Physician file; and
- The National Health Service Corps 2001 participant listing.

These physician data files allow for the identification of the physician's active status. Some of the key status indicators to identify practicing physicians include ''clinically active'' and ''Federal employment'' status. Clinically active status was determined using the type of practice, professional employment, and major professional activity fields from AMA and AOA. For example, determining non-active status is based on physicians who—

(1) Are involved in administration, medical teaching, research, and other non-patient care activities; or

(2) Have self-identified as fully retired or otherwise inactive.

We believe that the indicator field of ''fully retired or otherwise inactive'' addresses the specific issue of a physician maintaining his or her license after he or she retires.

Comment: A commenter expressed concern about our use of the AMA database to determine the number of licensed physicians engaged in direct patient care in each State. The commenter claims that the AMA database overstates the number of practicing physicians in the State of California by at least 10,000 physicians. In light of this concern, the commenter stated that we should use State medical board licensing information rather than the AMA database in determining the physician counts.

Response: The physician data source used in calculating scarcity areas is contained in the 2001 Physician Characteristics file and the 2001 Physician Address file. These data are a compilation of the December 2001 AMA Master file, the December 2001 AOA Physician file, and the National Health Service Corps 2001 participant listing. We made the decision to use the AMA Master file as well as the other files as the sources of physician data in scarcity calculations because there is no other adequate source of national physician data. It may be possible to obtain physician data from each individual State agency, but doing so would entail considerable administrative and technical difficulties. Furthermore, methods of gathering and compiling data may be inconsistent in different States. State agencies may vary greatly in terms of the methods used to update physician databases, the frequency of updates, how the data are stored, the type of information collected, and so forth. In addition, States may use their own classification systems for physician specialties, types of practice, and other key information, and these systems may change over time.

Comment: A commenter encouraged us to implement similar incentive payment programs for non-physician practitioners, for example, Certified Registered Nurse Anesthetists and physician assistants.

Response: We do not have the authority to provide bonus payments to non-physicians. Sections 1833(m) and 1833(u) of the Act authorize bonus payments only to physicians.

Comment: A commenter requested that we immediately publish the already identified PSAs by zip code and specify the specialties in short demand within each eligible PSA.

Response: Lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus, are now available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment.* See Addenda J and H for the zip code list of PSAs for primary care and specialist care.

We have forwarded to the Health Resources and Services Administration the request for identification of specialties in short supply within PSAs. That Agency has responsibility for physician manpower issues.

Comment: A commenter requested that the list of scarcity areas should be made interim in the final fee schedule rule in order to give physicians sufficient time to review and comment on the proposal.

Response: Although we made these lists public on our Web site on October 1, 2004, we will accept comments for 60 days after the date of publication of this regulation on the zip codes and counties

qualifying as physician scarcity areas and will address the comments in next year's fee schedule.

Comment: A commenter expressed appreciation for our effort to fairly implement the incentive payments to physicians in scarcity areas. As this new incentive payment program is implemented, physicians must be informed that this bonus is available, and it must be simple for them to receive the bonus.

Response: We have already made available on our Web site at *http://www.cms.hhs.gov/providers/bonuspayment* the lists of the zip codes that are eligible for the automated payment, as well as a list of the counties that are eligible to receive the PSA bonus. We have also issued a *Medlearn* article to educate the physician community regarding Medicare physician incentive payment programs. For a copy of this provider education article go to: *http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/SE0449.pd.* Lastly, Medicare's contractors have established their own Web site links for the HPSA incentive payment program to facilitate the payment of these bonuses to eligible physicians.

Comment: A commenter expressed support of our proposed changes relating to incentive payments for services provided in areas designated as HPSAs and PSAs. The commenter also commended us for our prompt implementation of section 413 of the MMA. Another commenter expressed appreciation that the new 5 percent incentive is available to specialists in counties with short supply of these physicians.

Response: We appreciate this positive feedback from the provider community.

Comment: A commenter has questioned the rationale for our policy of imposing, as a condition of eligibility, the requirement that the specific location at which the service is furnished must be considered a HPSA or PSA. Since physicians do not always reside in the county where they provide services, identifying PSAs on one basis and paying for them on another basis may be problematic.

Response: According to section 1833 of the Act, we make bonus payments for physicians' services furnished in an eligible HPSA or PSA. Thus, the place of service controls the availability of the bonus. A physician providing a service in his or her office, a patient's home, or in a hospital may receive the incentive payment only if the service occurs within an eligible shortage or scarcity area.

Comment: One commenter believes that podiatric physicians, who are considered specialists, should be among those eligible to receive the additional 5 percent incentive payment.

Response: Section 1833(u) of the Act, as added by the MMA, specifically defines ''physician'' as one described in section 1861(r)(1) of the Act. Therefore, we do not have authority to make bonus payments to podiatrists.

Commenter: A commenter expressed concern that our systems had trouble implementing the HPSA bonuses under Method II for Critical Access Hospital (CAH) participation, and some providers have waited more than two years for increased Medicare payments.

Response: Although some fiscal intermediaries may not have been accustomed to processing physician claims, these systems were updated and the problems resolved as of July 1, 2004.

Comment: A commenter from California requested that physicians who provide Medicare services only through managed care not be included in our calculations. The commenter believes that including physicians who only treat managed care patients in the count to determine physician scarcity areas will lead to a gross overstatement of the number of physicians available to provide care to fee-for-service Medicare patients.

Response: We do not believe that we have the legal authority to exclude managed care physicians from the ratio calculations. Moreover, excluding managed care physicians in the county-wide physician tally would not change PSAs in California based on our calculations. In fact, excluding the managed care physicians would make five eligible areas ineligible.

Result of Evaluation of Comments

We are finalizing § 414.66 and § 414.67 as proposed. We are accepting public comments on the zip code areas.

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

1. Average Sales Price (ASP) Payment Methodology

a. Background

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

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

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

The new ASP drug payment system is based on data submitted to us quarterly by manufacturers. Payment amounts will be updated quarterly based on the manufacturer's ASP calculated for the most recent calendar quarter for which data are available. We intend to implement the quarterly pricing changes through program instructions or otherwise, as permitted under Section 1847A(c)(5)(C). For calendar quarters beginning on or after January 1, 2004, the statute requires manufacturers to report their ASP data to us for almost all Medicare Part B drugs not paid on a cost or prospective payment basis. Manufacturers' submissions are due to us not later than 30 days after the last day of each calendar quarter.

The methodology for developing Medicare drug payment allowances based on the manufacturer's submitted ASP data is described in this final rule and reflected in final revisions to the regulations at § 405.517 and new Subpart K in part 414. Several comments discussed aspects of the manufacturers' calculation of ASP that are beyond the scope of this final rule. We did not propose any changes to the regulations concerning the manufacturer's calculation of ASP. We also received other comments regarding the use of the least costly alternative (LCA) methodology when pricing drugs, and requests for new HCPCS codes for drugs and coverage of compounded drugs. These comments are also outside the scope of this final rule. We did not propose any changes to the LCA policy, the HCPCS process, or coverage of compounded drugs.

b. Provisions of the Final Rule

i. The ASP Methodology

Effective 2005, payment for certain drugs and biologicals not paid on a cost or prospective payment basis furnished on or after January 1, 2005 will be based on an ASP methodology.

As described in section 1847A(b)(3)(A) of the Act for multiple source drugs and section 1847A(b)(4)(A) for single source drugs, the ASP for all

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

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

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

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

Comment: One commenter suggested that we implement the ASP methodology on a pilot basis prior to a national rollout. A physician interest group recommended that we delay the implementation of the ASP payment system for at least one year. The interest group stated that we should inform physicians of the ASP for all covered drugs before the final rule is issued and allow physicians to comment on the proposed rates after an informed and complete review process.

Response: The law requires that the new ASP-based drug pricing system be implemented January 1, 2005. The January 1, 2005 prices will be based on the data submitted to us no later than 30 days after the end of the third calendar year quarter of 2004. Given the requirements surrounding the timing of the promulgation of the physician fee schedule final rule, we will not have the January 1, 2005 prices available before the publication of the final rule. However, our goal is to provide as much information on Medicare Part B drug payment rates as possible as early as possible prior to the January 1, 2005 effective date of those rates.

Comment: A provider asked that we earmark funds to enable physicians to transition from the AWP–15 percent payment system to the ASP + 6 percent payment system.

Response: We do not have statutory authority to create such a transition fund.

Comment: One commenter stated that the ASP plan does not account for price increases in a timely manner. Another commenter expressed concern that because ASP modifications lag by at least two calendar quarters, market prices would not be reflected in a drug's payment limit for at least six months after a pricing adjustment.

Response: The ASP methodology is based on average sales prices reported by manufacturers quarterly. Manufacturers must report to us no later than 30 days after the close of the quarter. We implement these new prices through program instructions or otherwise at the first opportunity after we receive the data, which is the calendar quarter after receipt.

Comment: Some commenters expressed concern that the ASP + 6 percent payment methodology would discourage providers from using generic drugs and would increase the tendency to use newer or more expensive agents.

Response: It is true that the higher the average sales price of a drug, the greater amount of money represented by 6 percent of that price. However, Section 1847A specifies that payment is at 106 percent of ASP. The law requires the use of the new ASP + 6 percent payment system except in the limited instances described below in Sections V and VI.

Comment: Several commenters suggested that we should establish a mechanism to provide the public with an opportunity to identify errors in the ASP-based payment rates before the start of the calendar quarter in which the rates are effective. They believe that this mechanism would minimize errors by permitting posting of the rates several weeks prior to the effective date.

Response: Our goal is to provide as much information on Medicare Part B drug payment rates as possible as early as possible prior to the effective date of those rates.

Comment: A physician specialty group recommended that we use our inherent reasonableness authority to increase drug payments up to 15 percent where necessary to make the Medicare payment level sufficient to cover the price of drugs charged by specialty distributors that service the physician office market.

Response: We do not have sufficient data to determine whether our inherent reasonableness authority would apply in this instance. Even if our inherent reasonableness authority were triggered, our data are insufficient to determine whether the adjustment the commenters request would be appropriate.

Comment: Several commenters urged us to weigh the full range of potential consequences to patient care, especially in the oncology setting, with the implementation of the ASP payment methodology. They recommended that we take into consideration concerns such as the potential inability of providers to purchase drugs below the new reimbursement rate, the inability of oncologists to provide access to important under-reimbursed support services, and the disproportionate impact of these changes on rural providers necessitating a shift in care of sick cancer patient from community settings to the hospital. Some commenters suggested that we place a form on its Web site enabling beneficiaries to identify access problems. One commenter suggested that we perform a 1-year monitoring study to evaluate the quality of care issues and delay implementation until the results of the study are known.

Response: Although we do not expect access problems under the new ASP + 6 percent payment system, we will be monitoring patient access through our 1–800–MEDICARE line, regional office staff, claims analysis, and other environmental scanning activities. We will work with Congress if access issues arise. The law requires that the new ASP-based drug pricing system be implemented January 1, 2005.

Comment: Several commenters expressed concern regarding the statements on joining group purchasing organizations (GPOs) to improve their purchasing power. They indicate that

the size of the discount is based on the individual GPO member's purchases, not the combined purchases of the GPO members. Thus, membership in a GPO would not necessarily result in a greater discount. They also point out that retail pharmacies do not have access to GPO purchasing arrangements. One commenter requested that we offer more tangible suggestions for obtaining drugs at the ASP +6 percent price other than encouraging physicians to participate in purchasing groups.

Response: The law requires that the new ASP-based drug pricing system be implemented January 1, 2006. A recent survey of oncology practices performed by the American Society of Clinical Oncology indicated that the purchase price of drugs is not necessarily driven by practice size. It would appear that smaller purchasers are on average sometimes able to achieve similar drug pricing to larger purchasers. The OIG is conducting a study due not later than October 1, 2005, on the ability of different size physician practices in the specialties of hematology, hematology/oncology, and medical oncology to obtain drugs at 106 percent of the average sales price. We are currently conducting another MMA-mandated study of sales of drugs to large volume purchasers that is due not later than January 1, 2006. We will seek to work with physicians, providers, and suppliers on ways to encourage prudent purchasing, including to the extent practicable the dissemination of information on lower cost suppliers of Medicare Part B drugs. We would welcome suggestions on ways to accomplish this goal.

Comment: One commenter suggested that classes of trade should be taken into account when establishing ASP payment rates.

Response: The law does not permit the exclusion of or differentiation by classes of trade in the calculation of the ASP payment rates, except for the specific statutory exceptions described in the Medicaid best price calculation under sections 1927(c)(1)(C)(i) and 1927(c)(1)(C)(ii)(III) of the Act. The statute specifies a payment rate of 106 percent of ASP.

Comment: A drug manufacturer urges us to reject any requests to publish the NDC-specific ASPs as the publishing of the rates would facilitate inappropriate conduct.

Response: The law does not permit the disclosure of NDC level ASPs in a form that discloses the identity of a specific manufacturer or prices charged by the manufacturer except in accordance with Section 1927(b)(3)(D) of the Act. That provision permits the disclosure of such data as the Secretary determines to be necessary to effectuate the provisions of section 1847A of the Act.

v. Limitations on ASP

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

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

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

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

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

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

Comment: One commenter urged us to provide further guidance on the widely available market price (WAMP) methodology, specifically how the OIG will compare ASP to WAMP. The commenter also requested guidance on how WAMP will be determined in the case of multiple drugs represented by a single J-code. Other commenters stated that we should provide greater guidance for how it will substitute WAMP for ASP. These commenters also suggested that we provide guidance on how it will treat quarterly oscillations between ASP and WAMP.

Response: The OIG is developing its methodology regarding the widely available market price. Because the determination of WAMP is within OIG's purview, we believe it is premature to address the implementation issues prior to the OIG establishing its methodology and conducting its first review.

Comment: Several commenters recommend that we make adjustments where there is a disparity between the ASP-based payment limit and the physician acquisition cost. These commenters recommended that we raise the payment rate if the WAMP is higher than ASP.

Response: Section 1847A of the Act does not provide authority to increase the ASP-based payment system based on the review of the OIG.

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

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

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

Comment: Several commenters requested that we provide guidance on how the payment rate for a new drug in its second calendar quarter will be determined. They recommend that we utilize the same methodology for the 2nd quarter payment as for the 1st quarter; that is, use the WAC or methodologies in effect on November 1, 2003.

Response: Pursuant to section 1847A(c)(4) of the Act, during an initial period (not to exceed a full calendar quarter) where data on prices for sales for a drug are not sufficiently available from the manufacturer to compute an ASP, we will pay based on WAC or the methodologies in effect on November 1, 2003 for a limited period. This time period will start on the date that sales of the drug begin and end at the beginning of the quarter after we receive information from the manufacturer regarding ASP for the first full quarter of sales.

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

Section 1841(o)(1)(A)(iv) of the Act requires that influenza, pneumococcal, and hepatitis B vaccines described in subparagraph (A) or (B) of section 1861(s)(10) of the Act be paid based on 95 percent of the average wholesale price (AWP) of the drug. The AWP payment rates for these vaccines will be updated quarterly. No commenters objected.

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

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

We received numerous comments regarding our proposed payments rate of ASP minus 3 percent. Those comments and responses are provided below.

Comment: Commenters questioned the basis for our decision to pay for separately reimbursed drugs at a rate of ASP minus three percent. These commenters stated that ASP minus 3 percent was not acquisition cost as determined by OIG and did not reflect the acquisition cost relationship between these drugs. Some commenters questioned the relationship between the ASP definition used by the OIG and the current definition. Commenters stated that we should base the payment rates on the acquisition cost of each drug as reported by the OIG updated to 2005 rather than an ASP-based formula. Some commenters indicated that the acquisition cost should be updated to 2005 and suggested an update using the same annual factor used for budget neutrality calculations. For drugs not included in the OIG report, some commenters suggested that we use the same methodology for most other Medicare Part B drugs, namely ASP plus 6 percent. Commenters indicated we should consider two tiers of payment based on provider size to minimize the discrepancy between large and small providers or in the absence of two tiers base the payment on the acquisition cost of the facilities not owned or managed by the four largest providers. Commenters also asked for clarification of the payment basis for separately billable ESRD drugs other than EPO billed by hospital based ESRD facilities since these drugs historically were not paid based on AWP but rather based on reasonable cost.

Response: We agree with the commenters who suggested we base the 2005 payment rates for separately billable ESRD drugs on the actual dollar value of the acquisition costs as determined by the IG rather than the acquisition costs relative to the ASP. We also agree that we should update the IG acquisition costs to calculate 2005 rates. After consideration of the available price data, we have determined that the Producer Price Index (PPI) for prescription preparations is the most appropriate price measure for updating EPO and other separately billable drugs from 2003 to 2005. The PPI for prescription preparations is released monthly by the Bureau of Labor Statistics, and reflects price changes at the wholesale or manufacturer stage. By comparison, the Consumer Price Index (CPI) for prescription drugs reflects price changes at the retail stage. Because EPO and many of the separately billable drugs used by dialysis facilities are purchased directly from the manufacturer, the use of a price index that measures wholesale rather than retail prices is more appropriate. The PPI for prescription drugs is the measure used in the various market baskets that update Medicare payments to hospitals, physicians, skilled nursing facilities, and home health agencies. In addition, the PPI for prescription drugs was recommended for use in the proposed composite rate market basket detailed in the 2003 Report to Congress.

Based on historical data through the second quarter of 2004, we used the Global Insight Inc. forecast of the PPI for prescription drugs to determine the update factors for 2004 and 2005. We feel the use of an independent forecast, in this case from Global Insight Inc., is superior to using the Naational Health Expenditure projections for drug prices (which is the CPI for prescription drugs) and is consistent with the methodology used in projecting market basket increases for Medicare prospective payment systems.

We also agree with those commenters who suggested that the drugs not contained in the IG study should be paid at ASP plus 6 percent. We believe it is appropriate for the payment amount for these drugs when separately billed by ESRD facilities during 2005 to be the same as the payment amount for other entities that are paid by Medicare on other than a cost or prospective payment basis. We do not agree with commenters that we should establish separate drug payment rates for large and small providers. For reasons discussed in the section of this final rule on the ESRD composite rate, we believe it is appropriate to establish a single add-on payment to the composite rate and therefore appropriate to establish the same drug payment rates for both large and small providers. We do not believe it is appropriate to base the payment amount on only the higher acquisition cost of the facilities not owned or managed by the four largest providers and not take into account the acquisition costs of the largest four providers who represent the majority of the drug expenditures. Section 1881(b)(13)(A)(ii) of the Social Security Act refers to ''the acquisition cost of the drug or biological'' and not the acquisition costs of the drug or biological. In accordance with the statute and our understanding of Congressional intent for 2005, we believe it is more appropriate to base the 2005 payment amounts on a weighted average of the acquisition costs of the four largest providers and the other

facilities rather than base the 2005 payment amounts solely on the acquisition costs of the other facilities.

In response to the commenters who requested clarification of the payment basis for separately billable ESRD drugs other than EPO billed by hospital-based ESRD facilities, we did not propose changes to the reasonable cost payment basis for these drugs. The OIG did not study separately billable ESRD drugs other than EPO billed by hospital-based ESRD facilities and accordingly, we did not propose to change the payment basis for these drugs.

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

In 2005, section 1841(o)(1)(D)(i) of the Act requires that an infusion drug furnished through an item of DME covered under section 1861(n) of the Act be paid 95 percent of the average wholesale price for that drug in effect on October 1, 2003. No commenters objected.

2. Drug Administration Payment Policy and Coding Effective in 2005

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

The AMA's CPT Editorial Panel established a workgroup, with representatives from affected specialties that met earlier this year to develop recommendations to the CPT Editorial Panel in August. Based on these recommendations, that panel adopted several new drug administration codes and revised several existing codes. Subsequently, the AMA's Relative Value Update Committee (RUC) met at the end of September to make recommendations to us on the practice expense resource inputs and work relative values for the new and revised drug administration codes.

We indicated in the proposed rule that we would consider whether it is necessary for us to make coding changes effective January 1, 2005 through the use of G-codes (because the 2005 CPT book will have already been published), and we requested public comment. As described in detail below, we are establishing new G-codes for 2005 that correspond with the new CPT codes that will become active in 2006. These new G-codes are interim until 2006.

The new CPT codes can be categorized into the following three categories of drug administration services: infusion for hydration; nonchemotherapy therapeutic/diagnostic injections and infusions other than hydration; and chemotherapy administration (other than hydration) which includes infusions/injections. There are some important changes in the new codes relative to current drug administration coding. The infusion of substances such as monoclonal antibody agents or other biologic response modifiers is reported under the chemotherapy codes, instead of the nonchemotherapy infusion codes, as is currently the case. There are also new codes in both the chemotherapy and nonchemotherapy sections for reporting the additional sequential infusion of different substances or drugs.

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

We received many comments on various aspects of coding and payment for drug administration services in response to the proposed rule. We are also responding below to comments we received on the January 7, 2004 interim final rule with comment period that announced the provisions of section 303 of the MMA affecting drug administration services that took effect in 2004 (69 FR 1094). Specifically, section 303 of the MMA required the following changes in 2004: a transitional adjustment that increases payments for specific drug administration services by 32 percent in 2004 (and 3 percent in 2005); establishing work RVUs for certain drug administration services equal to the work RVUs for a level 1 office medical visit for an established patient; the incorporation of supplemental survey data in the calculation of the practice expense RVUs for drug administration codes; and allowing oncologists to bill for multiple drug administrations by the ''push'' technique on a single day.

Comment: Many commenters supported the efforts to promptly evaluate existing drug administration codes to ensure accurate reporting and billing for services. They support our proposal to use G-codes until the new CPT codes are active. They asked us to adopt the recommendations of the CPT Editorial Panel for new drug administration codes.

Response: We appreciate the support of the commenters of all of the efforts to expeditiously review and update these codes. We also would like to specifically recognize the efforts of the CPT Editorial Panel's Drug Administration Workgroup to develop the new CPT codes, the Editorial Panel for its consideration and approval of the new codes, and the RUC for its similar efforts to develop recommendations for the inputs for the new codes.

We have reviewed the recommendations of the CPT Editorial Panel and, with one exception noted below, agree with their new and revised codes for drug administration for 2005. Because the new CPT codes will not be included in the 2005 CPT, we have decided to establish G-codes, where applicable. At this time, we anticipate these new G-codes will be temporary until the new CPT codes become active January 1, 2006.

A listing of the old CPT codes and their corresponding G-codes are in the table below. Some of the old CPT codes will correspond to more than one G-code, and there are codes that will allow physicians to bill for services that previously did not have a code or were bundled into other services.

The drug administration codes are divided into three categories: infusion codes for hydration; codes for therapeutic/diagnostic injections; and chemotherapy administration codes. The descriptions of the codes below are taken primarily from the AMA CPT Editorial Panel. We are including these specific descriptions here in order to provide as much information as possible about the new G-codes prior to their implementation on January 1, 2005. However, we anticipate that we will issue further instructions regarding the appropriate use of these G-codes, including clarifications, interpretations, and other modifications to the following guidance (apart from the G-codes

themselves) as part of any instructions issued through a subregulatory process.

The codes for hydration (G0345 and G0346 in the table below) are for reporting hydration intravenous (IV) infusions consisting of a prepackaged fluid and electrolytes. These codes are not used to report infusion of drugs or other substances. The codes for chemotherapy administration are to be used for reporting the administration of non-radionuclide anti-neoplastic drugs, and anti-neoplastic agents provided for treatment of noncancer diagnoses, or substances such as monoclonal antibody agents and other biologic response modifiers. The remaining codes are for reporting injections and infusions for all drug administrations that were previously reported using CPT codes 90780–90788, 96400, and 96408–96414 (other than those described above as hydration or chemotherapy).

TABLE 8: Comparison of old CPT codes to G codes

Hydration

Old CPT	G Code	Descriptor
90780	G0345	Intravenous infusion, hydration; initial, up to one hour
90781	G0346	each additional hour, up to eight (8) hours

Injections and Infusions (Non-Chemotherapy, other than hydration)

Old CPT	G Code	Descriptor
90780	G0347	Intravenous infusion, for therapy/diagnosis, initial, up to one hour
90781	G0349	additional sequential infusion, up to one hour
90781	G0348	each additional hour, up to eight (8) hours
N/A	G0350	Concurrent infusion

Old CPT	G Code	Descriptor
90782	G0351	Therapeutic or diagnostic injection
90783	N/A	intra-arterial
90784	G0353	intravenous push, single or initial substance/drug
N/A	G0354	each additional sequential intravenous push
90788	N/A	Intramuscular injection of antibiotic
90799	N/A	Unlisted injection or infusion

Chemotherapy Administration

Old CPT	G Code	Descriptor
96400	G0355	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic
96400	G0356	hormonal anti-neoplastic
96405	N/A	Chemotherapy administration; intralesional, up to and including 7 lesions
96406	N/A	intralesional, more than 7 lesions
96408	G0357	intravenous, push technique, single or initial substance/drug
96408	G0358	intravenous, push technique, each additional substance/drug
96410	G0359	Chemotherapy administration, intravenous infusion technique; Up to one hour, single or initial substance/drug
96412	G0360	each additional hour, one to eight (8) hours
96414	G0361	initiation of prolonged chemotherapy infusion
96412	G0362	each additional sequential infusion, up to one hour
96420	N/A	Chemotherapy administration, intra-arterial; push technique
96422	N/A	infusion technique, up to one hour
96423	N/A	infusion technique, each additional hour, one to eight hours

96425	N/A	infusion technique, initiation of prolonged infusion (more than eight hours)
96440	N/A	Chemotherapy administration into pleural cavity
96445	N/A	Chemotherapy administration into peritoneal cavity
96450	N/A	Chemotherapy administration into CNS
96520	N/A	Refilling and maintenance of portable pump
N/A	G0363	Irrigation of implanted venous access device for drug delivery systems
96530	N/A	Refilling and maintenance of implantable pump
96542	N/A	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents

The following coding guidance is based on the CPT Editorial Panel's explanatory language for the new CPT codes. As noted above, we plan to issue further guidance as needed.

Infusions that were previously reported under CPT code 90780 (non-chemotherapy infusion, 1st hour) will be billed under one of three G-codes beginning January 1, 2005. The first hour of a hydration infusion will be billed under G0345. The first hour of infusion of a nonchemotherapy drug other than hydration will be billed under G0347. The first hour of infusion of anti-neoplastic agents provided for treatment of noncancer diagnoses or substances such as monoclonal antibody agents and other biologic response modifiers is billed under G0359.

Similarly, services that were previously reported under CPT code 90781 (non-chemotherapy infusion, each additional hour) will be billed under one of four G-codes beginning January 1, 2005. Each additional hour of a hydration infusion will be billed under G0346. Each additional hour of a nonchemotherapy infusion will be billed under G0348. Currently, if a second (or other subsequent) nonchemotherapy drug is administered sequentially, the physician would bill code 90781 for the additional hour of infusion. Under the new G-codes, the physician will bill G0349, the sequential administration of a second or subsequent nonchemotherapy drug. In addition, each additional hour of the infusion of anti-neoplastic agents for the treatment of noncancer diagnoses or substances such as monoclonal antibodies and other biological modifiers is billed under G0360.

Injections that were previously billed under CPT code 90782 will now be billed under HCPCS code G0351. Physicians should use HCPCS code G0352 for injections previously billed under CPT code 90783. Nonchemotherapy drugs administered by IV push (currently using CPT code 90784) should now be billed under HCPCS code G0353. The CPT book does not currently contain a code for physicians to bill a second (or other subsequent) nonchemotherapy drug administered by IV push. The CPT Editorial Panel created a new code for each additional nonchemotherapy drug administered by IV push. For 2005, the physician should bill HCPCS code G0354.

The CPT coding system will be deleting code 90788 (Intramuscular injection of antibiotic) in 2006. We are maintaining CPT code 90788 as an active code until it is changed in the CPT coding system and instructions are provided on the code to bill in its place beginning January 1, 2006.

Chemotherapy injections, previously billed under the CPT code 96400, will now be billed using one of two new G-codes. For injection of nonhormonal anti-neoplastic drugs, the physician should bill HCPCS code G0355. For injection of hormonal anti-neoplastic drugs, the physician should bill HCPCS code G0356. CPT is not recommending any changes to CPT codes 96405 (Chemotherapy administration; intralesional, up to and including 7 lesions) and 96406 (more than 7 lesions), and these codes will remain active for Medicare in 2005.

Chemotherapy drugs administered by IV push (currently billed under CPT code 96408, or, if the drug meets the expanded definition of chemotherapy including monoclonal antibodies or other biologic response modifiers, currently billed under CPT code 90784) should be billed using G0357 for the initial drug administered. In 2004, Medicare paid for the second (or other subsequent) chemotherapy drug administered by IV push under CPT code 96408. CPT will be establishing a code that recognizes the resource inputs associated with each additional chemotherapy drug administered by IV push. For 2005, the analogous code to bill the second (or other subsequent) chemotherapy drug administered by IV push is G0358.

The first hour of chemotherapy administration, previously billed under CPT code 96410, should now be billed under CPT code G0359. Each additional hour of chemotherapy (previously billed under CPT code 96412) should now be billed under CPT code G0360. CPT is also recommending a new code for the first hour of a different chemotherapy drug administered sequentially by infusion. If a second chemotherapy drug is administered sequentially, the physician should bill for HCPCS G0362 for the first hour of infusion of the second drug. All additional hours (up to eight total hours) of chemotherapy infusion should be billed using HCPCS code G0360. Prolonged chemotherapy infusions (8 hours or more, previously billed under code 96414) should be billed in 2005 using HCPCS code G0361.

For three codes (G0350, G0354, G0363), the table above has an ''N/A'' listed in the ''Old CPT'' column, meaning there were no CPT codes that existed explicitly for these services. These services will now be billable under the new coding system. For instance, CPT will be establishing a code for a ''concurrent infusion.'' A concurrent infusion refers to the simultaneous infusion of two nonchemotherapy drugs. We are using temporary code G0350 for this service. Code G0350 is an add-on code. It must be reported as an ''add-on'' or with another code and our payment reflects the incremental resources associated with infusing the second drug. For example, if two nonchemotherapy drugs are infused concurrently, the physician bills G0347 for the initial drug infused and G0350 as an add-on.

As indicated above, HCPCS code G0354 is a new code for each additional sequentialnonchemotherapy drug administered by IV push. HCPCS code G0354 is also an add-on code. In general, G0354 will be an add-on to G0353. However, it is possible that a nonchemotherapy drug administered by IV push may follow the administration of a chemotherapy drug administered by IV push, and HCPCS code G0354 would then be an add-on to HCPCS code G0357.

HCPCS code G0363 is a new code for irrigation of an implanted venous access device. There is currently no code to describe this service. Medicare will pay for G0363 if it is the only service provided that day. If there is a visit or other drug administration service provided on the same day, payment for this service is bundled into payment for the other service.

We are creating the following new add-on G-codes: G0346, G0348, G0349, G0350, G0354, G0358, G0360 and G0362. As indicated above, add-on codes must be billed with other codes, and our payment reflects the incremental resources associated with providing the additional service. The initial codes that these add-on codes could potentially be billed with include: G0345, G0347, G0353, G0357 and G0359. If a combination of chemotherapy, nonchemotherapy drugs, and/or hydration is administered by infusion sequentially, the initial code that best describes the service should always be billed irrespective of the order in which the infusions occur.

Comment: In the January 7, 2004 interim final rule with comment, we revised our payment policy for pushes of chemotherapy drugs to allow for payment of multiple pushes of different chemotherapy agents in one day. A commenter asked that we revise our policy for multiple pushes of nonchemotherapy agents, to allow multiple billings on a single day.

Response: The CPT/RUC recommendations address this comment. New codes have been created to account for the resources associated with multiple chemotherapy and nonchemotherapy drugs administered by IV push. HCPCS code G0353 is used for the initial IV push of a nonchemotherapy drug, while HCPCS code G0354 is used for each additional push of a nonchemotherapy drug. For chemotherapy drugs administered by IV push, HCPCS code G0357 is used for the first drug administered, while HCPCS code G0358 is used for each additional drug.

We also note that existing CPT codes 90782–90788 (Therapeutic, prophylactic or diagnostic injections) currently have a status indicator of ''T'', which means that payment for the service is bundled unless it is the only service billed by the physician for the patient that day. However, based on the RUC recommendations and the resulting values for the injection services, we are making the status indicator on HCPCS codes G0351—G0354 an ''A'', which will allow them to be separately paid even if another physician fee schedule service is billed for the same patient that day.

Comment: A commenter stated that, given the increased work and practice expense RVUs for drug administration codes, it follows that both the work and practice expense RVUs for the immunization administration codes (90471, 90472, 90473, and 90474) should also be increased. The commenter argued that the service involved in administering vaccines is more intense/complex than the service involved in the drug infusion codes.

Response: We agree with the commenter that the physician work and practice expenses associated with administering injections are similar to immunizations. In addition, we would point out that we currently pay for vaccine administrations (G0008–G0010) based on crosswalking the RVUs to CPT code 90471. Therefore, any changes to the physician work and practice expense RVUs for code 90471 would also affect payments for vaccine administrations.

Because we agree these services should be similar in the amount of physician work involved, we are assigning the physician work value recommended by the RUC for code 90782 (G-code G0351) to code 90471 and HCPCS G-codes G0008–G0010. We are combining the utilization data for all of these codes to determine a single practice expense RVU that will be applied to each of these codes.

We are also assigning a work RVU of 0.15 to code 90472. Codes 90473 (Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)) and 90474 (Each additional vaccine (single or combination vaccine/toxoid)) are currently not covered. We are changing the status of these codes to ''R'', or restricted, meaning they are payable under some circumstances after carrier review. These codes will be carrier priced.

Comment: If a patient receives chemotherapy infusions, CPT code 96410 is used to report the infusion of the first drug up to one hour. Chemotherapy drugs are usually administered sequentially. Thus, if a patient receives the administration of a second chemotherapy drug at the same treatment session, CPT code 96412 is used to report the infusion of the second drug for each additional hour of infusion. In 2004, the national payment, including the transitional payment adjustment of 32 percent, for CPT code 96410 is $217. The comparable payment for CPT code 96412 is $48.

Commenters pointed out that this policy does not take into account the levels of complexity of administration and resource consumption. The administration of multiple drugs requires additional preparation time, supplies, and patient education, not currently accounted for in CPT code 96412.

Response: The CPT/RUC recommendations addressed this issue. We are implementing new code G0362, Chemotherapy administration, intravenous technique; each additional sequential infusion, up to one hour. This code will allow, effective January 1, 2005, physicians to begin to bill for the first hour of chemotherapy of the second chemotherapy drug administered.

Comment: Several commenters requested clarification that the changes to the drug administration codes resulting from the CPT changes and our G-codes would be exempted from budget neutrality by the provision at section 1848(c)(2)(B)(iv)(III), as added by MMA section 303(a)(1). This provision stipulates that the evaluation of the existing drug administration codes described above as leading to the interim G-codes and the new CPT codes for 2006, is to be exempt from budget neutrality.

Response: The commenters are correct that the additional expenditures that result from the interim G-code changes we are implementing in this rule are exempt from budget neutrality.

Comment: Several commenters asked that we continue payment for drug administration codes at the 2004 levels, which included the 32 percent transitional payment adjustment, instead of paying at the 3 percent transitional payment adjustment for 2005, or adopt other measures. For example, commenters suggested temporary codes to offset the large reductions that would otherwise go into effect in 2005.

Response: Section 303(a)(4) of the MMA is very specific on the application of the transitional payment adjustments in 2004 and 2005. We do not have the legal authority to continue payments based on the 2004 payment levels. In 2005, the transitional adjustment percentage for drug administration

decreases from 32 percent to 3 percent. No transitional percentage is applied in 2006 or subsequent years.

Comment: One commenter requested additional temporary G-codes to offset the payment reductions for oncologists that would otherwise go into effect in 2005. According to this commenter, the payment amount associated with each of these codes would be a percentage add-on amount sufficient to offset the reductions in drug margins and payments for drug administration services.

Response: We have worked extensively with the major associations representing oncologists and their patients to ensure that Medicare continues to pay appropriately for these extremely critical services. The payment changes we made for 2004, the new G-codes, and allowing additional payment for injections and additional infusions, either have already increased, or will increase, payments for drug administration services. The impacts of these changes are discussed extensively in the impact analysis section of this final rule.

In addition, as we indicated above, we plan to analyze any shift or change in utilization patterns once the payment changes for drugs and drug administration required by MMA go into effect. While we do not believe the changes will result in access problems, we plan to continue studying this issue.

Comment: One commenter expressed concern that the reductions in payments to oncologists described in the proposed rule could make it difficult, if not impossible, for many patients to continue to access cancer care in nonhospital community settings.

Response: As noted above, we have taken several steps to increase payments for drug administration services in this final rule. We recognize that oncology patients in the Medicare population undergoing chemotherapy face serious and unique issues and problems related to quality of care throughout the life cycle of their disease process; from the time of first diagnosis, through treatment, until the patient experiences an end to medical (including hospice) care. Patients, national cancer organizations, and medical providers have identified certain factors that they believe affect the comfort and ultimately the care for cancer patients in the physician office setting.

We believe that the goals and objectives of optimal treatment include reviewing and analyzing pain control management, minimization of nausea and vomiting, explaining treatment options, outlining existing chemotherapy regimens, assessing quality of life, assessing patient symptoms and complaints, supporting and educating caregivers, and avoidance of unnecessary Emergency Department visits and inpatient hospitalizations. Further, we believe that clinicians armed with appropriate assessments can proactively intervene with medical treatment and nonmedical assistance to help ameliorate some of the distressing and unpleasant, but frequent and predictable, events that may accompany certain cancers and chemotherapeutic regimens used to combat cancer.

The Secretary has been given the authority under sections 402(a)(1)(B) and 402(a)(2) of the Social Security Act Amendments of 1967 (Pub. L. 90–248), as amended, to develop and engage in experiments and demonstration projects to provide incentives for economy, while maintaining or improving quality in provision of health services. In order to identify and assess certain oncology services in an office-based oncology practice that positively affect outcomes in the Medicare population, we will initiate a one-year demonstration project for CY 2005. While we encourage optimal care in all facets of treatment, the focus of the demonstration project will be on three areas of concern often cited by patients: pain control management, the minimization of nausea and vomiting, and the reduction of fatigue.

Practitioners participating in the project must provide and document specified services related to pain control management and minimization of nausea and vomiting, and the reduction of fatigue. To facilitate the collection of this information, we have established 12 new G-codes to be reported by program participants.

G-Codes for Assessment of Nausea and/or Vomiting

G9021: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level one: not at all (for use in a Medicare-approved demonstration project).

G9022: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level two: a little (for use in a Medicare-approved demonstration project).

G9023: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level three: quite a bit (for use in a Medicare-approved demonstration project).

G9024: Chemotherapy assessment for nausea and/or vomiting, patient reported, performed at the time of chemotherapy administration; assessment level four: very much (for use in a Medicare-approved demonstration project).

G-Codes for Assessment for Pain

G9025: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level one: not at all (for use in a Medicare-approved demonstration project).

G9026: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level two: a little (for use in a Medicare-approved demonstration project).

G9027: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration assessment level three: quite a bit (for use in a Medicare-approved demonstration project).

G9028: Chemotherapy assessment for pain, patient reported, performed at the time of chemotherapy administration, assessment level four: very much (for use in a Medicare-approved demonstration project).

G-Codes for Assessment for Lack of Energy (Fatigue)

G9029: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level one: not at all (for use in a Medicare approved demonstration project).

G9030: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level two: a little (for use in a Medicare approved demonstration project).

G9031: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level three: quite a bit (for use in a Medicare approved demonstration project).

G9032: Chemotherapy assessment for lack of energy (fatigue), patient reported, performed at the time of chemotherapy administration, assessment level four: very much (for use in a Medicare-approved demonstration project).

The codes correspond to four patient assessment levels (''not at all,'' ''a little,'' ''quite a bit,'' or ''very much'') for each of the following three patient status factors: nausea and/or vomiting;

pain; and lack of energy (fatigue). These levels, based on the Rotterdam scale, were chosen since they appear to be less burdensome for the practitioner and more easily understood by the patient. Participating practitioners must bill the applicable G-codes for each patient status factor (that is, one G-code each for patient comfort assessment factors: nausea and/or vomiting; pain; and fatigue) assessed during a chemotherapy encounter in order to receive payment under the demonstration. A G-code for each patient status factor must appear on the claim for payment to be made under the demonstration project. A patient chemotherapy encounter is defined as chemotherapy administered through intravenous infusion or push, limited to once per day. During the course of the demonstration, an additional payment of $130 per encounter will be paid to participating practitioners for submitting the patient assessment data as described above.

Any office-based physician or nonphysician practitioner operating within the State scope of practice laws who takes care of and administers chemotherapy to oncology patients in an office setting is eligible to participate in this demonstration project. By billing the designated G-codes, the practitioner self-enrolls in the project and agrees to all of the terms and conditions of the demonstration project.

This information will help us to work with those who care for cancer patients to determine ways to improve the quality of care and quality of life for patients as demonstrated by measuring objective parameters and the medical response to those standardized measurements. The evaluation of the project will be based on data reported to us by the practitioners and the use of our administrative claims data to examine Emergency Department visits and inpatient hospitalizations.

We anticipate that further information regarding this demonstration project will be forthcoming after publication of this final rule.

Comment: Commenters pointed out that, under the MMA, we added physician work RVUs to specified drug administration codes equivalent to a level 1 established office visit. They indicated that we should also have increased the practice expense inputs for the same drug administration codes to account for the practice expense inputs associated with a level 1 established office visit.

Response: Section 1848(c)(2)(H)(iii) of the Act (as added by 303(a)(1)(B) of the MMA) specified that we increase the work RVUs for drug administration services equal to the work RVUs for a level 1 established patient office visit (CPT code 99211). As indicated in the January 7, 2004 **Federal Register** (69 FR 1093), we established work RVUs of 0.17 for specific CPT codes that met the statutory definition of ''drug administration services.''

However, the legislation did not direct us to also increase the practice expense RVUs of the drug administration codes to include the clinical staff time associated with a level 1 office visit. The practice expense inputs of the existing CPT codes for drug administration were refined in 2002. We believe the recommendations from the PEAC included the typical clinical staff time associated with each drug administration service.

The CPT Editorial Panel approved new and revised codes for drug administration services for 2005. Depending upon the service, the RUC is recommending work RVUs for the new drug administration codes that may equal, exceed or be less than 0.17. Although section 1848(c)(2)(H)(iii) of the Act requires that the work RVUs for drug administration services shall equal those of a level 1 office medical visit, new subparagraph (J) requires the Secretary to ''promptly evaluate existing drug administration codes for physicians' services''. The statute further indicates that the ''Secretary shall use existing processes for the consideration of coding changes and * * * in establishing relative values * * *''

Because we typically use the CPT and RUC processes to establish codes and relative values, we believe the statute gives us authority to establish work RVUs at a level other than those of a level 1 established patient office visit. Therefore, for 2005, we are accepting the RUC recommendations for the interim G-codes even though they result in work RVUs that are different than 0.17.

Comment: Several organizations and physicians commented that the Medicare payments for the chemotherapy codes do not include payment for many services provided by an oncology practice. These services include support services such as nutrition counseling, social work services, case management, psychosocial counseling, and educational services provided by an oncology nurse to the patient.

Response: Under certain circumstances, Medicare does make explicit payment for clinical social worker and medical nutrition therapy services. Medicare can pay separately for the services of clinical psychologists (CPs), clinical social workers (CSWs), and nurse practitioners (NPs), clinical nurse specialists (CNS) and physician assistants (PAs).

CPs can bill directly for services and supplies they are legally authorized by the State to perform that could also be furnished by a physician or incident to a physician's service. Payment for CP services is made at 100 percent of the physician fee schedule for services they are authorized to provide that are comparable to those of a physician.

CSWs can furnish services for the diagnosis and treatment of mental illnesses that they are legally authorized by the State to provide. Payment for CSW services is made at 75 percent of the CP fee schedule, which is 100 percent of the physician fee schedule.

NPs, CNSs and PAs can bill for mental health services consistent with their authority under law to furnish physician services. They may also bill for services furnished incident to their own professional services that fall under the State scopes of practice. Payment for these services is made at 85 percent of the physician fee schedule. Medicare will pay for medical nutrition therapy services provided by a registered dietitian or nutrition professional for a beneficiary with diabetes or renal disease. Based on a comment on our August 20, 2003 proposed rule (68 FR 50428), we understand that social worker services could involve different tasks (''helping patients with their health insurance, filling and refilling prescriptions'') than those that are explicitly paid for by Medicare. However, we believe Medicare does pay for these services indirectly through the practice expense RVUs for drug administration services. If these services are typically provided to cancer patients, we believe the RUC could consider whether it is possible for resource inputs for these types of staff to be incorporated into the new drug administration codes. We also believe that the RUC could consider whether these types of staff activities are unique to physicians who provide drug administration or if they apply to other physicians' services as well.

Comment: Current CPT code 96412 (infusion techniques, one to 8 hours, each additional hour) is an add-on code, billed in addition to the primary code, 96410 (the first hour of chemotherapy). There is no national coding policy that explains how this add-on code is to be reported if less than a full hour of chemotherapy infusion is provided. A commenter pointed out that the Medicare carriers have different policies for reporting this service. Some carriers require the infusion to extend at least 16 minutes into the subsequent hour before

an add-on code can be billed, and others impose a 31 minute requirement. The commenter asked that we establish a uniform policy for the carriers to follow.

Response: The CPT Editorial Panel addressed this issue as part of its review of the drug administration codes. Effective in 2006, the add-on code is to be used for ''infusion intervals of greater than thirty minutes beyond one hour increments''. We are adopting this policy for chemotherapy administration codes furnished on or after January 1, 2005.

Comment: The nonchemotherapy subcutaneous injection is currently reported and paid under CPT code 90782, while a chemotherapy subcutaneous injection is currently reported under CPT code 96400. Some commenters recommended that we permit billing for nonchemotherapy injections for cancer patients to be made under CPT code 96400. They believe this code more appropriately reflects the practice expenses related to supportive care for chemotherapy.

Response: The CPT Editorial Panel explicitly addressed this issue by creating separate drug administration codes for hydration, nonchemotherapy infusions and injections, and chemotherapy infusions and injections. It further expanded the definition of chemotherapy to include those drugs where the resource costs associated with the drug administration are similar to those administered as anti-neoplastics. Other drugs administered in support of chemotherapy, such as anti-emetics and drugs to prevent anemia, are billed using the injection code, G0351, which replaces CPT code 90782 (consistent with the CPT recommendations). We have reviewed the practice expense inputs for this code from the RUC and accepted their recommendation.

Comment: Some commenters asked that complex non-oncology infusions, such as Remicade, be paid at the same level as chemotherapy infusions. They indicate that these nonchemotherapy infusions have similar complexity and resource use as chemotherapy infusions.

Response: The CPT recommendations address this issue. The codes for chemotherapy administration are for reporting the administration of non-radionuclide, anti-neoplastic drugs, anti-neoplastic agents provided for treatment of noncancer diagnoses or substances such as monoclonal antibody agents, and other biologic response modifiers.

Comment: Some commenters inquired about the recognition of a severe drug reaction management code that could be used during the administration of high complexity biologic medications and less frequently during other drug administrations or chemotherapy services. While the CPT Drug Administration Workgroup supported the creation of a severe drug reaction management code, the CPT Editorial Panel did not approve this code.

Response: We recognize that considerable physician effort may be required to monitor and attend to patients who develop significant adverse reactions to chemotherapy drugs, or otherwise have complications in the course of chemotherapy treatment. Physicians may not be aware that these services can be billed using existing CPT codes. The following scenarios are examples where existing codes may be used in addition to the routine billing for the physician's care of a cancer patient:

- Bill for the Physician Visit. If a patient has a significant adverse reaction to drugs during a chemotherapy session and the physician intervenes, the physician could bill for a visit in addition to the chemotherapy administration services.
- Bill for the Higher-Level Physician Visit. If the patient had already seen the physician prior to a chemotherapy session for a problem that is unrelated to the supervision of the administration of chemotherapy drugs, the physician may bill a visit for a significant adverse drug reaction. The total time, resources, and complexity of the physician's interaction with the patient may justify a higher level of visit service.
- Bill for a Prolonged Service. If the patient had a physician visit prior to the chemotherapy session and experienced a significant adverse reaction to drugs on the same day, the physician can bill a prolonged service code in addition to the physician visit. There are several code combinations to use depending on the number of minutes involved. The physician must have a face-to-face encounter with the patient and must spend at least 30 minutes beyond the threshold or typical time for that level of visit for the physician to bill for the prolonged service code.
- Bill for Critical Care Service. If the patient had a physician visit prior to the chemotherapy session and experienced a life-threatening adverse reaction to the drugs, the physician could bill for a critical care service in addition to the visit if the physician's work involves at least 30 minutes of direct face-to-face involvement managing the patient's life-threatening condition. Examples of life-threatening conditions are: central nervous failure, circulatory failure, shock, renal, hepatic, metabolic, and/or respiratory failure.

These instructions are published here for informational purposes, and we anticipate that we will issue further instructions regarding the appropriate use of these G-codes including clarifications, interpretations and other modifications to the following guidance as part of any instructions issued through a subregulatory process.

Comment: The American Urological Association (AUA) commented in response to the January 7, 2004 interim final rule to ask us to include the following codes in the MMA-mandated evaluation of existing drug administration codes for physicians' services to ensure accurate reporting and billing for such services: CPT codes 11980, 11981, 11982, 11983, 51700, 51720, 54200, 54231, and 54235. The AUA asked that we consider applying the transitional adjustment payment to these codes for 2005.

Response: We presented these codes to the CPT Drug Administration Workgroup. After subsequent discussion with representatives of the AUA, the AUA withdrew these codes from consideration by the workgroup.

These codes are not subject to the ''transitional adjustment payment provision'' because they are not included in the definition of ''drug administration codes.''

Comment: Ophthalmologists frequently perform the procedure photodynamic therapy (CPT code 67221 and 67225) by infusing the drug Visudyne. While separate payment is allowed for the drug, the infusion is considered an integral part of the photodynamic therapy code. Thus, the physician is not allowed to bill a separate code for the infusion of the drug.

According to one commenter, Visudyne is also a drug used in cancer chemotherapy. The commenter pointed out that when Visudyne is provided for photodynamic therapy, ophthalmologists incur drug administration costs similar to oncologists who use infused drugs.

The AAO asked why we did not include CPT codes 67221 and 67225 among the drug administration codes that benefited under the MMA.

Response: In this instance, the infusion of the drug is an integral part of the surgical procedure and it was valued by the RUC and CMS that way. The code of which it is a part is not considered a drug administration code under section 303 of the MMA.

3. Blood Clotting Factor

For clotting factors furnished on or after January 1, 2005, we proposed to establish a separate payment of $0.05

per unit to hemophilia treatment centers, homecare companies and other suppliers for the items and services associated with the furnishing of blood clotting factor. Section 303(e)(1) of the MMA requires the Secretary, after review of the January 2003 report to the Congress by the Comptroller General of the United States, to establish a furnishing fee for the items and services associated with the furnishing of blood clotting factor.

Based on a review of the Government Accountability Office (GAO) report and data received from various clotting factor providers, we proposed a furnishing fee in order to cover the administrative costs associated with supplying the clotting factor. As outlined in the MMA, any separate payment amount established may include the mixing and delivery of factors, including special inventory management and storage requirements, as well as ancillary supplies and patient training necessary for the self-administration of these factors. The MMA states that, in determining the separate payment, the total amount of payments and these separate payments must not exceed the total amount of payments that would have been made for the factors if the amendments in section 303 of the MMA had not been enacted.

As indicated in the GAO report, ''[w]hen Medicare's payment for clotting factor more closely reflects acquisition costs, we recommend that the Administrator establish a separate payment for providers based on the costs of delivering clotting factor to Medicare beneficiaries.'' Effective upon implementation of the ASP-based payment rates, payment for blood clotting factors will more closely reflect acquisition costs, since payment will be based on the average sales price as reported by drug manufacturers plus 6 percent.

Therefore, we stated in the August 5, 2004 proposed rule that in the absence of additional data we believe that a furnishing fee of $0.05 per unit for the cost of delivering clotting factor is an appropriate amount. However, we also sought updated data and comments on the GAO report, as well as information on the fixed and variable costs of furnishing clotting factor. We recognized that there may be alternatives to a fee, which varies entirely based on the number of units of clotting factor furnished. We indicated we would closely examine all data and information submitted in order to make a final determination with respect to the appropriateness of the $0.05 per unit amount.

We received comments from various sources including, but not limited to, hemophilia treatment centers, hemophilia coalitions, and other suppliers of clotting factors regarding our request for additional data and information on the appropriateness of our proposed fee. The comments and responses are provided below.

Comment: Many commenters recommended that we incorporate cost information received from homecare providers and any updated cost data from hemophilia treatment centers in determining the separate furnishing fee payment amount for 2005. The commenters cited an industry-sponsored survey of full-service hemophilia homecare companies that recommended a furnishing fee of $0.20 per unit. This survey collected CY 2003 data from three hemophilia homecare suppliers that the commenter indicated supplied 42 percent of all Medicare hemophilia patients. Commenters also stated that the GAO report was inadequate to serve as the basis for determining the separate payment for clinically appropriate items and services related to furnishing blood clotting factor. They questioned the accuracy of the recommended payment range in the GAO report, given what they viewed as an insufficient sample size; that is, the GAO report received data from only 4 hemophilia treatment centers and lacked any cost data from national or regional full-service hemophilia homecare providers. These commenters also indicated that the GAO survey may have included homecare companies that purchase clotting factor at a lower price through the Public Health Service's 340B program. More information on the 340B program is available on the Health Resources and Services Administration's Web site at *http://bphc.hrsa.gov/opa/howto.htm.* The commenters also stated that the GAO report focused solely on estimating providers' blood clotting factor delivery costs, which the GAO defined as inventory management, storage, shipping, and the provision of ancillary supplies. According to the commenters, the MMA directed us to establish a separate payment for items and services related to the furnishing of blood clotting factor that takes into consideration a wider range of items and services than the delivery costs addressed in the GAO report, for example patient education.

Response: We agree with the commenters that full-service hemophilia homecare companies provide services that may be of benefit to Medicare beneficiaries with hemophilia, such as disease and patient management activities. However, we do not believe that the scope of the furnishing fee includes these services. As noted above, Section 303(e) specifies the items and services that may be taken into consideration in setting the furnishing fee. Disease and patient management activities are not included in the items and services specified in Section 303(e). However, these activities may be more appropriately addressed through a future phase of the new Medicare Chronic Care Improvement Program.

The new Medicare Chronic Care Improvement Program is an important component of the MMA and demonstrates a commitment to improving and strengthening the traditional fee-for-service Medicare program. This program is the first large-scale chronic care improvement initiative under the Medicare fee-for-service program. We will select organizations that will offer self-care guidance and support to chronically ill beneficiaries. These organizations will help beneficiaries manage their health and adhere to their physicians' plans of care, and help ensure that they seek or obtain medical care that they need to reduce their health risks. More information regarding this program is available on the CMS Web site at *http://www.cms.hhs.gov/medicarereform/ccip/.*

With regard to the other costs identified in the comments and in the industry-sponsored survey, we also do not believe the scope of a furnishing fee includes costs associated with sales and marketing. We do not believe it is appropriate to build an explicit profit margin into the furnishing fee, but rather have the margin associated with the furnishing fee result from efficient furnishing of clotting factor. We agree with the commenters that the GAO report did not include amounts for education and that these are appropriate for the furnishing fee. Therefore, after removing the costs associated with sales and marketing, an explicit profit margin, and patient management, the resulting figure from the homecare survey is $0.14 per unit of clotting factor. We are establishing the furnishing fee for 2004 at $0.14 per unit of clotting factor. For years after 2005, the MMA specifies that the furnishing fee for clotting factor must be updated by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

Comment: One commenter recommended that the beneficiary's 20 percent coinsurance not be applicable to this separate payment. The commenter indicated that the additional financial

burden would limit many beneficiaries' access to this lifesaving product.

Response: Under provisions designed to protect the Medicare program from fraud and abuse, a broad waiver of beneficiary cost sharing of the type the commenter recommends would not be permitted. However, we make no statement regarding the applicability of existing statutory and regulatory provisions that may allow for the waiver of cost sharing in certain cases.

4. Supplying Fee

Section 1842(o)(6) of the Social Security Act requires the Secretary to pay a supplying fee (less applicable deductible and coinsurance) to pharmacies for immunosuppressive drugs described in section 1861(s)(2)(J) of the Act, oral anticancer chemotherapeutic drugs described in section 1861(s)(2)(Q) of the Act, and oral anti-emetic drugs used as part of an anticancer chemotherapeutic regimen described in section 1861(s)(2)(T) of the Act, as determined appropriate by the Secretary. In the interim final rule published on January 7, 2004 (69 FR 1084), we considered this fee to be bundled into the current payment for these drugs for 2004 and did not establish a separately billable supplying fee.

Effective January 1, 2005, we proposed to establish a separately billable supplying fee of $10 per prescription for immunosuppressive drugs, oral anti-cancer chemotherapeutic drugs and oral anti-emetic drugs. We based this proposed fee on information provided by retail chain pharmacies on the costs of supplying these drugs to non-Medicare patients combined with steps to reduce the administrative burden associated with billing Medicare.

We also sought data and information on the additional services pharmacies provide to Medicare beneficiaries, the extent to which oral drugs can be furnished without these additional services and the extent to which such services are covered under Medicare. Additionally, we requested comments concerning whether the supplying fee should be somewhat higher during the initial month following a Medicare beneficiary's transplant to the extent that additional resources are required for example, due to more frequent changes in prescriptions for immunosuppressive drugs.

Comment: Several commenters stated that they were not in a position to determine whether the proposed $10.00 supplying fee was adequate since they did not know the actual 2005 payment rates for Part B drugs. These commenters indicated that the supplying fee needed to cover return on investment, the costs of supplying the drugs, and make up for any differences between the product costs and the ASP based payment for the drug. Some commenters indicated that aside from the adequacy of the ASP-based payment for the drug, a $10.00 supplying fee appeared to be too low. These commenters indicated that the average cost to a retail pharmacy to dispense a non-Medicaid third party or cash paying prescription ranges anywhere from $7.50–$8.00. The commenters indicated that Medicare should pay at least $2.00–$2.50 more per prescription since costs associated with supplying Medicare prescriptions are higher.

We received a comment from a large retail pharmacy indicating that a supplying fee of $25 would be adequate to cover the higher costs of dispensing Medicare Part B oral drugs.

We received comments from specialty immunosuppressive pharmacies that included information from a recent survey of their supplying costs. The survey indicated that the cost for specialty pharmacies to dispense Medicare Part B immunosuppressants is $35.48 per prescription. The specialty immunosuppressive pharmacies indicated that they provide services not typically provided by retail chain drug stores or large mail-order pharmacy benefit management companies. These services include direct patient care through pro-active pharmacist contact, expeditious processing and turnaround of medication orders, direct billing of Medicare and coordination of benefits on behalf of transplant patients to reduce the costs to the patients, and maintaining expensive immunosuppressant in stock to ensure timely receipt when needed by beneficiaries. These pharmacies also indicated that the retail chains typically do not supply immunosuppressive drugs or file Medicare claims.

Several commenters indicated that the lack of on-line adjudication for Medicare claims was one of the major drivers, among other reasons, for the additional costs of supplying Medicare prescription.

Response: We agree that the cost of supplying Medicare Part B oral drugs is higher than many other payers because of the lack of on-line adjudication for Medicare Part B oral drug claims. Due to operational issues, we do not anticipate the establishment of an on-line adjudication system in the near future. Accordingly, we believe it is appropriate to establish a supplying fee higher than the fees paid by some other payers with on-line adjudication. We note that many other payers with on-line adjudication have fees in the range of $5–$10 per prescription. We note that this is consistent with the approximately $8 cost for non-Medicaid dispensing stated by some commenters and described earlier. Other than administrative costs associated with billing Medicare Part B for oral drugs, we do not agree with commenters that the supplying fee for these drugs should exceed the dispensing fees of other payers because we do not believe there are other significant differences between supplying Medicare Part B and other oral drugs. We also do not agree that the supplying fee should include product costs. Product costs are paid through the ASP + 6 percent drug payment system. For the additional burden associated with billing Medicare Part B for oral drugs, we note the commenters who suggested an additional fee of approximately $2 for Medicare billing costs. Added to the $8 non-Medicaid fee described above, this would result in a supplying fee of approximately $10. We also note the survey of the specialty immunosuppressive pharmacies that indicated Medicare claims processing costs of approximately $8. This same survey also indicated total personnel costs of approximately $9, a portion of which we assume is attributable to the additional work associated with Medicare billings because the comments indicated Medicare billing was labor-intensive. Using the $5 to $10 figures for payers with on-line adjudication described above, the specialty pharmacy data on Medicare claims processing costs and personnel costs, we developed a range of possible supplying fees based on the specialty pharmacy data. Depending upon the portion of the personnel costs associated with Medicare billings, this would result in a supplying fee between a minimum of $13 (= $5 + $8) and a maximum of $27 (= $10 + $8 + $9). The comment of the large chain pharmacy recommending a $25 supplying fee indicated that this amount would be adequate to cover the costs of supplying Medicare Part B drugs including the additional costs of processing Medicare claims; however, this amount included a margin for profit. We do not believe it is appropriate to build an explicit profit margin into the supplying fee, but rather have the margin associated with the supplying fee result from efficient supplying of these drugs. Although the profit margin included in the $25 was not explicitly stated in the comment, if we assume a 5 percent margin, then a supplying fee of approximately $24 would cover the large chain pharmacy's

costs of supplying Medicare Part B drugs. We are not indicating that 5 percent is an appropriate margin.

There was variability in the submitted comments with respect to an appropriate supplying fee. On the low end, analysis of the submitted comments would indicate a supplying fee of $10. On the high end, the analysis would indicate a supplying fee of $27. Given the variability in the values and assumptions included in various calculations, we do not think it is appropriate to simply take the rounded midpoint of this range, $19, as the supplying fee. However, we do not think it appropriate to take the maximum amount of this range, $27, given that it is unlikely that all of the personnel costs indicated in the specialty pharmacy survey are related to the costs of billing for oral Medicare Part B drugs. The amount in the comment from the large chain pharmacy, after adjusting for a possible profit margin, or $24, is consistent with our belief that not all of the additional personnel costs identified in the specialty pharmacy survey are related to the costs of billing for oral Medicare Part B drugs. We are therefore establishing a per prescription supplying fee of $24 as the value consistent with both the large retail pharmacy comment (after making an adjustment for built-in profit margins) and the higher end of the broad range of the specialty pharmacy survey. Although we believe that a $24 supplying fee coupled with the ASP-based drug payment will not result in any access problems for Medicare beneficiaries, we will monitor access as we implement the new ASP-based payment system.

Comment: Some commenters recommended that we update the supplying fee annually. Some commenters indicated this fee should be updated by the average annual increase in the costs of pharmacies supplying these drugs to Medicare beneficiaries (costs such as rent, utilities and salaries), but no less than the increase in the medical care inflation index for the most recent twelve months for which it can be calculated before the next calendar year.

Response: We will study the issue of appropriate future increases for the supplying fee and proceed, as necessary, through notice and comment rulemaking.

Comment: A specialty organization suggested that we develop a sliding supplying fee, which would be calculated as a percentage of the cost that the pharmacy incurred in acquiring a particular drug.

Response: We do not agree that the supplying fee should vary by product costs. Product costs are paid through the ASP-based drug payment system.

Comment: Several commenters agreed with our suggestion to increase the supplying fee in the first month following a transplant, but recommended that we extend this increase to at least the first 3 months following the transplant. One commenter suggested that extra resources are associated with frequent changes in prescriptions during the initial month following a beneficiary's organ transplant. One commenter recommended a fee of $50 for an initial prescription fill. However, one commenter advocated against a supplying fee that distinguished between new and refill prescriptions stating that it would be impractical, of questionable benefit and would discourage long-term pharmacy-patient relationships as pharmacy providers would only have an incentive to serve patients in the short term.

Response: We agree that additional costs are most likely to occur nearer the time when the beneficiary has a transplant. In order to recognize these costs, we are establishing a higher supplying fee of $50 for the supplying of the initial oral immunosuppressive prescription in the first month after a beneficiary has a transplant because the costs of supplying immunosuppressives are likely to be higher immediately following a transplant, when the practitioner is adjusting the dose of immunosuppressive drugs. With regard to the comment opposing higher supplying fees for new patients regardless of their transplant date, we agree with the commenter that it would result in inappropriate incentives and are not implementing any such fee.

Comment: Commenters recommended that the supplying fee should account for the different prices paid by pharmacies and physicians, recognizing that these are separate classes of trade that may not have access to comparable pricing. Thus, we should increase the supplying fee associated with providing and overseeing the use of oral anti-cancer drugs.

Response: We do not agree that the supplying fee should vary by product costs. Product costs are paid through the ASP based drug payment system.

Comment: Commenters recommended that we extend the supplying fee to physicians that directly supply covered oral anti-cancer, immunosuppressive and oral anti-emetic drugs to patients, as well as create a dose management and compliance fee for physicians that prescribe oral chemotherapy products. These commenters state that we could use the premise that the MMA does not provide a definition of the word ''pharmacy'' and we could permit payment of a supplying fee to include a physician acting in the capacity of a pharmacist. Alternatively, commenters suggested that we use its inherent reasonableness authority to extend the supplying fee to physicians.

Response: Given our current understanding of Congressional intent, we do not believe it would be appropriate to pay a supplying fee to physicians. Moreover, we do not have sufficient data to determine whether our inherent reasonableness authority would apply in this instance. However, we will study these issues further.

5. Billing Requirements

In the proposed rule, we proposed the following changes to certain billing requirements and clarified policy for other billing requirements in an effort to reduce a pharmacy's costs of supplying covered immunosuppressive and oral chemotherapy drugs to Medicare beneficiaries:

• *Original signed order.* We clarified Medicare's policy regarding the necessity of an original signed order before the filling of a prescription. According to the Medicare Program Integrity Manual (section 5.1 of Chapter 5), which addresses the ordering requirement for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), including drugs, most DMEPOS items can be dispensed based on a verbal order from a physician. A written order must be obtained before submitting a claim, but that written order may be faxed, photocopied, electronic, or pen and ink. The order for the drug must specify the name of the drug, the concentration (if applicable), the dosage, and the frequency of administration. The clarification of this requirement should reduce a pharmacy's costs of supplying covered immunosuppressive and oral drugs to Medicare beneficiaries to the extent that pharmacies are currently applying an original signed prescription requirement.

Comment: Commenters recommended that a prescription be filled and billed based solely on a verbal order from a physician and an actual signed written prescription should not be necessary before billing.

Response: The policy that allows dispensing based on a verbal order but requires a written order for billing applies to all DMEPOS items. This policy balances fraud and abuse concerns with prompt dispensing of DMEPOS items to beneficiaries. We

point out that the written order from the physician can be faxed, photocopied, electronic, or pen and ink. We currently allow pharmacies to accept electronic prescriptions from physicians.

• *Assignment of Benefits Form.* We proposed to eliminate use of the Assignment of Benefits form for Part B items and services, including drugs, where Medicare payment can only be made on an assigned basis. For Part B covered oral drugs, this would be a means of reducing a pharmacy's costs of supplying these drugs to Medicare beneficiaries. Currently, pharmacies must obtain a completed Assignment of Benefits form in order to receive payment from Medicare. This requirement increases a pharmacy's cost of supplying covered drugs to Medicare beneficiaries, as other payers do not impose this requirement. Thus, we do not believe that it is necessary for an assignment of benefits form to be filled out for drugs covered under Part B, since payment for them can only be made on an assignment-related basis.

Comment: Some commenters suggested that the Assignment of Benefits form be eliminated for diabetic supplies dispensed by pharmacy suppliers.

Response: Our proposal to eliminate the Assignment of Benefits form applied to services where Medicare payment can only be made on an assigned basis. That is not the case with diabetic supplies. Thus, we are not eliminating the AOB form for diabetic supplies.

• *DMERC Information Form (DIF).* The DIF is a form created by the DMERC Medical Directors that contains information regarding the dates of the beneficiary's transplant and other diagnosis information. This form is a one-time requirement that pharmacies must complete in order to receive payment. Since section 1861(s)(2)(J) of the Act no longer imposes limits on the period of time for coverage of immunosuppressive drugs, we believe that the information on transplant diagnosis can be captured through other means (for example, diagnosis codes on the Part B claim form).

Comment: Several commenters applauded our efforts to eliminate use of the DIF in an effort to reduce the cost that the billing requirements imposed. These commenters asked that we ensure that this requirement is applied uniformly by all the DMERCs.

Response: We appreciate the support regarding the elimination of the DIF form. Action is being taken to eliminate the DIF form, including accommodating systems issues and providing for notifications. We anticipate resolution of issues to occur soon and elimination would occur next year.

• *Other Billing Issues.* We also received other comments regarding other billing issues related to the supplying of immunosuppressive, oral anti-cancer, and oral anti-emetic drugs.

Comment: Commenters suggested that we allow physicians to bill the carrier when oral drugs are provided directly by the physician in his office rather than having the physician bill the DMERC for the oral anti-cancer drug. Others stated that we should allow for billing for pharmaceutical products to be conducted on current electronic platforms, because ''batch billing'' creates operational and patient care problems, and adds significant participation costs. Commenters also stated that we should eliminate the requirement for a diagnosis code to be present on the prescription; while, at the same time, adopt the usage of the physician's DEA number instead of the UPIN number when submitting claims.

Response: We thank the commenters for identifying these issues. We plan to examine these aspects of billing.

6. Shipping Time Frame

In the proposed rule, we highlighted the fact that the guidelines regarding the time frame for subsequent deliveries of refills of DMEPOS products had been revised. Effective February 2, 2004, the shipping of refills of DMEPOS products may occur ''approximately'' on the 25th day of the month in the case of a month's supply. In the proposed rule, we emphasized the word ''approximately''; while we indicated that normal ground service shipping would allow delivery in 5 days, if there were circumstances where ground service could not occur in 5 days, the guideline would still be met if the shipment occurs in 6 or 7 days. This change should eliminate the need for suppliers to utilize overnight shipping methods and would permit the shipping of drugs via less expensive ground service.

F. Section 952—Revision to Reassignment Provisions

As discussed in the August 5, 2004 proposed rule, section 1842(b)(6)(A)(ii) of the Act, as amended by section 952 of the MMA, allows, in many circumstances, a physician or NPP to reassign payment for Medicare-covered services, regardless of the site of service, providing there is a contractual arrangement between the physician or NPP and the entity through which the entity submits the bill for those services. Thus, the services may be provided on or off the premises of the entity receiving the reassigned payments. The MMA Conference Agreement states that entities that retain independent contractors may enroll in the Medicare program. The expanded exception created by section 952 of the MMA applies to those situations when an entity seeks to obtain the medical services of a physician or NPP.

Section 952 of the MMA states that reassignment is permissible if the contractual arrangement between the entity that submits the bill for the service and the physician or NPP who performs the service meets the program integrity and other safeguards as the Secretary may determine to be appropriate. The Conference Agreement supports appropriate program integrity efforts for entities with independent contractors that bill the Medicare program, including joint and several liability (that is, both the entity accepting reassignment and the physician or NPP providing a service are both liable for any Medicare overpayments). The Conference Agreement also recommends that physicians or NPPs have unrestricted access to the billings submitted on their behalf by entities with which they contract. We incorporated these recommended safeguards in a change to the Medicare Manual, implementing section 952 of the MMA that was published on February 27, 2004. In the August 5, 2004 rule, we proposed to revise § 424.71 and § 424.80 to reflect these safeguards, as well as the expanded exception established by section 952 of the MMA.

Section 952 of the MMA revises only the statutory reassignment exceptions relevant to services provided in facilities and clinics (section 1842(b)(6)(A)(ii) of the Act). Section 952 of the MMA does not alter an individual or entity's obligations under any other applicable Medicare statutes or regulations governing billing or claims submission.

In addition, physician group practices should be mindful that compliance with the physicians' services exception and the in-office ancillary services exception to the physician self-referral prohibition in section 1877 of the Act requires that a physician or NPP who is engaged by a group practice as an independent contractor may provide ''designated health services'' to the group practice's patients only in the group's facilities. See the definition of physician in the group at 42 CFR 411.351.

We also cautioned that parties must be mindful that contractual arrangements involving reassignment may not be used to camouflage inappropriate fee-splitting arrangements

or payments for referrals. In the August 5, 2004 proposed rule, we solicited comments on potential program vulnerabilities and on possible additional program integrity safeguards to guard against those vulnerabilities.

Comment: We received positive comments for the proposed changes to the reassignment rules from two physician associations and one association representing non-physician practitioners.

Response: We are pleased to receive positive feedback to the changes to the reassignment rules. We believe these changes balance the need to respond to the changing business arrangements in the delivery of health care services with the need to protect the Medicare trust funds from fraudulent and abusive billing practices.

Comment: An association representing emergency medicine physicians and numerous members of that association commented that requiring independent contractor physicians to have unrestricted access to the billings submitted on their behalf is not sufficient to ensure such access. The commenters requested that we revise our regulations to require the entity submitting the bills to provide duplicates of the Medicare remittance notices (which indicate the services billed and the amounts paid for those services) to the independent contractor physicians. Some of the commenters requested that we require independent contractor physicians to receive itemized monthly reports of the claims submitted and remittances received on their behalf.

Response: We believe that requiring independent contractors to have unrestricted access to the billings submitted on their behalf is sufficient to satisfy the independent contractors' need to review the claims information.

We recognize that some independent contractors may not wish to receive copies of all bills submitted on their behalf. It would place an unnecessary burden on entities if we require them to furnish duplicate remittance notices to independent contractors on a routine basis. Similarly, it would place a significant burden on our claims processing systems if we were obligated to provide duplicate remittance notices to those who have reassigned their payments. We note that the method and frequency of obtaining access to billing records is an issue that the independent contractor and the entity to which the independent contractor is reassigning payments can resolve in their written contract.

Comment: A commenter asked whether or not the new reassignment exception (which essentially expanded or revised the previous exceptions pertaining to independent contractors), established by section 952 of the MMA, is available when one entity contracts with a second entity, which in turn contracts with a physician or non-physician practitioner to furnish services for the first entity.

Response: We refer to this situation as an indirect contractual arrangement between the independent contractor furnishing the service and the entity doing the billing and receiving payment (excluding billing agents). Thus, the reassignment is between the individual furnishing the service and the entity receiving the reassigned benefits. Indirect contractual arrangements were permissible prior to passage of section 952 of the MMA and remain permissible. The CMS–855–R enrollment form would need to be completed by the entity receiving the reassigned benefits and the person furnishing the service. In accordance with section 952 of the MMA, the contractual arrangement and any program integrity safeguard requirements deemed appropriate by the Secretary are between the independent contractor and the entity receiving the reassigned payments, with the program integrity safeguards applying to both parties. If the parties involved also wish to include the intermediary entity in a similar contract, and apply standards identical or similar to the program integrity safeguards to their arrangement, they have that option; but, it is not required or necessary to comply with the exception to the reassignment prohibition for contractual arrangements.

Comment: Several members of the Congress urged us not to delay the enrollment process of providers or suppliers while implementing section 952 of the MMA.

Response: We do not expect any delays in provider or supplier enrollment to result from implementing the reassignment provisions of this regulation. We are sensitive to the need for an efficient and timely enrollment process. If the new reassignment exception results in the submission of a particularly high volume of claims, or if a Medicare contractor has to process a large number of new enrollment applications, it is possible that delays may occur in some cases. A provider or supplier whose enrollment was delayed must contact the appropriate Medicare contractor's provider or supplier enrollment office to discuss the reasons for the delay.

Comment: A trade association of physician specialists asked that we clarify our definitions of onsite and off-site services. This trade association also requested that we further describe the potential program vulnerabilities that the revised Medicare reassignment exception might create.

Response: We consider onsite services to be services of an independent contractor that are performed in space owned or leased by the entity billing and receiving the reassigned payments. We consider offsite services to be services of an independent contractor that are performed in space that is not owned or leased by the entity billing and receiving the reassigned payments, that is, services performed off the premises.

The Congress originally passed the prohibition on reassignment provision due to experience with fraudulent and abusive billing practices. As we discussed in the preamble to the August 5, 2004 proposed rule, the new reassignment exception for contractual arrangements will potentially permit myriad relationships and financial arrangements. Some of these relationships may have the potential to increase fraudulent and abusive billing practices that the reassignment rules were designed to prevent. We also stated in the proposed rule that the new reassignment exception does not alter an individual's or entity's obligations under existing Medicare statutes and regulations (for example, the physician self-referral prohibition, the anti-kickback statute, purchased diagnostic test rules, incident to rules, etc.).

Comment: Several commenters expressed concern over the recent growth of so-called pod, salon, turnkey, mini-mall, or condo labs, especially since section 952 of the MMA appears to liberalize the Medicare reassignment rules.

As we understand the situation, some entities have created a building or a floor of a building that contains a number of cubicles, each of which is equipped with a microscope and other supplies that enable a pathologist to go to a particular cubicle or pod to analyze any tissue sample that is submitted by the group practice that rents pod space on a full-time basis. Apparently, some of the owners of these anatomical laboratories assert that each pod is a centralized location for a laboratory that is owned by a group practice. Other owners assert that each pod serves as an offsite office of a pathologist who works for a group practice as an independent contractor.

These entities market their services to specialists in certain disciplines, such as gastroenterology, urology, and dermatology, which rely on a high

volume of anatomic pathology services. The commenters stated that these lab arrangements are subject to excess, waste, and abuse, including, but not limited to: (a) Generation of medically unnecessary biopsies; (b) kickbacks; (c) fee-splitting; and, (d) referrals that would otherwise be prohibited under the physician self-referral statute.

The commenters agree with us that safeguards are necessary to prevent the increased incidence of fraudulent and abusive billing practices resulting from the new reassignment exception for contractual arrangements. To reach the goal of closing any loophole for excess, waste, and abuse opened by the new independent contractor reassignment exception, the commenters provided several suggestions. One commenter recommends that we add language to proposed § 424.80(d) that would prohibit a physician from making a reassignment to another physician, under the independent contractor exception, if the physicians do not practice in substantially the same medical specialty. This limitation would not apply if the entity accepting the assignment is a bona fide multi-specialty physician practice, meaning that it employs (on a W–2 basis) physicians who regularly practice in two or more specialties of medicine.

The commenters believe that the regulations need to state more clearly that all requirements of the purchased diagnostic test rules and purchased test interpretation rules need to be met. In other words, the commenters want to prevent the new reassignment exception from applying to services furnished by independent contractor pathologists.

These commenters are urging us to review these practices to see if they fail to meet existing obligations under the physician self-referral prohibition or anti-kickback statute. The commenters believe that these business arrangements are exploiting the in-office ancillary services exception and other exceptions to the physician self-referral prohibition.

Response: We appreciate comments that specify situations where fraud and abuse may occur and propose solutions to prevent such occurrences. While we decline to incorporate the commenters' suggested regulatory revisions at this time, we share the commenters' concerns. We will be paying close attention to this issue, and may initiate future rulemaking to address arrangements that are fraudulent or abusive.

To respond to commenters' concerns, we are amending the regulations governing reassignment at § 424.80(a) to clarify that nothing in § 424.80 alters an individual or entity's obligations under other Medicare statutes or rules, including, but not limited to, the physician self-referral prohibition (section 1877 of the Act), the anti-kickback statute (section 1128(B)(b)(1) of the Act), the regulations regarding purchased diagnostic tests, and regulations regarding services and supplies provided incident to a physician's services.

In response to the concerns expressed by the commenters, we wish to further expand on the fact that section 952 of the MMA did not affect the obligation of an individual or entity to comply with the physician self-referral prohibition (section 1877 of the Act and the corresponding regulations). As stated in the proposed rule, ''physician group practices should be mindful that compliance with the in-office ancillary services exception to the physician self-referral prohibition requires that a physician who is engaged by a group practice on an independent contractor basis must provide services to the group practice's patients in the group's facilities. As noted in the Phase I physician self-referral final rule (66 FR 887), ''we consider an independent contractor physician to be 'in the group practice' if: (1) He or she has a contractual arrangement to provide services to the group's patients in the group practice's facilities; (2) the contract contains compensation terms that are the same as those that apply to group members under section 1877(h)(4)(iv) of the Act or the contract fits in the personal services exception; and, (3) the contract complies with the reassignment rules * * * '' See also 66 FR 886.'' This test is specified at § 411.351 in the definition of physician in the group practice, which contains a premises requirement independent of the reassignment rules.

In addition, the use of independent contractors at off-premises locations may impact the ability of a group practice to meet the definition of a group practice at § 411.352 for purposes of complying with section 1877 of the Act. Accordingly, some group practices may need to be careful about the number of physician-patient encounters that independent contractors perform off-premises to ensure that they meet the 75 percent patient-physician encounters test as set forth in § 411.352(h).

We will continue to monitor compliance with the reassignment rules and we will analyze the impact of the physician self-referral prohibition on ''pod'' labs. If we determine that changes to the physician self-referral prohibition are necessary, these changes will be made in a separate rulemaking document.

Comment: We received a number of comments and recommendations from three organizations that utilize the services of independent contractor emergency department physicians. One of the three organizations represents management companies that employ independent contractor emergency department physicians. The commenters believe that the changes to the reassignment rules necessitated by section 952 of the MMA should be implemented in a manner that does not impose additional burdens on the Medicare enrollment process. They believe that implementation of the proposed regulations could impede the enrollment process. They expressed concern that amendments to current contracts might be necessary to incorporate the program integrity safeguards included in the proposed regulations. Since they believe requiring contract amendments would be burdensome and costly to hospitals, they are urging us not to require parties to amend their contracts to reflect the program integrity safeguards that we proposed.

Response: We do not believe that implementation of the proposed regulations will impede the enrollment process. Our proposed regulations would not require parties to amend their contracts to reflect the program integrity safeguards. We plan to include the program integrity safeguard requirements on the CMS–855–R enrollment form. The program integrity safeguards will apply to arrangements entered into pursuant to the new reassignment exception for contractual arrangements, regardless of whether the parties reference the safeguards in their contracts.

Comment: Three commenters representing groups that utilize independent contractor emergency physicians strongly oppose our implementation of the two proposed program integrity safeguard requirements: (1) Joint and several liability/responsibility for Medicare overpayments; and (2) unrestricted access to the billings for services provided by independent contractors. The commenters believe that establishing program integrity safeguards is premature and that we should first formally assess the need for such safeguards. These commenters also ask us to clearly define joint and several liability/responsibility. They express concern over our attempt to impose joint and several liability/responsibility on both the contracting entity and practitioner furnishing the services and

note that the CMS–855–R enrollment form certification holds the enrolling provider or supplier responsible for any Medicare overpayments. The commenters argue that we should impose these program integrity safeguards on employer/employee relationships if we are going to impose them on contractual arrangements. The commenters ask how we would monitor compliance with joint and several liability/responsibility. The commenters also have concerns about regulating access to claims submitted by an entity for services furnished by an independent contractor. In their view, this type of requirement should be part of the compliance programs of entities and employers rather than mandated as part of the reassignment rules.

Response: We disagree with the commenters' assertion that it is premature to implement the proposed program integrity safeguards. Section 952 of the MMA specifically authorizes the Secretary to implement program integrity safeguards. Further, in the Conference Report to the MMA, the Congress specifically highlighted the two program integrity safeguards that we have proposed.

Our assessment of the need for program integrity safeguards is based upon prior experience with certain types of entities and their subsidiary billing companies. For example, on April 6, 2000, Lewis Morris, Assistant Inspector General for Legal Affairs, Office of Inspector General (OIG), U.S. Department of Health and Human Services, testified before the House Committee on Commerce, Subcommittee on Oversight and Investigations regarding Medicare and third-party billing companies. Mr. Morris of the OIG detailed the upcoding activities of two firms that provided billing services for entities contracting with emergency department physicians. One firm paid $15 million and the other paid $15.5 million to settle their respective liabilities. Moreover, as we have noted, we have received numerous comments from physicians stating that they have been prevented from seeing the Medicare remittance notices for services they furnished, on penalty of termination.

In addition, we understand the commenters' concerns that if the Agency plans to implement the two proposed program integrity safeguards, we should apply these same program integrity safeguards to employees, as well as to independent contractors. Joint and several responsibility/liability and unrestricted access to billings may or may not be appropriate for employees and employers as it is for the parties involved in contractual arrangements. CMS will study this issue further, and if necessary will address it in a separate rulemaking document.

We use the words responsibility and liability interchangeably, and in the context of claims filing and payment, they both have the same meaning. We define joint and several liability/responsibility to mean that both the person furnishing a service and the entity billing for that service (and to which payments have been reassigned) can be held liable or responsible for any errors in billing that result in a Medicare overpayment, including, but not limited to, upcoding and billing for services never rendered.

We will monitor the program integrity safeguards as we monitor all other program integrity requirements. We also believe that entities and independent contractors will report violations to us, since both may be held responsible for any Medicare overpayments. If an independent contractor is refused access to the billings submitted on his or her behalf, the independent contractor may report this to the appropriate Medicare contractor.

Comment: An organization representing entities that use independent contactor emergency department physicians believes if we retain the proposed program integrity requirements, then these requirements should be clarified and included in other reassignment exceptions and in other Medicare conditions of participation.

Response: It is our goal to have the program integrity requirements identified and included on the appropriate CMS–855–R enrollment form. As we have discussed above, while we will study whether it is appropriate to extend the program integrity safeguards to employer/employee relationships, we do not believe it is necessary to include the program integrity requirements in other reassignment exceptions (or in other Medicare conditions of participation) at this time.

Comment: Three commenters representing organizations that use independent contractor emergency physicians recommend that we revise our definition of entity to specifically identify the types of entities that are listed in the Conference Report to section 952 of the MMA. They believe that our existing definition which defines entity as a person, group or facility enrolled in the Medicare program is ambiguous and inconsistent with Congressional intent. Therefore, they are recommending that we add the language to the definition that specifies that an entity includes but is not limited to, a hospital, clinic, medical group, a physician practice management organization, or a staffing company. One of the commenters opposes stating that entities need to be enrolled in Medicare in the definition of entity because the commenter believes it is not necessary to include such information in the regulations on reassignment. This commenter believes that instructions on enrollment should be addressed in an enrollment regulation. The commenter also states that our current reassignment regulation does not define facility as a hospital or other institution enrolled in the Medicare program. These groups believe that their proposed definition of entity more accurately reflects the language from the Statement of the Managers filed by the MMA Conference Committee and is included in the Conference Report (Conference Agreement). Finally, these groups do not believe that a definition of entity is necessary, since we do not define employer in the reassignment regulations definition section.

Response: We continue to believe that our definition of entity in the proposed rule is appropriate. We believe that defining entity as a person, group, or facility that is enrolled in Medicare encompasses all entities that are allowed to bill and receive payment from Medicare, and does not prevent those entities that were specifically identified in the Conference Report from benefiting from the new contractual arrangement reassignment exception. We will not specifically include a staffing company in the definition of entity because a staffing company cannot enroll in Medicare as a staffing company. Staffing companies can enroll as either a group practice or clinic, depending on how they are licensed or allowed to do business in the state where they are located. We further believe that a definition of entity is necessary to distinguish between entities that are allowed to reassign their right to payment and to receive reassigned payments from entities that are not allowed to reassign their right to payment or to receive reassigned payments (for example, billing agents, entities that provide services under arrangements, and substitute physicians, (for example, locum tenens physicians or physicians working on a reciprocal basis) all of which are not required to enroll in Medicare).

Comment: Three commenters representing organizations that use independent contractor emergency physicians found our use of the term supplier confusing when denoting the physician or non-physician practitioner

that contracts with an entity and reassigns his or her right to bill and receive payment. Specifically, the commenters found the proposed revision to § 424.80(c) (Prohibition on reassignment of claims by suppliers) confusing because it refers to a hospital or facility as the supplier of services for purposes of the reassignment revision when Medicare already has regulations that separately define provider and supplier. The commenters recommend that we clarify our intent regarding the use of the term supplier.

Response: In instances of reassignment, the supplier is the person furnishing the service and reassigning his or her right to bill and receive payment to another entity. This is consistent with our definition of supplier in § 400.202. In our proposed revision to § 424.80(c), we state that the employer or entity is considered to be the supplier of the services for subparts C, D, and E of this part, subject to the provisions of paragraph (d) of the section. Once a supplier reassigns his or her right to receive Medicare payments, the entity receiving the reassigned payments essentially takes the place of the supplier. We have revised § 424.80(c) to reflect the new contractual arrangement reassignment exception. The existing § 424.80(c) includes the same formulation and we have simply proposed to replace the words ''facility'' and ''system'' with ''entity,'' because the new exception for payment to an entity under a contractual arrangement now replaces the previous exceptions for payment to a facility or health care delivery system.

Comment: Three commenters that use independent contractor emergency physicians expressed concern about our statement in the preamble to the proposed rule that the new reassignment exception may create fraud and abuse vulnerabilities, which may not become apparent until the program has experience with the range of contractual arrangements permitted by the new reassignment exception. These groups do not believe that the new reassignment exception will result in an increase in violations of the types addressed in the preamble to the proposed rule. The groups also disagree with our statement in the preamble to the proposed rule that contractual arrangements with independent contractor physicians may be used to camouflage inappropriate fee-splitting arrangements or payment for referrals. These groups state that Medicare does not govern fee-splitting arrangements, that policing such arrangements is a matter of State law, and that Medicare reassignment policy has no direct effect on this issue. They question why we have expressed concern over potential violations of the physician self-referral prohibition, because section 952 of the MMA does not affect or otherwise change the obligation of providers and suppliers to comply with the physician self-referral prohibition and its accompanying regulations.

Response: The Congress originally passed the prohibition on reassignment provision because of increasing fraud and abuse in billing practices. Since the new reassignment exception has expanded the circumstances under which suppliers can reassign their right to receive Medicare payments, we are concerned that the potential exists for an increased incidence of fraud and abuse, which may not become apparent until the program has experience with the range of contractual arrangements permitted by the new reassignment exception. Fee-splitting arrangements may violate the physician self-referral prohibition and the anti-kickback statute. Preventing fraudulent and abusive billing practices continues to be the primary purpose of the reassignment rules, even as they are amended to reflect changing practices in the delivery of health care.

We agree that section 952 of the MMA does not change the obligations of providers and suppliers under the physician self-referral prohibition, and all other Medicare statutes and regulations. We are incorporating this clarification in § 424.80(a).

Comment: Three organizations that use independent contractor emergency physicians raised procedural concerns regarding the timing of the final rule, which is effective January 1, 2005. The commenters claim that providers and suppliers do not have time to comply with the new program integrity safeguards. They are asking us to provide providers and suppliers with an additional time frame of at least six months for compliance with the program integrity safeguards, if they are finalized. They recommend that we make the new safeguards applicable to enrollment applications submitted on or after the effective date of the final rule.

Response: We do not believe additional time is necessary for compliance with the program integrity safeguards. Providers and suppliers will not have to amend contracts to include the proposed program integrity requirements. Thus, enrollment applications are not affected by this regulation. The program integrity safeguards will be effective on the effective date of this final rule and these requirements will be applicable to all Medicare providers and suppliers affected by the section 952 change to the reassignment rules.

Comment: One commenter believes that the public comment period for this rule was shortened to 50 days instead of the 60-day comment period required by statute. The proposed rule was published in the **Federal Register** on August 5, 2004 and the public comment period ended at 5 p.m. on September 24, 2004.

Response: While the law requires that we provide a 60-day public comment period and that the notice of proposed rulemaking be published in the **Federal Register**, it does not require that the date of **Federal Register** publication be the first day of the comment period. The two requirements are independent. We post the proposed rule on our Web site on the date of display of the proposed rule at the Office of the Federal Register, satisfying the requirement for a 60-day comment period. By making the proposed rule available on the CMS Web site (as well as at the Office of the Federal Register), we provided the public with access to not only the proposed rule, but also to all of the supporting files and documents cited in the proposed rule in a manner that can be used for analysis. We note that the computer files posted on the Web site can be used for independent analysis. Therefore, we believe that beginning the comment period for the proposed rule with the display date at the Office of the Federal Register, and posting the proposed rule and data files on the CMS Web site on the display date, fully complies with the statute and provides a far better opportunity for the public to have meaningful input than the past practice under which the comment period began with the publication date in the **Federal Register**, a week or longer after the display date and no other data in any other form was furnished.

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

In the August 5, 2004 proposed rule, we stated that for dates of service beginning on or after January 1, 2004, Medicare would pay for IVIG administered in the home. The benefit is for the drug and not for the items or services related to the administration of the drug when administered in the home, if deemed medically appropriate. The implementing instructions for this benefit were provided in a transmittal released on January 23, 2004. We received several comments regarding this new benefit. The comments and our responses are provided below.

Comment: Several commenters expressed concern regarding the lack of coverage for the items and services needed to administer IVIG. These commenters urged us to use our authority to pay for the items that are necessary for the effective use of IVIG.

Response: The MMA provided coverage for the approved pool plasma derivative for treatment in the home; however, new section 1861(zz) of the Act specifically precludes coverage for the items and services related to the administration of the derivative.

Comment: The commenter stated that on January 23, 2004, we released a transmittal implementing the new IVIG coverage. The transmittal contained the following language: ''for coverage of IVIG under this benefit, it is not necessary for the derivative (IVIG) to be administered through a piece of durable medical equipment.'' Commenters stated that this language has resulted in the denial of coverage of IVIG for patients because providers are using the rationale that it is medically unnecessary to infuse IVIG through an infusion pump and therefore IVIG is medically unnecessary. The commenters recommended that we issue a new transmittal stating that IVIG is to be covered even when administered through durable medical equipment (DME), as determined necessary by a physician.

Response: It was not our intention to deny any beneficiary the coverage of IVIG in the home. It appears that the sentence that references the use of DME for the administration of IVIG is both confusing and misleading. Therefore, we will issue a new transmittal removing the apparent DME restriction.

Result of Evaluation of Comments

We are finalizing the proposed revisions to § 410.10 without alteration.

H. Section 623—Payment for Renal Dialysis Services

Section 623 of the MMA amended section 1881(b) of the Act and directed the Secretary to revise the current renal dialysis composite rate payment system. The MMA included several major provisions that require the development of revised composite payment rates for ESRD facilities.

The following is a summary of the proposed revisions to the composite payments rate methodology implementing provisions in section 623 of the MMA that are required to be effective January 1, 2005.

- The proposed rule provides for a 1.6 percent increase to the current composite payment rates effective January 1, 2005.
- The proposed rule included an add-on to the composite rate for the difference between current payments for separately billable drugs and payments based on a revised drug pricing methodology using acquisition costs. For purposes of this adjustment, in the proposed rule, we defined acquisition costs as the ASP minus 3 percent. We proposed a single adjustment to the composite payment rates for both hospital-based and independent facilities, equal to 11.3 percent.
- In the proposed rule, we discussed the reinstatement of the ESRD exceptions process for pediatric facilities as provided in section 623(b) of MMA. The statute defines pediatric ESRD facilities as renal facilities at least 50 percent of whose patients are under age 18. Since April 1, 2004, we have accepted ESRD composite rate exception requests from ESRD facilities that believe they qualify for exceptions as pediatric ESRD facilities.
- Section 1881(b)(12)(D) of the Act, added by section 623(d)(1) of the MMA gives the Secretary discretionary authority to revise the current wage indexes and the urban and rural definitions used to develop them. In the proposed rule, we proposed to take no action at this time to revise the current composite rate wage indexes. Because of the potential payment implications of recently revised definitions of urban areas, we believe further study is required.
- The proposed rule described the proposed methodology for a case-mix adjustment to a facility's composite payment rate based on the statutorily required limited number of patient characteristics. We used co-morbidity data for all Medicare ESRD patients obtained from the Form CMS–2728, supplemented with co-morbidity information obtained from Medicare claims. We measured the degree of the relationship between specified co-morbidities and ESRD facility per treatment costs, controlling for the effects of other variables, using standard least square regression. The source of the per treatment costs was the Medicare cost report. The result, after all necessary statistical adjustments, was a set of eight case-mix adjustment factors based on age, gender, AIDS, and peripheral vascular disease (PVD). Section 623(d)(1) of the MMA requires that aggregate payments under the case-mix adjusted composite payment system be budget neutral. Therefore, the proposed rule provided an adjustment 0.8390 to be applied to a facility's composite payment rate to account for the effects of the case-mix adjustments.

A. Composite Rate Increase

The current composite payment rates applicable to urban and rural hospital-based and independent ESRD facilities were effective January 1, 2002. Section 623(a)(3) of the MMA requires that the composite rates in effect on December 31, 2004 be increased by 1.6 percent. The updated wage adjusted rates were published in Tables 18 and 19 of the proposed notice.

The tables reflected the updated hospital-based and independent facility composite rate of $132.41 and $128.35, respectively, adjusted by the current wage index. The rates shown in the tables do not include any of the basic case-mix adjustments required under section 623 of the MMA.

Comment: Although there were no specific comments on the 1.6 percent adjustment, several commenters wanted to emphasize the importance of providing an annual adjustment to the composite rate in order to recognize the increased costs that face renal dialysis facilities. They stated that failure to increase the composite rate on a regular basis has caused dialysis providers to suffer a significant loss of income from their Medicare reimbursement and that dialysis facilities are the only Medicare entities that do not receive a statutorily mandated annual increase in their reimbursement rates.

Response: We do not have the authority to establish an annual update to the composite payment rates. Section 4201(a)(2) of Pub. L. 101–508 effectively froze the methodology for calculation of the rates, including the data and definitions used as of January 1, 1991. Since that time, the Congress has set the composite payment rate for ESRD services furnished to Medicare beneficiaries. As a result, we do not have the authority to update the composite payment rate.

B. Composite Rate Adjustments To Account for Changes in Pricing of Separately Billable Drugs and Biologicals

Section 623(d) of MMA provides for an add-on to the composite rate for thedifference between current payments for separately billable drugs and payments based on a revised drug pricing methodology using acquisition costs.

In the proposed notice we proposed to pay for separately billable ESRD drugs using ASP minus 3 percent based on the average relationship of acquisition costs to average sales prices from the drug manufacturers as outlined in the OIG report. We developed the proposed drug add-on adjustment using the ASP minus

3 percent drug prices. As discussed below, the drug add-on adjustment for this final rule is based on average acquisition costs for the top ten ESRD drugs updated to 2005 and ASP plus 6 percent for the remaining separately billable ESRD drugs. *See* section III.E, Payment for Covered Outpatient Drugs and Biologicals, for a discussion of the final payment methodology for ESRD separately billable drugs.

In the proposed notice, we outlined the methodology and data used to develop the proposed drug add-on adjustment to the composite rate of 11.3 percent for both hospital-based and independent ESRD facilities. Since the composite rate payment for hospital-based facilities is higher than the composite rate for independent facilities, the proposed adjustment results in a higher payment rate for hospital-based facilities. The 2005 composite rates (including the 1.6 percent increase) would be $132.41 for hospital-based facilities and $128.35 for independent facilities with the hospital-based facilities' rate higher by $4.06. We found this result consistent with section 1881(b)(7) of the Act, which requires that our payment methods differentiate between hospital-based facilities and others. We also indicated that the proposed methodology for making this drug add-on adjustment to the composite rate is designed to ensure that the aggregate payments to ESRD facilities for separately billable drugs would be budget neutral with what would have been paid absent the MMA provisions.

The proposed rule also discussed an alternative approach that produced separate adjustments to the composite rate of 2.7 percent for hospital-based and 12.8 percent for independent facilities. In contrast to a single add-on, separate add-on adjustments would result in a significantly higher composite payment rate for independent facilities than hospital-based facilities, of $8.79 more per treatment.

Comment: We received many comments from independent facilities, chain organizations and groups objecting to our proposal to establish a single add-on adjustment to the composite payment rate. Several commenters expressed concern that since hospital-based facilities are paid reasonable cost for their separately billed drugs other than EPO, those facilities should receive an adjustment based only on the spread related to EPO payments. They stated that our proposal to spread the drug savings to all facilities does not comply with the provision in the statute that they believe is intended to hold facilities harmless with respect to their drug payment profit margins. The commenters also contend that since hospital-based facilities already receive about $4.00 per treatment more than independent facilities, they should not share in the drug add-on adjustment for other than their specific EPO usage.

Response: As we indicated in the proposed rule, we believe that the statutory language supports one uniform drug add-on adjustment to composite payment rates set forth in section 1881(b)(7) of the Act after updating by 1.6 percent. The provision speaks of one ''difference between payment amounts'' and ''acquisition costs * * * as determined by the Inspector General.'' It is reasonable to infer that the Congress intended us to compute one ''difference'' based only on the payment amounts under sections 1842(o) and 1881(b)(11) of the Act.

Although the language of section 1881(b)(7) contemplates differential composite rates for hospital-based facilities and 623(d) contemplates existing composite rates as the starting point for application of the new rate adjustments prescribed under section 1881(b)(12)(A) of the Act, the MMA language does not suggest that these adjustments would be applied differentially across facilities. Otherwise, all of the adjustments, including case-mix and budget neutrality would have to be developed separately based on facility type.

We note that the amount of the drug add-on has decreased significantly from the proposed rule as a result of our revised policy of paying for ESRD drugs for 2005. Since the drug payment amounts increased, the amount of the drug add-on to the composite rate decreased. The resulting drug add-on amount is now 8.7 percent.

We also note that there is not a significant difference in composite rates for independent facilities under single and separate add-ons. With a single add-on of 8.7 percent, the 2005 composite rate for independent facilities would be $139.52. Under a separate add-on approach, the 2005 composite rate for independent facilities would be $140.93, a difference of $1.41 or about 1 percent before taking other considerations into account. This difference is about 27 percent less than the difference based on the approach and figures in the proposed rule.

While a composite rate difference of $1.41 is important, such difference does not take into account two other factors: (1) Since Medicare's 2005 payments for ESRD drugs will be a weighted average of the acquisition costs determined by the Inspector General, the payment amounts for the most utilized ESRD drugs (such as EPO) will be significantly higher than payment based on ASP–3 percent; and (2) Beginning with 2005, Medicare will pay separately for syringes that are currently included in the EPO payments.

With separate add-ons, the composite rate for the independent facilities would be $7.33 higher than the composite rate for hospital-based facilities. However, the composite rate for hospital-based facilities would be $10.33 lower under separate add-ons than under a single add-on approach. We believe the current difference in composite rates where the hospital-based rate is about $4.00 higher than the independent facility rate would effectively be preserved with a single add-on and significantly reversed with separate add-ons.

Finally, we note that a key purpose of the MMA legislation was to eliminate the cross-subsidization of composite rate payments by drug payments. If the composite rate was inadequate before the MMA provision, it was inadequate for both hospital-based and independent facilities. As such, increasing the composite rate by relatively greater amounts for independent facilities than hospital-based facilities would place the latter facilities at a competitive disadvantage relative to the former facilities.

Comment: One comment from a drug manufacturer suggested that in order to preserve high quality care to ESRD patients and prevent cost shifting behavior, we should require a facility to provide the full range of separately reimbursable drugs and biologicals in order to receive the drug add-on adjustment.

Response: We do not believe the statute permits imposing such a requirement as a condition for receiving the add-on adjustment to the composite rate. However, other regulations require that ESRD facilities provide appropriate care to each patient based on a plan of care that would include the administration of medically necessary drugs as prescribed by the patient's dialysis physician.

1. Growth Factors Used To Update Drug Expenditures and Prices

Comment: One commenter noted that, in the proposed rule, we updated the 2004 ASP drug prices to 2005 prices by using the projected annual growth factor for National Health Expenditures prescription drugs of 3.39 percent. This commenter wanted to know why we did not use the actual growth factors for separately billable drugs that are furnished by ESRD facilities to ESRD

patients. The commenter states that this factor is currently running about 39 percent.

Response: After consideration of the available price data, as discussed in the section on payment for ESRD separately billable drugs, we have determined that the Producer Price Index (PPI) for prescription preparations is the most appropriate price measure for updating EPO and other separately billable drugs from 2003 to 2005. The PPI for prescription preparations is released monthly by the Bureau of Labor Statistics, and reflects price changes at the wholesale or manufacturer stage. By comparison, the Consumer Price Index (CPI) for prescription drugs reflects price changes at the retail stage. Because EPO and many of the separately billable drugs used by dialysis facilities are purchased directly from the manufacturer, the use of a price index that measures wholesale rather than retail prices is more appropriate. The PPI for prescription drugs is the measure used in the various market baskets that update Medicare payments to hospitals, physicians, and skilled nursing facilities, and home health agencies. In addition, the PPI for prescription drugs was recommended for use in the proposed composite rate market basket detailed in the 2003 Report to the Congress.

Based on historical data through the second quarter of 2004, we used the Global Insight Inc. forecast of the PPI for prescription drugs to determine the update factors for 2004 and 2005. We feel the use of an independent forecast, in this case from Global Insight Inc., is superior to using the NHE projections for drug prices (which is the CPI for prescription drugs) and is consistent with the methodology used in projecting market basket increases for Medicare prospective payment systems.

Comment: One comment questioned the 3 percent growth rate that we used in the proposed rule to estimate 2005 Medicare AWP payment amounts for purposes of calculating the drug add-on amount. Specifically, the commenter asked whether the 3 percent figure represented the AWP growth trends for all drugs as opposed to the AWP growth trends for only ESRD separately billable drugs and biologicals. The commenter also asked for clarification of the timeframe used to establish the historical trend.

Several comments also expressed concern that we used a 10-quarter average as an approximation for 2002 expenditures, and as a result, the projected 2005 drug expenditures were understated. These comments strongly recommended that we establish an accurate baseline using actual 2002 expenditures. A study performed for commenters by an industry consultant was cited as confirming that our base year estimate is materially below actual drug spending computed using CMS's 2002 Outpatient Five Percent Standard Analytic File (SAF). Commenters were also concerned that the drug add-on does not reflect the true difference between payments under the current system and acquisition costs described by the OIG.

Response: We have taken all these comments into consideration and have re-evaluated our 2005 projection of aggregate ESRD facility drug expenditures. We did not use an average over 10 quarters to determine aggregate drug payments. The 10 quarters of data were used only to establish historical growth trends. However, we determined that our estimates of aggregate drug payment amounts were in fact understated because they did not include deductibles and coinsurance. Since drug payment rates are set at 100 percent of the allowable payment, we incorrectly calculated the aggregate drug payment for 2005. We revised our calculation to ensure that we capture the allowable payment before deductible and coinsurance are removed. In addition, we updated our estimates to incorporate the June 2004 update to the 2003 standard analytical file. The 3 percent growth represents our best estimate of the expected growth rate in AWP prices. In addition, due to numerous coding changes for the various ESRD drugs, we were unable to do direct comparisons for each of the AWP prices from year-to-year. Therefore, we believe the 3 percent inflation factor we used to update the AWP prices is appropriate.

Comment: One comment expressed concern that the projected number of dialysis treatments in 2005 would be overstated if home peritoneal dialysis (PD) treatments for home patients are included because facilities do not bill for non-EPO drugs in that setting.

Response: Since ESRD facilities also receive composite rate payments for their Method I home patients, the drug add-on would also apply to composite rate payments for those patients. Therefore, it is appropriate for us to count those treatments in projecting the number of dialysis treatments for computation of the drug add-on amount. We did not, however, count treatments attributable to Method II home patients since payment for these patients is made based on reasonable charges as opposed to the composite rate.

Comment: One comment from a patient organization raised concern that the add-on provision would remove any incentives the current payment policy creates for facilities to provide separately billable drugs and biologicals to dialysis patients. This comment suggested that we establish new clinical guidelines or indicators to ensure that dialysis patients receive necessary drugs and biologicals. This commenter also asked whether we have longer term plans to revise payment for dialysis treatment and ancillary services.

Response: We share this commenters concern that changes in payments to dialysis facilities could produce perverse incentives for dialysis facilities to skimp on care to ESRD patients. In order to ensure that patients continue to receive quality care, we are revising the ESRD facility conditions for coverage so that they are more patient-centered and outcome-oriented. We will publish proposed ESRD conditions by the end of 2004. We note that section 623 of MMA also requires us to develop a bundled, case-mix adjusted payment system and report to the Congress by October 1, 2005. This section also requires the establishment of a demonstration to test the revised payment system over a 3-year period beginning January 1, 2006.

2. Update Methodology for Drug Add-on Adjustment in 2006

Comment: Several commenters recommended that we publish the methodology that we intend to use to update the drug add-on component of the basic case-mix adjusted payment amounts, beginning in 2006, and that we provide the opportunity for public comment.

Response: We did not propose a mechanism for updating the 2006 payments in this document since this rule addresses payment for 2005. It is our intent to publish a proposed rule in mid-2005 to address payment changes for 2006. The public will be given an opportunity to comment on those proposals at that time.

3. Computation of Final Drug Add-On Adjustment to the Composite Payment Rate

To develop the final drug add-on adjustment we used historical total aggregate payments for separately billed ESRD drugs for half of 2000 and all of 2001, 2002 and 2003. For EPO, these payments were broken down according to type of ESRD facility (hospital-based versus independent). We also used the 2003 data on dialysis treatments performed by these two types of facilities over the same period.

I. 2005 Average Acquisition Payment (AAP) Amounts

The OIG report contained 2003 average acquisition costs for the top ten drugs supplied by the four largest dialysis chain organizations and by a sample of those facilities not managed by the four largest chain organizations. According to the OIG report, these ten drugs accounted for about 98 percent of total expenditures for separately billed drugs furnished by ESRD facilities. The report also indicated that payment to the four largest dialysis chains accounted for 73 percent of Medicare drug reimbursement in 2002. Therefore, we weighted the average acquisition costs using a 73–27 split. As discussed earlier, we then updated the 2003 weighted average acquisition costs to arrive at the 2005 AAP amounts by using the PPI for prescription drugs. These factors were 4.81 percent and 3.72 percent for 2004 and 2005, respectively.

TABLE 9:

	2003 Average Acquisition Costs	2005 Average Acquisition Payment Amounts
Epogen	$8.98	$9.76
Calcitriol	0.88	0.96
Doxercalciferol	2.39	2.60
Iron dextran	10.07	10.94
Iron sucrose	0.34	0.37
Levocarnitine	12.53	13.63
Paricalcitol	3.68	4.00
Sodium ferric glut	4.55	4.95
Alteplase, Recombinant	29.19	31.74
Vancomycin	2.74	2.98

II. Estimated 2005 Medicare Payment Amounts Based on 95 Percent of AWP

We estimated what Medicare would pay for ESRD drugs in 2005 if the MMA had not been enacted. We adjusted the first quarter 2004 Medicare payment amounts (95 percent of AWP), based on the prices from the January 2004 Single Drug Pricer, for drugs other than EPO, to estimate 2005 prices by using an estimated AWP growth of 3 percent. As discussed earlier, these growth factors are based on historical trends of AWP pricing over years. We did not increase the price for Epogen since payment was maintained at $10.00 per thousand units prior to MMA.

TABLE 10:

Drugs	Estimated 2005 Pre-MMA Medicare Payment Amounts
Epogen	$10.00
Calcitriol	1.42
Doxercalciferol	5.67
Iron dextran	18.45
Iron sucrose	0.68
Levocarnitine	35.23
Paricalcitol	5.49
Sodium ferric glut	8.42
Alteplase, Recombinant	37.80
Vancomycin	7.24

III. Dialysis Treatments

We updated the number of dialysis treatments based on 2003 data by actuarial projected growth in the number of ESRD beneficiaries. Since Medicare covers a maximum of three treatments per week, utilization growth is limited, and therefore any increase in the number of treatments will be due to enrollment. In 2005, we project there will be a total of 34.8 million treatments performed.

IV. Estimated Drug Spending

We updated the total aggregate 2003 Epogen drug spending for hospital-based and independent facilities using historical trend factors. For 2004 and 2005, we increased the 2003 spending levels by trend factors of 1.0 percent for hospital-based facilities and by 10.0 percent for independent facilities based on historical growth from 2000 to 2003.

We also updated the aggregate AWP based spending for separately billed drugs, other than EPO, for independent facilities by using the 10 percent growth factor for Epogen. Since aggregate spending in this category show extremely varied growth in recent history, we could not establish a clear growth trend. For this reason we decided to apply the Epogen growth rate to the other separately billed drugs. Given the problems establishing growth trends for the other drugs, plus the fact the expenditures for Epogen account for about 70 percent of the total spending for the top ten ESRD drugs, we believe this approach to updating all of the separately billed drugs is appropriate.

Additionally, we deducted 50 cents for each administration of Epogen from the total Epogen spending for both hospital based and independent facilities, to account for payment for syringes that is currently included in the EPO payments. Payment for syringes used in administering EPO will be made separately beginning January 1, 2005. In 2005, we estimate that the total spending for syringes associated with the administration of Epogen will amount to $1.6 million for hospital-based facilities and $27 million for independent facilities. For 2005, we estimate that the total spending for Epogen provided in hospital-based facilities will be $210 million, and $2.913 billion for drugs provided in independent facilities ($2.003 billion for Epogen and $910 million for other drugs).

V. Add-On Calculation and Budget Neutrality

For each of the ten drugs in the previous tables, we calculated the percent by which 2005 AAP amounts are projected to be different from the payment amounts under the pre-MMA system. For Epogen, this amount is 2 percent. We applied this 2 percent figure to the total aggregate drug payments for Epogen in hospital-based facilities, resulting in a difference of $5 million.

Since the top 10 ESRD drugs will be paid at 2005 AAP amounts and the remainder will be paid at ASP plus six percent, we then calculated a weighted average of the percentages by which AAP amounts would be below current Medicare prices, for the top 10 drugs, and the percentage by which ASP plus 6 percent would be below current Medicare payment amounts. For other than the top ten drugs, we do not have detailed data on expenditures for drugs billed by ESRD facilities. Therefore, we computed the percentage by which ASP plus 6 percent is below the estimated 2005 pre-MMA payment amounts for those drugs, using the average of the comparable ASP prices for the top 10 ESRD drugs. This procedure resulted in a weighted average of 13 percent by which the overall revised 2005 drug payment amounts applicable to independent facilities is projected to be less than the 2005 estimated pre-MMA system (that is, 95 percent of AWP). We then applied the 13 percent weighted average to total aggregate drug spending projections for independent facilities, producing a projected difference of $385 million.

Combining the 2005 estimates of $5 million and $385 million, for a total of $390 million and then distributing this over a total projected 34.8 million treatments would result in an add-on to the per treatment composite rate of 8.7 percent. We estimate that an 8.7 percent adjustment to the ESRD composite payment rate would be needed to achieve budget neutrality with respect to drug expenditures for ESRD facilities.

A. Patient Characteristic Adjustments

As explained in the proposed rule, the current ESRD composite payment rates are not adjusted for variation in patient characteristics or case-mix. Section 623(d)(1) of the MMA added section 1881(b)(12)(A) of the Act to require that the outpatient dialysis services included in the composite rate be case-mix adjusted. Specifically, the statute requires us to establish a basic case-mix adjusted prospective payment system for dialysis services. Also, the statute requires adjustments under this system for a limited number of patient characteristics. In the proposed notice, we described the development of the methodology for the proposed patient characteristic case-mix adjusters required under the MMA.

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

TABLE 11:

	Age	Adjustment factor
Female	<65 years	1.11
	65-79 years	1.00
	>79 years	1.16
Male	<65 years	1.21
	65-79 years	1.17
	>79 years	1.23
AIDS		1.15
PVD		1.07

Although the magnitude of some of the patient-specific case-mix adjustments appears to be significant, facility level variation in case-mix is limited because of the overall similarity of the distribution of patients among the eight case-mix classification categories across facility classification groups.

We received a significant number of comments regarding the case-mix adjustment factors, which are summarized in this section with our corresponding responses.

1. Sample Data Used To Develop the Basic Case-Mix System

Comment: Comments regarding the sample or universe used to derive the proposed basic case-mix adjustments in the proposed rule expressed concerns about the size of the sample, the number of hospitals and freestanding facilities included, as well as the number of facilities excluded from the data.

Response: We used the database established by our contractor to develop the basic case-mix system in the proposed rule. Facility cost report data were matched to the corresponding facility billing data to insure that the sample reflected the most valid and reliable data available. The specific methodology used to develop the database is discussed in Kidney Epidemiology and Cost Center's (KECC's) Phase I report. The Phase I report entitled: ''An Expanded Medicare Outpatient End Stage Renal Disease PPS—Phase I'' is available on the University of Michigan Web site: *http://www.sph.umich.edu/kecc.* The contractor has been updating the data files for subsequent phases of their research and is beginning to analyze these data for the bundled prospective payment system. The data used for the basic case-mix proposed system were also assessed in terms of consistency. Data from 2000, 2001, and 2002 were examined separately as well as combined to determine if there were consistent trends over the 3-year period. The data were updated to include the latest 2002 data that was available as of September 2004. The updated data reflect an increase of approximately 10 percent in the number of facilities represented in the database.

Comment: Several comments expressed concerns regarding the timeliness of the data used to develop the proposed case-mix measures. These concerns focused on the availability of cost reports for 2002. In the proposed notice we acknowledged we were delayed in obtaining cost reports for 2002 and that the final rule would reflect the most recent data on the number of cost reports available.

Response: Table 12 indicates the number of dialysis facilities with at least one cost report for 2000 to 2002. This table also reflects the availability of the most recent cost reports data for 2002 and reflects an increase from the proposed rule of an additional 564 cost reports for the independent facilities in 2002.

TABLE 12:

	2000	2001	2002
Independent Facilities	3034	3067	3072
Hospital-based Facilities	476	470	456

The availability of cost reporting data may be delayed because of a number of factors including late submissions by facilities and necessary reconciliation and verification of data by fiscal intermediaries prior to submission to our data systems. The comment on delays and availability of data is also related to concerns expressed by other comments regarding the reporting of co-morbid conditions. Several comments addressed potential inconsistencies in

facility reporting of co-morbid conditions, specifically with the impact of the variation of the reporting of AIDs noted in the 2000 data compared to other years. This variation, coupled with the potential incompleteness of the 2002 data, led us to examine options for selecting the time period to be used for determining the case-mix adjustments.

In this final rule, we have decided to use combined data for the 3-year period 2000–2002, to determine the case-mix adjustment factors. The use of combined data enables us to eliminate any impact caused by annual variation in reporting, delays in the availability of administrative files, and overemphasizing the predictive significance of selected variables, because case-mix variables are combined and averaged over a 3-year period, thus representing a more stable database.

Comment: Several comments focused on the number of facilities that were excluded from the study sample in the development of the proposed case-mix adjustments. For the proposed regulation, we excluded from our sample facilities where cost report data could not be matched to claims data and vice versa, or where key data elements were missing. In addition we excluded outlier facilities (those with high or low average costs, or high or low proportions of co-morbid conditions.) Data from small facilities (fewer than 20 patients) and those with existing composite rate exceptions were also excluded.

Response: We concurred with the recommendation to reassess the sample. For the final rule, we are including, within the sample, data for facilities with existing exceptions. However, we have continued to exclude data for small facilities, outliers, and facilities with missing or unusable data. Missing data excluded approximately 11 percent of the sample, and not including small facilities or outlier facilities eliminated approximately 9 percent of the study sample.

We did not accept the suggestion that smaller sized facilities were proxies for rural facilities, however, and we will continue to study the rural and urban issue in future research and in updates to the wage index.

Overall, including those facilities with exceptions provides a more robust study sample. In this way any effects on the case-mix values due to fluctuations in the data from year to year are greatly diminished.

Comment: Several commenters objected that the database used to develop the basic case mix was not available. One commenter indicated that not having the data made it difficult to evaluate the impact of the proposed case-mix variables on specific facilities.

Response: The database developed for the basic case-mix system is the same database that was developed by the University of Michigan for the ongoing research project to develop a bundled payment system. This database was compiled using our administrative data. We make available for purchase data available in the form of public use files or standard analytic files. Commenters can use the same data files that were used by the University of Michigan to develop the database used. The proposed rule provides the factors necessary to determine impact on individual facilities based on the case-mix within that facility. In addition, we have expanded our discussion of the impact of the case-mix adjustments and have provided a more detailed example to assist facilities in evaluating the impact of the case mix on their specific facilities.

2. Including Co-Morbid Conditions in the Case-Mix Adjustment

Comment: A number of comments expressed concerns regarding the coding of co-morbid conditions. Some comments acknowledged that limited time has been spent by ESRD facilities in coding multiple conditions. Some stressed that training should be provided to ensure that facilities understand this reporting requirement. One commenter attributed the proposed delay in implementation of the case-mix adjustments to potential difficulties in coding co-morbid conditions and in integrating these coded conditions into the payment.

Response: We considered the commenters concerns regarding incorporating co-morbid conditions and the findings from analyzing more recent data. Although our regression modeling suggests that the inclusion of co-morbidities in the case-mix system would be appropriate, we are concerned that the data available to determine patient level co-morbidities may not accurately reflect diagnoses relevant to the dialysis patient population. Therefore, in this final rule we are not including co-morbidities as case-mix adjustments. As discussed later in this section, we are establishing the case-mix adjustments based on the following variables: age, body mass index (BMI) and body surface area (BSA). More recent analysis of the data and clinical concerns expressed regarding the inclusion of AIDs and selected PVD diagnoses support this decision. However, while co-morbid conditions are not currently part of the basic case-mix system, we encourage all facilities to more thoroughly report and code co-morbid conditions on their claims. This will enable appropriate refinements to the basic case-mix adjustments and also provide a better database from which we can develop case-mix measures for a bundled payment system.

Comment: One commenter representing a chain of ESRD facilities stated that we overstated the prevalence of patients with peripheral vascular disease (PVD). The commenter maintained that overstating the incidence of PVD in the ESRD outpatient population results in an overstatement of the offset for budget neutrality because of the proposed 1.07 case-mix adjuster for PVD patients, thereby decreasing the otherwise applicable composite payment rate prior to case-mix adjustments. The commenter identified 51 diagnoses from the list of PVD diagnosis codes included in the proposed rule that he believed were either not reflective of PVD in ESRD patients, were not usually considered as a cause of PVD in ESRD patients, or were poorly differentiated clinically and could occur even in the absence of PVD. The commenter believed that these 51 diagnoses should be excluded from our list of PVD diagnoses for purposes of determining the case-mix and budget neutrality adjustments to the composite payment rates. Another commenter pointed out that there is substantial clinical disagreement about the definition of PVD and that the ESRD claims data presently do not contain sufficient information to implement the proposed PVD adjustor.

Response: The selection of specific co-morbid conditions for purposes of adjusting the composite payment rates to reflect the patient characteristics associated with cost differences across facilities is an important issue, and we appreciate the commenter's suggestions. However, we disagree with the recommendation that we exclude certain diagnoses because they are not usually considered a cause of ESRD in patients. We believe that whether a particular co-morbid condition caused the onset of ESRD is irrelevant. The important factor is whether a particular co-morbid condition is associated with facility differences in composite rate costs, regardless of their role in the etiology of ESRD.

We agree with the commenter's suggestion that diagnoses which can occur in the absence of PVD will be excluded for purposes of applying a case mix adjustment based on PVD. In addition, there is apparent disagreement among clinicians as to whether certain

diagnoses are reflective of PVD in ESRD patients, and we will try to achieve as much consensus as possible before proceeding to implement a case mix adjuster which purports to reflect PVD. Accordingly, we are eliminating the case mix adjustment for PVD as set forth in the proposed rule. We point out that further analyses with more restricted sets of diagnostic codes revealed that the omitted codes were still strong predictors of costs. We intend to revisit the issue of appropriate co-morbidity adjustments as we continue our research to develop the bundled ESRD payment system.

We point out that our case mix model that included PVD explained about 35.7 percent of the variation in facility composite rate costs. By comparison, our model using five age groups without co-morbidities explains about 35.6 percent of the cost variations. Although PVD was a statistically significant case mix variable, its contribution to the model's performance overall in explaining facility differences in costs was minimal. While co-morbidity adjustments will be excluded under the basic case mix adjusted composite payment system, accuracy in the reporting of co-morbid conditions on the bills will become increasingly important because of the likelihood that a bundled ESRD payment system will include co-morbidities associated with differences in patient resource consumption.

Comment: Two commenters recommended that we exclude AIDS as a co-morbidity warranting case-mix adjustment. These commenters stated that because of State laws requiring that a patient's AIDS status be kept confidential, most facilities do not know whether their patients have AIDS. This does not pose a risk to other patients or caregivers because of the universal precautions which dialysis facilities are required to use in order to prevent exposure and infection.

Response: Because the claims data contain primarily the patient's primary diagnosis, AIDS is not likely to be recorded as a claims diagnosis for outpatient dialysis patients. Requiring the recording of the AIDS diagnosis on the bills would create powerful incentives for ESRD facilities to circumvent confidentiality restrictions. In those States with AIDS confidentiality requirements, the diagnosis is not likely to be recorded at all. Given the relatively low incidence of AIDS patients in the outpatient dialysis population, the fact that facilities in States with AIDS confidentiality requirements would be potentially disadvantaged if AIDS were included as a payment adjuster, and the fact that the relationship between AIDS and dialysis costs was not stable from year to year, we have decided to eliminate AIDS as a basis for case-mix adjustment to the composite payment rates at the present time.

3. Case-Mix Adjustment for Gender

Comment: One commenter suggested that we eliminate gender as one of the patient characteristic variables used to case-mix adjust the composite payment rates. The commenter stated that gender was essentially a surrogate for differences in height and weight measures that would yield a superior case-mix adjustment.

Response: Although height and weight are much better predictors of facility variation in composite rate costs, these data were only available on the Form CMS 2728, not on the bills submitted for payment. Accordingly, we used gender as a surrogate measure in proposing adjustments, because gender is reported on the outpatient bill (for example, UB92 or the equivalent electronic form). However, the National Uniform Billing Committee has approved the use of two new value codes for reporting weight and height (A8—weight in kilograms, A9—height in centimeters) on the billing forms effective January 1, 2005.

The mandatory reporting of height and weight permits the development of case mix measures that reflect both variables, such as BMI and BSA, each of which are superior to weight alone as predictors of resource use. Given the impending availability of height and weight data on the outpatient dialysis bill, we examined the predictive power of weight, BMI, and BSA in lieu of gender based on data reported on the Form 2728 from 2000 through 2002. We found that both BMI and BSA are superior predictors to weight alone and that BSA, coupled with a variable for low BMI, is the best predictor of facility differences in composite rate costs. Accordingly, we have eliminated gender in this final rule as a patient classification variable for purposes of case mix adjustment. Instead we are substituting BSA, and a variable for low BMI, each of which are explained in another section of this final rule.

4. Age Groupings Used in Proposed Case-Mix Adjustment

Comment: Several comments indicated that the proposed age groups were too broad. Some of the comments recommended that we create more age categories for purposes of the case-mix adjustments.

Response: In the proposed rule we established three age categories for example: less than 65, 65–79, and greater than 79. In reassessing the study sample and the proposed case mix adjusters, we also explored the age categories. We concur with the comments to expand the number of age categories. For the final rule, there will be five age groupings. These are: 18–44, 45–59, 60–69, 70–79, and 80+. Patients under 18 are discussed in the following section on pediatrics. We believe that the revisions to the age groupings more accurately describe the distribution of the patient population and reflect more refined predictors of age for payment purposes.

Comment: One commenter asked what would happens under our proposed adjustment if during the course of a month, an ESRD patient's age changed and they cross the line into another case-mix adjustment factor. For example, on August 15 a 64-year-old ESRD patient turns 65. They questioned how is this situation is handled and is the age used as of the last day of the month.

Response: We believe it is appropriate to handle this situation as it is handled for enrollment. Thus, for a month when the patient has a birthday that puts him or her into another age category, the first of the month would be the effective date of the patient's new age category.

5. Case-Mix Adjustment for Pediatric Patients

Comment: Several commenters expressed concern over the lack of a case-mix adjustment for pediatric ESRD patients. The commenters stated that although section 623(b) of the MMA provided for an exception process for pediatric ESRD facilities, qualification for a pediatric exception is limited to those facilities where pediatric patients (those under age 18), comprise at least 50 percent of the caseload. The commenters pointed out that ESRD pediatric patients are unusually resource intensive and costly and are widely scattered among facilities, most of which would not qualify as pediatric facilities under the definition set forth in the statute. The commenters recommended that we develop a case-mix adjuster for pediatric ESRD patients using other data sources.

Response: Using the same regression methodology described in the proposed rule, we attempted to develop a case-mix adjuster for outpatient ESRD patients under age 18. However, based on the approximately 600 Medicare patients for whom bills were available each year from 2000 through 2002, the results were highly variable, statistically

unstable, and therefore inappropriate for development of a case-mix adjuster in accordance with the proposed rule's methodology. However, because of the costliness of pediatric ESRD patients, we believe that an alternative case-mix adjustment is warranted, particularly for those facilities, which do not meet the definition of a pediatric facility under section 623(b) of the MMA.

As the commenter correctly pointed out, some facilities would not qualify for consideration for the pediatric exception provided in the law because their pediatric caseload does not constitute 50 percent of their patients. These facilities may still incur substantial costs for the treatment of pediatric ESRD patients. Pending the development of more refined case-mix adjustments that are more sensitive to individual variation in treatment costs under a fully bundled ESRD PPS, we are providing for a single adjustment to a facility's otherwise applicable composite payment rate, developed based on the methodology described below, for outpatient ESRD pediatric treatments. We want to emphasize that the pediatric adjustment factor resulting from this methodology is intended to be a temporary measure. It will only apply until we can develop an adjustor under the bundled ESRD PPS that is more similar with the case-mix adjustments that would apply to non-pediatric ESRD patients.

During the period from November 1, 1993 to the present time, we identified 19 hospital-based and one freestanding ESRD facility, each of which sought and received an atypical services exception based on the higher costs incurred for the treatment of outpatient pediatric patients. For each of these facilities we obtained the number of treatments at the time the exception was submitted and determined the unadjusted composite payment rate that would have applied beginning January 1, 2005 without regard to any exception amount, that is, each facility's unadjusted composite payment rate was inflated to January 1, 2005 to reflect the statutory increases of 1.2 percent effective January 1, 2000, 2.4 percent effective January 1, 2001, and 1.6 percent effective January 1, 2005.

We then subtracted the inflated January 1, 2005 unadjusted composite rate from each facility's composite payment rate, including the exception amount granted, to obtain the estimated amount of the exception projected to 2005. This amount was multiplied by the number of treatments previously provided, summed for all 20 facilities, and then divided by the number of treatments for all 20 providers to yield an average atypical services exception amount per treatment. The average exception amount for ESRD facilities that received exceptions due to their pediatric caseload, adjusted to 2005, was $86.79 per treatment. The average unadjusted composite payment rate for these same 20 facilities projected to 2005, similarly weighted by the number of treatments, was $139.32. Thus, the average composite payment rate adjusted to January 1, 2005, including the average exception amount of $86.79, was $139.32 + $86.79 or $226.11. Because the average exception amount was calculated from facilities located in areas with differing wage levels, we converted the average pediatric exception amount to a ratio, $226.11/$139.32 or 1.62.

This is the case-mix adjustment factor that will be applied to each facility's composite payment rate per treatment for outpatient maintenance dialysis services furnished to pediatric patients. This includes both in-facility and home dialysis. Applying the adjuster multiplicatively in this manner recognizes the wage index variation in labor costs among urban and rural areas built into the composite rates. Notwithstanding this case-mix adjustment per treatment for ESRD pediatric patients, facilities who otherwise qualify as a pediatric facility under section 623(b) of the MMA will be permitted to seek an exception to this rate if they believe their circumstances warrant a higher payment rate under the atypical services exception provisions set forth in the regulations. We intend the pediatric adjustment factor of 1.62 to be a temporary measure. We anticipate its elimination once the case-mix methodology that will apply in the context of the bundled ESRD PPS is developed. We want the same methodology to apply to both pediatric and non-pediatric ESRD patients.

6. Facility Level Control Variables Used in the Proposed Regression Model

In developing the regression model used to derive the case-mix adjustments, we included variables reflective of facility characteristics. Because facility characteristics do account for differences in facility composite rate costs, we included them in the regression model through the use of facility control variables, so that the patient characteristic case-mix adjusters are not distorted. The facility control variables included the wage index, facility size (based on the annual number of treatments), facility status as hospital-based or freestanding, percent of patients with urea reduction ratios greater than or equal to 65 percent, chain ownership, year of cost report, and percent of pediatric patients treatments. These variables were not used to calculate the basic case-mix adjustment factors.

Comment: One comment questioned the inclusion of the proportion of patients with urea reduction ratios (URRs) greater than 65 as a facility control variable in the least squares regression model used to develop the case-mix adjustment factors. The comment maintained that because a patient's URR may be correlated with other co-morbid conditions, the coefficients for the variables tested in the model might be distorted. The comment recommended an evaluation of the degree of association between URR and the main co-morbid conditions to determine the extent of any multicolinearity. The comment further stated that if URR is appropriate as a facility control variable, then other surrogates of dialysis efficiency, such as standardized mortality ratio and proportion of patients with hemoglobin readings above specified target levels, should also be considered as control variables.

Response: We believe that case-mix adjustments to the composite payment rate must be determined by patient and not by facility characteristics. To the extent that facility differences in costs are statistically explained by facility and not patient characteristics, we account for them in the regression model through the use of control variables, so that the potential case-mix adjusters are not distorted. Facility control variables were not used to develop the adjustment factors to the composite payment rates.

For example, chain affiliation, facility size, and status as a hospital-based or freestanding facility were associated with statistically significant differences in facility costs. However, it would be inappropriate to object to the payment rates based on a facility belonging to a particular chain, or based on the number of annual treatments.

To test for multicolinearity, that is, to ensure that each co-morbidity tested for inclusion in the regression model was not correlated with other variables, we ran a correlation matrix. The correlation matrix included URR. URR was found not to correlate with any of the co-morbidities tested; in statistical parlance, it was orthogonal. Accordingly, low URR was not a surrogate of co-morbidity. Therefore, we believe it was appropriate to treat URR as a quality of care outcome measure at each facility. The effect of using URR as a facility control variable was to ensure that the case-mix adjustment factors were not distorted for facilities with similar URR outcomes. For example, if

larger patients receive lower doses of dialysis, not controlling for URR could impart a downward bias on the coefficient for patient size. The comment also suggested the use of other variables as facility control variables such as standardized mortality ratio (SMR) and hemoglobin count. Because SMR standardizes or controls for the effect of case mix on the ratio, we would have to ensure consistency in the reporting of specified co-morbidities on the bills in order to ensure the validity of each facility's SMR. That consistency currently does not exist. Facilities are only required to report hematocrit/hemoglobin on the claims available for those patients receiving erythropoeitin (EPO). However, because the proportion of patients receiving EPO is high, the use of hematocrit/hemoglobin as another outcome facility control variable is feasible, but mainly in the context of the bundled payment system. Since the drugs and lab tests associated with anemia management are paid outside the composite payment rate, hematocrit/hemoglobin level would not be appropriate as a control variable applicable to composite rate costs.

7. Propriety of Case-Mix Adjustment

Comment: Several commenters expressed reservations about our proceeding with the implementation of a case-mix adjustment to the composite payment rates using the methodology set forth in the proposed rule. One commenter cited the May 19, 2004 report prepared by the KECC of the University of Michigan, which pointed out that the proposed case-mix variables collectively explained less than 1 percent of the facility variation in composite rate costs, although the addition of facility control variables increased this proportion to about 33 percent. One commenter stated that the low explanatory power of the proposed case-mix variables indicated that they do not accurately predict cost variation and are flawed. The commenter suggested that we defer applying a case-mix model until the results of the demonstration project mandated under section 623(e) of the MMA are available.

Response: We would have preferred to develop a case-mix adjustment in the context of a bundled outpatient ESRD PPS. In a fully bundled PPS, which section 623(f) of the MMA anticipates, routine and separately billable dialysis related services, drugs, and clinical laboratory tests would be included in the payment bundle. KECC's previous research revealed that, for separately billable services, case-mix explained about 23 percent of the variation in cost across dialysis facilities. (*See* Hirth, *et al.*, Is Case-Mix Adjustment Necessary for an Expanded Dialysis Bundle?, Health Care Financing Review, 2003, 24, pages 77–88).

However, the enactment of Pub. L. No. 108–173 foreclosed the option of deferring implementation of a casemix adjusted composite rate based on a limited number of patient characteristics effective January 1, 2005. We do not believe that the statutory directive set forth in section 623(d) of the MMA permits us to defer the development of a basic case-mix measure, one based on a ''limited number of patient characteristics.''

We do not agree with the statement that, because the proposed case-mix adjusters collectively account for about 1 percent of the facility variation in composite rate costs, the variables used are fundamentally flawed. In fact, when data is combined over three years, each of the proposed case-mix variables is highly significant statistically, despite the low proportion of facility variation in costs explained. A more important indicator of the importance of the case mix factors identified is the size of the adjustments. If the identified case mix variables did not have a meaningful relationship with costs, the magnitude of the adjustment factors would be insignificant or trivial. They are not. As explained in this final rule, based on our analysis of the comments we received, we have revised the case-mix variables used to adjust the composite payment rates. Our research to develop a statistically robust clinically coherent case-mix measure in the context of the fully bundled ESRD PPS will continue.

8. Alternative Case-Mix Variables

Comment: Several commenters suggested alternative case-mix variables which they believe account for patient differences in resource consumption and would better distinguish facility differences in composite rate costs. The patient characteristics proposed by commenters included quarterly serum albumin values, cancer, limb amputation, gastrointestinal disorders, body mass index, weight, revised age groupings, hypertension, duration of dialysis treatment, and others. The commenters indicated that, based on their clinical judgment, the suggested factors were more likely to be predictors of variability in the cost of care than the proposed AIDS and PVD co-morbidities. A few commenters recommended a delay in the implementation of the case-mix adjusted composite payment rates pending evaluation of the suggested variables. A number of comments indicated that BMI was a significant predictor of cost and recommended that BMI be included in the case-mix adjustment. Another commenter recommended BSA be examined as a potential case-mix predictor.

Response: We appreciate all of the comments we received proposing alternative case-mix variables. We welcome suggestions for case-mix refinement based on sound clinical judgment, especially when analyses including separately billable ESRD services are performed as our research for development of the bundled ESRD payment system progresses. However, we point out, that unless the existence of a suggested co-morbidity or patient characteristic could be determined from either the Form CMS 2728 or claims data which could be linked to a specific ESRD dialysis patient, we were unable to evaluate its potential to predict facility differences in composite rate costs. Furthermore, unless a patient characteristic can be reported on the UB 92 claim form (or the equivalent electronic version), it cannot be used to adjust a facility's composite payment rate. These limitations eliminate for consideration many of the commenters' suggested alternative patient characteristic variables.

Nonetheless, our regression model evaluated 35 patient characteristics including weight, BMI, BSA, seven types of cancer, diabetes, chronic obstructive pulmonary disease, four types of heart disease, and race. Co-morbidities selected for inclusion in the model with significant negative coefficients were removed from subsequent iterations of the stepwise regression model. The inclusion of such co-morbidities would have resulted in reductions in the otherwise applicable composite rate payments. Because we can now require the reporting of height and weight on the claim form beginning January 1, 2005, we have adopted the commenters' suggestions to use either BMI or BSA as a predictor variable. We selected BSA and low BMI because they improve the model's ability to predict the costs of composite rate service compared to using BMI or weight alone. In addition, we have increased the number of age groups from three to five and eliminated gender as a payment variable entirely.

As explained later in the ''Implementation Date'' section, we do not believe it would be appropriate to further delay the implementation of the basic case-mix adjustment. We proposed delaying implementation of the case-mix payments until April 1, 2005 in order to ensure all systems, programming, and other operational requirements are in place. Between publication of this final rule and the

implementation date, we will conduct training programs to ensure that facilities understand both the payment methodology and reporting requirements necessary to ensure appropriate payment to ESRD facilities.

9. Continuing Research To Develop a More Fully Bundled Case-Mix System

Comment: Several comments requested additional detail regarding the continuing research for the development of a more fully bundled system.

Response: The research activities for the fully bundled system have focused on updating the database. Research efforts since the passage of MMA have focused on supporting the Congressional mandate for the development of a limited number of case-mix variables. Following the publication of this rule, we anticipate that the emphasis will return to the development of a bundled prospective payment system that includes bundling of drugs, clinical laboratory tests, and other items that are separately billed by such facilities. This research will be reflected in an October 1, 2005 Report to the Congress.

In addition, the MMA requires us to establish the fully case-mix adjusted demonstration which will bundle into the payments both separately billable drugs and biologicals and clinical labs. Both the Report to the Congress and the demonstration will be supported by continuing research.

10. Body Measurements as Case-Mix Adjusters

In the proposed rule, we had discussed the importance of the BMI as a measure of resource consumption related to the composite payment rate. At that time, our analysis indicated that patients with very low or high BMI were more costly to treat. At the time of the publication of the proposed rule, we had no mechanism to obtain indicators for height and weight on the claims form. We had indicated that we would be exploring adding height and weight to the bills.

Comment: A number of commenters endorsed the use of low BMI as an appropriate surrogate for the severity of morbid conditions associated with malnourishment in the dialysis population, and some suggested that a BMI below 20.0 kg/m^2 is generally considered in the underweight range. In addition, we also received comments regarding the inclusion of a measure of BSA.

Response: We concur with the comments to include BMI and BSA as case-mix adjusters reflecting patient characteristics that explain variation in the reported costs for composite rate services. We have obtained approval to collect both height and weight on the bill through the use of two new value codes. ESRD facilities will be required to report height and weight using these value codes, so that payment can be based on the case-mix adjusted composite rate payment system on April 1, 2005.

For the implementation of the basic case-mix payments, we are providing an adjustment for low BMI, that is, any patient with a BMI less than 18.5 kg/m^2. We included this variable because our regression analysis indicated that those patients who are underweight and malnourished consume more resources than other patients. Although we received one comment suggesting defining low BMI as 20 kg/m^2, we chose the measure of low BMI that is consistent with the CDC and NIH definition for malnourishment. Furthermore, our exploration of alternative BMI thresholds did not improve the model's ability to predict the costs of composite rate services.

In addition, we are providing case-mix adjustments based on BSA. Our research into this body measurement indicated that BSA (meters^2) is a good predictor of composite rate resource consumption. We examined all of the formulas for BSA. While we found very little differences between the formulas in predictive power, we are adopting the Dubois and Dubois formula for BSA since our literature search revealed that this particular formula was the most widely known and accepted. This formula is: $BSA=W^{0.425} * H^{0.725} * 0.007184$ (DuBois D. and DuBois, EF. ''A Formula to Estimate the Approximate Surface Area if Height and Weight be Known'': Arch. Int. Med. 1916 17:863–71.), where w and h represent weight in kilograms and height in centimeters, respectively.

In addition, we explored a number of options for setting the reference values for the BSA. We examined the distributions for both the midpoint of the BSA and the count of dialysis patients by age, body surface and low BMI. Based on this analysis, we are setting the reference point at a BSA of 1.84 (the average BSA among dialysis patients in 2002). By setting the reference point at the average BSA, the adjusters will reflect the relationship of a specific patient's BSA to the average BSA of all patients. Therefore, some adjusters will be greater than 1.0 and some will be less than 1.0. In this way, we are able to minimize the magnitude of the budget neutrality offset to the composite payment rate.

The following presents an example of the method for calculating patient level multipliers that were derived from the coefficients resulting from the regression model that includes control variables, expanded age groups, BSA, and an indicator for low BMI (<18.5 kg/m^2). The model excluded small facilities, and outliers.

Case-mix adjuster = Age factor * low BMI factor * BSA factor

Although we could have selected any increment, we believed an increment of 0,1 provided and appropriate degree of precision of the calculation of the exponent used to compute the BSA case-mix adjustment. The BSA factor is defined as an exponent equal to the value of the patient's BSA minus the reference BSA of 1.84 divided by 0.1. The BSA adjustment factor of 1.037 is then exponentiated based on the calculated BSA factor as 1.037 ((BSA - 1.84)/0.1)

For Example: The case-mix adjuster for a 47-year old person who is underweight (BMI<18.5 kg/m^2) and has a body surface area of 2.0 m^2 is calculated by using the 1.84 BSA reference point:

Age Factor = 1.055
Low BMI Factor = 1.112
BSA Factor = $1.037\ ((2.0-1.84)/0.1) = 1.037^{(1.6)} = 1.060$
Case-Mix Adjuster = 1.055 * 1.112 * 1.06 = 1.244

The resulting case-mix adjustment factor of 1.244 for this patient would be applied to the facility's composite payment rate that is adjusted for area wage index, drug add-on, and budget neutrality.

11. Budget Neutrality for Case-Mix Adjustment

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

In order to account for the payment effect related to the case-mix adjustment, we proposed to standardize the composite rate by dividing by the average case-mix modifier of 1.1919. The proposed budget neutrality adjustment to the composite rate was 0.8390. However, we were not able to simulate case-mix effects at the bill level

because co-morbidities are generally not reported on the ESRD bill. We still intend to refine our case-mix adjustments once we have more complete patient data on the ESRD bill. In this final rule, we have refined our adjustment for budget neutrality related to the case-mix factor. We simulated payment for each ESRD provider by applying a facility-specific case-mix multiplier to the composite rate applicable for that facility. Since the pediatric case-mix adjustment was developed outside the regression model, we simulated payments separately for those treatments. The results of these tow computations were then combined to arrive at the total case-mix adjusted payments. We also simulated payment for each provider as if they did not receive any case-mix adjustments. We then compared the total simulated payments with case-mix adjustment to total simulated payments without case-mix adjustment. The resulting budget neutrality adjustment to the composite rate is 0.9116.

B. Revised Patient Characteristic Adjustments

The following section discusses in detail the final case-mix adjustments to the ESRD composite rate payment.

In summary, based on the comments that we received on the proposed case-mix and additional analyses prepared by our contractor, KECC, in this final rule, we are modifying the proposed case-mix adjustments. We have broadened the number of age groups to include five age categories and added low BMI and BSA as measures. We have also included a specific case-mix adjustment for pediatric patients under age 18. We excluded the proposed categories gender and co-morbid conditions. We will be using a limited number of patient characteristics for the basic case mix system; however, we believe that these adjustments adequately explain variation in the reported costs per treatment for the composite rate services consistent with the legislative requirement. The adjustment factors for the basic case mix are listed in Table 13 below.

TABLE 13:

Variable		Multiplier
Age	Pediatrics <18 **	1.62
	18-44	1.223
	45-59	1.055
	60-69	1.000
	70-79	1.094
	80+	1.174
Body Surface Area (per 0.1 Δ BSA of 1.84)		1.037
Low BMI (<18.5 kg/m^2)		1.112

** BSA and BMI adjustment do not apply to pediatric patients.

The following table illustrates the average case-mix adjustment by type of provider based on the 2002 data that was used to develop the adjustment factors.

Table 14:

Facility Type	Average Case-Mix Adjustment
All	1.0967
Independent	1.0963
Hospital-Based	1.0990
Urban	1.0957
Rural	1.1009
Small (<5k treatments/yr.)	1.1027
Medium (<5-10k treatments/yr.)	1.0995
Large (>10k treatments/yr.)	1.0947
Non-Profit	1.1004
For-Profit	1.0957

As illustrated in table 14, regardless of the type of provider, the projected average case-mix adjustments for patient characteristics do not vary significantly.

C. Rural Facilities

Comments: Some commenters focused on the potential impact the revised composite rate payment system could have on rural facilities. They were initially concerned that excluding small facilities from the overall sample actually reflected the elimination of rural facilities from the sample. As a means of resolving this issue, they suggested that a rural facility exception be restored.

Response: The MMA provision for composite rate exceptions limited the availability of exceptions only to pediatric facilities. To the extent that a qualifying pediatric facility is located in a rural area, it would be able to apply for an exception to its composite payment rate.

D. Dual Eligible Dialysis Population

Comment: One commenter expressed concerns regarding potential impact on the dual eligible population, specifically with respect to coverage of deductibles and coinsurance amounts. Concern was expressed regarding the impact of this proposal on the Medicaid population on a state-by-state basis.

Response: We recognize that this is an important issue for ESRD facilities and can be particularly problematic for chain organizations that own facilities in multiple States. While we cannot direct States for payment for dual eligible beneficiaries, we will take appropriate action to ensure that States are aware of the changes we are implementing so they can take steps to adjust their payments for dual eligible dialysis patients.

E. Budget Neutrality

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

For the proposed drug payment add-on adjustment, we indicated in the proposed rule that the methodology we used to estimate the difference between the current and proposed drug payments was designed so that aggregate payments would be budget neutral.

In addition, the proposed rule provided for a budget neutrality adjustment to the composite payment rate of 0.8390 to account for the effects of the proposed case-mix adjustments on aggregate expenditures.

Comment: We received a number of comments concerning our application of the budget neutrality provision of section 623 of MMA. Specifically, many comments suggested that we did not comply with Congressional intent that facilities would be held harmless by this provision, that is, that facilities would not receive lower payments then they otherwise would have.

Response: Section 623 of MMA requires that aggregate payments in 2005 not exceed payments that would otherwise be paid. The budget neutrality provision is to ensure that total aggregate payments from the Medicare trust fund will not increase or decrease as a result of changes in the payment methodology. As with other Medicare payment systems, changes in the payment mechanism will result in the redistribution of Medicare dollars across facilities. There is no provision (nor any implication) in section 623 of the MMA that guarantees that individual facilities would receive the same amount of payment under a case-mix adjusted system as they did previously.

The final budget neutrality adjustment to the ESRD composite payment rate applicable to the case mix adjustments (including the pediatric adjustment) is 0.9116. Also in the proposed rule, the calculation of the drug add-on adjustment was designed to ensure budget neutrality with respect to aggregate drug payments.

F. Geographic Index

Comment: Several comments expressed disappointment that we did not propose revisions to the current outdated wage indexes reflected in the composite payment rates, despite the discretionary authority set forth in section 623(d)(1) of the MMA to replace them. These comments stated that this decision likely would have the greatest impact on facilities located in high cost and high wage areas, where competitive labor market pressures are more

pronounced. Comments generally were in favor of using the most up-to-date information available for developing a revised composite rate wage index.

Response: The wage index currently used in the composite rates is a blend of two wage index values, one based on hospital wage data from fiscal year 1986 and the other developed from 1980 data from the Bureau of Labor Statistics. The wage index is calculated for each urban and rural area based on 1980 U.S. Census definitions of metropolitan statistical areas (MSAs) and areas outside of MSAs. Restrictions apply to the wage index values used to develop the composite payment rates. Payments to facilities in areas where labor costs fall below 90 percent of the national average, or exceed 130 percent of that average, are not adjusted below the 90 percent or above the 130 percent level. This effectively means that facilities located in areas with wage index values less than 0.90 are paid more than they would receive if we fully adjusted for area wage differences. Conversely, facilities in locales with wage index values greater than 1.30 are paid less than they would receive if we fully adjusted payment for these higher wage levels.

We agree that the current ESRD composite rate wage indexes, and the definitions of the geographic areas on which they are based, need to be updated. On June 6, 2003, OMB issued Bulletin 03–04, which announced new geographic areas based on the 2000 Census. The extent to which we use the new OMB geographic definitions, incorporate them into the various prospective payment systems (PPSs) we administer, and whether we rely on hospital wage and employment data to develop new composite rate wage index values will have the potential to significantly redistribute payments among ESRD facilities.

In the August 11, 2004 **Federal Register** (69 FR 48916), we announced how we were revising the hospital wage index used in connection with inpatient PPS. Although one comment stated that we should adopt the same wage index used in connection with the inpatient PPS, several of the hospital wage index revisions stem from specific provisions of law (for example, geographic reclassification of hospitals) and would not necessarily be appropriate to apply to a revised ESRD wage index for the composite payment rates. Because of the discretion afforded the Secretary in developing a new wage index for ESRD payment purposes, we are carefully assessing the propriety and payment implications of policy options before recommending revisions to the current measure. We will not take action to replace the current composite rate wage index at this time. We point out that, in accordance with section 623(d)(1) of the MMA, any revisions to the wage index ultimately adopted must be phased in over a multiyear period.

G. Payment Exceptions and the Revised Composite Payment Rate

1. Application of Statutory Increases to Exception Amounts

Comment: Several comments were critical of our policy of not applying increases to composite rates, mandated by the Congress, to amounts paid under exceptions. The comments maintained that this policy is inequitable, precludes the proper application of inflation updates to costs that we had recognized as appropriate in granting the exception, and over time erodes the value of the exception because of the cumulative impact of an effective ''historical freeze.''

Response: The commenters are correct that we have only applied the Congressionally mandated statutory increases to the basic wage index adjusted composite payment rates, not to exception payments. For example, a provider which was authorized a $12.00 atypical services exception amount per treatment in addition to its otherwise applicable composite payment rate of $125.00 effective August 12, 2000 would not be entitled to the 2.4 percent increase applicable to composite rate payments on January 1, 2001, because its exception rate of $137.00 exceeded its basic rate of $125.00 increased by 2.4 percent or $128.00. While the commenter believes that our policy of not applying the Congressional mandated increases to exception amounts is unfair, we believe that the policy is consistent with the law. Section 422(a)(2)(C) of SCHIP, enacted December 21, 2000, states as follows in pertinent part:

> Any exception rate under such section in effect on December 31, 2000 * * * shall continue in effect so long as such rate is greater than the composite rate as updated * * *.

Thus, the statute seems to distinguish between an exception rate and the composite rate, as ''updated'' by the Congress. The clear implication of the text is that the exception rate is not so updated. Accordingly, we believe that our policy of not applying mandated composite rate increases to exception amounts is consistent with the statute. Moreover, we point out that section 422(a)(2) of SCHIP prohibited the granting of new exceptions and that we are providing facilities the option of either retaining their exception rates, or at any time, electing payment under the case-mix adjusted composite payment rates. We do not believe providers, given this option, will be disadvantaged.

2. Home Dialysis Training Exceptions

Comment: We received comments asking for clarification concerning home dialysis training exceptions since the proposed rule only addressed exceptions in a very general way. They stated that the rule proposes that each facility with an exception rate would compare their exception rate to the new basic case-mix adjusted prospective payment and then decide if it wishes to withdraw the exception rate and be subject to the basic case-mix adjusted composite rate. The commenters stated that this language does not consider a facility that would choose to accept the basic case-mix adjusted prospective payment for its chronic treatments, but continue its exception rates for the training of home patients. The home training exception is the most widely used exception and provides a higher rate for the higher cost of training a patient in fewer than the maximum number of allowed treatments.

Response: We agree and are providing that a home training exception rate may be continued. Facilities with home training exceptions will be able to retain their current exception training rates as well as take advantage of the case-mix adjusted rate for non-training dialysis.

3. New Exception Window

Comment: One commenter requests that a new ''exceptions window'' for pediatric facilities be opened in early 2005. It will not be until after this rule is final that its members will be able to determine the exact impact of this new methodology on their operations.

Response: Section 623(b) of MMA reinstated exceptions for qualifying pediatric facilities defined as facilities with at least 50 percent of their patients under 18 years of age. The current exception window for pediatric facilities closed on September 27, 2004. At this time, future exception windows will be open only for pediatric facilities. The exceptions process is opened each time there is a legislative change in the composite payment rate or when we open the exception window. The fiscal intermediary will notify the ESRD pediatric facilities when a new exception window opens. However, it is our intent to open pediatric exception windows on an annual basis.

4. Home Dialysis Training Rates

Comment: One commenter asked if the training rate add-on to the composite rate would still be applied.

Response: Yes, the following rates will apply for self-dialysis or home dialysis training sessions:

- For intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD) and hemodialysis training, the facility's case-mix adjusted payment excluding any approved exception rates will be increased by $20 per training session, furnished up to three times per week.
- For continuous ambulatory peritoneal dialysis (CAPD), the facility's case-mix adjusted payment excluding any approved exception rates will be increased by $12 per training session, furnished up to three times per week.

Based on the example for John Smith in section L (Example of Payment Calculation Under the Case-Mix Adjusted Composite Rate System), the hemodialysis (IPD & CCPD) training rate would be his case-mix adjusted rate of $170.80, increased by the training add-on of $20 for a total training rate of $190.80. For CAPD training, the training rate would be $182.80 ($170.80+$12)

H. Implementation Date

Comment: We received a number of comments supporting our proposed delay in implementing the case-mix portion of the revised composite payment methodology. Many comments maintained that the proposed April 1, 2005 effective date was overly ambitious, and some suggested that a July 1, 2005 implementation date would be more realistic given the need for facility and fiscal intermediary training and education.

Response: The MMA requires that the basic case-mix adjusted composite payment rates be effective for services beginning January 1, 2005. Despite the statute's specificity, we pointed out in the proposed rule that all of the numerous systems, programming, and operational changes necessary to implement the case-mix adjusted payments cannot be completed in time for a January 1, 2005 implementation date.

As presented in the proposed rule, we considered two options that we believed effectively complied with the statute's January 1, 2005 implementation date. While we stated in the proposed rule that either of these options substantively complies with the January 1, 2005 implementation date requirement of the statute, we rejected both alternatives.

The likelihood of payment error, potential disruption of facility payments, and the cost of reprocessing bills militated against either option. We proposed instead an April 1, 2005 implementation date for the basic case-mix adjustments to the composite payment rates, including the budget neutrality reduction. This option avoids the need for reprocessing of bills and applies the budget neutrality adjustment applicable to the case-mix adjustments effective April 1, 2005. Although we agree with the comment that a July 1, 2005 effective date would be ideal in light of the systems and operational changes required to implement the case-mix provisions, we believe that an April 1, 2005 effective date for the case-mix adjustments is feasible, and have decided not to revise that date. We have concluded based on our evaluation of ESRD claims processing systems that the April 1, 2005 implementation date is achievable. As we stated in the proposed rule, the 1.6 percent increase to the composite payment rates and drug add-on will be effective January 1, 2005.

I. Summary of Final Rule Implementing Changes to the ESRD Composite Payment Rate (Section 623 of MMA)

As set forth in this final rule, we will increase the ESRD composite payment rates by 1.6 percent effective January 1, 2005 in accordance with section 623(a) of the MMA. Also, the composite payment rates will be increased January 1, 2005 by 8.7 percent to reflect revisions to the drug pricing methodology for separately billable drugs, as discussed previously in this rule (Composite Rate Adjustments to Account for Changes in Pricing of Separately Billable Drugs and Biologicals). This section explains the development and computation of the revised drug add-on, which differs from the 11.3 percent amount described in the proposed rule, and our response to comments which advocated separate add-on amounts for hospital-based and independent facilities.

Despite the discretionary authority set forth in section 623(d)(1) of the MMA to replace the current outdated wage index used in the composite payment rates, we are taking no action to revise the wage index at the present time. A revised wage index will potentially significantly redistribute ESRD payments. We believe that further study is warranted before we revised the current index. Those assessments are presently underway.

We have also adopted a revised basic case-mix methodology for adjusting the composite payment rates based on a limited number of patient characteristics, as prescribed in section 623(d) of the MMA. The development and application of the revised case-mix adjusters were previously explained in the ''Revised Patient Characteristic Adjustments'' section of this final rule. The variables for which adjustments will be applied to each facility's composite payment rate include age, BSA, and low BMI. In response to comments, we eliminated gender in this final rule as a patient classification variable for purposes of case-mix adjustment, substituting BSA and a low BMI variable instead. We have also increased the number of age categories from three to five, and eliminated co-morbidities pending further study. Because height and weight are necessary to compute each patient's BSA and BMI, those measurements, in centimeters and kilograms, respectively, will be required on the UB 92 for outpatient ESRD services furnished on and after January 1, 2005. This final rule also provides for a case-mix adjustment of 1.62 to a facility's composite payment rate for pediatric ESRD patients (that is, under age 18). The methodology used to develop the pediatric case-mix adjustment factor of 1.62 is described in the ''Case-Mix Adjustment for Pediatrics Patients'' section of this rule. Although the MMA requires that the basic case-mix adjusted composite payment rates be effective for services beginning January 1, 2005, the systems and operational changes necessary to implement them cannot be completed in time for a prospective January 1, 2005 effective date. The case-mix adjustments and the applicable budget neutrality adjustment of 0.9116 will be effective April 1, 2005.

Example of Payment Calculation Under the Case-Mix

Example 1

Adjusted Composite Rate System

The following example presents 2 patients dialyzing at Neighbor Dialysis, an independent ESRD facility located in Baltimore, MD.

Calculation of Basic Composite Rate for Neighbor Dialysis

Wage adjusted composite rate for independent facilities in Baltimore, MD: $134.93

Wage adjusted composite rate increased by drug add-on adjustment $134.93 × 1.087: $146.67

Adjusted Facility Composite Rate after budget neutrality adjustment ($146.67 × 0.9116): $133.70

Patient #1

John Smith attains age 18 on April 10, 2005 and undergoes hemodialysis. John

weighs 75.5 kg. and is 181.5 cm. in height. Because John Smith attains age 18 April 10, he is considered age 18 for the entire month of April, and would not be classified as a pediatric patient.

Calculation of Case Mix Adjusted Payment

The BSA and BMI for John Smith will be calculated by the PRICER program used to compute the composite payment for each patient based on the height and weight reported on the UB 92. However, the computations of the BSA and BMI for John Smith are shown below:

BSA = $0.007184 \times (\text{height})^{0.725} \times (\text{weight})^{0.425}$

BSA = $0.007184 \times 181.5^{0.725} \times 75.5^{0.425}$

BSA = $0.007184 \times 43.4196 \times 6.2824 = 1.960$

BMI = $\text{weight}/\text{height(m)}^2$

John Smith is 181.5 cm. in height, which converts to 1.815 meters.

BMI = $75.5/1.815^2 = 22.919$

The case mix adjustment factor for John Smith, an 18 year old whose BMI exceeds 18.5 kg/m^2 and has a BSA of 1.960 is calculated as follows:

Age adjustment factor (age 18–44) 1.223

BMI adjustment factor (BMI ≥ 18.5 kg/m^2) 1.000

BSA adjustment factor ($1.037^{1.960-1.84/0.1}$) 1.0446

Case mix adjustment factor ($1.223 \times 1.000 \times 1.0446$) 1.2775

Basic case mix adjusted composite payment ($133.70 \times 1.2775) $170.80

Patient 2

Jane Doe is a 82 year old malnourished patient who undergoes hemodialysis. Jane is 158.0 cm. in height.

Calculation of Case Mix Adjusted Payment

The BSA and BMI for Jane Doe, which will be automatically computed by the PRICER program, are calculated as follows:

BSA = $0.007184 \times (\text{height})^{0.725} \times (\text{weight})^{0.425}$

BSA = $0.007184 \times 158.0^{0.725} \times 31.25^{0.425}$

BSA = $0.007184 \times 39.2669 \times 4.3183 = 1.2182$

BMI = $\text{weight}/\text{height(m)}^2$

Jane Doe is 158 cm. in height, which converts to 1.580 meters.

BMI = $31.25/1.580^2 = 12.5180$

The case mix adjustment factor for Jane Doe, an 82 year old whose BMI is less than 18.5 kg/m^2 and has a BSA of 1.2182, is calculated as follows:

Age adjustment factor (age 80+) 1.174

BMI adjustment factor (BMI ≤ 18.5 kg./m^2) 1.112

BSA adjustment factor ($1.037^{1.2182-1.84/0.1}$) 0.7978

Case-mix adjustment factor ($1.174 \times 1.112 \times 0.7978$) 1.0415

Basic case mix adjusted composite payment ($133.70 \times 1.0415) $139.24

Example 2

Linda Jones is age 16 and undergoes peritoneal dialysis at Community Hospital, a hospital-based facility in New York City. Linda weighs 35 kg and is 160.0 cm in height. The basic composite rate for Linda Jones is calculated as follows:

Wage adjusted composite rate for hospital-based facilities in New York, New York: $146.35

Wage adjusted composite rate increased by drug adjustment factor ($146.35 × 1.087): $159.08

Adjusted Facility Composite Rate after budget neutrality adjustment ($159.08 × 0.9116) $145.02

Because Linda is a pediatric ESRD patient, the automatic pediatric adjustment factor of 1.62 applies. Neither the age, BMI, nor BSA adjustments are applicable because Linda is less than age 18.

Pediatric adjusted composite rate ($145.02 × 1.62) $234.93

If Community Hospital were entitled to a composite rate exception, then the provider could elect to retain its exception rate in lieu of receiving the otherwise applicable pediatric payment rate of $234.93.

Impact Analysis

Comment: One commenter observed that the budgetary impact on the Medicare program of proposed section 623 changes (impact table) generally indicates an ''overall'' neutral or modest reimbursement increase for all types of dialysis facilities (independent and rural, for profit and non-profit, urban and rural). This commenter requested data that indicate the number of dialysis facilities that are operating at a loss in the U.S., by corresponding facility characteristics shown in the impact table.

Response: The purpose of the impact table is to simulate what ESRD facilities will receive in payments under the MMA section 623 changes compared to what ESRD facilities would receive without any changes to the current composite payment rates. We do not have data to determine whether or not a facility may operate at a loss under MMA section 623.

J. Section 731—Coverage of Routine Costs for Category A Clinical Trials

Before the enactment of the MMA, Medicare did not cover services related to a noncovered Category A device. The MMA authorizes Medicare to cover the routine costs associated with certain Category A clinical trials for services furnished on or after January 1, 2005. For a trial to qualify for payment, it must meet certain criteria to ensure that the trial conforms to appropriate scientific and ethical standards. In addition, the MMA established additional criteria for trials initiated before January 1, 2010 to ensure that the devices involved in these trials are intended for use in the diagnosis, monitoring, or treatment of an immediately life-threatening disease or condition. Seven commenters were in favor of this provision. Of them, four had additional comments. One commenter was against the provision.

Comment: One commenter stated that this provision would result in money being taken away from the pool of money for physician payments of non-experimental procedures.

Response: We considered this issue in determining the SGR for 2005. Since we have made a regulatory change to allow for coverage of routine costs associated with Category A clinical trials, we are required by statute to reflect any increased costs of this policy in the 2005 SGR. At this time, we are estimating that the costs associated with coverage of routine costs of Category A clinical trials will increase Medicare spending for physicians' services by less than 0.1 percent. However, we are reviewing this issue and we will adjust our estimates once we have actual spending data for 2005.

Comment: One commenter specifically requested that we define routine costs.

Response: We discuss and define routine costs in section 310.1 of the Medicare National Coverage Determination Manual (pub 100.3). We will take this comment into consideration if we decide to revise section 310.1 in the future.

Comment: Two commenters recommended that we adopt a definition of ''immediately life-threatening'' that would allow contractors some level of flexibility when they apply this criteria to evaluate trials.

Response: We will consider the importance of some level of flexibility in defining ''immediately life-threatening.'' Although we are not defining this term in our regulation, we intend to provide guidance through implementing instructions.

Comment: Another commenter suggested that contractors determine in advance if trials satisfy the immediately life threatening requirement.

Response: We are considering implementation requirements and will take this suggestion under advisement.

Result of Evaluation of Comments

We are finalizing the changes to § 405.207 as proposed.

K. Section 629—Part B Deductible

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

We proposed to update § 410.160(f), ''Amount of the Part B annual deductible,'' to conform to the MMA and to reflect that the Medicare Part B deductible is $100 for calendar years 1991 through 2004.

Comment: Commenters stated that they understand that we are following the statute in implementing this provision, but encouraged us to educate Medicare beneficiaries regarding this change.

Response: We agree that it is important to educate beneficiaries about the deductible, as well as the other provisions of the MMA, such as the new screening benefits, and we will be using publications such as the ''Medicare and You Handbook'' for this purpose.

Result of Evaluation of Comments

We are finalizing the proposed changes to § 410.160(f).

L. Section 512—Hospice Consultation

1. Coverage of Hospice Consultation Services

As discussed in the proposed rule published August 5, 2004, effective January 1, 2005, section 512 of the MMA provides for payment to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. Payment would be made on behalf of a beneficiary who is terminally ill (which is defined as having a prognosis of 6 months or less if the disease or illness runs its normal course), has not made a hospice election, and has not previously received the pre-election hospice services specified in section 1812(a)(1)(5) of the Act as added by section 512 of the MMA. These services comprise an evaluation of an individual's need for pain and symptom management, counseling the individual regarding hospice and other care options, and may include advising the individual regarding advanced care planning.

We believe that most individuals will seek this type of service from their own physicians. Thus, we do not expect that the services of a hospice physician would be necessary for all individuals who elect hospice. However, a beneficiary, or his or her physician, may seek the expertise of a hospice medical director or physician employee of a hospice to assure that a beneficiary's end-of-life options for care and pain management are discussed and evaluated.

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

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

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

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

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

Comment: Several commenters requested that this provision be extended to contracted physicians and nurse practitioners.

Response: Section 1812(a)(5) of the Act explicitly indicates that a physician employed by a hospice agency must provide the services under this provision. We recognize that contractual relationships are permitted by hospice agencies for medical director and physicians' services under the hospice benefit as described in section 1861(dd) of the Act. However, the plain language of section 1812(a)(5) provides only for employees of the hospice to furnish the service.

Section 1812(a)(5) of the Act also requires that this service be provided by a physician as defined in section 1861(r)(1) of the Act. While nurse practitioners may serve as attending physicians for beneficiaries who have elected the hospice benefit, this provision does not permit non-physicians to provide this pre-hospice service.

Comment: We received several comments that supported this provision as beneficial for end-of-life care.

Response: We believe that this provision supports and supplements options available to beneficiaries as they make end-of-life decisions when the individual's health care provider and community resources are not able to provide the expertise and information.

Comment: We received a comment suggesting that the certification of a terminal illness, with a 6-month prognosis if the disease runs its normal course, be eliminated and that this service should be available to any individual deemed to be terminal.

Response: Section 1812(a)(5) of the Act explicitly indicates that this one-time service is available to Medicare beneficiaries who are terminally ill and have not previously elected the hospice benefit. Section 1861(dd)(3)(A) of the Act defines the phrase ''terminally ill'' as denoting a medical prognosis that the individual's life expectancy is 6 months or less. Since section 1812(a)(5) of the Act specifies that the beneficiary must have a terminal illness, which includes the 6-month prognosis, we have no authority to eliminate this definition.

Since the benefit is a pre-hospice one, we have not required that a certification be completed before this service is provided. Nonetheless, in the judgment of the individual's physician, the individual must be terminally ill, that is, having a 6-month or less life expectancy if the disease or illness runs its normal course.

2. Payment for Hospice Consultation Services

Section 512(b) of the MMA amends section 1814(i) of the Act and establishes payment for this service at an amount equal to an amount established for an office or other outpatient visit for E/M associated with presenting problems of moderate severity and requiring medical decision-making of low complexity under the physician fee schedule, other than the portion of such amount attributable to the practice expense component. No existing CPT or HCPCS code specifically represents these services. We proposed establishing a new HCPCS code, G0337 (proposed as G0xx4) *Hospice—evaluation and counseling services, pre-election.* The hospice would use this new HCPCS code to submit claims to the Regional Home Health Intermediary (RHHI) for payment for this service. Utilization of the code would allow us to provide payment for the service, as well as enable us to monitor the frequency with which the code is used and assess its appropriate use. Payments by hospices to physicians or others in a position to refer patients for services furnished under this provision may implicate the Federal anti-kickback statute.

In accordance with the statute, we proposed that the payment amount for this service would be based on the work and malpractice expense RVUs for CPT code 99203 multiplied by the CF (1.34 Work RVU + 0.10 Malpractice RVU) * (CF). The CPT code for an office or outpatient visit for the E/M of a new patient represents a detailed history, detailed examination and medical decision making of low complexity. We believe that this E/M service is quite similar to the components of the new service provided by a medical director or physician employed by the hospice agency. Assuming that there are no changes in RVUs for CPT code 99203, and that the CY 2005 update to the physician fee schedule is the 1.5 percent specified in the MMA, the national payment amount for this service would be $54.57 for this service (1.44 * $37.8975).

Comment: We received several comments indicating that CPT Code 99203, a mid-level office visit with a new patient, does not accurately reflect the complexity associated with the hospice consultation. One commenter suggested using CPT code 99205. In addition, commenters stated that payment for this benefit should reflect the length and intensity of each consultation.

Response: Section 1814(i)(4) of the Act explicitly states that the payment for this service be equal to an amount established for an office or outpatient visit with presenting problems of moderate severity and requiring low complexity medical decision-making. We believe that CPT code 99203, rather than CPT code 99205, most closely conforms to the statutory language. However, in order to establish a payment rate that excludes the practice expense component and to ensure that we pay for the service only once, we established a G code.

Comment: We received one comment that indicated that existing consultation codes coupled with a place of service should be used.

Response: We appreciate the concern about introducing another code into a complex system of codes. While the title of the provision indicates that this is a consultative service, we believe that, unlike other consultations, beneficiaries are able to seek this service without a referral. Moreover, we need to be able to distinguish this service so that we can ensure that it is furnished only once to an individual. In addition, existing E&M codes are billed by physicians. This provision is billed by the hospice agency and is not a result of reassignment of payment by a physician to a hospice agency. Finally, the G code will allow us to track utilization of this new benefit.

Result of Evaluation of Comments

We are adopting our proposed policy and revising the regulations at § 418.205 and § 418.304(d). We are also finalizing our proposal to pay for this service using a G code (G0337) *Hospice—evaluation and counseling services, pre-election,* with the payment based on the work and malpractice expense RVUs for CPT code 99203.

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

Section 1832(a)(1)(E) of the Act, as added by section 302(a)(2) of the MMA, requires the Secretary to establish clinical conditions of coverage standards for items of DME. The statute requires the Secretary to establish types or classes of covered items that require a face-to-face examination of the individual by a physician or specified practitioner. Due to the timeframe and the extensive number of public comments received, we will implement this provision at a later date. We will address all public comments in a future **Federal Register** document.

N. Section 614—Payment for Certain Mammography Services

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

As stated in the August 5, 2004 proposed rule, section 614 of the MMA amended section 1833(t)(1)(B)(iv) of the

Act to exclude payment for screening and diagnostic mammograms from the OPPS. Beginning January 1, 2005, we will pay for diagnostic mammograms under the OPPS based on the payments established under the physician fee schedule. Thus, both diagnostic and screening mammography services provided in the OPPS setting will now be paid based on the physician fee schedule.

Comment: Commenters expressed support for this proposed change in payment and believe it will assist in ensuring that these services are available to women at risk for breast cancer.

Response: We agree that it is important to ensure access to these services. Additional discussion of the MMA provision can also be found in the OPPS final rule, ''Medicare Program; Changes to the Hospital Outpatient Prospective Payment System and CY 2005 Payment Rates'' currently under development.

O. Section 305—Payment for Inhalation Drugs

The August 5, 2004 proposed rule contained the ASP plus 6 percent payment amounts based on data received from manufacturers' ASP for the first quarter of 2004 for albuterol sulphate and ipratropium bromide. We indicated that such payment amounts were not the payment rates for 2005 and specified that Medicare payment rates for the first quarter of 2005 would be based on data submitted by manufacturers from the third quarter of 2004.

We proposed to establish a separate dispensing fee for inhalation drugs. We noted that Medicare currently pays a monthly dispensing fee of $5 for each inhalation drug used in a nebulizer. We requested information about an appropriate dispensing fee amount.

We also proposed to make several changes related to billing for inhalation drugs. We proposed to allow a prescription for inhalation drugs written by a physician and filled by a pharmacy to be increased from 30-day to a 90-day period. We indicated that we had recently revised the guidelines regarding the time frame for delivery of refills of DMEPOS products to occur no sooner than ''approximately five days'' prior to the end of usage for the current product. We emphasized the word ''approximately'' in this time frame. The change allows shipping of inhalation drug refills on ''approximately'' the 25th day of the month in the case of a 30-day supply and on ''approximately'' the 85th day in the case of a 90-day supply. We indicated our belief that such revision eliminates the need for suppliers to use overnight shipping of inhalation drugs and allows shipping of inhalation drugs by less expensive ground service.

We also clarified the ordering requirements for DMEPOS items, including drugs. Drugs, including, inhalation drugs, can be dispensed with a verbal physician order and without a written prescription. Although a written prescription must be obtained before submitting a claim, we reiterated that we allowed photocopied, electronic, or pen and ink prescriptions. We pointed out the recent revision to the Program Integrity Manual of acceptable proof of delivery requirements for DMEPOS items. Finally, we proposed to eliminate the requirement that pharmacies have a signed Assignment of Benefits (AOB) form from a beneficiary in order for Medicare to make a payment. Our proposal would eliminate a billing requirement for all drugs, including inhalation drugs and other items where Medicare payment is only made on an assigned basis.

Comment: A number of commenters, particularly retail pharmacies, indicated that they are not able to obtain albuterol sulfate at the $0.04 per milligram and ipratropium bromide at the $0.30 per milligram rates specified in the proposed rule based on manufacturer submissions of data for the first quarter of 2004. A large company indicated that the ASPs stated in the proposed rule for albuterol sulfate and ipratropium bromide were extremely close to its own acquisition costs and inferred that the payment amount would be below smaller providers' purchase prices. A commenter questioned the suggestion in the proposed rule that because albuterol sulfate and ipratropium bromide are generic drugs with multiple manufacturers a pharmacy might be able to obtain them at a price below the average. The commenter suggested that this is highly speculative because we have not yet received the information from manufacturers to set the ASP for the first quarter of 2005.

Response: The ASP plus 6 percent prices for drugs in the proposed rule were calculated based on manufacturer submissions of data covering the first quarter of 2004. We indicated that such ASP plus 6 percent figures were not actual payment rates for the first quarter of 2005. ASP data submitted by manufacturers for the second quarter of 2004 show some significant changes for inhalation drugs. The data show that the ASP plus 6 percent would be $0.05 per milligram for albuterol sulfate, a 25 percent increase, and $0.45 per milligram for ipratropium bromide, a 50 percent increase. We also note that in its recent study, ''Medicare: Appropriate Dispensing Fee Needed for Suppliers of Inhalation Therapy Drugs'' (GAO–05–72), the GAO found that acquisition costs of inhalation drugs varied widely. The GAO found that acquisition costs of albuterol sulfate ranged from $0.04 to $0.08 and ipratropium bromide ranged from $0.23 to $0.64. Based on the submission of manufacturer's average sales price data for the second quarter of 2004, Medicare's payment rates for ipratropium bromide and albuterol sulfate are within the acquisition cost range found by the GAO. The GAO also found that acquisition cost was not necessarily related to the size of the supplier.

Comment: One commenter suggested that we should consider delaying the implementation of cuts in Medicare reimbursement for inhalation drugs until 2006. The commenter suggested that a delay would ensure that physicians and beneficiaries have a range of options available for managing respiratory diseases.

Response: We do not believe that we can delay the implementation of the ASP payment system until 2006 because the MMA provides for the implementation of the ASP payment system in 2005.

Comment: Commenters strongly supported our proposal to pay a separate dispensing fee for inhalation drugs, but we received varied comments on the scope of services appropriately included in a dispensing fee. Commenters indicated that an appropriate dispensing fee is necessary because the costs associated with dispensing these drugs typically exceed ASP plus six percent. Without adequate compensation, commenters argued that Medicare beneficiary access to inhalation drugs would be harmed. Commenters referenced an August 2004 report prepared for the American Association of Homecare (AAH) by a consultant that surveyed 109 homecare pharmacies between the end of May and the middle of July 2004. Commenters cited survey results from the report suggesting that 89 percent of suppliers would discontinue providing inhalation drugs to Medicare beneficiaries in the absence of adequate compensation. One commenter believes it is reasonable to expect that reducing Medicare payment for inhalation drugs will trigger an increase in emergency room visits, doctor visits, and hospital admissions. Other commenters suggested a dispensing fee that is too low would result in a concentrated market, thereby adversely affecting beneficiary choice and access.

The AAH study indicated that in order to maintain 2004 levels of service to Medicare beneficiaries and provide an operating margin of 7 percent, Medicare would have to pay an additional payment of $68.10 per service encounter. This figure includes an average of the costs reported as being incurred during the first quarter of 2004 for the pharmacies that responded to the AAH survey. The study defined a service encounter as each instance one or more billing codes were submitted to Medicare for payment. The study reported that the typical Medicare beneficiary has 8.8 service encounters each year, or one service encounter every 42 days. Most commenters who cited the AAH study supported a fee of $68.10 per service encounter.

Commenters also cited another AAH report, dated September 2001 (and updated to 2003) from a different consultant, who surveyed a sample of 19 homecare pharmacies and found that drug acquisition costs accounted for 26 percent of costs incurred by homecare pharmacies. Facility, labor, delivery, patient care and education, billing and collection costs and other direct costs were found to account for 46 percent; indirect costs such as management information systems, regulatory compliance programs, professional liability insurance and field and corporate administration was 25 percent; and bad debt was 3 percent. The study concluded that homecare pharmacies generated after-tax returns of 9.2 percent.

A retail pharmacy commented that a dispensing fee five to six times the current dispensing fee of $5 is necessary to cover its costs. Another retail pharmacy indicated that a dispensing fee of $25 would be an adequate dispensing fee, including the additional costs of processing Medicare claims and instructing the patient on using the drugs, and would be profitable for it.

A manufacturer urged CMS to conduct a study of the appropriate pharmacy activities and their costs in calculating a dispensing fee. The commenter believes such a study would yield a more accurate amount than data and information provided as part of comments to proposed rules does. One inhalation company indicated that the costs of rent, delivery and salary had recently increased by specific percentages. Several commenters opposed the inclusion in the dispensing fee of a transitional payment. Another commenter strongly urged establishing a dispensing fee that include an appropriate transitional payment, given the significant payment reductions scheduled to begin in 2005.

On the scope of services, commenters indicated that various services involved with dispensing inhalation drugs to Medicare beneficiaries such as: (i) Training beneficiaries and caregivers on proper use of drugs with nebulizers; (ii) establishing and revising a plan of care and coordinating care; (iii) providing in-home visits; (iv) providing 24-hours/7-days a week on-call personnel; (v) contacting physicians and beneficiaries regarding dispensing of inhalation drugs; (vi) providing follow-up contact with beneficiaries, including compliance monitoring and refill calls. Commenters indicated that they felt CMS has the authority to pay for costs associated with delivering inhalation drugs under the durable medical equipment (DME) benefit.

An association representing pharmacists recommended an expansion of Part B to include compensation for therapy management services furnished by pharmacists. An association representing respiratory therapists recommended a separate payment for beneficiary training by practitioners with documented evidence of education, clinical training and competency testing, such as respiratory therapists. A company suggested that we establish a basic dispensing fee and separately reimbursable codes for those who provide additional services, reflecting the range of management services involved with inhalation drugs. Another association acknowledged that although limited peer reviewed studies exist on the role of homecare providers and the respiratory practitioners in furnishing care to COPD patients, significant anecdotal data and a consensus within the pulmonary medicine and respiratory therapy professional communities support the role and contribution of home respiratory care providers. Several commenters indicated that training a beneficiary on using a nebulizer should also be reimbursed. However, they pointed out that training cannot be done by the physician or physician's staff because many physicians do not have a nebulizer on which to train the beneficiary and the Medicare payment is not sufficient to cover the physician's staff time.

Response: We appreciate the support for our proposal to establish a dispensing fee as well as the information about the levels and components of such a fee.

The October 12, 2004 GAO report is based on a survey of 12 companies representing 42 percent of the inhalation therapy market. The GAO found wide variation in suppliers' monthly costs associated with dispensing inhalation drugs. In addition, the GAO found that large suppliers do not necessarily have lower costs and do not necessarily realize economies in costs associated with dispensing inhalation therapy drugs. The GAO indicated that the wide range is due in part to the range of services offered by suppliers and that some costs incurred by suppliers may not be necessary to dispense inhalation drugs, for example marketing, overnight shipping, and 24-hour hotlines for beneficiary questions. The GAO report indicates that the range of costs suppliers are incurring is a good starting point for a dispensing fee amount, but that the appropriate dispensing fee Medicare pays must take into account how excess payments affect the costs.

We note the extreme variation that the GAO found in the costs of dispensing nebulized drugs to Medicare beneficiaries: GAO found that per patient monthly costs of dispensing these medications ranged from a low of $7 to a high of $204 in 2003. Because it appears that the GAO survey and the 2004 AAH survey may have included different costs and services, further research is needed to understand these differences. In addition to the GAO and AAH studies, we note the wide range of comments indicating what services a dispensing fee should cover. We believe that before a determination can be made as to an appropriate dispensing fee for inhalation drugs after 2005, we need to more fully understand the components of and the reasons behind the current variability in the costs of furnishing of these drugs and the services being provided. We intend to work with the AAH, others concerned with inhalation therapy and our partners in the Department of Health and Human Services to explore these issues more fully.

In the interim, for 2005, we are establishing a $57 monthly fee and an $80 90-day fee for furnishing inhalation drugs using data in the AAH study and the GAO report. We established the monthly fee based on the weighted average of the costs for new and established patients from the 2004 AAH study after excluding sales and marketing, bad debt, and an explicit profit margin. Because the AAH study did not establish a fee for the 90-day period, we applied the methodology used in the GAO report to the data in the AAH study to calculate the 2005 90-day fee. Accordingly, we assumed that direct costs associated with a monthly fee are similar to the direct costs associated with the 90-day fee and then we tripled the indirect costs. We intend to further examine the conversion of per

encounter costs as reported in the AAH study to comparable monthly and 90-day cost figures.

We note that although the AAH study contained costs related to services that may be of potential benefit to our beneficiaries, and many commenters indicated that we should provide payment for these and the other services described above, we are concerned that these services may be outside the scope of a dispensing fee. We are continuing to study these services and associated cost categories as the new payment systems are implemented and we gain experience with them. We intend to revisit this issue and proceed through notice and comment rulemaking in order to establish an appropriate dispensing fee for 2006.

Comment: A commenter suggested that the dispensing fee be established on a per dose basis. It was argued that this would provide Medicare with protection against pharmacies dispensing partial shipments or shipments more frequently than 30 or 90 days in order to increase the number of dispensing fees. We received comments in support of a need-based dispensing fee to accommodate additional drugs when beneficiaries suffer from disease flare-ups. We also received comments indicating that beneficiary's prescriptions change, often during the first month. Other commenters cited the AAH study, which calculated different costs associated with dispensing inhalation drugs for new patients and established patient.

Response: The dispensing fee we are establishing covers all drugs shipped to a beneficiary during a month (or 90-day period) regardless of the number of times a supplier ships inhalation drugs to a beneficiary. If a supplier does not supply the prescription in full, it is the supplier's responsibility to fill and deliver the remainder of the prescription, but Medicare will not pay additional monthly dispensing fees. We will monitor the issue about partial shipments and potentially erroneous billing for multiple monthly dispensing fees. We also are concerned that a per-dose dispensing fee could provide an incentive to supply more drugs.

The 2005 fee is an average across all beneficiaries, new and established, and covers additional drugs shipped during a month if a beneficiary's prescription changes. We will study the issue further of different dispensing fees for new and established beneficiaries and the frequency that additional drugs are shipped for prescription changes.

Comment: A manufacturer recognized that compounded products can be covered under certain circumstances and that compounding could be included appropriately in a dispensing fee. Another manufacturer expressed concern about including compounding in the activities that a dispensing fee covers. A suggestion was made that a HCPCS modifier be used for inhalation drugs that are compounded.

Response: The costs of compounding are included in the AAH study but are not separately identified in the direct cost line items. Because the 2005 fee is based on the AAH study, we need to avoid duplicate payment. With compounding bundled into the fee for 2005, we have concerns about paying separately for compounding in 2005.

Comment: A commenter recommended that we address compounding circumstances that might be inconsistent with FDA's policy prohibiting pharmacy compounding of two or more separate FDA-approved products when a combination product approved by the FDA is commercially available and compounding that might be done without the necessary controls to ensure drug product sterility and potency.

Response: The fact that we consider compounding to be included in the 2005 fee to furnish inhalation drugs does not in any way support practices that are inconsistent with FDA guidelines.

Comment: The commenter also suggested that we consider creating a HCPCS modifier for drugs that a prescribing physician intends to be compounded but which a pharmacy dispenses separately in non-compounded form. The commenter believes that such a modifier would help discourage pharmacies from leaving the responsibility for compounding to the beneficiary who would be combining the drugs in non-sterile, uncontrolled conditions.

Response: We understand the commenter's concerns and will study this issue.

Comment: We received comments suggesting that the actual savings attributable to MMA section 305 may be both higher and lower than the November 20, 2003 Congressional Budget Office (CBO) estimate for MMA section 305. One company suggested that the actual savings could be less than estimated by CBO because the ASP model potentially motivates drug manufacturers to increase drug costs, which will be directly passed on to the government. Other commenters cited two different estimates from the AAH report. Using one calculation, the commenters argued that a dispensing fee of $68.10 per encounter would still enable Medicare to achieve savings of $350 million per year or more than $4 billion over 10 years. Using another calculation, the commenters argued that the savings would be $7 billion over the 10-year budget-scoring window. The commenters indicated that the $4 billion savings figure was comparable to the initial projections made by the Congressional Budget Office (CBO) in 2003 and the $7 billion figure was in excess of the CBO estimated savings. Commenters cited these figures to argue that establishment of a per service encounter fee of $68.10 would set the payment at the level originally envisioned by Congress. Another commenter suggested that a dispensing fee of $0.85 per 2.5 mg dose for albuterol sulfate and $0.97 per dose for a blended mix of other inhalation drugs including ipratropium bromide would be consistent with what they believe are the 17.7 percent savings assumed by CBO. One commenter indicated that CBO underestimated the savings from section 305.

Response: MMA specifically requires the use of the ASP methodology to establish more appropriate payment rates for drugs. MMA explicitly requires the establishment of a supplying fee for Part B covered oral drugs as determined to be appropriate by the Secretary. MMA also explicitly requires establishment of a furnishing fee for blood clotting factors. However, MMA does not specify a particular dispensing fee amount for inhalation drugs, nor does MMA specify a method to determine a dispensing fee for inhalation drugs. Accordingly, CMS used existing authority to propose in the NPRM that an appropriate dispensing fee be established. Because MMA did not require a specific method or amount for a dispensing fee for inhalation drugs, we find the arguments unpersuasive that a dispensing fee of a particular amount was envisioned by Congress or consistent with Congressional intent as reflected in a CBO estimate.

Comment: We received comments that supported and opposed the use of 90-day prescriptions. One commenter supporting the proposed change indicated that most beneficiaries who receive nebulized medications suffer from chronic lung diseases and will require medication to manage their disease for prolonged periods. The commenter indicated that allowing a prescription for 90-days would reduce paperwork and redundant effort for beneficiaries, physicians and DME suppliers. A commenter indicated that there would be modest savings in dispensing, billing and shipping costs with allowance of a 90-day supply of

refills. One company suggested savings of 12.5 percent, most notably in shipping. Commenters opposing 90-day prescriptions gave various reasons, including that beneficiaries may experience side effects and change prescriptions within the first month and a certain percent of beneficiaries die each month resulting in non-returnable product. In addition, some argued that pharmacy savings for a 90-day shipment would not be significant because shipping costs account for only an estimated 16 percent of supplier's non-acquisition costs associated with providing inhalation drugs. Another company argued that a 90-day shipment would substantially increase provider's expenses for boxes and shipping. Some commenters agreed that certain chronic use medications should be provided in larger quantities, but urged caution due to the practices of some suppliers who automatically ship additional product without knowing whether the patient's current supply is exhausted. Some comments suggested that a 60-day supply might be more cost-effective in the long-term because there would be a reduced risk that large quantities of medications might be wasted. Another commenter suggested that the policy be defined to cover only drugs that are proven to be stable for at least 90 days following dispensing.

Response: As we indicated in the proposed rule, we believe that reasonableness should govern filling a monthly vs. 90-day prescription depending on the circumstances of the beneficiary. We agree with the commenter that the initial prescription for a new patient should be written for a 30-day period because of the potential for adverse reactions or changes in the treatment regimen. We would expect prescriptions for new patients to be for 30-day periods. In addition, we believe that it is reasonable for physicians to write a 30-day prescription for those beneficiaries who they believe are less stable. Similarly, we believe that refill prescriptions for 90-day periods are reasonable, particularly for stable beneficiaries. Although the Medicare program would achieve savings from the appropriate use of 30-day and 90-day prescriptions, we believe that given the comments it would be prudent for us to monitor the 90-day supply issue. Section 4.26.1, the Proof of Delivery Methods section of the Program Integrity Manual, instructs that suppliers of DMEPOS product refills contact the beneficiary prior to dispensing the refill to ensure that the refilled item is necessary and confirm any changes or modifications to the order. Suppliers who ship either a 30-day or 90-day supply of inhalation drugs without knowing the beneficiary's current supply is exhausted would be in violation of this policy. The 90-day period should not be of concern for inhalation drugs because most of these drugs are stable for at least 90-days and thus can be dispensed for such period. We would revisit this issue if additional inhalation drugs that are unstable after 90-days become available.

Because we received limited data on costs of furnishing a 90-day supply, it is more difficult to determine a 2005 fee for furnishing a 90-day supply of inhalation drugs. However, given that this is an optional payment arrangement for beneficiaries whose course of treatment has stabilized to the point that the required dosage can be predicted with a reasonable degree of certainty over a 90-day period, we believe that it is important to establish a 90-day fee. As described earlier, we are establishing a 90-day fee for furnishing inhalation drugs by applying the methodology from the GAO report to the data in the AAH study. We assumed all of the direct costs associated with a monthly fee are similar to the direct costs associated with a 90-day fee and we tripled the indirect costs. We plan to study this issue further.

Comment: Many commenters acknowledged that most DMEPOS items, including drugs, can be dispensed based on verbal orders. Several commenters objected to the requirement that a written order from the physician still must be obtained before billing. They suggested that we revise policy so that a prescription could be both filled and billed based solely on a verbal order from a physician. They pointed out that the requirement that a pharmacy still obtain a written order for a prescription in order to be able to bill Medicare creates a significant administrative burden for a pharmacy because it often requires persistent follow-up with a physician. Another commenter suggested that we consider accepting electronic transmissions of prescriptions, for example, e-scripts. Another commenter requested clarification of the rule for dispensing based on a verbal order for inhalation drugs and the proposed requirement that an order for an item of DMEPOS be signed and dated within 30 days of a face-to-face examination of a beneficiary.

Response: The policy that allows dispensing based on a verbal order but requires a written order for billing applies to all DMEPOS items. This policy balances fraud and abuse concerns with prompt dispensing of DMEPOS items to beneficiaries. Written orders from the physician can be faxed, photocopied, or provided via electronic or pen and ink forms. In accordance with current policy, pharmacies may accept electronic prescriptions from physicians.

Beneficiaries receiving inhalation drugs are having face-to-face exams routinely and generally do not need additional visits to re-order their drugs. A single face-to-face exam is generally sufficient for items ordered, that is, we would not require a separate face-to-face exam for the nebulizer and for the inhalation drugs. We assume that physicians would order them at the same time because they are used together.

Comment: One commenter supported the revision made earlier this year that provides flexibility regarding the timeframe for refilling Medicare prescriptions. The commenter noted that most third party plans allow pharmacies to refill prescriptions within five days of the end of usage for the previous prescription quantity dispensed. Another commenter recommended that the time frame for subsequent deliveries be expanded beyond five days. The commenter indicated that they believe a five-day time frame is too short a period for ground service and would not eliminate the need for overnight shipping. This is based on the commenter's experience that beneficiaries do not respond to calls to confirm that they need additional supply until the beneficiary has only a few days' supply left.

Response: As we indicated in the proposed rule, the revised time frame for delivery of refills of DMEPOS products provides for refills to occur no sooner than ''approximately five days prior to the end of the usage for the current product.'' In the proposed rule we emphasized the word ''approximately.'' While we believe that normal ground service would allow delivery in five days, if there were circumstances where ground service could not occur in five days, the guideline would still be met if the shipment occurs in six or seven days. As another commenter noted, the five-day standard is consistent with the time frame for shipping used by most third party plans. Given the consistency with private sector plans, because the requirement applies to all DMEPOS product refills, and because the standard is not a firm five-day limit, we do not believe that it is necessary to lengthen the standard. We will study further the ability of a supplier to contact beneficiaries for refills compared with its ability to provide

beneficiary and caregiver training on a monthly basis.

Comment: One commenter indicated that the DMERCs have not consistently implemented the revised proof of delivery provisions but that they are engaged in dialogue with CMS and the DMERCs to clarify the requirements and standardize their interpretation across the four DMERCs. Other commenters suggested that the proof of delivery requirement be eliminated.

Response: We encourage dialogue to ensure consistent understanding and application of the proof of delivery requirements. The proof of delivery requirements have recently undergone an extensive review and revision and, based on the need to prevent fraud and abuse, we see a need to continue them.

Comment: Those commenters who addressed our proposed elimination of the Assignment of Benefits (AOB) form for items and services, including drugs, where assignment is required by statute, supported our proposed change. Commenters agreed that obtaining an AOB in each instance is redundant because the supplier is required by statute to accept the assignment. Some commenters suggested that a onetime AOB be obtained from the beneficiary that will be valid for every DMEPOS item he or she receives during the period of his or her medical necessity.

Response: We appreciate the support for our proposal. As discussed in section IV of this final rule, we are adopting our proposal to eliminate the requirement for AOB form for items and services, including drugs, where assignment is required by statute. We do not agree with the suggestion to allow for a one-time AOB form to cover items and services provided in the future because there could be fraud and abuse issues.

Comment: We received conflicting comments about the impact of the changes and clarifications relating to billing requirements on the costs of dispensing inhalation drugs.

Commenters differed on the impact of the revisions to the proof of delivery requirements that we pointed out in the proposed rule that went into effect in early 2004. One company that currently uses automated systems indicated that the revision to the proof of delivery requirements would not generate savings for them. Commenters indicated that the DMERCs have not consistently implemented the changes, and that consequently there has not been significant administrative relief and subsequent savings.

We received conflicting comments about the impact of the revised time frame for shipping guidelines. While one commenter indicated that savings had already been achieved because the provision had already been implemented, another commenter indicated that the revision would have negligible effect because the commenter would not change its existing business practice of using overnight shipping.

One commenter said it had already adopted the provision of prescriptions being filled by verbal order, followed up by a written order for the claim submission and that these changes did not generate any additional savings for the commenter. Some suggested that the elimination of the AOB form for drugs would have limited savings because some suppliers currently obtain the AOB form at the same time that they obtain other forms that would be continued. Retail pharmacies agreed that elimination of the AOB form and verbal prescription order would reduce their paperwork. However, inhalation companies did not agree.

Response: We understand the commenters concerns and will study the impact of these billing changes on the different suppliers' costs as the new payment system is implemented.

Comment: Several commenters suggested that we review and consider changing several aspects of billing that might have cost-savings potential for suppliers of drugs. Several commenters indicated that Medicare's lack of on-line adjudication represented a significant cost and burden to them. One retail pharmacy commented that pharmacies face higher than normal rejection rate on claims because Medicare claims are not processed on-line, resulting in higher administrative costs. Others commented that pharmacies that dispense Medicare prescriptions must obtain documentation that is typically provided by the physician. For example, one company indicated that suppliers are held responsible for the appropriate medical necessity documentation in the patient's medical record but that the supplier has no control over physician records. Some suggested that we consider eliminating the requirement that a diagnosis code be required on the prescription. One pharmacy commented that pharmacies should not be expected to verify that the physician has in fact performed a face-to-face exam for the purpose of treating and evaluating the patient's medical condition or whether the physician has created appropriate documents in his records. Rather, the pharmacy believes that this responsibility should be left to the physician, and the creation of a prescription should be all that is needed to verify that the physician has complied with all Medicare requirements. A commenter noted that Medicare requires that suppliers submit claims with the physician's Unique Physician Identification Number (UPIN) while most third party plans require the physician's DEA number and suggested that we consider adopting usage of the physician's DEA number instead of UPIN. A pharmacy commented that dispensing units are different than current National Council for Prescription Drug Programs (NCPDP) standards; Medicare reimburses products based on a per mg price while the NCPDP standard suggests reimbursement on a per ml price. The pharmacy indicated that this makes it more difficult for the pharmacy to calculate proper reimbursement for these Medicare claims. Other commenters suggested that the Medicare enrollment and reenrollment process for suppliers be significantly streamlined. A retail pharmacy indicated that Medicare requires pharmacy suppliers to submit extensive and often duplicative pharmacy-specific paperwork that is more voluminous than any other third party plan in which retail pharmacies participate. One inhalation company suggested certain aspects of billing such as the requirement that the supplier query the physician and beneficiary to find out if the beneficiary had already received a same or similar item from another supplier. The company also identified what it claimed are several other labor-intensive, costly aspects of Medicare billing including electronic claims filing requirements; information system programming and testing; paperwork and new business procedures required to be compliant with HIPAA; Medicare and secondary insurance benefits verification and qualification; responding to significantly increased pre-payment audit activities; administering the Patient Financial Hardship Waiver prior to billing deductible and coinsurance amounts; billing and writing off beneficiary cost-sharing as bad debts; and differing DMERC policies concerning documentation needed to support home inhalation therapies.

Response: We thank the commenters for identifying these items. We plan to examine these aspects of billing. To the extent that there are different interpretations or applications of national policy by DMERCs, our goal is increased standardization.

Comment: A comment from a group focused on respiratory care indicated that there may be over utilization of albuterol sulfate. The comment indicated that a large amount of scientific evidence concludes that high albuterol sulfate use is indicative of

poor overall disease management. The commenter further indicated that Medicare's costs related to the use of albuterol sulfate may result from the fact that alternative drug treatment regimes are not adequately considered in the management of the patient's disease. The commenter urged us to examine the underlying causes of high utilization rates of albuterol sulfate.

Response: Our goal is to ensure that Medicare beneficiaries have access to the appropriate drugs to treat their diseases. We believe that the availability of discounts through the Medicare drug card and the implementation of the Part D drug benefit beginning in 2006 promote treatment decisions being made based on the best clinical evidence, rather than being influenced by differential coverage.

Comment: We received many comments addressing the issue of nebulizers versus metered dose inhalers (MDIs). Most commenters questioned whether a significant shift of Medicare beneficiaries to MDIs would occur when MDIs are covered in the Part D drug benefit beginning in 2006. We received many comments, studies and literature reviews on nebulizers and MDIs. Some commenters identified the specific disadvantages of MDIs and holding chambers or spacers. Some commenters questioned the conclusion of the literature review mentioned in the proposed rule that nebulizers are not clinically superior in delivering inhalation drugs than MDIs and the commenters asserted that the two are not fully substitutes. Some commenters quantified the costs to beneficiaries of nebulizers and MDIs. One commenter pointed out that MDIs would increase in 2006 based on the ban of the propellent chlorofluorocarbon. Another commenter questioned the point in the proposed rule that MDIs are more portable than nebulizers since advances in nebulizer technology have included additional portability. The commenter noted that since Medicare covers only one standard nebulizer, many of their patients have purchased portable nebulizers on an out-of-pocket basis to use as a second device while outside of their home.

Response: A number of drugs are available to treat the persons with asthma or who develop COPD. These include drugs, often inhaled, that expand the bronchial tubes and allow the patient to breathe more freely. Depending on the needs of the individual patient, these medications can be delivered using nebulizers or MDIs. Although nebulizers have long been covered under Medicare Part B, the MMA expanded access to MDIs beginning in 2006 through the new Medicare Part D drug benefit. While two meta-analyses cited by one commenter are consistent with the literature review mentioned in the proposed rule that found a lack of overall clinical superiority of MDIs over nebulizers, we recognize that even after coverage of MDIs begins in the Part D drug benefit in 2006, due to their particular circumstances, many beneficiaries will require the use of nebulizers and that nebulizers will continue to play an important role in inhalation therapy. Part B does not currently cover MDIs and we will gain experience with the costs of MDIs as the Part D drug benefit is implemented.

Comment: Comments were received from respiratory drug distributors and homecare providers addressing drugs that are supplied from the manufacturer in more than one form. One company suggested that since inhalation drugs are provided by the manufacturer in two forms, a premixed solution or as a powder (or other concentrate) that is diluted by the pharmacist, the ASP should be calculated separately for each of these two forms in order to reflect the different acquisition costs to the pharmacy for the different forms. The company suggested use of a modifier for the J-code to distinguish between these two forms for reimbursement purposes.

Response: We disagree. Consistent with the statute, the ASP is calculated by the HCPCS codes rather than the NDC code. This allows flexibility in appropriate drug delivery.

Comment: We received letters from individual beneficiaries and their family members indicating that the beneficiary has tried MDIs unsuccessfully and that inhalation drugs administered through a nebulizer were a successful treatment. They asked us not to assume that everyone on a nebulizer could be switched to inhalers and asked that we allow inhalation medications administered through nebulizers to remain funded by Medicare.

Response: We recognize that nebulizers are required by many beneficiaries due to their particular health circumstances. We did not propose to eliminate Medicare funding for inhalation medications administered through nebulizers.

Comment: Several commenters questioned why there should be public funding for COPD treatments for persons who chose to smoke cigarettes. The commenters indicate that it may be too harsh a policy to cease all reimbursement for COPD treatments, but they suggested two alternatives: (1) No individual who currently smokes should receive any Medicare benefit for the treatment of any respiratory condition, and (2) Any individual who historically smoked heavily and receives treatment for respiratory disorders should face an annual deductible equal to the cost of smoking a pack of cigarettes a day.

Response: As we indicated in the proposed rule, smoking has been linked to a large number of health problems and is the leading cause of cancer and pulmonary disease. The Department of Health and Human Services (HHS) has been actively encouraging Americans to quit smoking through its smoking cessation initiatives. Americans who quit smoking will enjoy longer, healthier lives and avoid diseases such as COPD. However, the Medicare law does not limit benefits to persons who do not currently smoke, nor does the Medicare law impose a deductible that is different for smokers and non-smokers. This regulation implements the law as it is currently written.

Result of Evaluation of Comments

In the proposed rule, we requested comments on the appropriate separate dispensing fee for inhalation drugs used in a nebulizer. In this final rule we are establishing 2005 fees of $57.00 for furnishing a 30-day prescription and $80.00 for furnishing a 90-day prescription for inhalation drugs. This fee would be paid in addition to the Medicare payment amount for the drug.

As discussed in section IV, we are finalizing our proposal to eliminate the Assignment of Benefits (AOB) form for items and services, including drugs, where assignment is required by statute. We reiterate language in the recently updated guidelines for DMEPOS refills, emphasizing the word ''approximately''. This allows for refill prescriptions to be shipped by ground service on ''approximately'' the 25th or 85th day of the respective prescription period. In addition, we clarified the ordering requirements for DMEPOS items, including drugs, which can be dispensed with just a verbal physician order.

P. Section 706—Coverage of Religious Nonmedical Health Care Institution Services Furnished in the Home

1. Background

Section 706(a) of the MMA amended section 1821(a) of the Act by adding home health services to the list of services furnished to an individual by a religious nonmedical health care institution (RNHCI). Section 706(b) added section 1861(aaa) to the Act to expand the term ''home health agency'' (HHA) to include a RNHCI. However,

this expansion is limited to RNHCI items (specified durable medical equipment) and services furnished in the beneficiary's home when the items and services are comparable to those provided by a HHA that is not a RNHCI. Moreover, payment may not be in excess of $700,000 per calendar year, and may not be made after December 31, 2006. Accordingly, we are implementing changes to the RNHCI regulation to include services furnished in the home that result from the enactment of the MMA and that are becoming effective January 1, 2005.

The new time-limited home health services benefit will be referred to as ''home benefit'' or ''home services'' throughout this rule. The RNHCI home benefit may only be provided to an eligible beneficiary who is confined to the home for health reasons and who has a condition that makes the beneficiary eligible to receive services under Medicare home health. Additionally, the beneficiary must have an effective RNHCI election and receive his or her home services from the RNHCI. The home benefit is not a substitute for hospice care. As in the original RNHCI benefit, Medicare will pay only for nonmedical services in the home, but not for those religious items or services provided by the RNHCI. Additionally, RNHCI home service patients who have a documented need for a specified DME item can obtain that item with the applicable deductible and coinsurance.

2. Legislative History

In 1965, payments to Christian Science sanatoria (inpatient nonmedical care facilities for bedfast patients) were included in the initial provisions of Medicare under title XVIII of the Act. In 1996, in *Children's Healthcare Is a Legal Duty, Inc.* v. *Vladeck,* 938 F. Supp. 1466 (D. Minn. 1996) (''*CHILD I*''), a Federal district court held that some of the provisions pertaining to Christian Science sanatoria were unconstitutional on the grounds that they were sect specific, in violation of the Establishment Clause of the U.S. Constitution.

Section 4454 of the BBA amended section 1861(a)(1) of the Act, deleting Christian Science sanatoria from the Act and creating instead the RNHCI benefit to provide Medicare Part A and Medicaid access for all religious groups whose belief structure does not include medical intervention. We note that, in the Conference Report to the BBA (H.R. Conference Report, No. 105–217, at 768 (1997)), the Congress specified that the RNHCI provisions were a sect-neutral accommodation available to any person who is relying on a religious method of healing and for whom the acceptance of medical health services would be inconsistent with his or her religious beliefs. Further, the Congressional conferees were convinced that the RNHCI provisions fully responded to and satisfied the constitutional concerns that had been addressed by the district court in CHILD I.

Besides adding the new RNHCI benefit, section 4454 of the BBA also added sections 1861(ss) and 1821 to the Act. Section 1861(ss) sets forth:

- The ten requirements that a provider must meet in order to be considered a RNHCI;
- Parameters for oversight and monitoring;
- Authority for Federal review of items and services provided for excessive or fraudulent claims; and
- Parameters for ownership/affiliations.

As in the past, the new provisions do not mention the use of a religious counselor or practitioner; we consider that to be the responsibility of the patient.

Section 1821 of the Act provides for conditions for coverage of RNHCI services including:

- The election, revocation, and limitations of the RNHCI benefit (section 1821(b));
- The monitoring and safeguarding against expenditures (section 1821(c)); and
- The sunset provisions for the RHNCI benefit (section 1821(d)).

Section 1821(a) of the Act, as amended by the MMA, provides for Part A payment for inpatient hospital services, post-hospital extended care services, or home health services furnished to a beneficiary in, or by, a RNHCI only when the beneficiary has:

- A valid election for the RNHCI benefit in effect; and
- A condition that would qualify for inpatient hospital, extended care services, or home health if the beneficiary were an inpatient or resident in a hospital or skilled nursing facility, or was a patient residing at home under the care of a HHA that was not a RNHCI.

The election of the RNHCI benefit becomes effective immediately after execution and remains in effect for a lifetime or until revoked. As described in section 1821(b) of the Act, the election is a written statement signed by the beneficiary or the beneficiary's legal representative which states that:

- The individual is conscientiously opposed to the acceptance of nonexcepted medical treatment;
- The individual's acceptance of that nonexcepted treatment would be inconsistent with the individual's sincere religious beliefs; and
- The individual's receipt of nonexcepted medical care constitutes a revocation of the election.

The RNHCI election may be revoked by voluntarily notifying the Secretary in writing of the revocation or the election may be revoked by simply receiving nonexcepted medical care for which payment is sought under Medicare. Once a RNHCI election is revoked twice, the next election may not take place until a date that is at least one year from the date of the most recent revocation. Any election thereafter does not become effective before a date that is at least five years after the date of the previous revocation. The receipt of excepted medical care does not result in a revocation of the election. As stated in § 403.702 of the regulations, the following definitions apply—

- *Excepted medical care or treatment* for purposes of the RNHCI benefit is defined as medical care or treatment (including medical or other health care services) received involuntarily (for example, following an accident), or required by any level of government (for example, immunizations).
- *Nonexcepted medical care or treatment* refers to all medical care or treatment that is not defined as excepted medical care or treatment. The beneficiary always retains the right to receive medical care under Medicare based on his or her level of coverage (for example, Part A, Parts A and B). However, using nonexcepted care will result in the revocation of the RNHCI election.

On November 30, 1999, we published the RNHCI interim final rule with comment period in the **Federal Register** (64 FR 67028), effective on January 31, 2000. The final RNHCI regulations were published on November 28, 2003 (68 FR 66710). There are currently 16 RNHCIs in the United States: Three in California; two each in Florida and Ohio; and one each in: Colorado, Illinois, Indiana, Massachusetts, New York, Texas, Virginia, Washington, and Wisconsin.

3. Summary of Section 706 of the MMA

Section 706 of the MMA amended the Act to extend Medicare coverage of RNHCI items and services to the RNHCI beneficiary's home when the items and services are comparable to those provided by a HHA that is not a RNHCI.

Specifically, section 706(a) of the MMA amended section 1821(a) of the Act by adding home health services to the list of services furnished to an individual by a RNHCI. Section 706(b) of the MMA added section 1861(aaa) to the Act to expand the term ''home

health agency'' to include a RNHCI as defined in section 1861(ss)(1) of the Act, but only for items and services that are ordinarily furnished by a RNHCI to individuals in their homes, and that are comparable to items and services furnished to individuals by a HHA that is not a RNHCI. Section 1861(aaa)(2)(A) of the Act states that, subject to section 1861(aaa)(2)(B), payment may be made for services provided by a RNHCI only to the extent and under the conditions, limitations, and requirements that are in regulations consistent with section 1821 of the Act. Section 1861(aaa)(2)(B) states that payment may not be made for RNHCI home services under section 1861(aaa)(2)(A) of the Act in excess of $700,000 per calendar year, or after December 31, 2006.

This interim final rule amends the existing RNHCI regulations in Subpart G to implement section 706 of the MMA.

4. Discussion

a. Implementation of Section 706 of the MMA

As stated above, section 706 of the MMA added section 1861(aaa)(1) to the Act to expand the term ''home health agency'' to include a RNHCI, as defined in section 1861(ss)(1) of the Act, but only for items and services that are ordinarily furnished by that institution to individuals in their homes, and that are comparable to items and services furnished by a HHA that is not a RNHCI. This posed a number of implementation challenges as a RNHCI does not conform to the statutory definition or requirements of a HHA in section 1861(m) of the Act, which is based on a medical model. Some of these challenges result from the fact that—

- RNHCIs were established to accommodate those religious groups that do not believe in the use of physicians to direct or supervise health care; and
- RNHCI nursing does not correspond to the statutory or regulatory parameters established by Medicare for ''skilled care'' in the home setting.

In addition, the RNHCI payment methodology does not readily lend itself to payment to the RNHCI for items and services under the RNHCI home benefit. Therefore, in an effort to implement the intent of the amendment, we will generally use the definition and requirements for a RNHCI, rather than a HHA (with some exceptions), in order to extend RNHCI services into the home environment. However, in order to aid in determining comparability, we are also utilizing, when appropriate, some of the home health requirements set forth in section 1861(m) of the Act.

The presence of physician orders and oversight is a keystone in the operational viability of a HHA and nonexistent in the RNHCI, where the religious practitioner (noncovered by Medicare) is the primary focal person in establishing the course for the religious method of healing. In addition, the RNHCI nurse further assists the patient in navigating the course established for the religious method of healing. To address the need for oversight for the RNHCI home benefit as with the current inpatient RNHCI benefit, we are implementing section 706 of the MMA by continuing to require that the RNHCI utilization review committee review the need for care (expanded now to include both admission to the home benefit and continued care in the home setting), and to oversee the utilization of items and services in the time-limited home benefit. The utilization review committee, however, cannot act in place of a physician in ordering items and services other than those designated specifically for the purpose of this time-limited RNHCI home benefit. A claim from any other individual or provider attempting to seek Medicare payment for non-designated RHNCI home benefit items and services without a physician order will be disallowed.

We also recognize that implementing section 706 is particularly challenging in light of the fact that no sophisticated physical treatments or procedures are provided in RNHCIs, while conventional medical care becomes more technical every year, making the care delivered by HHA personnel increasingly complex. The major challenge was determining comparability between home health services for HHAs defined in part 409 subpart E, and RNHCI services which are nonmedical in nature.

Medicare pays for supportive care or dependent services under the home health benefit only when under the orders and direction of a licensed physician if there is a medical need for skilled health care by a registered nurse, physical therapist, speech-language therapist, occupational therapist, or medical social worker. Under the Medicare home health benefit, when there is no longer a need for the ''skilled'' health care services, the supportive dependent services no longer qualify for payment. Based on section 1861(m) of the Act, we believe that Medicare home health care benefits are skilled-care oriented. These benefits were not designed to provide coverage for care related to help with activities of daily living unless the patient requires skilled nursing care or physical or speech therapy. The RNHCI nurse may be skilled in ministering to a beneficiary's religious needs (not covered by Medicare), but does not have the training or nursing skill sets required of credentialed/licensed health care professionals (for example, a registered nurse). While the RNHCI nurse may provide supportive care, that care is focused primarily on religious healing and meeting basic beneficiary needs for assistance with activities of daily living (for example, bathing, toileting, dressing, ambulation), as part of creating an environment for religious healing. The care provided by a RNHCI nurse is not at the level of either a registered nurse or a licensed practical nurse. The physical care provided by a RNHCI nurse is at a level that could be considered as supportive, but is decidedly not skilled nursing care as that term is understood under the Medicare home health program.

In the search for comparability of services, we considered the requirements and functions of the home health aide contained in sections 1861(m) and 1891(a)(3)(A) of the Act and in the regulations at 42 CFR 484.36. We performed a parallel review of the activities and skills utilized by home health aides and RNHCI nurses to determine comparability at an operational level. We determined that both the RNHCI nurse and the home health aide perform the following basic tasks—

- Assisting with activities of daily living (ADLs) that include: ambulation, bed-to-chair transfer, and assisting with range of motion exercises; bathing, shampoo, nail care, and dressing; feeding and nutrition; and toileting;
- Performing light housekeeping, incident to visit; and
- Documenting the visit.

However, the home health aide is also responsible for—

- Care of catheters and drainage equipment;
- Checking oxygen and other respiratory equipment;
- Communicating with nurse or other skilled team members;*
- Assisting with exercises as ordered by PT, OT or speech language therapist;
- Observation and reporting of existing medical conditions;*
- Recognizing and responding to emergency situations (including CPR);
- Routine care of prosthetics and orthotics;
- Taking and reporting vital signs;*
- Using basic infection control procedures;* and
- Care of wound/stoma dressings.

The home health aide during a home visit will usually perform at least three of the four skills marked with an

asterisk (*) from the ten skills listed. The remaining areas of responsibility are carried out as indicated by the patient's needs and the patient's care plan.

In analyzing the outcomes of the home health aide/RNHCI nurse review, we found that both groups engaged in the comparable tasks of assisting with activities of daily living, performing light housekeeping (incident to visit), and documenting the visit. Therefore, we will pay for the performance of these tasks by a RNHCI nurse in the home under the home benefit established by section 706 of the MMA. However, in reviewing for comparability of these services, we also found that the Medicare requirements for a home health aide exceed the preparation and skills of the RNHCI nurse for furnishing physical care. The home health aide performs activities that support the patient's prescribed medical therapeutic regimen and contribute to the Outcome and Assessment Information Set (OASIS) data collection effort. Moreover, we assumed that a significant portion of each RNHCI nurse visit is focused on religious activity (noncovered by Medicare). However, in spite of the difference in skill levels and the incorporation of non-covered religious activity into a visit, Medicare payment for the RNHCI home benefit is based on a fixed payment per visit, rather than on a total number of hours or number of caregivers involved. Unlike the home health benefit, the RNHCI benefit does not involve multiple levels of covered caregivers. Under the home health PPS only the *low utilization payment adjustment* (LUPA) rate provides for payment for individual home health visits. Due to the uniqueness of the RNHCI and RNHCI nurses in the Medicare program, we have developed a payment rate that is a percentage of the PPS LUPA rate for home health aide visits provided under the home health PPS, which we believe adequately represents the percentage of comparable tasks performed by the RNHCI nurse. Only a visit by a RNHCI nurse to a home is payable by Medicare. The cost for the religious portion of the visit continues to be the responsibility of the individual patient or the specific RNHCI.

Another challenge was posed by the provision of DME items for RNHCI patients in the home, since all DME is covered for Medicare payment only when ordered by a physician. That physician order may provide the RNHCI patient with the desired DME item, but will also revoke the patient's election for RNHCI care. We addressed the issue of DME by reviewing those items that are routinely found in a RNHCI that are comparable to those used by a HHA that is not a RNHCI. This resulted in a list of DME items that one could normally buy or rent off the shelf from a community pharmacy or health care supply store. For purposes of this time-limited benefit, we are permitting the RNHCI nurse to order from this list of designated items under the oversight of the RNHCI utilization review committee. A listing of these items is provided in Table 15 below.

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TABLE 15:

DME with HCPCS Codes Available for the Home Benefit	
CANES	
E0100	Cane, includes canes of all materials, adjustable or fixed, with tip
E0105	Cane, quad or three prong, includes canes of
	all materials, adjustable or fixed, with tip
CRUTCHES	
E0112	Crutches, underarm, wood, adjustable or fixed, pair, with pads, tips, and handgrips
E0113	Crutch, underarm, wood, adjustable or fixed, pair, with pad, tip, and handgrip
E0114	Crutches, underarm, other than wood,adjustable or fixed, pair, with pads, tips, and handgrips
E0116	Crutch, underarm, other than wood, adjustable or fixed, with pad, tip and handgrip
WALKERS	
E0130	Walker, rigid (pickup), adjustable or fixed height
E0135	Walker, folding (pickup), adjustable or fixed height
E0141	Walker, rigid, wheeled, adjustable or fixed height
E0143	Walker, folding, wheeled, adjustable or fixed height
COMMODES	
E0163	Commode chair, stationary, with fixed arms
E0167	Pail or pan for use with commode chair
WHEELCHAIRS	
K0001	Standard wheelchair
HOSPITAL BEDS and ACCESSORIES	
E0250	Hospital bed, fixed height, with any type side rails, with mattress
E0255	Hospital bed, variable height, hi-lo, with any type side rails, with mattress
E0260	Hospital bed, semi-electric (head and foot adjustment), with any type side rails, with mattress
E0275	Bed pan, standard, metal or plastic
E0276	Bed pan, fracture, metal or plastic
E0290	Hospital bed, fixed height, without side rails, with mattress

E0292	Hospital bed, variable height, hi-lo, without side rails, with mattress
E0325	Urinal; male, jug-type, any material
E0326	Urinal; female, jug-type, any material

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We will provide the specifics for implementing the DME items and payment under this time-limited benefit in later Medicare program instructions.

Under section 1861(aaa)(2)(B) of the Act, payments for the RNHCI home benefit may not be made that exceed $700,000 per calendar year, and not after December 31, 2006. Under the RNHCI home benefit, Medicare will pay only for nonmedical health services in the home, as well as for those DME items included in Table 15 of this preamble. Medicare will not pay for religious items or services provided by the RNHCI. We have developed a special billing system for those RNHCI providers offering the home benefit to monitor expenditures on home services and items for purposes of staying within the statutory calendar year expenditure limit.

5. RNHCI Regulatory Provisions—RNHCI Medicare Benefits, Conditions of Participation, and Payment

As noted previously, to implement section 706 of the MMA, we reviewed the requirements for both HHAs and RNHCIs to identify the most feasible approach. Accordingly, we have made the following changes to the RNHCI regulations:

a. Basis and Purpose of Religious Non-Medical Health Care Institutions Providing Home Services—§ 403.764

We added § 403.764 to set forth the basis and purpose of the RNHCI home benefit. Specifically, we added subsection (a) to include a reference to section 1861(aaa) of the Act to the general RNHCI authority noted in § 403.700 and a description of the provisions of section 1861(aaa). We also added subsection (b) to describe the home benefit, the statutory annual fiscal limitation, and the sunset provision.

b. Definitions and Terms—§ 403.702

We made no changes to the regulation.

c. Conditions for Coverage—§ 403.720

We made no changes to the regulation.

We wish to emphasize that the RNHCI home benefit is an option available to each RNHCI, and the facility is not required to offer this service to either gain or maintain RNHCI status.

The RNHCI home benefit is not to be confused with hospice care that may involve more frequent visits and can involve institutional services. If, for some reason, the RNHCI home-serviced patient requires more than what is provided under the RNHCI home benefit, RNHCI or other institutional services may be required.

d. Valid Election Requirements—§ 403.724

We made no changes to the regulation because no modification or clarification to this requirement is needed to implement the RNHCI home benefit. Section 1821(b) of the Act addresses the issues involved in beneficiary election of RNHCI services.

e. Conditions of Participation—§ 403.730 through § 403.746

We have not changed the following conditions of participation, as they do not require any modification or clarification for implementing the RNHCI home benefit:

- Patient Rights (§ 403.730)
- Quality Assessment and Performance Improvement (§ 403.732)
- Administration (§ 403.738)
- Staffing (§ 403.740)

We have not changed the following conditions of participation, as they are specific to institutions and are not applicable to the implementation of the RNHCI home benefit:

- Food Services (§ 403.734)
- Discharge Planning (§ 403.736)
- Physical Environment (§ 403.742)
- Life Safety From Fire (§ 403.744)

The following condition of participation requires the addition of a new standard to reflect the additional responsibility necessary for implementing the RNHCI home benefit:

- Utilization Review (§ 403.746)

As explained previously, the utilization review committee will review the need for care and oversee the utilization of items and services for the RNHCI home benefit. Accordingly, § 403.746 will be revised to reflect the additional responsibility necessary for implementing the RNHCI home benefit. Specifically, § 403.746 will be modified to add a new subsection (c) to read as follows:

(c) *Standard: Utilization review committee role in RNHCI home services.* In addition to the requirements in (b), the utilization review committee is responsible for the admission and continued care review (at least every 30 days) of each patient in the RNHCI home services program. The utilization review committee is responsible for oversight and monitoring of the home services program, including the purchase and utilization of designated durable medical equipment (DME) items for beneficiaries in the program.

We again note that under the RNHCI home benefit, one of the tasks of the RNHCI nurse is to order from a selected group of DME items that meet the documented needs presented by a patient, if that need is presented by the patient. The utilization review committee will provide oversight for the DME orders and utilization of the items. The utilization review committee cannot act as a physician in ordering DME items other than those items designated specifically for the purpose of this time limited RNHCI benefit. A claim from any other individual or provider attempting to seek Medicare payment for non-designated RNHCI home benefit DME items without a physician order will be disallowed.

In implementing section 706 of the MMA, we have also revised the regulations to add the following provisions:

a. Requirements for Coverage and Payment of RNHCI Home Services (§ 403.766)

The RNHCI home benefit is an option available to each RNHCI, but it is not a service that the facility must offer to gain or maintain RNHCI status. With the exception of limited DME items, we have determined that services that RNHCI nurses provide are generally covered for Medicare payment under the time limited RNHCI home benefit as these services (for example, assistance with ADLs, light housekeeping incident to the visit, and documentation of the visit), are comparable to the services of home health aides in HHAs that are not RNHCIs.

To reflect the requirements of this limited benefit, we are adding a new section 403.766. Specifically, in § 403.766(a), we are requiring the RNHCI provider to submit a notice of intent if it is interested in providing RNHCI home services. This will help us facilitate the implementation of the RNHCI home benefit by letting us focus our efforts on those providers interested in providing this new benefit. The RNHCI provider is also responsible for providing RNHCI home services to eligible beneficiaries. We are imposing this requirement because we believe the RNHCI provider itself is responsible for providing the RNHCI home services, directly or under arrangement, to the eligible beneficiary. This means that the beneficiary cannot contract directly with a supplier or RNHCI nurse, but that the RNHCI provider itself is responsible for provision of the RNHCI home benefit services. This requirement conforms to the ''under arrangement'' requirement that home health agencies generally have to comply with to receive payment under the home health prospective payment system (*see* § 409.100(a)(2)). Furthermore, because the RNHCI is not a supplier, we are explicitly requiring the RNHCI provider to make arrangements for suppliers to furnish the designated RNHCI home benefit DME items. Likewise, the RNHCI provider will have to arrange for the RNHCI nursing services. While the RNHCI regulations currently require the RNHCI provider to have a utilization review plan and committee in place, we believe it would be prudent in the RNHCI home benefit regulation to explicitly require the RNHCI home benefit provider to have a utilization review committee that assumes the additional responsibility for the oversight and monitoring of the items and RNHCI nursing services provided under the home benefit. Lastly, because the RNHCI home benefit does not supersede or otherwise replace the existing RNHCI benefit, the provider will continue to have to meet all the existing applicable RNHCI regulatory requirements in subpart G of part 403.

We will also define an ''eligible beneficiary'' for the RNHCI home benefit in § 403.766(b). First, the beneficiary must elect to receive RNHCI services. Clearly, the RNHCI home benefit can only be provided to a beneficiary who has elected RNHCI services. Second, we believe that the purpose of providing a home benefit by a RNHCI provider was not to expand the basic eligibility criteria for receiving home health services. In fact, section 1821(a) of the Act, as amended by the MMA, now states that payment for RNHCI home services be made only if the individual has an election in effect and has a condition such that the individual would otherwise qualify for Medicare home health services. Specifically, this means that the individual must be confined to the home, as defined in section 1814(a) of the Aft and have a condition that would make him or her eligible to receive Medicare home health services. Third, much like the requirement that the RNHCI provider is responsible for providing RNHCI home services directly or under arrangement to the beneficiary, the beneficiary can only receive RNHCI home services through the RNHCI. The purpose of this requirement is to provide Medicare payment for the RNHCI home benefit only to beneficiaries who receive these services through the RNHCI. This requirement is consistent with section 1821(a) of the Act, as amended, which provides Medicare payment for home services furnished an individual by a RNHCI. We note that under the home health benefit beneficiaries are responsible for the deductible and coinsurance for DME furnished as a home health services. We see no reason to modify that requirement for beneficiaries receiving RNHCI home services. As this is a new benefit for RNHCI beneficiaries, we wish to make it clear that they are responsible for deductible and coinsurance for the designated RNHCI home benefit DME items in the same manner as Medicare beneficiaries receiving DME under the home health benefit.

b. Excluded Services (§ 403.768)

Under the home health benefit, certain items and services are excluded under the benefit. The RNHCI home benefit will exclude the same items and services, which are:

- Drugs and biologicals;
- Transportation;
- Services that would not be covered as inpatient services;
- Housekeeping services;
- Services covered under the ESRD program;
- Prosthetic devices; and
- Medical social services provided to family members.

Accordingly, we are adding a new § 403.768 to reflect the services excluded under the RNHCI home benefit.

In addition, we note that the statute does not provide for the provision of the RNHCI home benefit in a home health agency that is not a RNHCI, and we will provide for this exclusion in the regulation. We wish to reiterate that items and services not provided by a RNHCI but instead provided by a supplier or RNHCI nurse not under arrangement with the RNHCI are not included under the RNHCI home benefit. The regulation will also note this exclusion.

c. Payment for RNHCI Home Services (§ 403.770)

As discussed above, providing home services in the RNHCI environment incorporates many of the same components of the provision of home health aide services under the Medicare home health benefit. Because this is a new benefit not contemplated under the original RNHCI legislation, an appropriate payment methodology needed to be developed. As explained previously, we believe that an appropriate proxy for the cost of providing RNHCI home services can be found in the low utilization payment amount for home health aide visits under the Medicare home health PPS. Generally, Medicare home health services are reimbursed a prospectively set payment amount for a 60-day episode of care, adjusted for case mix. This 60-day episode payment includes costs for non-routine medical supplies, as well as costs for the six major home health disciplines, including home health aide services. The home health episode payment rate does not include reimbursement for durable medical equipment, which is paid through a separate DME fee schedule. The home health PPS rates were required to be budget neutral to what would have been expended under the reasonable cost system. The 60-day episode rate is updated annually by some percentage of the home health market basket, as dictated by law, and is adjusted by the hospital wage index to account for geographic variations in labor costs.

Medicare home health services may also be paid on a visit basis if the home health episode has four or fewer visits. Medicare pays on the basis of a national per-visit amount by discipline, referred to as low utilization payment adjustment (LUPA), adjusted for case mix. As mentioned previously, the LUPA rate for home health aide services is a very close approximation of the cost of providing home services in the RNHCI environment. However, due to the difference in skill levels and the incorporation of RNHCI religious activities that are not covered by Medicare, payment for the RNHCI home benefit is set at 80 percent of the per visit rate for a home health aide visit under the Medicare home health benefit.

The policies and rationale governing LUPA payments under the Medicare home health benefit are described in the July 3, 2000 HH PPS final rule (65 FR 41127). Generally, low utilization episodes are paid at a standardized average per visit amount, adjusted for geographic differences in wages, which will be the basis of calculating payment under the RNHCI home benefit program. These amounts are updated annually by the home health market basket percentage as dictated by statute and are being used for the RNHCI home benefit. For CY 2005, the Medicare HHA PPS rates were updated by the home health market basket minus 0.8 percent. The HHA PPS LUPA amount for CY 2005 is $44.76 for a home health aide visit, as published in the **Federal Register** October 23, 2004 (69 FR 62124). Because we believe the intent is to provide comparable home health services to a beneficiary at home provided by a RNHCI, we believe it is similarly necessary to develop a payment methodology to reflect the provision of these comparable services. As previously mentioned, we have determined that the LUPA payment, as calculated under the home health PPS and adjusted for geographic differences in wages is an appropriate payment methodology for the RNHCI home benefit. We further note that as the LUPA will be updated by the applicable market basket percentage under the home health PPS, we will also adopt the updated LUPA payment for CY 2006 as the basis of payment for the RNHCI home benefit in CY 2006. An update of the HHA payment rates is published annually in the **Federal Register**, with CY 2006 updated figures available in Fall 2005. As mentioned above, the beneficiary receiving the RNHCI home benefit will be responsible for deductible and coinsurance for the designated RNHCI home benefit DME items. The regulation will indicate that payment for DME as a RNHCI home item is made less the deductible and coinsurance amount.

In view of the small size and low volume of most RNHCIs, we will use a 30-day cycle for the submission of RNHCI home benefit claims. Unlike standard HHAs that use a 60-day cycle, the RNHCI will use a 30-day cycle for both payment request and as a minimum for continued care home benefit review by the utilization review committee. Specific instructions on the processing of RNHCI home benefit payments will be issued in separate Medicare instructions.

Example of LUPA Payment Adapted for RNHCI Home Benefit Payment:

A RNHCI in Baltimore, Maryland is providing the RNHCI home benefit to a patient with a RNHCI election. The RNHCI has provided 12 visits within a 30-day cycle. The RNHCI would determine the payment for the home benefit visits as follows:

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TABLE 16:

Computation of Wage Index Adjusted Low Utilization Payment for the RNHCI Home Benefit

		Final wage standardized and budget neutral per-visit payment amount per 30 days for 2005
1. Home Health Aide Visit (2005)		$ 44.76
2. RNHCI Nurse Visit	(0.80 * $ 44.76)	35.81
3. Calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit	(0.76775 * $.35.81)	27.49
4. Apply wage index factor for Baltimore, MD	(0.9907 * $ 27.49)	27.23
5. Calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit	(0.23225 * $ 35.81)	8.32
6. Subtotal—Low Utilization Payment Adjustment (LUPA) wage for 1 RNHCI nurse visit	($ 27.49 +$ 8.32)	$ 35.55
7. Total - Calculate total Low Utilization Payment Adjustment (LUPA) for 12 RNHCI nurse visits provided during the 30-day episode	(12 * $ 35.55)	$ 426.60

Note: The same "labor"/"non-labor" portions applied in the home health PPS will be used
calculating the RNHCI LUPA payments.

Step 1. Take the home health aide visit base rate for the involved year from the home health PPS update published.

Step 2. To calculate the RNHCI nurse visit base rate, multiply the home health aide visit base rate ($ 44.76) by the allowed percentage for a RNHCI nurse visit (0.80 percent) =($ 35.81).

Step 3. To calculate the labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the labor portion of 0 .76775 by the RNHCI nurse visit rate from Step 2 ($ 35.81) =($ 27.49).

Step 4. Apply the wage index for the involved Metropolitan Statistical Area (MSA)

from the home health PPS payment update published annually each November in the **Federal Register** (Baltimore, MD =0.9907) multiplied by the labor portion of the RNHCI nurse visit from Step 3 ($ 27.49) =($27.23).

Step 5. To calculate the non-labor portion of the Standardized Budget Neutral Per-Visit Payment Amount for 1 RNHCI nurse visit, multiply the non-labor portion of 0.23225 by the RNHCI nurse visit rate from Step 2 ($ 35.81) =($ 8.32).

Step 6. To calculate the LUPA rate for 1 RNHCI nurse visit, add the products from Step 4 ($27.49) and Step 5 ($ 8.32) =($ 35.55).

Step 7. To calculate the LUPA payment for RNHCI nurse visits to one beneficiary in a 30-day period, multiple the product of Step 6 ($ 35.55) by the number of visits (12) =($ 426.60).

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IV. Other Issues

A. Provisions Related to Therapy Services

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

Section 1862(a)(20) of the Act permits payment for therapy services furnished incident to a physician's professional services only if the practitioner meets the standards and conditions that would apply to the therapy services if they were furnished by a therapist, with the exception of any licensing requirement. We proposed to amend the regulations at § 410.26, § 410.59, § 410.60, and § 410.62 to reflect the statutory prohibition on payment for ''therapy'' services of individuals who do not meet the existing qualification and training standards for therapists (with the exception of licensure) as these standards are set out in § 484.4.

As discussed in the August 5, 2004 proposed rule, section 1862(a)(20) of the Act refers only to PT, OT, and SLP services and not to any other type of therapy or service. This section applies to covered services of the type described in sections 1861(p), 1861(g) and 1861(ll) of the Act; it does not, for example, apply to therapy provided by qualified clinical psychologists. This section also does not apply to services that are not covered either as therapy or as E/M services provided incident to a physician or NPP, such as recreational therapy, relaxation therapy, athletic training, exercise physiology, kinesiology, or massage therapy services.

In the following discussion, the phrase ''therapy services'' means only PT, OT, and SLP. Also, ''therapist'' means only a physical therapist, occupational therapist, and speech-language pathologist.

Section 1861(s)(2)(K) of the Act permits certain NPPs, specifically PAs, NPs, and CNSs, to function as physicians for the purposes of furnishing therapy services which they are legally authorized to perform by the State in which the services are performed. Therefore, in our responses to comments in the following discussion, the statements concerning therapy services that apply to physicians also apply to PAs, NPs, and CNSs.

We received many comments on this proposal from professionals and associations for audiologists, speech-language pathologists, physical therapists, occupational therapists, long term care facilities, kinesiotherapists, massage therapists, athletic trainers, nurses, and physicians such as physiatrists, neurologists, podiatrists, chiropractors, osteopaths, medical groups, and family practitioners.

The proposal describes covered Medicare services and is not intended to affect the policies of other insurers who may cover services that Medicare does not, for example, therapy services performed by massage therapists or athletic trainers.

Comment: Several associations believe that this proposal is based on an incorrect interpretation of the intent of section 1862(a)(20) of the Act. Some claim that the proposed clarification is prohibited by the statute. They note the lack of any elaboration upon the Congress' intent in the Conference Report accompanying section 4541(b) of the BBA, but suggest the provision was based on a 1994 OIG report, ''Physical Therapy in Physicians' Offices'' (OEI–02–90–00590, March 1994). In the view of some commenters, the intended effect of section 1862(a)(20) of the Act was to apply to incident to therapy services the standards and conditions related to treatment plans, the need for goals, and the requirement that therapy is to be restorative. This position is based on the fact that these standards were the focus of the 1994 OIG report. The commenters point out that the report did not compare therapist services to services furnished by nontherapists in a physician's office, but it only compared the services billed by therapists to those billed by physicians.

Commenters argued that the plain meaning of section 1862(a)(20) of the Act indicates that incident to services are not necessarily furnished by therapists. They point to the parenthetical exclusion of licensure requirements in the statutory language as evidence that the Congress did not intend to apply the personnel requirements applicable to therapists in private practice to incident to therapy services. Some commenters believe this exclusion was intended to preserve the right of physicians to supervise auxiliary personnel that were not licensed as therapists. They suggest that we are creating a de facto licensure requirement.

Comments from the two members of the Congress who introduced the act that resulted in section 1862(a)(20) of the Act support the proposed rule, stating that the proposed clarification meets the intent of the law when it was passed by the Congress in 1997. These commenters confirm that the legislation was based in part on the 1994 OIG report and the intent was to establish ''a consistent standard for the delivery for PT services to ensure quality patient care.'' Two additional comments were received from the Congress in support of the proposal.

Response: Our interpretation is based on the plain language of the law: no payment may be made for incident to therapy services ''that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) * * * ''

The second sentence of section 1861(p) of the Act reads as follows:

''The term 'outpatient physical therapy services' also includes PT services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary.''

It is evident then, that the standards and conditions referenced in section 1862(a)(20) of the Act encompass qualifications of the individual providing the therapy. Consequently, we disagree with those commenters who suggest that it was not the intent of section 1862(a)(20) of the Act to apply the personnel qualifications of the second sentence of section 1861(p) of the Act to therapy provided incident to a physician's service. We believe our interpretation of the law is further supported by the comment received from the Congress members who sponsored the original bill that became section 1862(a)(20) of the Act.

According to the proposed requirements, a person who is trained in therapy, but has not completed the further requirements of therapy licensure, may provide services incident to a physician's services. These individuals are not therapists, since they are not licensed, but they are qualified personnel who may, under direct supervision, provide therapy services incident to a physician.

A physician may utilize supervised unlicensed staff and may bill for a covered therapy service incident to the physician's service if it is provided according to Medicare policies, including coverage and incident to policies.

Comment: Commenters also note that qualifications at § 484.4 are in the home health agency section of the regulations, while the second sentence of section 1861(p) of the Act (referenced by section 1862(a)(20) of the Act) does not apply to therapy provided in home health agencies.

Response: The statute specifies therapy services provided incident to a physician must meet the standards and conditions that would apply to a therapist, except licensure. For the history of the qualifications for the private practice setting, please see the discussion in this rule as described below in section IV.A.2, ''Qualification Standards and Supervision Requirements in Therapy Private Practice Settings.'' We proposed to apply to all settings the qualifications in § 484.4 because they are standards that currently apply to therapists in provider settings. It is our intent to make therapist qualifications consistent in all settings (unless otherwise required by statute). Therefore, unless a person meets the standards in § 484.4, except licensure, their services may not be billed as therapy services incident to a physician's service, regardless of any other training, other licensure or certification or other experience they may have. For example, the services of chiropractors or athletic trainers who do not meet the requirements in § 484.4 except licensure, cannot be billed as therapy services incident to a physician's service.

Comment: Several associations indicated that we are changing our interpretation of the statute. They assumed any instruction relevant to the law was made in 1998 through Transmittal 1606. That transmittal provided guidance for therapy services, but did not address the qualification of the people who furnish therapy incident to physician services. It was also suggested that we delay implementation to allow further study and comment from interested parties. The AMA urged us to withdraw proposed changes and reissue a later proposal after consulting with all affected physician and other health professional organizations.

Also, the commenters note that the Administrative Procedure Act (APA) requires that we characterize this as a change rather than a clarification.

Response: In the past, we did not discuss the plain language of the law ecause we did not believe it needed extensive clarification. However, it has become clear to us that contractors have varied in their policies.

Some contractors created local policies that paid only for services provided by licensed therapists in all settings including incident to a physician's service. Others had no policies that assured the qualifications of personnel furnishing services billed as therapy services incident to a physician.

Study of the utilization of therapy services, internal discussions with contractors and medical review of claims for the purpose of error rate analysis all suggested that the services being performed in the offices of physicians did not consistently meet the standards and conditions we applied to therapy services in private practice or in provider settings. Problems associated with an imprecise definition of therapy services were discussed at length in Section 4.1 of the ''Study and Report on Outpatient Therapy Utilization'' (the DynCorp utilization study) found at *http://www.cms.hhs.gov/medlearn/therapy.* Review of medical records following this report reinforced the personnel qualification problem.

In Pub. 100–04, the Medicare Claims Processing Manual at chapter 5, section 20, there is a list of codes that represent services that are always therapy services (available online at *http://www.cms.hhs.gov/manuals/104_claims/clm104c05.pdf).* Whenever these codes are billed, they must have a modifier that identifies the type of therapy (PT, OT, or SLP) and the services provided must meet the standards and conditions that apply to outpatient therapy services. In the medical review of therapy claims, there were frequent observations of ''always therapy'' services performed by persons other than therapists, which were billed inappropriately as therapy.

Since the qualifications of therapists and therapy services continued to be problematic, we chose to raise the subject of therapist qualifications last year. Last year's comments made it clear that there is widespread use of nontherapists, particularly athletic trainers, in the offices of physicians and those services are being billed as therapy services. The volume of similar comments this year made it evident to us that the clarification was needed.

We characterize this statement as a clarification because it merely restates the law. Moreover, we announced our clarification in the proposed rule, and it has been subject to comment in last year's proposed rule and again this year. So, assuming that it did change policy, its promulgation meets the requirements of the APA.

In addition, we note that we continue to pay only for covered services whether they are therapy or other services. Coverage rules in the Program Integrity Manual, chapter 13.5.1, require, for example, that the service be safe, effective, in accordance with accepted standards of medical practice, and furnished by qualified personnel.

We recognize there has been inconsistent application of this statutory requirement. Therefore, in order to allow sufficient time for physicians to adjust their practices, and to avoid disrupting ongoing therapy in affected practices, we will delay implementation

until manual instructions are published. We anticipate publication of manual instructions on or after March 1, 2005.

Comment: Many commenters offered the opinion that restricting payment for therapy services to those performed by therapists would reduce access and quality of care and increase costs. They noted that it is more convenient for therapy to be available in a physician's office than at another site. Also, there was concern that therapists may not work in rural areas, especially because there is a shortage of qualified therapists.

Response: The statute requires that those who provide therapy services meet therapy standards. It provides an exception for licensure in an incident to setting, but it does not provide an exception for rural areas. Since recent changes allow physical and occupational therapists that are enrolled in Medicare to work for physicians, there is no legal impediment to physicians being able to provide therapy services in their offices without the use of nontherapists. The Department of Labor Bulletin 2572, titled ''Occupational Projections and Training Data 2004–05 Edition'', suggests no shortage of therapists.

Nor do we find evidence to suggest the quality of care will be decreased by the use of personnel trained in therapy services as opposed to those trained in other disciplines. The cost of therapy services to Medicare will not be changed by the use of appropriately trained personnel.

Comment: Many comments from physical therapists and PT associations agreed in principle with consistently defining the qualifications for therapists in all settings. They point out that, although the statute allows unlicensed people to provide therapy services incident to the services of a physician, the purpose of licensure is to assure that services are safely and effectively furnished by professionals who have demonstrated the necessary knowledge and skills. The statute permits the use of therapists who have not met licensing requirements and those whose licenses were revoked due to malpractice or fraud. The supervision requirement that the physician be present somewhere in the suite, but not in line of sight, is insufficient to assure the safety and quality of service provided by unlicensed staff.

Response: Although the law permits unlicensed individuals to provide services incident to the services of a physician, we believe physicians will be motivated to screen employees to weed out sanctioned or incompetent people who have training in therapy since physicians would be liable for the actions of an incompetent employee. We require direct supervision of the employee by the physician as a minimum standard, but a physician will provide whatever guidance and supervision is required to assure the safety, effectiveness and quality of the service.

Comment: Many comments were received from individuals such as athletic trainers, kinesiotherapists, massage therapists and chiropractors describing their training as equal or superior to therapists' and suggesting that they provide care similar to therapists.

Response: The statute allows Medicare to pay only for PT, OT and SLP services. Comments from therapists and nontherapists agreed that their training and licensure is unique to their professions, and they are separately trained and licensed for those unique professions. It is clear that many nontherapist health care practitioners are well-trained professionals dedicated to the provision of quality treatment for their patients. However, their training is not in PT, OT, or SLP, but in the other disciplines for which they are licensed or accredited.

Comment: A number of physicians and associations for physicians wrote to tell us that they believe it is their right and within their authority to decide who can provide effective therapy services in their offices.

Response: The statute requires Medicare to pay only for services that meet the standards and conditions, except licensure, that apply to therapists. It is the right and responsibility of a physician to recommend services for patients that in the physician's judgment are needed and effective. Medicare, however, need not pay for all services that a physician recommends. We are required to pay for services that are covered in the statute and to deny payment for services that are not covered, even if the physician considers those services necessary and effective.

Comment: Some physicians wrote to tell us they are currently billing Medicare for therapy services when athletic trainers perform services in their offices. Several commenters asked what services may be billed to Medicare when provided by auxiliary staff who are qualified as athletic trainers, or who have certification in fields other than therapy.

Response: While some carriers may have paid claims for incident to therapy services furnished by individuals without therapy training, we have never had a policy that permits athletic trainers or any other staff who do not have training in PT to provide services that are billed as PT services. Carrier payment for a service is not conclusive evidence that the service was appropriately rendered. Billing with a code that does not accurately represent the service provided is inappropriate. If identified by carrier medical review, these claims must be denied, and further development of the claim may be indicated to determine if there was intent to bill improperly.

Medicare defines PT, OT and SLP as services that require the skills of a physical therapist, occupational therapist or speech-language pathologist. Therapy codes are priced based on the salaries and expenses of therapists and we expect that therapy claims are made for services of therapists (or, for incident to services by someone with their training, except for licensure).

When a service is not a covered service, it is inappropriate to bill Medicare for that service as a service incident to a physician, or as an E/M service. For example, if a service is appropriately described as acupuncture or athletic training or massage therapy, Medicare will not pay for that service because it is not covered.

A physician may not bill Medicare for a service that is on the list of ''always therapy'' services (see Pub. 100–04, the Medicare Benefit Policy Manual, chapter 5, section 20) if the service was done by staff that is not qualified to provide a skilled therapy service, because that is not a covered therapy service. The ''always therapy'' codes always require a modifier to describe whether the service was PT, OT or SLP.

There are covered services that other staff, such as athletic trainers, may perform with other training, however, these are not therapy services. Other codes on the therapy list are ''sometimes therapy'' services and require modifiers only when they are therapy services rather than physician services. For example, a physician may apply a surface neurostimulator (CPT 64550) as an isolated service, outside of a therapy plan of care and appropriately bill the code without a therapy modifier. That service is not a therapy service. If that physician supervises auxiliary personnel in the provision of that same nontherapy service, the auxiliary personnel does not have to be qualified as a therapist because the service rendered is not therapy. In any case, when Medicare is billed for a service, the person providing the service must be qualified to provide the service, as determined by the contractor in accordance with coverage requirements

in Pub. 100–08, the Medicare Program Integrity Manual, chapter 13.5.1. However, if a therapist provides the service under any circumstance, or if either the physician or qualified personnel provides the service as part of a therapy plan of care, it is a therapy service and it requires a modifier. In cases where there is doubt, the contractor will determine whether the service is therapy or is not therapy.

Further information about services that may be completed by non-therapists will be available in implementing instructions.

Comment: The American Chiropractic Association commented that doctors of chiropractory are authorized to perform PT services in all but two States, Michigan and Washington. They request that we note that fact in our commentary and in the regulation. They note that Doctors of Chiropractic are included in the definition of ''physician'' and they propose language in addition to that in § 484.4 to define the qualifications of chiropractors, in order to recognize the State-authorized practice privileges of Doctors of Chiropractic.

Response: Chiropractors may bill services to Medicare as physicians, but only for the purposes of providing manipulation of the spine for the correction of a subluxation, which is a chiropractor service, and not a therapy service. For these manipulation services, chiropractors may directly *supervise* employees who provide incident to services. However, as Medicare physicians, chiropractors are not authorized to *order* therapy services or to perform any other services. To qualify to provide therapy services incident to a physician, chiropractors must meet all of the criteria set forth at § 484.4 except licensure.

Comment: Several associations and some individuals commented that we are creating a monopoly for therapists to provide therapy services and unnecessarily restricting other professions from providing therapy services.

Response: We are bound by the statutory authority given to us in section 1832 of the Act to pay only for services for which there are benefits enumerated in the statute. PT, OT and SLP have benefits in section 1861 of the Act. Therefore, Medicare pays only for those services.

Comment: Several commenters noted that some NPPs, specifically PAs, NPs, and CNSs, may perform therapy services billable under Medicare as therapy services if their State scope of practice allows. The commenters question whether those NPPs may also perform therapy services incident to a physician or NPP.

Response: Medicare does not impose therapy training requirements on physicians whose State scope of practice allows them to perform therapy services. Section 1861(s)(2)(K) of the Act permits PAs, NPs, and CNSs, to furnish services which would be physicians' services, that is, to function as physicians for purposes of furnishing services, including therapy services, which they are legally authorized to perform by the State in which the services are performed. Therefore, this final rule has been modified to reflect that in States that authorize physicians, PAs, NPs, and CNSs to provide one or more of the therapy services (PT, OT, or SLP services), those NPPs may provide the services incident to the services of a physician or NPP under the same conditions as physicians, that is, without meeting the training requirements applicable to therapists.

Results of Evaluation of Comments

To the extent that this policy is different from current manual text, we proposed this rule and received comments. We are finalizing the proposal in this final rule with the changes noted above in accordance with the APA. We will implement this regulation through manual guidance on or after March 1, 2005.

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

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

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

Since 1999, when therapy services are provided by PTAs and OTAs in the private practice of a PT or OT, the services must be personally supervised by the PTPP or OTPP. In response to a requirement to report to the Congress on State standards for supervision of PTAs, we contracted with the Urban Institute. The Urban Institute found that no State has the strict, full-time personal supervision requirement, for any setting, that Medicare places on PTAs in PTPPs. (The report examined only PTAs, who are more heavily regulated by the States than OTAs).

To provide a consistent therapy assistant supervision policy, we proposed to revise the regulations at § 410.59 and § 410.60 to require direct supervision of PTAs and OTAs when PTs or OTs provide therapy services in private practice. We also specifically solicited comments regarding the proposed PTA supervision policy, and whether or not it would have implications for the quality of services provided, or for Medicare spending, either through increased capacity to provide these services, or, in the event that the Congress again extends the moratorium on the implementation of the limits on Medicare reimbursement for therapy services imposed by the BBA of 1997.

In addition, as discussed in the August 5, 2004 proposed rule, the current OTPP or PTPP regulations at § 410.59(c) and § 410.60(c) do not reference qualification requirements for therapy assistants or other staff working for PTs and OTs in private practices. In order to create consistent requirements for therapists and for therapy assistants, we proposed to restore the qualifications by adding the cross-reference to the qualifications at § 484.4 for privately practicing therapists and their therapy assistants at § 410.59 and § 410.60.

Comment: Commenters representing therapy organizations, as well as individual providers, were supportive of our proposal to revise the regulations at § 410.59 and § 410.60 to require direct, rather than personal, supervision of PTAs and OTAs when therapy services are provided by PTs or OTs in private practice.

(We use the 3 supervision levels defined at § 410.32, personal, direct, and

general, to describe the supervision requirements for various Medicare services and settings.)

Many commenters also stated that this is consistent with the Medicare requirements in other provider settings, such as hospitals, HHAs and rehabilitation agencies and is also consistent with the Medicare requirements for therapists in private practice that were in place prior to 1999. Commenters also believe that this will assist in ensuring access to therapy services and in protecting patient privacy.

Response: Requiring direct supervision of therapy assistants in PT and OT private practice settings is consistent with the supervision requirements that PTs and OTs in independent practice were required to meet, prior to 1999, at § 410.59(c) and § 410.60(c). This direct supervision requirement in PT and OT private practices requiring the therapist to be on site or ''in the office suite'' differs from our therapy assistant supervision requirements in institutional settings (for example, outpatient hospital departments, HHAs, and rehabilitation agencies). In those settings, PTs and OTs may provide general supervision of therapy assistants without being on-site.

We agree that changing the level of supervision of therapy assistants from personal to direct will help to improve access to medically necessary services.

Comment: A few commenters stated they believe permitting general supervision, rather than direct, is more consistent with State therapy supervision requirements. While State requirements vary, this variation may be due to the fact that PTAs are not licensed in some States. Other commenters stated that therapy assistants are qualified to provide services without having therapists in-the-room to provide personal supervision.

Response: A review of State practice acts revealed that Medicare's personal in-the-room supervision requirement for therapy assistants in PT and OT private practices was more stringent than any State supervision requirement for any setting. The Urban Institute report also found that most States permit a supervision level similar to our general supervision requirement for institutional settings. However, we believe that services delivered by therapy assistants in private practices require a higher level of therapist supervision than those provided in institutional settings where stringent standards for Medicare participation are enforced through State survey and certification programs, rather than the simplified carrier enrollment process for the PT or OT private practice offices.

Comment: One commenter stated that only licensed therapists should be allowed to provide and bill for therapy and another commenter demanded that therapy services only be reimbursed when provided by a therapist, not any other professional, including nurses, PAs, or chiropractors, and not by therapy assistants. They suggested that without this requirement there would be program abuses.

Response: We concur with the therapy associations and the overwhelming majority of commenters that therapy assistants are qualified by their training and education to provide services without the personal in-the-room supervision in the private practice setting. This does not mean, however, that therapy assistants may bill for the services they provide. Under the law, only PTs and OTs in private practice may bill Medicare for the therapy services provided by PTAs and OTAs. These therapists enroll in the Medicare program and receive a provider identification number (PIN) in order to file claims for the therapy services provided as a PTPP or OTPP. Institutional therapy providers bill Medicare on behalf of the PTs, OTs, and speech language pathologists who provide therapy services in these settings.

Other professionals, including nurses, athletic trainers, and chiropractors do not meet the statutory requirements for therapists in section 1861(p) of the Act and as implemented at § 484.4. We proposed to amend the regulations at § 410.59 and § 410.60 to specify that only individuals meeting the qualification standards and training consistent with § 484.4 may bill and receive Medicare payment for therapy services. In addition, a State license or certification in PT or OT will continue to be required for therapist providing services as PTPPs or OTPPs.

When PAs, NPs, or CNSs are authorized by their State practice acts to provide physical or occupational therapy services, and these NPPs are acting within their capacity to provide physician services under section 1861(s)(2)(K) of the Act, their services are considered therapy services.

Comment: One commenter stated that allowing lesser trained individuals such as therapist assistants to provide services if a therapist supervises, but prohibiting physicians from delegating performance of these services to doctors of chiropractic inappropriately gives therapists more authority than physicians.

Response: Medicare law recognizes chiropractors as physicians, but only for the limited purpose of providing manipulation of the spine for the correction of a subluxation. In order to qualify as a PT or OT for Medicare purposes, chiropractors would need to meet all of the criteria set forth at § 484.4.

Comment: In response to our request for information on the impact of this proposed change on the quality of services and Medicare spending, several individuals stated that the proposed change would not affect the way therapists practice, since they are fully accountable for services provided under their direction and, therefore, the change would not diminish the quality of services. Furthermore, commenters believe the change would also allow the appropriate and efficient utilization of therapist assistants because the in-the-room supervision unnecessarily drives up the cost of health care without providing additional consumer protection.

The American Physical Therapy Association (APTA) anticipates there will be little, if any, increase in spending as a result of this policy and believes that any increases would be due to improving access to medically necessary outpatient therapy services provided by qualified practitioners. For spending implications, the APTA believes it is highly unlikely that physical therapists would significantly alter their staffing patterns and thereby increase spending as a result of this change in policy. The majority of States have laws that establish limits on the number of PTAs that a PT can supervise (referred to as ''supervision ratios''). For example, a large number of States have a supervision ratio of one PT to two PTAs. There are also a limited number of PTAs whom PTs could supervise, and APTA does not anticipate substantial growth in the number of PTAs in the foreseeable future. To the contrary, the number of PTA education programs is declining.

Furthermore, services of PTs in private practice comprise a relatively small percentage of services billed under the Medicare program. Therefore, the overall financial impact of any change in the supervision requirement in this setting would be minimal.

Response: We appreciate the information provided by the commenters. Other opportunities already exist for therapists to provide services under Medicare in rehabilitation agencies and CORFs where the therapy assistant supervision level is general. Therapists opting to utilize therapy assistants might be more

likely to own a rehabilitation facility where the physical or occupational therapy assistant supervision level is general, rather than a private practice office where the therapist is required to be on-site to supervise services of the therapy assistant. The Urban Institute Report confirmed the limited number of therapy assistants available to be hired and found that workforce and distribution percentages of PTs and PTAs parallel each other, with nearly 25 percent of PTAs employed by PTPPs. We believe that the State supervision requirements and the limited number of PTAs are likely to limit the financial implications of this change. We plan to monitor this area to determine whether volume changes occur and, if so, in what settings they occur.

Comment: Commenters supported our proposal to revise § 410.59 and § 410.60 to cross-reference the qualifications at § 484.4 for privately practicing therapists and their therapy assistants.

Response: We appreciate the numerous letters of support for this proposal, including the national and State-level therapy organizations, other professional organizations, and many therapists and therapy assistants.

Result of Evaluation of Comments

We will finalize the proposed revisions to § 410.59 and § 410.60 to require direct supervision of PTAs and OTAs when therapy services are provided by PTs or OTs in private practice and also to cross-reference the qualifications at § 484.4 for privately practicing therapists and their therapy assistants.

3. Other Technical Revisions

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

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

In addition, we proposed a technical change at § 484.4 to correct the title ''physical therapy assistant'' to ''physical therapist assistant'' and proposed amending § 410.59(e) and § 410.60(e) to include a reference to the 2-year moratorium on the therapy caps established by section 624 of the MMA.

Comment: Commenters representing therapy specialty organizations supported these changes.

Response: We will finalize these changes as proposed.

Result of Evaluation of Comments

We are finalizing the changes as proposed.

B. Low Osmolar Contrast Media

High osmolar and low osmolar contrast media (LOCM) are used to enhance the images produced by various types of diagnostic radiological procedures. When the Medicare physician fee schedule was established, findings of studies of patients receiving both types of contrast media had been published, and the ACR had adopted criteria for the use of LOCM. At that time, we determined that the older, less expensive high osmolar contrast media (HOCM) could be used safely in a large percentage of the Medicare population. However, we also decided that separate payment for LOCM may be made for patients with certain medical characteristics. We adopted the ACR criteria, with some modification, as the basis for a policy that separate payments are made for the use of LOCM in radiological procedures for patients meeting certain criteria. These criteria were established at § 414.38. Under these conditions, we pay for LOCM, utilizing HCPCS codes A4644 through A4646.

In the August 5, 2004 rule, we proposed to revise the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This proposal would make Medicare payment for LOCM consistent across settings since, under the OPPS, there is no longer a payment difference between LOCM and other contrast materials.

We also proposed that, effective January 1, 2005, payment for LOCM would be made on the basis of the ASP plus six percent in accordance with the standard methodology for drug pricing established by the MMA. However, because the technical portions of radiology services are currently valued in the nonphysician work pool and the CPEP inputs for these services are not used in calculating payment, we also indicated we would continue to reduce payment for LOCM by eight percent to avoid any duplicate payment for contrast media.

Comment: Commenters representing radiology, interventional radiology, and imaging contrast manufacturers were supportive of this proposed change; however, our payment methodology of ASP plus six percent minus eight percent was questioned. Two commenters also believe that the implementation date for the application of ASP methodology should be changed from January 1, 2005. One requested an effective date of April 1, 2005 and the other requested an effective date of January 1, 2006.

Response: We appreciate the commenters' support for this change. We stated in the proposed rule that effective January 1, 2005, payment for LOCM would be made on the basis of the ASP plus six percent. However, there is an October 30, 2004 deadline for submission of the ASP data used for the January 1, 2005 payment, and this date occurred prior to our finalizing the proposed payment methodology for LOCM. Therefore, the ASP payment methodology for LOCM will be made effective April 1, 2005. Manufacturers of LOCM will be required to submit their fourth quarter 2004 (4Q04) ASP information to us on or before January 30, 2005. Subsequent data must be submitted within 30 days after the end of each calendar quarter. The 4Q04 data will be used to determine the April 1, 2005 ASP plus six percent payment limits. Further information on the specific format of the data submission and the address to which the information can be sent is found on the CMS ASP Web site, specifically at *http://www.cms.hhs.gov/providers/drugs/asp.asp.*

Our policy to reduce payment for LOCM by 8 percent stems from the fact that the technical component RVUs for these procedures took into account the use of (and expenses for) HOCM in the (see the November 25, 1991 final rule (56 FR 59502)). However, since that time, the price differential between HOCM and LOCM has declined. In addition, upon further review, we are not able to determine accurately the degree of duplicate payment that might occur when both the imaging procedure and LOCM are billed. Therefore, we are not applying the eight percent reduction to the LOCM payment as proposed. The payment for LOCM will be consistent with the payment rate for the majority of drugs administered by physicians.

Comment: One contrast agent industry association suggested that we issue additional codes for the reporting of contrast media.

Response: For 2005, we are continuing to use the current three HCPCS codes in the reporting of low osmolar contrast agents. However, we are exploring the possibility of additional codes to accurately capture the cost differences among all contrast agents as well as the differing clinical

uses, concentration, and dose administrations. We welcome input from the medical community and the manufacturers of contrast media on this issue.

Comment: A commenter suggested that we use a model to capture volume and concentration variances of LOCM. In this model, ASP would be calculated as ASP = Total Sales/Total Volume.

Response: This suggested methodology does not take into account the weighted average for each national drug code (NDC) within a HCPCS code that must be used to derive an appropriate ASP code price.

Result of Evaluation of Comments

We are revising the regulations at § 414.38 to eliminate the criteria for the payment of LOCM. In addition, effective April 1, 2005, payment for LOCM will be made on the basis of the ASP plus six percent.

C. Payments for Physicians and Practitioners Managing Patients on Dialysis

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

In response to comments received on billing procedures for physicians and practitioners managing patients on dialysis when the dialysis patient is hospitalized during the month, we stated in the November 7, 2003 **Federal Register** (68 FR 63220) that ESRD-related visits furnished to patients in observation status would not be counted as visits under the MCP but would be paid separately. Prior to this, long-standing Medicare policy had included ESRD-related visits furnished in the observation setting within the MCP. However, upon further review of this issue, in the proposed rule published August 5, 2004, we proposed a revision to this policy and stated that ESRD-related visits provided to patients by the MCP physician in an observation setting would be counted as visits for purposes of billing the MCP codes.

Comment: Several commenters expressed support for allowing ESRD-related visits provided to patients by the MCP physician in the observation setting to be counted for purposes of billing the MCP codes. However, Kidney Care Partners (KCP) and the Renal Physicians Association (RPA) requested clarification as to how a physician or practitioner who is not part of the MCP practice team should bill for visits furnished in the hospital observation setting. The RPA suggested that a hemodialysis procedure with single physician evaluation as described by CPT code 90935 be used.

Response: Physicians or practitioners who are not part of the MCP practice team but who furnish a visit to an ESRD beneficiary in the observation setting can bill the appropriate observation codes that accurately describe the service (CPT codes 99217 through 99220). A hemodialysis procedure with single physician visit as described by CPT code 90935 will only be used when the beneficiary is an inpatient or for outpatient dialysis services for a non-ESRD patient.

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

Since changing our payments for physicians and practitioners managing patients on dialysis, we have received a number of comments from the nephrology community requesting guidance on billing for outpatient ESRD-related services provided to transient patients and in partial month scenarios (for example, when the patient is hospitalized during the month or receives a kidney transplant). To address this issue, we proposed to change the description of the G codes for ESRD-related home dialysis services, less than full month, as identified by G0324 through G0327. The new descriptor would include other partial month scenarios, in addition to patients dialyzing at home. The proposed descriptors for G0324 through G0327 are as follows:

- G0324, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age;
- G0325, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between two and eleven years of age;
- G0326, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day, for patients between twelve and nineteen years of age.
- G0327, End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day, for patients twenty years of age and over.

In the August 5, 2004 proposed rule, we stated that these G codes would provide a consistent way to bill for outpatient ESRD-related services provided under the following circumstances:

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

However, we noted that this proposed change to the descriptions of G0324 through G0327 was intended to accommodate unusual circumstances when the outpatient ESRD-related services would not be paid for under the MCP and that use of the codes would be limited to the circumstances listed above. Physicians who have an on-going formal agreement with the MCP physician to provide cursory visits during the month (for example ''rounding physicians'') could not use the per diem codes.

Clarification on Billing for Transient Patients

In the August 5, 2004 proposed rule, we stated that, for transient patients who are away from their home dialysis site and at another site for fewer than 30 consecutive days, the revised per diem G codes (G0324 through G0327) would be billed by the physician or practitioner responsible for the transient patient's ESRD-related care. Only the physician or practitioner responsible for the traveling ESRD patient's care would be permitted to bill for ESRD-related services using the per diem G codes (G0324 through G0327).

If the transient patient is under the care of a physician or practitioner other than his or her regular MCP physician for a complete month, the physician or practitioner responsible for the transient patient's ESRD-related care would not be able to bill using the per diem codes. We also solicited comments on when a patient will be considered transient.

Comment: Several commenters, including the ASN, KCP, and the RPA, supported our proposed change to the description of HCPCS codes G0324–G0327 (per diem codes). The KCP believed that this change would provide a consistent billing method when the patient is transient, furnished home dialysis (less than full month), and for other partial month scenarios when the patient is hospitalized, has a transplant or when the patient expires. Additionally, several commenters praised us for our willingness to work with the renal community to address the multitude of issues surrounding the way physicians and practitioners are paid for managing patients on dialysis.

However, the RPA and KCP suggested that, in addition to the situations described in the proposed rule, the per diem codes as described by G0324 through G0327 should be used to bill whenever one or more visits occurred

during the month regardless of whether the complete monthly assessment was furnished.

Response: As explained in the proposed rule, we believe the per diem codes will only be used for unusual circumstances where the ongoing management of an ESRD patient would not be paid through the MCP. As discussed earlier, we proposed to allow the per diem codes only in specific circumstances. However, after further review of this issue, we believe that it would also be appropriate to use the per diem codes when the beneficiary's MCP practitioner changes permanently during the month. For example, the ESRD beneficiary moves from one State to another and a new MCP physician or practitioner has the ongoing responsibility for the E/M of the patient's ESRD-related care who is not part of the same group practice as an employee of the previous MCP physician. We addressed this issue in a recent instruction published on September 17, 2004 (CR 3414 ''Payment for Outpatient ESRD-Related Services'', Transmittal 300). For more information on this instruction please visit our Web site at *http://www.cms.hhs.gov/manuals/* and select 2004 transmittals under the program transmittals link.

However, we will not permit the use of per diem codes (HCPCS codes G0324 through G0327) for all instances when the MCP physician or practitioner furnishes at least one visit during the month without regard to the status of a complete monthly assessment of the patient. We are concerned that permitting the per diem codes to be used in this manner may undermine the MCP. For example, the ESRD MCP includes various physician and practitioner services such as the establishment of a dialyzing cycle, outpatient E/M of the dialysis visit(s), telephone calls, patient management as well as clinically appropriate physician or practitioner visit(s) during the month. At least one of the visits must include a clinical examination of the vascular access site furnished face-to-face by a physician, CNS, NP or PA. When a practitioner bills for the MCP, the medical record must document that all of these services are furnished. By using the per diem codes in the manner suggested by the commenter, it would not be necessary for the practitioner to provide a complete monthly assessment of the ESRD beneficiary to receive payment for the ongoing management of patients on dialysis.

Comment: With regard to the ESRD-related services for home dialysis patients, less than full month, one healthcare corporation believes that the proposed coding changes continue to penalize nephrologists for prescribing home therapy because a per diem (pro-rated) payment is made when a hospitalization occurs. The commenter believes that this policy results in an inequity as compared to a physician providing 2–3 visits per month for center-based dialysis patients. Additionally, the commenter argues that the pro-rated methodology used for home dialysis patients (partial month) is inconsistent with how we pay the MCP physician for patients undergoing dialysis treatments in a dialysis facility.

The commenter believes that we should increase the payment for ESRD-related services for home dialysis patients to a level that is at least as high as the ESRD-related services (for full month) with 4 or more visits per month. The commenter contends that raising the payment amount for home-based dialysis patients would result in revenue opportunities similar to those available in the center-based scenario and would provide a greater incentive for home dialysis treatment.

Response: We do not agree with the commenter's statement that an inconsistency exists in the way we pay the MCP physician for managing a home dialysis patient (less than full month) and center dialysis patient (less than full month).

Our proposed change to the description of HCPCS codes G0324 through G0327 would apply to dialysis patients who receive dialysis in a dialysis center or other facility during the month as well as to home dialysis patients. For example, if a center dialysis patient is hospitalized during the month, has a transplant, or expires before a complete assessment is furnished (including a face-to-face examination of the vascular access site), the MCP physician would use the per diem rate to bill for ESRD-related care. When either a home dialysis patient or a patient who receives dialysis in a dialysis facility is hospitalized, the MCP physician or practitioner may bill for inpatient hemodialysis visits as appropriate (for example CPT codes 90935 and 90937).

Additionally, we believe the current payment level for physicians managing patients on home dialysis for a full month already provides an incentive for an increased use of home dialysis. For instance, payment for the monthly management of home dialysis patients is made at the same rate as the MCP with 2 to 3 visits. However, a monthly visit is not required as a condition of payment for physicians and practitioners managing home dialysis patients. Essentially, a physician or practitioner managing ESRD patients who receive dialysis in a dialysis facility would be required to furnish 2 to 3 face-to-face visits in order to receive the same level of payment as he or she would have received for managing a home dialysis patient. We do not believe it would be appropriate to pay physicians managing home dialysis patients at the highest MCP amount when no visits are required as a condition of payment.

Definition of a ''Transient Patient''

Comment: The RPA and KCP believe that it would be more appropriate to refer to these patients as ''visiting patients''. The RPA suggested that a ''visiting patient'' be defined as a ''patient receiving dialysis or renal-related care whose care is temporarily supervised (for less than one month's time) by a physician who is not a member of the practice that usually charges under the MCP or G codes''.

Response: We believe the term ''transient patients'' better describes a beneficiary who is away from his or her home dialysis site for less than a full month.

General Comments on Our Changes in Payments for Physicians and Practitioners Managing Patients on Dialysis

Comment: One commenter requested clarification as to how ESRD-related visits furnished to beneficiaries residing in a skilled nursing facility (SNF) adjacent to a hospital should be handled. The commenter explained that his SNF patients with ESRD usually receive dialysis treatments in an independent dialysis facility connected to a hospital's SNF. However, in cases when the patient is ''too ill'' to be transported to the independent dialysis facility, the dialysis treatment occurs in the inpatient dialysis treatment area (but the patient is not admitted to the hospital as an inpatient). The commenter noted that ESRD-related visits may be furnished while the patient is dialyzing or at the SNF when the patient is not dialyzing.

Response: Although we have not issued specific instructions on this issue, we believe that ESRD-related visits furnished to SNF residents are similar to other ongoing management services under the MCP. As such, ESRD-related visits furnished to patients residing in a SNF will be counted for purposes of billing the MCP codes. However, if the beneficiary is admitted to the hospital as an inpatient, the appropriate inpatient visit code will be used, for example, CPT code 90935.

Comment: With regard to our revisions to the MCP (as published in the CY 2004 final rule), the American Association of Kidney Patients (AAKP) questioned if we have any current data on or future plans to study whether access to nephrologists or the quality of medical care for ESRD patients has been improved or impaired. Additionally, AAKP questioned whether we have any plans to develop additional proposals (beyond the telehealth proposal) to address access needs in rural and other underserved areas.

Response: In evaluating the MCP, we will be looking for trends in hospitalization rates and resource utilization for ESRD patients. Moreover, we understand the challenges nephrologists face in visiting all patients on dialysis. To that end, we believe that our policy to allow clinical nurse specialists, nurse practitioners and physician assistants to furnish visits under the MCP, along with our addition of specific ESRD-related services to the list of Medicare telehealth services, will help ameliorate access issues.

Comment: The RPA and the ASN continued to express concerns with the changes made in the CY 2004 final rule to the way physicians are paid for managing patients on dialysis. The RPA strongly believes that many of the underlying principles of the new HCPCS codes for managing ESRD patients need to be changed. The RPA cited the impact on rural providers, the lack of gradation in payment amounts between furnishing 2 and furnishing 3 visits per month, and the premise that more visits will equate to better quality of care as major shortcomings of the new ESRD MCP.

The RPA and ASN emphasized their belief that more physician and practitioner visits per month does not correlate to efforts to improve the quality of care for ESRD patients. RPA contends that a stratified MCP system based on the number of monthly physician and practitioner visits is unnecessarily complicated and believes that the vast majority of nephrologists provided appropriate ESRD-related care under the previous MCP. To that end, the RPA urged us to implement a simpler system based on a minimum number of patient visits and a new documentation requirement for the services provided under the MCP.

Response: We appreciate the commenters' suggestions and will consider these comments as we continue to refine how we pay for physicians and practitioners managing patients on dialysis.

Results of Evaluation of Comments

ESRD-related visits provided to patients by the MCP physician or practitioner in an observation setting will be counted as visits for purposes of billing the MCP codes.

Moreover, we will change the description of the G codes for ESRD-related home dialysis services, less than full month, as identified by G0324 through G0327. The new descriptor will include other partial month scenarios, in addition to patients dialyzing at home. The descriptors for G0324 through G0327 will be as follows:

- G0324: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients under two years of age.
- G0325: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between two and eleven years of age.
- G0326: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients between twelve and nineteen years of age.
- G0327: End stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients twenty years of age and over.

The revised per diem ESRD-related services G codes will be used for outpatient ESRD-related services provided in the following scenarios:

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

D. Technical Revision—§ 411.404

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

Commenters were supportive of this proposed change and we are finalizing it as proposed.

E. Diagnostic Psychological Tests

All diagnostic tests covered under section 1861(s)(3) of the Act and payable under the physician fee schedule must be furnished under the appropriate level of supervision by a physician as defined in section 1861(r) of the Act. Section 410.32(b)(2)(iii) states an exception to these physician supervision requirements for clinical psychologists and independently practicing psychologists (who are not clinical psychologists) which allows them to personally perform diagnostic psychological testing services without physician supervision. However, diagnostic psychological tests performed by anyone other than a clinical psychologist or an independently practicing psychologist must be provided under the general supervision of a physician as defined in section 1861(r) of the Act. Accordingly, clinical psychologists and independently practicing psychologists have not been permitted to supervise others in the administration of diagnostic psychological tests.

As discussed in the August 5, 2004 proposed rule, we were asked to re-evaluate our regulations regarding clinical psychologists' supervision of diagnostic psychological tests, and additional information concerning provision of these services was also supplied. Based upon our review of this issue, we determined that clinical psychologists possess knowledge sufficient to direct test selection and interpret test data. Therefore, we proposed to change the requirements at § 410.32(b)(2)(iii) to permit clinical psychologists to supervise the performance of diagnostic psychological and neuropsychological testing services.

Comment: Two specialty societies representing psychologists and many individual commenters were in support of the change. One major association representing psychiatrists and a few individual commenters opposed the proposal. According to the association, expanding the supervision requirements will not lessen the burden on physicians and healthcare facilities within rural areas. In addition, this association asked that we provide data showing that the change to the supervision requirements will reduce the burden on physicians and health care facilities, and that access will be improved in rural areas.

Response: We appreciate the positive comments in support of this proposal.

In response to the request for evidence that this change will reduce burden and improve access, we would first note that our primary reason for proposing this change was that we believe clinical psychologists possess the core knowledge to sufficiently supervise the administration of these tests. By enabling them to do so, this change will allow greater flexibility in their practices.

With regard to improved access in rural areas, we noted previously in this rule that we recognize mental health HPSAs for incentive payments for psychiatrists. Accordingly, we believe that the expansion of the supervision requirements will help improve access in these areas.

Result of Evaluation of Comments

As proposed, we are revising § 410.32(b)(2)(iii) to permit clinical psychologists to supervise the performance of diagnostic psychological and neuropsychological testing services.

F. Care Plan Oversight

Care Plan Oversight (CPO) refers to the supervision of patients receiving Medicare-covered home health or hospice services requiring complex multidisciplinary care modalities, including regular development and review of plans of care. In the August 5, 2004 rule, we proposed to revise § 414.39 to clarify that NPPs can perform home health CPO; however, they cannot certify a patient for home health services and sign the plan of care. We also proposed the conditions under which NPP services may be billed for CPO and explained that the proposed conditions are meant to ensure that the NPP has seen and examined the patient and that the appropriate and established relationship exists between the physician who certifies the patient for home health services and the NPP who will provide the home health CPO.

Comment: Several commenters support the proposed revision and conditions of coverage. They support the integrated practice arrangements required by proposed § 414.39(c)(2)(iii). They believe the proposed conditions ensure appropriate, ongoing supervision of both the patient's condition and the NPP.

Response: We appreciate the commenters' support for this proposal.

Comment: We received a comment from an association representing home care physicians requesting that we include PAs in the clarification because PAs increasingly play the same role as NPs in home health care and bill under the same house call codes.

Response: We agree with the commenter that we include PAs in the clarification. The definition of NPPs in proposed § 414.39(a) includes NPs, CNSs, and PAs. However, we also note that PAs cannot bill directly for their own services.

Comment: We received a comment requesting that we clearly state the definition of the appropriate relationship between the physician and the NPP. The commenter requested that we cross-reference applicable State standards because the meaning of collaboration varies across States and some States require employment relationships. Also, the commenter recommended that we require a written agreement regarding the responsibilities for managing care when the NP or PA is not from the same organization as the physician who has certified the skilled home care services.

Response: We agree that State laws or regulations governing collaborative relationships, where applicable, would be useful in this regard. In the absence of State laws or regulations, NPs and CNSs will be required to document their scope of practice and indicate the relationships they have with physicians to handle issues outside their scope of practice. If the NPP is a PA, the physician signing the plan of care also must be the physician who provides general supervision of PA services for the practice.

Comment: We received a comment requesting that this clarification be made retroactive to at least FY 2000 to allow denied claims to be resubmitted. The commenter stated that many claims for CPO services by NPs were denied over the past several years, despite CMS and legislative intent to have these claims reimbursed.

Response: We clarified in the November 1, 2000 final rule (65 FR 65407) that CPO services of NPPs, practicing within the scope of State law applicable to their services, could be paid under Medicare. However, our policy has also been that the physician who bills for CPO must be the same physician who signs the plan of care.

Appeal rights are available for these claims for CPO services provided by NPPs in HHAs if the appeal is requested within 120 days of the date of the claim denial. If appeal rights have expired, the physician or supplier may request a reopening for any reason within 12 months of the date of the notice of initial determination. After the 12-month period, but within 4 years from the date of the initial determination, a reopening may be requested for good cause. The decision on whether to reopen a claim at the request of the physician or supplier is at the discretion of the Medicare contractor.

Comment: We received comments noting that this clarification does not allow NPs, CNSs, or PAs to certify a patient for home health care services or to sign the plan of care. The commenters noted that certification by NPPs is not currently permitted under the statute. One of the commenters recommended that we revise the rules on certification and recertification to allow NPs, CNSs, or PAs to perform them.

Response: The commenters are correct that the statute (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act) requires a physician to certify a patient for home health care services or to sign the plan of care. Therefore, the issue of whether to allow NPs, CNSs, or PAs to certify a patient for home health care services or to sign the plan of care is not within the purview of this rule.

Result of Evaluations of Comments

We are adopting the proposed changes to § 414.39 that clarify that NPPs can provide care plan oversight for beneficiaries who receive home health services.

G. Assignment of Medicare Claims—Payment to the Supplier

The current regulation requires the beneficiary (or the person authorized to request payment on the beneficiary's behalf) to assign a claim to the supplier for an assignment to be effective. However, over time, the Act was amended in various sections to require that Medicare payment for certain services would only be made on an assigned basis regardless of whether or not the beneficiary actually assigns the claim to the supplier. In these instances, the current requirement in § 424.55(a), which specifies that the beneficiary assign the claim to the supplier, is now unnecessary. Therefore, we proposed to create an exception to the general rule in § 424.55(a). New § 424.55(c) would eliminate the requirement that beneficiaries assign claims to suppliers in situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier.

Comment: The ACLA supports the proposal and agrees that this new exception to the requirement for beneficiaries to assign benefits in situations where benefits can, by statute, only be paid on an assigned basis will reduce the paperwork burden on beneficiaries and suppliers.

Response: We agree that the proposed regulation will reduce the paperwork burden on beneficiaries and suppliers and we are finalizing the revisions as proposed.

Result of Evaluation of Comments

We are finalizing § 424.55(c) as proposed.

H. Additional Issues Raised by Commenters

Comment: Two specialty societies representing plastic surgeons and

podiatrists, as well as the RUC, recommended that the global period for CPT 15342, Application of bilaminate skin substitute/neodermis; 25 sq cm, be changed from a 10-day global period to a 0-day global period. The commenters stated that the plastic surgeons generally perform this procedure on more severely injured patients, such as burn patients, who are often seen in the inpatient setting. The podiatrists, on the other hand, typically treat patients with diabetic foot ulcers in the outpatient setting. Therefore, the commenters contend that though the work required to perform the procedure is the same for both specialties, the post-surgical work and time are not and the change in the global period would allow both scenarios to be paid appropriately.

Response: We understand that this code can represent differing scenarios. However, while podiatrists perform approximately 45 percent of the procedures and general surgeons 17 percent, plastic surgeons perform only 7 percent. In addition, only 9 percent are performed in the inpatient hospital setting. Our general approach and the one adopted by the RUC for valuing all services is to base our review on the typical patient. In this case, the podiatric scenario would clearly dominate and applying a 10-day global period to capture the post-procedure office visit appears appropriate. However, we would be willing to discuss this issue further with the specialties involved and with the RUC.

Comment: The American Society of Anesthesiologists (ASA) provided comments asking that we consider revising the current teaching regulations to place teaching anesthesiologists' reimbursements on par with the teaching of resident physicians in surgery and other high-risk specialties. Also, that we redefine the HCPCS claims service modifier ''AA'' to include both the personal administration of the anesthesia by the physician and teaching up to two resident physicians concurrently. In its comments, the ASA stated that it believes we possess the authority under the terms of section 1871 of the Medicare statute to make the requested change in its teaching reimbursement rules, effective January 1, 2005, as follows: the agency can treat the rule as a logical outgrowth of a prior proposal; it can issue a final rule with comment period as part of the 2005 physician payment final rule; or, it can promptly issue a free-standing rule proposing the change and allow for public comment and subsequent effectiveness along with the 2005 physician payment rule. The American Association of Nurse Anesthetists (AANA) asked that, if we review proposed revisions to the teaching anesthesiologist rules, that we carefully consider how these revisions might impact teaching Certified Registered Nurse Anesthetists (CRNAs). The AANA commented that our rules should not favor one type of provider over another.

Response: Surgical services are paid differently than anesthesia services. For example, surgical codes usually have global periods and payment includes the payment for the surgical procedure and postoperative visits during the global period. Anesthesia services include the preanesthesia examination and evaluation, the anesthesia service associated with the surgical service, and immediate postanesthesia care. Currently, the teaching physician's presence during the key or critical period criteria applies to both the services of the teaching surgeon and the teaching anesthesiologist. The key or critical services are different for the service of each specialty.

We plan to explore these issues further prior to deciding whether to include this change in the proposed rule for 2006.

Comment: We received comments from a manufacturer, many providers and individuals requesting that new HCPCS codes be created for a specific laser surgery treatment for benign prostatic hyperplasia. Commenters stated that current CPT codes used for billing this service under the physician fee schedule are not specific to the unique technology involved with this laser surgery treatment and result in underpayment when this technology is used. They noted that under the hospital OPPS, this treatment was assigned to a new technology code.

We also received requests from other individuals for new G codes and payment for other specific services, and for certain HCPCS codes that currently are paid only under OPPS.

Response: We do not believe that it is necessary to create new HCPCS codes for these services. Commenters that believe the existing CPT codes do not reflect their technology or services, may contact the AMA's CPT Editorial Panel to review these matters, particularly since the CPT Editorial Panel has a new coding classification specifically for new and emerging technologies.

There will be situations where codes are used under OPPS but not recognized under the physician fee schedule (PFS) because of the different payment methodologies.

Comment: A specialty society urged us to discontinue use of the HCPCS codes for positron emission tomography (PET) procedures and to instruct physicians to use the available CPT codes. They also urged us to adopt RUC recommendations for new PET codes rather than carrier price these services. The commenter stated they would like to meet to discuss these new codes and PET/computed tomography (CT) technology.

Response: We will continue to use HCPCS codes and carrier price these services at this time. We will be examining the overall issue of Medicare coding, payment, and coverage of PET services and would be happy to meet with the specialty society to discuss this issue.

General Issues

We also received comments on issues and concerns that were beyond the scope of the proposed rule. These include: The need for quality standards for diagnostic imaging; concerns about outreach and access; requests for revisions to current policy; and, concerns about the accuracy of code descriptors. While we will try to ensure these comments are provided to appropriate CMS components, commenters should also feel free to contact the appropriate CMS components about their concerns. To the extent that these comments involved valuation of services under the physician fee schedule, we are also soliciting comments on services for which the physician work may be misvalued. See section VI for additional information on this process.

V. Refinement of Relative Value Units for Calendar Year 2005 and Response to Public Comments on Interim Relative Value Units for 2004

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

A. Summary of Issues Discussed Related to the Adjustment of Relative Value Units

Section V.B. and V.C. of this final rule describes the methodology used to review the comments received on the RVUs for physician work and the process used to establish RVUs for new and revised CPT codes. Changes to codes on the physician fee schedule reflected in Addendum B are effective for services furnished beginning January 1, 2005.

B. Process for Establishing Work Relative Value Units for the 2004 Physician Fee Schedule

Our November 7, 2003 final rule (69 FR 1084) contained the work RVUs for Medicare payment for existing

procedure codes under the physician fee schedule and interim RVUs for new and revised codes beginning January 1, 2004. We considered the RVUs for the interim codes to be subject to public comment under the annual refinement process. (Note that the November rule was subsequently revised on January 7, 2004 to reflect revisions to procedure codes required by the MMA.) In this section, we summarize the refinements to the interim work RVUs published in the November 7, 2003 rule and our establishment of the work RVUs for new and revised codes for the 2005 physician fee schedule.

C. Work Relative Value Unit Refinements of Interim Relative Value Units

1. Methodology (Includes Table Titled ''Work Relative Value Unit Refinements of the 2003 Interim and Related Relative Value Units'')

Although the RVUs in the January 2004 final rule were used to calculate 2004 payment amounts, we considered the RVUs for the new or revised codes to be interim. We accepted comments for a period of 60 days. We received substantive comments on approximately 12 CPT codes with interim work RVUs.

To evaluate these comments we used a process similar to the process used since 1997. (See the October 31, 1997 final rule (62 FR 59084) for the discussion of refinement of CPT codes with interim work RVUs.) We convened a multispecialty panel of physicians to assist us in the review of the comments. The comments that we did not submit to panel review are discussed at the end of this section, as well as those that were reviewed by the panel. We invited representatives from the organizations from which we received substantive comments to attend a panel for discussion of the code on which they had commented. The panel was moderated by our medical staff, and consisted of the following voting members:

- One or two clinicians representing the commenting organization.
- One primary care clinician nominated by the American College of Physicians and American Society of Internal Medicine.
- Four carrier medical directors.
- Four clinicians with practices in related specialties who were expected to have knowledge of the service under review.

The panel discussed the work involved in the procedure under review in comparison to the work associated with other services under the physician fee schedule. We assembled a set of 300 reference services and asked the panel members to compare the clinical aspects of the work of the service a commenter believed was incorrectly valued to one or more of the reference services. In compiling the set, we attempted to include: (1) Services that are commonly performed whose work RVUs are not controversial; (2) services that span the entire spectrum from the easiest to the most difficult; and (3) at least three services performed by each of the major specialties so that each specialty would be represented. The intent of the panel process was to capture each participant's independent judgment based on the discussion and his or her clinical experience. Following the discussion, each participant rated the work for the procedure. Ratings were individual and confidential, and there was no attempt to achieve consensus among the panel members.

We then analyzed the ratings based on a presumption that the interim RVUs were correct. To overcome this presumption, the inaccuracy of the interim RVUs had to be apparent to the broad range of physicians participating in each panel.

Ratings of work were analyzed for consistency among the groups represented on each panel. In addition, we used statistical tests to determine whether there was enough agreement among the groups of the panel and whether the agreed-upon RVUs were significantly different from the interim RVUs published in Addendum C of the final rule. We did not modify the RVUs unless there was a clear indication for a change. If there was agreement across groups for change, but the groups did not agree on what the new RVUs should be, we eliminated the outlier group and looked for agreement among the remaining groups as the basis for new RVUs. We used the same methodology in analyzing the ratings that we first used in the refinement process for the 1993 physician fee schedule. The statistical tests were described in detail in the November 25, 1992 final rule (57 FR 55938).

Our decision to convene multispecialty panels of physicians and to apply the statistical tests described above was based on our need to balance the interests of those who commented on the work RVUs against the redistributive effects that would occur in other specialties.

We also received comments on RVUs that were interim for 2004, but for which we did not submit the RVUs to the panel for review for a variety of reasons. These comments and our decisions on those RVUs commented upon are discussed in further detail below.

Table 17 below lists those interim codes reviewed under the refinement panel process described in this section. This table includes the following information:

- CPT Code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- 2004 Work RVU. The work RVUs that appeared in the January 2004 rule are shown for each reviewed code.
- Requested Work RVU. This column identifies the work RVUs requested by commenters.
- 2005 Work RVU. This column contains the final RVUs for physician work.

TABLE 17:

Codes Reviewed Under the Refinement Panel Process

CPT code*	Mod	Descriptor	2004 work RVU	Requested work RVU	2005 work RVU
43752		Nasal/orogastric w/stent	0.68	0.82	0.81
63103		Remove vertebral body add-on	3.90	5.00	4.82

*All CPT codes and descriptions copyright 2004 American Medical Association. All rights reserved and applicable FARS/DFARS clauses apply.

2. Interim 2004 Codes

CPT code 43752 *Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report).*

The RUC recommended a work RVU of 0.82 for this service based on a comparison of this procedure to CPT code 44500, *Introduction of long gastrointestinal tube.* While we agreed that CPT code 43752 is similar in work intensity to CPT code 44500, we believed the intra-service time is more appropriately valued at the 25th percentile (15 minutes of intra-service time vs. 20 minutes of intra-service time). This reduced the total time associated with CPT code 43752 from 30 minutes to 25 minutes. We applied the ratio of the RUC recommended value of 0.82 work RVU over 30 minutes to the revised intra-service time of 25 minutes and assigned 0.68 interim work RVUs for CPT code 43752.

Comment: Commenters disagreed with our decision not to accept the RUC recommended WRVU of 0.82 and with our rejection of the survey time, particularly since this service involves both tube placement and imaging. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2004 multispecialty validation panel ratings, we have assigned 0.81 work RVUs to CPT code 43752.

CPT code 63103 *Vertebral corpectomy (vertebral body resection), partial or complete, lateral extracavitary approach with decompression of spinal cord and/or nerve root(s) (for example, for tumor or retropulsed bone fragments); thoracic or lumbar, each additional segment (List separately in addition to code for primary procedure).*

The RUC recommended a work RVU of 5.00 for this service based on a comparison of this procedure to CPT code 63088, the add-on code for the vertebral corpectomy, thoracic lumbar approach. We stated that it was unclear from the clinical vignettes supplied by the specialty society whether the additional corpectomy would more commonly involve the lumbar or the thoracic region of the spine. There is a significant difference in work intensity associated with the resection of an additional corpus in the thoracic region as opposed to the lumbar region. For this reason we applied the ratio of the reference service (CPT code 63088) to its primary service (CPT code 63087) to CPT code 63101 (primary service associated with CPT 63103) to assign 3.90 interim work RVUs for CPT code 63103.

Comment: Commenters requested that we withdraw the arbitrary reduction of the work RVU for CPT code 63103 stating that the unique aspects of the lateral extracavitary approach make the location in the lumbar and thoracic spine less relevant than the actual exposure of an additional level itself. The commenters stated that in contrast to anterior thoracic or lumbar approaches for vertebral corpectomy, the lateral extracavitary approach requires an unrelated and significantly greater muscle dissection of spinal/paraspinal tissues, as well as an additional rib, transverse process, and pedicle removal with isolation and division of another pair of segmental vessels. Based on these comments, we referred this code to the multispecialty validation panel for review.

Response: As a result of the statistical analysis of the 2004 multispecialty validation panel ratings, we have assigned 4.82 work RVUs to CPT code 63103.

CPT codes 38207 *Transplant preparation of hematopoietic progenitor cells; cryopreservation and storage,* 38208 *Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, without washing,* 38209 *Transplant preparation of hematopoietic progenitor cells; thawing of previously frozen harvest, with washing* 38210 *Transplant preparation of hematopoietic progenitor cells; specific cell depletion within harvest, T-cell depletion,* 38211 *Transplant preparation of hematopoietic progenitor cells; tumor cell depletion,* 38212 *Transplant preparation of hematopoietic progenitor cells; red blood cell removal,* 38213 *Transplant preparation of hematopoietic progenitor cells; platelet depletion,* 38214 *Transplant preparation of hematopoietic progenitor cells; plasma (volume) depletion,* 38215 *Transplant preparation of hematopoietic progenitor cells; cell concentration in plasma, mononuclear, or buffy coat layer.*—These codes were new for CY 2003 but we did not receive the final RUC recommendations in time for inclusion in the final rule. In the December 31, 2002 rule we discussed the interim RUC recommendations and our concerns for removing these codes from the laboratory fee schedule, and paying them instead on the physician fee schedule (67 FR 80007). We received the final RUC recommendations in May 2003 and in the November 7, 2003 final rule we stated we were maintaining a status indicator ''I'' for these services making them not valid for payment under the physician fee schedule. (Note: In the December 31, 2002 rule, as part of the discussion about these CPT codes, we discussed the creation of HCPCS codes G0265, *Cryopreservation, freezing and storage of cells for therapeutic use, each cell line;* G0266 *Thawing and expansion of frozen cells for therapeutic use, each aliquot;* and G0267, *Bone marrow or peripheral stem cell harvest,*

modification or treatment to eliminate cell type(s) (for example, T-cells, metastic carcinoma). We stated that these HCPCS codes are paid under the laboratory fee schedule.)

Comment: We received comments regarding these codes in response to the 2002 and 2003 final rules. Commenters expressed concern, which was shared by the RUC about the CMS decision pertaining to these CPT codes. They stated that CMS was invited to conduct site visits to observe and have a better understanding of these services. They believe such visits would provide additional information on these services and allow for a more informed decision about their placement on the physician fee schedule.

Response: CPT codes 38207, 38208, 38209, 38210, 38211, 38212, 38213, 38214 and 38215 reflect services that are typically provided by laboratory personnel who require general oversight and supervision by a laboratory physician, analogous to a physician providing oversight in a blood banking facility. Based on site visits, we continue to believe that these services are not typically provided by a physician. We recognize that variability pertaining to the clinical and laboratory management of patients does exist and that in some bone marrow transplant centers these laboratory services are closely supervised and managed by physicians. These centers, however, do not reflect the typical practice pattern for the majority of bone marrow transplant centers. Therefore, we will continue to allow use of HCPCS codes G0265 Cryopreservation, freezing and storage of cells for therapeutic use, each cell line and G0266 Thawing and expansion of frozen cells for therapeutic use, each aliquot to report these services, and G0267 Bone marrow or peripheral stem cell harvest, modification or treatment to eliminate cell type(s) (for example, T-cells, metastatic carcinoma). These services are currently on the laboratory fee schedule. We welcome additional comments to help us better determine whether to place CPT codes 38207 through 38215 on either the physician or laboratory fee schedule.

Note: We identified the services provided within transplant centers as clinical services typically provided by a physician in conjunction with the following codes: CPT codes 38205—Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogenic, CPT 38206—Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous, CPT codes 38240—Bone Marrow or bone derived peripheral stem cell transplantation; allogenic, CPT code 38241—Bone Marrow or bone derived peripheral stem cell transplantation; autologous, and CPT code 38242—Bone Marrow or bone derived peripheral stem cell transplantation; allogeneic lymphocyte donor infusions. We believe the physician work RVUs assigned by the RUC to these codes (CPT code 38205–1.50, CPT code 38206–1.50, CPT code 38240–2.24 RVUs, CPT code 38241–2.24 RVUs, and CPT code 38242–1.71 RVUs) appropriately reflect the physician work intensity for each of these services and reaffirm our prior decision announced in 2002. CPT code 38204—Management of recipient hematopoietic progenitor cell donor search and cell acquisition was valued at 2.00 RVUs by the RUC in 2002. We believe there may be physician work when providing this service. However, information obtained during our site visits revealed that the bulk of the service was provided by the transplant coordinator, who worked closely with the physician. It is unclear at this point what the appropriate value will be for the physician who provides this service. We welcome comments on this issue.

CPT code 76514 *Ophthalmic ultrasound, echography, diagnostic; corneal pachymetry, unilateral or bilateral (determination of corneal thickness).*—We accepted the RUC recommendation of 0.17 work RVUs.

Comments: The American Academy of Ophthalmology commented that the assigned work RVU does not accurately reflect the value intended by the RUC or CPT; the value should be doubled. The Academy stated that the problem arose when the RUC recommended to CPT that the descriptor should be changed from unilateral to unilateral or bilateral. The commenter suggested that either the descriptor be changed to reflect only the unilateral, which will take a while to accomplish, or that we increase valuation to correctly reflect valuation by RUC.

Response: Because we have no data that indicates whether the unilateral or bilateral procedure is more typical, we are not changing the RVUs at this time. We would suggest that the Academy contact the CPT Editorial Panel if a change to the descriptor would be helpful to the specialty.

Establishment of Interim Work Relative Value Units for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System Codes (HCPCS) for 2005 (Includes Table Titled ''American Medical Association Specialty Relative Value Update Committee and Health Care Professionals Advisory Committee Recommendations and CMS's Decisions for New and Revised 2005 CPT Codes'')

One aspect of establishing RVUs for 2005 was to assign interim work RVUs for all new and revised CPT codes. As described in our November 25, 1992 notice on the 1993 physician fee schedule (57 FR 55983) and in section III.B. of the November 22, 1996 final rule (61 FR 59505 through 59506), we established a process, based on recommendations received from the AMA's RUC, for establishing interim work RVUs for new and revised codes.

This year we received work RVU recommendations for 149 new and revised CPT codes from the RUC. Our staff and medical officers reviewed the RUC recommendations by comparing them to our reference set or to other comparable services for which work RVUs had previously been established. We also considered the relationships among the new and revised codes for which we received RUC recommendations and agreed with the majority of the relative relationships reflected in the RUC values. In some instances, although we agreed with the relationships, we nonetheless revised the work RVUs to achieve work neutrality within families of codes. That is, the work RVUs have been adjusted so that the sum of the new or revised work RVUs (weighted by projected frequency of use) for a family will be the same as the sum of the current work RVUs (weighted by projected frequency of use) for the family of codes. We reviewed all the RUC recommendations and accepted approximately 99 percent of the RUC recommended values. For approximately 1 percent of the recommendations, we agreed with the relativity established by the RUC, but needed to adjust work RVUs to retain budget neutrality.

We received four recommendations from the HCPAC. We agreed with two of these recommendations and disagreed with two of them.

Table 18, titled ''AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2005 CPT Codes,'' lists the new or revised CPT codes, and their associated work RVUs, that will be interim in 2005. This

table includes the following information:

- A ''#'' identifies a new code for 2005.
- CPT code. This is the CPT code for a service.
- Modifier. A ''26'' in this column indicates that the work RVUs are for the professional component of the code.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC recommendations. This column identifies the work RVUs recommended by the RUC.
- HCPAC recommendations. This column identifies the work RVUs recommended by the HCPAC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in greater detail following this table. An ''(a)'' indicates that no RUC recommendation was provided.
- 2005 Work RVUs. This column establishes the interim 2005 work RVUs for physician work.

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TABLE 18: AMA RUC and HCPAC Recommendations and CMS Decisions for New and Revised 2005 CPT Codes

*CPT CODE	Mod	Description	RUC recommendation	HCPAC recommendation	CMS Decision	2004 work RVU
#11004		Debride genitalia & perineum	10.31	----------	Agree	10.31
#11005		Debride abdom wall	13.75	----------	Agree	13.75
#11006		Debride genit/per/abdom wall	12.61	----------	Agree	12.61
#11008		Remove mesh from abd wall	5.00	----------	Agree	5.00
#19296		Place po breast cath for rad	3.63	----------	Agree	3.63
#19297		Place breast cath for rad	1.72	----------	Agree	1.72
#19298		Place breast rad tube/caths	6.00	----------	Agree	6.00
#27412		Autochondrocyte implant knee	23.23	----------	Agree	23.23
#27415		Osteochondral knee allograft	18.49	----------	Agree	18.49
#29866		Autgrft implnt, knee w/scope	13.88	----------	Agree	13.88
#29867		Allgrft implnt, knee w/scope	17.00	----------	Agree	17.00
#29868		Meniscal trnspl, knee w/scpe	23.59	----------	Agree	23.59
#31545		Remove vc lesion w/scope	6.30	----------	Agree	6.30
#31546		Remove vc lesion scope/graft	9.73	----------	Agree	9.73
#31620		Endobronchial us add-on	1.40	----------	Agree	1.40
31630		Bronchoscopy dilate/fx repr	3.81	----------	Agree	3.81
31631		Bronchoscopy, dilate w/stent	4.36	----------	Agree	4.36
#31636		Bronchoscopy, bronch stents	4.30	----------	Agree	4.30
#31637		Bronchoscopy, stent add-on	1.58	----------	Agree	1.58
#31638		Bronchoscopy, revise stent	4.88	----------	Agree	4.88
#32019		Insert pleural catheter	4.17	----------	Agree	4.17
#32855		Prepare donor lung, single	(a)	----------	(a)	Carrier
#32856		Prepare donor lung, double	(a)	----------	(a)	Carrier
#33933		Prepare donor heart/lung	(a)	----------	(a)	Carrier
#33944		Prepare donor heart	(a)	----------	(a)	Carrier
#34803		Endovas aaa repr w/3-p part	24.00	----------	Agree	24.00
#36475		Endovenous Rf, 1st Vein	6.72	----------	Agree	6.72
#36476		Endovenous rf, vein add-on	3.38	----------	Agree	3.38
#36478		Endovenous Laser, 1st Vein	6.72	----------	Agree	6.72

#36479	Endovenous laser vein addon	3.38	----------	Agree	3.38
#36818	Av fuse, uppr arm, cephalic	11.52	----------	Agree	11.52
36819	Av fuse, uppr arm, basilic	13.98	----------	Agree	13.98
37205	Transcath iv stent, percut	8.27	----------	Agree	8.27
37206	Transcath iv stent/perc addl	4.12	----------	Agree	4.12
#37215	Transcath stent, cca w/eps	18.71	----------	Agree	18.71
#37216	Transcath stent, cca w/o eps	17.98	----------	Agree	17.98
#43257	Uppr gi scope w/thrml txmnt	5.50	----------	Agree	5.50
#43644	Lap gastric bypass/roux-en-y	27.83	----------	Agree	27.83
#43645	Lap gastr bypass incl smll i	29.96	----------	Agree	29.96
#43845	Gastroplasty duodenal switch	Carrier	----------	Agree	Carrier
#44137	Remove intestinal allograft	Carrier	----------	Agree	Carrier
#44715	Prepare donor intestine	(a)	----------	(a)	Carrier
#44720	Prep donor intestine/venous	5.00	----------	Agree	5.00
#44721	Prep donor intestine/artery	7.00	----------	Agree	7.00
#45391	Colonoscopy w/endoscope us	5.09	----------	Agree	5.09
#45392	Colonoscopy w/endoscopic fnb	6.54	----------	Agree	6.54
#46947	Hemorrhoidopexy by stapling	5.20	----------	Agree	5.20
47140	Partial removal, donor liver	54.92	----------	Agree	54.92
47141	Partial removal, donor liver	67.40	----------	Agree	67.40
47142	Partial removal, donor liver	74.89	----------	Agree	74.89
#47143	Prep donor liver, whole	(a)	----------	(a)	Carrier
#47144	Prep donor liver, 3-segment	(a)	----------	(a)	Carrier
#47145	Prep donor liver, lobe split	(a)	----------	(a)	Carrier
#47146	Prep donor liver/venous	6.00	----------	Agree	6.00
#47147	Prep donor liver/arterial	7.00	----------	Agree	7.00
#48551	Prep donor pancreas	(a)	----------	(a)	Carrier
#48552	Prep donor pancreas/venous	4.30	----------	Agree	4.30
#50323	Prep cadaver renal allograft	(a)	----------	(a)	Carrier
#50325	Prep donor renal graft	(a)	----------	(a)	Carrier
#50327	Prep renal graft/venous	4.00	----------	Agree	4.00
#50328	Prep renal graft/arterial	3.50	----------	Agree	3.50
#50329	Prep renal graft/ureteral	3.34	----------	Agree	3.34
50360	Transplantation of kidney	31.48	----------	Agree	31.48
50365	Transplantation of kidney	36.75	----------	Agree	36.75
#50391	Instll rx agnt into rnal tub	1.96	----------	Agree	1.96
50547	Laparo removal donor kidney	25.46	----------	Agree	25.46
#57267	Insert mesh/pelvic flr addon	4.88	----------	Agree	4.88
57282	Colpopexy, extraperitoneal	8.85	----------	Disagree	6.86
#57283	Colpopexy, intraperitoneal	14.00	----------	Disagree	10.84
#58356	Endometrial cryoablation	Carrier	----------	Agree	Carrier
#58565	Hysteroscopy, sterilization	7.02	----------	Agree	7.02
#58956	Bso, omentectomy w/tah	20.78	----------	Agree	20.78
#63050	Cervical laminoplasty	20.75	----------	Agree	20.75
#63051	C-laminoplasty w/graft/plate	24.25	----------	Agree	24.25
#63295	Repair of laminectomy defect	5.25	----------	Agree	5.25
66710	Ciliary transscleral therapy	4.77	----------	Agree	4.77

#66711	Ciliary endoscopic ablation	6.60	----------	Agree	6.60
75960	Transcath iv stent rs&i	0.82	----------	Agree	0.82
76075	Dxa bone density, axial	0.30	----------	Agree	0.30
76076	Dxa bone density/peripheral	0.22	----------	Agree	0.22
#76077	Dxa bone density/v-fracture	0.17	----------	Agree	0.17
#76510	Ophth us, b & quant a	1.55	----------	Agree	1.55
76511	Ophth us, quant a only	0.94	----------	Agree	0.94
76512	Ophth us, b w/non-quant a	0.94	----------	Agree	0.94
76513	Echo exam of eye, water bath	0.66	----------	Agree	0.66
76514	Echo exam of eye, thickness	0.17	----------	Agree	0.17
#76820	Umbilical artery echo	0.50	----------	Agree	0.50
#76821	Middle cerebral artery echo	0.70	----------	Agree	0.70
76827	Echo exam of fetal heart	0.58	----------	Agree	0.58
76828	Echo exam of fetal heart	0.56	----------	Agree	0.56
77750	Infuse radioactive materials	4.90	----------	Agree	4.90
#78811	Tumor imaging (pet), limited	1.54	----------	Agree	1.54
#78812	Tumor image (pet)/skul-thigh	1.93	----------	Agree	1.93
#78813	Tumor image (pet) full body	2.00	----------	Agree	2.00
#78814	Tumor image pet/ct, limited	2.20	----------	Agree	2.20
#78815	Tumorimage pet/ct skul-thigh	2.44	----------	Agree	2.44
#78816	Tumor image pet/ct full body	2.50	----------	Agree	2.50
#79005	Nuclear rx, oral admin	1.80	----------	Agree	1.80
#79101	Nuclear rx, iv admin	1.96	----------	Agree	1.96
79200	Nuclear rx, intracav admin	1.99	----------	Agree	1.99
79300	Nuclr rx, interstit colloid	1.60	----------	Agree	1.60
79440	Nuclear rx, intra-articular	1.99	----------	Agree	1.99
#79445	Nuclear rx, intra-arterial	2.40	----------	Agree	2.40
79999	Nuclear medicine therapy	Carrier	----------	Agree	Carrier
84165	Protein e-phoresis, serum	0.37	----------	Agree	0.37
#84166	Protein e-phoresis/urine/csf	0.37	----------	Agree	0.37
86334	Immunofix e-phoresis, serum	0.37	----------	Agree	0.37
#86335	Immunfix e-phorsis/urine/csf	0.37	----------	Agree	0.37
#88184	Flowcytometry/ tc, 1 marker	0.00	----------	Agree	0.00
#88185	Flowcytometry/tc, add-on	0.00	----------	Agree	0.00
#88187	Flowcytometry/read, 2-8	1.36	----------	Agree	1.36
#88188	Flowcytometry/read, 9-15	1.69	----------	Agree	1.69
#88189	Flowcytometry/read, 16 & >	2.23	----------	Agree	2.23
#88360	Tumor immunohistochem/manual	1.10	----------	Agree	1.10
88361	Tumor immunohistochem/comput	1.18	----------	Agree	1.18
88365	Insitu hybridization (fish)	1.20	----------	Agree	1.20
#88367	Insitu hybridization, auto	1.30	----------	Agree	1.30
#88368	Insitu hybridization, manual	1.40	----------	Agree	1.40
#90465	Immune admin 1 inj, < 8 yrs	0.17	----------	Agree	0.17
#90466	Immune admin addl inj, < 8 y	0.15	----------	Agree	0.15
#90467	Immune admin o or n, < 8 yrs	0.17	----------	Agree	0.17
#90468	Immune admin o/n, addl < 8 y	0.15	----------	Agree	0.15
90471	Immunization admin	0.17	----------	Agree	0.17

90472	Immunization admin, each add	0.15	----------	Agree	0.15
#91034	Gastroesophageal reflux test	0.97	----------	Agree	0.97
#91035	G-esoph reflx tst w/electrod	1.59	----------	Agree	1.59
#91037	Esoph imped function test	0.97	----------	Agree	0.97
#91038	Esoph imped Funct Test > 1h	1.10	----------	Agree	1.10
#91040	Esoph balloon distension tst	0.97	----------	Agree	0.97
#91120	Rectal sensation test	0.97	----------	Agree	0.97
93741	Analyze ht pace device sngl	0.80	----------	Agree	0.80
93742	Analyze ht pace device sngl	0.91	----------	Agree	0.91
#93745	Set-up cardiovert-defibrill	(a)	----------	(a)	Carrier
#93890	Tcd, vasoreactivity study	1.00	----------	Agree	1.00
#93892	Tcd, emboli detect w/o inj	1.15	----------	Agree	1.15
#93893	Tcd, emboli detect w/inj	1.15	----------	Agree	1.15
#94452	Hast w/report	0.31	----------	Agree	0.31
#94453	Hast w/oxygen titrate	0.40	----------	Agree	0.40
#95928	C motor evoked, uppr limbs	1.50	----------	Agree	1.50
#95929	C motor evoked, lwr limbs	1.50	----------	Agree	1.50
95971	Analyze neurostim, simple	0.78	----------	Agree	0.78
95972	Analyze neurostim, complex	1.50	----------	Agree	1.50
95973	Analyze neurostim, complex	0.92	----------	Agree	0.92
#95978	Analyze neurostim brain/1h	3.50	----------	Agree	3.50
#95979	Analyz neurostim brain addon	1.64	----------	Agree	1.64
#97597	Active wound care/20 cm or <	----------	0.58	Agree	0.58
#97598	Active wound care > 20 cm	----------	0.80	Agree	0.80
#97605	Neg press wound tx, < 50 cm	----------	0.55	Disagree	0.00
#97606	Neg press wound tx, > 50 cm	----------	0.60	Disagree	0.00

(a) No Final RUC recommendation provided

\# New CPT codes

* All CPT codes copyright 2005 American Medical Association

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Table 19, which is titled ''AMA RUC ANESTHESIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED 2005 CPT CODES'', lists the new or revised CPT codes for anesthesia and their base units that will be interim in 2005. This table includes the following information:

- CPT code. This is the CPT code for a service.
- Description. This is an abbreviated version of the narrative description of the code.
- RUC Recommendations. This column identifies the base units recommended by the RUC.
- CMS decision. This column indicates whether we agreed or we disagreed with the RUC recommendation. Codes for which we did not accept the RUC recommendation are discussed in grreater detail following this table.
- 2005 Base Units. This column establishes the 2005 base units for these services.

TABLE 19:
AMA RUC ANESTHSIA RECOMMENDATIONS AND CMS DECISIONS FOR NEW AND REVISED CPT CODES

*CPT CODE	Description	RUC recommendation	CMS Decision	2005 Base Units
#00561	Anesth, heart surg <age 1	25.00	Agree	25.00

*All CPT codes copyright 2005 American Medical Association.

New CPT code.

Discussion of Codes for Which There Were No RUC Recommendations or for Which the RUC Recommendations Were Not Accepted

The following is a summary of our rationale for not accepting particular RUC work RVU or base unit recommendations. It is arranged by type of service in CPT order. Additionally, we discuss those CRP codes for which we received no RUC recommendations for physician work RVUs. This summary refers only to work RVUs or base units.

New and Revised Codes for 2005

CPT mode 97605 *Negative pressure wound therapy (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters* and CPT code 97606 *Negative pressure wound therapy* (for example, vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.—The RUC HCPAC review board recommended 0.55 work RVUs for CPT code 97605 and 0.60 work RVUs for CPT code 97606, which we did not accept. We disagree with their recommendation that these services contain physician work and will not assign work RVUs. Further, when the negative pressure wound therapy service does not encompass selective debridement, we consider this service to represent a dressing change and will not make separate payment. When the negative pressure wound therapy service includes the need for selective debridement, we consider the services represented by CPT codes 97605 and 97606 to be bundled into CPT codes 97597 or 97598, the new debridement codes, which will be appropriately billed. We are assigning a status indicator of ''B'' to these two new CPT codes (97605 and 97606), meaning that we will not make separate payment for these services.

CPT code 57282, *Colpopexy, vaginal; extra-peritoneal approach (sacrospinous, iliococcygeus) and CPT code 57283 Colpopexy, vaginal; intra-peritoneal approach (uterosacral, levator myorrhaphy).*—The CPT Editorial Panel revised an existing code (57282) and created a new code (57283) to describe vaginal extra and intraperitoneal colpopexies. The RUC recommended maintaining the current work PVUs of 8.85 for 57282 and recommended 14.00 work PVUs for 57283. Previously, both the extra-peritoneal approach and intra-peritoneal approach were billed under CPT code 57282. Effective January 1, 2005, CPT code 57282 will be used to report colpopexy, vaginal; extra-peritoneal approach, while CPT code 57283 will be used to report colpopexy vaginal; intraperitoneal approach. Although we agree with the relativity established by the RUC, we believe that the work RVUs for CPT code 57282 should have been adjusted to reflect that the intra-peritoneal approach is now being reported using CPT code 57283. In order to retain work neutrality between these two services, we adjusted the work RVUs using the utilization crosswalks provided by the specialty survey to account for the work that was previously associated with performing these procedures when only one code existed. This results in work RVUs of 6.86 for CPT code 57282 and 10.84 work RVUs for CPT code 57283.

We have not received the final recommendations from the RUC on these services and carriers will price these services in 2005.

CPT Code 32855 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; unilateral;* CPT Code 32856 *Backbench standard preparation of cadaver donor lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare pulmonary venous/atrial cuff, pulmonary artery, and bronchus; bilateral;* CPT Code 33933 *Backbench standard preparation of cadaver donor heart/lung allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, and trachea for implantation;* CPT Code 33944 *Backbench standard preparation of cadaver donor heart allograft prior to transplantation, including dissection of allograft from surrounding soft tissues to prepare aorta, superior vena cava, inferior vena cava, pulmonary artery, and left atrium for implantation;* CPT Code 44715 *Backbench standard preparation of cadaver or living donor intestine allograft prior to transplantation, including mobilization and fashioning of the superior mesenteric artery and vein;* CPT Code 47143 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; without trisegment or lobe spilt;* CPT Code 47144 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with trisegment split of whole liver graft into two partial liver grafts (that is, left lateral segment (segments II and III) and right trisegment (segments I and IV through VIII));* CPT Code 47145 *Backbench standard preparation of cadaver donor whole liver graft prior to allotransplantation, including cholecystectomy, if necessary, and dissection and removal of surrounding soft tissues to prepare the vena cava, portal vein, hepatic artery, and common bile duct for implantation; with lobe split of whole liver graft into two partial liver grafts (that is, left lobe (segments II, III, and IV) and right lobe (segments I and V through VIII));* CPT Code 48551 *Backbench standard preparation of cadaver donor pancreas allograft prior to transplantation, including dissection of allograft from surrounding soft tissues, splenectomy, duodenotomy, ligation of bile duct, ligation of mesenteric vessels, and Y-graft arterial anastomoses from iliac artery to superior mesenteric artery and to splenic artery,* CPT Code 50323 *Backbench standard preparation of cadaver donor renal allograft prior to transplantation, including dissection and removal of perinephric fat, diaphragmatic and retroperitoneal attachments, excision of adrenal gland, and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary;* CPT Code 50325 *Backbench standard preparation of living donor renal allograft (open or laparoscopic) prior to transplantation, including dissection and removal of perinephric fat and preparation of ureter(s), renal vein(s), and renal artery(s), ligating branches, as necessary;* and CPT Code 93745 *Initial set-up and programming by a physician of wearable cardioverter-defibrillator includes initial programming of system, establishing baseline electronic ECG, transmission of data to data repository, patient instruction in wearing system and patient reporting of problem or events.*

Establishment of Interim Practice Expense RVUs for New and Revised Physician's Current Procedural Terminology (CPT) Codes and New Healthcare Common Procedure Coding System (HCPCS) Codes for 2005

We have developed a process for establishing interim practice expense RVUs for new and revised codes that is similar to that used for work RVUs. Under this process, the RUC recommends the practice expense direct inputs (the staff time, supplies and equipment) associated with each new code. We then review the recommendations in a manner similar to our evaluation of the recommended work RVUs.

The RUC recommendations on the practice expense inputs for the new and revised 2005 codes were submitted to us as interim recommendations.

We have accepted, in the interim, the practice expense recommendations submitted by the RUC for the codes listed in the table titled ''AMA RUC and HCPAC RVU Recommendations and CMS Decisions for New and Revised 2005 CPT Codes.'' However, we will be reviewing the supplies, including the DNA probes, for the new and revised in situ hybridization codes (CPT 88365, 88367 and 88368) to ensure that the practice expense database accurately reflects the supplies associated with these services.

Other Issues

Comment: The RUC requested that we modify the definition of the ''preservice'' portion for the 0-, 10- and 90-day global periods to state, ''The preservice period includes the physicians' services following the visit at which the decision for surgery is finalized until the time of the operative procedure.'' The current definition of the preservice time for the 0 and 10-day global periods includes the preservice work occurring on the day of surgery, while the 90-day global period includes the preservice work occurring the day before surgery.

Response: We are reluctant to revise the definition of preservice until there is further review of the issue. Though the suggested change in preservice definition for physician work would correspond to the change made in the definition for practice expense purposes, that revision was made at the beginning of the practice expense refinement. It is not clear to us how the relativity would be maintained between existing codes valued under the current definition and new codes valued using an expanded definition of preservice work. In addition, among different procedures, there is most likely much variation in the time period between the decision to perform surgery and the time of the operative procedure. The absence of a specific timeframe could result in an inconsistent application of the definition. However, we would look forward to further discussion with the RUC concerning this issue.

Comment: Solid compensator-based intensity modulated radiation therapy (IMRT) is one of the IMRT technologies currently paid using the radiation therapy CPT code 77418, *Intensity modulated treatment delivery.* For 2005, CPT created a Category III tracking code 0073T, *Compensator-based beam modulation treatment delivery of inverse planned treatment using three or more high resolution (milled or cast) compensatory convergent beam modulated fields, per treatment session.* CPT instructions for CPT code 77418 now specifically exclude this technology.

Physicians performing compensator-based IMRT expressed concern that we generally carrier price tracking codes and that carriers often will not pay for them, considering services reported with a tracking code to be experimental. One commenter requested that, in order to allow payment for solid compensator-based IMRT under the physician fee schedule, we assign RVUs to the new CPT tracking code 0073T.

Response: As noted by the commenters, we generally do not nationally price tracking codes, which are most often used to report new or experimental services. Rather, we designate them as carrier priced until there is sufficient volume and information to develop appropriate RVUs. However, solid compensator based IMRT is an established technology that is currently paid both under the physician fee schedule and in the hospital outpatient department. We are concerned that having this service be reported using a carrier-priced tracking code could have an adverse effect on access to this technology. Therefore, we are assigning interim RVUs to this tracking code. For payment under the physician fee schedule, we will crosswalk the practice expense and malpractice RVUs assigned to CPT code 77418 to the Category III tracking code 0073T. (Note that this is a technical component only service and there are no associated physician work RVUs.)

Comment: For 2005, CPT has eliminated CPT code 79900, *Provision of Therapeutic Radiopharmaceuticals.* We received comments from several organizations and individuals concerning elimination of this CPT code. Commenters requested we either grant a grace period for the CPT code or reinstate the HCPCS code Q3001, *Radioelements for brachytherapy, any type, each,* so that payment can be made under the physician fee schedule.

Response: We are reinstating HCPCS code Q3001 under the physician fee schedule. This service will be carrier priced.

Note that there have been new HCPCS drug administration codes for physicians' services established for CY 2005. Please see section III.E.2 for specific information related to these new HCPCS codes.

VI. Five-Year Refinement of Relative Value Units

[If you choose to comment on issues in this section, please include the caption ''Five Year Refinement of Work Relative Value Units for Calendar Year 2004'' at the beginning of your comments.]

A. Background

The work RVUs were originally developed by a research team at the Harvard School of Public Health in a cooperative agreement with us. Harvard established the work RVUs for almost all fee schedule codes. The RVUs for anesthesia services were based on relative values from the American Society of Anesthesiology. The original RVUs for radiology codes were based on the American College of Radiology relative value scale. The work RVUs reflect the physician's effort in providing a service by accounting for: the physician's time; the technical difficulty of the procedure; the average severity of illness among patients receiving the procedure; and the degree of physical and mental effort required of the physician to perform the procedure.

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less than every 5 years. We initiated the first 5-year review in 1994 and refinements went into effect beginning in 1997. The second 5-year review began in 1999 and refinements went into effect beginning in 2002. It is now time to begin the third 5-year review of the physician work RVUs with the resulting changes being effective beginning in 2007.

As part of the final rule published December 8, 1994 (59 FR 63453), we solicited public comment on all work RVUs for approximately 7,000 CPT and HCPCS codes. The scope of the 5-year review was limited to work values, since at that time, the statute required practice expense and malpractice RVUs be calculated based on 1991 allowed charges and practice expense and malpractice expense shares for the specialties performing the services. Also, the December 8, 1994 final rule

outlined the proposed process for refinement of the work RVUs and provided a suggested format for submission of comments.

We indicated that we were particularly interested in receiving comments on physicians' services for which medical practice had changed since the Harvard surveys were performed, but for which there were no code changes and, therefore, no reconsideration of whether the work RVUs were still accurate. As a result of the December 8, 1994 final rule, we received more than 500 comments on approximately 1,100 codes. Subsequent to review of the comments by our medical staff, comments on approximately 700 codes were forwarded to the AMA's Specialty Society RUC for review. An additional 300 codes identified by our staff as potentially misvalued were also forwarded to the RUC. A process similar to that used for the annual physician fee schedule update was used for evaluating the proposed changes to the work RVUs and a notice discussing these proposed changes was published in the May 3, 1996 **Federal Register** (61 FR 19992). As outlined in this notice, we proposed to increase the work RVUs for 28 percent of the codes; we proposed to maintain the work RVUs for 61 percent of the codes and we proposed to decrease the work RVUs for 11 percent of the codes. (Our proposed work RVUs agreed with the RUC recommendations for 93 percent of the codes.) In response to the May 3, 1996 proposed notice, we received more than 2,900 comments on approximately 133 codes plus all anesthesia services. In order to address these comments, we convened multi-specialty panels of physicians. A detailed discussion of this process, as well as the results of the 5-year review were included in the final rule with comment period published November 22, 1996 (61 FR 59490).

We initiated the second 5-year review by soliciting comments on potentially misvalued work RVUs for all services in the CY 2000 physician fee schedule in the November 2, 1999, final rule (64 FR 59427). We indicated that the scope of the second 5-year review would be restricted to work RVUs, since resource-based malpractice RVUs had only just been implemented in CY 2000, and we were in the middle of transitioning to a fully resource-based system for practice expense RVUs.

In our July 17, 2000 proposed rule (66 FR 31028), we explained the process used to conduct the second 5-year review of work, beginning with the solicitation of comments on services that were potentially misvalued, in our November 2, 1999 final rule with comment period.

We received comments from approximately 30 specialty groups, organizations, and individuals involving over 900 procedure codes. After review by our medical staff, we shared all of the comments we received concerning potentially misvalued services with the RUC.

The RUC submitted work RVU recommendations for all of the codes we forwarded with the exception of the anesthesia codes and conscious sedation codes. We analyzed all of the RUC recommendations and evaluated both the recommended work RVUs and the rationale for the recommendations. If we had concerns about the application of a particular methodology, but thought the recommended work RVUs were reasonable, we verified that the recommended work RVUs were appropriate by using alternative methodologies. We announced our proposed decisions on the revised work RVUs in the proposed notice published June 8, 2001 (66 FR 31028).

Overall, we proposed to accept 92 percent of RUC recommended work RVUs (RVUs or 792 services). Of the RUC recommendations we disagreed with, we proposed to increase the work RVUs for 37 services and decrease the work RVUs for 22 services. We did not accept the RUC recommendations of an increase for 6 services that were previously reviewed by a multi-specialty physician panel in 2000. The Health Care Professional Advisory Committee (HCPAC), an advisory committee to the RUC representing non-physician health professionals, also reviewed a total of 12 services as part of the 5-year review. For 5 of the services reviewed, the HCPAC did not offer a recommendation. Of the remaining 7 services, we proposed to accept the HCPAC recommendations.

Comments received on the June 8, 2001 proposed notice generally supported our proposed changes. In addition, we received more than 125 comments on approximately 39 specific codes plus all the anesthesia services. The majority of these comments addressed the gastrointestinal endoscopy codes and anesthesia services. As with the first 5-year review, we convened a multi-specialty panel of physicians to assist us in the review of the comments. For additional information about this process, the comments received, and the results of the second 5-year review, see the final rule with comment period published November 2, 2001 (66 FR 55285).

B. Scope of the 5-Year Refinement

As with the second 5-year review, we are soliciting comments only on the work RVUs that may be inappropriately valued. The malpractice RVUs were implemented in CY 2000 and revisions to these RVUs are addressed as part of this final rule.

We are not including the practice expense RVUs as part of this refinement. The PEAC, an advisory committee of the RUC, has been providing us with recommendations for refining the direct practice expense inputs (clinical staff, supplies, and equipment) used in calculating the practice expense RVUs for established codes. As discussed in the August 5, 2004 proposed rule, the PEAC held its last meeting March 2004 and future practice expense issues, including the refinement of the remaining codes not addressed by the PEAC, would be handled by the RUC. As we determine the process that will be used to refine the remaining codes, we will also be considering how to address future review of practice expense RVUs. We would also welcome comments on how this might be addressed. However, to the extent that there are changes in physician time or in the number or level of post procedure visits as a result of the 5-year review of work, there would be a potential impact on the practice expense inputs, and we would revise the inputs accordingly.

C. Refinement of Work Relative Value Units

During the first and second 5-year reviews, we relied on public commenters to identify services that were potentially misvalued.

For the third 5-year review, we are again requesting comments on potentially misvalued work RVUs for all services in the CY 2005 physician fee schedule. However, we recognize that this process generally elicits comments focusing on undervalued codes. Therefore, in addition to the codes submitted by commenters, we will also identify codes (especially high-volume codes across specialties) that:

- Are valued as being performed in the inpatient setting, but that are now predominantly performed on an outpatient basis; and
- Were not reviewed by the RUC, (that is, Harvard RVUs are still being used, or there is no information).

Public comments must include the appropriate CPT code (for example, CPT code 90918) and the suggested RVUs (for example, 11.00 RVUs), and evidence that the current work RVU is misvalued. Failure to provide this information may result in our inability

to evaluate the comments adequately. We will consider all comments on all work RVUs in the development of a proposed rule that we intend to publish in 2006. In that rule, we will propose the revisions to work RVUs that we believe are needed. We will then review and analyze the comments received in response to our proposed revisions and publish our decisions in the 2006 final rule.

In addition to internal review and analysis, we propose to share comments we receive on all work RVUs with the RUC, which currently makes recommendations to us on the assignment of RVUs to new and revised CPT codes. This process was used during the last 5-year review, and we believe that it was beneficial. The RUC's perspective will be helpful because of its experience in recommending RVUs for new and revised CPT codes since we implemented the physician fee schedule. Furthermore, the RUC, by virtue of its multispecialty membership and consultation with approximately 65 specialty societies, involves the medical community in the refinement process.

D. Nature and Format of Comments on Work Relative Value Units

While all written public comments are welcomed, based on our past experience we have found it particularly beneficial if the comments include certain information: the CPT code or codes recommended for review, a clinical description of the service(s), the current work RVUs and the suggested work RVUs. Because our initial assumption will be that each code is currently appropriately valued, the commenter may also include some rationale to support the need for review. For example, one approach would be to compare the physician work of each nominated code to the work involved in an analogous service that has higher or lower work RVUs. In other situations, the commenter could demonstrate that there is a rank order anomaly within a family of codes. Another reason for reviewing the physician work involved in a service could be that the physician time or intensity required by the procedure has changed since it was last reviewed, perhaps because of a change in technology or in patient characteristics.

The RUC has also developed more detailed ''Compelling Evidence Standards'' which are used by the RUC as part of their process to determine if a recommendation to change the work RVUs is warranted for a given code. We are including these standards below solely for informational purposes so that commenters are aware what kind of information will be needed to make a successful argument to the RUC for changing work RVUs.

RUC Compelling Evidence Standards

The RUC operates with the initial presumption that the current values assigned to the codes under review are correct. This presumption can be challenged by a society or other organization presenting a compelling argument that the existing values are no longer rational or appropriate for the codes in question. The argument for a change must be substantial and meet the RUC's compelling evidence standards. This argument must be provided in the comment letter to us, and then later to the RUC in writing on the Summary of Recommendation form. The following guidelines may be used to develop a ''compelling argument'' that the published relative value for a service is inappropriately valued:

- Documentation in the peer-reviewed medical literature or other reliable data that there have been changes in physician work due to one or more of the following:

+ Technique
+ Knowledge and technology
+ Patient population
+ Site-of-service
+ Length of hospital stay
+ Physician time

- An anomalous relationship between the code being valued and other codes. For example, if code A describes a service that requires more work than codes B, C, and D, but is nevertheless valued lower. The specialty would need to assemble evidence on service time, technical skill, patient severity, complexity, length of stay and other factors for the code being considered and the codes to which it is compared. These reference services may be both inter- and intra-specialty.
- Evidence that technology has changed physician work that is, diffusion of technology.
- Analysis of other data on time and effort measures, such as operating room logs or national and other representative databases.
- Evidence that incorrect assumptions were made in the previous valuation of the service, as documented, such as:

+ A misleading vignette, survey or flawed crosswalk assumptions in a previous evaluation;

+ A flawed mechanism or methodology used in the previous valuation, for example, evidence that no pediatricians were consulted in assigning pediatric values; and

+ A previous survey was conducted by one specialty to obtain a value, but in actuality that service is currently provided primarily by physicians from a different specialty according to utilization data.

We emphasize, however, as we reiterated for the last 5-year review, that we retain the responsibility for analyzing the comments on the suggested work RVU revisions, developing the proposed rule, evaluating the comments on the proposed rule, and deciding whether to revise RVUs. We are not delegating this responsibility to the RUC or any other organization.

VII. Update to the Codes for Physician Self-Referral Prohibition

[If you choose to comment on issues in this section, please include the caption ''Physician Self-Referral Designated Health Services'' at the beginning of your comments.]

A. Background

Section 1877 of the Act prohibits a physician from referring a Medicare beneficiary for certain designated health services (DHS) to a health care entity with which the physician (or a member of the physician's immediate family) has a financial relationship, unless an exception applies. The following services are DHS, as specified in section 1877 of the Act and in regulations at § 411.351:

- Clinical laboratory services.
- Physical therapy, occupational therapy, and speech-language pathology services.
- Radiology and certain other imaging services.
- Radiation therapy services and supplies.
- Durable medical equipment and supplies.
- Parenteral and enteral nutrients, equipment, and supplies.
- Prosthetics, orthotics, and prosthetic devices and supplies.
- Home health services.
- Outpatient prescription drugs.
- Inpatient and outpatient hospital services.

In § 411.351, the entire scope of the first four of these DHS categories is defined in a list of CPT/HCPCS codes (the Code List), which is updated annually to account for changes in the most recent CPT and HCPCS publications. The updated Code List appears as an addendum to the physician fee schedule final rule and is available on our Web site at *http://cms.hhs.gov/medlearn/refphys.asp.* We also include in the Code List those items and services that may qualify for either of the following two exceptions to the physician self-referral prohibition:

- EPO and other dialysis-related drugs furnished in or by an ESRD facility (§ 411.351(g)).
- Preventive screening tests, immunizations or vaccines (§ 411.351(h)).

The Code List was updated in the physician fee schedule final rule published in the **Federal Register** on November 7, 2003 (68 FR 63196). It was subsequently corrected in a notice that was published in the **Federal Register** on March 26, 2004 (69 FR 15729). We also published the Phase II physician self-referral interim final rule with comment period on March 26, 2004 in the **Federal Register** (69 FR 16054), which made several additional changes to the Code List, effective July 26, 2004.

The updated all-inclusive Code List effective January 1, 2005 is presented in Addendum L of this final rule.

B. Response to Comments

We received two public comments relating to the Code List published in the November 7, 2003 physician fee schedule final rule. One commenter supported the exclusion of interventional radiology services from the definition of radiology and certain other imaging services, as reflected on the Code List. The other commenter raised a concern over the exclusion of nuclear medicine services as a DHS.

Additionally, the proposed physician fee schedule rule that was published on August 5, 2004 in the **Federal Register** (69 FR 47488) generated one comment relating to the Code List. That comment and our response also are provided below. We note that we will address in a separate **Federal Register** document those public comments relating to the Code List that were received in response to the Phase II physician self-referral final rule published on March 26, 2004.

Comment: One commenter requested that we include nuclear medicine services as DHS. The commenter is concerned that physicians may engage in lucrative financial relationships associated with nuclear medicine studies such as PET scans.

Response: We are mindful of the issue raised by the commenter, and we continue to consider the application of section 1877 of the Act to nuclear medicine procedures. However, we note that the purpose of this update is merely to conform the Code List to the most recent publications of HCPCS and CPT codes. Substantive changes to DHS definitions, such as that advocated by the commenter, are beyond the scope of this rulemaking.

Comment: One commenter asked us to clarify that the Code List does not define all DHS and that we indicate where providers can obtain more information on the remaining categories. Additionally, the commenter suggested that we define all DHS in the Code List and that the definitions be included in the quarterly updated Microsoft Excel spreadsheet of RVU values, global periods and supervision levels for Medicare covered services posted on our Web site.

Response: We believe that most readers are aware that the Code List does not define every DHS category. Nevertheless, we will add a footnote to the Code List indicating that § 411.351 defines those DHS categories not reflected on the Code List.

The comment advocating that we define all DHS by CPT or HCPCS code on the Code List would require a substantive change to existing DHS definitions and is therefore beyond the scope of this rulemaking. We will explore the possibility of identifying certain DHS in the National Physician Fee Schedule Relative Value File (*http://www.cms.hhs.gov/providers/pufdownload/rvudown.asp*).

C. Revisions Effective for 2005

Tables 20 and 21, in this section, identify the additions and deletions, respectively, to the comprehensive Code List included in the Phase II physician self-referral interim final rule published March 26, 2004. Tables 20 and 21 also identify the additions and deletions to the lists of codes used to identify the items and services that may qualify for the exceptions in § 411.355(g) (regarding EPO and other dialysis-related outpatient prescription drugs furnished in or by an ESRD facility) and in § 411.355(h) (regarding preventive screening tests, immunizations and vaccines).

We will consider comments for the codes listed in Tables 20 and 21 below, if we receive them by the date specified in the **DATES** section of this final rule. We will not consider any comment that advocates a substantive change to any of the DHS defined in § 411.351.

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TABLE 20: ADDITIONS TO THE PHYSICIAN SELF-REFERRAL

HCPCS/CPT[1] CODES	
CLINICAL LABORATORY SERVICES	
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
36415	Routine venipuncture
PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES	
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
G0329	Electromagntic tx for ulcers
RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES	
76077	Dxa bone density/v-fracture
76510	Ophth us, b & quant a
76820	Umbilical artery echo
76821	Middle cerebral artery echo

93890 Tcd, vasoreactivity study

93892 Tcd, emboli detect w/o inj

0067T Ct colonography;dx

Q0092 Set up port xray equipment

RADIATION THERAPY SERVICES AND SUPPLIES

19296 Place po breast cath for rad

19297 Place breast cath for rad

19298 Place breast rad tube/caths

57155 Insert uteri tandems/ovoids

58346 Insert Heyman uteri capsule

0073T Delivery, comp imrt

0082T Stereotactic rad delivery

0083T Stereotactic rad tx mngmt

DRUGS USED BY PATIENTS UNDERGOING DIALYSIS

[no additions]

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

80061 Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

82465 Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

82947 Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]

82950 Glucose test [only when billed with ICD-9-CM code V77.1]

82951 Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]

83718 Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

84478 Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]

90656 Flu vaccine no preserv 3 & >

[1]CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

TABLE 21: DELETIONS TO THE PHYSICIAN SELF-REFERRAL HCPCS/CPT[1] CODES

CLINICAL LABORATORY SERVICES

G0001 Drawing blood for specimen

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY SERVICES

97601 Wound(s) care, selective

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

[no deletions]

RADIATION THERAPY SERVICES AND SUPPLIES

50559 Renal endoscopy/radiotracer

DRUGS USED BY PATIENTS UNDERGOING DIALYSIS

[no deletions]

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

[no deletions]

[1]CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

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The additions specified in Table 20 generally reflect new CPT and HCPCS codes that become effective January 1, 2005 or that became effective since our last update. It also reflects the addition of codes that will be recognized by Medicare for payment purposes effective January 1, 2005.

Additionally, we are adding HCPCS code Q0092 to the category of radiology and certain other imaging services since it may be billed in conjunction with the provision of portable x-ray services and had been inadvertently omitted.

We are also adding two existing brachytherapy codes (CPT 57155 and 58346) to the category of radiation therapy services and supplies. As noted in the March 26, 2004 Phase II physician self-referral interim final rule (69 FR at 16104–16105), brachytherapy is a DHS. We inadvertently omitted these codes when compiling the Code List.

Table 20 also reflects the addition of a flu vaccine code (CPT 90656), CV screening blood tests (CPT 80061, 82465, 83718 and 84478) and diabetes screening tests (CPT 82947, 82950 and 82951) to the list that identifies preventive screening tests, immunizations and vaccines that may qualify for the exception described in § 411.355(h) for such items and services. The physician self-referral prohibition will not apply to these services if the conditions set forth in § 411.355(h) are satisfied. We note that CPT codes 80061, 82465, 83718, 84478, 82947, 82950, and 82951 are eligible for the exception at § 411.355(h) only when billed with the appropriate screening diagnosis codes specified on the Code List for each test.

Table 21 reflects the deletions necessary to conform the Code List to the most recent publications of CPT and HCPCS codes.

VIII. Physician Fee Schedule Update for Calendar Year 2005

A. Physician Fee Schedule Update

The physician fee schedule update is determined using a formula specified by statute. Under section 1848(d)(4) of the Act, the update is equal to the product of 1 plus the percentage increase in the MEI (divided by 100) and 1 plus the update adjustment factor (UAF). For CY 2005, the MEI is equal to 3.1 percent (1.031). The UAF is −7.0 percent (0.930). Section 1848(d)(4)(F) of the Act requires an additional 0.8 percent (1.008) increase to the update for 2005. The product of the MEI (1.031), the UAF (0.930), and the statutory adjustment factor (1.008) equals the CY 2005 update of −3.3 percent (0.967). However, section 601 of the MMA amended section 1848(d) of the Act to specify that the update to the single CF for 2005 cannot be less than 1.5 percent. Because the statutory formula will yield an update of −3.3 percent, consistent with section 601 of the MMA, we are establishing a 2005 physician fee schedule update of 1.5 percent.

Our calculations of all of the above figures are explained below.

B. The Percentage Change in the Medicare Economic Index Medicare Economic Index (MEI)

The MEI measures the weighted-average annual price change for various inputs needed to produce physicians' services. The MEI is a fixed-weight input price index, with an adjustment for the change in economy-wide multifactor productivity. This index, which has 2000 base year weights, is comprised of two broad categories: physician's own time and physician's practice expense.

The physician's own time component represents the net income portion of business receipts and primarily reflects the input of the physician's own time into the production of physicians' services in physicians' offices. This category consists of two subcomponents: wages and salaries, and fringe benefits.

The physician's practice expense category represents nonphysician inputs used in the production of services in physicians' offices. This category consists of wages and salaries and fringe benefits for nonphysician staff and other nonlabor inputs. The physician's practice expense component also includes the following categories of nonlabor inputs: office expense, medical materials and supplies, professional liability insurance, medical equipment, professional car, and other expenses. The components are adjusted to reflect productivity growth in physicians' offices by the 10-year moving average of multifactor productivity in the private nonfarm business sector. The Table 22 below presents a listing of the MEI cost categories with associated weights and percent changes for price proxies for the 2005 update. For calendar year 2005, the increase in the MEI is 3.1 percent, which includes a 0.9 percent change in the 10-year moving average of multifactor productivity. This result is the result of a 3.0 percent increase in Physician's Own Time and a 5.2 percent increase in Physician's Practice Expense. Within the Physician's Practice Expense, the largest increase occurred in Professional Liability Insurance, which increased 23.9 percent.

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TABLE 22:

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]		
Cost Categories and Price Measures	CY 2000 Weights[2]	CY 2005 Percent Changes
Medicare Economic Index Total, productivity adjusted	n/a	3.1
Productivity: 10-year moving average of multifactor productivity, private nonfarm business sector*	n/a	0.9
Medicare Economic Index Total, without productivity adjustment	100.000	4.0
1. Physician's Own Time[3]	52.466	3.0
a. Wages and Salaries: Average Hourly Earnings, private nonfarm	42.730	2.1
b. Fringe Benefits: Employment Cost Index, benefits, private nonfarm	9.735	6.8
2. Physician's Practice Expense[3]	47.534	5.2
a. Nonphysician Employee Compensation	18.653	3.8
1. Wages and Salaries: Employment Cost Index, wages and salaries, weighted by occupation	13.808	3.0

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]		
2. Fringe Benefits: Employment Cost Index, fringe benefits, white collar	4.845	6.1
b. Office Expense: Consumer Price Index for Urban Areas (CPI-U), housing	12.209	2.3
c. Drugs and Medical Materials and Supplies	4.319	4.0
1. Medical Materials and Supplies: Producer Price Index (PPI), surgical appliances and supplies/CPI-U, medical equipment and supplies (equally weighted)	2.011	2.0
2. Pharmaceuticals: Producer Price Index (PPI ethical prescription drugs)	2.308	5.6
d. Professional Liability Insurance: Professional liability insurance premiums[4]	3.865	23.9
e. Medical Equipment: PPI, medical instruments and equipment	2.055	1.9
f. Other Expenses	6.433	1.4

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]
* As of September 22, 2004, Bureau of Labor Statistics had not released the estimates of nonfarm multifactor productivity growth for 2002. Therefore, we used the most recently available information (thru CY 2001) to develop the productivity adjustment for the CY 2005 update. This produces a productivity adjustment that is equivalent to the one used in the CY 2004 update.
1 The rates of historical change are estimated for the 12-month period ending June 30, 2004, which is the period used for computing the CY 2005 update. The price proxy values are based upon the latest available Bureau of Labor Statistics data as of September 22, 2004.
2 The weights shown for the MEI components are the 2000 base-year weights, which may not sum to subtotals or totals because of rounding. The MEI is a fixed-weight, Laspeyres-type input price index whose category weights indicate the distribution of expenditures among the inputs to physicians' services for CY 2000. To determine the MEI level for a given year, the price proxy level for each component is multiplied by its 2000 weight. The sum of these products (weights multiplied by the price index levels) over all cost categories yields the composite MEI level for a given year. The annual percent change in the MEI levels is an estimate of price change over time for a fixed market basket of inputs to physicians' services.
3 The measures of productivity, average hourly earnings, Employment Cost Indexes, as well as the various Producer and Consumer Price Indexes can be found on the Bureau of Labor Statistics website- *http://stats.bls.gov*.

INCREASE IN THE MEDICARE ECONOMIC INDEX UPDATE FOR CALENDAR YEAR 2005[1]	
4	Derived from data collected from several major insurers (the latest available historical percent change data are for the period ending second quarter of 2004).
n/a	Productivity is factored into the MEI categories as an adjustment to the price variables; therefore, no explicit weight exists for productivity in the MEI.

C. The Update Adjustment Factor

Section 1848(d) of the Act provides that the physician fee schedule update is equal to the product of the MEI and a UAF. The UAF is applied to make actual and target expenditures (referred to in the statute as ''allowed expenditures'') equal. Allowed expenditures are equal to actual expenditures in a base period updated each year by the sustainable growth rate (SGR). The SGR sets the annual rate of growth in allowed expenditures and is determined by a formula specified in section 1848(f) of the Act.

1. Calculation Under Current Law

Under section 1848(d)(4)(B) of the Act, the UAF for a year beginning with 2001 is equal to the sum of the following—

• Prior Year Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services for the prior year (the year prior to the year for which the update is being determined) and the amount of the actual expenditures for those services for that year;

+ Dividing that difference by the amount of the actual expenditures for those services for that year; and

+ Multiplying that quotient by 0.75.

• Cumulative Adjustment Component. An amount determined by—

+ Computing the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services from April 1, 1996, through the end of the prior year and the amount of the actual expenditures for those services during that period;

+ Dividing that difference by actual expenditures for those services for the prior year as increased by the sustainable growth rate for the year for which the update adjustment factor is to be determined; and

+ Multiplying that quotient by 0.33.

Section 1848(d)(4)(E) of the Act requires the Secretary to recalculate allowed expenditures consistent with section 1848(f)(3) of the Act. Section 1848(f)(3) specifies that the SGR (and, in turn, allowed expenditures) for the upcoming CY (2005 in this case), the current CY (2004) and the preceding CY (2003) are to be determined on the basis of the best data available as of September 1 of the current year. Allowed expenditures are initially estimated and subsequently revised twice. The second revision occurs after the CY has ended (that is, we are making the final revision to 2003 allowed expenditures in this final rule). Once the SGR and allowed expenditures for a year have been revised twice, they are final.

Table 23 shows annual and cumulative allowed expenditures for physicians' services from April 1, 1996 through the end of the current CY, including the transition period to a CY system that occurred in 1999. Also shown is the SGR corresponding with each period. The calculation of the SGR is discussed in detail below.

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TABLE 23:

Period	Annual Allowed Expenditures ($ in billions)	Annual Actual Expenditures ($ in billions)	Cumulative Allowed Expenditures ($ in billions)	Cumulative Actual Expenditures ($ in billions)	FY/CY SGR
4/1/96-3/31/97	$48.9	$48.9	$48.9	$48.9	N/A
4/1/97-3/31/98	50.5	49.4	99.4	98.4	FY 1998=3.2%
4/1/98-3/31/99	52.6	50.5	152.0	148.9	FY 1999=4.2%
1/1/99-3/31/99	13.3	13.1	([1])	148.9	FY 1999=4.2%
4/1/99-12/31/99	42.1	39.5	([2])	188.4	FY 2000=6.9%
1/1/99-12/31/99	55.3	52.6	194.1	188.4	FY 1999/2000[(3)]
1/1/00-12/31/00	59.4	58.1	253.4	246.5	CY 2000=7.3%
1/1/01-12/31/01	62.0	66.3	315.5	312.9	CY 2001=4.5%
1/1/02-12/31/02	67.2	71.0	382.6	383.8	CY 2002=8.3%
1/1/03-12/31/03	72.1	76.8	454.6	460.6	CY 2003=7.3%
1/1/04-12/31/04	77.1	84.9	531.8	545.5	CY 2004=7.0%

1/1/05-12/31/05	80.4	N/A	612.2	N/A	CY 2005=4.3%

(1) Allowed expenditures for the first quarter of 1999 are based on the FY 1999 SGR.

(2) Allowed expenditures for the last three quarters of 1999 are based on the FY 2000 SGR.

(3) Allowed expenditures in the first year (April 1, 1996--March 31, 1997) are equal to actual expenditures. All subsequent figures are equal to quarterly allowed expenditure figures increased by the applicable SGR. Cumulative allowed expenditures are equal to the sum of annual allowed expenditures. We provide more detailed quarterly allowed and actual expenditure data on our website under the Medicare Office of the Actuary's (OACT) publications at the following address: http://www.cms.hhs.gov/statistics/actuary/. We expect to update the website with the most current information later this month.

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Consistent with section 1848(d)(4)(E) of the Act, Table 23 includes our final revision of allowed expenditures for 2003, a recalculation of allowed expenditures for 2004, and our initial estimate of allowed expenditures for 2005. To determine the update adjustment factor for 2005, the statute requires that we use allowed and actual expenditures from April 1, 1996 through December 31, 2004 and the 2005 SGR. Consistent with section 1848(d)(4)(E) of the Act, we will be making further revisions to the 2004 and 2005 SGRs

and 2004 and 2005 allowed expenditures. Because we have incomplete actual expenditure data for 2004, we are using an estimate for this period. Any difference between current estimates and final figures will be taken into account in determining the update adjustment factor for future years.

We are using figures from Table 23 in the statutory formula illustrated below:

UAF = Update Adjustment Factor
$Target_{04}$ = Allowed Expenditures for 2004 or $77.1 billion
$Actual_{04}$ = Estimated Actual Expenditures for 2004 = $84.9 billion
$Target_{4/96–12/04}$ = Allowed Expenditures from 4/1/1996–12/31/2004 = $531.8 billion
$Actual_{4/96–12/04}$ = Estimated Actual Expenditures from 4/1/1996–12/31/2003 = $545.5 billion
SGR_{05} = 4.3 percent (1.043)

Section 1848(d)(4)(D) of the Act indicates that the UAF determined under section 1848(d)(4)(B) of the Act for a year may not be less than −0.070 or greater than 0.03. Since −0.120 is less than −0.070, the UAF for 2005 will be −0.070.

Section 1848(d)(4)(A)(ii) of the Act indicates that 1 should be added to the UAF determined under section 1848(d)(4)(B) of the Act. Thus, adding 1 to −0.070 makes the update adjustment factor equal to 0.930.

IX. Allowed Expenditures for Physicians' Services and the Sustainable Growth Rate

A. Medicare Sustainable Growth Rate

The SGR is an annual growth rate that applies to physicians' services paid by Medicare. The use of the SGR is intended to control growth in aggregate Medicare expenditures for physicians' services. Payments for services are not withheld if the percentage increase in actual expenditures exceeds the SGR. Rather, the physician fee schedule update, as specified in section 1848(d)(4) of the Act, is adjusted based on a comparison of allowed expenditures (determined using the SGR) and actual expenditures. If actual expenditures exceed allowed expenditures, the update is reduced. If actual expenditures are less than allowed expenditures, the update is increased.

Section 1848(f)(2) of the Act specifies that the SGR for a year (beginning with 2001) is equal to the product of the following four factors:

(1) The estimated change in fees for physicians' services.

(2) The estimated change in the average number of Medicare fee-for-service beneficiaries.

(3) The estimated projected growth in real GDP per capita.

(4) The estimated change in expenditures due to changes in law or regulations.

In general, section 1848(f)(3) of the Act requires us to publish SGRs for 3 different time periods, no later than November 1 of each year, using the best data available as of September 1 of each year. Under section 1848(f)(3)(C)(i) of the Act, the SGR is estimated and subsequently revised twice (beginning with the FY and CY 2000 SGRs) based on later data. (There were also provisions in the Act to adjust the FY 1998 and FY 1999 SGRs. See the February 28, 2003 **Federal Register** (68 FR 9567) for a discussion of these SGRs). Under section 1848(f)(3)(C)(ii) of the Act, there are no further revisions to the SGR once it has been estimated and subsequently revised in each of the 2 years following the preliminary estimate. In this final rule, we are making our preliminary estimate of the 2005 SGR, a revision to the 2004 SGR, and our final revision to the 2003 SGR.

B. Physicians' Services

Section 1848(f)(4)(A) of the Act defines the scope of physicians' services covered by the SGR. The statute indicates that ''the term ''physicians' services'' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.'' We published a definition of physicians' services for use in the SGR in the **Federal Register** (66 FR 55316) on November 1, 2001. We defined physicians' services to include many of the medical and other health services listed in section 1861(s) of the Act. For purposes of determining allowed expenditures, actual expenditures, and SGRs through December 31, 2002, we have specified that physicians' services include the following medical and other health services if bills for the items and services are processed and paid by Medicare carriers (and those paid through intermediaries where specified):

- Physicians' services.
- Services and supplies furnished incident to physicians' services.
- Outpatient PT services and outpatient OT services.
- Antigens prepared by, or under the direct supervision of, a physician.
- Services of PAs, certified registered nurse anesthetists, CNMs, clinical psychologists, clinical social workers, NPs, and CNSs.
- Screening tests for prostate cancer, colorectal cancer, and glaucoma.
- Screening mammography, screening pap smears, and screening pelvic exams.
- Diabetes outpatient self-management training services.
- Medical nutrition therapy services.
- Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests (including outpatient diagnostic laboratory tests paid through intermediaries).
- X-ray, radium, and radioactive isotope therapy.
- Surgical dressings, splints, casts, and other devices used for the reduction of fractures and dislocations.
- Bone mass measurements.

Sections 611 through 613 of the MMA, respectively, modified section 1861(s) of the Act to add Medicare coverage for an initial preventive exam,

CV screening blood tests, and diabetes screening tests. We believe that these services are commonly performed or furnished by a physician or in a physician's office and are including them in the definition of physicians' services for purposes of the SGR.

Comment: We received a number of comments requesting that we use our administrative authority to remove drugs from the SGR. According to one of these comments, drugs are not physicians' services and should never have been included in the SGR. One of these comments indicated that the SGR ''is a seriously flawed formula that will continue to require frequent Congressional intervention to avoid payment cuts * * *'' According to this comment, ''the Administration should reduce the price tag and help pave the way for an appropriate long-term solution by removing drugs from the SGR pool.'' We also received a number of comments suggesting that we use our administrative authority to adjust the SGR for changes in spending associated with national coverage determinations (NCDs).

Response: We remain concerned about forecasts of reductions in physician fees and will carefully consider the issues raised by the comments when we make changes to the physician fee schedule for 2006. We believe that the physician payment system should be structured to control costs and achieve predictable and stable changes to Medicare's rates while being equitable to physicians. We note that administrative changes affecting the SGR would have significant long-term cost implications but will not have an impact on the update for 2006 or the subsequent few years. Therefore, without a statutory change, there will still be a reduction in physicians' fee schedule rates for 2006 and subsequent years. Towards those goals, we have already taken several actions that will improve Medicare's physician payment system:

- Using multifactor productivity in place of labor productivity in the MEI beginning in 2003. This change increased the physician fee schedule update by 0.7 percentage points for 2003 and was estimated to increase Medicare spending by $14.5 billion over 10 years.
- Increasing the weight of malpractice costs in the MEI from 3.2 to 3.9 percent, a 21 percent increase beginning in 2004.
- Incorporating an increase in malpractice premiums of 16.9 percent into the 2004 MEI and 23.9 percent into the 2005 MEI. The increased weight for malpractice in the MEI makes the index a more accurate representation of inflation in physician office costs.

C. Preliminary Estimate of the SGR for 2005

Our preliminary estimate of the 2005 SGR is 4.3 percent. We first estimated the 2005 SGR in March and made the estimate available to the Medicare Payment Advisory Commission and on our Web site. Table 24 shows that March 2004 and our current estimates of the factors included in the 2005 SGR.

TABLE 24:

Statutory Factors	March Estimate	Current Estimate
Fees	2.6 percent (1.026)	1.3 percent (1.013)
Enrollment	-0.2 percent (0.998)	-0.3 percent (0.997)
Real Per Capita GDP	2.2 percent (1.022)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.0 percent (1.010)
Total	4.6 percent (1.046)	4.3 percent (1.043)

Note: Consistent with section 1848(f)(2) of the Act, the statutory factors are multiplied, not added, to produce the total (that is, $1.013 \times 0.997 \times 1.022 \times 1.010 = 1.37$). A more detailed explanation of each figure is provided below in section H.1.

D. Revised Sustainable Growth Rate for 2004

Our current estimate of the 2004 SGR is 7.0 percent. Table 25 shows our preliminary estimate of the 2004 SGR that was published in the **Federal Register** on November 7, 2003 (68 FR 63249) and our current estimate.

TABLE 25:

Statutory Factors	November 7, 2003 Estimate	Current Estimate
Fees	2.7 percent (1.027)	1.4 percent (1.014)
Enrollment	1.7 percent (1.017)	1.7 percent (1.017)
Real Per Capita GDP	2.8 percent (1.028)	2.2 percent (1.022)
Law and Regulation	0.0 percent (1.000)	1.5 percent (1.015)
Total	7.4 percent (1.074)	7.0 percent (1.070)

A more detailed explanation of each figure is provided below in section H.2.

E. Final Sustainable Growth Rate for 2003

The SGR for 2003 is 7.3 percent. Table 26 shows our preliminary estimate of the SGR published in the **Federal Register** on December 31, 2002 (67 FR 80027), our revised estimate published in the **Federal Register** on November 7, 2003 (67 FR 63249) and the final figures

determined using the latest available data.

TABLE 26:

Statutory Factors	12/31/02 Estimate	11/7/03 Estimate	Final
Fees	2.9 percent (1.029)	2.8 percent (1.028)	2.8 percent (1.028)
Enrollment	1.2 percent (1.012)	2.4 percent (1.024)	2.3 percent (1.023)
Real Per Capita GDP	3.3 percent (1.033)	1.4 percent (1.014)	2.0 percent (1.020)
Law and Reg	0.0 percent (1.000)	0.0 percent (1.000)	0.0 percent (1.000)
Total	7.6 percent (1.076)	6.7 percent (1.067)	7.3 percent (1.073)

A more detailed explanation of each figure is provided below in section H.2.

F. Calculation of 2005, 2004, and 2003 Sustainable Growth Rates

1. Detail on the 2005 SGR

All of the figures used to determine the 2005 SGR are estimates that will be revised based on subsequent data. Any differences between these estimates and the actual measurement of these figures will be included in future revisions of the SGR and allowed expenditures and incorporated into subsequent physician fee schedule updates.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for CY 2005

This factor is calculated as a weighted average of the 2005 fee increases for the different types of services included in the definition of physicians' services for the SGR. Medical and other health services paid using the physician fee schedule are estimated to account for approximately 83.9 percent of total allowed charges included in the SGR in 2005 and are updated using the MEI. The MEI for 2005 is 3.1 percent. Diagnostic laboratory tests are estimated to represent approximately 7.1 percent of Medicare allowed charges included in the SGR for 2005. Medicare payments for these tests are updated by the Consumer Price Index for Urban Areas (CPI–U). However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008.

Drugs are estimated to represent 9.0 percent of Medicare allowed charges included in the SGR in 2005. As indicated earlier in this final rule, sections 303 and 304 of the MMA require Medicare to pay for most drugs at 106 percent of ASP beginning January 1, 2005. We estimated a weighted average change in fees for drugs included in the SGR using the ASP plus 6 percent pricing methodology of −14.7 percent for 2005. Table 27 shows the weighted average of the MEI, laboratory and drug price changes for 2005.

TABLE 27:

	Weight	Update
Physician	0.839	3.1
Laboratory	0.071	0.0
Drugs	0.090	-14.7
Weighted Average	1.000	1.3

We estimate that the weighted-average increase in fees for physicians' services in 2005 under the SGR (before applying any legislative adjustments) will be 1.3 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2004 to 2005

This factor is our estimate of the percent change in the average number of fee-for-service enrollees from 2004 to 2005. Services provided to Medicare+Choice (M+C) plan enrollees are outside the scope of the SGR and are excluded from this estimate. OACT estimates that the average number of Medicare Part B fee-for-service enrollees will decrease by 0.3 percent from 2004 to 2005. Table 28 illustrates how this figure was determined.

TABLE 28:

	2004	2005
Overall	39.041 million	39.547 million
Medicare+Choice	4.671 million	5.275 million
Net	34.370 million	34.272 million
Percent Increase		-0.3 percent

An important factor affecting fee-for-service enrollment is beneficiary enrollment in M+C plans. Because it is difficult to estimate the size of the M+C enrollee population before the start of a calendar year, at this time we do not know how actual enrollment in M+C plans will compare to current estimates. For this reason, the estimate may change substantially as actual Medicare fee-for-service enrollment for 2005 becomes known.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2005

We estimate that the growth in real per capita GDP from 2004 to 2005 will be 2.2 percent. Our past experience indicates that there have also been large changes in estimates of real per capita GDP growth made before the year begins and the actual change in GDP computed after the year is complete. Thus, it is likely that this figure will change as actual information on economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in CY 2005 Compared With CY 2004

There are a number of statutory provisions that will affect the 2005 SGR. As indicated above, sections 303 and 304 of the MMA changed Medicare payment for drugs. These provisions also changed Medicare payments for the administration of drugs. Section 303(a)(1) amended section 1848(c)(2) of the Act to require the Secretary to make a number of changes that increased Medicare payment for drug administration beginning January 1, 2004. These changes permanently increased Medicare payments for drug administration by a weighted average of 110 percent. Section 303(a)(4) of the MMA required an additional transitional adjustment (temporary increase) to Medicare's payment for drug administration of 32 percent for 2004 and 3 percent for 2005. The change in the transitional adjustment of 32 percent for 2004 to 3 percent for 2005 would reduce Medicare payments for drug administration between 2004 and 2005. However, some of this reduction will be lessened because we are also adopting changes to the codes and payment amounts for drug administration based on recommendations from the AMA's CPT Editorial Panel and Relative Value Update Committee (RUC), under the authority of section 1848(c)(2)(J) of the Act. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We are further increasing physician fee schedule payments by paying separately for injections provided on the same day as another physician fee schedule service. We estimate that changes to our policy on injections and the changes to our drug administration payments taken together will increase physician spending by 0.2 percent.

We are also adjusting the SGR to account for OACT's assumptions about predicted physician behavior in response to the payment reductions. OACT assumes that reduced fees are likely to be met by a combination of an increase in volume and a shift in the mix or intensity of services furnished to Medicare beneficiaries so as to offset 30 percent of the payment reduction that would otherwise occur. Because OACT assumes that physicians will offset some of the loss in payments that will occur from changes in Medicare payments for drugs (as described earlier) and drug administration and the change in payment can be attributed to a change in law, we are increasing the SGR by 0.4 percent for this factor. (Discussion may change based on recent decisions.)

There are several other statutory provisions that are estimated to increase Medicare spending for physicians' services under the SGR. Section 413(a) of the MMA establishes a 5 percent increase in the physician fee schedule payment for services provided in physician scarcity areas. Section 413(b) improves the procedures for paying the 10 percent physician fee schedule bonus payment for services provided in health professional shortage areas. We estimate that the provisions of section 413 will increase Medicare physician fee schedule payments by 0.1 percent.

Sections 611 through 613 of the MMA, respectively, provide Medicare coverage for an initial preventive physical examination, CV and diabetes screening tests. We estimate that new Medicare coverage for these preventive services will increase spending for physicians' services under the SGR by 0.3 percent. Taken together, we estimate that all of the statutory provisions for 2005 will increase Medicare spending for physicians' services by 0.5 percent.

Comment: We received comments concerned that we will underestimate the costs associated with the initial preventive physical examination. These comments suggested that we should account for ''both spending due to use of the new or expanded benefit, as well as additional services triggered by implementation of the new benefit.'' We received other comments concerned that we will underestimate the cost of CV and diabetes screening tests because we will use the national coverage determination (NCD) process to decide if any additional tests may be eligible for coverage. The commenters have this concern because we do not adjust the SGR for NCDs.

Response: Our estimates of the costs of the initial preventive physical exam and the CV and diabetes screening tests account for utilization of other Medicare services (preventive and nonpreventive) that may result from coverage of the new preventive services. We also note that our current estimates of the initial preventive examination and CV and diabetes screening tests are based only on our projections without any data on actual use of the benefits. The statute requires us to revise our current estimate of the 2005 SGR no later than November 1, 2005 and to make a final revision to our estimate no later than November 1, 2006. At the time we make the final revision to the 2005 SGR, we will have complete data on use of the new preventive services that will enable us to more accurately reflect these costs in the SGR.

With respect to the comments about use of the NCD process to establish additional CV and diabetes screening tests that will be eligible for Medicare coverage, the regulation lists the common types of tests that are currently

used to screen patients for these conditions. Our adjustment to the SGR will cover all of the costs associated with these new Medicare covered screening tests. However, if we use the NCD process to cover additional tests, we will consider this issue further.

2. Detail on the 2004 SGR

A more detailed discussion of our revised estimates of the four elements of the 2004 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2004

This factor was calculated as a weighted average of the 2004 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

We estimate that services paid using the physician fee schedule account for approximately 83.7 percent of total allowed charges included in the SGR in 2004. These services were updated using the 2004 MEI of 2.9 percent. We estimate that diagnostic laboratory tests represent approximately 7.1 percent of total allowed charges included in the SGR in 2004. Medicare payments for these tests are updated by the CPI–U. However, section 629 of the MMA specifies that diagnostic laboratory services will receive an update of 0.0 percent from 2004 through 2008. We estimate that drugs represent 9.2 percent of Medicare allowed charges included in the SGR in 2004. Historically, Medicare paid for drugs under section 1842(o) of the Act at 95 percent of average wholesale price (AWP). However, with some exceptions, sections 303 and 304 of the MMA generally require Medicare to pay for drugs at 85 percent of the AWP determined as of April 1, 2003 or a specified percentage of AWP based on studies by the Government Accountability Office and the Office of the Inspector General in 2004. (We implemented section 303 and 304 of the MMA in an interim final rule published in the **Federal Register** on January 7, 2004 (see 69 FR 1086). Taking sections 303 and 304 of the MMA into account, we estimate a weighted average change in fees for drugs included in the SGR of −11.7 percent for 2004. Table 29 shows the weighted average of the MEI, laboratory and drug price changes for 2004.

TABLE 29:

	Weight	Update
Physician	0.837	2.9
Laboratory	0.071	0.0
Drugs	0.092	-11.7
Weighted Average	1.000	1.4

After taking into account the elements described in Table 29, we estimate that the weighted-average increase in fees for physicians' services in 2004 under the SGR (before applying any legislative adjustments) will be 1.4 percent. Our November 7, 2003 estimate of this factor was 2.7 percent. The reduction from 2.7 percent to our current estimate of 1.4 percent is primarily due to application of the drug pricing changes required by sections 303 and 304 of the MMA.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2003 to 2004

OACT estimates that the average number of Medicare Part B fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) increased by 1.7 percent in 2004. Table 30 illustrates how we determined this figure.

TABLE 30:

	2003	2004
Overall	38.465 million	39.041 million
Medicare+Choice	4.655 million	4.671 million
Net	33.810 million	34.370 million
Percent Increase		1.7 percent

OACT's estimate of the 1.7 percent change in the number of fee-for-service enrollees, net of M+C enrollment for 2004 compared to 2003, is the same as our original estimate published in the November 7, 2003 final rule (68 FR 63250). While our current projection based on data from 8 months of 2004 is the same as our original estimate when we had no data, it is still possible that our final estimate of this figure will be different once we have complete information on 2004 fee-for-service enrollment.

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2004

We estimate that the growth in real per capita GDP will be 2.2 percent for 2004. Our past experience indicates that there have also been large differences between our estimates of real per capita GDP growth made prior to the year's end and the actual change in this factor. Thus, it is likely that this figure will change further as complete actual information on 2004 economic performance becomes available to us in 2005.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2004 Compared With 2003

There are four statutory provisions that are increasing 2004 Medicare spending relative to 2003. Section 412 of the MMA established a floor of 1.0 on adjustments to the physician work relative value unit for the geographic practice cost index (GPCI) for the years 2004 through 2006. Section 602 of the MMA increases the GPCIs for work, practice expense, and malpractice in Alaska to 1.67. Because these provisions increase the work GPCIs that are below 1.0 to 1.0 and, for services in Alaska, we estimate that sections 412 and 602 of the MMA are increasing 2004 Medicare spending included in the SGR by 0.6 percent. Sections 303 and 304 of the MMA increased Medicare's payments for drug administration in 2004. It further exempted the increases in payment from the budget neutrality provisions of section 1848(c)(2) of the Act. We estimate the section 303 and 304 provisions will increase spending for physicians' services by 0.8 percent in 2004. Taken together, we estimate that statutory provisions are increasing 2004 spending for physicians' services by 1.5 percent (after accounting for rounding).

3. Detail on the 2003 SGR

A more detailed discussion of our revised estimates of the four elements of the 2003 SGR follows.

Factor 1—Changes in Fees for Physicians' Services (Before Applying Legislative Adjustments) for 2003

This factor was calculated as a weighted average of the 2003 fee increases that apply for the different types of services included in the definition of physicians' services for the SGR.

Services paid using the physician fee schedule accounted for approximately 83.0 percent of total Medicare allowed charges included in the SGR for 2003 and are updated using the MEI. The MEI for 2003 was 3.0 percent. Diagnostic laboratory tests represent approximately 7.2 percent of total Medicare allowed charges included in the SGR and are updated by the CPI–U. The CPI–U applied to payments for laboratory services for 2003 was 1.1 percent. Drugs represented approximately 9.8 percent of total Medicare allowed charges included in the SGR for 2003. According to section 1842(o) of the Act, Medicare pays for drugs based on 95 percent of AWP. Using wholesale pricing information and Medicare utilization for drugs included in the SGR, we estimate a weighted average fee increase for drugs of 1.9 percent for 2003. Table 31 shows the weighted average of the MEI, laboratory, and drug price increases for 2003.

TABLE 31:

	Weight	Update
Physician	0.830	3.0
Laboratory	0.072	1.1
Drugs	0.098	1.9
Weighted Average	1.000	2.8

After taking into account the elements described in Table 31, we estimate that the weighted-average increase in fees for physicians' services in 2003 under the SGR (before applying any legislative adjustments) was 2.8 percent.

Factor 2—The Percentage Change in the Average Number of Part B Enrollees From 2002 to 2003

We estimate the increase in the number of fee-for-service enrollees (excluding beneficiaries enrolled in M+C plans) from 2002 to 2003 was 2.3 percent. Our calculation of this factor is based on complete data from 2003. Table 32 illustrates the calculation of this factor.

TABLE 32:

	2002	2003
Overall	38.049 million	38.465 million
Medicare+Choice	5.005 million	4.655 million
Net	33.044 million	33.810 million
Percent Increase		2.3 percent

Factor 3—Estimated Real Gross Domestic Product Per Capita Growth in 2003

We estimate that the growth in real per capita GDP was 2.0 percent in 2003. This figure is a final one based on complete data for 2003.

Factor 4—Percentage Change in Expenditures for Physicians' Services Resulting From Changes in Law or Regulations in 2003 Compared With 2002

There are no statutory or regulatory changes that affect Medicare expenditures for services included in the SGR in 2003.

X. Anesthesia and Physician Fee Schedule Conversion Factors (CF) for Calendar Year 2005

The 2005 physician fee schedule CF will be $37.8975. The 2005 national average anesthesia conversion factor is $17.7594.

Physician Fee Schedule Conversion Factor

Under section 1848(d)(1)(A) of the Act, the physician fee schedule CF is equal to the CF for the previous year multiplied by the update determined under section 1848(d)(4) of the Act. Using this formula would result in a 3.3 percent reduction to the physician fee schedule CF for 2005. However, section 601 of the MMA amended section 1848(d) of the Act to specify that the update to the single CF for 2004 and 2005 will not be less than 1.5 percent. Because the statutory formula will yield a 3.3 percent reduction to the 2005 physician fee schedule CF and the amendments to the statute indicate that the update for 2005 cannot be less than 1.5 percent, we are increasing the physician fee schedule conversion factor by 1.5 percent.

We illustrate the calculation for the 2005 physician fee schedule CF in Table 33 below.

TABLE 33:

2004 Conversion Factor	$37.3374
2005 Update	1.5 percent (1.015)
2005 Conversion Factor	$37.8975

• *Anesthesia Fee Schedule Conversion Factor*

Anesthesia services do not have RVUs like other physician fee schedule services. Therefore, we account for any necessary RVU adjustments through an adjustment to the anesthesia fee schedule CF. The only adjustment we are applying to the anesthesia fee schedule CF for 2005 is the physician fee schedule update. We used the following figures to determine the anesthesia fee schedule CF (see Table 34).

TABLE 34:

2004 Anesthesia Conversion Factor	$17.4969
2005 Update	1.5 percent (1.0150)
2005 Anesthesia Conversion Factor	$17.7594

XI. Telehealth Originating Site Facility Fee Payment Amount Update

Section 1834(m) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001 through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the MEI as defined in section 1842(i)(3) of the Act. The MEI increase for 2005 is 3.1 percent.

Therefore, for CY 2005, the payment amount for HCPCS code ''Q3014, telehealth originating site facility fee'' is 80 percent of the lesser of the actual charge or $21.86. The Medicare telehealth originating site facility fee and MEI increase by the applicable time period is shown in Table 35.

TABLE 35:

Facility Fee	MEI Increase	Period
$20.00	N/A	10/01/2001 - 12/31/2002
$20.60	3.0%	01/01/2003 - 12/31/2003
$21.20	2.9%	01/01/2004 - 12/31/2004
$21.86	3.1%	01/01/2005 - 12/31/2005

XII. Provisions of the Final Rule

The provisions of this final rule restate the provisions of the August 2004 proposed rule, except as noted elsewhere in the preamble.

XIII. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substances of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds

good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

We believe that providing a notice and comment procedure with regard to the RNHCI home benefit would be contrary to the public interest. The RNHCI home benefit provisions were added by the Congress to get a RNHCI benefit to those beneficiaries who are confined to the home. We believe that the Congress intended to provide the benefit to the homebound RNHCI beneficiaries as means of providing a similar home option as is offered to the general Medicare population. However, this expanded benefit is, by statute, a time limited benefit. Any delay in implementation could prevent beneficiaries from utilizing this expanded benefit at all or could seriously impinge on the amount of time they can use the benefit. Therefore, we find good cause to waive notice and comment procedures as contrary to the public interest with regard to the RNHCI home benefit. We are, however, providing a 60-day period for public comment.

XIV. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995 (PRA), we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. In order to fairly evaluate whether OMB should approve an information collection, section 3506(c)(2)(A) of the PRA requires that we solicit comment on the following issues:

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

Section 403.766 Requirements for Coverage/Payment of Home Services

In summary, § 403.766 states the RNHCI provider must submit a written letter of intent to us if they choose to participate in offering the home service benefit.

The burden associated with this requirement is the time and effort of the RNHCI provider to prepare and submit a letter of intention. It is estimated that this two-sentence letter should take no longer than 15 minutes to prepare and submit. There are currently 16 RNHCI providers and, if all elected to participate, it would result in a one-time burden of 4 hours.

We have submitted a copy of this final rule with comment to OMB for its review of the information collection requirements described above. These requirements are not effective until they have been approved by OMB.

Section 410.16 Initial Preventive Physical Examination: Conditions for Limitations on Coverage

In summary, § 410.16 requires the furnishing of education, counseling and referral services as part of an initial preventive physical examination, a written plan for obtaining the appropriate screening and other preventive services which are also covered as separate Medicare B Part services.

The burden associated with this requirement is the time required of the physician or practitioner to provide beneficiaries with education, counseling, and referral services and to develop and provide a written plan for obtaining screening and other preventive services.

While these requirements are subject to the PRA; we believe the burden associated with these requirements to be usual and customary business practice; therefore, the burden for this collection requirement is exempt under 5 CFR 1320.3(b)(2)&(3).

Section 411.404 Criteria for Determining That a Beneficiary Knew That Services Were Excluded From Coverage as Custodial Care or as Not Reasonable and Necessary

In summary, § 411.404 requires that written notice must be given to a beneficiary, or someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

Although this section is subject to the PRA, the burden associated with this requirement is currently captured and accounted for in two currently approved information collections under OMB numbers 0938–0566 and 0938–0781.

Section 418.205 Special Requirements for Hospice Pre-Election Evaluations and Counseling Services

In summary, § 418.205 states that written documentation is required and must be maintained for referral requests and services furnished.

While these information collection requirements are subject to the PRA, the burden associated with them is exempt as defined in 5 CFR 1320.3(b)(2).

If you comment on these information collection and recordkeeping requirements, please mail copies directly to the following: Centers for Medicare & Medicaid Services Office of Strategic Operations and Regulatory Affairs, Attn: Melissa Musotto (CMS–1429–FC) Room C5–13–28, 7500 Security Boulevard, Baltimore, MD 21244–1850; and Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn: Christopher Martin, CMS Desk Officer (CMS–1429–P), *Christopher Martin@omb.eop.gov.* FAX (202) 395–6974.

XV. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the ''DATES'' section of this preamble, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

XVI. Regulatory Impact Analysis

We have examined the impact of this rule as required by Executive Order 12866 (September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 16, 1980 Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), and Executive Order 13132.

Executive Order 12866 (as amended by Executive Order 13258, which merely reassigns responsibilities of duties) directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis must be prepared for final rules with economically significant effects (that is, a final rule that would have an annual effect on the economy of $100 million or more in any 1 year, or would adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities).

As indicated in more detail below, we expect that the physician fee schedule provisions included in this final rule will redistribute more than $100 million in 1 year. We also anticipate that the combined effect of several provisions of the MMA implemented in this final rule will increase spending by more than $100 million. Other MMA provisions implemented in this final rule are expected to reduce spending by more than $100 million. We are considering this final rule to be economically significant because its provisions are expected to result in an increase, decrease or aggregate redistribution of Medicare spending that will exceed $100 million. Therefore, this final rule is a major rule and we have prepared a regulatory impact analysis.

The RFA requires that we analyze regulatory options for small businesses and other entities. We prepare a regulatory flexibility analysis unless we certify that a rule would not have a significant economic impact on a substantial number of small entities. The analysis must include a justification concerning the reason action is being taken, the kinds and number of small entities the rule affects, and an explanation of any meaningful options that achieve the objectives with less significant adverse economic impact on the small entities.

Section 1102(b) of the Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. This analysis must conform to the provisions of section 603 of the RFA. For purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital that is located outside a Metropolitan Statistical Area and has fewer than 100 beds. We have determined that this final rule would have minimal impact on small hospitals located in rural areas. Of 517 hospital-based ESRD facilities located in rural areas, only 40 are affiliated with hospitals with fewer than 100 beds.

For purposes of the RFA, physicians, nonphysician practitioners, and suppliers are considered small businesses if they generate revenues of $6 million or less. Approximately 95 percent of physicians are considered to be small entities. There are about 875,000 physicians, other practitioners and medical suppliers that receive Medicare payment under the physician fee schedule. There are in excess of 20,000 physicians and other practitioners that receive Medicare payment for drugs. As noted previously in this final rule and described further below, we are implementing significant changes to the payments for drugs.) The 20,000 physicians that receive payments for drugs are generally concentrated in the specialties of oncology, urology, rheumatology and infectious disease. Of the physicians in these specialties, approximately 40 percent are in oncology and 45 percent in urology.

For purposes of the RFA, approximately 98 percent of suppliers of durable medical equipment (DME) and prosthetic devices are considered small businesses according to the Small Business Administration's (SBA) size standards. We estimate that 106,000 entities bill Medicare for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) each year. Total annual estimated Medicare revenues for DME suppliers exceed approximately $4.0 billion. Of this amount, approximately $1.6 billion are for DME drugs. These suppliers will be affected by the payment changes being made in this final rule for drugs.

In addition, most ESRD facilities are considered small entities, either based on nonprofit status, or by having revenues of $29 million or less in any year. We consider a substantial number of entities to be affected if the rule is estimated to impact more than 5 percent of the total number of small entities. Based on our analysis of the 785 nonprofit ESRD facilities considered small entities in accordance with the above definitions, we estimate that the combined impact of the changes to payment for renal dialysis services included in this rule would have a 1.6 percent increase in payments relative to current composite rate payments.

The analysis and discussion provided in this section, as well as elsewhere in this final rule, complies with the RFA requirements. Section 202 of the Unfunded Mandates Reform Act of 1995 also requires that agencies assess anticipated costs and benefits before issuing any rule that may result in expenditures in any year by State, local, or tribal governments, in the aggregate, or by the private sector, of $110 million. Medicare beneficiaries are considered to be part of the private sector for this purpose. The net impact of the provisions of this rule, including those related to the MMA, are estimated to result in a savings to beneficiaries of nearly $485 million for FY 2005. However, we note that this savings figure compares FY 2005 beneficiary costs occurring as a result of provisions of this final rule to FY 2005 estimated beneficiary costs in the absence of final rule implementation (that is, the savings figure compare beneficiary costs with implementation of the ASP drug payment provisions to continuing the AWP drug payment methodology). The specific effects of the provisions being implemented in this final rule are explained in greater detail below.

We have examined this final rule in accordance with Executive Order 13132 and have determined that this regulation would not have any significant impact on the rights, roles, or responsibilities of State, local, or tribal governments.

We have prepared the following analysis, which, together with the information provided in the rest of this preamble, meets all assessment requirements. It explains the rationale for and purposes of the rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we use to minimize the burden on small entities. As indicated elsewhere in this final rule, we are refining resource-based practice expense RVUs and making a variety of other changes to our regulations, payments, or payment policy to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. We are also implementing several changes resulting from the MMA, including changes to Medicare payment rates for outpatient drugs, changes to the payment for renal dialysis services, creating new preventive health care benefits and creating incentive payment program improvements for physician scarcity.

We are providing information for each of the policy changes in the relevant sections of this final rule. We are unaware of any relevant Federal rules that duplicate, overlap or conflict with this final rule. The relevant sections of this final rule contain a description of significant alternatives if applicable.

A. Resource-Based Practice Expense and Malpractice Relative Value Units

Under section 1848(c)(2) of the Act, adjustments to RVUs may not cause the amount of expenditures to differ by more than $20 million from the amount of expenditures that would have resulted without such adjustments. We are implementing several changes that would result in a change in expenditures that would exceed $20 million if we made no offsetting adjustments to either the conversion factor or RVUs.

With respect to practice expense RVUs, our policy has been to meet the budget-neutrality requirements in the statute by incorporating a rescaling adjustment in the practice expense methodologies. That is, we estimate the aggregate number of practice expense RVUs that will be paid under current and revised policy in CY 2005. We

apply a uniform adjustment factor to make the aggregate number of revised practice expense RVUs equal the number estimated that would be paid under current policy. While we are continuing to apply this policy for general changes in coding and RVUs, we are increasing aggregate physician fee schedule payments to account for the higher payments for drug administration. These increases in payment are being made under the authority of section 1848(c)(2)(J) of the Act that exempts the changes in payments for drug administration from the budget neutrality requirements of section 1848(c)(2)(B)(iv) of the Act.

Table 36 shows the specialty level impact on payment of the practice expense and malpractice RVU changes being implemented for CY 2005. Our estimates of changes in Medicare revenues for physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. We are using 2003 Medicare claims processed and paid through June 30, 2004, that we estimate are 98.5 percent complete, and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here. The payment impacts reflect averages for each specialty based on Medicare utilization. The payment impact for an individual physician would be different from the average, based on the mix of services the physician provides. The average change in total revenues would be less than the impact displayed here because physicians furnish services to both Medicare and non-Medicare patients and specialties may receive substantial Medicare revenues for services that are not paid under the physician fee schedule. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the physician fee schedule. The table shows only the payment impact on physician fee schedule services.

The column labeled ''NPRM Impacts'' shows the effect of the changes in payment attributable to practice expense and malpractice RVUs from the proposed rule. (*See* 69 FR 47556 through 47559 for a complete description of the payment changes shown in this column). We have also made some additional changes to the practice expense and malpractice RVUs since the proposed rule in response to comments and additional information that became available to us during the comment period. The additional changes in payment based on further refinements of the practice expense RVUs generally have no specialty level impact. The 1 percent increase in payment for vascular surgery shown in the practice expense refinements column is attributed to substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources for CPT code 93880. Similarly, the increase in practice expense RVUs for diagnostic testing facilities is also attributable to the increase in payment for 93880 and 93925 due to the substitution of a vascular ultrasound room for a general ultrasound room in the equipment resources.

The column labeled ''Additional Malpractice RVU Refinements'' show the additional impact of changes in the malpractice expense RVUs since the proposed rule on total payment for physician fee schedule services. As explained earlier, we are making several changes to malpractice RVUs that will change the impacts we illustrated in the proposed rule. We are removing assistants-at-surgery from the Medicare utilization that goes into determining the malpractice RVUs. Relative to the proposed rule, this change will increase total payments to neurosurgeons by nearly 1 percent. We also increased the ISO risk classification for the all physician crosswalk used for podiatry increasing their payments by 1 percent relative to the proposed rule. Several specialty groups, including dermatology commented that the major surgery risk factor should not be used for the dermatology codes. Relative to the proposed rule, payments to dermatologists will decrease by approximately 1 percent as a result of this change. The changes also increase payment to the specialty of allergy/immunology by nearly 1 percent relative to the proposed rule. This increase occurs because we are setting a minimum value of 0.01 malpractice RVUs. In the proposed rule, we did show malpractice RVUs in Addendum B if the rounded RVU equaled 0.0.

The column labeled ''Immunizations/Injections'' shows the impact of making separate payment for injections provided on the same day as another physician fee schedule service and the increase in payment for immunizations. These changes generally benefit those specialties that provide injections and immunizations in their offices. The provision is estimated to increase payment by 2 percent to family practice and by 1 percent to general practice, geriatrics, internal medicine and pediatrics. The column labeled ''Total'' shows the combined percentage change in payments resulting from the practice expense and malpractice RVU changes including those that were described in the proposed rule and the additional changes we are making in this final rule.

As explained in the proposed rule, the practice expense refinements will reduce payments to audiologists by approximately 4 percent. Virtually all of the reduction in payment is due to the refinement of procedure code 92547. We accepted the PEAC recommendation to reduce the clinical staff time of the audiologist involved in this service from 71 minutes to 1 minute. The refinement of clinical staff and equipment resulted in a reduction from 1.15 to 0.08 practice expense RVUs producing the 4 percent reduction in payments shown in table 37. However, this impact assumes no change in how frequently these services are performed. While we received comments suggesting that the code was valued based on only one occurrence of the service, the commenter asserted that it is typically performed more than once per day. Currently, CPT allows it only to be billed once per day. If CPT were to change its policy and the service was billed more frequently, the impact shown in table 37 would be less than shown here.

In the proposed rule, we estimated that payments to vascular surgeons would increase by 3 percent as a result of the repricing of medical equipment used in performing noninvasive vascular diagnostic tests. As indicated above, the total increase in payments including the additional refinements we made to equipment will make the total increase in payment from RVU changes equal to 4 percent. We originally estimated that payments to interventional radiology would increase by 2 percent due practice expense refinements and the establishment of nonfacility pricing for procedure codes 35470 to 35476. Due to additional practice expense RVU refinements, we are now estimating that the total increase in payments will be 3 percent. We are estimating slightly less than a 3.5 percent increase in payment to oral and maxillofacial surgeons from the refinement of medical supplies for procedure codes 21210 and 21215. The estimated impact for this specialty is slightly less than we were estimating for the proposed rule. As we indicated in the proposed rule, the 1 percent decrease in payment to nurse practitioners and geriatricians is

attributed to the refinement of the nonfacility practice expense RVUs for nursing facility visits (procedure codes 99301 through 99316). These impacts are unchanged from the proposed rule.

As we indicated in the proposed rule, the increases for pathology and independent laboratories result from use of a practice expense survey provided by the College of American Pathology (CAP). The increases in the final rule are similar to the figures we estimated for the proposed rule. We further note that independent laboratories receive approximately 20 percent of their total Medicare revenues from physician fee schedule services. The remaining 80 percent of their Medicare revenues are from clinical diagnostic laboratory services that will be unchanged by use of the CAP survey data. Thus, total Medicare revenues to independent laboratories as a result of using the CAP survey will increase by slightly more than 1 percent (or 20 percent of the 6 percent increase in physician fee schedule revenues). There will be little or no impact on all other specialties from use of the CAP survey.

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TABLE 36:
Impact of Practice Expense and Malpractice RVU Changes on Total Medicare Allowed Charges by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Additional Practice Expense Refinements	Additional Malpractice RVU Refinements	Injections Immunizations	Total
Physicians:						
ALLERGY/IMMUNOLOGY	$ 161	-2%	0%	1%	0%	-1%
ANESTHESIOLOGY	$ 1,422	0%	0%	0%	0%	0%
CARDIAC SURGERY	$ 359	0%	0%	1%	0%	1%
CARDIOLOGY	$ 6,579	0%	0%	0%	0%	0%
COLON AND RECTAL SURGERY	$ 110	1%	0%	0%	0%	1%
CRITICAL CARE	$ 130	0%	0%	0%	0%	0%
DERMATOLOGY	$ 1,864	1%	0%	-1%	0%	0%
EMERGENCY MEDICINE	$ 1,687	0%	0%	0%	0%	0%
ENDOCRINOLOGY	$ 279	0%	0%	0%	0%	0%
FAMILY PRACTICE	$ 4,456	0%	0%	0%	2%	1%
GASTROENTEROLOGY	$ 1,634	0%	0%	0%	0%	0%
GENERAL PRACTICE	$ 1,003	0%	0%	0%	1%	1%
GENERAL SURGERY	$ 2,264	1%	0%	0%	0%	1%
GERIATRICS	$ 116	-1%	0%	0%	1%	0%
HAND SURGERY	$ 57	0%	0%	0%	0%	0%
INTERNAL MEDICINE	$ 8,784	0%	0%	0%	1%	1%
INTERVENTIONAL RADIOLOGY	$ 191	2%	1%	0%	0%	3%
NEPHROLOGY	$ 747	1%	0%	0%	0%	1%

NEUROLOGY	$	1,197	0%	0%	0%	0%	0%
NEUROSURGERY	$	492	-1%	0%	1%	0%	0%
NUCLEAR MEDICINE	$	85	0%	0%	0%	0%	0%
OPHTHALMOLOGY	$	4,566	-1%	0%	0%	0%	-1%
ORTHOPEDIC SURGERY	$	2,903	0%	0%	0%	0%	0%
OTOLARNGOLOGY	$	814	0%	0%	0%	0%	0%
PATHOLOGY	$	846	2%	0%	0%	0%	2%
PEDIATRICS	$	60	-1%	0%	0%	1%	0%
PHYSICAL MEDICINE	$	680	0%	0%	0%	0%	0%
PLASTIC SURGERY	$	283	1%	0%	0%	0%	0%
PSYCHIATRY	$	1,109	0%	0%	0%	0%	0%
PULMONARY DISEASE	$	1,446	0%	0%	0%	0%	0%
RADIATION ONCOLOGY	$	1,163	0%	0%	0%	0%	0%
RADIOLOGY	$	4,693	0%	0%	0%	0%	0%
THORACIC SURGERY	$	464	0%	0%	0%	0%	1%
VASCULAR SURGERY	$	487	3%	1%	0%	0%	4%
Practitioners:							
AUDIOLOGIST	$	28	-4%	0%	0%	0%	-4%
CHIROPRACTOR	$	658	-1%	0%	0%	0%	-1%
CLINICAL PSYCHOLOGIST	$	494	0%	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$	317	0%	0%	0%	0%	0%
NURSE ANESTHETIST	$	485	0%	0%	0%	0%	0%
NURSE PRACTITIONER	$	556	-1%	0%	0%	0%	-1%
OPTOMETRY	$	666	0%	0%	0%	0%	0%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	0%	0%	0%	4%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	0%	0%	0%	-2%
PHYSICIAN ASSISTANT	$	414	0%	0%	0%	0%	0%
PODIATRY	$	1,392	-1%	0%	1%	0%	1%
Suppliers:							
DIAGNOSTIC TESTING FACILITY	$	879	1%	1%	0%	0%	2%

INDEPENDENT LABORATORY	$	452	6%	0%	0%	0%	6%	0%	1%	0%
PORTABLE X-RAY SUPPLIER	$	92	0%	0%	0%	0%	0%	0%	0%	0%
Other:										
ALL OTHER	$	93	2%	0%	0%	0%	0%	0%	0%	0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	0%	0%	0%	0%	0%	0%	0%

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As discussed in section II.C of this rule, we are making changes to the malpractice RVUs based on more current malpractice premium data. As anticipated from past revisions to the malpractice RVUs, use of more current malpractice premium data results in minimal impacts on the specialty level payments. The table below shows the impact on total physician fee schedule revenues from the changes to the malpractice RVUs, the additional changes resulting from this final rule and the total impact. See Table 37, ''Impact of Malpractice RVU Changes Proposed Rule and Final Rule'', for a breakdown of the impacts of these revisions on individual specialties. As described above, policies we are adopting in this final rule will increase payments for allergy, neurosurgery and podiatry and decrease payments for dermatology relative to the proposed rule. These changes will also slightly increase payments to cardiac surgery, orthopedic surgery, thoracic surgery and result in a smaller increase in payment for vascular surgery.

Table 37:
Impact Malpractice RVU Changes
Proposed Rule and Final Rule

Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Change due to Final Rule	% Change in Total Payment from MP RVU Changes
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-0.9%	0.8%	-0.1%
ANESTHESIOLOGY	$ 1,422	0.0%	0.0%	0.1%
CARDIAC SURGERY	$ 359	-0.1%	0.5%	0.4%
CARDIOLOGY	$ 6,579	0.0%	-0.2%	-0.1%
COLON AND RECTAL SURGERY	$ 110	0.6%	0.1%	0.7%
CRITICAL CARE	$ 130	0.5%	-0.2%	0.3%
DERMATOLOGY	$ 1,864	0.7%	-0.9%	-0.2%
EMERGENCY MEDICINE	$ 1,687	0.0%	0.0%	0.0%
ENDOCRINOLOGY	$ 279	0.1%	-0.1%	0.0%
FAMILY PRACTICE	$ 4,456	0.0%	-0.1%	-0.1%
GASTROENTEROLOGY	$ 1,634	0.5%	0.1%	0.6%
GENERAL PRACTICE	$ 1,003	0.0%	-0.1%	-0.1%
GENERAL SURGERY	$ 2,264	0.5%	0.1%	0.6%
GERIATRICS	$ 116	0.3%	-0.2%	0.1%
HAND SURGERY	$ 57	-0.1%	0.1%	0.0%
HEMATOLOGY/ONCOLOGY	$ 1,747	0.0%	-0.1%	0.0%
INFECTIOUS DISEASE	$ 401	0.4%	-0.3%	0.1%
INTERNAL MEDICINE	$ 8,784	0.1%	-0.1%	0.0%
INTERVENTIONAL RADIOLOGY	$ 191	0.0%	0.0%	-0.1%
NEPHROLOGY	$ 747	0.1%	-0.1%	0.0%
NEUROLOGY	$ 1,197	0.2%	-0.1%	0.2%
NEUROSURGERY	$ 492	-0.6%	0.9%	0.3%
NUCLEAR MEDICINE	$ 85	-0.1%	0.0%	-0.1%
OBSTETRICS/GYNECOLOGY	$ 582	0.1%	0.0%	0.1%
OPHTHALMOLOGY	$ 4,566	0.0%	0.0%	0.0%
ORTHOPEDIC SURGERY	$ 2,903	-0.4%	0.4%	0.0%
OTOLARNGOLOGY	$ 814	-0.1%	0.0%	-0.1%
PATHOLOGY	$ 846	0.2%	0.0%	0.2%
PEDIATRICS	$ 60	-0.1%	0.0%	0.0%
PHYSICAL MEDICINE	$ 680	0.2%	-0.1%	0.1%
PLASTIC SURGERY	$ 283	0.6%	-0.5%	0.2%
PSYCHIATRY	$ 1,109	0.3%	-0.3%	0.0%
PULMONARY DISEASE	$ 1,446	0.3%	-0.2%	0.1%
RADIATION ONCOLOGY	$ 1,163	0.0%	0.0%	0.0%
RADIOLOGY	$ 4,693	-0.3%	0.0%	-0.3%
RHEUMATOLOGY	$ 412	-0.1%	0.0%	-0.1%
THORACIC SURGERY	$ 464	0.0%	0.4%	0.4%
UROLOGY	$ 1,695	0.0%	0.0%	-0.1%
VASCULAR SURGERY	$ 487	0.1%	0.2%	0.3%
Practitioners:				
AUDIOLOGIST	$ 28	-0.1%	0.1%	0.0%
CHIROPRACTOR	$ 658	-0.2%	0.0%	-0.2%
CLINICAL PSYCHOLOGIST	$ 494	-0.1%	0.0%	-0.1%
CLINICAL SOCIAL WORKER	$ 317	0.0%	0.0%	0.0%

NURSE ANESTHETIST	$	485	0.0%	0.0%	0.0%
NURSE PRACTITIONER	$	556	0.2%	-0.2%	0.1%
OPTOMETRY	$	666	0.2%	-0.1%	0.1%
ORAL/MAXILLOFACIAL SURGERY	$	36	0.6%	0.0%	0.6%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-1.3%	-0.1%	-1.4%
PHYSICIAN ASSISTANT	$	414	-0.1%	0.1%	0.1%
PODIATRY	$	1,392	-0.4%	1.1%	0.7%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	0.0%	0.0%	0.0%
INDEPENDENT LABORATORY	$	452	0.2%	0.0%	0.2%
PORTABLE X-RAY SUPPLIER	$	92	-0.1%	0.0%	-0.1%
Other:					
ALL OTHER	$	93	0.0%	0.0%	0.0%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0.0%	0.0%	0.0%

Section 1848(d) and (f) of the Act requires the Secretary to set the physician fee schedule update under the sustainable growth rate (SGR) system. For 2004 and 2005, the statute requires the update to be no less than 1.5 percent. Using the statutory formula in section 1848(d)(4) will produce an update of less than 1.5 percent for 2005. Therefore, the physician fee schedule update for 2005 will be 1.5 percent. We have included a complete discussion of our methodology for calculating the SGR and physician fee schedule update in another section of this final rule. Table 38 below shows the estimated change in average payments by specialty resulting from changes to the practice expense and malpractice RVUs and the 2005 physician fee schedule update. (Please note that the table does not include the specialties of Hematology/Oncology, Urology, Rheumatology, Obstetrics/Gynecology and Infectious Disease. There are unique issues related to drug administration that will further affect these specialties that are presented in detail below).

Table 38:

Impact of Practice Expense and Malpractice RVU Changes
and Physician Fee Schedule Update on Total Medicare Allowed Charges
by Physician, Practitioner and Supplier Subcategory

Specialty	Medicare Allowed Charges ($ in Millions)	Practice Expense & Malpractice RVU Changes	Physician Fee Schedule Update	Total
Physicians:				
ALLERGY/IMMUNOLOGY	$ 161	-1%	1.5%	1%
ANESTHESIOLOGY	$ 1,422	0%	1.5%	2%
CARDIAC SURGERY	$ 359	1%	1.5%	2%
CARDIOLOGY	$ 6,579	0%	1.5%	2%
COLON AND RECTAL SURGERY	$ 110	1%	1.5%	2%
CRITICAL CARE	$ 130	0%	1.5%	2%
DERMATOLOGY	$ 1,864	0%	1.5%	2%
EMERGENCY MEDICINE	$ 1,687	0%	1.5%	2%
ENDOCRINOLOGY	$ 279	0%	1.5%	2%
FAMILY PRACTICE	$ 4,456	1%	1.5%	3%
GASTROENTEROLOGY	$ 1,634	0%	1.5%	2%
GENERAL PRACTICE	$ 1,003	1%	1.5%	2%
GENERAL SURGERY	$ 2,264	1%	1.5%	2%
GERIATRICS	$ 116	0%	1.5%	1%
HAND SURGERY	$ 57	0%	1.5%	2%
INTERNAL MEDICINE	$ 8,784	1%	1.5%	2%
INTERVENTIONAL RADIOLOGY	$ 191	3%	1.5%	4%
NEPHROLOGY	$ 747	1%	1.5%	2%
NEUROLOGY	$ 1,197	0%	1.5%	2%
NEUROSURGERY	$ 492	0%	1.5%	2%
NUCLEAR MEDICINE	$ 85	0%	1.5%	2%
OPHTHALMOLOGY	$ 4,566	-1%	1.5%	0%
ORTHOPEDIC SURGERY	$ 2,903	0%	1.5%	1%
OTOLARNGOLOGY	$ 814	0%	1.5%	2%
PATHOLOGY	$ 846	2%	1.5%	4%

PEDIATRICS	$	60	0%	1.5%	2%
PHYSICAL MEDICINE	$	680	0%	1.5%	1%
PLASTIC SURGERY	$	283	0%	1.5%	2%
PSYCHIATRY	$	1,109	0%	1.5%	1%
PULMONARY DISEASE	$	1,446	0%	1.5%	2%
RADIATION ONCOLOGY	$	1,163	0%	1.5%	1%
RADIOLOGY	$	4,693	0%	1.5%	2%
THORACIC SURGERY	$	464	1%	1.5%	2%
VASCULAR SURGERY	$	487	4%	1.5%	6%
Practitioners:					
AUDIOLOGIST	$	28	-4%	1.5%	-2%
CHIROPRACTOR	$	658	-1%	1.5%	1%
CLINICAL PSYCHOLOGIST	$	494	0%	1.5%	1%
CLINICAL SOCIAL WORKER	$	317	0%	1.5%	1%
NURSE ANESTHETIST	$	485	0%	1.5%	2%
NURSE PRACTITIONER	$	556	-1%	1.5%	0%
OPTOMETRY	$	666	0%	1.5%	1%
ORAL/MAXILLOFACIAL SURGERY	$	36	4%	1.5%	5%
PHYSICAL/OCCUPATIONAL THERAPY	$	998	-2%	1.5%	-1%
PHYSICIAN ASSISTANT	$	414	0%	1.5%	1%
PODIATRY	$	1,392	1%	1.5%	2%
Suppliers:					
DIAGNOSTIC TESTING FACILITY	$	879	2%	1.5%	3%
INDEPENDENT LABORATORY	$	452	6%	1.5%	8%
PORTABLE X-RAY SUPPLIER	$	92	0%	1.5%	1%
Other:					
ALL OTHER	$	93	1%	1.5%	3%
ALL PHYSICIAN FEE SCHEDULE	$	65,803	0%	1.5%	2%

Table 39 shows the impact on payments for selected high-volume procedures of all of the changes previously discussed. We selected these procedures because they are the most commonly provided procedures by a broad spectrum of physician specialties, or they are of particular interest to the physician community (for example, the initial preventive physical exam and EKG, codes G0344, G0366, G0367 and G0368). We note that the table below shows Medicare payment for the administration of an influenza vaccine, G0008, increasing from $8.21 to $18.57, or 126 percent. As explained earlier, we are establishing the same RVUs for the administration of a vaccine and an injection. For 2005 only, we will pay 3 percent more for the injection ($19.13) because of the transitional adjustment required by section 303. After 2005, the payment for the administration of a vaccine and an injection will be the same. This table shows the combined impact of the change in the practice expense and malpractice RVUs and the estimated physician fee schedule update on total payment for the procedure. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility practice expense RVUs refer to § 414.22(b)(5)(i). The table shows the estimated change in payment rates based on provisions of this final rule and the estimated physician fee schedule update.

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Table 39:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Procedures

			Non-Facility			Facility		
CODE	MOD	DESCRIPTION	Old	New	% Change	Old	New	% Change
11721		Debride nail, 6 or more	$ 38.08	$ 38.66	2%	$ 29.87	$ 29.94	0%
17000		Destroy benign/premlg lesion	$ 60.49	$ 61.39	1%	$ 35.84	$ 45.10	26%
27130		Total hip arthroplasty	N/A	N/A	N/A	$1,370.28	$1,383.26	1%
27244		Treat thigh fracture	N/A	N/A	N/A	$1,115.27	$1,128.97	1%
27447		Total knee arthroplasty	N/A	N/A	N/A	$1,475.95	$1,493.16	1%
33533		CABG, arterial, single	N/A	N/A	N/A	$1,882.18	$1,905.49	1%
35301		Rechanneling of artery	N/A	N/A	N/A	$1,114.89	$1,122.52	1%
43239		Upper GI endoscopy, biopsy	$321.85	$333.88	4%	$ 159.43	$ 162.58	2%
66821		After cataract laser surgery	$240.83	$248.23	3%	$ 237.09	$ 230.42	-3%
66984		Cataract surg w/iol, 1 stage	N/A	N/A	N/A	$ 684.39	$ 684.05	0%
67210		Treatment of retinal lesion	$577.98	$599.54	4%	$ 560.81	$ 573.39	2%
71010	26	Chest x-ray	$ 9.33	$ 9.47	2%	$ 9.33	$ 9.47	2%
76091	26	Mammogram, both breasts	$ 44.80	$ 45.10	1%	$ 44.80	$ 45.10	1%
76091		Mammogram, both breasts	$ 96.33	$ 97.40	1%	N/A	N/A	N/A
76092	26	Mammogram, screening	$ 36.22	$ 36.38	0%	$ 36.22	$ 36.38	0%
76092		Mammogram, screening	$ 84.76	$ 85.65	1%	N/A	N/A	N/A
77427		Radiation tx management, x5	$169.14	$172.05	2%	$ 169.14	$ 172.05	2%
78465	26	Heart image (3d), multiple	$ 76.17	$ 77.31	1%	$ 76.17	$ 77.31	1%
88305	26	Tissue exam by pathologist	$ 41.44	$ 42.07	2%	$ 41.44	$ 42.07	2%
90801		Psy dx interview	$150.84	$153.48	2%	$ 142.26	$ 144.39	1%
90862		Medication management	$ 51.15	$ 52.30	2%	$ 48.17	$ 49.27	2%
90935		Hemodialysis, one evaluation	N/A	N/A	N/A	$ 72.06	$ 73.14	1%
92012		Eye exam established pat	$ 63.47	$ 65.18	3%	$ 36.22	$ 37.14	3%
92014		Eye exam & treatment	$ 93.34	$ 96.26	3%	$ 58.99	$ 60.64	3%
92980		Insert intracoronary stent	N/A	N/A	N/A	$ 812.09	$ 830.33	2%
93000		Electrocardiogram, complete	$ 26.51	$ 27.29	3%	N/A	N/A	N/A
93010		Electrocardiogram report	$ 8.96	$ 9.10	2%	$ 8.96	$ 9.10	2%
93015		Cardiovascular stress test	$106.78	$108.39	2%	N/A	N/A	N/A
93307	26	Echo exam of heart	$ 49.29	$ 49.27	0%	$ 49.29	$ 49.27	0%
93510	26	Left heart catheterization	$252.77	$257.32	2%	$ 252.77	$ 257.32	2%
98941		Chiropractic manipulation	$ 36.22	$ 36.76	1%	$ 31.74	$ 31.83	0%
99203		Office/outpatient visit, new	$ 95.96	$ 97.02	1%	$ 71.69	$ 72.38	1%
99213		Office/outpatient visit, est	$ 52.65	$ 52.68	0%	$ 35.47	$ 35.62	0%
99214		Office/outpatient visit, est	$ 82.14	$ 82.62	1%	$ 57.87	$ 59.12	2%

99222	Initial hospital care	N/A	N/A	N/A	$ 111.27	$ 112.93	1%
99223	Initial hospital care	N/A	N/A	N/A	$ 154.95	$ 157.27	1%
99232	Subsequent hospital care	N/A	N/A	N/A	$ 54.89	$ 56.09	2%
99233	Subsequent hospital care	N/A	N/A	N/A	$ 78.04	$ 79.58	2%
99236	Observ/hosp same date	N/A	N/A	N/A	$ 226.26	$ 223.60	-1%
99239	Hospital discharge day	N/A	N/A	N/A	$ 95.21	$ 96.64	2%
99243	Office consultation	$120.60	$122.79	2%	$ 92.22	$ 93.99	2%
99244	Office consultation	$170.63	$172.81	1%	$ 136.65	$ 138.70	2%
99253	Initial inpatient consult	N/A	N/A	N/A	$ 97.45	$ 98.91	1%
99254	Initial inpatient consult	N/A	N/A	N/A	$ 140.39	$ 142.12	1%
99261	Follow-up inpatient consult	N/A	N/A	N/A	$ 22.40	$ 22.36	0%
99262	Follow-up inpatient consult	N/A	N/A	N/A	$ 44.80	$ 45.48	2%
99263	Follow-up inpatient consult	N/A	N/A	N/A	$ 66.09	$ 67.46	2%
99283	Emergency dept visit	N/A	N/A	N/A	$ 61.61	$ 62.15	1%
99284	Emergency dept visit	N/A	N/A	N/A	$ 95.58	$ 97.02	2%
99291	Critical care, first hour	$242.69	$256.57	6%	$ 203.12	$ 207.68	2%
99292	Critical care, addÏl 30 min	$107.91	$114.07	6%	$ 101.56	$ 104.22	3%
99302	Nursing facility care	$ 97.82	$ 87.92	-10%	$ 82.52	$ 87.92	7%
99303	Nursing facility care	$120.97	$108.39	-10%	$ 102.68	$ 108.39	6%
99312	Nursing fac care, subseq	$ 63.10	$ 56.85	-10%	$ 51.53	$ 56.85	10%
99313	Nursing fac care, subseq	$ 86.25	$ 79.96	-7%	$ 72.43	$ 79.96	10%
99348	Home visit, est patient	$ 75.42	$ 72.01	-5%	N/A	$ 68.22	N/A
99350	Home visit, est patient	$169.89	$165.23	-3%	N/A	$ 160.31	N/A
G0008	Admin influenza virus vac	$ 8.21	$ 18.57	126%	N/A	N/A	N/A
G0317	ESRDrelsvc 4+/mo;20+yr	$303.18	$307.73	2%	$ 303.18	$ 307.73	2%
G0344	Initial preventive exam	N/A	$ 97.40	N/A	N/A	$ 72.76	N/A
G0366	EKG for initial prevent exam	N/A	$ 27.29	N/A	N/A	N/A	N/A
G0367	EKG tracing for initial prev	N/A	$ 17.81	N/A	N/A	N/A	N/A
G0368	EKG interpret & report preve	N/A	$ 9.10	N/A	N/A	$ 9.10	N/A

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Section 303(a)(1) of the MMA amended section 1848(c)(2) of the Act to require increased work and practice expense RVUs for drug administration services. Section 303(a)(4) of the MMA required an additional temporary increase in payment to specific drug administration services of 32 percent for 2004 and 3 percent for 2005. Table 41 shows the payment amounts for selected high-volume drug administration CPT codes from 2002 to 2006 including the effect of the transition adjustment of 32 percent required for 2004 and 3 percent for 2005. Because we may also pay an additional $130 per encounter under the national demonstration project in 2005, we are also including the effect of this additional payment where applicable. Table 42 that follows table 41 shows the payment amount for 2004 and 2005 without the additional transition adjustment required by the MMA and national demonstration payment amount. By showing the payment amounts without the transition and demonstration, we can isolate the permanent change in the payment amounts that is occurring as a result of the MMA, the CPT/RUC review and the physician fee schedule update. The amounts shown in the table include the effect of the 1.5 percent update for 2004 and 2005. As described above, the CPT and RUC have recommended changes to the coding and payment for drug administration services. The CPT/RUC review was undertaken at our request under the authority of section 1848(c)(2)(J) of the Act that requires the Secretary to promptly evaluate existing drug administration codes using existing processes. While this review was completed expeditiously, CPT did not have sufficient time to adopt the coding recommendations into the 2005 version of CPT. For this reason, we are establishing new G-codes for 2005 that correspond with the new CPT codes that will become active in 2006.

Tables 41 and 42 show the payment amounts for the most frequently performed drug administration services from 2002 to 2004 under the CPT codes and payment for the comparable service in 2005 using the G code. For instance, a therapeutic injection was previously billed under the CPT code 90782. This same service will now be billed using HCPCS code G0351. As a result of the RUC review, our acceptance of their recommendations for refinements to the practice expense inputs, our policy of pooling the utilization for the injection with vaccine administration, and the required reduction in the transitional adjustment, payment for this service will be reduced from $24.64 in 2004 to $19.13 in 2005. However, the 2004 transition adjustment largely accounts for the decline. If the transitional adjustment of 32 percent for 2004 and 3 percent for 2005 were not applied, payment for the injection would be virtually the same in 2005 as in 2004, a decline of $0.10 from $18.67 to $18.57. This table shows the permanent large increase in payment for this code from 2002 to 2005. The payment for a therapeutic injection increased from $3.98 in 2002 to $19.13 in 2005, a 381

percent increase (or $18.57 if the transitional adjustment were not applied, a 367 percent increase).

CPT is also recommending separate codes for the administration of hormonal anti-neoplastic subcutaneous/intramuscular (SC/IM) injections from other anti-neoplastic injections. Under the current CPT codes, all anti-neoplastics administered SC/IM are billed using CPT code 96400. HCPCS code G0356 will be used for the administration of hormonal anti-neoplastic injections. CPT code 96400 is currently paid $64.07. Its comparable code for 2005 (G0356) will be paid $36.69 or a reduction of 43 percent. Without the transition, payment for the code would have been reduced from $48.54 to $35.62 or 27 percent between 2004 and 2005. However, payment for this code increased from $5.07 to $35.62 (without the transition) between 2002 and 2005 or by 603 percent.

There is currently one CPT code for anti-neoplastic drugs administered by intravenous (IV) push (96408). In 2004, physicians are receiving $154.76 for CPT code 96408. Payment in 2005 for G0351 (the comparable code) will be $125.69. In addition, Medicare may also pay an additional $130.00 per encounter under the demonstration increasing the total payment to $255.69 or an increase of 65 percent between 2004 and 2005. Without the transitional adjustments or the demonstration, payment for this service would have increased from $117.24 in 2004 to $122.03 in 2003 or by 4 percent. From 2002 to 2005, payment will have increased from $35.11 to $122.03 (without the transition), or a 248 percent increase.

CPT will be creating new codes that distinguish between the first and subsequent administration of a drug by IV push to the same patient on the same day. The RUC is recommending fewer inputs for the subsequent administration of a drug by IV push than the initial drug. We are creating code G0358 for each subsequent drug administered by IV push for 2005. Before the enactment of the MMA, Medicare allowed CPT code 96408 to be paid only once per patient per day. However, as a result of the MMA, we changed our policy and allowed physicians to bill and be paid for more than one administration of a chemotherapy drug by IV push to the same patient on a single day (see 69 FR 1094–1095). Thus, because separate codes do not currently exist for the multiple administrations of chemotherapy drugs by IV push on a single day, physicians currently are paid at the rate for 96408 (or $154.76) for each subsequent administration. Using the CPT's and RUC recommendations, we will pay $72.99 for subsequent drugs administered by IV push using HCPCS code G0358. While the payment is less in 2005 and 2004, payment remains higher in 2005 than in 2003 and prior years when Medicare provided no payment for the subsequent administration of a drug by IV push.

We are creating HCPCS codes G0359 and G0360 for the initial and subsequent hour respectively of chemotherapy drugs administered by IV infusion. As described in the drug administration section, CPT has changed its definition of chemotherapy to include infusion of substances such as monoclonal antibody agents or other biologic response modifiers in addition to anti-neoplastic drugs. Thus, services previously billed under the CPT code 90780 (initial hour) and 90781 (each additional hour) that meet this new definition of chemotherapy will now be billed under CPT code G0359 (initial hour) and G0360 (each additional hour). Payment for the infusion of substances such as monoclonal antibody agents or other biologic response modifiers paid under CPT code 90780 will be increasing from $117.79 in 2004 to $177.61 in 2005 using HCPCS code G0359, a 51 percent increase. Without including the transition adjustment, payment for these services will have increased by 93 percent from $89.24 in 2004 to $172.43 in 2005 or by 325 percent from the 2002 rate of $40.54. Payment for the subsequent hour infusion under CPT code 90781 will increase from $33.02 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 22 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 56 percent from $25.02 in 2004 to $39.03 in 2005 or 93 percent from its 2002 rate of $20.27.

Anti-neoplastic agents that were previously billed under CPT code 96410 (initial hour) and 96412 (each additional hour) will also be billed under codes G0359 and G0360. We have listed codes G0359 and G0360 twice to reflect that Medicare payment for each respective code is paid under two different CPT codes for services rendered prior to January 1, 2005. Payment for the initial hour of an anti-neoplastic agent administered by infusion under CPT code 96410 will be going from $217.35 in 2004 to $177.61 in 2005. Including the $130.00 per encounter demonstration payment in this amount brings the total payment to $307.61, an increase of 65 percent. Without including the transition adjustment, payment for these services will have increased by 5 percent from $164.66 in 2004 to $172.43 in 2005 or by 209 percent from the 2002 rate of $55.75. Payment for the subsequent hour infusion under CPT code 96412 will decrease from $48.30 in 2004 to $40.21 in 2005 under HCPCS code G0360 or by 17 percent. Without including the transition adjustment, payment for the subsequent hour infusion will have increased 7 percent from $36.59 in 2004 to $39.03 in 2005. Payment for the subsequent hour infusion of an anti-neoplastic agent has been reduced by 6 percent from its 2002 rate of $41.63. The reduction in payment is occurring because resource-based pricing replaced the use of charge-based RVUs when the services were removed from the nonphysician work pool in 2004.

The CPT is also recommending a new code for the initial hour of a subsequent chemotherapy drug administered by infusion. The new code would recognize that there are higher resources associated with the first hour of infusion of a subsequent drug than there are in the subsequent hour of the initial drug. Under current CPT coding, the first hour of a subsequent drug administered by IV infusion is paid under CPT code 96412. In 2004, Medicare pays $48.30 for this service. In 2005, we will pay $86.66 or 79 percent more for HCPCS code G0362 that will be used for the initial hour of a subsequent drug administered by IV infusion. Without including the transition adjustment, payment for this service will have increased 130 percent from $36.59 in 2004 to $84.13 in 2005 or 102 percent from the 2002 rate of $41.63.

The volume-weighted average permanent increase in payment among all drug administration services is approximately 117 percent from 2003 to 2005 including the effect of the CPT/RUC recommendations but excluding the effect of the transition adjustment. Including the effect of the transition (but not the demonstration payment) makes the volume-weighted increase in payment for these codes more than 120 percent from 2003 to 2005.

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Table 40:

Impact of Final Rule and Physician Fee Schedule Update
on Medicare Payment for Selected Drug Administration Services
Including the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment with Transition	2005 Payment with Transition	2005 Demo Payment*	2005 w/Transition and Demo	% Change 04 to 05
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 24.64	$ 19.13	N/A	$ 19.13	-22%
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 64.07	$ 36.69	N/A	$ 36.69	-43%
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 154.76	$ 125.69	$130.00	$ 255.69	65%
N/A	G0358	IV push each additional drug	N/A	N/A	$ 154.76	$ 72.99	N/A	$ 72.99	-53%
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 217.35	$ 177.61	$130.00	$ 307.61	42%
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 117.79	$ 177.61	N/A	$ 177.61	51%
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 48.30	$ 40.21	N/A	$ 40.21	-17%
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 33.02	$ 40.21	N/A	$ 40.21	22%
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 48.30	$ 86.66	N/A	$ 86.66	79%

- The demonstration payments will only be made once per day per patient with a diagnosis of cancer. Thus, we are only showing them as an additional payment to an initial drug administration service when an anti-neoplastic agent is administered.

Table 41:

Impact of Proposed Rule and Physician Fee Schedule Update on Medicare Payment for Selected Drug Administration Services Excluding the Effect of the 32 and 3% Transition Adjustments and Demonstration Project

Old Code	New Code	Description	2002 Payment	2003 Payment	2004 Payment without Transition	2005 Payment without Transition
90782	G0351	Therapeutic/diagnostic injec	$ 3.98	$ 4.41	$ 18.67	$ 18.57
96400	G0356	Hormonal anti-neoplastic	$ 5.07	$ 37.52	$ 48.54	$ 35.62
96408	G0357	IV push single/initial subst	$ 35.11	$ 37.52	$ 117.24	$ 122.03
N/A	G0358	IV push each additional drug	N/A	N/A	$ 117.24	$ 70.87
96410	G0359	Chemotherapy IV one hr initi	$ 55.75	$ 59.22	$ 164.66	$ 172.43
90780	G0359	Chemotherapy IV one hr initi	$ 40.54	$ 42.67	$ 89.24	$ 172.43
96412	G0360	Each additional hr 1-8 hrs	$ 41.63	$ 44.14	$ 36.59	$ 39.03
90781	G0360	Each additional hr 1-8 hrs	$ 20.27	$ 21.70	$ 25.02	$ 39.03
96412	G0362	Each add sequential infusion	$ 41.63	$ 44.14	$ 36.59	$ 84.13

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Table 42 below shows the impact of physician fee schedule changes for selected specialties that receive a significant portion of their total Medicare revenues from drugs. Table 43 that follows table 42 shows the combined impact of the physician fee schedule and drug payment changes on total Medicare revenues. Our estimates of changes in Medicare revenues for drugs and physician fee schedule services compare payment rates for 2005 with payment rates for 2004 using 2003 Medicare utilization for both years. For physician fee schedule services, we mapped the 2003 Medicare utilization to the code set in use for 2005 based on assumptions about how the new drug administration codes will be billed. These assumptions are based on our consultations with the American Society of Clinical Oncology and other physician specialty societies that participated in the CPT's Drug Administration workgroup. We are using 2003 Medicare claims processed and paid through June 30, 2004 that we

estimate are 98.5 complete and have adjusted the figures to reflect a full year of data. Thus, because we are using a single year of utilization, the estimated changes in revenues reflect payment changes only between 2004 and 2005. To the extent that there are year-to-year changes in the volume and mix of drugs and physician fee schedule services provided by physicians, the actual impact on total Medicare revenues will be different than those shown here.

The column labeled ''NPRM Impacts'' shows the impact of the practice expense and malpractice RVU changes described earlier. The refinements of the practice expense RVUs and 5-year review of malpractice will have little or no impact on physician fee schedule payments for the 5 specialties shown. The column labeled ''Coding and RVU Changes'' shows the impact of our adoption of the CPT/RUC recommended revisions to the codes and payment amount for drug administration services. We estimate that the changes from the CPT/RUC process will increase physician fee schedule payments for oncologists by 5 percent. This impact is generally attributable to higher permanent increases in payment for the administration of drugs by IV push (G0357), infusion (G0359 and G0360) and the ability to be paid at a higher rate for the initial hour of infusion of a subsequent drug administered. We estimate that the changes from the CPT/RUC process will increase payments to rheumatologists by 4 percent. This impact is due to the change in the definition of the chemotherapy that will allow rheumatologists to bill substances such as monoclonal antibody agents or other biologic response modifiers using the chemotherapy administration codes. The CPT/RUC changes will have little or no specialty level impact on other specialties that administer drugs.

The next column shows the effect of the drug administration transition on Medicare physician fee schedule revenues for the specialties shown. As explained earlier, section 303(a)(4) requires that the transition adjustment percentage be reduced from 32 percent in 2004 to 3 percent in 2005. The change to the transition payment percentage will reduce payments for the specialties that provide drug administration services. The reduction has a larger impact on oncologists than the other physician specialties shown because drug administration services represent a larger proportion of their physician fee schedule revenues.

The column labeled ''Additional Payments for Injections'' shows the effect of paying for injections (as well as non-chemotherapy drugs administered by IV push) provided on the same day as other physician fee schedule services. We estimate that this policy change will increase payment an estimated 3 percent for oncologists and 1 percent for other specialties. This policy change will also modestly increase payment to other specialties that provide injections (primarily family practitioners and internists) and has been incorporated into the earlier impact tables.

The next column shows the impact of the 1.5 percent physician fee schedule update. The column labeled ''One-Year Demonstration Project'' shows the impact of our plan to establish a national demonstration project that will pay oncologists $130 for providing specific services to their patients and reporting patient quality data. If oncologists participate in this demonstration project and provide the required services and requested information, we estimate that their payments will increase by 15 percent. Taken together, we estimate that the coding and RVU changes, the change to the transition amount for drug administration, the additional payments for injections, the physician fee schedule update and the national demonstration project will increase physician fee schedule payments to oncologists by 10 percent. The combined impact of these factors (other than the national demonstration project) will increase physician fee schedule payments by 1 percent urologists, 5 percent for rheumatologists, 1 percent for obstetrics/gynecologists and 0 percent for infectious disease.

Table 43 shows the combined impact of changes we are making to Medicare drug and physician fee schedule payments for the same specialties shown in table 42. The payment impacts for drugs are based on the 2nd quarter ASP submissions from drug manufacturer's and reflect ¾ of an annualized increase in drug prices between the 2nd quarter of 2004 and the 1st quarter of 2005 of 3.39 percent or 2.54 percent. The drug payment impacts are based on ASP prices for drugs accounting for approximately 94 percent of Medicare's total drug payments. Of Medicare's total payments for drugs, at least 4 percent are paid under ''not otherwise classified (NOC)'' codes (*i.e.* J3490 and J0999). Thus, we based our impacts on ASP prices for drugs accounting for approximately 98 percent of Medicare revenues that are not in the NOC category.

The column labeled ''% of Total Medicare Revenues from Fee Schedule'' shows the proportion of total Medicare revenues received from physician fee schedule services. The following column shows the physician fee schedule payment impact. All of the payment impacts are the same as those shown in Table 43. The following column shows the proportion of total Medicare revenues received from drugs, while the next column shows the payment impact from adoption of the ASP drug payment methodology. The next 3 columns show combined Medicare revenues from all sources and the combined Medicare payment impact from the earlier described changes being adopted for 2005.

Our estimates of changes in Medicare revenues for both drugs and drug administration services compare payment rates for 2005 with payment rates for 2004 using the same utilization in both years. We used 2003 utilization for these comparative impacts since they are the latest data available. Thus, the estimated changes in revenues reflect *purely* price changes between 2004 and 2005. We note that these impacts and percentages represent averages for each specialty or supplier. The percentages and impacts for any individual physician are dependent on the mix of drugs and physician fee schedule services they provide to Medicare beneficiaries. For this analysis, we are also supplementing the data showing the change in revenues with volume growth based on historical trends.

As indicated in Table 43, physician fee schedule services account for approximately 28 percent of oncology's 2004 Medicare revenues. The changes we are adopting in this final rule are estimated to increase Medicare payments for physician fee schedule services by 10 percent from 2004 to 2005. We estimate that approximately 69 percent of total 2004 Medicare revenues for oncologists are attributed to drugs and the adoption of the ASP pricing methodology will reduce these revenues by 13 percent. We based our analysis on drugs accounting for approximately 92 percent of total oncology drug revenues (and 99 percent of oncology drug revenues not paid under NOC codes). The actual impact on oncologists' total Medicare revenues will be different from these estimated impacts to the extent that utilization of drugs and drug administration services does increase. In recent years, increasing utilization, for example, drug spending growth in excess of 20 percent per year, has occurred. The weighted average of the drug and physician fee schedule changes assuming no change in utilization would decrease Medicare revenues to oncology by 6 percent. However, if the volume of drugs and physician fee schedule services

increased at historical rates, total Medicare revenues for oncologists are estimated to increase by 4 percent between 2004 and 2005, excluding the demonstration project. If we include the demonstration project, Medicare revenues to oncologists are estimated to increase by 8 percent between 2004 and 2005. We note that our actuaries' estimates of section 303 with the drug prices and policy changes in this final rule match earlier estimates of the FY 2005 and 10-year savings figures.

We estimate that urology receives approximately 57 percent of their 2004 total revenues from physician fee schedule services and 35 percent from drugs. We estimate that physician fee schedule revenues for urologists will increase by approximately 1 percent from 2004 to 2005. Based on ASP prices for drugs accounting for 100 percent of urologists' drug revenues, we estimate a 40 percent reduction assuming no growth in the volume of services provided. In this scenario, combined Medicare payments to urologists would decline approximately 14 percent. However, if the volume of physician fee schedule services and drugs were to grow at historical rates, we estimate that Medicare revenues to urologists would decline by 8 percent.

We estimate that physician fee schedule revenues account for approximately 49 percent of rheumatology's total revenues. Drugs account for approximately 44 percent rheumatology's total revenues. Physician fee schedule revenues are estimated to increase 5 percent for rheumatology and revenues from drugs are estimated to decline by 8 percent. Assuming no growth in utilization, the combined reduction in rheumatologists' revenues would be 1 percent. If the volume of drugs and physician fee schedule services grew at historical rates, rheumatologists' revenues from Medicare would increase by 9 percent.

We estimate that physician fee schedule revenues account for approximately 87 percent of total revenues for obstetrics/gynecology. These revenues are anticipated to increase by 1 percent. Drug revenues represent 13 percent of total Medicare revenues for obstetrics/gynecology and are estimated to decline by 21 percent. Assuming no growth in utilization, we estimated that obstetrics/gynecology's combined Medicare revenues would decline by 2 percent. Using the historical projected rates of growth for the volume of drugs and physician fee schedule services would make the estimated change in revenues equal an increase of 4 percent.

We estimate that physician fee schedule revenues account for approximately 94 percent of total revenues for infectious disease physicians. These payments are not estimated to change. The remainder of Medicare revenues for infectious disease physicians can be attributed to drugs. These payments are expected to decline by 25 percent. The weighted average change in infectious disease revenues from the changes we are adopting in this final rule is -2 percent assuming no growth in the volume of drugs and physician fee schedule services. If future growth in the volume of drugs and physician fee schedule services were to grow at historical rates, revenues to infectious disease physicians would increase would increase 7 percent.

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Table 42:

Impact of Drug and Physician Fee Schedule Payment Changes
on Total Medicare Allowed Charges
for Selected Specialties

		Physician Fee Schedule						
Specialty	Medicare Allowed Charges ($ in Millions)	NPRM Impacts	Coding and RVU Changes	Drug Administration Transition	Additional Payments for Injections	Physician Fee Schedule Update	One-Year Demonstration Project	Total
HEMATOLOGY/ONCOLOGY	$ 1,747	0%	5%	-12%	3%	1.5%	15%	10%
UROLOGY	$ 1,695	0%	0%	-1%	0%	1.5%	N/A	1%
RHEUMATOLOGY	$ 582	0%	4%	-2%	1%	1.5%	N/A	5%
OBSTETRICS/GYNECOLOGY	$ 412	0%	0%	-1%	0%	1.5%	N/A	1%
INFECTIOUS DISEASE	$ 401	0%	0%	-1%	0%	1.5%	N/A	0%

Table 43:
Combined Payment Impact
Drug and Physician Fee Schedule Payment Changes
for Selected Specialties

	Physician Fee Schedule		Drugs			All Revenues			
Specialty	% of Total Medicare Revenues from Fee Schedule	% Change Medicare Physician Fee Schedule Revenues	% of Total Medicare Revenues from Drugs	% Change Medicare Drug Revenues	Combined Medicare Revenues All Sources ($ in Millions)	Combined % Change All Medicare Revenues Constant Utilization	Combined % Change All Medicare Revenues** w/Utilization Growth
HEMATOLOGY/ONCOLOGY	28%	10%	69%	-13%	$ 6,346	-6%	8%
UROLOGY	57%	1%	35%	-40%	$ 2,967	-14%	-8%
RHEUMATOLOGY	49%	5%	44%	-8%	$ 844	-1%	16%
OBSTETRICS/GYNECOLOGY	87%	1%	13%	-21%	$ 667	-2%	5%
INFECTIOUS DISEASE	94%	0%	6%	-25%	$ 428	-2%	7%

** Note: We estimate that Medicare payments to oncologists would increase by 8% between 2004 and 2005 if growth in the volume of drugs and physician fee schedule services were to continue growing at historical rates and the effect of the demonstration project was included. Revenue projections including price and volume changes for the other specialties are shown as well.

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B. Geographic Practice Cost Indices

As discussed in section II.B, in this rule, we are proposing changes to the work and practice expense GPCIs based on new census data. The resulting geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 3.5 percent or a decrease by more than 1.6 percent for any given locality in 2005. These geographic redistributions would not result in an overall increase in the current geographic adjustment indices by more than 7 percent or a decrease by more than 3.5 percent for any given locality in 2006. Addenda F and G illustrate the

locality specific overall impact of this proposal. The GAF, as displayed in Addenda F and G is a weighted composite index of the individual revisions to the work, practice expense, and malpractice expense GPCIs, respectively. The malpractice GPCI was updated as part of the November 7, 2003 final rule, and the MMA provisions were addressed in the final rule published on January 7, 2004.

C. Coding Issues

1. Additions to the List of Medicare Telehealth Services

In section II.D, we are adding end stage renal disease (ESRD) services, as represented by HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, G03178 to the list of telehealth services. We believe that this change will have little effect on Medicare expenditures.

2. National Pricing of G0238/G0239 (Respiratory Therapy Service Codes)

As discussed earlier in the preamble, we are using the nonphysician workpool to value two respiratory therapy service codes (G0238 and G0239) that are currently carrier priced. We believe that this change will eliminate the uncertainty surrounding payment of these codes when performed in comprehensive outpatient rehabilitation facilities that are paid under the physician fee schedule through fiscal intermediaries. We do not anticipate that nationally pricing these services will have a significant impact on Medicare expenditures.

3. New HCPCS Code for Bone Marrow Aspiration

We are implementing a new HCPCS add-on code, GO367 for instances when a bone marrow aspiration and a bone marrow biopsy are performed on the same day through a single incision. While this coding change will allow for a small additional payment for the second procedure performed through a single incision on the same day, we anticipate that the costs will be insignificant.

4. New HCPCS Code for Venous Mapping

As stated earlier in the preamble, we are implementing a new HCPCS code G0365, for mapping of vessels for hemodialysis access. Payment for this code will be crosswalked by CPT code 93990, Doppler Flow Testing. We anticipate that the costs of this change will be minor and may result in improved care to Medicare beneficiaries and less long-term costs to Medicare.

D. MMA Provisions

1. Section 611—Preventive Physical Examination

As discussed earlier in this preamble, the MMA authorizes coverage of an initial preventive physical examination effective January 1, 2005, subject to certain eligibility and other limitations. This new benefit will result in an increase in Medicare expenditures for new payments made to physicians and other practitioners who provide these examinations and for any medically necessary follow-up tests, counseling, or treatment that may be required as a result of the coverage of these examinations. The impact of this provision is shown in the following table.

TABLE 44:
Medicare Cost Estimates for MMA Provision 611
(in millions)

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 611	$40	$40	$40	$40	$40

2. Section 613—Diabetes Screening

Section 613 of the MMA adds subsection (yy) to section 1861 of the Social Security Act and mandates coverage of diabetes screening tests, effective on or after January 1, 2005. We expect that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physicians' office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. The impact of this provision is shown in Table 45 that follows.

3. Section 612—Cardiovascular Screening

Section 612 of the MMA provides for Medicare coverage for cholesterol and other lipid or triglyceride levels of cardiovascular screening blood tests for the early detection of abnormalities associated with an elevated risk for such diseases effective on or after January 1, 2005. We estimate that this change in coverage for certain beneficiaries will result in an increase in Medicare payments. These payments will be made to physician office laboratories and other laboratory suppliers who perform these tests as a result of the increased frequency of coverage of these tests. Increased Medicare program expenditures for this provision are shown in Table 45 below.

TABLE 45:
Medicare Cost Estimates for MMA Provisions 612 and 613
(in millions)

MMA Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 612 Cholesterol and Blood Lipid	50	80	90	90	100
Sec. 613 Diabetes Screening	20	40	50	60	80

4. Section 413—Incentive Payment for Physician Scarcity

a. Physician Scarcity Areas

Section 413(a) of the MMA provides a new 5-percent incentive payment to physicians who furnish services in physician scarcity areas. The MMA provides for paying primary care physicians furnishing services in a primary care scarcity area, and specialty physicians furnishing services in a specialist care scarcity county, an additional amount equal to 5 percent of the amount paid for their professional services under the fee schedule from January 1, 2005 to December 31, 2007. We estimate that this new incentive payment for physicians' services will result in an increase in Medicare payments that are shown in Table 46.

b. Improvement to Medicare HPSA Incentive Payment Program

Section 413(b) of the MMA amended section 1833(m) of the Act to mandate that we automate payment of the 10 percent HPSA incentive payment to eligible physicians. Since the inception of the HPSA incentive payment program, physicians have been required to determine their eligibility and correctly code their Medicare claims using modifiers. We estimate that this change to the HPSA incentive payment program to provide for automation of payment will result in an increase in Medicare payments because many eligible physicians are not applying for bonuses due to the burden of verifying eligibility. The impact of this provision is shown in Table 46.

TABLE 46:
Medicare Cost Estimates for MMA Provisions
(in millions)

MMA Provision	FY05	FY06	FY07	FY08	FY09
Sec. 413(a) Physician Scarcity Areas	30	50	50	20	-
Sec. 413(b) Improvement to HPSA	20	30	30	30	30

5. Sections 303–304—Payment for Covered Outpatient Drugs and Biologicals and Section 305—Payment for Inhalation Drugs

Sections 303 and 304 of the MMA make changes to Medicare payment for covered outpatient drugs and biologicals and changes to the administration of those drugs. Section 305 makes changes to payment for inhalation drugs. We implemented provisions of sections 303 through 305 changing payments in 2004 for drugs and their administration in the January 7, 2004 **Federal Register** (69 FR 1084). In this final rule, we are making further changes to Medicare's payment for drugs and drug administration for 2005 required by sections 303 through 305 of the MMA. As indicated earlier in this final rule, we are revising the codes and payments for drug administration based on recommendations of the CPT Editorial Board and the Relative Value Update Committee. Consistent with section 1848(c)(2)(J) of the Act (as amended by section 303(a) of the MMA), the increase in payment resulting from this review are exempt from the budget neutrality requirements that apply to changes in RVUs. We are further increasing payments to physicians that treat patients with cancer who participate in a national demonstration project. In addition, we are also paying a supplying fee of $50 per month for the first month and $24 for each subsequent month for Medicare Part B oral drug prescriptions. We are also proposing to pay a furnishing fee of $0.14 per unit of clotting factor and a dispensing fee of $57 per month for inhalation drugs. Taking all of these provisions into account, we estimate Medicare savings for section 303–305 as follows:

TABLE 47:

Medicare Cost (Savings)
Estimates for MMA Provision 303-305
(in millions)

Provision	FY05	FY06	FY07	FY08	FY09
303-305	(730)	(1,300)	(1,650)	(1,820)	(1,990)

6. Section 952—Reassignment

The reassignment provisions discussed in section III.F is currently estimated to have no significant impact on Medicare expenditures.

7. Section 623—Payment for Renal Dialysis Services

a. Effects on the Medicare Program (Budgetary Effect)

Because the basic case mix adjusted composite payment rate and the revised payment for ESRD drugs must be budget neutral in accordance with section 623(d)(1) of the MMA, except for the statutorily required 1.6 percent increase set forth in section 623(a), we estimate that there would be no budgetary impact for the Medicare program beyond this increase. The impact of this provision (net of beneficiary liability) is shown in the following table:

TABLE 48:

Medicare Cost Estimates for MMA Provision 623
(in millions)

Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Section 623	$40	$50	$50	$60	$60

b. Impact on ESRD Providers

To understand the impact of the changes affecting payments to ESRD facilities that result from enactment of the MMA on different categories of ESRD facilities, it is necessary to compare estimated payments under the current payment system (current payments) to estimated payments under the revisions to the composite rate payment system as set forth in this final rule (MMA payments). To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and MMA payments contain similar inputs. Therefore, we simulated MMA payments only for those ESRD facilities for which we are able to calculate both current payment and MMA payment.

Due to data limitations, we are unable estimate current and MMA payments for 461 facilities that bill for ESRD drugs. ESRD providers were grouped into the categories based on characteristics provided in the Online Survey and Certification and Reporting (OSCAR) file and the most recent cost report data from HCRIS. We also used the June 2004 update of CY 2003 Standard Analytical File (SAF) claims as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. As we stated in the proposed rule, this final rule impact on providers uses updated OSCAR, cost report and claims data.

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Table 49:

Impact of MMA Section 623
Payments to Hospital Based and Independent ESRD Facilities
(Includes Drug and Composite Rate Payments)

[Percent change in total payments to ESRD facilities (both program and beneficiaries)]

	Number Of facilities	Number of Dialysis Treatments (in millions)	Effect of Changes In Drug Payments 1/	Effect of 1.6% Composite rate Update on Total Payments 2/	Effect of Case Mix 3/	Overall Effect 4/
All	3,907	31.0	0.0	1.0	0.0	1.0
Independent	3,390	27.5	-0.6	1.0	0.0	0.4
Hospital Based	517	3.5	5.2	1.1	0.3	6.6
Size						
Small <5000 treatment per year	1,274	3.9	0.2	1.0	0.5	1.5
Medium 5000-10000 treatments per yr	1,586	11.5	-0.3	1.0	0.1	0.7
Large > 10000 treatments per year	1,047	15.6	0.2	1.0	-0.2	1.0
Type of Ownership						
For-profit	2,782	22.6	-0.7	1.0	-0.2	0.1
Not-for-profit	785	5.8	3.0	1.1	0.4	4.3
Other	340	2.6	0.5	1.0	0.6	1.8
Urban	2,903	25.0	0.0	1.0	-0.1	0.9
Rural	1,004	6.0	-0.1	1.0	0.4	1.1
Region						
New England	128	1.1	0.8	1.0	-0.3	1.7
Middle Atlantic	498	4.3	0.5	1.0	-0.5	1.2

East North Central	570	4.6	0.3	1.0	1.0	1.9
West North Central	270	1.7	1.0	1.0	1.3	2.9
South Atlantic	920	7.2	-0.9	0.9	0.5	0.3
East South Central	317	2.3	-0.9	0.9	1.2	0.7
West South Central	530	4.3	-0.9	1.0	-0.3	-0.1
Mountain	204	1.3	2.4	1.0	-0.7	3.0
Pacific	442	3.8	0.8	1.0	-1.7	0.8
Puerto Rico	28	0.4	0.7	1.0	-4.1	-0.9

1/ This column shows the effect of the changes in drug payments to ESRD providers. These include changes in payment for separately billable drugs and the 8.7% drug add-on.

2/ This column shows the effect of the 1.6% update to the composite rate on total payments to ESRD providers. Note that ESRD providers receive an average of 39% of their total revenues from separately billable drugs which results in an average net increase of 1.0%.

3/ This column shows impact of case-mix adjustments only.

4/ This column shows the overall effect of payments to ESRD facilities with and without the application of MMA Section 623. The MMA provisions include the 1.6% increase, the 8.7% drug add-on, and the case-mix adjustments times treatments plus MMA payment for separately billable drugs. The current payment to ESRD facilities includes the current composite rate times treatments plus current drug payments for separately billable drugs.

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Table 49 shows the impact of MMA Section 623 on hospital based and independent facilities. We have included both composite rate payments as well as payments for separately billable drugs and biologicals because both are effected by section 623 of the MMA. The first column of Table 49 identifies the type of ESRD provider, the second column indicates the number of ESRD facilities for each type, and the third column indicates the number of dialysis treatments.

The fourth column shows the effect of the changes in drug payments to ESRD

providers. The overall effect of changes in drug payments is budget-neutral as required by MMA. The drug add-on adjustment is designed to result in the same aggregate amount of expenditures as would have been made without the statutory policy change.

Current payments for drugs represent 2005 Medicare reimbursement using 95 percent of AWP prices for the top ten drugs. Medicare spending for drugs other than EPO is estimated using 2004 AWP prices updated by a 3 percent inflation factor times actual drug utilization from 2003 claims. EPO is priced $10 per 1000 units (EPO units are estimated using payments because the units field on bills represents the number of EPO administrations rather than the number EPO units). Medicare spending under the MMA is 2003 average acquisition cost for the top ten drugs updated to 2005 figures (using the PPI for prescriptions drugs) times actual drug utilization from 2003 claims. These inflation factors were 4.81 percent and 3.72 percent for 2004 and 2005, respectively.

Payment for drugs under MMA also includes the 8.7 percent drug add-on to the composite rate. This amount is computed by multiplying the composite rate for each provider (with the 1.6 percent increase) times dialysis treatments from 2003 claims. Column 4 is computed by comparing spending under MMA provisions for drugs including the 8.7 percent drug add-on amount to spending under current payments for drugs. In order to make column 4 comparable with rest of Table 49, current composite rate payments to ESRD facilities were included in both current and MMA spending calculations.

Column 5 shows the effect of the 1.6 percent increase to the composite rate on total payments to ESRD providers. While all ESRD providers will get a 1.6 percent increase to their composite rate, this table shows the net effect of this increase on ESRD providers' total Medicare revenues (both drug and composite rate payments combined), and therefore does not show a 1.6 percent increase.

On average, ESRD providers receive an average of 39 percent of their total revenues from separately billable drugs and 61 percent of their total revenues from composite rate payment. Since the 1.6 percent increase is applied to the 61 percent portion of their total Medicare revenues, the 1.6 percent composite rate increase is also arithmetically equal to a 1.0 percent increase in ESRD providers' total Medicare revenues. Column 5 is computed by combining MMA payment for drugs (including the 8.7 percent drug add-on amount) with: (1) current composite rate times dialysis treatments from 2003 claims or (2) composite rate with 1.6 percent increase times dialysis treatments from 2003 claims. The difference between these two combinations is the net effect of the 1.6 percent increase on total payments to ESRD providers. In order to isolate the effect of the 1.6 percent increase, the computation in Column 5 assumes that drug payments to ESRD providers remain constant.

Column 6 shows the impact of the case-mix adjustments as described earlier in this preamble of this final rule. Because MMA requires this adjustment to be budget-neutral in the aggregate, there is no overall impact on ESRD providers as a whole. While the case-mix adjustment will have an impact within the various provider types, Column 6 shows that the effect between provider groupings is minimal. Column 6 is computed as the difference between payments to ESRD providers with the case-mix adjustments compared to payments to providers without the case-mix adjustments. As described earlier in this preamble, we developed a case-mix budget neutrality factor to meet the MMA requirement that payment be budget-neutral with respect to aggregate payments. Therefore, there is no change for ESRD providers in the aggregate. We note that when applying the case-mix adjustments, we did so at the facility level.

Column 7 shows the overall effect of all changes in drug and composite rate payments to ESRD providers. The overall effect of payments to ESRD facilities is measured as the difference between payment with and without application of MMA section 623 as described in this final rule and current payment. MMA payment is computed by multiplying the composite rate for each provider (with both 1.6 percent increase and the 8.7 percent add-on) times dialysis treatments from 2003 claims times the appropriate case-mix adjustment by provider. In addition, MMA payment includes payments for separately billable drugs under the revised pricing methodology as described in this preamble. Current payment is the current composite rate for each provider times dialysis treatments from 2003 claims plus current drug payments for separately billable drugs.

The overall impact to ESRD providers in aggregate is 1.0 percent. Among the three separately shown effects, the effect of changes in drug payments has the most variation among provider type and contributes most to the overall effect. Separately billable ESRD drugs are paid differently to hospital-based and independent ESRD providers. As discussed earlier in this preamble, we are using a single drug add-on to the composite rates for both hospital based and independent facilities. The 6.6 percent increase in payments to hospital-based providers is largely due to the single drug add-on to the composite rate.

8. Section 731—Coverage of Routine Costs for Category A Clinical Trials

The coverage of routine costs associated with certain Category A clinical trials as discussed in MMA section 731(b) will have no significant impact on Medicare expenditures.

9. Section 629—Part B Deductible

As explained earlier in the preamble, section 629 of the MMA provides for annual updates to the Medicare Part B deductible. The MMA stipulates that the Medicare Part B deductible will be $110 for calendar year 2005, and, for subsequent years, the deductible will be the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) of the Act, ending with that subsequent year (rounded to the nearest dollar). We note that while this MMA provision results in a savings to the Medicare program, it also increases beneficiary costs by an equal amount and was implemented in a **Federal Register** notice published on September 9, 2004 (69 FR 54675).

TABLE 50: ESTIMATED MEDICARE SAVINGS FOR MMA PROVISION 629

[in millions]

MMA provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
Sec. 629	110	290	440	590	770

10. Section 512—Hospice Consultation Service

As explained in section III.K of this preamble, effective January 1, 2005, section 512 of the MMA provides for payment to be made to a hospice for specified services furnished by a physician who is either the medical director of, or an employee of, a hospice agency. We estimate that this MMA provision will increase Medicare expenditures by $10 million per year beginning in 2005.

11. Section 706 Coverage of Religious Nonmedical Health Care Institution (RNHCI) Services Furnished in the Home

We anticipate that the time limited RNHCI home benefit will either meet or fall short of the annual $700,000 per calendar year statutory spending limit and therefore will not have a significant financial impact on the Medicare program.

E. Other Issues

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

As discussed in section IV.A, we are amending the regulations to include the statutory requirement that only individuals meeting the existing qualification and training standards for therapists (with the exception of licensure) consistent with § 484.4 qualify to provide therapy services incident to physicians' services. We believe that while this will have little impact on Medicare expenditures, it will assist in ensuring the quality of services provided to beneficiaries.

2. Supervision Requirements for Therapy Assistants in Private Practice

As discussed earlier in section IV.A, we are revising the regulations at § 410.59 and § 410.60 to replace a requirement to provide personal supervision and instead require direct supervision of physical therapist assistants and occupational therapy assistants when therapy services are provided by physical therapists or occupational therapists in private practice. This policy change will provide beneficiaries access to medically necessary therapy services, under a physician-certified plan of care. We believe that this change could result in a 5 percent increase in therapy billing in therapy private practice settings with an estimated cost of $9 million for FY 2005. Projected costs for FY 2006 are $17 million while each subsequent year would only increase by $1 million each year, assuming the therapy caps are applied.

3. Low Osmolar Contrast Media

As discussed earlier in the preamble, we are revising the regulations at § 414.38 to eliminate the restrictive criteria for the payment of LOCM. This regulation will make payment for LOCM consistent across Medicare payment systems. Shown in the following table are estimates of program costs due to the removal of the restrictive criteria for administering LOCM, assuming increased utilization and removal of the 8 percent reduction. Without current ASP data, we could not include the additional impact of the change in payment for LOCM to ASP plus 6 percent, effective April 1, 2005. Contrast-enhanced procedures that most commonly use LOCM, the typical ranges of LOCM amounts used by modality, and the cost ranges for LOCM in the marketplace were considered in valuing the additional program costs.

TABLE 51:

Regulatory Provision	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009
LOCM	20	30	30	30	30

4. Payments for Physicians and Practitioners Managing Patients on Dialysis

We believe that the proposals with respect to ESRD-related services furnished to patients in observation settings and payment for outpatient ESRD-related services for partial month scenarios discussed earlier in section xx provide clarification of current policy surrounding these issues. We do not believe these proposals will have a significant impact on Medicare expenditures.

5. Supervision of Clinical Psychological Testing

We are changing the supervision requirements regarding who can supervise diagnostic psychological testing services. As previously discussed, having ancillary staff supervised by clinical psychologists will enable these practitioners with a higher level of expertise to oversee psychological testing and potentially relieve burdens on physicians and healthcare facilities.

Additionally, in rural areas, we anticipate that permitting psychologists to supervise diagnostic psychological testing services will reduce delays in testing, diagnosis, and treatment that could result from the unavailability of physicians to supervise the tests. We believe that this revision to the supervision requirements will have little impact on Medicare expenditures.

6. Care Plan Oversight

As discussed earlier in the preamble, we are revising § 414.39 to clarify that NPPs can perform home health care plan oversight even though they cannot certify a patient for home health services and sign the plan of care. We do not expect that this change will have an impact on Medicare expenditures, since it is primarily a clarification in policy.

7. Assignment of Medicare Claims

The changes with respect to assignment of Medicare claims are currently estimated to have no significant impact on Medicare expenditures. However, as stated earlier in this preamble at section IV.G, we believe the changes will reduce the paperwork burden on beneficiaries and suppliers.

F. Alternatives Considered

This final rule contains a range of policies, including proposals related to specific MMA provisions. The preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised and presents rationale for our decisions and, when possible, alternatives that were considered.

G. Impact on Beneficiaries

There are a number of changes made in this rule that would have an effect on

beneficiaries. In general, we believe these changes will improve beneficiary access to services that are currently covered or will expand the Medicare benefit package to include new services. As explained in more detail below, the MMA or regulatory provisions may increase beneficiary liability in some cases. Any changes in aggregate beneficiary liability from a particular provision will be a function of the coinsurance (20 percent if applicable for the particular provision after the beneficiary has met the deductible) and the effect of the aggregate cost (savings) of the provision on the calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings).

The MMA provisions that expand Medicare benefits include: Section 611, adding an initial preventive physical exam for newly eligible Medicare beneficiaries; section 612 providing coverage of cardiovascular screening blood tests; and section 613, providing coverage for diabetes screening tests for Medicare beneficiaries at risk for diabetes. While the initial preventive physical examination for newly eligible Medicare beneficiaries is subject to deductible and coinsurance, we believe Medicare beneficiaries will continue to benefit from expanded coverage for this service. We believe many beneficiaries have supplemental insurance coverage or Medicaid that pays the Medicare deductible on their behalf and there will be no immediate additional out-of-pocket cost. Further, even if a beneficiary pays nearly all of the costs of this new benefit, the preventive office visit will substitute for another service a beneficiary may need to meet the annual deductible and the beneficiary will receive more covered benefits at little additional cost. There are no out-of-pocket costs to the beneficiary for the cardiovascular screening blood tests and diabetes screening tests.

Other proposals in this rule related to the MMA will also impact beneficiary liability, with the most significant related to indexing of the part B deductible (section 629 of the MMA) and the drug administration payment changes (sections 303 and 305 of the MMA). MMA provisions that improve administration of the 10 percent HPSA bonus and provide an additional 5 percent bonus payment to physicians in Medicare scarcity areas will have no impact on beneficiary liability because the bonus payments are applied to the amount Medicare pays the physician net of beneficiary liability. These provisions will also improve access for Medicare beneficiaries by increasing payments to physicians in areas that traditionally have had a low ratio of physicians to population.

We are summarizing the impact of all of the changes we are adopting in this rule in table 52. We note that Medicare savings estimates are relative to projected expenditures that would occur if the provisions of the MMA and this final regulation were not implemented. Thus, the savings figures are reductions in beneficiary liability relative to the amounts they otherwise would have paid. The figures do not necessarily mean that we are estimating that beneficiaries will have lower out-of-pocket costs in 2005 than 2004.

TABLE 52:
Estimated Medicare Beneficiary
Impact of MMA Provisions Being Implemented
In this Final Rule
(in millions)

Provision	FY 05	FY06	FY07	FY08	FY09
Sections 303-305	-$570	-$930	-$1,090	-$1,200	-$1,320
Section 611	20	20	20	20	20
Section 612	13	20	23	23	25
Section 613	5	10	13	15	20
Section 413(a)	8	13	13	5	-
Section 413(b)	5	8	8	8	8
Section 623	20	25	25	30	30
Section 629	110				
Section 512	5	5	5	5	5
LOCM	10	15	15	15	15
Physical Therapy	0	10	10	10	10

The implementation of MMA provisions related to drugs and drug administration will reduce Medicare beneficiary liability for Medicare covered services even after including the additional increases in payment for drug administration and establishing a supplying fee for immunosuppressive drugs, a furnishing fee for the clotting factor and a dispensing fee for immunosuppressive drugs. We do not believe that the drug and drug administration payment changes required by the MMA are intended to lessen beneficiary access to care. As indicated earlier, the changes we are making to Medicare payments for the administration of drugs are permanently increasing them by a weighted average of more than 117 percent between 2003 and 2005 and they are being increased by an additional 3 percent for 2005 only. While payments for drugs are being reduced between 2004 and 2005, the statute requires Medicare to pay for them at 6 percent more than their average sales price or the price they are purchased at in the market after taking into account rebates and discounts. Nevertheless, we acknowledge that there is a concern among physicians and others that the large changes in Medicare's payments may affect their ability or willingness to continue making drugs and related services available. CMS' Office of Research

Demonstrations and Information is analyzing Medicare utilization for drugs and drug administration beginning in 2002 and plans to continue to analyze the data for shifts or changes in utilization patterns as the information becomes available to us. To date, we have no evidence that beneficiaries are having any problems with access to drugs. While we do not believe the payment changes for drugs and drug administration will result in access problems, we plan to continue studying this issue. We also note that the MMA requires the Medicare Payment Advisory Commission (MedPAC) to study related issues. Specifically, section 303(a)(5) of the MMA requires MedPAC to study items and services furnished by oncologists and drug administration services furnished by other specialists.

We are also undertaking several changes using our administrative authority that will affect Medicare beneficiaries. Our proposal to remove restrictions that limit Medicare payment for use of low osmolar contrast material to specific indications would update Medicare's payment policy to be consistent with the standard practice of medicine and will improve the quality of care for beneficiaries.

In accordance with the provisions of Executive Order 12866, this regulation was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 403

Grant programs-health, Health insurance, Hospitals, Intergovernmental relations, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 405

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medical devices, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 418

Health facilities, Hospice care, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 484

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 486

Grant programs-health, Health facilities, Medicare, Reporting and recordkeeping requirements, X-rays.

■ For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services amends 42 CFR chapter IV as follows:

PART 403—SPECIAL PROGRAMS AND PROJECTS

Subpart G—Religious Nonmedical Health Care Institutions—Benefits, Conditions of Participation, and Payment

■ 1. The authority citation for part 403 continues to read as follows:

Authority: 42 U.S.C. 1359b–3 and secs 1102 and 1871 of the Social Security act (42 U.S.C. 1302 and 1395hh).

■ 2. Section 403.746 is amended by adding a new paragraph (c) to read as follows:

§ 403.746 Condition of participation: Utilization review.

* * * * *

(c) *Standard: Utilization review committee role in RNHCI home services.* In addition to the requirements in paragraphs (a) and (b) of this section, the utilization review committee is responsible for:

(1) The admission, and at least every 30 days, the continued care review of each patient in the RHNCI home services program.

(2) Oversight and monitoring of the home services program, including the purchase and utilization of designated durable medical equipment items for beneficiaries in the program.

■ 3. In subpart G, § 403.764 through § 403.770 are added to read as follows:

§ 403.764 Basis and purpose of religious nonmedical health care institutions providing home service.

(a) *Basis.* This subpart implements sections 1821, 1861, 1861(e), 1861(m), 1861(y), 1861(ss) and 1861(aaa), 1869 and 1878 of the Act regarding Medicare payment for items and services provided in the home setting furnished to eligible beneficiaries by religious nonmedical health care institutions (RNHCIs).

(b) *Purpose.* The home benefit provides for limited durable medical equipment (DME) items and RNHCI services in the home setting that are fiscally limited to $700,000 per calendar year, with an expiration date of December 31, 2006, or the date on which the 2006 spending limit is reached.

§ 403.766 Requirements for coverage and payment of RNHCI home services.

(a) Medicare Part B pays for RNHCI home services if the RNHCI provider does the following:

(1) Submit a notice of intent to CMS to exercise the option of providing home service.

(2) Provide RNHCI services to eligible beneficiaries,

(3) Arrange with suppliers to furnish appropriate DME items as required to meet documented eligible beneficiary needs.

(4) Arrange for RNHCI nurse home visits to eligible beneficiaries.

(5) Have a utilization committee that assumes the additional responsibility for the oversight and monitoring of the items and RNHCI nursing services provided under the home benefit.

(6) Meet all applicable requirements set forth in subpart G of this part.

(b) To be an eligible beneficiary to RNHCI home services the beneficiary must:

(1) Have an effective election in place.

(2) Be confined to the home, as specified in § 409.42(a) of this chapter.

(3) Have a condition that makes him or her eligible to receive services covered under Medicare home health.

(4) Receive home services and DME items from a RNHCI.

(5) Be responsible for deductible and coinsurance for DME, as specified in § 409.50 of this chapter.

§ 403.768 Excluded services.

In addition to items and services excluded in § 409.49 of this chapter, items and services are also excluded if they are provided by:

(a) A HHA that is not a RNHCI.

(b) A supplier who is not providing RNHCI designated items under arrangement with a RNHCI.

(c) A nurse who is not providing RNHCI home nursing services under arrangement with a RNHCI.

§ 403.770 Payments for home services.

(a) The RNHCI nursing visits are paid at the modified low utilization payment

adjusted (LUPA) rate used under the home health prospective payment system at § 484.230 of this chapter.

(b) Appropriate DME items are paid as priced by Medicare, minus the deductible and coinsurance liability of the beneficiary.

PART 405—FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED

■ 4. The authority citation for part 405 continues to read as follows:

Authority: Secs. 1102, 1861, 1862(a), 1871, 1874, 1881, and 1886(k) of the Social Security Act (42 U.S.C. 1302, 1395x, 1395y(a), 1395hh, 1395kk, 1395rr, and 1395ww(k)), and sec. 353 of the Public Health Service Act (42 U.S.C. 263a).

■ 5. Section 405.207 is amended by revising paragraph (b) to read as follows:

§ 405.207 Services related to a noncovered device.

* * * * *

(b) *When payment is made.* Medicare payment may be made for—

(1) Covered services to treat a condition or complication that arises due to the use of a noncovered device or a noncovered device-related service; or

(2) Routine care services related to experimental/investigational (Category A) devices as defined in § 405.201(b); and furnished in conjunction with an FDA-approved clinical trial. The trial must meet criteria established through the national coverage determination process; and if the trial is initiated before January 1, 2010, the device must be determined as intended for use in the diagnosis, monitoring or treatment of an immediately life-threatening disease or condition.

(3) Routine care services related to a non-experimental/investigational (Category B) device defined in § 405.201(b) that is furnished in conjunction with an FDA-approved clinical trial.

■ 6. Section 405.517 is amended by adding a new paragraph (a)(3) to read as follows:

§ 405.517 Payment for drugs and biologicals that are not paid on a cost or prospective payment basis.

(a) *Applicability.* * * *

(3) *Payment for drugs and biologicals on or after January 1, 2005.* Effective January 1, 2005, payment for drugs and biologicals that are not paid on a cost or prospective payment basis are paid in accordance with part 414, subpart K of this chapter.

* * * * *

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

■ 7. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 8. Section 410.1 is amended by adding a new paragraph (a)(6) to read as follows:

§ 410.1 Basis and scope.

(a) * * *

(6) Section 1842(o)—Payment for drugs and biologicals not paid on a cost or prospective payment basis.

* * * * *

■ 9. Section 410.10 is amended by adding new paragraph (y) to read as follows:

§ 410.10 Medical and other health services: Included services.

* * * * *

(y) Intravenous immune globulin administered in the home for the treatment of primary immune deficiency diseases.

■ 10. Section 410.16 is added to read as follows:

§ 410.16 Initial preventive physical examination: Conditions for and limitations on coverage.

(a) *Definitions.* As used in this section, the following definitions apply:

Eligible beneficiary means an individual who receives his or her initial preventive physical examination within 6 months after the effective date of his or her first Medicare Part B coverage period, but only if that first Part B coverage period begins on or after January 1, 2005.

Initial preventive physical examination means all of the following services furnished to an eligible beneficiary by a physician or other qualified nonphysician practitioner with the goal of health promotion and disease detection:

(1) Review of the beneficiary's medical and social history with attention to modifiable risk factors for disease, as those terms are defined in this section.

(2) Review of the beneficiary's potential (risk factors) for depression, including current or past experiences with depression or other mood disorders, based on the use of an appropriate screening instrument for persons without a current diagnosis of depression, which the physician or other qualified nonphysician practitioner may select from various available standardized screening tests designed for this purpose and recognized by national professional medical organizations.

(3) Review of the beneficiary's functional ability, and level of safety as those terms are defined in this section, as described in paragraph (4) of this definition, based on the use of appropriate screening questions or a screening questionnaire, which the physician or other qualified nonphysician practitioner may select from various available screening questions or standardized questionnaires designed for this purpose and recognized by national professional medical organizations.

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

(5) Performance and interpretation of an electrocardiogram.

(6) Education, counseling, and referral, as deemed appropriate by the physician or qualified nonphysician practitioner, based on the results of the review and evaluation services described in this section.

(7) Education, counseling, and referral, including a brief written plan such as a checklist provided to the beneficiary for obtaining the appropriate screening and other preventive services that are covered as separate Medicare Part B benefits as described in section 1861(s)(10), section 1861(jj), section 1861(nn), section 1861(oo), section 1861(pp), section 1861(qq)(1), section 1861(rr), section 1861(uu), section 1861(vv), section 1861(xx)(1), and section 1861(yy) of the Act.

Medical history is defined to include, at a minimum, the following:

(1) Past medical and surgical history, including experiences with illnesses, hospital stays, operations, allergies, injuries, and treatments.

(2) Current medications and supplements, including calcium and vitamins.

(3) Family history, including a review of medical events in the beneficiary's family, including diseases that may be hereditary or place the individual at risk.

A *physician* for purposes of this section means a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Act).

A qualified nonphysician practitioner for purposes of this section means a physician assistant, nurse practitioner, or clinical nurse specialist (as authorized under section 1861(s)(2)((K)(i) and section

1861(s)(2)((K)(ii) of the Act and defined in section 1861(aa)(5) of the Act, or in § 410.74, § 410.75, and § 410.76).

Review of the beneficiary's functional ability and level of safety must include, at a minimum, a review of the following areas:

(1) Hearing impairment.
(2) Activities of daily living.
(3) Falls risk.
(4) Home safety

Social history is defined to include, at a minimum, the following:

(1) History of alcohol, tobacco, and illicit drug use.
(2) Diet.
(3) Physical activities.

(b) *Condition for coverage of an initial preventive physical examination.* Medicare Part B pays for an initial preventive physical examination provided to an eligible beneficiary, as described in this section, if it is furnished by a physician or other qualified nonphysician practitioner, as defined in this section.

(c) *Limitations on coverage of initial preventive physical examinations.* Payment may not be made for an initial preventive physical preventive examination that is performed for an individual who is not an eligible beneficiary as described in this section.

■ 11. A new § 410.17 is added to read as follows:

§ 410.17 Cardiovascular disease screening tests.

(a) *Definition.* For purposes of this subpart, the following definition apply:

Cardiovascular screening blood test means:

(1) A lipid panel consisting of a total cholesterol, HDL cholesterol, and triglyceride. The test is performed after a 12-hour fasting period.

(2) Other blood tests, previously recommended by the U.S. Preventive Services Task Force (USPSTF), as determined by the Secretary through a national coverage determination process.

(3) Other non-invasive tests, for indications that have a blood test recommended by the USPSTF, as determined by the Secretary through a national coverage determination process.

(b) *General conditions of coverage.* Medicare Part B covers cardiovascular disease screening tests when ordered by the physician who is treating the beneficiary (*see* § 410.32(a)) for the purpose of early detection of cardiovascular disease in individuals without apparent signs or symptoms of cardiovascular disease.

(c) *Limitation on coverage of cardiovascular screening tests.* Payment may be made for cardiovascular screening tests performed for an asymptomatic individual only if the individual has not had the screening tests paid for by Medicare during the preceding 59 months following the month in which the last cardiovascular screening tests were performed.

■ 12. A new § 410.18 is added to read as follows:

§ 410.18 Diabetes screening tests.

(a) *Definitions.* For purposes of this section, the following definitions apply:

Diabetes means diabetes mellitus, a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting blood sugar greater than or equal to 126 mg/dL on two different occasions; a 2-hour post-glucose challenge greater than or equal to 200 mg/dL on two different occasions; or a random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.

Pre-diabetes means a condition of abnormal glucose metabolism diagnosed using the following criteria: a fasting glucose level of 100—125 mg/dL, or a 2-hour post-glucose challenge of 140—199 mg/dL. The term pre-diabetes includes the following conditions:

(1) Impaired fasting glucose.
(2) Impaired glucose tolerance.

(b) *General conditions of coverage.* Medicare Part B covers diabetes screening tests after a referral from a physician or qualified nonphysician practitioner to an individual at risk for diabetes for the purpose of early detection of diabetes.

(c) *Types of tests covered.* The following tests are covered if all other conditions of this subpart are met:

(1) Fasting blood glucose test.

(2) Post-glucose challenges including, but not limited to, an oral glucose tolerance test with a glucose challenge of 75 grams of glucose for non-pregnant adults, a 2-hour post glucose challenge test alone.

(3) Other tests as determined by the Secretary through a national coverage determination.

(d) *Amount of testing covered.* Medicare covers the following for individuals:

(1) Diagnosed with pre-diabetes, two screening tests per calendar year.

(2) Previously tested who were not diagnosed with pre-diabetes, or who were never tested before, one screening test per year.

(e) *Eligible risk factors.* Individuals with the following risk factors are eligible to receive the benefit:

(1) Hypertension.
(2) Dyslipidemia.
(3) Obesity, defined as a body mass index greater than or equal to 30 kg/m^2.
(4) Prior identification of impaired fasting glucose or glucose intolerance.
(5) Any two of the following characteristics:
(i) Overweight, defined as body mass index greater than 25, but less than 30 kg/m^2.
(ii) A family history of diabetes.
(iii) 65 years of age or older.
(iv) A history of gestational diabetes mellitus or delivery of a baby weighing more than 9 pounds.

■ 13. Section 410.26 is amended by revising paragraph (c) to read as follows:

§ 410.26 Services and supplies incident to a physician's professional services: Conditions.

* * * * *

(c) *Limitations.* (1) Drugs and biologicals are also subject to the limitations specified in § 410.29.

(2) Physical therapy, occupational therapy and speech-language pathology services provided incident to a physician's professional services are subject to the provisions established in § 410.59(a)(3)(iii), § 410.60(a)(3)(iii), and § 410.62(a)(3)(ii).

■ 14. Section 410.32 is amended by revising paragraph (b)(2)(iii) to read as follows:

§ 410.32 Diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests: Conditions.

* * * * *

(b) * * *
(2) * * *

(iii) Diagnostic psychological testing services when—

(A) Personally furnished by a clinical psychologist or an independently practicing psychologist as defined in program instructions; or

(B) Furnished under the general supervision of a physician or a clinical psychologist.

* * * * *

■ 15. Section 410.59 is amended by—
■ A. Revising paragraph (a) introductory text and paragraph (a)(3)(ii).
■ B. Adding new paragraph (a)(3)(iii).
■ C. Revising paragraph (b) heading.
■ C. Revising paragraph (c)(2).
■ D. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.59 Outpatient occupational therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient occupational therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of

this chapter for an occupational therapist or by an appropriately supervised occupational therapy assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of, an occupational therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform occupational therapy services within the scope of State law. When an occupational therapy service is provided incident to the service of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to occupational therapy and occupational therapists, except that a license to practice occupational therapy in the State is not required.

(b) *Conditions for coverage of outpatient therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of occupational therapy services.* Occupational therapy services are performed by, or under the direct supervision of, an occupational therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 16. Section 410.60 is amended by—

■ A. Revising paragraph (a) introductory text.

■ B. Revising paragraph (a)(3)(ii).

■ C. Adding new paragraph (a)(3)(iii).

■ D. Revising paragraph (b) heading.

■ E. Revising paragraph (c)(2).

■ F. Adding new paragraph (e)(1)(iii).

The additions and revisions read as follows:

§ 410.60 Outpatient physical therapy services: Conditions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(iii) of this section, Medicare Part B pays for outpatient physical therapy services only if they are furnished by an individual meeting the qualifications in § 484.4 of this chapter for a physical therapist or by an appropriately supervised physical therapist assistant but only under the following conditions:

* * * * *

(3) * * *

(ii) By, or under the direct supervision of a physical therapist in private practice as described in paragraph (c) of this section; or

(iii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform physical therapy services under State law. When a physical therapy service is provided incident to the service of a physician, physician's assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to physical therapy and physical therapists, except that a license to practice physical therapy in the State is not required.

(b) *Condition for coverage of outpatient physical therapy services furnished to certain inpatients of a hospital or a CAH or SNF.* * * *

(c) * * *

(2) *Supervision of physical therapy services.* Physical therapy services are performed by, or under the direct supervision of, a physical therapist in private practice. All services not performed personally by the therapist must be performed by employees of the practice, directly supervised by the therapist, and included in the fee for the therapist's services.

* * * * *

(e) * * *

(1) * * *

(iii) The limitation is not applied for services furnished from December 8, 2003 through December 31, 2005.

* * * * *

■ 17. Section 410.62 is amended by—

■ A. Revising paragraph (a) introductory text and (a)(2)(i), (a)(2)(iii) and (a)(3).

■ B. Revising paragraphs (b) and (c).

The revisions read as follows:

§ 410.62 Outpatient speech-language pathology services: Conditions and exclusions.

(a) *Basic rule.* Except as specified in paragraph (a)(3)(ii) of this section, Medicare Part B pays for outpatient speech-language pathology services only if they are furnished by an individual who meets the qualifications for a speech-language pathologist in § 484.4 of this chapter and only under the following conditions:

* * * * *

(2) * * *

(i) Is established by a physician or, effective January 1, 1982, by either a physician or the speech-language pathologist who provides the services to the particular individual;

(ii) * * *

(iii) Meets the requirements of § 410.61.

(3) They are furnished—

(i) By a provider as defined in § 489.2 of this chapter, or by others under arrangements with, and under the supervision of, a provider; or

(ii) By, or incident to the service of, a physician, physician assistant, clinical nurse specialist, or nurse practitioner when those professionals may perform speech-language pathology services under State law. When a speech-language pathology service is provided incident to the services of a physician, physician assistant, clinical nurse specialist, or nurse practitioner, by anyone other than a physician, physician assistant, clinical nurse specialist, or nurse practitioner, the service and the person who furnishes the service must meet the standards and conditions that apply to speech-language pathology and speech-language pathologists, except that a license to practice speech-language pathology services in the State is not required.

(b) *Condition for coverage of outpatient speech-language pathology services to certain inpatients of a hospital, CAH, or SNF.* Medicare Part B pays for outpatient speech-language pathology services furnished to an inpatient of a hospital, CAH, or SNF who requires the services but has exhausted or is otherwise ineligible for benefit days under Medicare Part A.

(c) Excluded services. No service is included as an outpatient speech-language pathology service if it is not included as an inpatient hospital service if furnished to a hospital or CAH inpatient.

* * * * *

■ 18. Section 410.63 is amended by—

■ A. Revising paragraph (b) heading.

■ B. Adding a new paragraph (c).

The revision and addition reads as follows:

§ 410.63 Hepatitis B vaccine and blood clotting factors: Conditions.

* * * * *

(b) *Blood clotting factors: Conditions.* * * *

(c) *Blood clotting factors: Furnishing Fee.*

(1) Effective January 1, 2005, a furnishing fee of $0.14 per unit of clotting factor is paid to entities that furnish blood clotting factors unless the costs associated with furnishing the clotting factor are paid through another payment system, for example, hospitals that furnish clotting factor to patients during a Part A covered inpatient hospital stay.

(2) The furnishing fee for blood clotting factors furnished in 2006 or a subsequent year is be equal to the furnishing fee paid the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

■ 19. Section 410.78 is amended by—
■ A. Revising paragraph (a)(4).
■ B. Revising paragraph (b) introductory text.

The revisions read as follows:

§ 410.78 Telehealth services.

* * *

(4) *Originating site* means the location of an eligible Medicare beneficiary at the time the service being furnished via a telecommunications system occurs. For asynchronous store and forward telecommunications technologies, the only originating sites are Federal telemedicine demonstration programs conducted in Alaska or Hawaii.

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

■ 20. Section 410.160 is amended by revising paragraph (f) to read as follows:

§ 410.160 Part B annual deductible.

* * * * *

(f) *Amount of the Part B annual deductible.* (1) Beginning with expenses for services furnished during calendar year 2006, and for all succeeding years, the annual deductible is the previous year's deductible plus the annual percentage increase in the monthly actuarial rate for Medicare enrollees age 65 and over, rounded to the nearest dollar.

(2) For 2005, the deductible is $110.

(3) From 1991 through 2004, the deductible was $100.

(4) From 1982 through 1990, the deductible was $75.

(5) From 1973 through 1981, the deductible was $60.

(6) From 1966 through 1972, the deductible was $50.

* * * * *

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

■ 21. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 22. Section 411.15 is amended by—
■ A. Revising paragraph (a)(1).
■ B. Adding paragraph (k)(11).

The revision and addition read as follows:

§ 411.15 Particular services excluded from coverage.

* * * * *

(a) * * *

(1) Examinations performed for a purpose other than treatment or diagnosis of a specific illness, symptoms, complaint, or injury, except for screening mammography, colorectal cancer screening tests, screening pelvic exams, prostate cancer screening tests, glaucoma screening exams, or initial preventive physical examinations that meet the criteria specified in paragraphs (k)(6) through (k)(11) of this section.

* * * * *

(k) * * *

(11) In the case of initial preventive physical examinations, with the goal of health promotion and disease prevention, subject to the conditions and limitations specified in § 410.16 of this chapter.

* * * * *

■ 23. Section 411.404 is amended by revising paragraph (b) to read as follows:

§ 411.404 Criteria for determining that a beneficiary knew that services were excluded from coverage as custodial care or as not reasonable and necessary.

* * * * *

(b) *Written notice.* (1) Written notice is given to the beneficiary, or to someone acting on his or her behalf, that the services were not covered because they did not meet Medicare coverage guidelines.

(2) A notice concerning similar or reasonably comparable services furnished on a previous occasion also meets this criterion.

(3) After a beneficiary is notified that there is no Medicare payment for a service that is not covered by Medicare, he or she is presumed to know that there is no Medicare payment for any form of subsequent treatment for the non-covered condition.

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES.

■ 24. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(1) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(1)).

§ 414.38 [Removed]

■ 25. Section 414.38 is removed.
■ 26. Section 414.39 is amended by—
■ A. Revising paragraph (a).
■ B. Adding paragraph (c).

The revision and addition read as follows:

§ 414.39 Special rules for payment of care plan oversight.

(a) *General.* Except as specified in paragraphs (b) and (c) of this section, payment for care plan oversight is included in the payment for visits and other services under the physician fee schedule. For purposes of this section a nonphysician practitioner (NPP) is a nurse practitioner, clinical nurse specialist or physician assistant.

* * * * *

(c) *Special rules for payment of care plan oversight provided by nonphysician practitioners for beneficiaries who receive HHA services covered by Medicare.*

(1) An NPP can furnish physician care plan oversight (but may not certify a patient as needing home health services) if the physician who signs the plan of care provides regular ongoing care under the same plan of care as does the NPP billing for care plan oversight and either:

(i) The physician and NPP are part of the same group practice; or

(ii) If the NPP is a nurse practitioner or clinical nurse specialist, the physician signing the plan of care also has a collaborative agreement with the NPP; or

(iii) If the NPP is a physician assistant, the physician signing the plan of care is also the physician who provides general supervision of physician assistant services for the practice.

(2) Payment may be made for care plan oversight services furnished by an NPP when:

(i) The NPP providing the care plan oversight has seen and examined the patient;

(ii) The NPP providing care plan oversight is not functioning as a

consultant whose participation is limited to a single medical condition rather than multi-disciplinary coordination of care; and

(iii) The NPP providing care plan oversight integrates his or her care with that of the physician who signed the plan of care.

■ 27. Section 414.65 is amended by revising paragraph (a)(1) to read as follows:

§ 414.65 Payment for telehealth services.

(a) * * *

(1) The Medicare payment amount for office or other outpatient visits, consultation, individual psychotherapy, psychiatric diagnostic interview examination, pharmacologic management and end stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site) furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner.

* * * * *

■ 28. Section 414.66 is added to subpart B to read as follows:

§ 414.66 Incentive payments for physician scarcity areas.

(a) *Definition.* As used in this section, the following definitions apply.

Physician scarcity area is defined as an area with a shortage of primary care physicians or specialty physicians to the Medicare population in that area.

Primary care physician is defined as a general practitioner, family practice practitioner, general internist, obstetrician or gynecologist.

(b) Physicians' services furnished to a beneficiary in a Physician Scarcity Area (PSA) for primary or specialist care are eligible for a 5 percent incentive payment.

(c) Primary care physicians furnishing services in primary care PSAs are entitled to an additional 5 percent incentive payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

(d) Physicians, as defined in section 1861(r)(1) of the Act, furnishing services in specialist care PSAs are entitled to an additional 5 percent payment above the amount paid under the physician fee schedule for their professional services furnished on or after January 1, 2005 and before January 1, 2008.

■ 29. Section 414.67 is added to subpart B to read as follows:

§ 414.67 Incentive payments for Health Professional Shortage Areas.

(a) Physicians' services furnished to a beneficiary in a geographic-based Health Professional Shortage Area (HPSA) are eligible for a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(b) Physicians furnishing services in a geographic-based primary medical care HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule.

(c) Psychiatrists furnishing services in a mental health HPSA are entitled to a 10 percent incentive payment above the amount paid for their professional services under the physician fee schedule. (The only physicians eligible to receive the 10 percent incentive payment in mental health HPSAs that do not overlap with primary care HPSAs are psychiatrists.)

■ 30. Part 414 is amended by adding a new subpart K to read as follows:

Subpart K—Payment for Drugs and Biologicals in 2005

Sec.

Subpart K—Payment for Drugs and Biologicals in 2005

§ 414.900 Basis.

(a) This subpart implements section 1842(o) of the Act by specifying the methodology for determining the payment allowance limit for drugs and biologicals covered under Medicare Part B that are not paid on a cost or prospective payment system basis.

(b) Examples of drugs that are subject to the requirements specified in this subpart are:

(1) Drugs furnished incident to a physician's service; durable medical equipment (DME) drugs.

(2) Separately billable drugs at independent dialysis facilities not under the ESRD composite rate.

(3) Statutorily covered drugs, for example—

(i) Influenza.

(ii) Pneumococcal and hepatitis vaccines.

(iii) Antigens.

(iv) Hemophilia blood clotting factor.

(v) Immunosuppressive drugs.

(vi) Certain oral anti-cancer drugs.

§ 414.902 Definitions.

As used in this subpart, unless the context indicates otherwise—

Drug means both drugs and biologicals.

Manufacturer's average sales price means the price calculated and reported by a manufacturer under part 414, subpart J of this chapter.

Multiple source drug means a drug described by section 1847A(c)(6)(C) of the Act.

Single source drug means a drug described by section 1847A(c)(6)(D) of the Act.

Unit is defined as in part 414, subpart J of this chapter.

Wholesale acquisition cost (WAC) means the price described by section 1847A(c)(6)(B) of the Act.

§ 414.904 Basis of payment.

(a) *Method of payment.* Payment for a drug for calendar year 2005 is based on the lesser of—

(1) The actual charge on the claim for program benefits; or

(2) 106 percent of the average sales price, subject to the applicable limitations specified in paragraph (d) of this section or subject to the exceptions described in paragraph (e) of this section.

(b) *Multiple source drugs.* (1) *Average sales prices.* The average sales price for all drug products included within the same multiple source drug billing and payment code is the volume-weighted average of the manufacturers' average sales prices for those drug products.

(2) *Calculation of the average sales price.* The average sales price is determined by—

(i) Computing the sum of the products (for each National Drug Code assigned to the drug products) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug products.

(c) *Single source drugs.* (1) *Average sales price.* The average sales price is the volume-weighted average of the manufacturers' average sales prices for all National Drug Codes assigned to the drug or biological product.

(2) *Calculation of the average sales price.* The average sales price is determined by computing—

(i) The sum of the products (for each National Drug Code assigned to the drug product) of the manufacturer's average sales price and the total number of units sold; and

(ii) Dividing that sum by the sum of the total number of units sold for all NDCs assigned to the drug product.

(d) *Limitations on the average sales price.* (1) *Wholesale acquisition cost for a single source drug.* The payment limit for a single source drug product is the lesser of 106 percent of the average sales price for the product or 106 percent of

the wholesale acquisition cost for the product.

(2) *Payment limit for a drug furnished to an end-stage renal disease patient.* (i) Effective for drugs and biologicals furnished in 2005, the payment for such drugs and biologicals, including erythropoietin, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility and not paid on a cost basis is acquisition cost as determined by the Inspector General report as required by section 623(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 inflated by the percentage increase in the Producer Price Index.

(ii) Except as provided in paragraph (a) of this section, the payment for drugs and biologicals, furnished to an end-stage renal disease patient that is separately billed by an end-stage renal disease facility, is based on 106 percent of the average sales price.

(3) *Widely available market price and average manufacturer price.* If the Inspector General finds that the average sales price exceeds the widely available market price or the average manufacturer price by 5 percent or more in calendar year 2005, the payment limit in the quarter following the transmittal of this information to the Secretary is the lesser of the widely available market price or 103 percent of the average manufacturer price.

(e) *Exceptions to the average sales price.* (1) *Vaccines.* The payment limits for hepatitis B vaccine furnished to individuals at high or intermediate risk of contracting hepatitis B (as determined by the Secretary), pneumococcal vaccine, and influenza vaccine and are calculated using 95 percent of the average wholesale price.

(2) *Infusion drugs furnished through a covered item of durable medical equipment.* The payment limit for an infusion drug furnished through a covered item of durable medical equipment is calculated using 95 percent of the average wholesale price in effect on October 1, 2003 and is not updated in 2005.

(3) *Blood and blood products.* In the case of blood and blood products (other than blood clotting factors), the payment limits are determined in the same manner as the payment limits were determined on October 1, 2003.

(4) *Payment limit in a case where the average sales price during the first quarter of sales is unavailable.* In the case of a drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales of the drug are not sufficiently available from the manufacturer to compute an average sales price for the drug, the payment limit is based on the wholesale acquisition cost or the applicable Medicare Part B drug payment methodology in effect on November 1, 2003.

(f) Except as otherwise specified (see paragraph (e)(2) of this section) for infusion drugs, the payment limits are updated quarterly.

(g) The payment limit is computed without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

(h) The payment amount is subject to applicable deductible and coinsurance.

■ 31. Part 414 is amended by adding a new subpart L to read as follows:

Subpart L—Supplying and Dispensing Fees

Sec.
414.1000 Purpose.
414.1001 Basis of Payment.

§ 414.1000 Purpose.

This subpart implements section 1842(o)(2) and section 1842(o)(6) of the Act, as added by section 303(e)(2) of the MMA, by specifying a supplying fee for drugs and biologicals covered under Part B of Title XVIII of the Act that are described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

§ 414.1001 Basis of payment.

(a) A supplying fee of $24 shall be paid to a pharmacy for each supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J), 1861(s)(2)(Q), and 1861(s)(2)(T) of the Act.

(b) A supplying fee of $50 is paid to a pharmacy for the initial supplied prescription of drugs and biologicals described in sections 1861(s)(2)(J) of the Act provided to a patient during the first month following a transplant.

(c) During 2005, a dispensing fee of $57 is paid to a supplier for each dispensed 30-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 30-day supply.

(d) During 2005, a dispensing fee of $80 is paid to a supplier for each dispensed 90-day supply of inhalation drugs furnished through durable medical equipment covered under section 1861(n) of the Act, regardless of the number of partial shipments of that 90-day supply.

PART 418—HOSPICE CARE

■ 32. The authority citation for part 418 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 33. Section 418.205 is added to subpart F to read as follows:

§ 418.205 Special requirements for hospice pre-election evaluation and counseling services.

(a) *Definition.* As used in this section the following definition applies.

Terminal illness has the same meaning as defined in § 418.3.

(b) *General.* Effective January 1, 2005, payment for hospice pre-election evaluation and counseling services as specified in §418.304(d) may be made to a hospice on behalf of a Medicare beneficiary if the requirements of this section are met.

(1) *The beneficiary.* The beneficiary:

(i) Has been diagnosed as having a terminal illness as defined in § 418.3.

(ii) Has not made a hospice election.

(iii) Has not previously received hospice pre-election evaluation and consultation services specified under this section.

(2) *Services provided.* The hospice pre-election services include an evaluation of an individual's need for pain and symptom management and counseling regarding hospice and other care options. In addition, the services may include advising the individual regarding advanced care planning.

(3) *Provision of pre-election hospice services.*

(i) The services must be furnished by a physician.

(ii) The physician furnishing these services must be an employee or medical director of the hospice billing for this service.

(iii) The services cannot be furnished by hospice personnel other than employed physicians, such as but not limited to nurse practitioners, nurses, or social workers, physicians under contractual arrangements with the hospice or by the beneficiary's physician, if that physician is not an employee of the hospice.

(iv) If the beneficiary's attending physician is also the medical director or a physician employee of the hospice, the attending physician may not provide nor may the hospice bill for this service because that physician already possesses the expertise necessary to furnish end-of-life evaluation and management, and counseling services.

(4) *Documentation.* (i) If the individual's physician initiates the request for services of the hospice medical director or physician, appropriate documentation is required.

(ii) The request or referral must be in writing, and the hospice medical

director or physician employee is expected to provide a written note on the patient's medical record.

(iii) The hospice agency employing the physician providing these services is required to maintain a written record of the services furnished.

(iv) If the services are initiated by the beneficiary, the hospice agency is required to maintain a record of the services and documentation that communication between the hospice medical director or physician and the beneficiary's physician occurs, with the beneficiary's permission, to the extent necessary to ensure continuity of care.

■ 34. Section 418.304 is amended by adding paragraph (d) to read as follows.

§ 418.304 Payment for physician services.

* * * * *

(d) *Payment for hospice pre-election evaluation and counseling services.* The intermediary makes payment to the hospice for the services established in § 418.205. Payment for this service is set at an amount established under the physician fee schedule, for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity and requiring medical decision-making of low complexity other than the portion of the amount attributable to the practice expense component. Payment for this pre-election service does not count towards the hospice cap amount.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

■ 35. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

■ 36. Section 424.55 is amended by adding new paragraph (c) to read as follows:

§ 424.55 Payment to the supplier.

* * * * *

(c) *Exception.* In situations when payment under the Act can only be made on an assignment-related basis or when payment is for services furnished by a participating physician or supplier, the beneficiary (or the person authorized to request payment on the beneficiary's behalf) is not required to assign the claim to the supplier in order for an assignment to be effective.

■ 37. Section 424.71 is amended as follows:

■ A. The definition of ''Health care delivery system or system'' is removed.

■ B. The definition of the term ''Entity'' is added in alphabetical order.

The addition reads as follows:

§ 424.71 Definitions.

* * * * *

Entity means a person, group, or facility that is enrolled in the Medicare program.

* * * * *

■ 38. Section 424.80 is amended by—

■ A. Revising paragraph (a).

■ B. Revising paragraph (b)(2).

■ C. Removing paragraph (b)(3).

■ D. Redesignating paragraphs (b)(4) through (6) as paragraphs (b)(3) through (5), respectively.

■ E. Revising paragraph (c).

■ F. Adding a new paragraph (d).

The revisions and addition read as follows:

§ 424.80 Prohibition of reassignment of claims by suppliers.

(a) *Basic prohibition.* Except as specified in paragraph (b) of this section, Medicare does not pay amounts that are due a supplier under an assignment to any other person under reassignment, power of attorney, or any other direct arrangement. Nothing in this section alters a party's obligations under the anti-kickback statute (section 1128B(b) of the Act), the physician self-referral prohibition (section 1877 of the Act), the rules regarding physician billing for purchased diagnostic tests (§ 414.50 of this chapter), the rules regarding payment for services and supplies incident to a physician's professional services (§ 410.26 of this chapter), or other laws, rules, and regulations.

(b) * * *

(1) * * *

(2) *Payment to an entity under a contractual arrangement.* Medicare may pay an entity enrolled in the Medicare program if there is a contractual arrangement between the entity and the supplier under which the entity bills for the supplier's services, subject to the provisions of paragraph (d) of this section.

* * * * *

(c) *Rules applicable to an employer or entity.* An employer or entity that may receive payment under paragraph (b)(1) or (b)(2) of this section is considered the supplier of those services for purposes of subparts C, D, and E of this part, subject to the provisions of paragraph (d) of this section.

(d) *Reassignment to an entity under a contractual arrangement: Conditions and limitations.* (1) *Liability of the parties.* An entity enrolled in the Medicare program that receives payment under a contractual arrangement under paragraph (b)(2) of this section and the supplier that otherwise receives payment are jointly and severally responsible for any Medicare overpayment to that entity.

(2) *Access to records.* The supplier furnishing the service has unrestricted access to claims submitted by an entity for services provided by that supplier.

PART 484—HOME HEALTH SERVICES

■ 39. The authority citation for part 484 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

§ 484.4 [Amended]

■ 40. In § 484.4 in the definition of physical therapy assistant the term ''physical therapy assistant'' is removed and the term ''physical therapist assistant'' is added in its place wherever it appears.

PART 486—CONDITIONS FOR COVERAGE OF SPECIALIZED SERVICES FURNISHED BY SUPPLIERS

■ 41. The authority citation for part 486 continues to read as follows:

Authority: Sections 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart D—[Removed and Reserved]

■ 42. Part 486 subpart D, consisting of § 486.150 through § 486.163, is removed and reserved.

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

Dated: November 1, 2004.

Mark B. McClellan,

Administrator, Centers for Medicare & Medicaid Services.

Dated: November 1, 2004.

Tommy G. Thompson,

Secretary.

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

Addendum A—Explanation and Use of Addenda B

The addenda on the following pages provide various data pertaining to the Medicare fee schedule for physicians' services furnished in 2005. Addendum B contains the RVUs for work, non-facility practice expense, facility practice expense, and malpractice expense, and other information for all services included in the physician fee schedule.

In previous years, we have listed many services in Addendum B that are not paid under the physician fee schedule. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes and most alphanumeric

codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) in Addendum B.

Addendum B—2005 Relative Value Units and Related Information Used in Determining Medicare Payments for 2005

This addendum contains the following information for each CPT code and alphanumeric HCPCS code, except for alphanumeric codes beginning with B (enteral and parenteral therapy), E (durable medical equipment), K (temporary codes for nonphysicians' services or items), or L (orthotics), and codes for anesthesiology.

1. *CPT/HCPCS code.* This is the CPT or alphanumeric HCPCS number for the service. Alphanumeric HCPCS codes are included at the end of this addendum.

2. *Modifier.* A modifier is shown if there is a technical component (modifier TC) and a professional component (PC) (modifier -26) for the service. If there is a PC and a TC for the service, Addendum B contains three entries for the code: one for the global values (both professional and technical); one for modifier -26 (PC); and one for modifier TC. The global service is not designated by a modifier, and physicians must bill using the code without a modifier if the physician furnishes both the PC and the TC of the service.

Modifier -53 is shown for a discontinued procedure. There will be RVUs for the code (CPT code 45378) with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is included in the physician fee schedule and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the fee schedule if covered. There will be RVUs for codes with this status. The presence of an ''A'' indicator does not mean that Medicare has made a national decision regarding the coverage of the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payment for covered services is always bundled into payment for other services not specified. If RVUs are shown, they are not used for Medicare payment. If these services are covered, payment for them is subsumed by the payment for the services to which they are incident. (An example is a telephone call from a hospital nurse regarding care of a patient.)

C = Carrier-priced code. Carriers will establish RVUs and payment amounts for these services, generally on a case-by-case basis following review of documentation, such as an operative report.

E = Excluded from physician fee schedule by regulation. These codes are for items or services that we chose to exclude from the physician fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the physician fee schedule for these codes. Payment for them, if they are covered, continues under reasonable charge or other payment procedures.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Code not subject to a 90-day grace period.)

N = Noncovered service. These codes are noncovered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

P = Bundled or excluded code. There are no RVUs for these services. No separate payment should be made for them under the physician fee schedule.

—If the item or service is covered as incident to a physician's service and is furnished on the same day as a physician's service, payment for it is bundled into the payment for the physician's service to which it is incident (an example is an elastic bandage furnished by a physician incident to a physician's service).

—If the item or service is covered as other than incident to a physician's service, it is excluded from the physician fee schedule (for example, colostomy supplies) and is paid under the other payment provisions of the Act.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = Injections. There are RVUs for these services, but they are only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Exclusion by law. These codes represent an item or service that is not within the definition of ''physicians' services'' for physician fee schedule payment purposes. No RVUs are shown for these codes, and no payment may be made under the physician fee schedule. (Examples are ambulance services and clinical diagnostic laboratory services.)

4. *Description of code.* This is an abbreviated version of the narrative description of the code.

5. *Physician work RVUs.* These are the RVUs for the physician work for this service in 2005. Codes that are not used for Medicare payment are identified with a ''+.''

6. *Facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for facility settings.

7. *Non-facility practice expense RVUs.* These are the fully implemented resource-based practice expense RVUs for non-facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2005.

9. *Facility total.* This is the sum of the work, fully implemented facility practice expense, and malpractice expense RVUs.

10. *Non-facility total.* This is the sum of the work, fully implemented non-facility practice expense, and malpractice expense RVUs.

11. *Global period.* This indicator shows the number of days in the global period for the code (0, 10, or 90 days). An explanation of the alpha codes follows:

MMM = The code describes a service furnished in uncomplicated maternity cases including antepartum care, delivery, and postpartum care. The usual global surgical concept does not apply. See the 1999 Physicians' Current Procedural Terminology for specific definitions.

XXX = The global concept does not apply.

YYY = The global period is to be set by the carrier (for example, unlisted surgery codes).

ZZZ = Code related to another service that is always included in the global period of the other service. (Note: Physician work and practice expense are associated with intra-service time and in some instances the post-service time.)

BILLING CODE 4120–01–P

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0003T		C	Cervicography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0008T		C	Upper gi endoscopy w/suture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0010T		C	Tb test, gamma interferon	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0018T		C	Transcranial magnetic stimul	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0019T		I	Extracorp shock wave tx, ms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0020T		C	Extracorp shock wave tx, ft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0021T		C	Fetal oximetry, trnsvag/cerv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0023T		C	Phenotype drug test, hiv 1	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0024T		C	Transcath cardiac reduction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0026T		C	Measure remnant lipoproteins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0027T		C	Endoscopic epidural lysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0028T		C	Dexa body composition study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0029T		C	Magnetic tx for incontinence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0031T		C	Speculoscopy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0032T		C	Speculoscopy w/direct sample	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0033T		C	Endovasc taa repr incl subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0034T		C	Endovasc taa repr w/o subcl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0035T		C	Insert endovasc prosth, taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0036T		C	Endovasc prosth, taa, add-on	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0037T		C	Artery transpose/endovas taa	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0038T		C	Rad endovasc taa rpr w/cover	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0039T		C	Rad s/i, endovasc taa repair	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0040T		C	Rad s/i, endovasc taa prosth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0041T		C	Detect ur infect agnt w/cpas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0043T		C	Co expired gas analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0044T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0045T		C	Whole body photography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0046T		C	Cath lavage, mammary duct(s	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0047T		C	Cath lavage, mammary duct(s)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0049T		C	External circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0056T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0058T		C	Cryopreservation, ovary tiss	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0059T		C	Cryopreservation, oocyte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0060T		C	Electrical impedance scan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0061T		C	Destruction of tumor, breast	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0062T		C	Rep intradisc annulus;1 lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0063T		C	Rep intradisc annulus;>1lev	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0065T		C	Ocular photoscreen bilat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0066T		C	Ct colonography;screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	18.02	NA	0.13	18.15	NA	XXX
0074T		C	Online physician e/m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0076T		C	S&i stent/chest vert art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&i	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0082T		C	Stereotactic rad delivery	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0083T		C	Stereotactic rad tx mngmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0085T		C	Breath test heart reject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0088T		C	Rf tongue base vol reduxn	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0500F		I	Initial prenatal care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
0501F		I	Prenatal flow sheet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0502F		I	Subsequent prenatal care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
0503F		I	Postpartum care visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1000F		I	Tobacco use, smoking, assess	0.00	0.00	0.00	0.00	0.00	0.00	XXX
1001F		I	Tobacco use, non-smoking	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.15	0.54	0.10	3.52	1.91	XXX
10022		A	Fna w/image	1.27	2.54	0.42	0.08	3.89	1.77	XXX
1002F		I	Assess anginal symptom/level	0.00	0.00	0.00	0.00	0.00	0.00	XXX
10040		A	Acne surgery	1.18	1.01	0.79	0.06	2.25	2.03	010
10060		A	Drainage of skin abscess	1.17	1.21	0.93	0.12	2.50	2.22	010
10061		A	Drainage of skin abscess	2.40	1.82	1.50	0.26	4.48	4.16	010
10080		A	Drainage of pilonidal cyst	1.17	3.10	1.11	0.11	4.38	2.39	010
10081		A	Drainage of pilonidal cyst	2.45	4.07	1.50	0.25	6.77	4.20	010
10120		A	Remove foreign body	1.22	2.17	0.97	0.12	3.51	2.31	010
10121		A	Remove foreign body	2.69	3.51	1.78	0.32	6.52	4.79	010
10140		A	Drainage of hematoma/fluid	1.53	1.77	1.29	0.19	3.49	3.01	010
10160		A	Puncture drainage of lesion	1.20	1.60	1.08	0.14	2.94	2.42	010
10180		A	Complex drainage, wound	2.25	2.98	1.98	0.33	5.56	4.56	010
11000		A	Debride infected skin	0.60	0.58	0.22	0.07	1.25	0.89	000
11001		A	Debride infected skin add-on	0.30	0.23	0.11	0.03	0.56	0.44	ZZZ
11004		A	Debride genitalia & perineum	10.31	NA	3.90	0.67	NA	14.88	000
11005		A	Debride abdom wall	13.75	NA	5.56	0.96	NA	20.27	000
11006		A	Debride genit/per/abdom wall	12.61	NA	4.85	1.28	NA	18.74	000
11008		A	Remove mesh from abd wall	5.00	NA	2.02	0.61	NA	7.63	ZZZ
11010		A	Debride skin, fx	4.19	6.87	2.62	0.60	11.66	7.41	010
11011		A	Debride skin/muscle, fx	4.94	8.16	2.34	0.70	13.80	7.98	000
11012		A	Debride skin/muscle/bone, fx	6.87	12.10	3.84	1.12	20.09	11.83	000
11040		A	Debride skin, partial	0.50	0.52	0.21	0.06	1.08	0.77	000
11041		A	Debride skin, full	0.82	0.66	0.33	0.10	1.58	1.25	000
11042		A	Debride skin/tissue	1.12	0.97	0.44	0.13	2.22	1.69	000
11043		A	Debride tissue/muscle	2.38	3.38	2.59	0.29	6.05	5.26	010
11044		A	Debride tissue/muscle/bone	3.06	4.45	3.75	0.40	7.91	7.21	010
11055		R	Trim skin lesion	0.43	0.56	0.17	0.05	1.04	0.65	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.64	0.23	0.07	1.32	0.91	000
11057		R	Trim skin lesions, over 4	0.79	0.74	0.30	0.10	1.63	1.19	000
11100		A	Biopsy, skin lesion	0.81	1.25	0.37	0.04	2.10	1.22	000
11101		A	Biopsy, skin add-on	0.41	0.33	0.19	0.02	0.76	0.62	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11200		A	Removal of skin tags	0.77	1.04	0.76	0.05	1.86	1.58	010
11201		A	Remove skin tags add-on	0.29	0.16	0.12	0.02	0.47	0.43	ZZZ
11300		A	Shave skin lesion	0.51	0.99	0.21	0.03	1.53	0.75	000
11301		A	Shave skin lesion	0.85	1.11	0.38	0.05	2.01	1.28	000
11302		A	Shave skin lesion	1.05	1.30	0.46	0.05	2.40	1.56	000
11303		A	Shave skin lesion	1.24	1.58	0.52	0.07	2.89	1.83	000
11305		A	Shave skin lesion	0.67	0.85	0.27	0.07	1.59	1.01	000
11306		A	Shave skin lesion	0.99	1.10	0.42	0.08	2.17	1.49	000
11307		A	Shave skin lesion	1.14	1.29	0.49	0.08	2.51	1.71	000
11308		A	Shave skin lesion	1.41	1.45	0.59	0.13	2.99	2.13	000
11310		A	Shave skin lesion	0.73	1.11	0.32	0.05	1.89	1.10	000
11311		A	Shave skin lesion	1.05	1.23	0.49	0.06	2.34	1.60	000
11312		A	Shave skin lesion	1.20	1.42	0.55	0.06	2.68	1.81	000
11313		A	Shave skin lesion	1.62	1.80	0.72	0.10	3.52	2.44	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.85	1.99	0.88	0.07	2.91	1.80	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.23	2.05	1.02	0.10	3.38	2.35	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.51	2.22	1.08	0.13	3.86	2.72	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.79	2.39	1.32	0.17	4.35	3.28	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.06	2.70	1.40	0.21	4.97	3.67	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	2.76	3.06	1.65	0.32	6.14	4.73	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	0.98	1.76	0.93	0.10	2.84	2.01	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.42	2.06	1.11	0.13	3.61	2.66	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.63	2.25	1.33	0.15	4.03	3.11	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.01	2.58	1.45	0.20	4.79	3.66	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.43	2.80	1.60	0.25	5.48	4.28	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	3.77	3.48	2.10	0.42	7.67	6.29	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.06	2.20	1.31	0.08	3.34	2.45	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.48	2.33	1.49	0.13	3.94	3.10	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.72	2.54	1.57	0.15	4.41	3.44	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.29	2.91	1.81	0.21	5.41	4.31	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.14	3.47	2.18	0.29	6.90	5.61	010
11446		A	Exc face-mm b9+marg > 4 cm	4.48	4.04	2.77	0.42	8.94	7.67	010
11450		A	Removal, sweat gland lesion	2.73	5.03	2.02	0.34	8.10	5.09	090
11451		A	Removal, sweat gland lesion	3.94	6.60	2.54	0.51	11.05	6.99	090
11462		A	Removal, sweat gland lesion	2.51	5.11	2.01	0.30	7.92	4.82	090
11463		A	Removal, sweat gland lesion	3.94	6.82	2.68	0.51	11.27	7.13	090
11470		A	Removal, sweat gland lesion	3.25	5.06	2.26	0.39	8.70	5.90	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11471		A	Removal, sweat gland lesion	4.40	6.70	2.76	0.55	11.65	7.71	090
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.31	2.63	0.97	0.10	4.04	2.38	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	1.80	2.70	1.22	0.12	4.62	3.14	010
11602		A	Exc tr-ext mlg+marg 1.1-2 cm	1.95	2.82	1.26	0.13	4.90	3.34	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.19	3.07	1.33	0.16	5.42	3.68	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	2.40	3.37	1.39	0.20	5.97	3.99	010
11606		A	Exc tr-ext mlg+marg > 4 cm	3.42	4.06	1.73	0.36	7.84	5.51	010
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.19	2.59	0.95	0.10	3.88	2.24	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	1.76	2.70	1.24	0.12	4.58	3.12	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.09	2.96	1.39	0.14	5.19	3.62	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	2.61	3.33	1.58	0.20	6.14	4.39	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.06	3.74	1.77	0.27	7.07	5.10	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.29	4.63	2.39	0.44	9.36	7.12	010
11640		A	Exc face-mm malig+marg 0.5 <	1.35	2.65	1.11	0.10	4.10	2.56	010
11641		A	Exc face-mm malig+marg 0.6-1	2.16	3.02	1.53	0.16	5.34	3.85	010
11642		A	Exc face-mm malig+marg 1.1-2	2.59	3.40	1.71	0.19	6.18	4.49	010
11643		A	Exc face-mm malig+marg 2.1-3	3.10	3.80	1.96	0.25	7.15	5.31	010
11644		A	Exc face-mm malig+marg 3.1-4	4.02	4.68	2.45	0.37	9.07	6.84	010
11646		A	Exc face-mm mlg+marg > 4 cm	5.94	5.75	3.47	0.60	12.29	10.01	010
11719		R	Trim nail(s)	0.17	0.25	0.07	0.02	0.44	0.26	000
11720		A	Debride nail, 1-5	0.32	0.34	0.12	0.04	0.70	0.48	000
11721		A	Debride nail, 6 or more	0.54	0.44	0.21	0.07	1.05	0.82	000
11730		A	Removal of nail plate	1.13	1.03	0.43	0.14	2.30	1.70	000
11732		A	Remove nail plate, add-on	0.57	0.44	0.22	0.07	1.08	0.86	ZZZ
11740		A	Drain blood from under nail	0.37	0.55	0.35	0.04	0.96	0.76	000
11750		A	Removal of nail bed	1.86	2.16	1.75	0.22	4.24	3.83	010
11752		A	Remove nail bed/finger tip	2.67	2.99	2.99	0.35	6.01	6.01	010
11755		A	Biopsy, nail unit	1.31	1.57	0.77	0.15	3.03	2.23	000
11760		A	Repair of nail bed	1.58	2.62	1.78	0.20	4.40	3.56	010
11762		A	Reconstruction of nail bed	2.89	2.88	2.34	0.36	6.13	5.59	010
11765		A	Excision of nail fold, toe	0.69	1.78	0.76	0.08	2.55	1.53	010
11770		A	Removal of pilonidal lesion	2.61	3.48	1.50	0.31	6.40	4.42	010
11771		A	Removal of pilonidal lesion	5.73	5.64	3.31	0.73	12.10	9.77	090
11772		A	Removal of pilonidal lesion	6.97	7.50	5.07	0.88	15.35	12.92	090
11900		A	Injection into skin lesions	0.52	0.65	0.21	0.03	1.20	0.76	000
11901		A	Added skin lesions injection	0.80	0.66	0.35	0.03	1.49	1.18	000
11920		R	Correct skin color defects	1.61	3.70	1.09	0.23	5.54	2.93	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
11921		R	Correct skin color defects	1.93	3.96	1.27	0.28	6.17	3.48	000
11922		R	Correct skin color defects	0.49	1.14	0.25	0.07	1.70	0.81	ZZZ
11950		R	Therapy for contour defects	0.84	1.14	0.39	0.06	2.04	1.29	000
11951		R	Therapy for contour defects	1.19	1.49	0.51	0.11	2.79	1.81	000
11952		R	Therapy for contour defects	1.69	1.85	0.68	0.16	3.70	2.53	000
11954		R	Therapy for contour defects	1.85	2.44	0.90	0.24	4.53	2.99	000
11960		A	Insert tissue expander(s)	9.07	NA	10.39	1.28	NA	20.74	090
11970		A	Replace tissue expander	7.05	NA	6.13	1.03	NA	14.21	090
11971		A	Remove tissue expander(s)	2.13	9.11	3.79	0.30	11.54	6.22	090
11975		N	Insert contraceptive cap	+1.48	1.42	0.57	0.17	3.07	2.22	XXX
11976		R	Removal of contraceptive cap	1.78	1.72	0.68	0.21	3.71	2.67	000
11977		N	Removal/reinsert contra cap	+3.30	2.27	1.26	0.37	5.94	4.93	XXX
11980		A	Implant hormone pellet(s)	1.48	1.08	0.54	0.13	2.69	2.15	000
11981		A	Insert drug implant device	1.48	1.70	0.68	0.12	3.30	2.28	XXX
11982		A	Remove drug implant device	1.78	1.94	0.83	0.17	3.89	2.78	XXX
11983		A	Remove/insert drug implant	3.30	2.28	1.47	0.24	5.82	5.01	XXX
12001		A	Repair superficial wound(s)	1.70	1.98	0.77	0.16	3.84	2.63	010
12002		A	Repair superficial wound(s)	1.86	2.04	0.90	0.18	4.08	2.94	010
12004		A	Repair superficial wound(s)	2.24	2.32	1.01	0.22	4.78	3.47	010
12005		A	Repair superficial wound(s)	2.86	2.82	1.20	0.28	5.96	4.34	010
12006		A	Repair superficial wound(s)	3.66	3.39	1.51	0.38	7.43	5.55	010
12007		A	Repair superficial wound(s)	4.11	3.82	1.81	0.44	8.37	6.36	010
12011		A	Repair superficial wound(s)	1.76	2.13	0.78	0.17	4.06	2.71	010
12013		A	Repair superficial wound(s)	1.99	2.27	0.93	0.19	4.45	3.11	010
12014		A	Repair superficial wound(s)	2.46	2.57	1.06	0.23	5.26	3.75	010
12015		A	Repair superficial wound(s)	3.19	3.13	1.25	0.30	6.62	4.74	010
12016		A	Repair superficial wound(s)	3.92	3.55	1.52	0.38	7.85	5.82	010
12017		A	Repair superficial wound(s)	4.70	NA	1.89	0.49	NA	7.08	010
12018		A	Repair superficial wound(s)	5.52	NA	2.25	0.61	NA	8.38	010
12020		A	Closure of split wound	2.62	3.82	1.92	0.30	6.74	4.84	010
12021		A	Closure of split wound	1.84	1.82	1.41	0.23	3.89	3.48	010
12031		A	Layer closure of wound(s)	2.15	2.28	0.96	0.18	4.61	3.29	010
12032		A	Layer closure of wound(s)	2.47	3.84	1.79	0.17	6.48	4.43	010
12034		A	Layer closure of wound(s)	2.92	3.19	1.45	0.26	6.37	4.63	010
12035		A	Layer closure of wound(s)	3.42	5.19	2.15	0.38	8.99	5.95	010
12036		A	Layer closure of wound(s)	4.04	5.55	2.54	0.52	10.11	7.10	010
12037		A	Layer closure of wound(s)	4.66	6.09	2.96	0.62	11.37	8.24	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
12041		A	Layer closure of wound(s)	2.37	2.54	1.13	0.20	5.11	3.70	010
12042		A	Layer closure of wound(s)	2.74	3.26	1.46	0.19	6.19	4.39	010
12044		A	Layer closure of wound(s)	3.14	3.21	1.60	0.29	6.64	5.03	010
12045		A	Layer closure of wound(s)	3.63	5.26	2.28	0.40	9.29	6.31	010
12046		A	Layer closure of wound(s)	4.24	6.50	2.75	0.51	11.25	7.50	010
12047		A	Layer closure of wound(s)	4.64	6.34	3.08	0.56	11.54	8.28	010
12051		A	Layer closure of wound(s)	2.47	3.27	1.45	0.20	5.94	4.12	010
12052		A	Layer closure of wound(s)	2.77	3.22	1.43	0.19	6.18	4.39	010
12053		A	Layer closure of wound(s)	3.12	3.24	1.53	0.24	6.60	4.89	010
12054		A	Layer closure of wound(s)	3.45	3.56	1.63	0.30	7.31	5.38	010
12055		A	Layer closure of wound(s)	4.42	4.48	2.12	0.45	9.35	6.99	010
12056		A	Layer closure of wound(s)	5.23	6.75	3.05	0.57	12.55	8.85	010
12057		A	Layer closure of wound(s)	5.95	6.13	3.75	0.54	12.62	10.24	010
13100		A	Repair of wound or lesion	3.12	4.05	2.30	0.27	7.44	5.69	010
13101		A	Repair of wound or lesion	3.91	4.66	2.68	0.28	8.85	6.87	010
13102		A	Repair wound/lesion add-on	1.24	1.17	0.57	0.13	2.54	1.94	ZZZ
13120		A	Repair of wound or lesion	3.30	4.14	2.34	0.28	7.72	5.92	010
13121		A	Repair of wound or lesion	4.32	4.85	2.79	0.29	9.46	7.40	010
13122		A	Repair wound/lesion add-on	1.44	1.51	0.63	0.15	3.10	2.22	ZZZ
13131		A	Repair of wound or lesion	3.78	4.36	2.68	0.28	8.42	6.74	010
13132		A	Repair of wound or lesion	5.94	5.90	4.16	0.35	12.19	10.45	010
13133		A	Repair wound/lesion add-on	2.19	1.66	1.03	0.18	4.03	3.40	ZZZ
13150		A	Repair of wound or lesion	3.80	4.87	2.76	0.34	9.01	6.90	010
13151		A	Repair of wound or lesion	4.44	4.80	3.14	0.32	9.56	7.90	010
13152		A	Repair of wound or lesion	6.32	6.03	4.04	0.42	12.77	10.78	010
13153		A	Repair wound/lesion add-on	2.38	1.93	1.14	0.25	4.56	3.77	ZZZ
13160		A	Late closure of wound	10.46	NA	7.16	1.49	NA	19.11	090
14000		A	Skin tissue rearrangement	5.88	7.85	5.46	0.59	14.32	11.93	090
14001		A	Skin tissue rearrangement	8.46	9.41	7.07	0.83	18.70	16.36	090
14020		A	Skin tissue rearrangement	6.58	8.61	6.53	0.64	15.83	13.75	090
14021		A	Skin tissue rearrangement	10.04	9.98	8.28	0.83	20.85	19.15	090
14040		A	Skin tissue rearrangement	7.86	8.80	7.20	0.65	17.31	15.71	090
14041		A	Skin tissue rearrangement	11.47	10.59	8.67	0.76	22.82	20.90	090
14060		A	Skin tissue rearrangement	8.49	8.78	7.43	0.68	17.95	16.60	090
14061		A	Skin tissue rearrangement	12.27	11.60	9.50	0.77	24.64	22.54	090
14300		A	Skin tissue rearrangement	11.74	11.13	9.17	1.16	24.03	22.07	090
14350		A	Skin tissue rearrangement	9.60	NA	7.14	1.32	NA	18.06	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15000		A	Skin graft	3.99	3.79	2.18	0.48	8.26	6.65	000
15001		A	Skin graft add-on	1.00	1.35	0.41	0.14	2.49	1.55	ZZZ
15050		A	Skin pinch graft	4.29	6.91	5.11	0.56	11.76	9.96	090
15100		A	Skin split graft	9.04	12.58	7.82	1.25	22.87	18.11	090
15101		A	Skin split graft add-on	1.72	3.73	1.17	0.24	5.69	3.13	ZZZ
15120		A	Skin split graft	9.82	10.72	7.78	1.15	21.69	18.75	090
15121		A	Skin split graft add-on	2.67	4.50	1.84	0.35	7.52	4.86	ZZZ
15200		A	Skin full graft	8.02	9.40	6.20	0.97	18.39	15.19	090
15201		A	Skin full graft add-on	1.32	2.56	0.62	0.18	4.06	2.12	ZZZ
15220		A	Skin full graft	7.86	9.18	6.68	0.83	17.87	15.37	090
15221		A	Skin full graft add-on	1.19	2.32	0.56	0.16	3.67	1.91	ZZZ
15240		A	Skin full graft	9.03	10.20	7.95	0.94	20.17	17.92	090
15241		A	Skin full graft add-on	1.86	2.44	0.91	0.22	4.52	2.99	ZZZ
15260		A	Skin full graft	10.04	10.21	8.58	0.71	20.96	19.33	090
15261		A	Skin full graft add-on	2.23	2.69	1.40	0.21	5.13	3.84	ZZZ
15342		A	Cultured skin graft, 25 cm	1.00	1.85	0.55	0.11	2.96	1.66	010
15343		A	Culture skn graft addl 25 cm	0.25	0.09	0.09	0.03	0.37	0.37	ZZZ
15350		A	Skin homograft	3.99	6.46	3.84	0.49	10.94	8.32	090
15351		A	Skin homograft add-on	1.00	0.36	0.36	0.14	1.50	1.50	ZZZ
15400		A	Skin heterograft	3.99	4.01	4.01	0.46	8.46	8.46	090
15401		A	Skin heterograft add-on	1.00	1.89	0.44	0.14	3.03	1.58	ZZZ
15570		A	Form skin pedicle flap	9.20	11.30	6.76	1.27	21.77	17.23	090
15572		A	Form skin pedicle flap	9.26	9.49	6.45	1.18	19.93	16.89	090
15574		A	Form skin pedicle flap	9.87	10.68	7.79	1.18	21.73	18.84	090
15576		A	Form skin pedicle flap	8.68	9.75	6.88	0.87	19.30	16.43	090
15600		A	Skin graft	1.91	7.60	3.06	0.26	9.77	5.23	090
15610		A	Skin graft	2.42	4.69	3.42	0.34	7.45	6.18	090
15620		A	Skin graft	2.94	7.78	3.88	0.35	11.07	7.17	090
15630		A	Skin graft	3.27	7.04	4.15	0.33	10.64	7.75	090
15650		A	Transfer skin pedicle flap	3.96	7.14	4.21	0.42	11.52	8.59	090
15732		A	Muscle-skin graft, head/neck	17.81	18.04	12.21	1.97	37.82	31.99	090
15734		A	Muscle-skin graft, trunk	17.76	18.11	12.37	2.54	38.41	32.67	090
15736		A	Muscle-skin graft, arm	16.25	18.23	11.22	2.38	36.86	29.85	090
15738		A	Muscle-skin graft, leg	17.89	17.97	11.72	2.61	38.47	32.22	090
15740		A	Island pedicle flap graft	10.23	10.13	8.26	0.68	21.04	19.17	090
15750		A	Neurovascular pedicle graft	11.39	NA	9.04	1.40	NA	21.83	090
15756		A	Free myo/skin flap microvasc	35.18	NA	20.56	4.56	NA	60.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15757		A	Free skin flap, microvasc	35.18	NA	21.59	3.91	NA	60.68	090
15758		A	Free fascial flap, microvasc	35.05	NA	21.57	4.22	NA	60.84	090
15760		A	Composite skin graft	8.73	10.02	7.26	0.85	19.60	16.84	090
15770		A	Derma-fat-fascia graft	7.51	NA	6.68	1.03	NA	15.22	090
15775		R	Hair transplant punch grafts	3.95	4.23	1.30	0.52	8.70	5.77	000
15776		R	Hair transplant punch grafts	5.53	5.35	2.80	0.72	11.60	9.05	000
15780		A	Abrasion treatment of skin	7.28	11.52	8.25	0.67	19.47	16.20	090
15781		A	Abrasion treatment of skin	4.84	6.91	5.36	0.34	12.09	10.54	090
15782		A	Abrasion treatment of skin	4.31	9.85	6.55	0.34	14.50	11.20	090
15783		A	Abrasion treatment of skin	4.28	6.87	4.18	0.28	11.43	8.74	090
15786		A	Abrasion, lesion, single	2.03	3.35	1.32	0.13	5.51	3.48	010
15787		A	Abrasion, lesions, add-on	0.33	1.09	0.16	0.04	1.46	0.53	ZZZ
15788		R	Chemical peel, face, epiderm	2.09	6.71	3.08	0.13	8.93	5.30	090
15789		R	Chemical peel, face, dermal	4.91	8.09	4.80	0.21	13.21	9.92	090
15792		R	Chemical peel, nonfacial	1.86	7.09	4.45	0.13	9.08	6.44	090
15793		A	Chemical peel, nonfacial	3.73	6.28	4.38	0.21	10.22	8.32	090
15810		A	Salabrasion	4.73	NA	3.89	0.50	NA	9.12	090
15811		A	Salabrasion	5.38	5.49	4.77	0.80	11.67	10.95	090
15819		A	Plastic surgery, neck	9.37	NA	7.18	0.97	NA	17.52	090
15820		A	Revision of lower eyelid	5.14	6.97	5.56	0.41	12.52	11.11	090
15821		A	Revision of lower eyelid	5.71	7.35	5.71	0.45	13.51	11.87	090
15822		A	Revision of upper eyelid	4.44	5.83	4.49	0.36	10.63	9.29	090
15823		A	Revision of upper eyelid	7.04	7.85	6.43	0.50	15.39	13.97	090
15824		R	Removal of forehead wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	0.00	0.00	000
15831		A	Excise excessive skin tissue	12.38	NA	8.16	1.71	NA	22.25	090
15832		A	Excise excessive skin tissue	11.57	NA	8.34	1.64	NA	21.55	090
15833		A	Excise excessive skin tissue	10.62	NA	8.21	1.42	NA	20.25	090
15834		A	Excise excessive skin tissue	10.83	NA	7.69	1.60	NA	20.12	090
15835		A	Excise excessive skin tissue	11.65	NA	7.54	1.59	NA	20.78	090
15836		A	Excise excessive skin tissue	9.33	NA	6.78	1.32	NA	17.43	090
15837		A	Excise excessive skin tissue	8.42	8.55	7.37	1.18	18.15	16.97	090
15838		A	Excise excessive skin tissue	7.12	NA	6.06	0.60	NA	13.78	090
15839		A	Excise excessive skin tissue	9.37	8.82	6.39	1.18	19.37	16.94	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
15840		A	Graft for face nerve palsy	13.24	NA	9.97	1.33	NA	24.54	090
15841		A	Graft for face nerve palsy	23.23	NA	14.99	2.56	NA	40.78	090
15842		A	Flap for face nerve palsy	37.90	NA	22.91	4.89	NA	65.70	090
15845		A	Skin and muscle repair, face	12.55	NA	9.30	0.80	NA	22.65	090
15850		B	Removal of sutures	+0.78	1.56	0.30	0.05	2.39	1.13	XXX
15851		A	Removal of sutures	0.86	1.68	0.31	0.06	2.60	1.23	000
15852		A	Dressing change not for burn	0.86	1.84	0.33	0.09	2.79	1.28	000
15860		A	Test for blood flow in graft	1.95	0.83	0.78	0.25	3.03	2.98	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	7.94	NA	5.55	1.03	NA	14.52	090
15922		A	Removal of tail bone ulcer	9.89	NA	7.21	1.40	NA	18.50	090
15931		A	Remove sacrum pressure sore	9.23	NA	5.68	1.23	NA	16.14	090
15933		A	Remove sacrum pressure sore	10.83	NA	7.85	1.49	NA	20.17	090
15934		A	Remove sacrum pressure sore	12.67	NA	8.04	1.76	NA	22.47	090
15935		A	Remove sacrum pressure sore	14.55	NA	10.32	2.05	NA	26.92	090
15936		A	Remove sacrum pressure sore	12.36	NA	8.22	1.73	NA	22.31	090
15937		A	Remove sacrum pressure sore	14.19	NA	9.82	2.02	NA	26.03	090
15940		A	Remove hip pressure sore	9.33	NA	6.17	1.29	NA	16.79	090
15941		A	Remove hip pressure sore	11.41	NA	9.45	1.64	NA	22.50	090
15944		A	Remove hip pressure sore	11.44	NA	8.60	1.63	NA	21.67	090
15945		A	Remove hip pressure sore	12.67	NA	9.64	1.79	NA	24.10	090
15946		A	Remove hip pressure sore	21.54	NA	14.37	3.10	NA	39.01	090
15950		A	Remove thigh pressure sore	7.53	NA	5.41	1.01	NA	13.95	090
15951		A	Remove thigh pressure sore	10.70	NA	7.86	1.45	NA	20.01	090
15952		A	Remove thigh pressure sore	11.37	NA	7.75	1.59	NA	20.71	090
15953		A	Remove thigh pressure sore	12.61	NA	8.99	1.78	NA	23.38	090
15956		A	Remove thigh pressure sore	15.50	NA	10.77	2.16	NA	28.43	090
15958		A	Remove thigh pressure sore	15.46	NA	11.04	2.21	NA	28.71	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.86	0.26	0.08	1.83	1.23	000
16010		A	Treatment of burn(s)	0.87	0.66	0.63	0.09	1.62	1.59	000
16015		A	Treatment of burn(s)	2.35	NA	1.15	0.31	NA	3.81	000
16020		A	Treatment of burn(s)	0.80	1.29	0.58	0.08	2.17	1.46	000
16025		A	Treatment of burn(s)	1.85	1.76	0.96	0.19	3.80	3.00	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
16030		A	Treatment of burn(s)	2.08	2.17	1.12	0.24	4.49	3.44	000
16035		A	Incision of burn scab, initi	3.74	NA	1.58	0.45	NA	5.77	090
16036		A	Escharotomy; add'l incision	1.50	NA	0.60	0.20	NA	2.30	ZZZ
17000		A	Destroy benign/premlg lesion	0.60	0.97	0.54	0.03	1.60	1.17	010
17003		A	Destroy lesions, 2-14	0.15	0.11	0.07	0.01	0.27	0.23	ZZZ
17004		A	Destroy lesions, 15 or more	2.79	2.30	1.59	0.13	5.22	4.51	010
17106		A	Destruction of skin lesions	4.58	4.60	3.33	0.35	9.53	8.26	090
17107		A	Destruction of skin lesions	9.15	7.20	5.45	0.66	17.01	15.26	090
17108		A	Destruction of skin lesions	13.18	9.26	7.66	0.82	23.26	21.66	090
17110		A	Destruct lesion, 1-14	0.65	1.62	0.70	0.05	2.32	1.40	010
17111		A	Destruct lesion, 15 or more	0.92	1.67	0.81	0.05	2.64	1.78	010
17250		A	Chemical cautery, tissue	0.50	1.22	0.34	0.05	1.77	0.89	000
17260		A	Destruction of skin lesions	0.91	1.28	0.67	0.04	2.23	1.62	010
17261		A	Destruction of skin lesions	1.17	1.61	0.83	0.05	2.83	2.05	010
17262		A	Destruction of skin lesions	1.58	1.88	1.02	0.07	3.53	2.67	010
17263		A	Destruction of skin lesions	1.79	2.05	1.09	0.08	3.92	2.96	010
17264		A	Destruction of skin lesions	1.94	2.22	1.12	0.08	4.24	3.14	010
17266		A	Destruction of skin lesions	2.34	2.50	1.22	0.12	4.96	3.68	010
17270		A	Destruction of skin lesions	1.32	1.70	0.87	0.06	3.08	2.25	010
17271		A	Destruction of skin lesions	1.49	1.77	0.98	0.06	3.32	2.53	010
17272		A	Destruction of skin lesions	1.77	1.99	1.11	0.08	3.84	2.96	010
17273		A	Destruction of skin lesions	2.05	2.20	1.21	0.09	4.34	3.35	010
17274		A	Destruction of skin lesions	2.59	2.56	1.44	0.12	5.27	4.15	010
17276		A	Destruction of skin lesions	3.20	2.94	1.68	0.18	6.32	5.06	010
17280		A	Destruction of skin lesions	1.17	1.61	0.81	0.05	2.83	2.03	010
17281		A	Destruction of skin lesions	1.72	1.90	1.09	0.07	3.69	2.88	010
17282		A	Destruction of skin lesions	2.04	2.15	1.24	0.09	4.28	3.37	010
17283		A	Destruction of skin lesions	2.64	2.54	1.49	0.12	5.30	4.25	010
17284		A	Destruction of skin lesions	3.21	2.92	1.75	0.15	6.28	5.11	010
17286		A	Destruction of skin lesions	4.43	3.67	2.44	0.26	8.36	7.13	010
17304		A	1 stage mohs, up to 5 spec	7.59	8.24	3.56	0.32	16.15	11.47	000
17305		A	2 stage mohs, up to 5 spec	2.85	3.89	1.34	0.12	6.86	4.31	000
17306		A	3 stage mohs, up to 5 spec	2.85	3.91	1.35	0.12	6.88	4.32	000
17307		A	Mohs addl stage up to 5 spec	2.85	3.56	1.36	0.12	6.53	4.33	000
17310		A	Mohs any stage > 5 spec each	0.95	1.62	0.46	0.03	2.60	1.44	ZZZ
17340		A	Cryotherapy of skin	0.76	0.37	0.36	0.05	1.18	1.17	010
17360		A	Skin peel therapy	1.43	1.44	0.87	0.06	2.93	2.36	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1.98	0.31	0.08	2.90	1.23	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	0.71	0.60	ZZZ
19020		A	Incision of breast lesion	3.56	6.33	2.67	0.44	10.33	6.67	090
19030		A	Injection for breast x-ray	1.53	2.86	0.50	0.09	4.48	2.12	000
19100		A	Bx breast percut w/o image	1.27	2.08	0.42	0.16	3.51	1.85	000
19101		A	Biopsy of breast, open	3.18	4.50	1.91	0.38	8.06	5.47	010
19102		A	Bx breast percut w/image	2.00	3.83	0.66	0.14	5.97	2.80	000
19103		A	Bx breast percut w/device	3.69	11.49	1.23	0.30	15.48	5.22	000
19110		A	Nipple exploration	4.29	5.79	2.86	0.56	10.64	7.71	090
19112		A	Excise breast duct fistula	3.66	6.06	2.68	0.48	10.20	6.82	090
19120		A	Removal of breast lesion	5.55	4.54	3.06	0.72	10.81	9.33	090
19125		A	Excision, breast lesion	6.05	4.78	3.28	0.79	11.62	10.12	090
19126		A	Excision, addl breast lesion	2.93	NA	1.00	0.38	NA	4.31	ZZZ
19140		A	Removal of breast tissue	5.13	7.14	3.39	0.70	12.97	9.22	090
19160		A	Partial mastectomy	5.98	NA	3.42	0.79	NA	10.19	090
19162		A	P-mastectomy w/ln removal	13.51	NA	6.33	1.77	NA	21.61	090
19180		A	Removal of breast	8.79	NA	5.02	1.18	NA	14.99	090
19182		A	Removal of breast	7.72	NA	4.75	1.04	NA	13.51	090
19200		A	Removal of breast	15.47	NA	7.96	1.89	NA	25.32	090
19220		A	Removal of breast	15.70	NA	8.23	2.02	NA	25.95	090
19240		A	Removal of breast	15.98	NA	8.20	2.10	NA	26.28	090
19260		A	Removal of chest wall lesion	15.42	NA	11.15	2.07	NA	28.64	090
19271		A	Revision of chest wall	18.87	NA	17.95	2.59	NA	39.41	090
19272		A	Extensive chest wall surgery	21.52	NA	18.93	2.97	NA	43.42	090
19290		A	Place needle wire, breast	1.27	2.85	0.42	0.08	4.20	1.77	000
19291		A	Place needle wire, breast	0.63	1.21	0.21	0.04	1.88	0.88	ZZZ
19295		A	Place breast clip, percut	0.00	2.69	NA	0.01	2.70	NA	ZZZ
19296		A	Place po breast cath for rad	3.63	125.39	1.53	0.36	129.38	5.52	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.17	NA	2.53	ZZZ
19298		A	Place breast rad tube/caths	6.00	42.16	2.41	0.43	48.59	8.84	000
19316		A	Suspension of breast	10.67	NA	7.51	1.60	NA	19.78	090
19318		A	Reduction of large breast	15.60	NA	11.17	2.86	NA	29.63	090
19324		A	Enlarge breast	5.84	NA	4.89	0.84	NA	11.57	090
19325		A	Enlarge breast with implant	8.44	NA	6.52	1.30	NA	16.26	090
19328		A	Removal of breast implant	5.67	NA	5.02	0.90	NA	11.59	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
19330		A	Removal of implant material	7.58	NA	6.03	1.21	NA	14.82	090
19340		A	Immediate breast prosthesis	6.32	NA	3.11	1.04	NA	10.47	ZZZ
19342		A	Delayed breast prosthesis	11.18	NA	8.92	1.79	NA	21.89	090
19350		A	Breast reconstruction	8.91	13.84	7.17	1.39	24.14	17.47	090
19355		A	Correct inverted nipple(s)	7.56	10.25	4.70	0.92	18.73	13.18	090
19357		A	Breast reconstruction	18.13	NA	15.61	2.86	NA	36.60	090
19361		A	Breast reconstruction	19.23	NA	12.43	2.86	NA	34.52	090
19364		A	Breast reconstruction	40.94	NA	23.54	6.13	NA	70.61	090
19366		A	Breast reconstruction	21.25	NA	11.58	3.20	NA	36.03	090
19367		A	Breast reconstruction	25.69	NA	16.69	3.95	NA	46.33	090
19368		A	Breast reconstruction	32.37	NA	18.92	5.48	NA	56.77	090
19369		A	Breast reconstruction	29.78	NA	18.40	4.44	NA	52.62	090
19370		A	Surgery of breast capsule	8.04	NA	6.90	1.27	NA	16.21	090
19371		A	Removal of breast capsule	9.34	NA	7.82	1.59	NA	18.75	090
19380		A	Revise breast reconstruction	9.13	NA	7.70	1.42	NA	18.25	090
19396		A	Design custom breast implant	2.17	1.08	0.99	0.30	3.55	3.46	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.12	2.69	1.73	0.24	5.05	4.09	010
20005		A	Incision of deep abscess	3.41	3.49	2.25	0.44	7.34	6.10	010
2000F		I	Blood pressure, measured	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20100		A	Explore wound, neck	10.06	NA	4.46	1.24	NA	15.76	010
20101		A	Explore wound, chest	3.22	5.92	1.62	0.42	9.56	5.26	010
20102		A	Explore wound, abdomen	3.93	7.46	1.90	0.49	11.88	6.32	010
20103		A	Explore wound, extremity	5.29	8.58	3.39	0.71	14.58	9.39	010
20150		A	Excise epiphyseal bar	13.67	NA	7.03	2.01	NA	22.71	090
20200		A	Muscle biopsy	1.46	3.03	0.75	0.21	4.70	2.42	000
20205		A	Deep muscle biopsy	2.35	3.89	1.19	0.32	6.56	3.86	000
20206		A	Needle biopsy, muscle	0.99	6.50	0.63	0.07	7.56	1.69	000
20220		A	Bone biopsy, trocar/needle	1.27	4.56	0.79	0.09	5.92	2.15	000
20225		A	Bone biopsy, trocar/needle	1.87	24.45	1.13	0.22	26.54	3.22	000
20240		A	Bone biopsy, excisional	3.23	NA	2.55	0.42	NA	6.20	010
20245		A	Bone biopsy, excisional	7.77	NA	6.57	1.23	NA	15.57	010
20250		A	Open bone biopsy	5.02	NA	3.50	0.98	NA	9.50	010
20251		A	Open bone biopsy	5.55	NA	4.16	1.10	NA	10.81	010
20500		A	Injection of sinus tract	1.23	2.26	1.53	0.12	3.61	2.88	010
20501		A	Inject sinus tract for x-ray	0.76	2.91	0.25	0.04	3.71	1.05	000
20520		A	Removal of foreign body	1.85	2.91	1.76	0.21	4.97	3.82	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
20525		A	Removal of foreign body	3.49	9.14	2.62	0.49	13.12	6.60	010
20526		A	Ther injection, carp tunnel	0.94	0.97	0.52	0.12	2.03	1.58	000
20550		A	Inj tendon sheath/ligament	0.75	0.71	0.23	0.08	1.54	1.06	000
20551		A	Inj tendon origin/insertion	0.75	0.68	0.33	0.08	1.51	1.16	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.72	0.20	0.05	1.43	0.91	000
20553		A	Inject trigger points, =/> 3	0.75	0.82	0.22	0.05	1.62	1.02	000
20600		A	Drain/inject, joint/bursa	0.66	0.65	0.35	0.08	1.39	1.09	000
20605		A	Drain/inject, joint/bursa	0.68	0.76	0.36	0.08	1.52	1.12	000
20610		A	Drain/inject, joint/bursa	0.79	0.95	0.42	0.10	1.84	1.31	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.71	0.36	0.09	1.50	1.15	000
20615		A	Treatment of bone cyst	2.28	3.51	1.84	0.20	5.99	4.32	010
20650		A	Insert and remove bone pin	2.23	2.36	1.55	0.31	4.90	4.09	010
20660		A	Apply, rem fixation device	2.51	3.05	1.61	0.55	6.11	4.67	000
20661		A	Application of head brace	4.88	NA	4.91	1.11	NA	10.90	090
20662		A	Application of pelvis brace	6.06	NA	5.52	0.56	NA	12.14	090
20663		A	Application of thigh brace	5.42	NA	4.83	0.93	NA	11.18	090
20664		A	Halo brace application	8.05	NA	7.04	1.68	NA	16.77	090
20665		A	Removal of fixation device	1.31	2.15	1.35	0.18	3.64	2.84	010
20670		A	Removal of support implant	1.74	11.54	2.10	0.27	13.55	4.11	010
20680		A	Removal of support implant	3.34	8.78	3.72	0.54	12.66	7.60	090
20690		A	Apply bone fixation device	3.51	NA	2.51	0.58	NA	6.60	090
20692		A	Apply bone fixation device	6.40	NA	3.77	1.03	NA	11.20	090
20693		A	Adjust bone fixation device	5.85	NA	5.44	0.98	NA	12.27	090
20694		A	Remove bone fixation device	4.15	7.14	4.04	0.69	11.98	8.88	090
20802		A	Replantation, arm, complete	41.09	NA	20.95	3.78	NA	65.82	090
20805		A	Replant forearm, complete	49.93	NA	34.31	4.80	NA	89.04	090
20808		A	Replantation hand, complete	61.56	NA	42.22	6.81	NA	110.59	090
20816		A	Replantation digit, complete	30.89	NA	37.79	4.49	NA	73.17	090
20822		A	Replantation digit, complete	25.55	NA	34.59	3.55	NA	63.69	090
20824		A	Replantation thumb, complete	30.89	NA	36.54	4.57	NA	72.00	090
20827		A	Replantation thumb, complete	26.37	NA	36.47	3.63	NA	66.47	090
20838		A	Replantation foot, complete	41.35	NA	22.28	1.11	NA	64.74	090
20900		A	Removal of bone for graft	5.57	8.43	5.67	0.92	14.92	12.16	090
20902		A	Removal of bone for graft	7.54	NA	6.88	1.28	NA	15.70	090
20910		A	Remove cartilage for graft	5.33	NA	5.18	0.63	NA	11.14	090
20912		A	Remove cartilage for graft	6.34	NA	5.79	0.71	NA	12.84	090
20920		A	Removal of fascia for graft	5.30	NA	4.22	0.63	NA	10.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
20922		A	Removal of fascia for graft	6.60	7.54	4.87	0.71	14.85	12.18	090
20924		A	Removal of tendon for graft	6.47	NA	5.88	1.02	NA	13.37	090
20926		A	Removal of tissue for graft	5.52	NA	4.75	0.81	NA	11.08	090
20930		B	Spinal bone allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20931		A	Spinal bone allograft	1.81	NA	0.93	0.42	NA	3.16	ZZZ
20936		B	Spinal bone autograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
20937		A	Spinal bone autograft	2.79	NA	1.45	0.54	NA	4.78	ZZZ
20938		A	Spinal bone autograft	3.02	NA	1.56	0.62	NA	5.20	ZZZ
20950		A	Fluid pressure, muscle	1.26	6.84	0.99	0.19	8.29	2.44	000
20955		A	Fibula bone graft, microvasc	39.15	NA	24.27	4.81	NA	68.23	090
20956		A	Iliac bone graft, microvasc	39.21	NA	24.74	6.81	NA	70.76	090
20957		A	Mt bone graft, microvasc	40.59	NA	18.94	7.00	NA	66.53	090
20962		A	Other bone graft, microvasc	39.21	NA	26.52	6.16	NA	71.89	090
20969		A	Bone/skin graft, microvasc	43.85	NA	26.63	4.86	NA	75.34	090
20970		A	Bone/skin graft, iliac crest	43.00	NA	25.38	6.55	NA	74.93	090
20972		A	Bone/skin graft, metatarsal	42.93	NA	20.58	5.31	NA	68.82	090
20973		A	Bone/skin graft, great toe	45.69	NA	25.16	5.56	NA	76.41	090
20974		A	Electrical bone stimulation	0.62	0.69	0.54	0.10	1.41	1.26	000
20975		A	Electrical bone stimulation	2.60	NA	1.71	0.50	NA	4.81	000
20979		A	Us bone stimulation	0.62	0.80	0.34	0.09	1.51	1.05	000
20982		A	Ablate, bone tumor(s) perq	7.27	109.54	2.97	0.69	117.50	10.93	000
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.12	NA	7.09	1.05	NA	18.26	090
21015		A	Resection of facial tumor	5.28	NA	5.01	0.68	NA	10.97	090
21025		A	Excision of bone, lower jaw	10.04	12.24	9.35	1.31	23.59	20.70	090
21026		A	Excision of facial bone(s)	4.84	7.86	6.32	0.60	13.30	11.76	090
21029		A	Contour of face bone lesion	7.70	9.37	7.01	0.94	18.01	15.65	090
21030		A	Excise max/zygoma b9 tumor	4.49	6.33	5.03	0.51	11.33	10.03	090
21031		A	Remove exostosis, mandible	3.24	5.17	3.62	0.47	8.88	7.33	090
21032		A	Remove exostosis, maxilla	3.24	5.34	3.51	0.46	9.04	7.21	090
21034		A	Excise max/zygoma mlg tumor	16.15	15.92	12.66	1.69	33.76	30.50	090
21040		A	Excise mandible lesion	4.49	6.39	4.72	0.53	11.41	9.74	090
21044		A	Removal of jaw bone lesion	11.84	NA	9.37	1.14	NA	22.35	090
21045		A	Extensive jaw surgery	16.15	NA	12.35	1.53	NA	30.03	090
21046		A	Remove mandible cyst complex	12.98	NA	11.90	1.83	NA	26.71	090
21047		A	Excise lwr jaw cyst w/repair	18.72	NA	13.44	2.10	NA	34.26	090
21048		A	Remove maxilla cyst complex	13.48	NA	12.13	1.75	NA	27.36	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21049		A	Excis uppr jaw cyst w/repair	17.97	NA	13.02	1.57	NA	32.56	090
21050		A	Removal of jaw joint	10.75	NA	9.44	1.41	NA	21.60	090
21060		A	Remove jaw joint cartilage	10.21	NA	8.61	1.38	NA	20.20	090
21070		A	Remove coronoid process	8.19	NA	7.10	1.26	NA	16.55	090
21076		A	Prepare face/oral prosthesis	13.40	12.35	10.00	1.96	27.71	25.36	010
21077		A	Prepare face/oral prosthesis	33.70	31.33	26.00	4.51	69.54	64.21	090
21079		A	Prepare face/oral prosthesis	22.31	21.50	17.15	3.05	46.86	42.51	090
21080		A	Prepare face/oral prosthesis	25.06	24.49	19.36	3.64	53.19	48.06	090
21081		A	Prepare face/oral prosthesis	22.85	22.30	17.49	3.18	48.33	43.52	090
21082		A	Prepare face/oral prosthesis	20.84	19.34	15.73	3.08	43.26	39.65	090
21083		A	Prepare face/oral prosthesis	19.27	18.79	14.43	2.85	40.91	36.55	090
21084		A	Prepare face/oral prosthesis	22.48	22.43	17.70	2.24	47.15	42.42	090
21085		A	Prepare face/oral prosthesis	8.99	8.29	6.78	1.21	18.49	16.98	010
21086		A	Prepare face/oral prosthesis	24.88	23.74	19.43	3.68	52.30	47.99	090
21087		A	Prepare face/oral prosthesis	24.88	23.28	19.19	3.42	51.58	47.49	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	0.00	0.00	090
21100		A	Maxillofacial fixation	4.21	11.53	4.74	0.35	16.09	9.30	090
21110		A	Interdental fixation	5.20	9.56	8.36	0.65	15.41	14.21	090
21116		A	Injection, jaw joint x-ray	0.81	4.33	0.33	0.06	5.20	1.20	000
21120		A	Reconstruction of chin	4.92	10.58	7.49	0.60	16.10	13.01	090
21121		A	Reconstruction of chin	7.63	9.73	7.82	0.90	18.26	16.35	090
21122		A	Reconstruction of chin	8.51	NA	8.62	1.07	NA	18.20	090
21123		A	Reconstruction of chin	11.14	NA	10.80	1.40	NA	23.34	090
21125		A	Augmentation, lower jaw bone	10.60	55.22	8.32	0.77	66.59	19.69	090
21127		A	Augmentation, lower jaw bone	11.10	42.80	9.45	1.52	55.42	22.07	090
21137		A	Reduction of forehead	9.81	NA	7.73	1.32	NA	18.86	090
21138		A	Reduction of forehead	12.17	NA	9.53	1.72	NA	23.42	090
21139		A	Reduction of forehead	14.59	NA	11.06	1.18	NA	26.83	090
21141		A	Reconstruct midface, lefort	18.07	NA	13.65	2.33	NA	34.05	090
21142		A	Reconstruct midface, lefort	18.78	NA	12.82	2.37	NA	33.97	090
21143		A	Reconstruct midface, lefort	19.55	NA	14.31	1.65	NA	35.51	090
21145		A	Reconstruct midface, lefort	19.91	NA	13.90	2.81	NA	36.62	090
21146		A	Reconstruct midface, lefort	20.68	NA	15.33	3.06	NA	39.07	090
21147		A	Reconstruct midface, lefort	21.74	NA	15.05	1.83	NA	38.62	090
21150		A	Reconstruct midface, lefort	25.20	NA	16.76	2.53	NA	44.49	090
21151		A	Reconstruct midface, lefort	28.26	NA	22.95	2.28	NA	53.49	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21154		A	Reconstruct midface, lefort	30.47	NA	23.12	2.46	NA	56.05	090
21155		A	Reconstruct midface, lefort	34.40	NA	23.89	6.61	NA	64.90	090
21159		A	Reconstruct midface, lefort	42.32	NA	29.08	8.13	NA	79.53	090
21160		A	Reconstruct midface, lefort	46.37	NA	27.47	4.09	NA	77.93	090
21172		A	Reconstruct orbit/forehead	27.76	NA	13.75	3.51	NA	45.02	090
21175		A	Reconstruct orbit/forehead	33.12	NA	17.79	4.79	NA	55.70	090
21179		A	Reconstruct entire forehead	22.22	NA	14.13	2.77	NA	39.12	090
21180		A	Reconstruct entire forehead	25.15	NA	15.38	3.45	NA	43.98	090
21181		A	Contour cranial bone lesion	9.89	NA	7.46	1.32	NA	18.67	090
21182		A	Reconstruct cranial bone	32.14	NA	19.11	2.83	NA	54.08	090
21183		A	Reconstruct cranial bone	35.26	NA	20.83	4.44	NA	60.53	090
21184		A	Reconstruct cranial bone	38.18	NA	21.94	5.65	NA	65.77	090
21188		A	Reconstruction of midface	22.43	NA	18.87	1.67	NA	42.97	090
21193		A	Reconst lwr jaw w/o graft	17.12	NA	12.65	2.20	NA	31.97	090
21194		A	Reconst lwr jaw w/graft	19.81	NA	13.75	2.00	NA	35.56	090
21195		A	Reconst lwr jaw w/o fixation	17.21	NA	14.82	1.62	NA	33.65	090
21196		A	Reconst lwr jaw w/fixation	18.88	NA	15.69	2.06	NA	36.63	090
21198		A	Reconstr lwr jaw segment	14.14	NA	12.70	1.44	NA	28.28	090
21199		A	Reconstr lwr jaw w/advance	15.98	NA	9.11	1.42	NA	26.51	090
21206		A	Reconstruct upper jaw bone	14.08	NA	12.63	1.32	NA	28.03	090
21208		A	Augmentation of facial bones	10.21	22.33	9.58	1.09	33.63	20.88	090
21209		A	Reduction of facial bones	6.71	10.80	8.07	0.88	18.39	15.66	090
21210		A	Face bone graft	10.21	24.87	9.35	1.27	36.35	20.83	090
21215		A	Lower jaw bone graft	10.75	41.88	9.36	1.52	54.15	21.63	090
21230		A	Rib cartilage graft	10.75	NA	8.04	1.28	NA	20.07	090
21235		A	Ear cartilage graft	6.71	9.84	6.41	0.61	17.16	13.73	090
21240		A	Reconstruction of jaw joint	14.03	NA	12.05	2.23	NA	28.31	090
21242		A	Reconstruction of jaw joint	12.93	NA	11.51	1.77	NA	26.21	090
21243		A	Reconstruction of jaw joint	20.76	NA	17.43	3.18	NA	41.37	090
21244		A	Reconstruction of lower jaw	11.84	NA	12.09	1.27	NA	25.20	090
21245		A	Reconstruction of jaw	11.84	14.40	9.85	1.19	27.43	22.88	090
21246		A	Reconstruction of jaw	12.45	NA	9.04	1.34	NA	22.83	090
21247		A	Reconstruct lower jaw bone	22.60	NA	17.35	2.80	NA	42.75	090
21248		A	Reconstruction of jaw	11.46	12.13	9.40	1.54	25.13	22.40	090
21249		A	Reconstruction of jaw	17.49	16.72	12.69	2.46	36.67	32.64	090
21255		A	Reconstruct lower jaw bone	16.69	NA	16.13	2.37	NA	35.19	090
21256		A	Reconstruction of orbit	16.17	NA	11.82	1.64	NA	29.63	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21260		A	Revise eye sockets	16.50	NA	12.76	0.97	NA	30.23	090
21261		A	Revise eye sockets	31.44	NA	24.23	3.39	NA	59.06	090
21263		A	Revise eye sockets	28.38	NA	19.07	2.61	NA	50.06	090
21267		A	Revise eye sockets	18.87	NA	19.77	1.68	NA	40.32	090
21268		A	Revise eye sockets	24.44	NA	20.21	3.62	NA	48.27	090
21270		A	Augmentation, cheek bone	10.21	11.65	7.25	0.72	22.58	18.18	090
21275		A	Revision, orbitofacial bones	11.22	NA	8.16	1.28	NA	20.66	090
21280		A	Revision of eyelid	6.02	NA	5.92	0.42	NA	12.36	090
21282		A	Revision of eyelid	3.48	NA	4.48	0.26	NA	8.22	090
21295		A	Revision of jaw muscle/bone	1.53	NA	2.53	0.16	NA	4.22	090
21296		A	Revision of jaw muscle/bone	4.24	NA	4.91	0.34	NA	9.49	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21300		A	Treatment of skull fracture	0.72	2.36	0.26	0.12	3.20	1.10	000
21310		A	Treatment of nose fracture	0.58	2.28	0.15	0.06	2.92	0.79	000
21315		A	Treatment of nose fracture	1.51	4.23	1.88	0.14	5.88	3.53	010
21320		A	Treatment of nose fracture	1.85	3.91	1.62	0.18	5.94	3.65	010
21325		A	Treatment of nose fracture	3.76	NA	8.62	0.31	NA	12.69	090
21330		A	Treatment of nose fracture	5.37	NA	9.70	0.58	NA	15.65	090
21335		A	Treatment of nose fracture	8.60	NA	9.62	0.74	NA	18.96	090
21336		A	Treat nasal septal fracture	5.71	NA	9.61	0.56	NA	15.88	090
21337		A	Treat nasal septal fracture	2.70	6.12	3.57	0.28	9.10	6.55	090
21338		A	Treat nasoethmoid fracture	6.45	NA	14.02	0.79	NA	21.26	090
21339		A	Treat nasoethmoid fracture	8.08	NA	13.90	0.95	NA	22.93	090
21340		A	Treatment of nose fracture	10.75	NA	8.40	1.14	NA	20.29	090
21343		A	Treatment of sinus fracture	12.93	NA	15.47	1.49	NA	29.89	090
21344		A	Treatment of sinus fracture	19.69	NA	16.50	2.34	NA	38.53	090
21345		A	Treat nose/jaw fracture	8.15	9.84	7.17	0.92	18.91	16.24	090
21346		A	Treat nose/jaw fracture	10.59	NA	12.20	1.19	NA	23.98	090
21347		A	Treat nose/jaw fracture	12.67	NA	16.19	1.45	NA	30.31	090
21348		A	Treat nose/jaw fracture	16.66	NA	11.11	2.47	NA	30.24	090
21355		A	Treat cheek bone fracture	3.76	6.23	3.48	0.34	10.33	7.58	010
21356		A	Treat cheek bone fracture	4.14	7.12	4.55	0.46	11.72	9.15	010
21360		A	Treat cheek bone fracture	6.45	NA	5.93	0.72	NA	13.10	090
21365		A	Treat cheek bone fracture	14.93	NA	10.83	1.67	NA	27.43	090
21366		A	Treat cheek bone fracture	17.74	NA	11.33	2.48	NA	31.55	090
21385		A	Treat eye socket fracture	9.15	NA	8.28	0.96	NA	18.39	090
21386		A	Treat eye socket fracture	9.15	NA	7.07	0.98	NA	17.20	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21387		A	Treat eye socket fracture	9.69	NA	8.95	1.06	NA	19.70	090
21390		A	Treat eye socket fracture	10.11	NA	7.80	0.92	NA	18.83	090
21395		A	Treat eye socket fracture	12.66	NA	9.02	1.46	NA	23.14	090
21400		A	Treat eye socket fracture	1.40	2.61	1.87	0.14	4.15	3.41	090
21401		A	Treat eye socket fracture	3.26	7.99	3.49	0.38	11.63	7.13	090
21406		A	Treat eye socket fracture	7.00	NA	6.08	0.72	NA	13.80	090
21407		A	Treat eye socket fracture	8.60	NA	6.86	0.95	NA	16.41	090
21408		A	Treat eye socket fracture	12.36	NA	8.88	1.43	NA	22.67	090
21421		A	Treat mouth roof fracture	5.13	9.33	8.31	0.69	15.15	14.13	090
21422		A	Treat mouth roof fracture	8.31	NA	8.08	0.99	NA	17.38	090
21423		A	Treat mouth roof fracture	10.38	NA	9.32	1.24	NA	20.94	090
21431		A	Treat craniofacial fracture	7.04	NA	9.52	0.70	NA	17.26	090
21432		A	Treat craniofacial fracture	8.60	NA	8.06	0.81	NA	17.47	090
21433		A	Treat craniofacial fracture	25.31	NA	16.40	2.75	NA	44.46	090
21435		A	Treat craniofacial fracture	17.22	NA	12.70	1.96	NA	31.88	090
21436		A	Treat craniofacial fracture	28.00	NA	18.22	3.06	NA	49.28	090
21440		A	Treat dental ridge fracture	2.70	7.10	6.16	0.37	10.17	9.23	090
21445		A	Treat dental ridge fracture	5.37	9.75	8.37	0.76	15.88	14.50	090
21450		A	Treat lower jaw fracture	2.97	7.38	6.87	0.31	10.66	10.15	090
21451		A	Treat lower jaw fracture	4.86	9.35	8.40	0.60	14.81	13.86	090
21452		A	Treat lower jaw fracture	1.98	13.02	4.61	0.27	15.27	6.86	090
21453		A	Treat lower jaw fracture	5.53	10.74	10.73	0.73	17.00	16.99	090
21454		A	Treat lower jaw fracture	6.45	NA	6.26	0.81	NA	13.52	090
21461		A	Treat lower jaw fracture	8.08	24.46	12.66	0.97	33.51	21.71	090
21462		A	Treat lower jaw fracture	9.78	27.61	12.71	1.25	38.64	23.74	090
21465		A	Treat lower jaw fracture	11.89	NA	9.81	1.49	NA	23.19	090
21470		A	Treat lower jaw fracture	15.32	NA	12.02	1.94	NA	29.28	090
21480		A	Reset dislocated jaw	0.61	1.77	0.19	0.06	2.44	0.86	000
21485		A	Reset dislocated jaw	3.98	8.22	7.66	0.50	12.70	12.14	090
21490		A	Repair dislocated jaw	11.84	NA	9.69	1.94	NA	23.47	090
21493		A	Treat hyoid bone fracture	1.27	NA	0.55	0.12	NA	1.94	090
21494		A	Treat hyoid bone fracture	6.27	NA	3.54	0.57	NA	10.38	090
21495		A	Treat hyoid bone fracture	5.68	NA	8.42	0.46	NA	14.56	090
21497		A	Interdental wiring	3.85	8.45	7.64	0.50	12.80	11.99	090
21499		C	Head surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21501		A	Drain neck/chest lesion	3.80	6.42	3.82	0.44	10.66	8.06	090
21502		A	Drain chest lesion	7.11	NA	5.63	0.98	NA	13.72	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
21510		A	Drainage of bone lesion	5.73	NA	5.66	0.77	NA	12.16	090
21550		A	Biopsy of neck/chest	2.06	3.58	1.72	0.17	5.81	3.95	010
21555		A	Remove lesion, neck/chest	4.34	5.51	3.19	0.54	10.39	8.07	090
21556		A	Remove lesion, neck/chest	5.56	NA	4.10	0.66	NA	10.32	090
21557		A	Remove tumor, neck/chest	8.87	NA	5.35	1.08	NA	15.30	090
21600		A	Partial removal of rib	6.88	NA	5.73	0.96	NA	13.57	090
21610		A	Partial removal of rib	14.59	NA	8.86	2.76	NA	26.21	090
21615		A	Removal of rib	9.86	NA	6.68	1.44	NA	17.98	090
21616		A	Removal of rib and nerves	12.02	NA	8.02	1.85	NA	21.89	090
21620		A	Partial removal of sternum	6.78	NA	5.97	0.96	NA	13.71	090
21627		A	Sternal debridement	6.80	NA	6.30	0.99	NA	14.09	090
21630		A	Extensive sternum surgery	17.35	NA	11.84	2.52	NA	31.71	090
21632		A	Extensive sternum surgery	18.11	NA	11.11	2.56	NA	31.78	090
21685		A	Hyoid myotomy & suspension	12.98	NA	9.97	1.06	NA	24.01	090
21700		A	Revision of neck muscle	6.18	NA	4.44	0.45	NA	11.07	090
21705		A	Revision of neck muscle/rib	9.59	NA	5.58	1.43	NA	16.60	090
21720		A	Revision of neck muscle	5.67	2.46	2.46	0.88	9.01	9.01	090
21725		A	Revision of neck muscle	6.98	NA	5.44	1.20	NA	13.62	090
21740		A	Reconstruction of sternum	16.48	NA	8.52	2.35	NA	27.35	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0.00	0.00	0.00	0.00	090
21750		A	Repair of sternum separation	10.75	NA	6.11	1.55	NA	18.41	090
21800		A	Treatment of rib fracture	0.96	NA	1.34	0.09	NA	2.39	090
21805		A	Treatment of rib fracture	2.75	NA	3.20	0.38	NA	6.33	090
21810		A	Treatment of rib fracture(s)	6.85	NA	4.97	0.94	NA	12.76	090
21820		A	Treat sternum fracture	1.28	1.82	1.76	0.15	3.25	3.19	090
21825		A	Treat sternum fracture	7.40	NA	6.39	1.07	NA	14.86	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
21920		A	Biopsy soft tissue of back	2.06	3.28	1.47	0.15	5.49	3.68	010
21925		A	Biopsy soft tissue of back	4.48	5.17	3.24	0.59	10.24	8.31	090
21930		A	Remove lesion, back or flank	4.99	5.71	3.40	0.64	11.34	9.03	090
21935		A	Remove tumor, back	17.93	NA	9.62	2.39	NA	29.94	090
22100		A	Remove part of neck vertebra	9.72	NA	7.53	2.07	NA	19.32	090
22101		A	Remove part, thorax vertebra	9.80	NA	7.75	1.69	NA	19.24	090
22102		A	Remove part, lumbar vertebra	9.80	NA	8.11	1.68	NA	19.59	090
22103		A	Remove extra spine segment	2.34	NA	1.21	0.41	NA	3.96	ZZZ
22110		A	Remove part of neck vertebra	12.72	NA	9.16	2.70	NA	24.58	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
22112		A	Remove part, thorax vertebra	12.79	NA	9.27	2.44	NA	24.50	090
22114		A	Remove part, lumbar vertebra	12.79	NA	9.25	2.49	NA	24.53	090
22116		A	Remove extra spine segment	2.32	NA	1.17	0.47	NA	3.96	ZZZ
22210		A	Revision of neck spine	23.78	NA	15.41	5.35	NA	44.54	090
22212		A	Revision of thorax spine	19.39	NA	13.27	3.73	NA	36.39	090
22214		A	Revision of lumbar spine	19.42	NA	13.81	3.82	NA	37.05	090
22216		A	Revise, extra spine segment	6.03	NA	3.13	1.28	NA	10.44	ZZZ
22220		A	Revision of neck spine	21.34	NA	13.62	5.02	NA	39.98	090
22222		A	Revision of thorax spine	21.49	NA	11.13	3.43	NA	36.05	090
22224		A	Revision of lumbar spine	21.49	NA	14.22	4.04	NA	39.75	090
22226		A	Revise, extra spine segment	6.03	NA	3.09	1.23	NA	10.35	ZZZ
22305		A	Treat spine process fracture	2.05	2.31	1.92	0.35	4.71	4.32	090
22310		A	Treat spine fracture	2.61	2.80	2.35	0.48	5.89	5.44	090
22315		A	Treat spine fracture	8.83	9.68	7.33	1.79	20.30	17.95	090
22318		A	Treat odontoid fx w/o graft	21.47	NA	13.38	5.14	NA	39.99	090
22319		A	Treat odontoid fx w/graft	23.96	NA	14.71	5.93	NA	44.60	090
22325		A	Treat spine fracture	18.27	NA	12.07	3.76	NA	34.10	090
22326		A	Treat neck spine fracture	19.56	NA	12.70	4.25	NA	36.51	090
22327		A	Treat thorax spine fracture	19.17	NA	12.36	3.88	NA	35.41	090
22328		A	Treat each add spine fx	4.60	NA	2.26	0.93	NA	7.79	ZZZ
22505		A	Manipulation of spine	1.87	NA	0.94	0.30	NA	3.11	010
22520		A	Percut vertebroplasty thor	8.90	61.66	5.10	1.42	71.98	15.42	010
22521		A	Percut vertebroplasty lumb	8.33	55.97	4.95	1.33	65.63	14.61	010
22522		A	Percut vertebroplasty add'l	4.30	NA	1.68	0.69	NA	6.67	ZZZ
22532		A	Lat thorax spine fusion	23.96	NA	14.82	4.07	NA	42.85	090
22533		A	Lat lumbar spine fusion	23.09	NA	13.59	2.93	NA	39.61	090
22534		A	Lat thor/lumb, add'l seg	5.99	NA	3.03	1.18	NA	10.20	ZZZ
22548		A	Neck spine fusion	25.78	NA	15.80	5.54	NA	47.12	090
22554		A	Neck spine fusion	18.59	NA	12.34	4.33	NA	35.26	090
22556		A	Thorax spine fusion	23.42	NA	14.73	4.07	NA	42.22	090
22558		A	Lumbar spine fusion	22.25	NA	13.29	2.93	NA	38.47	090
22585		A	Additional spinal fusion	5.52	NA	2.79	1.18	NA	9.49	ZZZ
22590		A	Spine & skull spinal fusion	20.48	NA	13.32	4.63	NA	38.43	090
22595		A	Neck spinal fusion	19.36	NA	12.83	4.27	NA	36.46	090
22600		A	Neck spine fusion	16.12	NA	11.19	3.63	NA	30.94	090
22610		A	Thorax spine fusion	16.00	NA	11.41	3.43	NA	30.84	090
22612		A	Lumbar spine fusion	20.97	NA	14.20	4.36	NA	39.53	090

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CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
22614		A	Spine fusion, extra segment	6.43	NA	3.35	1.36	NA	11.14	ZZZ
22630		A	Lumbar spine fusion	20.81	NA	13.60	4.59	NA	39.00	090
22632		A	Spine fusion, extra segment	5.22	NA	2.66	1.14	NA	9.02	ZZZ
22800		A	Fusion of spine	18.22	NA	12.77	3.65	NA	34.64	090
22802		A	Fusion of spine	30.83	NA	19.59	6.08	NA	56.50	090
22804		A	Fusion of spine	36.22	NA	22.69	6.91	NA	65.82	090
22808		A	Fusion of spine	26.23	NA	16.30	4.78	NA	47.31	090
22810		A	Fusion of spine	30.22	NA	18.36	4.77	NA	53.35	090
22812		A	Fusion of spine	32.65	NA	20.06	5.25	NA	57.96	090
22818		A	Kyphectomy, 1-2 segments	31.78	NA	18.87	6.29	NA	56.94	090
22819		A	Kyphectomy, 3 or more	36.39	NA	20.05	7.59	NA	64.03	090
22830		A	Exploration of spinal fusion	10.83	NA	7.96	2.24	NA	21.03	090
22840		A	Insert spine fixation device	12.52	NA	6.49	2.71	NA	21.72	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	6.50	2.65	NA	21.71	ZZZ
22843		A	Insert spine fixation device	13.44	NA	6.60	2.79	NA	22.83	ZZZ
22844		A	Insert spine fixation device	16.42	NA	8.75	3.13	NA	28.30	ZZZ
22845		A	Insert spine fixation device	11.94	NA	6.07	2.76	NA	20.77	ZZZ
22846		A	Insert spine fixation device	12.40	NA	6.33	2.87	NA	21.60	ZZZ
22847		A	Insert spine fixation device	13.78	NA	7.02	2.96	NA	23.76	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	3.18	1.14	NA	10.31	ZZZ
22849		A	Reinsert spinal fixation	18.48	NA	11.73	3.80	NA	34.01	090
22850		A	Remove spine fixation device	9.51	NA	6.99	2.00	NA	18.50	090
22851		A	Apply spine prosth device	6.70	NA	3.36	1.46	NA	11.52	ZZZ
22852		A	Remove spine fixation device	9.00	NA	6.79	1.85	NA	17.64	090
22855		A	Remove spine fixation device	15.11	NA	9.66	3.40	NA	28.17	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	5.79	NA	3.22	0.75	NA	9.76	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.35	8.53	4.42	0.65	13.53	9.42	090
23020		A	Release shoulder joint	8.92	NA	7.56	1.52	NA	18.00	090
23030		A	Drain shoulder lesion	3.42	7.39	2.90	0.53	11.34	6.85	010
23031		A	Drain shoulder bursa	2.74	7.86	2.72	0.44	11.04	5.90	010
23035		A	Drain shoulder bone lesion	8.60	NA	8.27	1.44	NA	18.31	090
23040		A	Exploratory shoulder surgery	9.19	NA	7.86	1.56	NA	18.61	090
23044		A	Exploratory shoulder surgery	7.11	NA	6.43	1.20	NA	14.74	090
23065		A	Biopsy shoulder tissues	2.27	2.48	1.62	0.20	4.95	4.09	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23066		A	Biopsy shoulder tissues	4.15	7.67	3.98	0.61	12.43	8.74	090
23075		A	Removal of shoulder lesion	2.39	3.66	1.78	0.32	6.37	4.49	010
23076		A	Removal of shoulder lesion	7.62	NA	5.55	1.10	NA	14.27	090
23077		A	Remove tumor of shoulder	16.07	NA	10.21	2.28	NA	28.56	090
23100		A	Biopsy of shoulder joint	6.02	NA	5.65	1.03	NA	12.70	090
23101		A	Shoulder joint surgery	5.57	NA	5.33	0.94	NA	11.84	090
23105		A	Remove shoulder joint lining	8.22	NA	7.12	1.40	NA	16.74	090
23106		A	Incision of collarbone joint	5.95	NA	5.70	0.97	NA	12.62	090
23107		A	Explore treat shoulder joint	8.61	NA	7.39	1.47	NA	17.47	090
23120		A	Partial removal, collar bone	7.10	NA	6.46	1.21	NA	14.77	090
23125		A	Removal of collar bone	9.38	NA	7.56	1.59	NA	18.53	090
23130		A	Remove shoulder bone, part	7.54	NA	7.13	1.29	NA	15.96	090
23140		A	Removal of bone lesion	6.88	NA	5.22	1.04	NA	13.14	090
23145		A	Removal of bone lesion	9.08	NA	7.44	1.49	NA	18.01	090
23146		A	Removal of bone lesion	7.82	NA	7.11	1.35	NA	16.28	090
23150		A	Removal of humerus lesion	8.47	NA	6.92	1.27	NA	16.66	090
23155		A	Removal of humerus lesion	10.33	NA	8.33	1.78	NA	20.44	090
23156		A	Removal of humerus lesion	8.67	NA	7.38	1.49	NA	17.54	090
23170		A	Remove collar bone lesion	6.85	NA	6.02	1.05	NA	13.92	090
23172		A	Remove shoulder blade lesion	6.89	NA	6.28	1.01	NA	14.18	090
23174		A	Remove humerus lesion	9.50	NA	8.36	1.63	NA	19.49	090
23180		A	Remove collar bone lesion	8.52	NA	8.99	1.44	NA	18.95	090
23182		A	Remove shoulder blade lesion	8.14	NA	8.55	1.31	NA	18.00	090
23184		A	Remove humerus lesion	9.37	NA	9.31	1.59	NA	20.27	090
23190		A	Partial removal of scapula	7.23	NA	6.17	1.17	NA	14.57	090
23195		A	Removal of head of humerus	9.80	NA	7.73	1.68	NA	19.21	090
23200		A	Removal of collar bone	12.06	NA	8.72	1.78	NA	22.56	090
23210		A	Removal of shoulder blade	12.47	NA	8.99	1.97	NA	23.43	090
23220		A	Partial removal of humerus	14.54	NA	10.82	2.43	NA	27.79	090
23221		A	Partial removal of humerus	17.71	NA	11.72	3.03	NA	32.46	090
23222		A	Partial removal of humerus	23.88	NA	15.78	3.91	NA	43.57	090
23330		A	Remove shoulder foreign body	1.85	3.68	1.88	0.23	5.76	3.96	010
23331		A	Remove shoulder foreign body	7.37	NA	6.79	1.24	NA	15.40	090
23332		A	Remove shoulder foreign body	11.60	NA	9.32	1.97	NA	22.89	090
23350		A	Injection for shoulder x-ray	1.00	3.46	0.33	0.06	4.52	1.39	000
23395		A	Muscle transfer,shoulder/arm	16.82	NA	12.86	2.80	NA	32.48	090
23397		A	Muscle transfers	16.11	NA	11.37	2.65	NA	30.13	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23400		A	Fixation of shoulder blade	13.52	NA	10.07	2.27	NA	25.86	090
23405		A	Incision of tendon & muscle	8.36	NA	6.92	1.42	NA	16.70	090
23406		A	Incise tendon(s) & muscle(s)	10.77	NA	8.34	1.82	NA	20.93	090
23410		A	Repair rotator cuff, acute	12.43	NA	9.40	2.11	NA	23.94	090
23412		A	Repair rotator cuff, chronic	13.29	NA	9.89	2.26	NA	25.44	090
23415		A	Release of shoulder ligament	9.96	NA	7.99	1.70	NA	19.65	090
23420		A	Repair of shoulder	13.28	NA	10.84	2.27	NA	26.39	090
23430		A	Repair biceps tendon	9.97	NA	8.10	1.70	NA	19.77	090
23440		A	Remove/transplant tendon	10.46	NA	8.26	1.79	NA	20.51	090
23450		A	Repair shoulder capsule	13.38	NA	9.84	2.29	NA	25.51	090
23455		A	Repair shoulder capsule	14.35	NA	10.44	2.45	NA	27.24	090
23460		A	Repair shoulder capsule	15.35	NA	11.37	2.63	NA	29.35	090
23462		A	Repair shoulder capsule	15.28	NA	10.75	2.57	NA	28.60	090
23465		A	Repair shoulder capsule	15.83	NA	11.18	2.71	NA	29.72	090
23466		A	Repair shoulder capsule	14.20	NA	11.37	2.42	NA	27.99	090
23470		A	Reconstruct shoulder joint	17.12	NA	12.25	2.92	NA	32.29	090
23472		A	Reconstruct shoulder joint	21.07	NA	14.41	3.59	NA	39.07	090
23480		A	Revision of collar bone	11.16	NA	8.77	1.92	NA	21.85	090
23485		A	Revision of collar bone	13.41	NA	9.89	2.30	NA	25.60	090
23490		A	Reinforce clavicle	11.84	NA	8.69	1.46	NA	21.99	090
23491		A	Reinforce shoulder bones	14.19	NA	10.71	2.45	NA	27.35	090
23500		A	Treat clavicle fracture	2.08	2.87	2.52	0.29	5.24	4.89	090
23505		A	Treat clavicle fracture	3.68	4.41	3.84	0.59	8.68	8.11	090
23515		A	Treat clavicle fracture	7.40	NA	6.55	1.27	NA	15.22	090
23520		A	Treat clavicle dislocation	2.16	2.85	2.74	0.32	5.33	5.22	090
23525		A	Treat clavicle dislocation	3.59	4.54	3.94	0.44	8.57	7.97	090
23530		A	Treat clavicle dislocation	7.30	NA	5.93	1.20	NA	14.43	090
23532		A	Treat clavicle dislocation	8.00	NA	6.97	1.38	NA	16.35	090
23540		A	Treat clavicle dislocation	2.23	2.86	2.36	0.27	5.36	4.86	090
23545		A	Treat clavicle dislocation	3.25	4.19	3.36	0.34	7.78	6.95	090
23550		A	Treat clavicle dislocation	7.23	NA	6.37	1.22	NA	14.82	090
23552		A	Treat clavicle dislocation	8.44	NA	7.32	1.45	NA	17.21	090
23570		A	Treat shoulder blade fx	2.23	3.01	2.89	0.35	5.59	5.47	090
23575		A	Treat shoulder blade fx	4.05	4.88	4.31	0.56	9.49	8.92	090
23585		A	Treat scapula fracture	8.95	NA	7.64	1.53	NA	18.12	090
23600		A	Treat humerus fracture	2.93	4.55	3.55	0.46	7.94	6.94	090
23605		A	Treat humerus fracture	4.86	6.15	5.11	0.80	11.81	10.77	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
23615		A	Treat humerus fracture	9.34	NA	8.83	1.60	NA	19.77	090
23616		A	Treat humerus fracture	21.24	NA	14.14	3.63	NA	39.01	090
23620		A	Treat humerus fracture	2.40	3.61	2.98	0.38	6.39	5.76	090
23625		A	Treat humerus fracture	3.92	4.94	4.28	0.62	9.48	8.82	090
23630		A	Treat humerus fracture	7.34	NA	6.63	1.25	NA	15.22	090
23650		A	Treat shoulder dislocation	3.38	3.77	2.76	0.30	7.45	6.44	090
23655		A	Treat shoulder dislocation	4.56	NA	4.17	0.65	NA	9.38	090
23660		A	Treat shoulder dislocation	7.48	NA	6.38	1.27	NA	15.13	090
23665		A	Treat dislocation/fracture	4.46	5.33	4.72	0.69	10.48	9.87	090
23670		A	Treat dislocation/fracture	7.89	NA	6.83	1.34	NA	16.06	090
23675		A	Treat dislocation/fracture	6.04	6.63	5.83	0.96	13.83	12.83	090
23680		A	Treat dislocation/fracture	10.04	NA	8.11	1.70	NA	19.85	090
23700		A	Fixation of shoulder	2.52	NA	2.17	0.43	NA	5.12	010
23800		A	Fusion of shoulder joint	14.14	NA	10.41	2.24	NA	26.79	090
23802		A	Fusion of shoulder joint	16.58	NA	10.17	2.68	NA	29.43	090
23900		A	Amputation of arm & girdle	19.69	NA	11.71	3.11	NA	34.51	090
23920		A	Amputation at shoulder joint	14.59	NA	9.92	2.35	NA	26.86	090
23921		A	Amputation follow-up surgery	5.48	NA	5.08	0.77	NA	11.33	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.94	6.32	2.31	0.41	9.67	5.66	010
23931		A	Drainage of arm bursa	1.79	5.91	2.17	0.26	7.96	4.22	010
23935		A	Drain arm/elbow bone lesion	6.08	NA	5.91	1.02	NA	13.01	090
24000		A	Exploratory elbow surgery	5.81	NA	5.41	0.95	NA	12.17	090
24006		A	Release elbow joint	9.30	NA	7.75	1.48	NA	18.53	090
24065		A	Biopsy arm/elbow soft tissue	2.08	3.21	1.74	0.17	5.46	3.99	010
24066		A	Biopsy arm/elbow soft tissue	5.20	8.93	4.13	0.76	14.89	10.09	090
24075		A	Remove arm/elbow lesion	3.91	7.35	3.40	0.54	11.80	7.85	090
24076		A	Remove arm/elbow lesion	6.29	NA	4.86	0.92	NA	12.07	090
24077		A	Remove tumor of arm/elbow	11.74	NA	7.74	1.65	NA	21.13	090
24100		A	Biopsy elbow joint lining	4.92	NA	4.52	0.78	NA	10.22	090
24101		A	Explore/treat elbow joint	6.12	NA	5.93	1.03	NA	13.08	090
24102		A	Remove elbow joint lining	8.02	NA	6.86	1.28	NA	16.16	090
24105		A	Removal of elbow bursa	3.60	NA	4.39	0.60	NA	8.59	090
24110		A	Remove humerus lesion	7.38	NA	6.66	1.24	NA	15.28	090
24115		A	Remove/graft bone lesion	9.62	NA	7.21	1.66	NA	18.49	090
24116		A	Remove/graft bone lesion	11.79	NA	9.07	2.03	NA	22.89	090
24120		A	Remove elbow lesion	6.64	NA	5.92	1.09	NA	13.65	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24125		A	Remove/graft bone lesion	7.88	NA	6.16	1.06	NA	15.10	090
24126		A	Remove/graft bone lesion	8.30	NA	7.02	1.16	NA	16.48	090
24130		A	Removal of head of radius	6.24	NA	6.02	1.03	NA	13.29	090
24134		A	Removal of arm bone lesion	9.72	NA	8.85	1.62	NA	20.19	090
24136		A	Remove radius bone lesion	7.98	NA	7.22	1.38	NA	16.58	090
24138		A	Remove elbow bone lesion	8.04	NA	7.78	1.32	NA	17.14	090
24140		A	Partial removal of arm bone	9.17	NA	9.10	1.50	NA	19.77	090
24145		A	Partial removal of radius	7.57	NA	8.06	1.23	NA	16.86	090
24147		A	Partial removal of elbow	7.53	NA	8.60	1.27	NA	17.40	090
24149		A	Radical resection of elbow	14.18	NA	11.62	2.30	NA	28.10	090
24150		A	Extensive humerus surgery	13.25	NA	9.99	2.25	NA	25.49	090
24151		A	Extensive humerus surgery	15.56	NA	11.51	2.58	NA	29.65	090
24152		A	Extensive radius surgery	10.04	NA	7.73	1.48	NA	19.25	090
24153		A	Extensive radius surgery	11.52	NA	5.57	0.74	NA	17.83	090
24155		A	Removal of elbow joint	11.71	NA	8.40	1.90	NA	22.01	090
24160		A	Remove elbow joint implant	7.82	NA	6.89	1.27	NA	15.98	090
24164		A	Remove radius head implant	6.22	NA	5.77	1.02	NA	13.01	090
24200		A	Removal of arm foreign body	1.76	3.41	1.63	0.19	5.36	3.58	010
24201		A	Removal of arm foreign body	4.55	9.81	4.23	0.66	15.02	9.44	090
24220		A	Injection for elbow x-ray	1.31	3.63	0.44	0.09	5.03	1.84	000
24300		A	Manipulate elbow w/anesth	3.74	NA	5.71	0.62	NA	10.07	090
24301		A	Muscle/tendon transfer	10.18	NA	8.18	1.58	NA	19.94	090
24305		A	Arm tendon lengthening	7.44	NA	6.71	1.13	NA	15.28	090
24310		A	Revision of arm tendon	5.97	NA	5.58	0.94	NA	12.49	090
24320		A	Repair of arm tendon	10.54	NA	7.53	1.72	NA	19.79	090
24330		A	Revision of arm muscles	9.59	NA	7.88	1.58	NA	19.05	090
24331		A	Revision of arm muscles	10.63	NA	8.67	1.76	NA	21.06	090
24332		A	Tenolysis, triceps	7.44	NA	6.77	1.23	NA	15.44	090
24340		A	Repair of biceps tendon	7.88	NA	6.98	1.33	NA	16.19	090
24341		A	Repair arm tendon/muscle	7.89	NA	7.92	1.33	NA	17.14	090
24342		A	Repair of ruptured tendon	10.60	NA	8.52	1.78	NA	20.90	090
24343		A	Repr elbow lat ligmnt w/tiss	8.64	NA	8.15	1.40	NA	18.19	090
24344		A	Reconstruct elbow lat ligmnt	13.98	NA	11.52	2.33	NA	27.83	090
24345		A	Repr elbw med ligmnt w/tissu	8.64	NA	8.02	1.39	NA	18.05	090
24346		A	Reconstruct elbow med ligmnt	13.98	NA	11.34	2.31	NA	27.63	090
24350		A	Repair of tennis elbow	5.24	NA	5.58	0.86	NA	11.68	090
24351		A	Repair of tennis elbow	5.90	NA	5.92	1.00	NA	12.82	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24352		A	Repair of tennis elbow	6.42	NA	6.18	1.10	NA	13.70	090
24354		A	Repair of tennis elbow	6.47	NA	6.15	1.07	NA	13.69	090
24356		A	Revision of tennis elbow	6.67	NA	6.31	1.09	NA	14.07	090
24360		A	Reconstruct elbow joint	12.32	NA	9.47	2.01	NA	23.80	090
24361		A	Reconstruct elbow joint	14.06	NA	10.58	2.16	NA	26.80	090
24362		A	Reconstruct elbow joint	14.97	NA	10.04	2.58	NA	27.59	090
24363		A	Replace elbow joint	18.46	NA	13.71	2.96	NA	35.13	090
24365		A	Reconstruct head of radius	8.38	NA	7.20	1.41	NA	16.99	090
24366		A	Reconstruct head of radius	9.12	NA	7.54	1.51	NA	18.17	090
24400		A	Revision of humerus	11.04	NA	8.85	1.86	NA	21.75	090
24410		A	Revision of humerus	14.80	NA	10.31	2.55	NA	27.66	090
24420		A	Revision of humerus	13.42	NA	10.54	2.15	NA	26.11	090
24430		A	Repair of humerus	12.79	NA	9.74	2.17	NA	24.70	090
24435		A	Repair humerus with graft	13.15	NA	10.88	2.22	NA	26.25	090
24470		A	Revision of elbow joint	8.73	NA	7.72	1.48	NA	17.93	090
24495		A	Decompression of forearm	8.11	NA	8.74	1.16	NA	18.01	090
24498		A	Reinforce humerus	11.90	NA	9.26	2.02	NA	23.18	090
24500		A	Treat humerus fracture	3.21	4.85	3.68	0.48	8.54	7.37	090
24505		A	Treat humerus fracture	5.16	6.60	5.39	0.85	12.61	11.40	090
24515		A	Treat humerus fracture	11.63	NA	9.38	1.98	NA	22.99	090
24516		A	Treat humerus fracture	11.63	NA	9.11	1.99	NA	22.73	090
24530		A	Treat humerus fracture	3.49	5.20	4.04	0.55	9.24	8.08	090
24535		A	Treat humerus fracture	6.86	7.84	6.62	1.15	15.85	14.63	090
24538		A	Treat humerus fracture	9.42	NA	8.70	1.57	NA	19.69	090
24545		A	Treat humerus fracture	10.44	NA	8.45	1.79	NA	20.68	090
24546		A	Treat humerus fracture	15.67	NA	11.32	2.67	NA	29.66	090
24560		A	Treat humerus fracture	2.80	4.48	3.19	0.41	7.69	6.40	090
24565		A	Treat humerus fracture	5.55	6.61	5.52	0.90	13.06	11.97	090
24566		A	Treat humerus fracture	7.78	NA	8.16	1.29	NA	17.23	090
24575		A	Treat humerus fracture	10.64	NA	8.40	1.82	NA	20.86	090
24576		A	Treat humerus fracture	2.86	4.76	3.71	0.44	8.06	7.01	090
24577		A	Treat humerus fracture	5.78	6.93	5.84	0.94	13.65	12.56	090
24579		A	Treat humerus fracture	11.58	NA	8.83	1.98	NA	22.39	090
24582		A	Treat humerus fracture	8.54	NA	9.11	1.47	NA	19.12	090
24586		A	Treat elbow fracture	15.19	NA	11.23	2.58	NA	29.00	090
24587		A	Treat elbow fracture	15.14	NA	11.02	2.50	NA	28.66	090
24600		A	Treat elbow dislocation	4.22	4.86	3.50	0.47	9.55	8.19	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
24605		A	Treat elbow dislocation	5.41	NA	5.36	0.87	NA	11.64	090
24615		A	Treat elbow dislocation	9.41	NA	7.82	1.58	NA	18.81	090
24620		A	Treat elbow fracture	6.97	NA	6.25	1.03	NA	14.25	090
24635		A	Treat elbow fracture	13.17	NA	14.05	2.25	NA	29.47	090
24640		A	Treat elbow dislocation	1.20	1.84	0.80	0.12	3.16	2.12	010
24650		A	Treat radius fracture	2.16	3.78	2.75	0.33	6.27	5.24	090
24655		A	Treat radius fracture	4.39	5.95	4.79	0.68	11.02	9.86	090
24665		A	Treat radius fracture	8.13	NA	7.51	1.38	NA	17.02	090
24666		A	Treat radius fracture	9.48	NA	8.07	1.59	NA	19.14	090
24670		A	Treat ulnar fracture	2.54	4.11	3.07	0.39	7.04	6.00	090
24675		A	Treat ulnar fracture	4.71	6.00	4.97	0.77	11.48	10.45	090
24685		A	Treat ulnar fracture	8.79	NA	7.52	1.50	NA	17.81	090
24800		A	Fusion of elbow joint	11.18	NA	8.74	1.62	NA	21.54	090
24802		A	Fusion/graft of elbow joint	13.67	NA	10.38	2.26	NA	26.31	090
24900		A	Amputation of upper arm	9.59	NA	7.06	1.49	NA	18.14	090
24920		A	Amputation of upper arm	9.53	NA	6.94	1.58	NA	18.05	090
24925		A	Amputation follow-up surgery	7.06	NA	6.08	1.14	NA	14.28	090
24930		A	Amputation follow-up surgery	10.23	NA	7.24	1.62	NA	19.09	090
24931		A	Amputate upper arm & implant	12.70	NA	5.72	1.88	NA	20.30	090
24935		A	Revision of amputation	15.54	NA	8.02	2.12	NA	25.68	090
24940		C	Revision of upper arm	0.00	0.00	0.00	0.00	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.37	NA	6.87	0.53	NA	10.77	090
25001		A	Incise flexor carpi radialis	3.37	NA	4.23	0.52	NA	8.12	090
25020		A	Decompress forearm 1 space	5.91	NA	9.56	0.93	NA	16.40	090
25023		A	Decompress forearm 1 space	12.94	NA	14.94	1.96	NA	29.84	090
25024		A	Decompress forearm 2 spaces	9.49	NA	7.47	1.31	NA	18.27	090
25025		A	Decompress forearm 2 spaces	16.52	NA	9.97	1.72	NA	28.21	090
25028		A	Drainage of forearm lesion	5.24	NA	8.16	0.77	NA	14.17	090
25031		A	Drainage of forearm bursa	4.13	NA	7.92	0.60	NA	12.65	090
25035		A	Treat forearm bone lesion	7.35	NA	13.59	1.20	NA	22.14	090
25040		A	Explore/treat wrist joint	7.17	NA	7.30	1.13	NA	15.60	090
25065		A	Biopsy forearm soft tissues	1.99	3.22	1.90	0.16	5.37	4.05	010
25066		A	Biopsy forearm soft tissues	4.12	NA	7.06	0.62	NA	11.80	090
25075		A	Removal forearm lesion subcu	3.73	NA	5.89	0.51	NA	10.13	090
25076		A	Removal forearm lesion deep	4.91	NA	9.54	0.73	NA	15.18	090
25077		A	Remove tumor, forearm/wrist	9.75	NA	12.08	1.36	NA	23.19	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25085		A	Incision of wrist capsule	5.49	NA	7.12	0.83	NA	13.44	090
25100		A	Biopsy of wrist joint	3.89	NA	5.27	0.58	NA	9.74	090
25101		A	Explore/treat wrist joint	4.68	NA	5.89	0.75	NA	11.32	090
25105		A	Remove wrist joint lining	5.84	NA	7.30	0.91	NA	14.05	090
25107		A	Remove wrist joint cartilage	6.42	NA	8.34	0.98	NA	15.74	090
25110		A	Remove wrist tendon lesion	3.91	NA	7.05	0.61	NA	11.57	090
25111		A	Remove wrist tendon lesion	3.38	NA	4.70	0.52	NA	8.60	090
25112		A	Reremove wrist tendon lesion	4.52	NA	5.25	0.70	NA	10.47	090
25115		A	Remove wrist/forearm lesion	8.81	NA	14.03	1.30	NA	24.14	090
25116		A	Remove wrist/forearm lesion	7.10	NA	13.14	1.10	NA	21.34	090
25118		A	Excise wrist tendon sheath	4.36	NA	5.74	0.68	NA	10.78	090
25119		A	Partial removal of ulna	6.03	NA	7.60	0.93	NA	14.56	090
25120		A	Removal of forearm lesion	6.09	NA	12.08	0.98	NA	19.15	090
25125		A	Remove/graft forearm lesion	7.47	NA	12.84	1.06	NA	21.37	090
25126		A	Remove/graft forearm lesion	7.54	NA	13.01	1.27	NA	21.82	090
25130		A	Removal of wrist lesion	5.25	NA	6.42	0.80	NA	12.47	090
25135		A	Remove & graft wrist lesion	6.88	NA	7.51	0.99	NA	15.38	090
25136		A	Remove & graft wrist lesion	5.96	NA	6.59	1.03	NA	13.58	090
25145		A	Remove forearm bone lesion	6.36	NA	12.06	1.00	NA	19.42	090
25150		A	Partial removal of ulna	7.08	NA	8.21	1.15	NA	16.44	090
25151		A	Partial removal of radius	7.38	NA	12.72	1.18	NA	21.28	090
25170		A	Extensive forearm surgery	11.07	NA	15.15	1.69	NA	27.91	090
25210		A	Removal of wrist bone	5.94	NA	6.79	0.87	NA	13.60	090
25215		A	Removal of wrist bones	7.88	NA	8.75	1.19	NA	17.82	090
25230		A	Partial removal of radius	5.22	NA	6.14	0.78	NA	12.14	090
25240		A	Partial removal of ulna	5.16	NA	6.95	0.80	NA	12.91	090
25246		A	Injection for wrist x-ray	1.45	3.44	0.48	0.09	4.98	2.02	000
25248		A	Remove forearm foreign body	5.13	NA	8.52	0.69	NA	14.34	090
25250		A	Removal of wrist prosthesis	6.59	NA	6.10	0.98	NA	13.67	090
25251		A	Removal of wrist prosthesis	9.56	NA	7.92	1.25	NA	18.73	090
25259		A	Manipulate wrist w/anesthes	3.74	NA	5.72	0.60	NA	10.06	090
25260		A	Repair forearm tendon/muscle	7.79	NA	13.31	1.17	NA	22.27	090
25263		A	Repair forearm tendon/muscle	7.81	NA	13.26	1.14	NA	22.21	090
25265		A	Repair forearm tendon/muscle	9.87	NA	14.31	1.47	NA	25.65	090
25270		A	Repair forearm tendon/muscle	5.99	NA	12.03	0.93	NA	18.95	090
25272		A	Repair forearm tendon/muscle	7.03	NA	12.79	1.09	NA	20.91	090
25274		A	Repair forearm tendon/muscle	8.74	NA	13.62	1.34	NA	23.70	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25275		A	Repair forearm tendon sheath	8.49	NA	7.58	1.31	NA	17.38	090
25280		A	Revise wrist/forearm tendon	7.21	NA	12.63	1.06	NA	20.90	090
25290		A	Incise wrist/forearm tendon	5.28	NA	14.99	0.81	NA	21.08	090
25295		A	Release wrist/forearm tendon	6.54	NA	12.15	1.00	NA	19.69	090
25300		A	Fusion of tendons at wrist	8.79	NA	8.45	1.26	NA	18.50	090
25301		A	Fusion of tendons at wrist	8.39	NA	8.06	1.27	NA	17.72	090
25310		A	Transplant forearm tendon	8.13	NA	13.03	1.21	NA	22.37	090
25312		A	Transplant forearm tendon	9.56	NA	13.94	1.41	NA	24.91	090
25315		A	Revise palsy hand tendon(s)	10.18	NA	14.40	1.56	NA	26.14	090
25316		A	Revise palsy hand tendon(s)	12.31	NA	16.22	1.73	NA	30.26	090
25320		A	Repair/revise wrist joint	10.75	NA	11.39	1.58	NA	23.72	090
25332		A	Revise wrist joint	11.39	NA	9.17	1.81	NA	22.37	090
25335		A	Realignment of hand	12.86	NA	11.59	1.90	NA	26.35	090
25337		A	Reconstruct ulna/radioulnar	10.15	NA	11.08	1.58	NA	22.81	090
25350		A	Revision of radius	8.77	NA	13.97	1.43	NA	24.17	090
25355		A	Revision of radius	10.15	NA	14.61	1.72	NA	26.48	090
25360		A	Revision of ulna	8.42	NA	13.87	1.40	NA	23.69	090
25365		A	Revise radius & ulna	12.38	NA	15.64	2.13	NA	30.15	090
25370		A	Revise radius or ulna	13.34	NA	16.07	2.27	NA	31.68	090
25375		A	Revise radius & ulna	13.02	NA	16.42	2.24	NA	31.68	090
25390		A	Shorten radius or ulna	10.38	NA	14.58	1.63	NA	26.59	090
25391		A	Lengthen radius or ulna	13.63	NA	16.55	2.20	NA	32.38	090
25392		A	Shorten radius & ulna	13.93	NA	15.96	2.09	NA	31.98	090
25393		A	Lengthen radius & ulna	15.85	NA	17.58	2.73	NA	36.16	090
25394		A	Repair carpal bone, shorten	10.38	NA	8.06	1.58	NA	20.02	090
25400		A	Repair radius or ulna	10.90	NA	15.19	1.79	NA	27.88	090
25405		A	Repair/graft radius or ulna	14.36	NA	17.27	2.28	NA	33.91	090
25415		A	Repair radius & ulna	13.33	NA	16.51	2.14	NA	31.98	090
25420		A	Repair/graft radius & ulna	16.31	NA	18.27	2.59	NA	37.17	090
25425		A	Repair/graft radius or ulna	13.19	NA	21.39	1.80	NA	36.38	090
25426		A	Repair/graft radius & ulna	15.80	NA	16.55	2.52	NA	34.87	090
25430		A	Vasc graft into carpal bone	9.24	NA	7.34	1.26	NA	17.84	090
25431		A	Repair nonunion carpal bone	10.42	NA	8.40	1.89	NA	20.71	090
25440		A	Repair/graft wrist bone	10.42	NA	9.40	1.60	NA	21.42	090
25441		A	Reconstruct wrist joint	12.88	NA	10.00	2.01	NA	24.89	090
25442		A	Reconstruct wrist joint	10.83	NA	8.88	1.53	NA	21.24	090
25443		A	Reconstruct wrist joint	10.37	NA	8.77	1.36	NA	20.50	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25444		A	Reconstruct wrist joint	11.13	NA	9.03	1.69	NA	21.85	090
25445		A	Reconstruct wrist joint	9.68	NA	7.99	1.54	NA	19.21	090
25446		A	Wrist replacement	16.53	NA	11.92	2.45	NA	30.90	090
25447		A	Repair wrist joint(s)	10.35	NA	8.65	1.59	NA	20.59	090
25449		A	Remove wrist joint implant	14.47	NA	10.67	2.17	NA	27.31	090
25450		A	Revision of wrist joint	7.86	NA	10.19	1.35	NA	19.40	090
25455		A	Revision of wrist joint	9.48	NA	10.86	0.95	NA	21.29	090
25490		A	Reinforce radius	9.53	NA	13.73	1.43	NA	24.69	090
25491		A	Reinforce ulna	9.95	NA	14.46	1.58	NA	25.99	090
25492		A	Reinforce radius and ulna	12.31	NA	15.30	2.12	NA	29.73	090
25500		A	Treat fracture of radius	2.45	3.57	2.71	0.33	6.35	5.49	090
25505		A	Treat fracture of radius	5.20	6.54	5.42	0.81	12.55	11.43	090
25515		A	Treat fracture of radius	9.17	NA	7.46	1.55	NA	18.18	090
25520		A	Treat fracture of radius	6.25	6.86	6.06	1.02	14.13	13.33	090
25525		A	Treat fracture of radius	12.22	NA	9.99	2.00	NA	24.21	090
25526		A	Treat fracture of radius	12.96	NA	13.50	2.13	NA	28.59	090
25530		A	Treat fracture of ulna	2.09	3.76	2.86	0.32	6.17	5.27	090
25535		A	Treat fracture of ulna	5.13	6.01	5.29	0.84	11.98	11.26	090
25545		A	Treat fracture of ulna	8.89	NA	7.66	1.49	NA	18.04	090
25560		A	Treat fracture radius & ulna	2.44	3.69	2.60	0.33	6.46	5.37	090
25565		A	Treat fracture radius & ulna	5.62	6.70	5.42	0.89	13.21	11.93	090
25574		A	Treat fracture radius & ulna	7.00	NA	7.20	1.20	NA	15.40	090
25575		A	Treat fracture radius/ulna	10.43	NA	9.51	1.76	NA	21.70	090
25600		A	Treat fracture radius/ulna	2.63	4.09	2.97	0.40	7.12	6.00	090
25605		A	Treat fracture radius/ulna	5.80	7.23	6.22	0.95	13.98	12.97	090
25611		A	Treat fracture radius/ulna	7.76	NA	8.96	1.32	NA	18.04	090
25620		A	Treat fracture radius/ulna	8.54	NA	7.26	1.41	NA	17.21	090
25622		A	Treat wrist bone fracture	2.61	4.27	3.10	0.39	7.27	6.10	090
25624		A	Treat wrist bone fracture	4.52	6.30	5.07	0.73	11.55	10.32	090
25628		A	Treat wrist bone fracture	8.42	NA	7.82	1.36	NA	17.60	090
25630		A	Treat wrist bone fracture	2.88	4.18	2.94	0.43	7.49	6.25	090
25635		A	Treat wrist bone fracture	4.38	5.94	3.90	0.71	11.03	8.99	090
25645		A	Treat wrist bone fracture	7.24	NA	6.63	1.19	NA	15.06	090
25650		A	Treat wrist bone fracture	3.05	4.31	3.17	0.43	7.79	6.65	090
25651		A	Pin ulnar styloid fracture	5.35	NA	5.48	0.82	NA	11.65	090
25652		A	Treat fracture ulnar styloid	7.59	NA	7.00	1.20	NA	15.79	090
25660		A	Treat wrist dislocation	4.75	NA	4.71	0.57	NA	10.03	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
25670		A	Treat wrist dislocation	7.91	NA	6.99	1.26	NA	16.16	090
25671		A	Pin radioulnar dislocation	5.99	NA	6.15	0.98	NA	13.12	090
25675		A	Treat wrist dislocation	4.66	5.65	4.65	0.58	10.89	9.89	090
25676		A	Treat wrist dislocation	8.03	NA	7.30	1.33	NA	16.66	090
25680		A	Treat wrist fracture	5.98	NA	4.74	0.74	NA	11.46	090
25685		A	Treat wrist fracture	9.77	NA	7.80	1.56	NA	19.13	090
25690		A	Treat wrist dislocation	5.49	NA	5.50	0.86	NA	11.85	090
25695		A	Treat wrist dislocation	8.33	NA	7.09	1.32	NA	16.74	090
25800		A	Fusion of wrist joint	9.75	NA	9.09	1.54	NA	20.38	090
25805		A	Fusion/graft of wrist joint	11.26	NA	10.25	1.78	NA	23.29	090
25810		A	Fusion/graft of wrist joint	10.55	NA	9.90	1.64	NA	22.09	090
25820		A	Fusion of hand bones	7.44	NA	7.85	1.21	NA	16.50	090
25825		A	Fuse hand bones with graft	9.26	NA	9.23	1.40	NA	19.89	090
25830		A	Fusion, radioulnar jnt/ulna	10.04	NA	14.41	1.54	NA	25.99	090
25900		A	Amputation of forearm	9.00	NA	12.56	1.28	NA	22.84	090
25905		A	Amputation of forearm	9.11	NA	12.29	1.38	NA	22.78	090
25907		A	Amputation follow-up surgery	7.79	NA	11.76	1.10	NA	20.65	090
25909		A	Amputation follow-up surgery	8.95	NA	12.27	1.38	NA	22.60	090
25915		A	Amputation of forearm	17.05	NA	18.88	2.91	NA	38.84	090
25920		A	Amputate hand at wrist	8.67	NA	7.85	1.34	NA	17.86	090
25922		A	Amputate hand at wrist	7.41	NA	7.05	1.12	NA	15.58	090
25924		A	Amputation follow-up surgery	8.45	NA	8.09	1.32	NA	17.86	090
25927		A	Amputation of hand	8.79	NA	11.68	1.26	NA	21.73	090
25929		A	Amputation follow-up surgery	7.58	NA	5.87	1.14	NA	14.59	090
25931		A	Amputation follow-up surgery	7.80	NA	11.46	1.15	NA	20.41	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.54	5.56	1.63	0.17	7.27	3.34	010
26011		A	Drainage of finger abscess	2.19	8.81	2.32	0.32	11.32	4.83	010
26020		A	Drain hand tendon sheath	4.66	NA	5.35	0.72	NA	10.73	090
26025		A	Drainage of palm bursa	4.81	NA	5.12	0.75	NA	10.68	090
26030		A	Drainage of palm bursa(s)	5.92	NA	5.72	0.91	NA	12.55	090
26034		A	Treat hand bone lesion	6.22	NA	6.35	0.97	NA	13.54	090
26035		A	Decompress fingers/hand	9.50	NA	7.87	1.42	NA	18.79	090
26037		A	Decompress fingers/hand	7.24	NA	6.32	1.12	NA	14.68	090
26040		A	Release palm contracture	3.33	NA	4.05	0.53	NA	7.91	090
26045		A	Release palm contracture	5.55	NA	5.64	0.92	NA	12.11	090
26055		A	Incise finger tendon sheath	2.69	14.35	3.94	0.43	17.47	7.06	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26060		A	Incision of finger tendon	2.81	NA	3.51	0.44	NA	6.76	090
26070		A	Explore/treat hand joint	3.68	NA	3.36	0.46	NA	7.50	090
26075		A	Explore/treat finger joint	3.78	NA	3.78	0.51	NA	8.07	090
26080		A	Explore/treat finger joint	4.23	NA	4.85	0.64	NA	9.72	090
26100		A	Biopsy hand joint lining	3.66	NA	4.13	0.50	NA	8.29	090
26105		A	Biopsy finger joint lining	3.70	NA	4.23	0.58	NA	8.51	090
26110		A	Biopsy finger joint lining	3.52	NA	4.04	0.53	NA	8.09	090
26115		A	Removal hand lesion subcut	3.85	13.09	4.77	0.58	17.52	9.20	090
26116		A	Removal hand lesion, deep	5.52	NA	6.00	0.83	NA	12.35	090
26117		A	Remove tumor, hand/finger	8.54	NA	7.06	1.24	NA	16.84	090
26121		A	Release palm contracture	7.53	NA	6.96	1.16	NA	15.65	090
26123		A	Release palm contracture	9.28	NA	8.85	1.42	NA	19.55	090
26125		A	Release palm contracture	4.60	NA	2.44	0.70	NA	7.74	ZZZ
26130		A	Remove wrist joint lining	5.41	NA	5.34	0.94	NA	11.69	090
26135		A	Revise finger joint, each	6.95	NA	6.46	1.06	NA	14.47	090
26140		A	Revise finger joint, each	6.16	NA	6.04	0.91	NA	13.11	090
26145		A	Tendon excision, palm/finger	6.31	NA	6.05	0.96	NA	13.32	090
26160		A	Remove tendon sheath lesion	3.15	12.37	4.12	0.48	16.00	7.75	090
26170		A	Removal of palm tendon, each	4.76	NA	4.94	0.70	NA	10.40	090
26180		A	Removal of finger tendon	5.17	NA	5.41	0.78	NA	11.36	090
26185		A	Remove finger bone	5.24	NA	6.03	0.79	NA	12.06	090
26200		A	Remove hand bone lesion	5.50	NA	5.35	0.85	NA	11.70	090
26205		A	Remove/graft bone lesion	7.69	NA	6.89	1.19	NA	15.77	090
26210		A	Removal of finger lesion	5.14	NA	5.42	0.77	NA	11.33	090
26215		A	Remove/graft finger lesion	7.09	NA	6.31	0.97	NA	14.37	090
26230		A	Partial removal of hand bone	6.32	NA	5.91	0.99	NA	13.22	090
26235		A	Partial removal, finger bone	6.18	NA	5.81	0.94	NA	12.93	090
26236		A	Partial removal, finger bone	5.31	NA	5.32	0.79	NA	11.42	090
26250		A	Extensive hand surgery	7.54	NA	6.43	1.07	NA	15.04	090
26255		A	Extensive hand surgery	12.41	NA	9.37	1.66	NA	23.44	090
26260		A	Extensive finger surgery	7.02	NA	6.18	0.98	NA	14.18	090
26261		A	Extensive finger surgery	9.08	NA	6.17	1.13	NA	16.38	090
26262		A	Partial removal of finger	5.66	NA	5.33	0.88	NA	11.87	090
26320		A	Removal of implant from hand	3.97	NA	4.31	0.58	NA	8.86	090
26340		A	Manipulate finger w/anesth	2.50	NA	4.88	0.38	NA	7.76	090
26350		A	Repair finger/hand tendon	5.98	NA	14.61	0.91	NA	21.50	090
26352		A	Repair/graft hand tendon	7.67	NA	15.36	1.12	NA	24.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26356		A	Repair finger/hand tendon	8.06	NA	18.37	1.20	NA	27.63	090
26357		A	Repair finger/hand tendon	8.57	NA	15.63	1.32	NA	25.52	090
26358		A	Repair/graft hand tendon	9.13	NA	16.64	1.37	NA	27.14	090
26370		A	Repair finger/hand tendon	7.10	NA	15.11	1.10	NA	23.31	090
26372		A	Repair/graft hand tendon	8.75	NA	16.53	1.39	NA	26.67	090
26373		A	Repair finger/hand tendon	8.15	NA	16.04	1.23	NA	25.42	090
26390		A	Revise hand/finger tendon	9.18	NA	13.28	1.39	NA	23.85	090
26392		A	Repair/graft hand tendon	10.24	NA	16.72	1.52	NA	28.48	090
26410		A	Repair hand tendon	4.62	NA	11.94	0.71	NA	17.27	090
26412		A	Repair/graft hand tendon	6.30	NA	13.27	0.96	NA	20.53	090
26415		A	Excision, hand/finger tendon	8.33	NA	11.78	0.97	NA	21.08	090
26416		A	Graft hand or finger tendon	9.36	NA	14.59	0.79	NA	24.74	090
26418		A	Repair finger tendon	4.24	NA	12.32	0.64	NA	17.20	090
26420		A	Repair/graft finger tendon	6.76	NA	13.63	1.06	NA	21.45	090
26426		A	Repair finger/hand tendon	6.14	NA	13.16	0.93	NA	20.23	090
26428		A	Repair/graft finger tendon	7.20	NA	13.86	1.08	NA	22.14	090
26432		A	Repair finger tendon	4.01	NA	10.26	0.62	NA	14.89	090
26433		A	Repair finger tendon	4.55	NA	10.79	0.71	NA	16.05	090
26434		A	Repair/graft finger tendon	6.08	NA	11.54	0.93	NA	18.55	090
26437		A	Realignment of tendons	5.81	NA	11.57	0.89	NA	18.27	090
26440		A	Release palm/finger tendon	5.01	NA	13.43	0.74	NA	19.18	090
26442		A	Release palm & finger tendon	8.15	NA	15.94	1.18	NA	25.27	090
26445		A	Release hand/finger tendon	4.30	NA	13.14	0.64	NA	18.08	090
26449		A	Release forearm/hand tendon	6.99	NA	15.77	1.05	NA	23.81	090
26450		A	Incision of palm tendon	3.66	NA	7.33	0.58	NA	11.57	090
26455		A	Incision of finger tendon	3.63	NA	7.28	0.57	NA	11.48	090
26460		A	Incise hand/finger tendon	3.45	NA	7.14	0.54	NA	11.13	090
26471		A	Fusion of finger tendons	5.72	NA	11.24	0.87	NA	17.83	090
26474		A	Fusion of finger tendons	5.31	NA	11.39	0.75	NA	17.45	090
26476		A	Tendon lengthening	5.17	NA	10.93	0.77	NA	16.87	090
26477		A	Tendon shortening	5.14	NA	11.06	0.80	NA	17.00	090
26478		A	Lengthening of hand tendon	5.79	NA	11.84	0.89	NA	18.52	090
26479		A	Shortening of hand tendon	5.73	NA	11.56	0.91	NA	18.20	090
26480		A	Transplant hand tendon	6.68	NA	15.04	1.01	NA	22.73	090
26483		A	Transplant/graft hand tendon	8.28	NA	15.50	1.26	NA	25.04	090
26485		A	Transplant palm tendon	7.69	NA	15.36	1.13	NA	24.18	090
26489		A	Transplant/graft palm tendon	9.54	NA	12.06	1.19	NA	22.79	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26490		A	Revise thumb tendon	8.40	NA	12.82	1.20	NA	22.42	090
26492		A	Tendon transfer with graft	9.61	NA	13.60	1.40	NA	24.61	090
26494		A	Hand tendon/muscle transfer	8.46	NA	12.97	1.28	NA	22.71	090
26496		A	Revise thumb tendon	9.58	NA	13.23	1.44	NA	24.25	090
26497		A	Finger tendon transfer	9.56	NA	13.57	1.39	NA	24.52	090
26498		A	Finger tendon transfer	13.98	NA	16.16	2.09	NA	32.23	090
26499		A	Revision of finger	8.97	NA	13.04	1.34	NA	23.35	090
26500		A	Hand tendon reconstruction	5.95	NA	11.44	0.89	NA	18.28	090
26502		A	Hand tendon reconstruction	7.13	NA	12.02	1.12	NA	20.27	090
26504		A	Hand tendon reconstruction	7.46	NA	12.58	1.24	NA	21.28	090
26508		A	Release thumb contracture	6.00	NA	11.68	0.96	NA	18.64	090
26510		A	Thumb tendon transfer	5.42	NA	11.34	0.79	NA	17.55	090
26516		A	Fusion of knuckle joint	7.14	NA	12.23	1.08	NA	20.45	090
26517		A	Fusion of knuckle joints	8.82	NA	13.50	1.40	NA	23.72	090
26518		A	Fusion of knuckle joints	9.01	NA	13.39	1.31	NA	23.71	090
26520		A	Release knuckle contracture	5.29	NA	13.89	0.79	NA	19.97	090
26525		A	Release finger contracture	5.32	NA	13.97	0.80	NA	20.09	090
26530		A	Revise knuckle joint	6.68	NA	6.14	1.03	NA	13.85	090
26531		A	Revise knuckle with implant	7.90	NA	7.12	1.17	NA	16.19	090
26535		A	Revise finger joint	5.23	NA	3.74	0.71	NA	9.68	090
26536		A	Revise/implant finger joint	6.36	NA	9.65	0.94	NA	16.95	090
26540		A	Repair hand joint	6.42	NA	11.87	0.98	NA	19.27	090
26541		A	Repair hand joint with graft	8.61	NA	13.39	1.27	NA	23.27	090
26542		A	Repair hand joint with graft	6.77	NA	12.03	1.02	NA	19.82	090
26545		A	Reconstruct finger joint	6.91	NA	12.13	1.04	NA	20.08	090
26546		A	Repair nonunion hand	8.91	NA	15.03	1.43	NA	25.37	090
26548		A	Reconstruct finger joint	8.02	NA	12.85	1.18	NA	22.05	090
26550		A	Construct thumb replacement	21.21	NA	17.58	2.43	NA	41.22	090
26551		A	Great toe-hand transfer	46.51	NA	32.44	7.92	NA	86.87	090
26553		A	Single transfer, toe-hand	46.20	NA	22.68	2.40	NA	71.28	090
26554		A	Double transfer, toe-hand	54.87	NA	37.53	9.36	NA	101.76	090
26555		A	Positional change of finger	16.61	NA	18.18	2.46	NA	37.25	090
26556		A	Toe joint transfer	47.19	NA	33.32	2.55	NA	83.06	090
26560		A	Repair of web finger	5.37	NA	9.80	0.84	NA	16.01	090
26561		A	Repair of web finger	10.90	NA	12.34	1.45	NA	24.69	090
25562		A	Repair of web finger	14.98	NA	17.14	2.22	NA	34.34	090
26565		A	Correct metacarpal flaw	6.73	NA	12.01	0.99	NA	19.73	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26567		A	Correct finger deformity	6.81	NA	11.95	1.03	NA	19.79	090
26568		A	Lengthen metacarpal/finger	9.07	NA	15.43	1.49	NA	25.99	090
26580		A	Repair hand deformity	18.15	NA	13.64	2.27	NA	34.06	090
26587		A	Reconstruct extra finger	14.03	NA	9.21	1.52	NA	24.76	090
26590		A	Repair finger deformity	17.93	NA	13.94	2.74	NA	34.61	090
26591		A	Repair muscles of hand	3.25	NA	9.62	0.47	NA	13.34	090
26593		A	Release muscles of hand	5.30	NA	11.13	0.78	NA	17.21	090
26596		A	Excision constricting tissue	8.94	NA	8.82	1.38	NA	19.14	090
26600		A	Treat metacarpal fracture	1.96	3.61	2.65	0.29	5.86	4.90	090
26605		A	Treat metacarpal fracture	2.85	4.56	3.65	0.45	7.86	6.95	090
26607		A	Treat metacarpal fracture	5.35	NA	6.27	0.85	NA	12.47	090
26608		A	Treat metacarpal fracture	5.35	NA	6.25	0.87	NA	12.47	090
26615		A	Treat metacarpal fracture	5.32	NA	5.30	0.85	NA	11.47	090
26641		A	Treat thumb dislocation	3.93	4.57	3.53	0.40	8.90	7.86	090
26645		A	Treat thumb fracture	4.40	5.17	4.19	0.63	10.20	9.22	090
26650		A	Treat thumb fracture	5.71	NA	6.69	0.93	NA	13.33	090
26665		A	Treat thumb fracture	7.59	NA	6.61	0.88	NA	15.08	090
26670		A	Treat hand dislocation	3.68	4.26	2.94	0.38	8.32	7.00	090
26675		A	Treat hand dislocation	4.63	5.47	4.47	0.75	10.85	9.85	090
26676		A	Pin hand dislocation	5.51	NA	6.69	0.88	NA	13.08	090
26685		A	Treat hand dislocation	6.97	NA	6.14	1.07	NA	14.18	090
26686		A	Treat hand dislocation	7.93	NA	6.90	1.23	NA	16.06	090
26700		A	Treat knuckle dislocation	3.68	3.76	2.86	0.35	7.79	6.89	090
26705		A	Treat knuckle dislocation	4.18	5.33	4.30	0.61	10.12	9.09	090
26706		A	Pin knuckle dislocation	5.11	NA	5.09	0.78	NA	10.98	090
26715		A	Treat knuckle dislocation	5.73	NA	5.51	0.91	NA	12.15	090
26720		A	Treat finger fracture, each	1.66	2.78	2.05	0.22	4.66	3.93	090
26725		A	Treat finger fracture, each	3.33	4.77	3.50	0.49	8.59	7.32	090
26727		A	Treat finger fracture, each	5.22	NA	6.23	0.83	NA	12.28	090
26735		A	Treat finger fracture, each	5.97	NA	5.55	0.93	NA	12.45	090
26740		A	Treat finger fracture, each	1.94	3.13	2.70	0.29	5.36	4.93	090
26742		A	Treat finger fracture, each	3.84	4.99	3.88	0.56	9.39	8.28	090
26746		A	Treat finger fracture, each	5.80	NA	5.56	0.90	NA	12.26	090
26750		A	Treat finger fracture, each	1.70	2.48	2.01	0.21	4.39	3.92	090
26755		A	Treat finger fracture, each	3.10	4.42	3.00	0.40	7.92	6.50	090
26756		A	Pin finger fracture, each	4.38	NA	5.72	0.70	NA	10.80	090
26765		A	Treat finger fracture, each	4.16	NA	4.39	0.63	NA	9.18	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
26770		A	Treat finger dislocation	3.02	3.43	2.41	0.28	6.73	5.71	090
26775		A	Treat finger dislocation	3.70	5.19	3.81	0.52	9.41	8.03	090
26776		A	Pin finger dislocation	4.79	NA	6.00	0.76	NA	11.55	090
26785		A	Treat finger dislocation	4.20	NA	4.53	0.65	NA	9.38	090
26820		A	Thumb fusion with graft	8.25	NA	13.25	1.26	NA	22.76	090
26841		A	Fusion of thumb	7.12	NA	13.23	1.17	NA	21.52	090
26842		A	Thumb fusion with graft	8.23	NA	13.37	1.32	NA	22.92	090
26843		A	Fusion of hand joint	7.60	NA	12.35	1.15	NA	21.10	090
26844		A	Fusion/graft of hand joint	8.72	NA	13.36	1.32	NA	23.40	090
26850		A	Fusion of knuckle	6.96	NA	12.20	1.05	NA	20.21	090
26852		A	Fusion of knuckle with graft	8.45	NA	12.89	1.21	NA	22.55	090
26860		A	Fusion of finger joint	4.68	NA	11.19	0.72	NA	16.59	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	0.93	0.26	NA	2.93	ZZZ
26862		A	Fusion/graft of finger joint	7.36	NA	12.34	1.09	NA	20.79	090
26863		A	Fuse/graft added joint	3.89	NA	2.11	0.56	NA	6.56	ZZZ
26910		A	Amputate metacarpal bone	7.59	NA	11.22	1.15	NA	19.96	090
26951		A	Amputation of finger/thumb	4.58	NA	10.15	0.70	NA	15.43	090
26952		A	Amputation of finger/thumb	6.30	NA	11.66	0.93	NA	18.89	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.47	NA	7.21	1.17	NA	15.85	090
26991		A	Drainage of pelvis bursa	6.67	11.16	5.43	1.08	18.91	13.18	090
26992		A	Drainage of bone lesion	13.00	NA	10.38	2.13	NA	25.51	090
27000		A	Incision of hip tendon	5.61	NA	5.28	0.96	NA	11.85	090
27001		A	Incision of hip tendon	6.93	NA	6.09	1.22	NA	14.24	090
27003		A	Incision of hip tendon	7.33	NA	6.48	1.10	NA	14.91	090
27005		A	Incision of hip tendon	9.65	NA	7.82	1.66	NA	19.13	090
27006		A	Incision of hip tendons	9.67	NA	7.98	1.67	NA	19.32	090
27025		A	Incision of hip/thigh fascia	11.14	NA	8.55	1.79	NA	21.48	090
27030		A	Drainage of hip joint	12.99	NA	9.64	2.22	NA	24.85	090
27033		A	Exploration of hip joint	13.37	NA	9.92	2.29	NA	25.58	090
27035		A	Denervation of hip joint	16.66	NA	11.23	2.10	NA	29.99	090
27036		A	Excision of hip joint/muscle	12.86	NA	10.00	2.21	NA	25.07	090
27040		A	Biopsy of soft tissues	2.87	5.23	2.01	0.27	8.37	5.15	010
27041		A	Biopsy of soft tissues	9.88	NA	6.64	1.30	NA	17.82	090
27047		A	Remove hip/pelvis lesion	7.44	7.11	4.77	1.00	15.55	13.21	090
27048		A	Remove hip/pelvis lesion	6.24	NA	4.80	0.90	NA	11.94	090
27049		A	Remove tumor, hip/pelvis	13.64	NA	8.40	2.01	NA	24.05	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27050		A	Biopsy of sacroiliac joint	4.35	NA	4.42	0.60	NA	9.37	090
27052		A	Biopsy of hip joint	6.22	NA	5.88	1.05	NA	13.15	090
27054		A	Removal of hip joint lining	8.53	NA	7.34	1.46	NA	17.33	090
27060		A	Removal of ischial bursa	5.42	NA	4.37	0.79	NA	10.58	090
27062		A	Remove femur lesion/bursa	5.36	NA	5.19	0.92	NA	11.47	090
27065		A	Removal of hip bone lesion	5.89	NA	5.44	0.95	NA	12.28	090
27066		A	Removal of hip bone lesion	10.31	NA	8.44	1.73	NA	20.48	090
27067		A	Remove/graft hip bone lesion	13.81	NA	10.66	1.82	NA	26.29	090
27070		A	Partial removal of hip bone	10.70	NA	9.13	1.71	NA	21.54	090
27071		A	Partial removal of hip bone	11.44	NA	10.12	1.89	NA	23.45	090
27075		A	Extensive hip surgery	34.95	NA	19.20	5.50	NA	59.65	090
27076		A	Extensive hip surgery	22.09	NA	14.51	3.59	NA	40.19	090
27077		A	Extensive hip surgery	39.94	NA	22.66	6.07	NA	68.67	090
27078		A	Extensive hip surgery	13.42	NA	9.94	2.20	NA	25.56	090
27079		A	Extensive hip surgery	13.73	NA	9.54	1.89	NA	25.16	090
27080		A	Removal of tail bone	6.38	NA	4.83	0.92	NA	12.13	090
27086		A	Remove hip foreign body	1.87	4.55	1.82	0.23	6.65	3.92	010
27087		A	Remove hip foreign body	8.53	NA	6.66	1.30	NA	16.49	090
27090		A	Removal of hip prosthesis	11.13	NA	8.78	1.91	NA	21.82	090
27091		A	Removal of hip prosthesis	22.11	NA	13.99	3.78	NA	39.88	090
27093		A	Injection for hip x-ray	1.30	4.46	0.48	0.12	5.88	1.90	000
27095		A	Injection for hip x-ray	1.50	5.72	0.52	0.14	7.36	2.16	000
27096		A	Inject sacroiliac joint	1.40	4.35	0.33	0.10	5.85	1.83	000
27097		A	Revision of hip tendon	8.79	NA	6.41	1.55	NA	16.75	090
27098		A	Transfer tendon to pelvis	8.82	NA	7.02	0.95	NA	16.79	090
27100		A	Transfer of abdominal muscle	11.06	NA	8.66	1.78	NA	21.50	090
27105		A	Transfer of spinal muscle	11.75	NA	9.16	1.70	NA	22.61	090
27110		A	Transfer of iliopsoas muscle	13.24	NA	9.11	2.08	NA	24.43	090
27111		A	Transfer of iliopsoas muscle	12.13	NA	9.13	1.92	NA	23.18	090
27120		A	Reconstruction of hip socket	17.98	NA	11.84	2.97	NA	32.79	090
27122		A	Reconstruction of hip socket	14.96	NA	11.04	2.56	NA	28.56	090
27125		A	Partial hip replacement	14.67	NA	10.62	2.50	NA	27.79	090
27130		A	Total hip arthroplasty	20.09	NA	13.30	3.45	NA	36.84	090
27132		A	Total hip arthroplasty	23.27	NA	15.63	3.99	NA	42.89	090
27134		A	Revise hip joint replacement	28.48	NA	17.79	4.88	NA	51.15	090
27137		A	Revise hip joint replacement	21.14	NA	13.93	3.63	NA	38.70	090
27138		A	Revise hip joint replacement	22.14	NA	14.39	3.79	NA	40.32	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27140		A	Transplant femur ridge	12.22	NA	9.41	2.05	NA	23.68	090
27146		A	Incision of hip bone	17.40	NA	12.13	2.95	NA	32.48	090
27147		A	Revision of hip bone	20.55	NA	13.25	3.54	NA	37.34	090
27151		A	Incision of hip bones	22.48	NA	7.95	3.88	NA	34.31	090
27156		A	Revision of hip bones	24.59	NA	16.06	4.11	NA	44.76	090
27158		A	Revision of pelvis	19.71	NA	10.97	3.13	NA	33.81	090
27161		A	Incision of neck of femur	16.68	NA	12.10	2.87	NA	31.65	090
27165		A	Incision/fixation of femur	17.88	NA	12.91	3.07	NA	33.86	090
27170		A	Repair/graft femur head/neck	16.05	NA	11.30	2.76	NA	30.11	090
27175		A	Treat slipped epiphysis	8.45	NA	6.67	1.46	NA	16.58	090
27176		A	Treat slipped epiphysis	12.03	NA	9.01	2.20	NA	23.24	090
27177		A	Treat slipped epiphysis	15.06	NA	10.69	2.60	NA	28.55	090
27178		A	Treat slipped epiphysis	11.97	NA	8.42	2.06	NA	22.45	090
27179		A	Revise head/neck of femur	12.96	NA	9.99	2.23	NA	25.18	090
27181		A	Treat slipped epiphysis	14.66	NA	10.20	1.56	NA	26.42	090
27185		A	Revision of femur epiphysis	9.17	NA	7.52	2.37	NA	19.06	090
27187		A	Reinforce hip bones	13.52	NA	10.32	2.34	NA	26.18	090
27193		A	Treat pelvic ring fracture	5.55	5.09	5.09	0.93	11.57	11.57	090
27194		A	Treat pelvic ring fracture	9.64	NA	7.65	1.62	NA	18.91	090
27200		A	Treat tail bone fracture	1.84	2.22	2.15	0.26	4.32	4.25	090
27202		A	Treat tail bone fracture	7.03	NA	16.86	1.06	NA	24.95	090
27215		A	Treat pelvic fracture(s)	10.03	NA	7.08	1.93	NA	19.04	090
27216		A	Treat pelvic ring fracture	15.17	NA	9.59	2.66	NA	27.42	090
27217		A	Treat pelvic ring fracture	14.09	NA	10.14	2.35	NA	26.58	090
27218		A	Treat pelvic ring fracture	20.12	NA	11.40	3.45	NA	34.97	090
27220		A	Treat hip socket fracture	6.17	5.72	5.63	1.04	12.93	12.84	090
27222		A	Treat hip socket fracture	12.68	NA	9.97	2.10	NA	24.75	090
27226		A	Treat hip wall fracture	14.89	NA	7.81	2.45	NA	25.15	090
27227		A	Treat hip fracture(s)	23.41	NA	15.40	3.98	NA	42.79	090
27228		A	Treat hip fracture(s)	27.12	NA	17.62	4.61	NA	49.35	090
27230		A	Treat thigh fracture	5.49	5.51	5.10	0.90	11.90	11.49	090
27232		A	Treat thigh fracture	10.66	NA	7.17	1.68	NA	19.51	090
27235		A	Treat thigh fracture	12.14	NA	9.45	2.08	NA	23.67	090
27236		A	Treat thigh fracture	15.58	NA	11.05	2.66	NA	29.29	090
27238		A	Treat thigh fracture	5.51	NA	5.14	0.87	NA	11.52	090
27240		A	Treat thigh fracture	12.48	NA	9.47	2.06	NA	24.01	090
27244		A	Treat thigh fracture	15.92	NA	11.30	2.72	NA	29.94	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27245		A	Treat thigh fracture	20.28	NA	13.74	3.47	NA	37.49	090
27246		A	Treat thigh fracture	4.70	4.46	4.42	0.80	9.96	9.92	090
27248		A	Treat thigh fracture	10.43	NA	8.21	1.78	NA	20.42	090
27250		A	Treat hip dislocation	6.94	NA	4.62	0.61	NA	12.17	090
27252		A	Treat hip dislocation	10.37	NA	7.43	1.60	NA	19.40	090
27253		A	Treat hip dislocation	12.90	NA	9.78	2.20	NA	24.88	090
27254		A	Treat hip dislocation	18.23	NA	12.02	3.09	NA	33.34	090
27256		A	Treat hip dislocation	4.11	3.52	2.08	0.44	8.07	6.63	010
27257		A	Treat hip dislocation	5.21	NA	2.81	0.68	NA	8.70	010
27258		A	Treat hip dislocation	15.41	NA	10.87	2.59	NA	28.87	090
27259		A	Treat hip dislocation	21.52	NA	14.12	3.71	NA	39.35	090
27265		A	Treat hip dislocation	5.04	NA	4.79	0.61	NA	10.44	090
27266		A	Treat hip dislocation	7.48	NA	6.34	1.27	NA	15.09	090
27275		A	Manipulation of hip joint	2.27	NA	2.10	0.38	NA	4.75	010
27280		A	Fusion of sacroiliac joint	13.37	NA	10.26	2.38	NA	26.01	090
27282		A	Fusion of pubic bones	11.32	NA	8.00	1.85	NA	21.17	090
27284		A	Fusion of hip joint	23.41	NA	14.76	3.89	NA	42.06	090
27286		A	Fusion of hip joint	23.41	NA	15.79	3.09	NA	42.29	090
27290		A	Amputation of leg at hip	23.25	NA	14.06	3.32	NA	40.63	090
27295		A	Amputation of leg at hip	18.62	NA	11.31	2.88	NA	32.81	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.48	10.07	5.14	1.00	17.55	12.62	090
27303		A	Drainage of bone lesion	8.27	NA	6.98	1.40	NA	16.65	090
27305		A	Incise thigh tendon & fascia	5.91	NA	5.18	0.98	NA	12.07	090
27306		A	Incision of thigh tendon	4.61	NA	4.72	0.83	NA	10.16	090
27307		A	Incision of thigh tendons	5.79	NA	5.38	1.03	NA	12.20	090
27310		A	Exploration of knee joint	9.26	NA	7.58	1.58	NA	18.42	090
27315		A	Partial removal, thigh nerve	6.96	NA	4.95	1.09	NA	13.00	090
27320		A	Partial removal, thigh nerve	6.29	NA	5.23	1.05	NA	12.57	090
27323		A	Biopsy, thigh soft tissues	2.28	3.51	1.88	0.24	6.03	4.40	010
27324		A	Biopsy, thigh soft tissues	4.89	NA	4.18	0.73	NA	9.80	090
27327		A	Removal of thigh lesion	4.46	5.99	3.72	0.62	11.07	8.80	090
27328		A	Removal of thigh lesion	5.56	NA	4.37	0.83	NA	10.76	090
27329		A	Remove tumor, thigh/knee	14.12	NA	9.02	2.09	NA	25.23	090
27330		A	Biopsy, knee joint lining	4.96	NA	4.57	0.82	NA	10.35	090
27331		A	Explore/treat knee joint	5.87	NA	5.52	1.00	NA	12.39	090
27332		A	Removal of knee cartilage	8.26	NA	7.12	1.42	NA	16.80	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27333		A	Removal of knee cartilage	7.29	NA	6.67	1.26	NA	15.22	090
27334		A	Remove knee joint lining	8.69	NA	7.41	1.49	NA	17.59	090
27335		A	Remove knee joint lining	9.99	NA	8.22	1.72	NA	19.93	090
27340		A	Removal of kneecap bursa	4.17	NA	4.56	0.71	NA	9.44	090
27345		A	Removal of knee cyst	5.91	NA	5.62	0.99	NA	12.52	090
27347		A	Remove knee cyst	5.77	NA	5.42	0.97	NA	12.16	090
27350		A	Removal of kneecap	8.16	NA	7.24	1.40	NA	16.80	090
27355		A	Remove femur lesion	7.64	NA	6.77	1.31	NA	15.72	090
27356		A	Remove femur lesion/graft	9.47	NA	7.85	1.60	NA	18.92	090
27357		A	Remove femur lesion/graft	10.51	NA	8.70	1.92	NA	21.13	090
27358		A	Remove femur lesion/fixation	4.73	NA	2.52	0.82	NA	8.07	ZZZ
27360		A	Partial removal, leg bone(s)	10.48	NA	9.55	1.75	NA	21.78	090
27365		A	Extensive leg surgery	16.25	NA	11.68	2.73	NA	30.66	090
27370		A	Injection for knee x-ray	0.96	3.72	0.32	0.08	4.76	1.36	000
27372		A	Removal of foreign body	5.06	10.05	4.69	0.79	15.90	10.54	090
27380		A	Repair of kneecap tendon	7.15	NA	7.28	1.23	NA	15.66	090
27381		A	Repair/graft kneecap tendon	10.32	NA	9.09	1.76	NA	21.17	090
27385		A	Repair of thigh muscle	7.75	NA	7.63	1.34	NA	16.72	090
27386		A	Repair/graft of thigh muscle	10.54	NA	9.51	1.81	NA	21.86	090
27390		A	Incision of thigh tendon	5.32	NA	5.11	0.91	NA	11.34	090
27391		A	Incision of thigh tendons	7.19	NA	6.56	1.20	NA	14.95	090
27392		A	Incision of thigh tendons	9.19	NA	7.59	1.56	NA	18.34	090
27393		A	Lengthening of thigh tendon	6.38	NA	5.83	1.06	NA	13.27	090
27394		A	Lengthening of thigh tendons	8.49	NA	7.22	1.45	NA	17.16	090
27395		A	Lengthening of thigh tendons	11.71	NA	9.32	2.02	NA	23.05	090
27396		A	Transplant of thigh tendon	7.85	NA	7.00	1.32	NA	16.17	090
27397		A	Transplants of thigh tendons	11.26	NA	9.04	1.81	NA	22.11	090
27400		A	Revise thigh muscles/tendons	9.01	NA	7.25	1.31	NA	17.57	090
27403		A	Repair of knee cartilage	8.32	NA	7.18	1.43	NA	16.93	090
27405		A	Repair of knee ligament	8.64	NA	7.49	1.49	NA	17.62	090
27407		A	Repair of knee ligament	10.26	NA	8.32	1.71	NA	20.29	090
27409		A	Repair of knee ligaments	12.88	NA	9.95	2.22	NA	25.05	090
27412		A	Autochondrocyte implant knee	23.23	NA	14.80	4.33	NA	42.36	090
27415		A	Osteochondral knee allograft	18.49	NA	12.55	4.33	NA	35.37	090
27418		A	Repair degenerated kneecap	10.83	NA	8.90	1.87	NA	21.60	090
27420		A	Revision of unstable kneecap	9.82	NA	8.11	1.67	NA	19.60	090
27422		A	Revision of unstable kneecap	9.77	NA	8.12	1.68	NA	19.57	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27424		A	Revision/removal of kneecap	9.80	NA	8.09	1.68	NA	19.57	090
27425		A	Lat retinacular release open	5.21	NA	5.52	0.90	NA	11.63	090
27427		A	Reconstruction, knee	9.35	NA	7.80	1.58	NA	18.73	090
27428		A	Reconstruction, knee	13.98	NA	11.24	2.38	NA	27.60	090
27429		A	Reconstruction, knee	15.50	NA	12.41	2.67	NA	30.58	090
27430		A	Revision of thigh muscles	9.66	NA	8.00	1.66	NA	19.32	090
27435		A	Incision of knee joint	9.48	NA	8.48	1.67	NA	19.63	090
27437		A	Revise kneecap	8.45	NA	7.24	1.48	NA	17.17	090
27438		A	Revise kneecap with implant	11.21	NA	8.54	1.93	NA	21.68	090
27440		A	Revision of knee joint	10.41	NA	5.99	1.80	NA	18.20	090
27441		A	Revision of knee joint	10.80	NA	6.71	1.84	NA	19.35	090
27442		A	Revision of knee joint	11.87	NA	8.91	2.07	NA	22.85	090
27443		A	Revision of knee joint	10.91	NA	8.72	1.87	NA	21.50	090
27445		A	Revision of knee joint	17.65	NA	12.35	3.05	NA	33.05	090
27446		A	Revision of knee joint	15.82	NA	11.27	2.76	NA	29.85	090
27447		A	Total knee arthroplasty	21.45	NA	14.60	3.74	NA	39.79	090
27448		A	Incision of thigh	11.04	NA	8.60	1.90	NA	21.54	090
27450		A	Incision of thigh	13.96	NA	10.58	2.38	NA	26.92	090
27454		A	Realignment of thigh bone	17.53	NA	12.50	3.05	NA	33.08	090
27455		A	Realignment of knee	12.80	NA	9.88	2.22	NA	24.90	090
27457		A	Realignment of knee	13.43	NA	9.92	2.32	NA	25.67	090
27465		A	Shortening of thigh bone	13.85	NA	10.22	2.45	NA	26.52	090
27466		A	Lengthening of thigh bone	16.31	NA	11.83	2.74	NA	30.88	090
27468		A	Shorten/lengthen thighs	18.94	NA	12.35	3.27	NA	34.56	090
27470		A	Repair of thigh	16.05	NA	11.79	2.74	NA	30.58	090
27472		A	Repair/graft of thigh	17.69	NA	12.68	3.02	NA	33.39	090
27475		A	Surgery to stop leg growth	8.63	NA	7.21	1.36	NA	17.20	090
27477		A	Surgery to stop leg growth	9.84	NA	7.73	1.71	NA	19.28	090
27479		A	Surgery to stop leg growth	12.78	NA	9.64	2.75	NA	25.17	090
27485		A	Surgery to stop leg growth	8.83	NA	7.40	1.52	NA	17.75	090
27486		A	Revise/replace knee joint	19.24	NA	13.49	3.32	NA	36.05	090
27487		A	Revise/replace knee joint	25.23	NA	16.55	4.33	NA	46.11	090
27488		A	Removal of knee prosthesis	15.72	NA	11.70	2.70	NA	30.12	090
27495		A	Reinforce thigh	15.53	NA	11.41	2.66	NA	29.60	090
27496		A	Decompression of thigh/knee	6.10	NA	5.60	0.97	NA	12.67	090
27497		A	Decompression of thigh/knee	7.16	NA	5.43	1.14	NA	13.73	090
27498		A	Decompression of thigh/knee	7.98	NA	5.95	1.24	NA	15.17	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27499		A	Decompression of thigh/knee	8.99	NA	6.82	1.46	NA	17.27	090
27500		A	Treatment of thigh fracture	5.91	6.12	4.99	0.96	12.99	11.86	090
27501		A	Treatment of thigh fracture	5.91	5.79	5.38	1.01	12.71	12.30	090
27502		A	Treatment of thigh fracture	10.56	NA	8.11	1.72	NA	20.39	090
27503		A	Treatment of thigh fracture	10.56	NA	8.29	1.80	NA	20.65	090
27506		A	Treatment of thigh fracture	17.42	NA	12.78	2.95	NA	33.15	090
27507		A	Treatment of thigh fracture	13.97	NA	9.84	2.36	NA	26.17	090
27508		A	Treatment of thigh fracture	5.82	6.46	5.48	0.95	13.23	12.25	090
27509		A	Treatment of thigh fracture	7.70	NA	7.96	1.33	NA	16.99	090
27510		A	Treatment of thigh fracture	9.12	NA	7.33	1.49	NA	17.94	090
27511		A	Treatment of thigh fracture	13.62	NA	11.20	2.33	NA	27.15	090
27513		A	Treatment of thigh fracture	17.89	NA	13.88	3.07	NA	34.84	090
27514		A	Treatment of thigh fracture	17.27	NA	13.35	2.95	NA	33.57	090
27516		A	Treat thigh fx growth plate	5.36	6.35	5.51	0.78	12.49	11.65	090
27517		A	Treat thigh fx growth plate	8.77	NA	7.45	1.21	NA	17.43	090
27519		A	Treat thigh fx growth plate	15.00	NA	11.59	2.53	NA	29.12	090
27520		A	Treat kneecap fracture	2.86	4.54	3.44	0.45	7.85	6.75	090
27524		A	Treat kneecap fracture	9.99	NA	8.23	1.71	NA	19.93	090
27530		A	Treat knee fracture	3.77	5.31	4.42	0.62	9.70	8.81	090
27532		A	Treat knee fracture	7.29	7.36	6.45	1.24	15.89	14.98	090
27535		A	Treat knee fracture	11.48	NA	10.11	1.97	NA	23.56	090
27536		A	Treat knee fracture	15.63	NA	11.61	2.68	NA	29.92	090
27538		A	Treat knee fracture(s)	4.86	6.13	5.19	0.81	11.80	10.86	090
27540		A	Treat knee fracture	13.08	NA	9.51	2.22	NA	24.81	090
27550		A	Treat knee dislocation	5.75	6.01	4.93	0.72	12.48	11.40	090
27552		A	Treat knee dislocation	7.89	NA	6.95	1.33	NA	16.17	090
27556		A	Treat knee dislocation	14.39	NA	11.65	2.46	NA	28.50	090
27557		A	Treat knee dislocation	16.74	NA	13.12	2.89	NA	32.75	090
27558		A	Treat knee dislocation	17.69	NA	13.04	3.05	NA	33.78	090
27560		A	Treat kneecap dislocation	3.81	4.84	3.18	0.40	9.05	7.39	090
27562		A	Treat kneecap dislocation	5.78	NA	4.77	0.92	NA	11.47	090
27566		A	Treat kneecap dislocation	12.21	NA	9.32	2.10	NA	23.63	090
27570		A	Fixation of knee joint	1.74	NA	1.77	0.30	NA	3.81	010
27580		A	Fusion of knee	19.34	NA	14.80	3.27	NA	37.41	090
27590		A	Amputate leg at thigh	12.01	NA	6.67	1.72	NA	20.40	090
27591		A	Amputate leg at thigh	12.66	NA	8.64	1.95	NA	23.25	090
27592		A	Amputate leg at thigh	10.00	NA	6.17	1.44	NA	17.61	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27594		A	Amputation follow-up surgery	6.91	NA	5.17	1.01	NA	13.09	090
27596		A	Amputation follow-up surgery	10.58	NA	6.81	1.55	NA	18.94	090
27598		A	Amputate lower leg at knee	10.51	NA	7.02	1.61	NA	19.14	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.64	NA	4.53	0.84	NA	11.01	090
27601		A	Decompression of lower leg	5.63	NA	4.85	0.80	NA	11.28	090
27602		A	Decompression of lower leg	7.34	NA	5.13	1.08	NA	13.55	090
27603		A	Drain lower leg lesion	4.93	7.49	4.16	0.71	13.13	9.80	090
27604		A	Drain lower leg bursa	4.46	6.08	3.96	0.68	11.22	9.10	090
27605		A	Incision of achilles tendon	2.87	7.68	2.32	0.41	10.96	5.60	010
27606		A	Incision of achilles tendon	4.13	NA	3.36	0.68	NA	8.17	010
27607		A	Treat lower leg bone lesion	7.96	NA	6.17	1.29	NA	15.42	090
27610		A	Explore/treat ankle joint	8.33	NA	7.00	1.37	NA	16.70	090
27612		A	Exploration of ankle joint	7.32	NA	6.09	1.12	NA	14.53	090
27613		A	Biopsy lower leg soft tissue	2.17	3.23	1.80	0.21	5.61	4.18	010
27614		A	Biopsy lower leg soft tissue	5.65	7.13	4.44	0.77	13.55	10.86	090
27615		A	Remove tumor, lower leg	12.54	NA	9.39	1.77	NA	23.70	090
27618		A	Remove lower leg lesion	5.08	6.01	3.99	0.69	11.78	9.76	090
27619		A	Remove lower leg lesion	8.39	9.51	5.95	1.23	19.13	15.57	090
27620		A	Explore/treat ankle joint	5.97	NA	5.46	0.95	NA	12.38	090
27625		A	Remove ankle joint lining	8.29	NA	6.46	1.28	NA	16.03	090
27626		A	Remove ankle joint lining	8.90	NA	6.92	1.47	NA	17.29	090
27630		A	Removal of tendon lesion	4.79	7.56	4.38	0.73	13.08	9.90	090
27635		A	Remove lower leg bone lesion	7.77	NA	6.74	1.29	NA	15.80	090
27637		A	Remove/graft leg bone lesion	9.84	NA	8.29	1.64	NA	19.77	090
27638		A	Remove/graft leg bone lesion	10.55	NA	8.29	1.79	NA	20.63	090
27640		A	Partial removal of tibia	11.35	NA	10.31	1.84	NA	23.50	090
27641		A	Partial removal of fibula	9.23	NA	8.34	1.45	NA	19.02	090
27645		A	Extensive lower leg surgery	14.15	NA	12.05	2.35	NA	28.55	090
27646		A	Extensive lower leg surgery	12.64	NA	11.03	2.01	NA	25.68	090
27647		A	Extensive ankle/heel surgery	12.22	NA	7.61	1.74	NA	21.57	090
27648		A	Injection for ankle x-ray	0.96	3.52	0.33	0.08	4.56	1.37	000
27650		A	Repair achilles tendon	9.68	NA	7.51	1.57	NA	18.76	090
27652		A	Repair/graft achilles tendon	10.31	NA	8.03	1.68	NA	20.02	090
27654		A	Repair of achilles tendon	10.00	NA	7.14	1.56	NA	18.70	090
27656		A	Repair leg fascia defect	4.56	8.53	3.77	0.64	13.73	8.97	090
27658		A	Repair of leg tendon, each	4.97	NA	4.56	0.78	NA	10.31	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27659		A	Repair of leg tendon, each	6.80	NA	5.64	1.08	NA	13.52	090
27664		A	Repair of leg tendon, each	4.58	NA	4.55	0.75	NA	9.88	090
27665		A	Repair of leg tendon, each	5.39	NA	4.97	0.88	NA	11.24	090
27675		A	Repair lower leg tendons	7.17	NA	5.73	1.11	NA	14.01	090
27676		A	Repair lower leg tendons	8.41	NA	6.75	1.37	NA	16.53	090
27680		A	Release of lower leg tendon	5.73	NA	5.11	0.93	NA	11.77	090
27681		A	Release of lower leg tendons	6.81	NA	5.91	1.14	NA	13.86	090
27685		A	Revision of lower leg tendon	6.49	7.29	5.46	0.97	14.75	12.92	090
27686		A	Revise lower leg tendons	7.45	NA	6.49	1.24	NA	15.18	090
27687		A	Revision of calf tendon	6.23	NA	5.31	1.00	NA	12.54	090
27690		A	Revise lower leg tendon	8.70	NA	6.35	1.32	NA	16.37	090
27691		A	Revise lower leg tendon	9.95	NA	7.76	1.63	NA	19.34	090
27692		A	Revise additional leg tendon	1.87	NA	0.93	0.32	NA	3.12	ZZZ
27695		A	Repair of ankle ligament	6.50	NA	5.87	1.04	NA	13.41	090
27696		A	Repair of ankle ligaments	8.26	NA	6.43	1.28	NA	15.97	090
27698		A	Repair of ankle ligament	9.35	NA	6.94	1.47	NA	17.76	090
27700		A	Revision of ankle joint	9.28	NA	5.68	1.31	NA	16.27	090
27702		A	Reconstruct ankle joint	13.65	NA	10.46	2.35	NA	26.46	090
27703		A	Reconstruction, ankle joint	15.85	NA	11.23	2.72	NA	29.80	090
27704		A	Removal of ankle implant	7.61	NA	5.59	1.26	NA	14.46	090
27705		A	Incision of tibia	10.36	NA	8.17	1.74	NA	20.27	090
27707		A	Incision of fibula	4.36	NA	4.94	0.74	NA	10.04	090
27709		A	Incision of tibia & fibula	9.94	NA	8.13	1.69	NA	19.76	090
27712		A	Realignment of lower leg	14.23	NA	10.74	2.45	NA	27.42	090
27715		A	Revision of lower leg	14.37	NA	10.77	2.44	NA	27.58	090
27720		A	Repair of tibia	11.77	NA	9.40	2.01	NA	23.18	090
27722		A	Repair/graft of tibia	11.80	NA	9.13	2.00	NA	22.93	090
27724		A	Repair/graft of tibia	18.17	NA	12.36	3.12	NA	33.65	090
27725		A	Repair of lower leg	15.57	NA	11.91	2.62	NA	30.10	090
27727		A	Repair of lower leg	13.99	NA	10.34	2.41	NA	26.74	090
27730		A	Repair of tibia epiphysis	7.40	NA	6.42	1.70	NA	15.52	090
27732		A	Repair of fibula epiphysis	5.31	NA	4.93	0.77	NA	11.01	090
27734		A	Repair lower leg epiphyses	8.47	NA	6.28	1.35	NA	16.10	090
27740		A	Repair of leg epiphyses	9.29	NA	7.99	1.60	NA	18.88	090
27742		A	Repair of leg epiphyses	10.28	5.56	5.56	1.77	17.61	17.61	090
27745		A	Reinforce tibia	10.05	NA	8.17	1.70	NA	19.92	090
27750		A	Treatment of tibia fracture	3.19	4.76	3.85	0.51	8.46	7.55	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27752		A	Treatment of tibia fracture	5.83	6.65	5.67	0.98	13.46	12.48	090
27756		A	Treatment of tibia fracture	6.77	NA	6.46	1.15	NA	14.38	090
27758		A	Treatment of tibia fracture	11.65	NA	9.18	2.00	NA	22.83	090
27759		A	Treatment of tibia fracture	13.74	NA	10.31	2.35	NA	26.40	090
27760		A	Treatment of ankle fracture	3.01	4.68	3.59	0.45	8.14	7.05	090
27762		A	Treatment of ankle fracture	5.24	6.33	5.27	0.81	12.38	11.32	090
27766		A	Treatment of ankle fracture	8.35	NA	7.22	1.42	NA	16.99	090
27780		A	Treatment of fibula fracture	2.65	4.18	3.21	0.40	7.23	6.26	090
27781		A	Treatment of fibula fracture	4.39	5.49	4.64	0.71	10.59	9.74	090
27784		A	Treatment of fibula fracture	7.10	NA	6.47	1.21	NA	14.78	090
27786		A	Treatment of ankle fracture	2.84	4.46	3.33	0.43	7.73	6.60	090
27788		A	Treatment of ankle fracture	4.44	5.64	4.65	0.71	10.79	9.80	090
27792		A	Treatment of ankle fracture	7.65	NA	6.96	1.30	NA	15.91	090
27808		A	Treatment of ankle fracture	2.83	4.80	3.70	0.45	8.08	6.98	090
27810		A	Treatment of ankle fracture	5.12	6.24	5.15	0.80	12.16	11.07	090
27814		A	Treatment of ankle fracture	10.66	NA	8.56	1.82	NA	21.04	090
27816		A	Treatment of ankle fracture	2.89	4.38	3.41	0.41	7.68	6.71	090
27818		A	Treatment of ankle fracture	5.49	6.37	5.17	0.79	12.65	11.45	090
27822		A	Treatment of ankle fracture	10.98	NA	10.65	1.87	NA	23.50	090
27823		A	Treatment of ankle fracture	12.98	NA	11.47	2.21	NA	26.66	090
27824		A	Treat lower leg fracture	2.89	4.06	3.56	0.43	7.38	6.88	090
27825		A	Treat lower leg fracture	6.18	6.60	5.38	1.00	13.78	12.56	090
27826		A	Treat lower leg fracture	8.53	NA	8.82	1.46	NA	18.81	090
27827		A	Treat lower leg fracture	14.04	NA	12.76	2.39	NA	29.19	090
27828		A	Treat lower leg fracture	16.21	NA	13.93	2.76	NA	32.90	090
27829		A	Treat lower leg joint	5.48	NA	6.78	0.94	NA	13.20	090
27830		A	Treat lower leg dislocation	3.78	4.39	3.85	0.52	8.69	8.15	090
27831		A	Treat lower leg dislocation	4.55	NA	4.46	0.73	NA	9.74	090
27832		A	Treat lower leg dislocation	6.48	NA	6.17	0.97	NA	13.62	090
27840		A	Treat ankle dislocation	4.57	NA	3.76	0.45	NA	8.78	090
27842		A	Treat ankle dislocation	6.20	NA	5.12	0.97	NA	12.29	090
27846		A	Treat ankle dislocation	9.78	NA	7.93	1.63	NA	19.34	090
27848		A	Treat ankle dislocation	11.18	NA	9.71	1.88	NA	22.77	090
27860		A	Fixation of ankle joint	2.34	NA	1.98	0.38	NA	4.70	010
27870		A	Fusion of ankle joint, open	13.89	NA	10.52	2.34	NA	26.75	090
27871		A	Fusion of tibiofibular joint	9.16	NA	7.58	1.56	NA	18.30	090
27880		A	Amputation of lower leg	11.83	NA	7.13	1.73	NA	20.69	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
27881		A	Amputation of lower leg	12.32	NA	8.84	1.95	NA	23.11	090
27882		A	Amputation of lower leg	8.93	NA	6.48	1.28	NA	16.69	090
27884		A	Amputation follow-up surgery	8.20	NA	5.75	1.20	NA	15.15	090
27886		A	Amputation follow-up surgery	9.31	NA	6.51	1.38	NA	17.20	090
27888		A	Amputation of foot at ankle	9.66	NA	7.50	1.50	NA	18.66	090
27889		A	Amputation of foot at ankle	9.97	NA	6.47	1.44	NA	17.88	090
27892		A	Decompression of leg	7.38	NA	5.59	1.08	NA	14.05	090
27893		A	Decompression of leg	7.34	NA	5.46	1.09	NA	13.89	090
27894		A	Decompression of leg	10.47	NA	7.77	1.61	NA	19.85	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.73	2.98	1.95	0.34	6.05	5.02	010
28002		A	Treatment of foot infection	4.61	4.99	3.77	0.62	10.22	9.00	010
28003		A	Treatment of foot infection	8.40	6.23	5.22	1.13	15.76	14.75	090
28005		A	Treat foot bone lesion	8.67	NA	6.04	1.17	NA	15.88	090
28008		A	Incision of foot fascia	4.44	4.55	3.20	0.58	9.57	8.22	090
28010		A	Incision of toe tendon	2.84	2.37	2.37	0.37	5.58	5.58	090
28011		A	Incision of toe tendons	4.13	NA	3.30	0.59	NA	8.02	090
28020		A	Exploration of foot joint	5.00	6.01	4.13	0.72	11.73	9.85	090
28022		A	Exploration of foot joint	4.66	5.19	3.85	0.63	10.48	9.14	090
28024		A	Exploration of toe joint	4.37	5.21	3.92	0.57	10.15	8.86	090
28030		A	Removal of foot nerve	6.14	NA	3.65	0.76	NA	10.55	090
28035		A	Decompression of tibia nerve	5.08	5.85	4.09	0.70	11.63	9.87	090
28043		A	Excision of foot lesion	3.53	3.81	3.17	0.46	7.80	7.16	090
28045		A	Excision of foot lesion	4.71	5.37	3.60	0.63	10.71	8.94	090
28046		A	Resection of tumor, foot	10.16	8.76	6.47	1.35	20.27	17.98	090
28050		A	Biopsy of foot joint lining	4.24	4.89	3.59	0.60	9.73	8.43	090
28052		A	Biopsy of foot joint lining	3.93	4.91	3.43	0.53	9.37	7.89	090
28054		A	Biopsy of toe joint lining	3.44	4.72	3.23	0.46	8.62	7.13	090
28060		A	Partial removal, foot fascia	5.22	5.47	3.87	0.70	11.39	9.79	090
28062		A	Removal of foot fascia	6.51	6.51	4.01	0.84	13.86	11.36	090
28070		A	Removal of foot joint lining	5.09	5.21	3.81	0.73	11.03	9.63	090
28072		A	Removal of foot joint lining	4.57	5.52	4.30	0.67	10.76	9.54	090
28080		A	Removal of foot lesion	3.57	5.11	3.68	0.47	9.15	7.72	090
28086		A	Excise foot tendon sheath	4.77	7.98	4.68	0.75	13.50	10.20	090
28088		A	Excise foot tendon sheath	3.85	5.75	3.89	0.60	10.20	8.34	090
28090		A	Removal of foot lesion	4.40	5.14	3.45	0.59	10.13	8.44	090
28092		A	Removal of toe lesions	3.63	5.21	3.52	0.49	9.33	7.64	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
28100		A	Removal of ankle/heel lesion	5.65	7.96	4.69	0.80	14.41	11.14	090
28102		A	Remove/graft foot lesion	7.72	NA	5.94	1.15	NA	14.81	090
28103		A	Remove/graft foot lesion	6.49	NA	4.61	0.91	NA	12.01	090
28104		A	Removal of foot lesion	5.11	5.48	3.92	0.70	11.29	9.73	090
28106		A	Remove/graft foot lesion	7.15	NA	4.43	0.97	NA	12.55	090
28107		A	Remove/graft foot lesion	5.55	6.52	4.20	0.74	12.81	10.49	090
28108		A	Removal of toe lesions	4.15	4.59	3.25	0.53	9.27	7.93	090
28110		A	Part removal of metatarsal	4.07	5.21	3.22	0.54	9.82	7.83	090
28111		A	Part removal of metatarsal	5.00	6.27	3.65	0.68	11.95	9.33	090
28112		A	Part removal of metatarsal	4.48	5.80	3.57	0.62	10.90	8.67	090
28113		A	Part removal of metatarsal	4.78	6.05	4.31	0.63	11.46	9.72	090
28114		A	Removal of metatarsal heads	9.78	11.62	8.37	1.43	22.83	19.58	090
28116		A	Revision of foot	7.74	6.79	5.17	1.04	15.57	13.95	090
28118		A	Removal of heel bone	5.95	6.24	4.34	0.84	13.03	11.13	090
28119		A	Removal of heel spur	5.38	5.42	3.72	0.70	11.50	9.80	090
28120		A	Part removal of ankle/heel	5.39	7.28	4.41	0.77	13.44	10.57	090
28122		A	Partial removal of foot bone	7.28	6.83	5.26	0.98	15.09	13.52	090
28124		A	Partial removal of toe	4.80	4.99	3.65	0.60	10.39	9.05	090
28126		A	Partial removal of toe	3.51	4.21	2.99	0.45	8.17	6.95	090
28130		A	Removal of ankle bone	8.10	NA	6.71	1.25	NA	16.06	090
28140		A	Removal of metatarsal	6.90	7.22	4.76	0.92	15.04	12.58	090
28150		A	Removal of toe	4.08	4.83	3.28	0.53	9.44	7.89	090
28153		A	Partial removal of toe	3.65	4.31	2.68	0.47	8.43	6.80	090
28160		A	Partial removal of toe	3.73	4.56	3.33	0.49	8.78	7.55	090
28171		A	Extensive foot surgery	9.59	NA	5.42	1.33	NA	16.34	090
28173		A	Extensive foot surgery	8.79	7.59	5.19	1.13	17.51	15.11	090
28175		A	Extensive foot surgery	6.04	5.70	3.70	0.74	12.48	10.48	090
28190		A	Removal of foot foreign body	1.96	3.39	1.48	0.22	5.57	3.66	010
28192		A	Removal of foot foreign body	4.63	5.47	3.64	0.59	10.69	8.86	090
28193		A	Removal of foot foreign body	5.72	5.60	3.92	0.72	12.04	10.36	090
28200		A	Repair of foot tendon	4.59	5.09	3.55	0.61	10.29	8.75	090
28202		A	Repair/graft of foot tendon	6.83	7.21	4.49	0.91	14.95	12.23	090
28208		A	Repair of foot tendon	4.36	4.81	3.30	0.58	9.75	8.24	090
28210		A	Repair/graft of foot tendon	6.34	6.21	4.02	0.82	13.37	11.18	090
28220		A	Release of foot tendon	4.52	4.67	3.42	0.57	9.76	8.51	090
28222		A	Release of foot tendons	5.61	5.23	4.12	0.70	11.54	10.43	090
28225		A	Release of foot tendon	3.65	4.28	2.90	0.47	8.40	7.02	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
28226		A	Release of foot tendons	4.52	4.79	3.74	0.58	9.89	8.84	090
28230		A	Incision of foot tendon(s)	4.23	4.67	3.67	0.56	9.46	8.46	090
28232		A	Incision of toe tendon	3.38	4.52	3.31	0.45	8.35	7.14	090
28234		A	Incision of foot tendon	3.36	4.67	3.35	0.44	8.47	7.15	090
28238		A	Revision of foot tendon	7.72	7.24	4.93	1.06	16.02	13.71	090
28240		A	Release of big toe	4.35	4.63	3.48	0.58	9.56	8.41	090
28250		A	Revision of foot fascia	5.91	5.62	4.13	0.83	12.36	10.87	090
28260		A	Release of midfoot joint	7.95	6.32	4.99	1.14	15.41	14.08	090
28261		A	Revision of foot tendon	11.71	8.61	7.30	1.57	21.89	20.58	090
28262		A	Revision of foot and ankle	15.81	13.55	10.91	2.57	31.93	29.29	090
28264		A	Release of midfoot joint	10.33	7.73	7.28	1.54	19.60	19.15	090
28270		A	Release of foot contracture	4.75	4.89	3.73	0.62	10.26	9.10	090
28272		A	Release of toe joint, each	3.79	4.18	2.85	0.47	8.44	7.11	090
28280		A	Fusion of toes	5.18	6.24	4.48	0.73	12.15	10.39	090
28285		A	Repair of hammertoe	4.58	4.86	3.42	0.60	10.04	8.60	090
28286		A	Repair of hammertoe	4.55	4.79	3.25	0.58	9.92	8.38	090
28288		A	Partial removal of foot bone	4.73	5.93	4.88	0.65	11.31	10.26	090
28289		A	Repair hallux rigidus	7.03	7.98	5.76	1.02	16.03	13.81	090
28290		A	Correction of bunion	5.65	6.25	4.72	0.82	12.72	11.19	090
28292		A	Correction of bunion	7.03	7.46	5.53	0.92	15.41	13.48	090
28293		A	Correction of bunion	9.14	10.74	6.10	1.14	21.02	16.38	090
28294		A	Correction of bunion	8.55	7.43	4.71	1.10	17.08	14.36	090
28296		A	Correction of bunion	9.17	8.15	5.41	1.20	18.52	15.78	090
28297		A	Correction of bunion	9.17	8.94	6.25	1.32	19.43	16.74	090
28298		A	Correction of bunion	7.93	7.21	5.00	1.05	16.19	13.98	090
28299		A	Correction of bunion	10.56	8.76	6.06	1.38	20.70	18.00	090
28300		A	Incision of heel bone	9.53	NA	7.03	1.53	NA	18.09	090
28302		A	Incision of ankle bone	9.54	NA	6.88	1.42	NA	17.84	090
28304		A	Incision of midfoot bones	9.15	7.94	5.73	1.27	18.36	16.15	090
28305		A	Incise/graft midfoot bones	10.48	NA	6.72	1.27	NA	18.47	090
28306		A	Incision of metatarsal	5.85	6.83	4.17	0.84	13.52	10.86	090
28307		A	Incision of metatarsal	6.32	11.02	5.28	0.91	18.25	12.51	090
28308		A	Incision of metatarsal	5.28	5.74	3.68	0.70	11.72	9.66	090
28309		A	Incision of metatarsals	12.76	NA	7.95	2.02	NA	22.73	090
28310		A	Revision of big toe	5.42	5.74	3.55	0.70	11.86	9.67	090
28312		A	Revision of toe	4.54	5.43	3.63	0.63	10.60	8.80	090
28313		A	Repair deformity of toe	5.00	5.27	4.83	0.73	11.00	10.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
28315		A	Removal of sesamoid bone	4.85	4.89	3.33	0.63	10.37	8.81	090
28320		A	Repair of foot bones	9.17	NA	6.71	1.42	NA	17.30	090
28322		A	Repair of metatarsals	8.33	9.17	6.33	1.26	18.76	15.92	090
28340		A	Resect enlarged toe tissue	6.97	6.44	4.24	0.85	14.26	12.06	090
28341		A	Resect enlarged toe	8.40	6.93	4.81	1.05	16.38	14.26	090
28344		A	Repair extra toe(s)	4.25	5.74	3.63	0.52	10.51	8.40	090
28345		A	Repair webbed toe(s)	5.91	6.19	4.68	0.81	12.91	11.40	090
28360		A	Reconstruct cleft foot	13.32	NA	10.49	2.27	NA	26.08	090
28400		A	Treatment of heel fracture	2.16	3.63	3.05	0.33	6.12	5.54	090
28405		A	Treatment of heel fracture	4.56	4.83	4.62	0.72	10.11	9.90	090
28406		A	Treatment of heel fracture	6.30	NA	6.79	1.09	NA	14.18	090
28415		A	Treat heel fracture	15.95	NA	13.28	2.63	NA	31.86	090
28420		A	Treat/graft heel fracture	16.62	NA	12.91	2.75	NA	32.28	090
28430		A	Treatment of ankle fracture	2.09	3.39	2.56	0.30	5.78	4.95	090
28435		A	Treatment of ankle fracture	3.39	3.88	3.74	0.53	7.80	7.66	090
28436		A	Treatment of ankle fracture	4.70	NA	5.91	0.78	NA	11.39	090
28445		A	Treat ankle fracture	15.60	NA	11.03	2.55	NA	29.18	090
28450		A	Treat midfoot fracture, each	1.90	3.11	2.47	0.28	5.29	4.65	090
28455		A	Treat midfoot fracture, each	3.09	3.42	3.42	0.43	6.94	6.94	090
28456		A	Treat midfoot fracture	2.68	NA	4.15	0.44	NA	7.27	090
28465		A	Treat midfoot fracture, each	7.00	NA	6.31	1.08	NA	14.39	090
28470		A	Treat metatarsal fracture	1.99	3.12	2.44	0.29	5.40	4.72	090
28475		A	Treat metatarsal fracture	2.97	3.33	3.21	0.43	6.73	6.61	090
28476		A	Treat metatarsal fracture	3.37	NA	4.98	0.54	NA	8.89	090
28485		A	Treat metatarsal fracture	5.70	NA	5.44	0.83	NA	11.97	090
28490		A	Treat big toe fracture	1.09	2.01	1.64	0.14	3.24	2.87	090
28495		A	Treat big toe fracture	1.58	2.17	2.06	0.20	3.95	3.84	090
28496		A	Treat big toe fracture	2.33	8.25	3.19	0.36	10.94	5.88	090
28505		A	Treat big toe fracture	3.80	8.10	3.90	0.55	12.45	8.25	090
28510		A	Treatment of toe fracture	1.09	1.53	1.53	0.13	2.75	2.75	090
28515		A	Treatment of toe fracture	1.46	1.89	1.89	0.18	3.53	3.53	090
28525		A	Treat toe fracture	3.32	7.51	3.43	0.47	11.30	7.22	090
28530		A	Treat sesamoid bone fracture	1.06	1.44	1.44	0.14	2.64	2.64	090
28531		A	Treat sesamoid bone fracture	2.35	7.26	2.06	0.34	9.95	4.75	090
28540		A	Treat foot dislocation	2.04	2.40	2.40	0.25	4.69	4.69	090
28545		A	Treat foot dislocation	2.45	2.34	2.34	0.37	5.16	5.16	090
28546		A	Treat foot dislocation	3.20	6.91	4.38	0.52	10.63	8.10	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
28555		A	Repair foot dislocation	6.29	9.90	5.67	1.04	17.23	13.00	090
28570		A	Treat foot dislocation	1.66	2.42	2.33	0.22	4.30	4.21	090
28575		A	Treat foot dislocation	3.31	3.72	3.72	0.56	7.59	7.59	090
28576		A	Treat foot dislocation	4.16	NA	4.17	0.69	NA	9.02	090
28585		A	Repair foot dislocation	7.98	7.32	5.83	1.23	16.53	15.04	090
28600		A	Treat foot dislocation	1.89	2.81	2.68	0.27	4.97	4.84	090
28605		A	Treat foot dislocation	2.71	3.12	3.12	0.40	6.23	6.23	090
28606		A	Treat foot dislocation	4.89	NA	4.69	0.82	NA	10.40	090
28615		A	Repair foot dislocation	7.76	NA	8.04	1.29	NA	17.09	090
28630		A	Treat toe dislocation	1.70	1.57	1.00	0.19	3.46	2.89	010
28635		A	Treat toe dislocation	1.91	2.02	1.53	0.26	4.19	3.70	010
28636		A	Treat toe dislocation	2.77	3.87	2.62	0.43	7.07	5.82	010
28645		A	Repair toe dislocation	4.21	4.95	3.27	0.58	9.74	8.06	090
28660		A	Treat toe dislocation	1.23	1.26	0.79	0.13	2.62	2.15	010
28665		A	Treat toe dislocation	1.92	NA	1.43	0.25	NA	3.60	010
28666		A	Treat toe dislocation	2.66	5.88	2.58	0.43	8.97	5.67	010
28675		A	Repair of toe dislocation	2.92	7.14	3.35	0.45	10.51	6.72	090
28705		A	Fusion of foot bones	18.77	NA	12.43	3.05	NA	34.25	090
28715		A	Fusion of foot bones	13.08	NA	9.75	2.14	NA	24.97	090
28725		A	Fusion of foot bones	11.59	NA	8.24	1.85	NA	21.68	090
28730		A	Fusion of foot bones	10.74	NA	8.48	1.68	NA	20.90	090
28735		A	Fusion of foot bones	10.83	NA	7.82	1.67	NA	20.32	090
28737		A	Revision of foot bones	9.63	NA	6.80	1.46	NA	17.89	090
28740		A	Fusion of foot bones	8.01	10.86	6.46	1.22	20.09	15.69	090
28750		A	Fusion of big toe joint	7.29	11.91	6.66	1.11	20.31	15.06	090
28755		A	Fusion of big toe joint	4.73	6.10	3.75	0.65	11.48	9.13	090
28760		A	Fusion of big toe joint	7.74	7.97	5.51	1.06	16.77	14.31	090
28800		A	Amputation of midfoot	8.20	NA	5.79	1.15	NA	15.14	090
28805		A	Amputation thru metatarsal	8.38	NA	5.64	1.17	NA	15.19	090
28810		A	Amputation toe & metatarsal	6.20	NA	4.47	0.86	NA	11.53	090
28820		A	Amputation of toe	4.40	7.55	3.78	0.61	12.56	8.79	090
28825		A	Partial amputation of toe	3.58	6.99	3.48	0.50	11.07	7.56	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	2.96	1.73	0.40	5.61	4.38	000
29010		A	Application of body cast	2.06	3.28	1.77	0.45	5.79	4.28	000
29015		A	Application of body cast	2.41	2.97	1.60	0.29	5.67	4.30	000
29020		A	Application of body cast	2.11	3.18	1.41	0.28	5.57	3.80	000

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29025		A	Application of body cast	2.40	3.14	1.85	0.44	5.98	4.69	000
29035		A	Application of body cast	1.77	3.61	1.58	0.28	5.66	3.63	000
29040		A	Application of body cast	2.22	2.46	1.51	0.36	5.04	4.09	000
29044		A	Application of body cast	2.12	3.97	1.90	0.35	6.44	4.37	000
29046		A	Application of body cast	2.41	3.23	2.09	0.41	6.05	4.91	000
29049		A	Application of figure eight	0.89	1.30	0.53	0.12	2.31	1.54	000
29055		A	Application of shoulder cast	1.78	2.98	1.47	0.28	5.04	3.53	000
29058		A	Application of shoulder cast	1.31	1.56	0.72	0.16	3.03	2.19	000
29065		A	Application of long arm cast	0.87	1.33	0.75	0.14	2.34	1.76	000
29075		A	Application of forearm cast	0.77	1.26	0.68	0.12	2.15	1.57	000
29085		A	Apply hand/wrist cast	0.87	1.28	0.63	0.13	2.28	1.63	000
29086		A	Apply finger cast	0.62	0.96	0.49	0.07	1.65	1.18	000
29105		A	Apply long arm splint	0.87	1.23	0.51	0.12	2.22	1.50	000
29125		A	Apply forearm splint	0.59	1.02	0.39	0.07	1.68	1.05	000
29126		A	Apply forearm splint	0.77	1.21	0.46	0.06	2.04	1.29	000
29130		A	Application of finger splint	0.50	0.47	0.17	0.06	1.03	0.73	000
29131		A	Application of finger splint	0.55	0.74	0.24	0.04	1.33	0.83	000
29200		A	Strapping of chest	0.65	0.72	0.34	0.04	1.41	1.03	000
29220		A	Strapping of low back	0.64	0.72	0.39	0.04	1.40	1.07	000
29240		A	Strapping of shoulder	0.71	0.85	0.36	0.05	1.61	1.12	000
29260		A	Strapping of elbow or wrist	0.55	0.74	0.32	0.05	1.34	0.92	000
29280		A	Strapping of hand or finger	0.51	0.80	0.32	0.03	1.34	0.86	000
29305		A	Application of hip cast	2.03	3.34	1.76	0.33	5.70	4.12	000
29325		A	Application of hip casts	2.32	3.53	1.95	0.38	6.23	4.65	000
29345		A	Application of long leg cast	1.40	1.76	1.06	0.23	3.39	2.69	000
29355		A	Application of long leg cast	1.53	1.71	1.12	0.24	3.48	2.89	000
29358		A	Apply long leg cast brace	1.43	2.06	1.09	0.24	3.73	2.76	000
29365		A	Application of long leg cast	1.18	1.66	0.95	0.20	3.04	2.33	000
29405		A	Apply short leg cast	0.86	1.22	0.71	0.14	2.22	1.71	000
29425		A	Apply short leg cast	1.01	1.23	0.74	0.15	2.39	1.90	000
29435		A	Apply short leg cast	1.18	1.56	0.93	0.20	2.94	2.31	000
29440		A	Addition of walker to cast	0.57	0.69	0.27	0.08	1.34	0.92	000
29445		A	Apply rigid leg cast	1.78	1.80	0.96	0.26	3.84	3.00	000
29450		A	Application of leg cast	2.08	1.47	1.09	0.27	3.82	3.44	000
29505		A	Application, long leg splint	0.69	1.18	0.45	0.07	1.94	1.21	000
29515		A	Application lower leg splint	0.73	0.87	0.46	0.09	1.69	1.28	000
29520		A	Strapping of hip	0.54	0.85	0.47	0.03	1.42	1.04	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29530		A	Strapping of knee	0.57	0.79	0.33	0.04	1.40	0.94	000
29540		A	Strapping of ankle and/or ft	0.51	0.42	0.31	0.06	0.99	0.88	000
29550		A	Strapping of toes	0.47	0.42	0.28	0.06	0.95	0.81	000
29580		A	Application of paste boot	0.57	0.65	0.35	0.07	1.29	0.99	000
29590		A	Application of foot splint	0.76	0.51	0.29	0.09	1.36	1.14	000
29700		A	Removal/revision of cast	0.57	0.89	0.28	0.07	1.53	0.92	000
29705		A	Removal/revision of cast	0.76	0.82	0.38	0.12	1.70	1.26	000
29710		A	Removal/revision of cast	1.34	1.53	0.70	0.19	3.06	2.23	000
29715		A	Removal/revision of cast	0.94	1.17	0.40	0.10	2.21	1.44	000
29720		A	Repair of body cast	0.68	1.16	0.39	0.11	1.95	1.18	000
29730		A	Windowing of cast	0.75	0.81	0.35	0.12	1.68	1.22	000
29740		A	Wedging of cast	1.12	1.15	0.49	0.17	2.44	1.78	000
29750		A	Wedging of clubfoot cast	1.26	1.06	0.58	0.20	2.52	2.04	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.42	NA	6.97	0.98	NA	14.37	090
29804		A	Jaw arthroscopy/surgery	8.13	NA	7.62	1.38	NA	17.13	090
29805		A	Shoulder arthroscopy, dx	5.88	NA	5.67	1.00	NA	12.55	090
29806		A	Shoulder arthroscopy/surgery	14.35	NA	11.16	2.45	NA	27.96	090
29807		A	Shoulder arthroscopy/surgery	13.88	NA	10.99	2.36	NA	27.23	090
29819		A	Shoulder arthroscopy/surgery	7.61	NA	6.79	1.29	NA	15.69	090
29820		A	Shoulder arthroscopy/surgery	7.06	NA	6.22	1.20	NA	14.48	090
29821		A	Shoulder arthroscopy/surgery	7.71	NA	6.80	1.30	NA	15.81	090
29822		A	Shoulder arthroscopy/surgery	7.42	NA	6.69	1.27	NA	15.38	090
29823		A	Shoulder arthroscopy/surgery	8.16	NA	7.22	1.39	NA	16.77	090
29824		A	Shoulder arthroscopy/surgery	8.24	NA	7.53	1.41	NA	17.18	090
29825		A	Shoulder arthroscopy/surgery	7.61	NA	6.76	1.29	NA	15.66	090
29826		A	Shoulder arthroscopy/surgery	8.98	NA	7.53	1.54	NA	18.05	090
29827		A	Arthroscop rotator cuff repr	15.34	NA	11.53	2.63	NA	29.50	090
29830		A	Elbow arthroscopy	5.75	NA	5.34	0.96	NA	12.05	090
29834		A	Elbow arthroscopy/surgery	6.27	NA	5.83	1.06	NA	13.16	090
29835		A	Elbow arthroscopy/surgery	6.47	NA	5.88	1.11	NA	13.46	090
29836		A	Elbow arthroscopy/surgery	7.54	NA	6.79	1.21	NA	15.54	090
29837		A	Elbow arthroscopy/surgery	6.86	NA	6.13	1.18	NA	14.17	090
29838		A	Elbow arthroscopy/surgery	7.70	NA	6.89	1.27	NA	15.86	090
29840		A	Wrist arthroscopy	5.53	NA	5.32	0.83	NA	11.68	090
29843		A	Wrist arthroscopy/surgery	6.00	NA	5.62	0.92	NA	12.54	090
29844		A	Wrist arthroscopy/surgery	6.36	NA	5.82	1.04	NA	13.22	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
29845		A	Wrist arthroscopy/surgery	7.51	NA	6.47	0.99	NA	14.97	090
29846		A	Wrist arthroscopy/surgery	6.74	NA	6.05	1.06	NA	13.85	090
29847		A	Wrist arthroscopy/surgery	7.07	NA	6.19	1.08	NA	14.34	090
29848		A	Wrist endoscopy/surgery	5.43	NA	5.60	0.87	NA	11.90	090
29850		A	Knee arthroscopy/surgery	8.18	NA	5.04	1.17	NA	14.39	090
29851		A	Knee arthroscopy/surgery	13.08	NA	9.79	2.32	NA	25.19	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	8.76	1.82	NA	21.18	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	10.67	2.38	NA	27.17	090
29860		A	Hip arthroscopy, dx	8.04	NA	6.95	1.35	NA	16.34	090
29861		A	Hip arthroscopy/surgery	9.14	NA	7.34	1.55	NA	18.03	090
29862		A	Hip arthroscopy/surgery	9.89	NA	8.56	1.61	NA	20.06	090
29863		A	Hip arthroscopy/surgery	9.89	NA	8.51	1.42	NA	19.82	090
29866		A	Autgrft implnt, knee w/scope	13.88	NA	11.35	2.38	NA	27.61	090
29867		A	Allgrft implnt, knee w/scope	17.00	NA	13.22	2.76	NA	32.98	090
29868		A	Meniscal trnspl, knee w/scpe	23.59	NA	16.79	4.33	NA	44.71	090
29870		A	Knee arthroscopy, dx	5.06	NA	4.89	0.83	NA	10.78	090
29871		A	Knee arthroscopy/drainage	6.54	NA	5.87	1.12	NA	13.53	090
29873		A	Knee arthroscopy/surgery	5.99	NA	6.57	1.03	NA	13.59	090
29874		A	Knee arthroscopy/surgery	7.04	NA	6.07	1.07	NA	14.18	090
29875		A	Knee arthroscopy/surgery	6.30	NA	5.85	1.08	NA	13.23	090
29876		A	Knee arthroscopy/surgery	7.91	NA	7.02	1.36	NA	16.29	090
29877		A	Knee arthroscopy/surgery	7.34	NA	6.74	1.26	NA	15.34	090
29879		A	Knee arthroscopy/surgery	8.03	NA	7.12	1.38	NA	16.53	090
29880		A	Knee arthroscopy/surgery	8.49	NA	7.36	1.46	NA	17.31	090
29881		A	Knee arthroscopy/surgery	7.75	NA	6.96	1.33	NA	16.04	090
29882		A	Knee arthroscopy/surgery	8.64	NA	7.24	1.48	NA	17.36	090
29883		A	Knee arthroscopy/surgery	11.03	NA	9.06	1.89	NA	21.98	090
29884		A	Knee arthroscopy/surgery	7.32	NA	6.70	1.26	NA	15.28	090
29885		A	Knee arthroscopy/surgery	9.08	NA	7.97	1.56	NA	18.61	090
29886		A	Knee arthroscopy/surgery	7.53	NA	6.85	1.29	NA	15.67	090
29887		A	Knee arthroscopy/surgery	9.03	NA	7.93	1.55	NA	18.51	090
29888		A	Knee arthroscopy/surgery	13.88	NA	10.20	2.38	NA	26.46	090
29889		A	Knee arthroscopy/surgery	15.98	NA	12.43	2.73	NA	31.14	090
29891		A	Ankle arthroscopy/surgery	8.39	NA	7.51	1.38	NA	17.28	090
29892		A	Ankle arthroscopy/surgery	8.99	NA	7.74	1.41	NA	18.14	090
29893		A	Scope, plantar fasciotomy	5.21	6.28	3.99	0.65	12.14	9.85	090
29894		A	Ankle arthroscopy/surgery	7.20	NA	5.47	1.14	NA	13.81	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
29895		A	Ankle arthroscopy/surgery	6.98	NA	5.47	1.10	NA	13.55	090
29897		A	Ankle arthroscopy/surgery	7.17	NA	5.88	1.17	NA	14.22	090
29898		A	Ankle arthroscopy/surgery	8.31	NA	6.19	1.27	NA	15.77	090
29899		A	Ankle arthroscopy/surgery	13.89	NA	10.54	2.36	NA	26.79	090
29900		A	Mcp joint arthroscopy, dx	5.41	NA	5.86	0.93	NA	12.20	090
29901		A	Mcp joint arthroscopy, surg	6.12	NA	6.26	1.06	NA	13.44	090
29902		A	Mcp joint arthroscopy, surg	6.69	NA	6.54	1.12	NA	14.35	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.43	4.07	1.39	0.12	5.62	2.94	010
30020		A	Drainage of nose lesion	1.43	3.27	1.47	0.12	4.82	3.02	010
30100		A	Intranasal biopsy	0.94	1.97	0.82	0.07	2.98	1.83	000
30110		A	Removal of nose polyp(s)	1.63	3.24	1.57	0.14	5.01	3.34	010
30115		A	Removal of nose polyp(s)	4.34	NA	5.76	0.41	NA	10.51	090
30117		A	Removal of intranasal lesion	3.16	13.14	4.63	0.26	16.56	8.05	090
30118		A	Removal of intranasal lesion	9.68	NA	9.19	0.82	NA	19.69	090
30120		A	Revision of nose	5.26	6.49	6.00	0.52	12.27	11.78	090
30124		A	Removal of nose lesion	3.10	NA	3.61	0.25	NA	6.96	090
30125		A	Removal of nose lesion	7.15	NA	8.32	0.65	NA	16.12	090
30130		A	Removal of turbinate bones	3.37	NA	5.59	0.32	NA	9.28	090
30140		A	Removal of turbinate bones	3.42	NA	6.19	0.36	NA	9.97	090
30150		A	Partial removal of nose	9.13	NA	11.01	0.90	NA	21.04	090
30160		A	Removal of nose	9.57	NA	10.21	0.91	NA	20.69	090
30200		A	Injection treatment of nose	0.78	1.62	0.74	0.06	2.46	1.58	000
30210		A	Nasal sinus therapy	1.08	2.10	1.31	0.09	3.27	2.48	010
30220		A	Insert nasal septal button	1.54	4.23	1.53	0.13	5.90	3.20	010
30300		A	Remove nasal foreign body	1.04	4.63	1.91	0.08	5.75	3.03	010
30310		A	Remove nasal foreign body	1.96	NA	3.10	0.17	NA	5.23	010
30320		A	Remove nasal foreign body	4.51	NA	7.04	0.39	NA	11.94	090
30400		R	Reconstruction of nose	9.82	NA	15.49	1.03	NA	26.34	090
30410		R	Reconstruction of nose	12.96	NA	18.37	1.41	NA	32.74	090
30420		R	Reconstruction of nose	15.86	NA	17.91	1.46	NA	35.23	090
30430		R	Revision of nose	7.20	NA	16.01	0.77	NA	23.98	090
30435		R	Revision of nose	11.69	NA	19.35	1.19	NA	32.23	090
30450		R	Revision of nose	18.62	NA	21.89	1.93	NA	42.44	090
30460		A	Revision of nose	9.95	NA	9.94	1.03	NA	20.92	090
30462		A	Revision of nose	19.54	NA	20.24	2.51	NA	42.29	090
30465		A	Repair nasal stenosis	11.62	NA	11.97	1.05	NA	24.64	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
30520		A	Repair of nasal septum	5.69	NA	6.66	0.47	NA	12.82	090
30540		A	Repair nasal defect	7.74	NA	9.27	0.68	NA	17.69	090
30545		A	Repair nasal defect	11.36	NA	11.90	1.68	NA	24.94	090
30560		A	Release of nasal adhesions	1.26	4.77	2.13	0.10	6.13	3.49	010
30580		A	Repair upper jaw fistula	6.68	7.77	5.79	0.89	15.34	13.36	090
30600		A	Repair mouth/nose fistula	6.01	7.52	5.02	0.68	14.21	11.71	090
30620		A	Intranasal reconstruction	5.96	NA	8.83	0.57	NA	15.36	090
30630		A	Repair nasal septum defect	7.11	NA	7.95	0.61	NA	15.67	090
30801		A	Cauterization, inner nose	1.09	4.13	1.92	0.09	5.31	3.10	010
30802		A	Cauterization, inner nose	2.03	4.61	2.36	0.17	6.81	4.56	010
30901		A	Control of nosebleed	1.21	1.36	0.32	0.11	2.68	1.64	000
30903		A	Control of nosebleed	1.54	2.71	0.50	0.13	4.38	2.17	000
30905		A	Control of nosebleed	1.97	3.51	0.76	0.17	5.65	2.90	000
30906		A	Repeat control of nosebleed	2.45	3.89	1.20	0.20	6.54	3.85	000
30915		A	Ligation, nasal sinus artery	7.19	NA	6.69	0.59	NA	14.47	090
30920		A	Ligation, upper jaw artery	9.82	NA	8.97	0.80	NA	19.59	090
30930		A	Therapy, fracture of nose	1.26	NA	1.62	0.12	NA	3.00	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.15	2.84	1.40	0.09	4.08	2.64	010
31002		A	Irrigation, sphenoid sinus	1.91	NA	3.24	0.16	NA	5.31	010
31020		A	Exploration, maxillary sinus	2.94	8.53	5.18	0.29	11.76	8.41	090
31030		A	Exploration, maxillary sinus	5.91	11.50	6.66	0.58	17.99	13.15	090
31032		A	Explore sinus, remove polyps	6.56	NA	7.23	0.60	NA	14.39	090
31040		A	Exploration behind upper jaw	9.41	NA	9.82	0.85	NA	20.08	090
31050		A	Exploration, sphenoid sinus	5.27	NA	6.35	0.53	NA	12.15	090
31051		A	Sphenoid sinus surgery	7.10	NA	8.24	0.64	NA	15.98	090
31070		A	Exploration of frontal sinus	4.27	NA	5.93	0.40	NA	10.60	090
31075		A	Exploration of frontal sinus	9.15	NA	9.73	0.80	NA	19.68	090
31080		A	Removal of frontal sinus	11.40	NA	13.53	1.15	NA	26.08	090
31081		A	Removal of frontal sinus	12.73	NA	14.00	2.44	NA	29.17	090
31084		A	Removal of frontal sinus	13.49	NA	13.50	1.25	NA	28.24	090
31085		A	Removal of frontal sinus	14.18	NA	13.96	1.68	NA	29.82	090
31086		A	Removal of frontal sinus	12.84	NA	13.28	1.09	NA	27.21	090
31087		A	Removal of frontal sinus	13.08	NA	12.53	1.49	NA	27.10	090
31090		A	Exploration of sinuses	9.52	NA	12.55	0.93	NA	23.00	090
31200		A	Removal of ethmoid sinus	4.96	NA	9.21	0.30	NA	14.47	090
31201		A	Removal of ethmoid sinus	8.36	NA	9.17	0.82	NA	18.35	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31205		A	Removal of ethmoid sinus	10.22	NA	11.88	0.68	NA	22.78	090
31225		A	Removal of upper jaw	19.20	NA	17.82	1.69	NA	38.71	090
31230		A	Removal of upper jaw	21.91	NA	19.36	1.81	NA	43.08	090
31231		A	Nasal endoscopy, dx	1.10	3.38	0.88	0.09	4.57	2.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.30	1.48	0.20	6.68	3.86	000
31235		A	Nasal/sinus endoscopy, dx	2.64	4.91	1.72	0.26	7.81	4.62	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.19	1.88	0.28	8.45	5.14	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.23	2.09	0.27	8.76	5.62	000
31239		A	Nasal/sinus endoscopy, surg	8.69	NA	8.00	0.62	NA	17.31	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.73	0.24	NA	4.58	000
31254		A	Revision of ethmoid sinus	4.64	NA	2.85	0.45	NA	7.94	000
31255		A	Removal of ethmoid sinus	6.95	NA	4.11	0.73	NA	11.79	000
31256		A	Exploration maxillary sinus	3.29	NA	2.11	0.34	NA	5.74	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	3.29	0.55	NA	9.29	000
31276		A	Sinus endoscopy, surgical	8.84	NA	5.12	0.91	NA	14.87	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	2.45	0.39	NA	6.75	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	2.81	0.46	NA	7.84	000
31290		A	Nasal/sinus endoscopy, surg	17.21	NA	12.05	1.49	NA	30.75	010
31291		A	Nasal/sinus endoscopy, surg	18.16	NA	12.47	1.67	NA	32.30	010
31292		A	Nasal/sinus endoscopy, surg	14.74	NA	10.61	1.21	NA	26.56	010
31293		A	Nasal/sinus endoscopy, surg	16.19	NA	11.38	1.31	NA	28.88	010
31294		A	Nasal/sinus endoscopy, surg	19.03	NA	12.87	1.52	NA	33.42	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	14.27	NA	14.98	1.18	NA	30.43	090
31320		A	Diagnostic incision, larynx	5.25	NA	10.30	0.46	NA	16.01	090
31360		A	Removal of larynx	17.05	NA	16.72	1.40	NA	35.17	090
31365		A	Removal of larynx	24.12	NA	20.36	2.02	NA	46.50	090
31367		A	Partial removal of larynx	21.83	NA	21.89	1.81	NA	45.53	090
31368		A	Partial removal of larynx	27.05	NA	25.49	2.23	NA	54.77	090
31370		A	Partial removal of larynx	21.35	NA	22.26	1.81	NA	45.42	090
31375		A	Partial removal of larynx	20.18	NA	20.38	1.61	NA	42.17	090
31380		A	Partial removal of larynx	20.18	NA	20.60	1.69	NA	42.47	090
31382		A	Partial removal of larynx	20.49	NA	21.61	1.71	NA	43.81	090
31390		A	Removal of larynx & pharynx	27.49	NA	24.38	2.35	NA	54.22	090
31395		A	Reconstruct larynx & pharynx	31.04	NA	28.30	2.52	NA	61.86	090
31400		A	Revision of larynx	10.29	NA	13.77	0.85	NA	24.91	090
31420		A	Removal of epiglottis	10.20	NA	9.54	0.84	NA	20.58	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31500		A	Insert emergency airway	2.33	NA	0.55	0.19	NA	3.07	000
31502		A	Change of windpipe airway	0.65	0.31	0.28	0.05	1.01	0.98	000
31505		A	Diagnostic laryngoscopy	0.61	1.45	0.61	0.05	2.11	1.27	000
31510		A	Laryngoscopy with biopsy	1.92	3.30	1.25	0.16	5.38	3.33	000
31511		A	Remove foreign body, larynx	2.16	3.12	1.06	0.19	5.47	3.41	000
31512		A	Removal of larynx lesion	2.07	3.20	1.36	0.18	5.45	3.61	000
31513		A	Injection into vocal cord	2.10	NA	1.46	0.17	NA	3.73	000
31515		A	Laryngoscopy for aspiration	1.80	3.54	1.06	0.14	5.48	3.00	000
31520		A	Diagnostic laryngoscopy	2.56	NA	1.56	0.20	NA	4.32	000
31525		A	Diagnostic laryngoscopy	2.63	3.64	1.66	0.21	6.48	4.50	000
31526		A	Diagnostic laryngoscopy	2.57	NA	1.72	0.21	NA	4.50	000
31527		A	Laryngoscopy for treatment	3.27	NA	1.87	0.26	NA	5.40	000
31528		A	Laryngoscopy and dilation	2.37	NA	1.46	0.20	NA	4.03	000
31529		A	Laryngoscopy and dilation	2.68	NA	1.71	0.22	NA	4.61	000
31530		A	Operative laryngoscopy	3.38	NA	1.95	0.29	NA	5.62	000
31531		A	Operative laryngoscopy	3.58	NA	2.27	0.29	NA	6.14	000
31535		A	Operative laryngoscopy	3.16	NA	1.99	0.26	NA	5.41	000
31536		A	Operative laryngoscopy	3.55	NA	2.25	0.29	NA	6.09	000
31540		A	Operative laryngoscopy	4.12	NA	2.54	0.34	NA	7.00	000
31541		A	Operative laryngoscopy	4.52	NA	2.78	0.37	NA	7.67	000
31545		A	Remove vc lesion w/scope	6.30	NA	3.47	0.37	NA	10.14	000
31546		A	Remove vc lesion scope/graft	9.73	NA	4.97	0.78	NA	15.48	000
31560		A	Operative laryngoscopy	5.45	NA	3.15	0.43	NA	9.03	000
31561		A	Operative laryngoscopy	5.99	NA	3.37	0.48	NA	9.84	000
31570		A	Laryngoscopy with injection	3.86	5.67	2.38	0.31	9.84	6.55	000
31571		A	Laryngoscopy with injection	4.26	NA	2.60	0.34	NA	7.20	000
31575		A	Diagnostic laryngoscopy	1.10	1.90	0.89	0.09	3.09	2.08	000
31576		A	Laryngoscopy with biopsy	1.97	3.66	1.29	0.15	5.78	3.41	000
31577		A	Remove foreign body, larynx	2.47	3.76	1.53	0.21	6.44	4.21	000
31578		A	Removal of larynx lesion	2.84	4.28	1.52	0.23	7.35	4.59	000
31579		A	Diagnostic laryngoscopy	2.26	3.78	1.48	0.19	6.23	3.93	000
31580		A	Revision of larynx	12.36	NA	15.91	1.02	NA	29.29	090
31582		A	Revision of larynx	21.59	NA	25.80	1.74	NA	49.13	090
31584		A	Treat larynx fracture	19.61	NA	18.15	1.70	NA	39.46	090
31585		A	Treat larynx fracture	4.63	NA	6.69	0.37	NA	11.69	090
31586		A	Treat larynx fracture	8.02	NA	10.86	0.66	NA	19.54	090
31587		A	Revision of larynx	11.97	NA	9.26	1.03	NA	22.26	090

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CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31588		A	Revision of larynx	13.09	NA	13.61	1.06	NA	27.76	090
31590		A	Reinnervate larynx	6.96	NA	15.53	0.80	NA	23.29	090
31595		A	Larynx nerve surgery	8.33	NA	10.55	0.69	NA	19.57	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	3.19	0.80	NA	11.16	000
31601		A	Incision of windpipe	4.44	NA	2.40	0.40	NA	7.24	000
31603		A	Incision of windpipe	4.14	NA	1.71	0.44	NA	6.29	000
31605		A	Incision of windpipe	3.57	NA	1.19	0.38	NA	5.14	000
31610		A	Incision of windpipe	8.75	NA	8.26	0.80	NA	17.81	090
31611		A	Surgery/speech prosthesis	5.63	NA	7.06	0.47	NA	13.16	090
31612		A	Puncture/clear windpipe	0.91	1.10	0.35	0.08	2.09	1.34	000
31613		A	Repair windpipe opening	4.58	NA	5.99	0.44	NA	11.01	090
31614		A	Repair windpipe opening	7.11	NA	8.71	0.62	NA	16.44	090
31615		A	Visualization of windpipe	2.09	2.59	1.20	0.17	4.85	3.46	000
31620		A	Endobronchial us add-on	1.40	5.64	0.55	0.11	7.15	2.06	ZZZ
31622		A	Dx bronchoscope/wash	2.78	5.65	1.06	0.20	8.63	4.04	000
31623		A	Dx bronchoscope/brush	2.88	6.42	1.05	0.16	9.46	4.09	000
31624		A	Dx bronchoscope/lavage	2.88	5.77	1.05	0.16	8.81	4.09	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.81	1.21	0.20	9.37	4.77	000
31628		A	Bronchoscopy/lung bx, each	3.80	7.02	1.30	0.19	11.01	5.29	000
31629		A	Bronchoscopy/needle bx, each	4.09	14.25	1.40	0.17	18.51	5.66	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.72	0.34	NA	5.87	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.76	0.36	NA	6.48	000
31632		A	Bronchoscopy/lung bx, add'l	1.03	0.81	0.31	0.19	2.03	1.53	ZZZ
31633		A	Bronchoscopy/needle bx add'l	1.32	0.92	0.40	0.17	2.41	1.89	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	6.11	1.43	0.26	10.04	5.36	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.76	0.31	NA	6.37	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.56	0.13	NA	2.27	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.97	0.22	NA	7.07	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	2.07	0.46	NA	7.46	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	1.88	0.38	NA	7.28	000
31643		A	Diag bronchoscope/catheter	3.49	NA	1.23	0.20	NA	4.92	000
31645		A	Bronchoscopy, clear airways	3.16	5.14	1.12	0.19	8.49	4.47	000
31646		A	Bronchoscopy, reclear airway	2.72	4.86	1.00	0.16	7.74	3.88	000
31656		A	Bronchoscopy, inj for x-ray	2.17	7.29	0.83	0.16	9.62	3.16	000
31700		A	Insertion of airway catheter	1.34	2.15	0.68	0.10	3.59	2.12	000
31708		A	Instill airway contrast dye	1.41	2.03	0.46	0.07	3.51	1.94	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
31710		A	Insertion of airway catheter	1.30	NA	0.41	0.13	NA	1.84	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.34	0.07	NA	1.52	000
31717		A	Bronchial brush biopsy	2.12	8.25	0.79	0.14	10.51	3.05	000
31720		A	Clearance of airways	1.06	0.33	0.33	0.07	1.46	1.46	000
31725		A	Clearance of airways	1.96	0.65	0.58	0.15	2.76	2.69	000
31730		A	Intro, windpipe wire/tube	2.85	2.19	1.00	0.23	5.27	4.08	000
31750		A	Repair of windpipe	13.00	NA	17.55	1.12	NA	31.67	090
31755		A	Repair of windpipe	15.91	NA	24.52	1.31	NA	41.74	090
31760		A	Repair of windpipe	22.32	NA	10.71	2.78	NA	35.81	090
31766		A	Reconstruction of windpipe	30.38	NA	13.65	4.49	NA	48.52	090
31770		A	Repair/graft of bronchus	22.48	NA	10.24	2.80	NA	35.52	090
31775		A	Reconstruct bronchus	23.50	NA	11.79	2.98	NA	38.27	090
31780		A	Reconstruct windpipe	17.69	NA	11.05	1.65	NA	30.39	090
31781		A	Reconstruct windpipe	23.49	NA	12.12	2.21	NA	37.82	090
31785		A	Remove windpipe lesion	17.20	NA	10.18	1.59	NA	28.97	090
31786		A	Remove windpipe lesion	23.94	NA	13.09	3.26	NA	40.29	090
31800		A	Repair of windpipe injury	7.42	NA	9.24	0.78	NA	17.44	090
31805		A	Repair of windpipe injury	13.11	NA	7.21	1.81	NA	22.13	090
31820		A	Closure of windpipe lesion	4.48	5.66	3.65	0.39	10.53	8.52	090
31825		A	Repair of windpipe defect	6.80	7.66	5.37	0.56	15.02	12.73	090
31830		A	Revise windpipe scar	4.49	5.76	3.98	0.44	10.69	8.91	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
32000		A	Drainage of chest	1.54	3.05	0.48	0.09	4.68	2.11	000
32002		A	Treatment of collapsed lung	2.19	3.21	1.06	0.14	5.54	3.39	000
32005		A	Treat lung lining chemically	2.19	6.45	0.70	0.22	8.86	3.11	000
32019		A	Insert pleural catheter	4.17	19.96	1.65	0.42	24.55	6.24	000
32020		A	Insertion of chest tube	3.97	NA	1.35	0.42	NA	5.74	000
32035		A	Exploration of chest	8.66	NA	5.85	1.22	NA	15.73	090
32036		A	Exploration of chest	9.67	NA	6.43	1.38	NA	17.48	090
32095		A	Biopsy through chest wall	8.35	NA	5.36	1.17	NA	14.88	090
32100		A	Exploration/biopsy of chest	15.22	NA	7.82	2.16	NA	25.20	090
32110		A	Explore/repair chest	22.97	NA	10.73	3.13	NA	36.83	090
32120		A	Re-exploration of chest	11.52	NA	7.07	1.61	NA	20.20	090
32124		A	Explore chest free adhesions	12.70	NA	7.21	1.85	NA	21.76	090
32140		A	Removal of lung lesion(s)	13.91	NA	7.68	1.95	NA	23.54	090
32141		A	Remove/treat lung lesions	13.98	NA	7.55	1.98	NA	23.51	090
32150		A	Removal of lung lesion(s)	14.13	NA	7.60	1.96	NA	23.69	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
32151		A	Remove lung foreign body	14.19	NA	8.00	1.92	NA	24.11	090
32160		A	Open chest heart massage	9.29	NA	5.26	1.25	NA	15.80	090
32200		A	Drain, open, lung lesion	15.27	NA	8.61	1.93	NA	25.81	090
32201		A	Drain, percut, lung lesion	3.99	20.70	1.30	0.24	24.93	5.53	000
32215		A	Treat chest lining	11.31	NA	6.90	1.56	NA	19.77	090
32220		A	Release of lung	23.96	NA	12.95	3.41	NA	40.32	090
32225		A	Partial release of lung	13.94	NA	7.65	1.97	NA	23.56	090
32310		A	Removal of chest lining	13.42	NA	7.39	1.92	NA	22.73	090
32320		A	Free/remove chest lining	23.96	NA	12.15	3.39	NA	39.50	090
32400		A	Needle biopsy chest lining	1.76	2.12	0.55	0.10	3.98	2.41	000
32402		A	Open biopsy chest lining	7.55	NA	5.11	1.04	NA	13.70	090
32405		A	Biopsy, lung or mediastinum	1.93	0.67	0.63	0.11	2.71	2.67	000
32420		A	Puncture/clear lung	2.18	NA	0.68	0.14	NA	3.00	000
32440		A	Removal of lung	24.96	NA	12.89	3.56	NA	41.41	090
32442		A	Sleeve pneumonectomy	26.20	NA	14.76	3.81	NA	44.77	090
32445		A	Removal of lung	25.05	NA	14.06	3.62	NA	42.73	090
32480		A	Partial removal of lung	23.71	NA	12.06	3.38	NA	39.15	090
32482		A	Bilobectomy	24.96	NA	12.91	3.53	NA	41.40	090
32484		A	Segmentectomy	20.66	NA	11.38	2.94	NA	34.98	090
32486		A	Sleeve lobectomy	23.88	NA	13.24	3.48	NA	40.60	090
32488		A	Completion pneumonectomy	25.67	NA	13.78	3.66	NA	43.11	090
32491		R	Lung volume reduction	21.22	NA	12.62	2.94	NA	36.78	090
32500		A	Partial removal of lung	21.97	NA	12.35	3.14	NA	37.46	090
32501		A	Repair bronchus add-on	4.68	NA	1.54	0.65	NA	6.87	ZZZ
32520		A	Remove lung & revise chest	21.65	NA	11.31	3.04	NA	36.00	090
32522		A	Remove lung & revise chest	24.16	NA	12.12	3.28	NA	39.56	090
32525		A	Remove lung & revise chest	26.46	NA	12.80	3.72	NA	42.98	090
32540		A	Removal of lung lesion	14.62	NA	9.63	2.04	NA	26.29	090
32601		A	Thoracoscopy, diagnostic	5.45	NA	2.35	0.78	NA	8.58	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	2.52	0.84	NA	9.31	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	3.03	1.11	NA	11.94	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	3.45	1.23	NA	13.45	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	2.90	0.97	NA	10.79	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	3.33	1.20	NA	12.92	000
32650		A	Thoracoscopy, surgical	10.73	NA	6.76	1.50	NA	18.99	090
32651		A	Thoracoscopy, surgical	12.89	NA	7.23	1.82	NA	21.94	090
32652		A	Thoracoscopy, surgical	18.63	NA	10.14	2.60	NA	31.37	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
32653		A	Thoracoscopy, surgical	12.85	NA	6.97	1.79	NA	21.61	090
32654		A	Thoracoscopy, surgical	12.42	NA	7.53	1.62	NA	21.57	090
32655		A	Thoracoscopy, surgical	13.08	NA	7.24	1.82	NA	22.14	090
32656		A	Thoracoscopy, surgical	12.89	NA	7.94	1.82	NA	22.65	090
32657		A	Thoracoscopy, surgical	13.63	NA	7.68	1.94	NA	23.25	090
32658		A	Thoracoscopy, surgical	11.61	NA	7.35	1.62	NA	20.58	090
32659		A	Thoracoscopy, surgical	11.57	NA	7.45	1.61	NA	20.63	090
32660		A	Thoracoscopy, surgical	17.40	NA	9.48	2.06	NA	28.94	090
32661		A	Thoracoscopy, surgical	13.23	NA	7.79	1.82	NA	22.84	090
32662		A	Thoracoscopy, surgical	16.42	NA	8.82	2.16	NA	27.40	090
32663		A	Thoracoscopy, surgical	18.44	NA	10.76	2.66	NA	31.86	090
32664		A	Thoracoscopy, surgical	14.18	NA	7.63	2.33	NA	24.14	090
32665		A	Thoracoscopy, surgical	15.52	NA	8.13	2.13	NA	25.78	090
32800		A	Repair lung hernia	13.67	NA	7.41	1.86	NA	22.94	090
32810		A	Close chest after drainage	13.03	NA	7.52	1.87	NA	22.42	090
32815		A	Close bronchial fistula	23.12	NA	10.97	3.23	NA	37.32	090
32820		A	Reconstruct injured chest	21.45	NA	12.16	2.51	NA	36.12	090
32850		X	Donor pneumonectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32851		A	Lung transplant, single	38.57	NA	27.66	5.35	NA	71.58	090
32852		A	Lung transplant with bypass	41.74	NA	33.16	5.96	NA	80.86	090
32853		A	Lung transplant, double	47.74	NA	31.75	6.85	NA	86.34	090
32854		A	Lung transplant with bypass	50.90	NA	34.73	7.16	NA	92.79	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	20.24	NA	9.88	2.89	NA	33.01	090
32905		A	Revise & repair chest wall	20.72	NA	10.13	3.03	NA	33.88	090
32906		A	Revise & repair chest wall	26.73	NA	12.06	3.82	NA	42.61	090
32940		A	Revision of lung	19.40	NA	9.47	2.75	NA	31.62	090
32960		A	Therapeutic pneumothorax	1.84	1.73	0.56	0.16	3.73	2.56	000
32997		A	Total lung lavage	5.99	NA	1.91	0.54	NA	8.44	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	0.78	0.15	NA	3.17	000
33011		A	Repeat drainage of heart sac	2.24	NA	0.81	0.17	NA	3.22	000
33015		A	Incision of heart sac	6.79	NA	4.95	0.64	NA	12.38	090
33020		A	Incision of heart sac	12.59	NA	6.78	1.74	NA	21.11	090
33025		A	Incision of heart sac	12.07	NA	6.35	1.72	NA	20.14	090
33030		A	Partial removal of heart sac	18.68	NA	9.52	2.73	NA	30.93	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33031		A	Partial removal of heart sac	21.76	NA	10.03	3.10	NA	34.89	090
33050		A	Removal of heart sac lesion	14.34	NA	7.84	2.08	NA	24.26	090
33120		A	Removal of heart lesion	24.52	NA	11.58	3.57	NA	39.67	090
33130		A	Removal of heart lesion	21.36	NA	10.11	2.87	NA	34.34	090
33140		A	Heart revascularize (tmr)	19.97	NA	10.88	2.81	NA	33.66	090
33141		A	Heart tmr w/other procedure	4.83	NA	1.58	0.69	NA	7.10	ZZZ
33200		A	Insertion of heart pacemaker	12.46	NA	6.84	1.67	NA	20.97	090
33201		A	Insertion of heart pacemaker	10.16	NA	6.58	1.34	NA	18.08	090
33206		A	Insertion of heart pacemaker	6.66	NA	4.46	0.52	NA	11.64	090
33207		A	Insertion of heart pacemaker	8.03	NA	4.66	0.61	NA	13.30	090
33208		A	Insertion of heart pacemaker	8.12	NA	4.77	0.59	NA	13.48	090
33210		A	Insertion of heart electrode	3.30	NA	1.25	0.19	NA	4.74	000
33211		A	Insertion of heart electrode	3.39	NA	1.31	0.23	NA	4.93	000
33212		A	Insertion of pulse generator	5.51	NA	3.36	0.46	NA	9.33	090
33213		A	Insertion of pulse generator	6.36	NA	3.72	0.48	NA	10.56	090
33214		A	Upgrade of pacemaker system	7.74	NA	4.89	0.58	NA	13.21	090
33215		A	Reposition pacing-defib lead	4.75	NA	3.18	0.37	NA	8.30	090
33216		A	Insert lead pace-defib, one	5.77	NA	4.20	0.40	NA	10.37	090
33217		A	Insert lead pace-defib, dual	5.74	NA	4.23	0.41	NA	10.38	090
33218		A	Repair lead pace-defib, one	5.43	NA	4.30	0.39	NA	10.12	090
33220		A	Repair lead pace-defib, dual	5.51	NA	4.27	0.39	NA	10.17	090
33222		A	Revise pocket, pacemaker	4.95	NA	4.29	0.42	NA	9.66	090
33223		A	Revise pocket, pacing-defib	6.45	NA	4.59	0.45	NA	11.49	090
33224		A	Insert pacing lead & connect	9.04	NA	4.00	0.57	NA	13.61	000
33225		A	L ventric pacing lead add-on	8.33	NA	3.25	0.48	NA	12.06	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	3.82	0.61	NA	13.11	000
33233		A	Removal of pacemaker system	3.29	NA	3.27	0.23	NA	6.79	090
33234		A	Removal of pacemaker system	7.81	NA	4.91	0.58	NA	13.30	090
33235		A	Removal pacemaker electrode	9.39	NA	6.81	0.75	NA	16.95	090
33236		A	Remove electrode/thoracotomy	12.58	NA	7.43	1.66	NA	21.67	090
33237		A	Remove electrode/thoracotomy	13.69	NA	7.78	1.56	NA	23.03	090
33238		A	Remove electrode/thoracotomy	15.20	NA	8.20	1.95	NA	25.35	090
33240		A	Insert pulse generator	7.59	NA	4.58	0.48	NA	12.65	090
33241		A	Remove pulse generator	3.24	NA	2.96	0.21	NA	6.41	090
33243		A	Remove eltrd/thoracotomy	22.61	NA	11.46	2.10	NA	36.17	090
33244		A	Remove eltrd, transven	13.74	NA	8.89	1.00	NA	23.63	090
33245		A	Insert epic eltrd pace-defib	14.28	NA	7.90	1.98	NA	24.16	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33246		A	Insert epic eltrd/generator	20.68	NA	10.28	2.59	NA	33.55	090
33249		A	Eltrd/insert pace-defib	14.21	NA	8.36	0.83	NA	23.40	090
33250		A	Ablate heart dysrhythm focus	21.82	NA	11.02	3.06	NA	35.90	090
33251		A	Ablate heart dysrhythm focus	24.84	NA	11.66	3.49	NA	39.99	090
33253		A	Reconstruct atria	31.01	NA	13.82	4.45	NA	49.28	090
33261		A	Ablate heart dysrhythm focus	24.84	NA	11.77	3.38	NA	39.99	090
33282		A	Implant pat-active ht record	4.16	NA	4.02	0.25	NA	8.43	090
33284		A	Remove pat-active ht record	2.50	NA	3.53	0.15	NA	6.18	090
33300		A	Repair of heart wound	17.89	NA	9.23	2.56	NA	29.68	090
33305		A	Repair of heart wound	21.41	NA	10.61	3.07	NA	35.09	090
33310		A	Exploratory heart surgery	18.48	NA	9.58	2.56	NA	30.62	090
33315		A	Exploratory heart surgery	22.34	NA	10.88	3.23	NA	36.45	090
33320		A	Repair major blood vessel(s)	16.76	NA	8.22	2.03	NA	27.01	090
33321		A	Repair major vessel	20.17	NA	9.78	2.87	NA	32.82	090
33322		A	Repair major blood vessel(s)	20.59	NA	10.36	2.80	NA	33.75	090
33330		A	Insert major vessel graft	21.40	NA	10.26	2.73	NA	34.39	090
33332		A	Insert major vessel graft	23.92	NA	10.51	2.99	NA	37.42	090
33335		A	Insert major vessel graft	29.96	NA	13.33	4.19	NA	47.48	090
33400		A	Repair of aortic valve	28.46	NA	15.66	4.04	NA	48.16	090
33401		A	Valvuloplasty, open	23.87	NA	13.50	3.53	NA	40.90	090
33403		A	Valvuloplasty, w/cp bypass	24.85	NA	14.30	3.51	NA	42.66	090
33404		A	Prepare heart-aorta conduit	28.50	NA	14.54	4.29	NA	47.33	090
33405		A	Replacement of aortic valve	34.95	NA	18.29	5.09	NA	58.33	090
33406		A	Replacement of aortic valve	37.44	NA	19.12	5.38	NA	61.94	090
33410		A	Replacement of aortic valve	32.41	NA	16.58	4.61	NA	53.60	090
33411		A	Replacement of aortic valve	36.20	NA	18.74	5.29	NA	60.23	090
33412		A	Replacement of aortic valve	41.94	NA	20.40	6.29	NA	68.63	090
33413		A	Replacement of aortic valve	43.43	NA	20.81	6.46	NA	70.70	090
33414		A	Repair of aortic valve	30.30	NA	14.13	4.45	NA	48.88	090
33415		A	Revision, subvalvular tissue	27.11	NA	12.02	3.80	NA	42.93	090
33416		A	Revise ventricle muscle	30.30	NA	13.50	4.46	NA	48.26	090
33417		A	Repair of aortic valve	28.49	NA	13.61	4.05	NA	46.15	090
33420		A	Revision of mitral valve	22.67	NA	9.56	1.82	NA	34.05	090
33422		A	Revision of mitral valve	25.90	NA	13.65	3.76	NA	43.31	090
33425		A	Repair of mitral valve	26.96	NA	13.05	3.91	NA	43.92	090
33426		A	Repair of mitral valve	32.95	NA	17.13	4.77	NA	54.85	090
33427		A	Repair of mitral valve	39.94	NA	19.36	5.82	NA	65.12	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33430		A	Replacement of mitral valve	33.45	NA	17.29	4.85	NA	55.59	090
33460		A	Revision of tricuspid valve	23.56	NA	11.30	3.39	NA	38.25	090
33463		A	Valvuloplasty, tricuspid	25.58	NA	12.91	3.71	NA	42.20	090
33464		A	Valvuloplasty, tricuspid	27.29	NA	13.52	3.96	NA	44.77	090
33465		A	Replace tricuspid valve	28.75	NA	12.96	4.18	NA	45.89	090
33468		A	Revision of tricuspid valve	30.07	NA	13.65	4.03	NA	47.75	090
33470		A	Revision of pulmonary valve	20.78	NA	10.69	1.03	NA	32.50	090
33471		A	Valvotomy, pulmonary valve	22.22	NA	9.75	3.35	NA	35.32	090
33472		A	Revision of pulmonary valve	22.22	NA	11.86	3.52	NA	37.60	090
33474		A	Revision of pulmonary valve	23.01	NA	10.88	3.18	NA	37.07	090
33475		A	Replacement, pulmonary valve	32.95	NA	15.37	4.76	NA	53.08	090
33476		A	Revision of heart chamber	25.73	NA	11.96	2.39	NA	40.08	090
33478		A	Revision of heart chamber	26.70	NA	13.05	3.85	NA	43.60	090
33496		A	Repair, prosth valve clot	27.21	NA	12.74	4.01	NA	43.96	090
33500		A	Repair heart vessel fistula	25.51	NA	11.46	3.66	NA	40.63	090
33501		A	Repair heart vessel fistula	17.75	NA	8.28	1.84	NA	27.87	090
33502		A	Coronary artery correction	21.01	NA	11.07	2.96	NA	35.04	090
33503		A	Coronary artery graft	21.75	NA	9.73	1.86	NA	33.34	090
33504		A	Coronary artery graft	24.62	NA	11.81	3.32	NA	39.75	090
33505		A	Repair artery w/tunnel	26.80	NA	12.90	2.17	NA	41.87	090
33506		A	Repair artery, translocation	35.45	NA	14.56	4.62	NA	54.63	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.04	NA	0.45	ZZZ
33510		A	CABG, vein, single	28.96	NA	16.33	4.19	NA	49.48	090
33511		A	CABG, vein, two	29.96	NA	17.07	4.36	NA	51.39	090
33512		A	CABG, vein, three	31.75	NA	17.60	4.59	NA	53.94	090
33513		A	CABG, vein, four	31.95	NA	17.78	4.63	NA	54.36	090
33514		A	CABG, vein, five	32.70	NA	18.05	4.68	NA	55.43	090
33516		A	Cabg, vein, six or more	34.95	NA	18.80	5.02	NA	58.77	090
33517		A	CABG, artery-vein, single	2.57	NA	0.84	0.37	NA	3.78	ZZZ
33518		A	CABG, artery-vein, two	4.84	NA	1.58	0.70	NA	7.12	ZZZ
33519		A	CABG, artery-vein, three	7.11	NA	2.32	1.03	NA	10.46	ZZZ
33521		A	CABG, artery-vein, four	9.39	NA	3.07	1.35	NA	13.81	ZZZ
33522		A	CABG, artery-vein, five	11.65	NA	3.81	1.69	NA	17.15	ZZZ
33523		A	Cabg, art-vein, six or more	13.93	NA	4.53	2.06	NA	20.52	ZZZ
33530		A	Coronary artery, bypass/reop	5.85	NA	1.91	0.85	NA	8.61	ZZZ
33533		A	CABG, arterial, single	29.96	NA	16.46	4.33	NA	50.75	090
33534		A	CABG, arterial, two	32.15	NA	17.71	4.53	NA	54.39	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33535		A	CABG, arterial, three	34.45	NA	18.13	4.94	NA	57.52	090
33536		A	Cabg, arterial, four or more	37.44	NA	18.29	5.27	NA	61.00	090
33542		A	Removal of heart lesion	28.81	NA	12.99	4.18	NA	45.98	090
33545		A	Repair of heart damage	36.72	NA	15.62	5.13	NA	57.47	090
33572		A	Open coronary endarterectomy	4.44	NA	1.45	0.64	NA	6.53	ZZZ
33600		A	Closure of valve	29.47	NA	12.51	4.38	NA	46.36	090
33602		A	Closure of valve	28.50	NA	12.44	3.78	NA	44.72	090
33606		A	Anastomosis/artery-aorta	30.69	NA	13.67	4.37	NA	48.73	090
33608		A	Repair anomaly w/conduit	31.04	NA	14.10	4.69	NA	49.83	090
33610		A	Repair by enlargement	30.56	NA	13.60	4.52	NA	48.68	090
33611		A	Repair double ventricle	33.95	NA	14.13	4.33	NA	52.41	090
33612		A	Repair double ventricle	34.95	NA	15.15	5.23	NA	55.33	090
33615		A	Repair, modified fontan	33.95	NA	13.14	4.26	NA	51.35	090
33617		A	Repair single ventricle	36.94	NA	15.99	5.59	NA	58.52	090
33619		A	Repair single ventricle	44.93	NA	20.80	6.39	NA	72.12	090
33641		A	Repair heart septum defect	21.36	NA	9.57	3.10	NA	34.03	090
33645		A	Revision of heart veins	24.78	NA	11.77	3.63	NA	40.18	090
33647		A	Repair heart septum defects	28.69	NA	13.77	3.22	NA	45.68	090
33660		A	Repair of heart defects	29.96	NA	13.48	4.45	NA	47.89	090
33665		A	Repair of heart defects	28.56	NA	13.83	3.96	NA	46.35	090
33670		A	Repair of heart chambers	34.95	NA	13.17	4.61	NA	52.73	090
33681		A	Repair heart septum defect	30.56	NA	14.68	4.39	NA	49.63	090
33684		A	Repair heart septum defect	29.61	NA	13.62	3.46	NA	46.69	090
33688		A	Repair heart septum defect	30.57	NA	10.47	4.69	NA	45.73	090
33690		A	Reinforce pulmonary artery	19.52	NA	10.16	1.94	NA	31.62	090
33692		A	Repair of heart defects	30.70	NA	13.92	4.55	NA	49.17	090
33694		A	Repair of heart defects	33.95	NA	14.22	5.21	NA	53.38	090
33697		A	Repair of heart defects	35.95	NA	14.87	4.05	NA	54.87	090
33702		A	Repair of heart defects	26.50	NA	12.56	3.64	NA	42.70	090
33710		A	Repair of heart defects	29.67	NA	13.96	4.38	NA	48.01	090
33720		A	Repair of heart defect	26.52	NA	12.28	3.76	NA	42.56	090
33722		A	Repair of heart defect	28.37	NA	13.85	1.30	NA	43.52	090
33730		A	Repair heart-vein defect(s)	34.20	NA	14.12	4.96	NA	53.28	090
33732		A	Repair heart-vein defect	28.12	NA	13.38	3.64	NA	45.14	090
33735		A	Revision of heart chamber	21.36	NA	8.95	1.89	NA	32.20	090
33736		A	Revision of heart chamber	23.48	NA	11.85	3.05	NA	38.38	090
33737		A	Revision of heart chamber	21.73	NA	10.93	3.21	NA	35.87	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33750		A	Major vessel shunt	21.38	NA	10.21	1.16	NA	32.75	090
33755		A	Major vessel shunt	21.76	NA	8.80	3.22	NA	33.78	090
33762		A	Major vessel shunt	21.76	NA	10.15	3.10	NA	35.01	090
33764		A	Major vessel shunt & graft	21.76	NA	10.22	2.97	NA	34.95	090
33766		A	Major vessel shunt	22.73	NA	11.67	3.67	NA	38.07	090
33767		A	Major vessel shunt	24.46	NA	11.72	3.79	NA	39.97	090
33770		A	Repair great vessels defect	36.94	NA	14.68	5.67	NA	57.29	090
33771		A	Repair great vessels defect	34.60	NA	12.38	5.63	NA	52.61	090
33774		A	Repair great vessels defect	30.93	NA	14.66	4.75	NA	50.34	090
33775		A	Repair great vessels defect	32.15	NA	14.99	4.94	NA	52.08	090
33776		A	Repair great vessels defect	33.99	NA	15.80	5.02	NA	54.81	090
33777		A	Repair great vessels defect	33.41	NA	15.61	5.44	NA	54.46	090
33778		A	Repair great vessels defect	39.94	NA	16.89	6.13	NA	62.96	090
33779		A	Repair great vessels defect	36.16	NA	15.37	2.89	NA	54.42	090
33780		A	Repair great vessels defect	41.69	NA	19.08	3.64	NA	64.41	090
33781		A	Repair great vessels defect	36.40	NA	13.33	5.92	NA	55.65	090
33786		A	Repair arterial trunk	38.94	NA	16.71	5.66	NA	61.31	090
33788		A	Revision of pulmonary artery	26.58	NA	11.95	4.00	NA	42.53	090
33800		A	Aortic suspension	16.22	NA	8.11	2.43	NA	26.76	090
33802		A	Repair vessel defect	17.63	NA	9.22	2.24	NA	29.09	090
33803		A	Repair vessel defect	19.57	NA	9.76	3.17	NA	32.50	090
33813		A	Repair septal defect	20.62	NA	10.91	3.09	NA	34.62	090
33814		A	Repair septal defect	25.73	NA	12.64	3.80	NA	42.17	090
33820		A	Revise major vessel	16.27	NA	8.36	2.38	NA	27.01	090
33822		A	Revise major vessel	17.29	NA	8.95	2.66	NA	28.90	090
33824		A	Revise major vessel	19.49	NA	9.98	2.86	NA	32.33	090
33840		A	Remove aorta constriction	20.60	NA	10.29	2.14	NA	33.03	090
33845		A	Remove aorta constriction	22.09	NA	11.35	3.18	NA	36.62	090
33851		A	Remove aorta constriction	21.24	NA	10.68	3.14	NA	35.06	090
33852		A	Repair septal defect	23.67	NA	11.36	2.13	NA	37.16	090
33853		A	Repair septal defect	31.67	NA	14.82	4.42	NA	50.91	090
33860		A	Ascending aortic graft	37.94	NA	16.45	5.53	NA	59.92	090
33861		A	Ascending aortic graft	41.94	NA	17.71	6.07	NA	65.72	090
33863		A	Ascending aortic graft	44.93	NA	18.69	6.47	NA	70.09	090
33870		A	Transverse aortic arch graft	43.93	NA	18.38	6.28	NA	68.59	090
33875		A	Thoracic aortic graft	33.01	NA	14.09	4.73	NA	51.83	090
33877		A	Thoracoabdominal graft	42.54	NA	16.31	5.77	NA	64.62	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
33910		A	Remove lung artery emboli	24.55	NA	11.43	3.62	NA	39.60	090
33915		A	Remove lung artery emboli	20.99	NA	9.63	1.66	NA	32.28	090
33916		A	Surgery of great vessel	25.79	NA	11.34	3.64	NA	40.77	090
33917		A	Repair pulmonary artery	24.46	NA	12.18	3.66	NA	40.30	090
33918		A	Repair pulmonary atresia	26.41	NA	12.07	4.12	NA	42.60	090
33919		A	Repair pulmonary atresia	39.94	NA	17.51	5.90	NA	63.35	090
33920		A	Repair pulmonary atresia	31.90	NA	13.82	4.35	NA	50.07	090
33922		A	Transect pulmonary artery	23.48	NA	10.90	3.06	NA	37.44	090
33924		A	Remove pulmonary shunt	5.49	NA	1.84	0.82	NA	8.15	ZZZ
33930		X	Removal of donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	60.87	NA	28.77	8.95	NA	98.59	090
33940		X	Removal of donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	42.04	NA	21.39	6.08	NA	69.51	090
33960		A	External circulation assist	19.33	NA	4.91	2.60	NA	26.84	000
33961		A	External circulation assist	10.91	NA	3.61	0.90	NA	15.42	ZZZ
33967		A	Insert ia percut device	4.84	NA	1.84	0.35	NA	7.03	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.07	NA	0.94	000
33970		A	Aortic circulation assist	6.74	NA	2.28	0.82	NA	9.84	000
33971		A	Aortic circulation assist	9.68	NA	6.00	1.21	NA	16.89	090
33973		A	Insert balloon device	9.75	NA	3.31	1.22	NA	14.28	000
33974		A	Remove intra-aortic balloon	14.39	NA	7.88	1.68	NA	23.95	090
33975		A	Implant ventricular device	20.97	NA	6.28	2.99	NA	30.24	XXX
33976		A	Implant ventricular device	22.97	NA	7.55	3.20	NA	33.72	XXX
33977		A	Remove ventricular device	19.26	NA	11.07	2.77	NA	33.10	090
33978		A	Remove ventricular device	21.70	NA	11.75	3.20	NA	36.65	090
33979		A	Insert intracorporeal device	45.93	NA	14.92	6.80	NA	67.65	XXX
33980		A	Remove intracorporeal device	56.17	NA	25.24	8.35	NA	89.76	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	12.89	NA	6.71	1.77	NA	21.37	090
34051		A	Removal of artery clot	15.19	NA	7.78	2.18	NA	25.15	090
34101		A	Removal of artery clot	9.99	NA	5.35	1.38	NA	16.72	090
34111		A	Removal of arm artery clot	9.99	NA	5.35	1.35	NA	16.69	090
34151		A	Removal of artery clot	24.96	NA	10.40	3.47	NA	38.83	090
34201		A	Removal of artery clot	10.01	NA	5.41	1.42	NA	16.84	090
34203		A	Removal of leg artery clot	16.46	NA	8.06	2.31	NA	26.85	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
34401		A	Removal of vein clot	24.96	NA	10.66	2.94	NA	38.56	090
34421		A	Removal of vein clot	11.98	NA	6.29	1.54	NA	19.81	090
34451		A	Removal of vein clot	26.96	NA	11.44	3.70	NA	42.10	090
34471		A	Removal of vein clot	10.16	NA	5.30	1.14	NA	16.60	090
34490		A	Removal of vein clot	9.85	NA	5.42	1.33	NA	16.60	090
34501		A	Repair valve, femoral vein	15.98	NA	8.49	2.19	NA	26.66	090
34502		A	Reconstruct vena cava	26.91	NA	12.29	3.57	NA	42.77	090
34510		A	Transposition of vein valve	18.92	NA	9.41	2.27	NA	30.60	090
34520		A	Cross-over vein graft	17.92	NA	8.45	2.18	NA	28.55	090
34530		A	Leg vein fusion	16.62	NA	8.61	1.71	NA	26.94	090
34800		A	Endovas aaa repr w/sm tube	20.72	NA	9.16	2.30	NA	32.18	090
34802		A	Endovas aaa repr w/2-p part	22.97	NA	9.78	2.25	NA	35.00	090
34803		A	Endovas aaa repr w/3-p part	24.00	NA	10.21	1.99	NA	36.20	090
34804		A	Endovas aaa repr w/1-p part	22.97	NA	9.80	2.23	NA	35.00	090
34805		A	Endovas aaa repr w/long tube	21.85	NA	9.64	1.99	NA	33.48	090
34808		A	Endovas iliac a device addon	4.12	NA	1.37	0.53	NA	6.02	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	2.23	1.15	NA	10.12	000
34813		A	Femoral endovas graft add-on	4.79	NA	1.57	0.64	NA	7.00	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	3.23	1.41	NA	14.38	000
34825		A	Endovasc extend prosth, init	11.98	NA	6.14	1.26	NA	19.38	090
34826		A	Endovasc exten prosth, add'l	4.12	NA	1.37	0.43	NA	5.92	ZZZ
34830		A	Open aortic tube prosth repr	32.54	NA	13.69	4.52	NA	50.75	090
34831		A	Open aortoiliac prosth repr	35.29	NA	11.73	4.59	NA	51.61	090
34832		A	Open aortofemor prosth repr	35.29	NA	14.62	4.69	NA	54.60	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	4.43	1.63	NA	18.04	000
34834		A	Xpose, endoprosth, brachial	5.34	NA	2.19	0.75	NA	8.28	000
34900		A	Endovasc iliac repr w/graft	16.36	NA	7.58	1.90	NA	25.84	090
35001		A	Repair defect of artery	19.61	NA	9.55	2.73	NA	31.89	090
35002		A	Repair artery rupture, neck	20.97	NA	9.69	3.00	NA	33.66	090
35005		A	Repair defect of artery	18.09	NA	8.84	1.75	NA	28.68	090
35011		A	Repair defect of artery	17.97	NA	7.98	2.48	NA	28.43	090
35013		A	Repair artery rupture, arm	21.97	NA	9.67	3.04	NA	34.68	090
35021		A	Repair defect of artery	19.62	NA	9.41	2.76	NA	31.79	090
35022		A	Repair artery rupture, chest	23.15	NA	9.85	3.13	NA	36.13	090
35045		A	Repair defect of arm artery	17.54	NA	7.50	2.41	NA	27.45	090
35081		A	Repair defect of artery	27.97	NA	11.46	3.91	NA	43.34	090
35082		A	Repair artery rupture, aorta	38.44	NA	15.29	5.32	NA	59.05	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35091		A	Repair defect of artery	35.35	NA	13.56	5.04	NA	53.95	090
35092		A	Repair artery rupture, aorta	44.93	NA	17.63	6.22	NA	68.78	090
35102		A	Repair defect of artery	30.71	NA	12.35	4.39	NA	47.45	090
35103		A	Repair artery rupture, groin	40.44	NA	15.84	5.69	NA	61.97	090
35111		A	Repair defect of artery	24.96	NA	10.46	3.36	NA	38.78	090
35112		A	Repair artery rupture,spleen	29.96	NA	11.96	4.04	NA	45.96	090
35121		A	Repair defect of artery	29.96	NA	12.36	4.21	NA	46.53	090
35122		A	Repair artery rupture, belly	34.95	NA	13.80	4.69	NA	53.44	090
35131		A	Repair defect of artery	24.96	NA	10.74	3.70	NA	39.40	090
35132		A	Repair artery rupture, groin	29.96	NA	12.37	4.27	NA	46.60	090
35141		A	Repair defect of artery	19.97	NA	8.91	2.82	NA	31.70	090
35142		A	Repair artery rupture, thigh	23.27	NA	10.36	3.28	NA	36.91	090
35151		A	Repair defect of artery	22.61	NA	9.98	3.18	NA	35.77	090
35152		A	Repair artery rupture, knee	25.58	NA	11.37	3.55	NA	40.50	090
35180		A	Repair blood vessel lesion	13.60	NA	6.94	1.00	NA	21.54	090
35182		A	Repair blood vessel lesion	29.96	NA	12.79	4.31	NA	47.06	090
35184		A	Repair blood vessel lesion	17.97	NA	8.29	2.49	NA	28.75	090
35188		A	Repair blood vessel lesion	14.26	NA	7.63	2.13	NA	24.02	090
35189		A	Repair blood vessel lesion	27.96	NA	11.95	3.92	NA	43.83	090
35190		A	Repair blood vessel lesion	12.73	NA	6.47	1.76	NA	20.96	090
35201		A	Repair blood vessel lesion	16.12	NA	7.99	2.26	NA	26.37	090
35206		A	Repair blood vessel lesion	13.23	NA	6.55	1.84	NA	21.62	090
35207		A	Repair blood vessel lesion	10.13	NA	7.35	1.44	NA	18.92	090
35211		A	Repair blood vessel lesion	22.09	NA	10.61	3.15	NA	35.85	090
35216		A	Repair blood vessel lesion	18.72	NA	8.97	2.61	NA	30.30	090
35221		A	Repair blood vessel lesion	24.35	NA	9.93	3.27	NA	37.55	090
35226		A	Repair blood vessel lesion	14.48	NA	7.43	1.98	NA	23.89	090
35231		A	Repair blood vessel lesion	19.97	NA	9.76	2.78	NA	32.51	090
35236		A	Repair blood vessel lesion	17.08	NA	7.88	2.40	NA	27.36	090
35241		A	Repair blood vessel lesion	23.09	NA	11.12	3.46	NA	37.67	090
35246		A	Repair blood vessel lesion	26.41	NA	11.42	3.69	NA	41.52	090
35251		A	Repair blood vessel lesion	30.15	NA	11.79	4.05	NA	45.99	090
35256		A	Repair blood vessel lesion	18.33	NA	8.35	2.59	NA	29.27	090
35261		A	Repair blood vessel lesion	17.77	NA	8.01	2.54	NA	28.32	090
35266		A	Repair blood vessel lesion	14.89	NA	7.00	2.05	NA	23.94	090
35271		A	Repair blood vessel lesion	22.09	NA	10.51	3.12	NA	35.72	090
35276		A	Repair blood vessel lesion	24.21	NA	11.20	3.36	NA	38.77	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35261		A	Repair blood vessel lesion	27.96	NA	11.70	3.89	NA	43.55	090
35286		A	Repair blood vessel lesion	16.14	NA	8.05	2.30	NA	26.49	090
35301		A	Rechanneling of artery	18.67	NA	8.43	2.68	NA	29.78	090
35311		A	Rechanneling of artery	26.96	NA	11.74	3.38	NA	42.08	090
35321		A	Rechanneling of artery	15.98	NA	7.38	2.22	NA	25.58	090
35331		A	Rechanneling of artery	26.16	NA	11.23	3.72	NA	41.11	090
35341		A	Rechanneling of artery	25.07	NA	10.86	3.71	NA	39.64	090
35351		A	Rechanneling of artery	22.97	NA	9.59	3.30	NA	35.86	090
35355		A	Rechanneling of artery	18.47	NA	8.08	2.63	NA	29.18	090
35361		A	Rechanneling of artery	28.16	NA	11.70	3.96	NA	43.82	090
35363		A	Rechanneling of artery	30.15	NA	12.58	4.27	NA	47.00	090
35371		A	Rechanneling of artery	14.70	NA	6.95	2.08	NA	23.73	090
35372		A	Rechanneling of artery	17.97	NA	8.04	2.59	NA	28.60	090
35381		A	Rechanneling of artery	15.79	NA	7.81	2.18	NA	25.78	090
35390		A	Reoperation, carotid add-on	3.19	NA	1.06	0.45	NA	4.70	ZZZ
35400		A	Angioscopy	3.00	NA	1.11	0.42	NA	4.53	ZZZ
35450		A	Repair arterial blockage	10.05	NA	3.56	1.24	NA	14.85	000
35452		A	Repair arterial blockage	6.90	NA	2.60	0.90	NA	10.40	000
35454		A	Repair arterial blockage	6.03	NA	2.31	0.84	NA	9.18	000
35456		A	Repair arterial blockage	7.34	NA	2.76	1.01	NA	11.11	000
35458		A	Repair arterial blockage	9.48	NA	3.47	1.23	NA	14.18	000
35459		A	Repair arterial blockage	8.62	NA	3.17	1.17	NA	12.96	000
35460		A	Repair venous blockage	6.03	NA	2.27	0.82	NA	9.12	000
35470		A	Repair arterial blockage	8.62	88.86	3.35	0.72	98.20	12.69	000
35471		A	Repair arterial blockage	10.05	100.26	3.95	0.71	111.02	14.71	000
35472		A	Repair arterial blockage	6.90	64.35	2.74	0.60	71.85	10.24	000
35473		A	Repair arterial blockage	6.03	59.84	2.42	0.52	66.39	8.97	000
35474		A	Repair arterial blockage	7.35	87.73	2.89	0.59	95.67	10.83	000
35475		R	Repair arterial blockage	9.48	56.10	3.56	0.65	66.23	13.69	000
35476		A	Repair venous blockage	6.03	44.73	2.35	0.39	51.15	8.77	000
35480		A	Atherectomy, open	11.06	NA	4.04	1.28	NA	16.38	000
35481		A	Atherectomy, open	7.60	NA	2.87	1.10	NA	11.57	000
35482		A	Atherectomy, open	6.64	NA	2.56	0.89	NA	10.09	000
35483		A	Atherectomy, open	8.09	NA	3.02	1.11	NA	12.22	000
35484		A	Atherectomy, open	10.42	NA	3.77	1.28	NA	15.47	000
35485		A	Atherectomy, open	9.48	NA	3.53	1.31	NA	14.32	000
35490		A	Atherectomy, percutaneous	11.06	NA	4.70	0.76	NA	16.52	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35491		A	Atherectomy, percutaneous	7.60	NA	3.29	0.74	NA	11.63	000
35492		A	Atherectomy, percutaneous	6.64	NA	3.19	0.48	NA	10.31	000
35493		A	Atherectomy, percutaneous	8.09	NA	3.80	0.58	NA	12.47	000
35494		A	Atherectomy, percutaneous	10.42	NA	4.46	0.72	NA	15.60	000
35495		A	Atherectomy, percutaneous	9.48	NA	4.39	0.71	NA	14.58	000
35500		A	Harvest vein for bypass	6.44	NA	2.02	0.90	NA	9.36	ZZZ
35501		A	Artery bypass graft	19.16	NA	8.46	2.71	NA	30.33	090
35506		A	Artery bypass graft	19.64	NA	9.46	2.78	NA	31.88	090
35507		A	Artery bypass graft	19.64	NA	9.42	2.83	NA	31.89	090
35508		A	Artery bypass graft	18.62	NA	9.44	2.83	NA	30.89	090
35509		A	Artery bypass graft	18.04	NA	8.76	2.61	NA	29.41	090
35510		A	Artery bypass graft	22.97	NA	10.17	2.10	NA	35.24	090
35511		A	Artery bypass graft	21.17	NA	9.35	2.80	NA	33.32	090
35512		A	Artery bypass graft	22.47	NA	10.00	2.10	NA	34.57	090
35515		A	Artery bypass graft	18.62	NA	9.28	2.74	NA	30.64	090
35516		A	Artery bypass graft	16.30	NA	6.80	2.32	NA	25.42	090
35518		A	Artery bypass graft	21.17	NA	8.97	2.95	NA	33.09	090
35521		A	Artery bypass graft	22.17	NA	9.83	3.03	NA	35.03	090
35522		A	Artery bypass graft	21.73	NA	9.75	2.10	NA	33.58	090
35525		A	Artery bypass graft	20.60	NA	9.37	2.10	NA	32.07	090
35526		A	Artery bypass graft	29.91	NA	12.50	3.59	NA	46.00	090
35531		A	Artery bypass graft	36.15	NA	14.47	5.02	NA	55.64	090
35533		A	Artery bypass graft	27.96	NA	11.72	3.70	NA	43.38	090
35536		A	Artery bypass graft	31.65	NA	12.94	4.45	NA	49.04	090
35541		A	Artery bypass graft	25.76	NA	11.20	3.61	NA	40.57	090
35546		A	Artery bypass graft	25.50	NA	10.86	3.61	NA	39.97	090
35548		A	Artery bypass graft	21.54	NA	9.42	2.94	NA	33.90	090
35549		A	Artery bypass graft	23.31	NA	10.37	3.26	NA	36.94	090
35551		A	Artery bypass graft	26.63	NA	11.49	3.54	NA	41.66	090
35556		A	Artery bypass graft	21.73	NA	9.72	3.04	NA	34.49	090
35558		A	Artery bypass graft	21.17	NA	9.54	2.92	NA	33.63	090
35560		A	Artery bypass graft	31.95	NA	13.31	4.66	NA	49.92	090
35563		A	Artery bypass graft	24.16	NA	10.52	3.40	NA	38.08	090
35565		A	Artery bypass graft	23.17	NA	10.13	3.24	NA	36.54	090
35566		A	Artery bypass graft	26.88	NA	11.38	3.78	NA	42.04	090
35571		A	Artery bypass graft	24.02	NA	10.84	3.39	NA	38.25	090
35572		A	Harvest femoropopliteal vein	6.81	NA	2.24	0.98	NA	10.03	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
35583		A	Vein bypass graft	22.34	NA	10.15	3.13	NA	35.62	090
35585		A	Vein bypass graft	28.35	NA	12.21	3.97	NA	44.53	090
35587		A	Vein bypass graft	24.71	NA	11.45	3.46	NA	39.62	090
35600		A	Harvest artery for cabg	4.94	NA	1.62	0.72	NA	7.28	ZZZ
35601		A	Artery bypass graft	17.47	NA	8.62	2.52	NA	28.61	090
35606		A	Artery bypass graft	18.68	NA	9.01	2.63	NA	30.32	090
35612		A	Artery bypass graft	15.74	NA	7.88	2.03	NA	25.65	090
35616		A	Artery bypass graft	15.68	NA	8.10	2.13	NA	25.91	090
35621		A	Artery bypass graft	19.97	NA	8.67	2.86	NA	31.50	090
35623		A	Bypass graft, not vein	23.96	NA	10.49	3.43	NA	37.88	090
35626		A	Artery bypass graft	27.71	NA	11.97	3.94	NA	43.62	090
35631		A	Artery bypass graft	33.95	NA	13.83	4.86	NA	52.64	090
35636		A	Artery bypass graft	29.46	NA	12.29	4.06	NA	45.81	090
35641		A	Artery bypass graft	24.53	NA	11.06	3.45	NA	39.04	090
35642		A	Artery bypass graft	17.95	NA	8.68	2.25	NA	28.88	090
35645		A	Artery bypass graft	17.44	NA	8.27	2.47	NA	28.18	090
35646		A	Artery bypass graft	30.95	NA	13.10	4.35	NA	48.40	090
35647		A	Artery bypass graft	27.96	NA	11.77	3.91	NA	43.64	090
35650		A	Artery bypass graft	18.97	NA	8.36	2.66	NA	29.99	090
35651		A	Artery bypass graft	25.00	NA	10.72	3.22	NA	38.94	090
35654		A	Artery bypass graft	24.96	NA	10.65	3.48	NA	39.09	090
35656		A	Artery bypass graft	19.50	NA	8.60	2.73	NA	30.83	090
35661		A	Artery bypass graft	18.97	NA	8.92	2.66	NA	30.55	090
35663		A	Artery bypass graft	21.97	NA	9.97	3.06	NA	35.00	090
35665		A	Artery bypass graft	20.97	NA	9.44	2.96	NA	33.37	090
35666		A	Artery bypass graft	22.16	NA	10.64	3.11	NA	35.91	090
35671		A	Artery bypass graft	19.30	NA	9.36	2.72	NA	31.38	090
35681		A	Composite bypass graft	1.60	NA	0.53	0.22	NA	2.35	ZZZ
35682		A	Composite bypass graft	7.19	NA	2.38	1.02	NA	10.59	ZZZ
35683		A	Composite bypass graft	8.49	NA	2.82	1.20	NA	12.51	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	1.35	0.58	NA	5.97	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	1.13	0.47	NA	4.94	ZZZ
35691		A	Arterial transposition	18.02	NA	8.40	2.60	NA	29.02	090
35693		A	Arterial transposition	15.34	NA	7.72	2.20	NA	25.26	090
35694		A	Arterial transposition	19.13	NA	8.60	2.67	NA	30.40	090
35695		A	Arterial transposition	19.13	NA	8.55	2.71	NA	30.39	090
35697		A	Reimplant artery each	3.00	NA	1.02	0.41	NA	4.43	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
35700		A	Reoperation, bypass graft	3.08	NA	1.02	0.43	NA	4.53	ZZZ
35701		A	Exploration, carotid artery	8.49	NA	5.15	1.11	NA	14.75	090
35721		A	Exploration, femoral artery	7.17	NA	4.43	1.02	NA	12.62	090
35741		A	Exploration popliteal artery	7.99	NA	4.66	1.09	NA	13.74	090
35761		A	Exploration of artery/vein	5.36	NA	4.01	0.74	NA	10.11	090
35800		A	Explore neck vessels	7.01	NA	4.65	0.95	NA	12.61	090
35820		A	Explore chest vessels	12.86	NA	7.20	1.86	NA	21.92	090
35840		A	Explore abdominal vessels	9.76	NA	5.28	1.31	NA	16.35	090
35860		A	Explore limb vessels	5.54	NA	4.03	0.77	NA	10.34	090
35870		A	Repair vessel graft defect	22.14	NA	9.76	2.92	NA	34.82	090
35875		A	Removal of clot in graft	10.11	NA	5.18	1.38	NA	16.67	090
35876		A	Removal of clot in graft	16.97	NA	7.51	2.36	NA	26.84	090
35879		A	Revise graft w/vein	15.98	NA	7.69	2.26	NA	25.93	090
35881		A	Revise graft w/vein	17.97	NA	8.66	2.53	NA	29.16	090
35901		A	Excision, graft, neck	8.18	NA	5.30	1.14	NA	14.62	090
35903		A	Excision, graft, extremity	9.38	NA	6.15	1.29	NA	16.82	090
35905		A	Excision, graft, thorax	31.20	NA	13.18	4.37	NA	48.75	090
35907		A	Excision, graft, abdomen	34.95	NA	14.16	4.84	NA	53.95	090
36000		A	Place needle in vein	0.18	0.57	0.05	0.01	0.76	0.24	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.86	0.97	0.17	4.99	3.10	000
36005		A	Injection ext venography	0.95	7.65	0.31	0.06	8.66	1.32	000
36010		A	Place catheter in vein	2.43	19.30	0.79	0.19	21.92	3.41	XXX
36011		A	Place catheter in vein	3.14	27.82	1.06	0.28	31.24	4.48	XXX
36012		A	Place catheter in vein	3.51	18.95	1.19	0.24	22.70	4.94	XXX
36013		A	Place catheter in artery	2.52	21.36	0.69	0.23	24.11	3.44	XXX
36014		A	Place catheter in artery	3.02	20.12	1.03	0.19	23.33	4.24	XXX
36015		A	Place catheter in artery	3.51	23.66	1.19	0.22	27.39	4.92	XXX
36100		A	Establish access to artery	3.02	12.07	1.11	0.27	15.36	4.40	XXX
36120		A	Establish access to artery	2.01	10.70	0.65	0.15	12.86	2.81	XXX
36140		A	Establish access to artery	2.01	12.77	0.64	0.16	14.94	2.81	XXX
36145		A	Artery to vein shunt	2.01	12.55	0.66	0.13	14.69	2.80	XXX
36160		A	Establish access to aorta	2.52	13.48	0.84	0.25	16.25	3.61	XXX
36200		A	Place catheter in aorta	3.02	16.51	1.01	0.25	19.78	4.28	XXX
36215		A	Place catheter in artery	4.67	27.03	1.61	0.32	32.02	6.60	XXX
36216		A	Place catheter in artery	5.27	29.08	1.79	0.37	34.72	7.43	XXX
36217		A	Place catheter in artery	6.29	55.44	2.17	0.46	62.19	8.92	XXX
36218		A	Place catheter in artery	1.01	5.09	0.34	0.08	6.18	1.43	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
36245		A	Place catheter in artery	4.67	32.09	1.68	0.33	37.09	6.68	XXX
36246		A	Place catheter in artery	5.27	29.96	1.82	0.39	35.62	7.48	XXX
36247		A	Place catheter in artery	6.29	49.51	2.14	0.48	56.28	8.91	XXX
36248		A	Place catheter in artery	1.01	4.04	0.34	0.08	5.13	1.43	ZZZ
36260		A	Insertion of infusion pump	9.70	NA	4.88	1.28	NA	15.86	090
36261		A	Revision of infusion pump	5.44	NA	3.66	0.70	NA	9.80	090
36262		A	Removal of infusion pump	4.01	NA	2.75	0.52	NA	7.28	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.28	0.09	0.03	0.69	0.50	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.26	0.08	0.03	0.60	0.42	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.28	0.05	0.01	0.47	0.24	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.29	0.05	0.01	0.48	0.24	XXX
36415		I	Routine venipuncture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36416		B	Capillary blood draw	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	0.34	0.27	0.07	1.42	1.35	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	0.22	0.06	NA	1.04	XXX
36430		A	Blood transfusion service	0.00	1.01	NA	0.06	1.07	NA	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	0.29	0.10	NA	1.42	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	0.71	0.21	NA	3.15	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	1.01	0.16	NA	3.60	XXX
36460		A	Transfusion service, fetal	6.58	NA	2.24	0.79	NA	9.61	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.68	0.73	0.12	3.89	1.94	010
36471		A	Injection therapy of veins	1.57	3.07	0.96	0.19	4.83	2.72	010
36475		A	Endovenous rf, 1st vein	6.72	51.39	2.53	0.37	58.48	9.62	000
36476		A	Endovenous rf, vein add-on	3.38	7.88	1.14	0.18	11.44	4.70	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	46.77	2.53	0.37	53.86	9.62	000
36479		A	Endovenous laser vein addon	3.38	7.99	1.14	0.18	11.55	4.70	ZZZ
36481		A	Insertion of catheter, vein	6.98	5.73	2.59	0.54	13.25	10.11	000
36500		A	Insertion of catheter, vein	3.51	NA	1.37	0.23	NA	5.11	000
36510		A	Insertion of catheter, vein	1.09	3.89	0.61	0.10	5.08	1.80	000
36511		A	Apheresis wbc	1.74	NA	0.73	0.08	NA	2.55	000
36512		A	Apheresis rbc	1.74	NA	0.74	0.08	NA	2.56	000
36513		A	Apheresis platelets	1.74	NA	0.73	0.17	NA	2.64	000
36514		A	Apheresis plasma	1.74	16.97	0.71	0.08	18.79	2.53	000
36515		A	Apheresis, adsorp/reinfuse	1.74	66.30	0.66	0.08	68.12	2.48	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
36516		A	Apheresis, selective	1.22	84.05	0.48	0.08	85.35	1.78	000
36522		A	Photopheresis	1.67	32.37	0.96	0.13	34.17	2.76	000
36540		B	Collect blood venous device	0.00	0.00	0.00	0.00	0.00	0.00	XXX
36550		A	Declot vascular device	0.00	0.39	NA	0.37	0.76	NA	XXX
36555		A	Insert non-tunnel cv cath	2.68	5.75	0.80	0.12	8.55	3.60	000
36556		A	Insert non-tunnel cv cath	2.50	5.62	0.74	0.19	8.31	3.43	000
36557		A	Insert tunneled cv cath	5.09	21.14	2.65	0.57	26.80	8.31	010
36558		A	Insert tunneled cv cath	4.79	21.04	2.55	0.57	26.40	7.91	010
36560		A	Insert tunneled cv cath	6.24	29.67	3.03	0.57	36.48	9.84	010
36561		A	Insert tunneled cv cath	5.99	29.58	2.95	0.57	36.14	9.51	010
36563		A	Insert tunneled cv cath	6.19	26.74	2.98	0.83	33.76	10.00	010
36565		A	Insert tunneled cv cath	5.99	24.70	2.95	0.57	31.26	9.51	010
36566		A	Insert tunneled cv cath	6.49	25.50	3.11	0.57	32.56	10.17	010
36568		A	Insert picc cath	1.92	7.53	0.58	0.12	9.57	2.62	000
36569		A	Insert picc cath	1.82	7.34	0.57	0.19	9.35	2.58	000
36570		A	Insert picvad cath	5.31	33.17	2.72	0.57	39.05	8.60	010
36571		A	Insert picvad cath	5.29	33.24	2.71	0.57	39.10	8.57	010
36575		A	Repair tunneled cv cath	0.67	4.05	0.26	0.21	4.93	1.14	000
36576		A	Repair tunneled cv cath	3.19	6.94	1.84	0.20	10.33	5.23	010
36578		A	Replace tunneled cv cath	3.49	11.13	2.30	0.20	14.82	5.99	010
36580		A	Replace cvad cath	1.31	6.94	0.41	0.19	8.44	1.91	000
36581		A	Replace tunneled cv cath	3.43	19.49	1.92	0.20	23.12	5.55	010
36582		A	Replace tunneled cv cath	5.19	26.01	2.86	0.20	31.40	8.25	010
36583		A	Replace tunneled cv cath	5.24	26.03	2.88	0.20	31.47	8.32	010
36584		A	Replace picc cath	1.20	6.97	0.55	0.19	8.36	1.94	000
36585		A	Replace picvad cath	4.79	27.82	2.73	0.20	32.81	7.72	010
36589		A	Removal tunneled cv cath	2.27	2.24	1.39	0.24	4.75	3.90	010
36590		A	Removal tunneled cv cath	3.30	3.37	1.72	0.43	7.10	5.45	010
36595		A	Mech remov tunneled cv cath	3.59	17.25	1.45	0.24	21.08	5.28	000
36596		A	Mech remov tunneled cv cath	0.75	3.69	0.50	0.05	4.49	1.30	000
36597		A	Reposition venous catheter	1.21	2.40	0.44	0.08	3.69	1.73	000
36600		A	Withdrawal of arterial blood	0.32	0.49	0.09	0.02	0.83	0.43	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.23	0.08	NA	1.46	000
36625		A	Insertion catheter, artery	2.11	NA	0.53	0.25	NA	2.89	000
36640		A	Insertion catheter, artery	2.10	NA	1.04	0.21	NA	3.35	000
36660		A	Insertion catheter, artery	1.40	NA	0.44	0.14	NA	1.98	000
36680		A	Insert needle, bone cavity	1.20	NA	0.49	0.11	NA	1.80	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
36800		A	Insertion of cannula	2.43	NA	1.80	0.24	NA	4.47	000
36810		A	Insertion of cannula	3.96	NA	1.68	0.44	NA	6.08	000
36815		A	Insertion of cannula	2.62	NA	1.17	0.34	NA	4.13	000
36818		A	Av fuse, uppr arm, cephalic	11.52	NA	6.03	1.88	NA	19.43	090
36819		A	Av fuse, uppr arm, basilic	13.98	NA	6.37	1.92	NA	22.27	090
36820		A	Av fusion/forearm vein	13.98	NA	6.38	1.92	NA	22.28	090
36821		A	Av fusion direct any site	8.92	NA	4.65	1.21	NA	14.78	090
36822		A	Insertion of cannula(s)	5.41	NA	4.38	0.74	NA	10.53	090
36823		A	Insertion of cannula(s)	20.97	NA	9.37	2.82	NA	33.16	090
36825		A	Artery-vein autograft	9.83	NA	5.05	1.33	NA	16.21	090
36830		A	Artery-vein nonautograft	11.98	NA	5.23	1.64	NA	18.85	090
36831		A	Open thrombect av fistula	7.99	NA	3.94	1.08	NA	13.01	090
36832		A	Av fistula revision, open	10.48	NA	4.72	1.43	NA	16.63	090
36833		A	Av fistula revision	11.93	NA	5.20	1.64	NA	18.77	090
36834		A	Repair A-V aneurysm	9.92	NA	4.79	1.36	NA	16.07	090
36835		A	Artery to vein shunt	7.14	NA	4.32	0.98	NA	12.44	090
36838		A	Dist revas ligation, hemo	20.60	NA	9.38	2.99	NA	32.97	090
36860		A	External cannula declotting	2.01	1.77	0.68	0.14	3.92	2.83	000
36861		A	Cannula declotting	2.52	NA	1.49	0.26	NA	4.27	000
36870		A	Percut thrombect av fistula	5.15	53.03	3.15	0.33	58.51	8.63	090
37140		A	Revision of circulation	23.56	NA	10.48	1.99	NA	36.03	090
37145		A	Revision of circulation	24.57	NA	10.86	3.22	NA	38.65	090
37160		A	Revision of circulation	21.57	NA	9.25	2.78	NA	33.60	090
37180		A	Revision of circulation	24.57	NA	10.29	3.31	NA	38.17	090
37181		A	Splice spleen/kidney veins	26.64	NA	11.00	3.37	NA	41.01	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	6.06	1.00	NA	24.03	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	3.01	0.48	NA	11.48	000
37195		A	Thrombolytic therapy, stroke	+0.00	0.00	NA	0.00	0.00	NA	XXX
37200		A	Transcatheter biopsy	4.55	NA	1.50	0.27	NA	6.32	000
37201		A	Transcatheter therapy infuse	4.99	NA	2.54	0.36	NA	7.89	000
37202		A	Transcatheter therapy infuse	5.67	NA	3.03	0.46	NA	9.16	000
37203		A	Transcatheter retrieval	5.02	32.87	2.03	0.35	38.24	7.40	000
37204		A	Transcatheter occlusion	18.11	NA	5.90	1.51	NA	25.52	000
37205		A	Transcath iv stent, percut	8.27	NA	3.75	0.61	NA	12.63	000
37206		A	Transcath iv stent/perc addl	4.12	NA	1.43	0.32	NA	5.87	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	3.16	1.13	NA	12.56	000
37208		A	Transcath iv stent/open addl	4.12	NA	1.38	0.57	NA	6.07	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
37209		A	Exchange arterial catheter	2.27	NA	0.74	0.16	NA	3.17	000
37215		R	Transcath stent, cca w/eps	18.71	NA	9.09	1.09	NA	28.89	090
37216		R	Transcath stent, cca w/o eps	17.98	NA	8.81	1.04	NA	27.83	090
37250		A	Iv us first vessel add-on	2.10	NA	0.75	0.21	NA	3.06	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	0.55	0.19	NA	2.34	ZZZ
37500		A	Endoscopy ligate perf veins	10.98	NA	6.85	1.53	NA	19.36	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	10.86	NA	5.62	1.33	NA	17.81	090
37600		A	Ligation of neck artery	11.23	NA	6.63	1.41	NA	19.27	090
37605		A	Ligation of neck artery	13.09	NA	6.90	1.94	NA	21.93	090
37606		A	Ligation of neck artery	6.27	NA	4.56	1.23	NA	12.06	090
37607		A	Ligation of a-v fistula	6.15	NA	3.56	0.83	NA	10.54	090
37609		A	Temporal artery procedure	3.00	4.50	1.96	0.37	7.87	5.33	010
37615		A	Ligation of neck artery	5.72	NA	4.11	0.70	NA	10.53	090
37616		A	Ligation of chest artery	16.47	NA	8.08	2.29	NA	26.84	090
37617		A	Ligation of abdomen artery	22.03	NA	9.17	2.93	NA	34.13	090
37618		A	Ligation of extremity artery	4.83	NA	3.61	0.66	NA	9.10	090
37620		A	Revision of major vein	10.54	NA	5.71	0.93	NA	17.18	090
37650		A	Revision of major vein	7.79	NA	4.68	0.98	NA	13.45	090
37660		A	Revision of major vein	20.97	NA	9.05	2.46	NA	32.48	090
37700		A	Revise leg vein	3.72	NA	2.79	0.52	NA	7.03	090
37720		A	Removal of leg vein	5.65	NA	3.70	0.78	NA	10.13	090
37730		A	Removal of leg veins	7.32	NA	4.26	1.01	NA	12.59	090
37735		A	Removal of leg veins/lesion	10.51	NA	5.50	1.48	NA	17.49	090
37760		A	Ligation, leg veins, open	10.45	NA	5.34	1.39	NA	17.18	090
37765		A	Phleb veins - extrem - to 20	7.34	NA	4.62	0.48	NA	12.44	090
37766		A	Phleb veins - extrem 20+	9.29	NA	5.32	0.48	NA	15.09	090
37780		A	Revision of leg vein	3.83	NA	2.85	0.53	NA	7.21	090
37785		A	Ligate/divide/excise vein	3.83	5.19	2.72	0.51	9.53	7.06	090
37788		A	Revascularization, penis	21.98	NA	9.08	2.23	NA	33.29	090
37790		A	Penile venous occlusion	8.33	NA	4.37	0.59	NA	13.29	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	14.48	NA	6.17	1.88	NA	22.53	090
38101		A	Removal of spleen, partial	15.29	NA	6.52	1.96	NA	23.77	090
38102		A	Removal of spleen, total	4.79	NA	1.64	0.62	NA	7.05	ZZZ
38115		A	Repair of ruptured spleen	15.80	NA	6.64	2.00	NA	24.44	090
38120		A	Laparoscopy, splenectomy	16.97	NA	7.38	2.21	NA	26.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	0.89	0.17	NA	3.70	000
38204		B	Bl donor search management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38206		R	Harvest auto stem cells	1.50	NA	0.67	0.07	NA	2.24	000
38207		I	Cryopreserve stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38208		I	Thaw preserved stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38209		I	Wash harvest stem cells	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38210		I	T-cell depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38211		I	Tumor cell deplete of harvst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38212		I	Rbc depletion of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38213		I	Platelet deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38214		I	Volume deplete of harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38215		I	Harvest stem cell concentrte	0.00	0.00	0.00	0.00	0.00	0.00	XXX
38220		A	Bone marrow aspiration	1.08	3.72	0.52	0.06	4.86	1.66	XXX
38221		A	Bone marrow biopsy	1.37	3.93	0.65	0.07	5.37	2.09	XXX
38230		R	Bone marrow collection	4.53	NA	3.22	0.47	NA	8.22	010
38240		R	Bone marrow/stem transplant	2.24	NA	1.03	0.12	NA	3.39	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.04	0.14	NA	3.42	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	0.78	0.10	NA	2.59	000
38300		A	Drainage, lymph node lesion	1.99	4.30	2.05	0.24	6.53	4.28	010
38305		A	Drainage, lymph node lesion	5.99	NA	4.44	0.85	NA	11.28	090
38308		A	Incision of lymph channels	6.44	NA	3.74	0.85	NA	11.03	090
38380		A	Thoracic duct procedure	7.45	NA	5.68	0.80	NA	13.93	090
38381		A	Thoracic duct procedure	12.86	NA	6.88	1.83	NA	21.57	090
38382		A	Thoracic duct procedure	10.06	NA	5.75	1.37	NA	17.18	090
38500		A	Biopsy/removal, lymph nodes	3.74	3.69	2.08	0.48	7.91	6.30	010
38505		A	Needle biopsy, lymph nodes	1.14	2.05	0.78	0.09	3.28	2.01	000
38510		A	Biopsy/removal, lymph nodes	6.42	5.54	3.48	0.74	12.70	10.64	010
38520		A	Biopsy/removal, lymph nodes	6.66	NA	4.05	0.84	NA	11.55	090
38525		A	Biopsy/removal, lymph nodes	6.06	NA	3.29	0.80	NA	10.15	090
38530		A	Biopsy/removal, lymph nodes	7.97	NA	4.39	1.10	NA	13.46	090
38542		A	Explore deep node(s), neck	5.90	NA	4.48	0.62	NA	11.00	090
38550		A	Removal, neck/armpit lesion	6.91	NA	3.91	0.87	NA	11.69	090
38555		A	Removal, neck/armpit lesion	14.12	NA	8.53	1.78	NA	24.43	090
38562		A	Removal, pelvic lymph nodes	10.47	NA	5.77	1.21	NA	17.45	090
38564		A	Removal, abdomen lymph nodes	10.81	NA	5.24	1.32	NA	17.37	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
38570		A	Laparoscopy, lymph node biop	9.24	NA	3.97	1.13	NA	14.34	010
38571		A	Laparoscopy, lymphadenectomy	14.66	NA	5.64	1.16	NA	21.46	010
38572		A	Laparoscopy, lymphadenectomy	16.57	NA	7.07	1.89	NA	25.53	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	8.23	NA	6.23	0.76	NA	15.22	090
38720		A	Removal of lymph nodes, neck	13.59	NA	9.35	1.25	NA	24.19	090
38724		A	Removal of lymph nodes, neck	14.52	NA	9.83	1.31	NA	25.66	090
38740		A	Remove armpit lymph nodes	10.01	NA	4.94	1.31	NA	16.26	090
38745		A	Remove armpit lymph nodes	13.08	NA	6.07	1.71	NA	20.86	090
38746		A	Remove thoracic lymph nodes	4.88	NA	1.61	0.70	NA	7.19	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	1.67	0.63	NA	7.18	ZZZ
38760		A	Remove groin lymph nodes	12.93	NA	6.12	1.68	NA	20.73	090
38765		A	Remove groin lymph nodes	19.95	NA	8.80	2.46	NA	31.21	090
38770		A	Remove pelvis lymph nodes	13.21	NA	5.74	1.41	NA	20.36	090
38780		A	Remove abdomen lymph nodes	16.57	NA	8.20	1.87	NA	26.64	090
38790		A	Inject for lymphatic x-ray	1.29	7.35	0.76	0.13	8.77	2.18	000
38792		A	Identify sentinel node	0.52	NA	0.44	0.06	NA	1.02	000
38794		A	Access thoracic lymph duct	4.44	NA	3.45	0.31	NA	8.20	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	6.09	NA	4.65	0.85	NA	11.59	090
39010		A	Exploration of chest	11.77	NA	7.54	1.67	NA	20.98	090
39200		A	Removal chest lesion	13.60	NA	7.53	1.91	NA	23.04	090
39220		A	Removal chest lesion	17.39	NA	9.36	2.38	NA	29.13	090
39400		A	Visualization of chest	5.60	NA	4.85	0.80	NA	11.25	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.17	NA	6.45	1.73	NA	21.35	090
39502		A	Repair paraesophageal hernia	16.31	NA	7.14	2.14	NA	25.59	090
39503		A	Repair of diaphragm hernia	94.86	NA	33.37	10.87	NA	139.10	090
39520		A	Repair of diaphragm hernia	16.08	NA	8.04	2.20	NA	26.32	090
39530		A	Repair of diaphragm hernia	15.39	NA	7.13	2.08	NA	24.60	090
39531		A	Repair of diaphragm hernia	16.40	NA	7.38	2.19	NA	25.97	090
39540		A	Repair of diaphragm hernia	13.30	NA	6.22	1.75	NA	21.27	090
39541		A	Repair of diaphragm hernia	14.39	NA	6.58	1.90	NA	22.87	090
39545		A	Revision of diaphragm	13.35	NA	7.54	1.81	NA	22.70	090
39560		A	Resect diaphragm, simple	11.98	NA	6.28	1.55	NA	19.81	090
39561		A	Resect diaphragm, complex	17.47	NA	9.33	2.36	NA	29.16	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
4000F		I	Tobacco use txmnt counseling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4001F		I	Tobacco use txmnt, pharmacol	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4002F		I	Statin therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4006F		I	Beta-blocker therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4009F		I	Ace inhibitor therapy, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
4011F		I	Oral antiplatelet tx, rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
40490		A	Biopsy of lip	1.22	1.63	0.61	0.06	2.91	1.89	000
40500		A	Partial excision of lip	4.27	6.89	4.33	0.39	11.55	8.99	090
40510		A	Partial excision of lip	4.69	6.61	4.01	0.48	11.78	9.18	090
40520		A	Partial excision of lip	4.66	7.54	4.11	0.52	12.72	9.29	090
40525		A	Reconstruct lip with flap	7.54	NA	6.30	0.85	NA	14.69	090
40527		A	Reconstruct lip with flap	9.12	NA	7.35	0.99	NA	17.46	090
40530		A	Partial removal of lip	5.39	7.81	4.58	0.55	13.75	10.52	090
40650		A	Repair lip	3.63	6.79	3.29	0.38	10.80	7.30	090
40652		A	Repair lip	4.25	7.74	4.26	0.50	12.49	9.01	090
40654		A	Repair lip	5.30	8.60	4.93	0.60	14.50	10.83	090
40700		A	Repair cleft lip/nasal	12.77	NA	9.07	0.95	NA	22.79	090
40701		A	Repair cleft lip/nasal	15.83	NA	11.33	1.64	NA	28.80	090
40702		A	Repair cleft lip/nasal	13.02	NA	8.25	1.24	NA	22.51	090
40720		A	Repair cleft lip/nasal	13.53	NA	9.89	1.78	NA	25.20	090
40761		A	Repair cleft lip/nasal	14.70	NA	10.27	1.91	NA	26.88	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.17	2.96	1.77	0.12	4.25	3.06	010
40801		A	Drainage of mouth lesion	2.53	4.02	2.74	0.31	6.86	5.58	010
40804		A	Removal, foreign body, mouth	1.24	3.39	1.85	0.11	4.74	3.20	010
40805		A	Removal, foreign body, mouth	2.69	4.48	2.81	0.31	7.48	5.81	010
40806		A	Incision of lip fold	0.31	1.83	0.50	0.04	2.18	0.85	000
40808		A	Biopsy of mouth lesion	0.96	2.65	1.48	0.10	3.71	2.54	010
40810		A	Excision of mouth lesion	1.31	2.88	1.66	0.13	4.32	3.10	010
40812		A	Excise/repair mouth lesion	2.31	3.72	2.40	0.28	6.31	4.99	010
40814		A	Excise/repair mouth lesion	3.41	4.94	3.89	0.41	8.76	7.71	090
40816		A	Excision of mouth lesion	3.66	5.17	4.00	0.41	9.24	8.07	090
40818		A	Excise oral mucosa for graft	2.41	5.17	3.97	0.21	7.79	6.59	090
40819		A	Excise lip or cheek fold	2.41	4.08	3.09	0.27	6.76	5.77	090
40820		A	Treatment of mouth lesion	1.28	3.93	2.44	0.11	5.32	3.83	010
40830		A	Repair mouth laceration	1.76	3.72	2.09	0.19	5.67	4.04	010
40831		A	Repair mouth laceration	2.46	4.66	3.05	0.29	7.41	5.80	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
40840		R	Reconstruction of mouth	8.72	9.78	6.97	1.05	19.55	16.74	090
40842		R	Reconstruction of mouth	8.72	10.06	6.78	1.08	19.86	16.58	090
40843		R	Reconstruction of mouth	12.08	11.95	7.81	1.38	25.41	21.27	090
40844		R	Reconstruction of mouth	15.99	15.76	11.56	1.97	33.72	29.52	090
40845		R	Reconstruction of mouth	18.55	17.06	13.21	1.99	37.60	33.75	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.30	2.31	1.41	0.12	3.73	2.83	010
41005		A	Drainage of mouth lesion	1.26	3.33	1.72	0.12	4.71	3.10	010
41006		A	Drainage of mouth lesion	3.24	4.79	3.17	0.35	8.38	6.76	090
41007		A	Drainage of mouth lesion	3.10	5.14	3.02	0.31	8.55	6.43	090
41008		A	Drainage of mouth lesion	3.36	4.68	3.20	0.42	8.46	6.98	090
41009		A	Drainage of mouth lesion	3.58	4.97	3.57	0.46	9.01	7.61	090
41010		A	Incision of tongue fold	1.06	3.42	1.60	0.08	4.56	2.74	010
41015		A	Drainage of mouth lesion	3.95	5.40	4.14	0.46	9.81	8.55	090
41016		A	Drainage of mouth lesion	4.06	5.61	4.22	0.52	10.19	8.80	090
41017		A	Drainage of mouth lesion	4.06	5.63	4.30	0.53	10.22	8.89	090
41018		A	Drainage of mouth lesion	5.09	6.13	4.57	0.66	11.88	10.32	090
41100		A	Biopsy of tongue	1.63	2.42	1.42	0.15	4.20	3.20	010
41105		A	Biopsy of tongue	1.42	2.30	1.32	0.13	3.85	2.87	010
41108		A	Biopsy of floor of mouth	1.05	2.07	1.13	0.10	3.22	2.28	010
41110		A	Excision of tongue lesion	1.51	2.98	1.64	0.13	4.62	3.28	010
41112		A	Excision of tongue lesion	2.73	4.47	3.22	0.29	7.49	6.24	090
41113		A	Excision of tongue lesion	3.19	4.74	3.47	0.34	8.27	7.00	090
41114		A	Excision of tongue lesion	8.46	NA	7.19	0.83	NA	16.48	090
41115		A	Excision of tongue fold	1.74	3.29	1.85	0.18	5.21	3.77	010
41116		A	Excision of mouth lesion	2.44	4.35	2.80	0.23	7.02	5.47	090
41120		A	Partial removal of tongue	9.76	NA	15.31	0.83	NA	25.90	090
41130		A	Partial removal of tongue	11.13	NA	16.19	0.97	NA	28.29	090
41135		A	Tongue and neck surgery	23.06	NA	23.22	1.97	NA	48.25	090
41140		A	Removal of tongue	25.46	NA	26.67	2.24	NA	54.37	090
41145		A	Tongue removal, neck surgery	30.01	NA	30.54	2.58	NA	63.13	090
41150		A	Tongue, mouth, jaw surgery	23.01	NA	24.71	2.01	NA	49.73	090
41153		A	Tongue, mouth, neck surgery	23.73	NA	25.02	2.07	NA	50.82	090
41155		A	Tongue, jaw, & neck surgery	27.68	NA	26.80	2.42	NA	56.90	090
41250		A	Repair tongue laceration	1.91	2.74	1.18	0.19	4.84	3.28	010
41251		A	Repair tongue laceration	2.27	3.27	1.55	0.22	5.76	4.04	010
41252		A	Repair tongue laceration	2.97	3.89	2.25	0.29	7.15	5.51	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
41500		A	Fixation of tongue	3.70	NA	7.45	0.30	NA	11.45	090
41510		A	Tongue to lip surgery	3.41	NA	7.93	0.20	NA	11.54	090
41520		A	Reconstruction, tongue fold	2.73	4.62	3.62	0.27	7.62	6.62	090
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.17	2.59	1.28	0.12	3.88	2.57	010
41805		A	Removal foreign body, gum	1.24	2.67	2.21	0.13	4.04	3.58	010
41806		A	Removal foreign body,jawbone	2.69	3.58	3.03	0.36	6.63	6.08	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.31	3.89	1.87	0.31	6.51	4.49	010
41823		R	Excision of gum lesion	3.30	5.56	4.01	0.46	9.32	7.77	090
41825		A	Excision of gum lesion	1.31	3.06	2.24	0.15	4.52	3.70	010
41826		A	Excision of gum lesion	2.31	2.43	2.10	0.30	5.04	4.71	010
41827		A	Excision of gum lesion	3.41	5.51	3.66	0.35	9.27	7.42	090
41828		R	Excision of gum lesion	3.09	3.80	2.96	0.44	7.33	6.49	010
41830		R	Removal of gum tissue	3.34	4.96	3.62	0.44	8.74	7.40	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.59	5.02	3.46	0.30	7.91	6.35	090
41874		R	Repair tooth socket	3.09	4.84	3.17	0.44	8.37	6.70	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.23	2.56	1.25	0.12	3.91	2.60	010
42100		A	Biopsy roof of mouth	1.31	2.08	1.36	0.13	3.52	2.80	010
42104		A	Excision lesion, mouth roof	1.64	2.54	1.55	0.16	4.34	3.35	010
42106		A	Excision lesion, mouth roof	2.10	3.22	2.44	0.25	5.57	4.79	010
42107		A	Excision lesion, mouth roof	4.43	5.71	3.95	0.45	10.59	8.83	090
42120		A	Remove palate/lesion	6.16	NA	11.77	0.54	NA	18.47	090
42140		A	Excision of uvula	1.62	3.72	2.09	0.13	5.47	3.84	090
42145		A	Repair palate, pharynx/uvula	8.04	NA	7.49	0.65	NA	16.18	090
42160		A	Treatment mouth roof lesion	1.80	4.25	2.29	0.17	6.22	4.26	010
42180		A	Repair palate	2.50	3.07	2.10	0.21	5.78	4.81	010
42182		A	Repair palate	3.82	3.87	3.03	0.40	8.09	7.25	010
42200		A	Reconstruct cleft palate	11.98	NA	10.21	1.27	NA	23.46	090
42205		A	Reconstruct cleft palate	13.27	NA	10.07	1.56	NA	24.90	090
42210		A	Reconstruct cleft palate	14.48	NA	11.46	2.14	NA	28.08	090
42215		A	Reconstruct cleft palate	8.81	NA	9.07	1.30	NA	19.18	090
42220		A	Reconstruct cleft palate	7.01	NA	6.78	0.72	NA	14.51	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42225		A	Reconstruct cleft palate	9.53	NA	17.06	0.89	NA	27.48	090
42226		A	Lengthening of palate	9.99	NA	14.70	1.01	NA	25.70	090
42227		A	Lengthening of palate	9.51	NA	15.54	0.98	NA	26.03	090
42235		A	Repair palate	7.86	NA	11.86	0.72	NA	20.44	090
42260		A	Repair nose to lip fistula	9.79	10.19	7.06	1.25	21.23	18.10	090
42280		A	Preparation, palate mold	1.54	1.96	1.14	0.19	3.69	2.87	010
42281		A	Insertion, palate prosthesis	1.93	2.63	1.87	0.17	4.73	3.97	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.93	2.82	1.81	0.16	4.91	3.90	010
42305		A	Drainage of salivary gland	6.06	NA	4.72	0.53	NA	11.31	090
42310		A	Drainage of salivary gland	1.56	2.26	1.54	0.13	3.95	3.23	010
42320		A	Drainage of salivary gland	2.35	3.27	2.09	0.21	5.83	4.65	010
42325		A	Create salivary cyst drain	2.75	4.61	2.30	0.26	7.62	5.31	090
42326		A	Create salivary cyst drain	3.77	5.90	3.15	0.29	9.96	7.21	090
42330		A	Removal of salivary stone	2.21	3.14	1.84	0.19	5.54	4.24	010
42335		A	Removal of salivary stone	3.31	4.90	3.14	0.30	8.51	6.75	090
42340		A	Removal of salivary stone	4.59	6.04	3.93	0.43	11.06	8.95	090
42400		A	Biopsy of salivary gland	0.78	1.65	0.72	0.06	2.49	1.56	000
42405		A	Biopsy of salivary gland	3.29	4.00	2.45	0.28	7.57	6.02	010
42408		A	Excision of salivary cyst	4.53	5.91	3.61	0.45	10.89	8.59	090
42409		A	Drainage of salivary cyst	2.81	4.52	2.76	0.27	7.60	5.84	090
42410		A	Excise parotid gland/lesion	9.33	NA	6.22	0.91	NA	16.46	090
42415		A	Excise parotid gland/lesion	16.86	NA	10.86	1.46	NA	29.18	090
42420		A	Excise parotid gland/lesion	19.56	NA	12.37	1.67	NA	33.60	090
42425		A	Excise parotid gland/lesion	13.00	NA	8.61	1.13	NA	22.74	090
42426		A	Excise parotid gland/lesion	21.23	NA	13.01	1.85	NA	36.09	090
42440		A	Excise submaxillary gland	6.96	NA	4.79	0.60	NA	12.35	090
42450		A	Excise sublingual gland	4.61	5.90	4.25	0.42	10.93	9.28	090
42500		A	Repair salivary duct	4.29	5.68	4.18	0.41	10.38	8.88	090
42505		A	Repair salivary duct	6.17	7.12	5.36	0.56	13.85	12.09	090
42507		A	Parotid duct diversion	6.10	NA	6.53	0.49	NA	13.12	090
42508		A	Parotid duct diversion	9.09	NA	8.34	1.04	NA	18.47	090
42509		A	Parotid duct diversion	11.52	NA	10.19	0.93	NA	22.64	090
42510		A	Parotid duct diversion	8.14	NA	7.79	0.66	NA	16.59	090
42550		A	Injection for salivary x-ray	1.25	3.21	0.41	0.07	4.53	1.73	000
42600		A	Closure of salivary fistula	4.81	6.58	4.12	0.43	11.82	9.36	090
42650		A	Dilation of salivary duct	0.77	1.10	0.71	0.07	1.94	1.55	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42660		A	Dilation of salivary duct	1.13	1.35	0.85	0.09	2.57	2.07	000
42665		A	Ligation of salivary duct	2.53	4.17	2.59	0.23	6.93	5.35	090
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
42700		A	Drainage of tonsil abscess	1.62	2.65	1.70	0.13	4.40	3.45	010
42720		A	Drainage of throat abscess	5.41	4.83	3.79	0.47	10.71	9.67	010
42725		A	Drainage of throat abscess	10.70	NA	8.22	0.96	NA	19.88	090
42800		A	Biopsy of throat	1.39	2.18	1.40	0.11	3.68	2.90	010
42802		A	Biopsy of throat	1.54	4.76	2.06	0.13	6.43	3.73	010
42804		A	Biopsy of upper nose/throat	1.24	3.74	1.73	0.10	5.08	3.07	010
42806		A	Biopsy of upper nose/throat	1.58	4.07	1.93	0.13	5.78	3.64	010
42808		A	Excise pharynx lesion	2.30	3.09	1.93	0.19	5.58	4.42	010
42809		A	Remove pharynx foreign body	1.81	2.33	1.33	0.16	4.30	3.30	010
42810		A	Excision of neck cyst	3.25	5.71	3.54	0.30	9.26	7.09	090
42815		A	Excision of neck cyst	7.06	NA	6.41	0.62	NA	14.09	090
42820		A	Remove tonsils and adenoids	3.90	NA	3.29	0.31	NA	7.50	090
42821		A	Remove tonsils and adenoids	4.28	NA	3.50	0.35	NA	8.13	090
42825		A	Removal of tonsils	3.41	NA	3.17	0.25	NA	6.83	090
42826		A	Removal of tonsils	3.37	NA	3.03	0.28	NA	6.68	090
42830		A	Removal of adenoids	2.57	NA	2.56	0.20	NA	5.33	090
42831		A	Removal of adenoids	2.71	NA	2.84	0.22	NA	5.77	090
42835		A	Removal of adenoids	2.30	NA	2.46	0.21	NA	4.97	090
42836		A	Removal of adenoids	3.18	NA	2.96	0.26	NA	6.40	090
42842		A	Extensive surgery of throat	8.75	NA	10.99	0.72	NA	20.46	090
42844		A	Extensive surgery of throat	14.29	NA	16.23	1.19	NA	31.71	090
42845		A	Extensive surgery of throat	24.25	NA	23.18	2.06	NA	49.49	090
42860		A	Excision of tonsil tags	2.22	NA	2.40	0.18	NA	4.80	090
42870		A	Excision of lingual tonsil	5.39	NA	8.57	0.44	NA	14.40	090
42890		A	Partial removal of pharynx	12.92	NA	14.15	1.09	NA	28.16	090
42892		A	Revision of pharyngeal walls	15.81	NA	17.17	1.35	NA	34.33	090
42894		A	Revision of pharyngeal walls	22.85	NA	22.02	1.91	NA	46.78	090
42900		A	Repair throat wound	5.24	NA	3.66	0.53	NA	9.43	010
42950		A	Reconstruction of throat	8.09	NA	11.87	0.72	NA	20.68	090
42953		A	Repair throat, esophagus	8.95	NA	17.33	0.90	NA	27.18	090
42955		A	Surgical opening of throat	7.38	NA	10.67	0.80	NA	18.85	090
42960		A	Control throat bleeding	2.33	NA	1.96	0.20	NA	4.49	010
42961		A	Control throat bleeding	5.58	NA	4.96	0.46	NA	11.00	090
42962		A	Control throat bleeding	7.13	NA	5.91	0.59	NA	13.63	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
42970		A	Control nose/throat bleeding	5.42	NA	4.18	0.39	NA	9.99	090
42971		A	Control nose/throat bleeding	6.20	NA	5.12	0.51	NA	11.83	090
42972		A	Control nose/throat bleeding	7.19	NA	5.70	0.62	NA	13.51	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43020		A	Incision of esophagus	8.08	NA	5.41	0.88	NA	14.37	090
43030		A	Throat muscle surgery	7.68	NA	5.49	0.70	NA	13.87	090
43045		A	Incision of esophagus	20.09	NA	10.70	2.56	NA	33.35	090
43100		A	Excision of esophagus lesion	9.18	NA	6.22	0.92	NA	16.32	090
43101		A	Excision of esophagus lesion	16.22	NA	7.88	2.23	NA	26.33	090
43107		A	Removal of esophagus	39.94	NA	18.26	5.02	NA	63.22	090
43108		A	Removal of esophagus	34.14	NA	14.21	3.94	NA	52.29	090
43112		A	Removal of esophagus	43.43	NA	19.36	5.66	NA	68.45	090
43113		A	Removal of esophagus	35.22	NA	15.11	4.38	NA	54.71	090
43116		A	Partial removal of esophagus	31.17	NA	16.69	3.02	NA	50.88	090
43117		A	Partial removal of esophagus	39.94	NA	17.27	5.07	NA	62.28	090
43118		A	Partial removal of esophagus	33.15	NA	13.78	4.07	NA	51.00	090
43121		A	Partial removal of esophagus	29.15	NA	13.67	3.86	NA	46.68	090
43122		A	Partial removal of esophagus	39.94	NA	17.39	5.25	NA	62.58	090
43123		A	Partial removal of esophagus	33.15	NA	14.10	4.16	NA	51.41	090
43124		A	Removal of esophagus	27.28	NA	13.08	3.67	NA	44.03	090
43130		A	Removal of esophagus pouch	11.73	NA	7.56	1.18	NA	20.47	090
43135		A	Removal of esophagus pouch	16.08	NA	8.09	2.27	NA	26.44	090
43200		A	Esophagus endoscopy	1.59	4.13	1.07	0.13	5.85	2.79	000
43201		A	Esoph scope w/submucous inj	2.09	4.63	1.10	0.16	6.88	3.35	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.54	0.94	0.16	7.59	2.99	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	1.52	0.30	NA	5.58	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	1.52	0.28	NA	5.58	000
43215		A	Esophagus endoscopy	2.60	NA	1.20	0.23	NA	4.03	000
43216		A	Esophagus endoscopy/lesion	2.40	NA	1.06	0.20	NA	3.66	000
43217		A	Esophagus endoscopy	2.90	6.95	1.19	0.26	10.11	4.35	000
43219		A	Esophagus endoscopy	2.80	NA	1.35	0.24	NA	4.39	000
43220		A	Esoph endoscopy, dilation	2.10	NA	0.97	0.17	NA	3.24	000
43226		A	Esoph endoscopy, dilation	2.34	NA	1.03	0.19	NA	3.56	000
43227		A	Esoph endoscopy, repair	3.59	NA	1.45	0.28	NA	5.32	000
43228		A	Esoph endoscopy, ablation	3.76	NA	1.55	0.34	NA	5.65	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	1.31	0.24	NA	4.74	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	1.81	0.34	NA	6.62	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43234		A	Upper GI endoscopy, exam	2.01	5.32	0.87	0.18	7.51	3.06	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	5.17	1.02	0.19	7.75	3.60	000
43236		A	Uppr gi scope w/submuc inj	2.92	6.40	1.22	0.22	9.54	4.36	000
43237		A	Endoscopic us exam, esoph	3.98	NA	1.59	0.44	NA	6.01	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	1.96	0.44	NA	7.42	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.71	1.19	0.22	8.80	4.28	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	2.60	0.56	NA	10.01	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.10	0.21	NA	3.90	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	2.73	0.53	NA	10.56	000
43243		A	Upper gi endoscopy & inject	4.56	NA	1.79	0.35	NA	6.70	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	1.96	0.37	NA	7.37	000
43245		A	Uppr gi scope dilate strictr	3.18	NA	1.30	0.26	NA	4.74	000
43246		A	Place gastrostomy tube	4.32	NA	1.69	0.34	NA	6.35	000
43247		A	Operative upper GI endoscopy	3.38	NA	1.37	0.27	NA	5.02	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	1.31	0.24	NA	4.70	000
43249		A	Esoph endoscopy, dilation	2.90	NA	1.21	0.22	NA	4.33	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.31	0.26	NA	4.77	000
43251		A	Operative upper GI endoscopy	3.69	NA	1.48	0.29	NA	5.46	000
43255		A	Operative upper GI endoscopy	4.81	NA	1.88	0.36	NA	7.05	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	1.71	0.34	NA	6.39	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.20	0.36	NA	8.06	000
43258		A	Operative upper GI endoscopy	4.54	NA	1.78	0.34	NA	6.66	000
43259		A	Endoscopic ultrasound exam	5.19	NA	1.99	0.36	NA	7.54	000
43260		A	Endo cholangiopancreatograph	5.95	NA	2.28	0.44	NA	8.67	000
43261		A	Endo cholangiopancreatograph	6.26	NA	2.39	0.46	NA	9.11	000
43262		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.54	NA	10.70	000
43263		A	Endo cholangiopancreatograph	7.28	NA	2.76	0.54	NA	10.58	000
43264		A	Endo cholangiopancreatograph	8.89	NA	3.31	0.65	NA	12.85	000
43265		A	Endo cholangiopancreatograph	10.00	NA	3.69	0.73	NA	14.42	000
43267		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43268		A	Endo cholangiopancreatograph	7.38	NA	2.88	0.54	NA	10.80	000
43269		A	Endo cholangiopancreatograph	8.20	NA	3.07	0.61	NA	11.88	000
43271		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.54	NA	10.70	000
43272		A	Endo cholangiopancreatograph	7.38	NA	2.78	0.55	NA	10.71	000
43280		A	Laparoscopy, fundoplasty	17.22	NA	7.27	2.25	NA	26.74	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.13	NA	6.37	1.07	NA	16.57	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43305		A	Repair esophagus and fistula	17.36	NA	10.69	1.58	NA	29.63	090
43310		A	Repair of esophagus	25.35	NA	11.06	3.39	NA	39.80	090
43312		A	Repair esophagus and fistula	28.38	NA	11.89	3.96	NA	44.23	090
43313		A	Esophagoplasty congenital	45.21	NA	18.81	5.40	NA	69.42	090
43314		A	Tracheo-esophagoplasty cong	50.19	NA	19.18	6.58	NA	75.95	090
43320		A	Fuse esophagus & stomach	19.90	NA	9.20	2.53	NA	31.63	090
43324		A	Revise esophagus & stomach	20.54	NA	8.76	2.72	NA	32.02	090
43325		A	Revise esophagus & stomach	20.03	NA	8.78	2.59	NA	31.40	090
43326		A	Revise esophagus & stomach	19.71	NA	9.29	2.78	NA	31.78	090
43330		A	Repair of esophagus	19.74	NA	8.53	2.58	NA	30.85	090
43331		A	Repair of esophagus	20.10	NA	9.78	2.83	NA	32.71	090
43340		A	Fuse esophagus & intestine	19.58	NA	8.96	2.45	NA	30.99	090
43341		A	Fuse esophagus & intestine	20.82	NA	10.01	2.88	NA	33.71	090
43350		A	Surgical opening, esophagus	15.76	NA	8.44	1.41	NA	25.61	090
43351		A	Surgical opening, esophagus	18.32	NA	9.79	2.44	NA	30.55	090
43352		A	Surgical opening, esophagus	15.24	NA	8.38	1.97	NA	25.59	090
43360		A	Gastrointestinal repair	35.65	NA	15.07	4.83	NA	55.55	090
43361		A	Gastrointestinal repair	40.44	NA	16.88	4.43	NA	61.75	090
43400		A	Ligate esophagus veins	21.17	NA	9.43	1.91	NA	32.51	090
43401		A	Esophagus surgery for veins	22.06	NA	9.48	3.01	NA	34.55	090
43405		A	Ligate/staple esophagus	19.98	NA	9.58	2.76	NA	32.32	090
43410		A	Repair esophagus wound	13.45	NA	7.63	1.75	NA	22.83	090
43415		A	Repair esophagus wound	24.96	NA	11.74	3.39	NA	40.09	090
43420		A	Repair esophagus opening	14.33	NA	7.40	1.44	NA	23.17	090
43425		A	Repair esophagus opening	21.00	NA	9.97	2.92	NA	33.89	090
43450		A	Dilate esophagus	1.38	2.63	0.69	0.11	4.12	2.18	000
43453		A	Dilate esophagus	1.51	6.06	0.73	0.11	7.68	2.35	000
43456		A	Dilate esophagus	2.57	13.74	1.10	0.20	16.51	3.87	000
43458		A	Dilate esophagus	3.06	6.65	1.28	0.24	9.95	4.58	000
43460		A	Pressure treatment esophagus	3.79	NA	1.49	0.32	NA	5.60	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	11.03	NA	4.97	1.41	NA	17.41	090
43501		A	Surgical repair of stomach	20.01	NA	8.30	2.62	NA	30.93	090
43502		A	Surgical repair of stomach	23.10	NA	9.45	3.06	NA	35.61	090
43510		A	Surgical opening of stomach	13.06	NA	6.58	1.46	NA	21.10	090
43520		A	Incision of pyloric muscle	9.98	NA	5.25	1.32	NA	16.55	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43600		A	Biopsy of stomach	1.91	NA	0.66	0.14	NA	2.71	000
43605		A	Biopsy of stomach	11.96	NA	5.28	1.57	NA	18.81	090
43610		A	Excision of stomach lesion	14.58	NA	6.14	1.90	NA	22.62	090
43611		A	Excision of stomach lesion	17.81	NA	7.56	2.32	NA	27.69	090
43620		A	Removal of stomach	29.99	NA	11.79	3.91	NA	45.69	090
43621		A	Removal of stomach	30.68	NA	11.97	4.00	NA	46.65	090
43622		A	Removal of stomach	32.48	NA	12.58	4.25	NA	49.31	090
43631		A	Removal of stomach, partial	22.56	NA	9.15	2.94	NA	34.65	090
43632		A	Removal of stomach, partial	22.56	NA	9.15	2.94	NA	34.65	090
43633		A	Removal of stomach, partial	23.07	NA	9.32	3.02	NA	35.41	090
43634		A	Removal of stomach, partial	25.08	NA	10.08	3.30	NA	38.46	090
43635		A	Removal of stomach, partial	2.06	NA	0.70	0.27	NA	3.03	ZZZ
43638		A	Removal of stomach, partial	28.96	NA	11.88	3.75	NA	44.59	090
43639		A	Removal of stomach, partial	29.61	NA	11.68	3.85	NA	45.14	090
43640		A	Vagotomy & pylorus repair	16.99	NA	7.25	2.22	NA	26.46	090
43641		A	Vagotomy & pylorus repair	17.24	NA	7.36	2.18	NA	26.78	090
43644		A	Lap gastric bypass/roux-en-y	27.83	NA	11.21	3.13	NA	42.17	090
43645		A	Lap gastr bypass incl smll i	29.96	NA	12.01	3.51	NA	45.48	090
43651		A	Laparoscopy, vagus nerve	10.13	NA	4.76	1.33	NA	16.22	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	5.75	1.54	NA	19.42	090
43653		A	Laparoscopy, gastrostomy	7.72	NA	4.18	1.00	NA	12.90	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	0.00	0.00	YYY
43750		A	Place gastrostomy tube	4.48	NA	2.19	0.43	NA	7.10	010
43752		A	Nasal/orogastric w/stent	0.81	0.28	0.26	0.02	1.11	1.09	000
43760		A	Change gastrostomy tube	1.10	2.08	0.45	0.09	3.27	1.64	000
43761		A	Reposition gastrostomy tube	2.01	1.17	0.66	0.14	3.32	2.81	000
43800		A	Reconstruction of pylorus	13.67	NA	5.89	1.78	NA	21.34	090
43810		A	Fusion of stomach and bowel	14.63	NA	6.17	1.91	NA	22.71	090
43820		A	Fusion of stomach and bowel	15.35	NA	6.40	2.00	NA	23.75	090
43825		A	Fusion of stomach and bowel	19.19	NA	8.01	2.52	NA	29.72	090
43830		A	Place gastrostomy tube	9.52	NA	4.84	1.20	NA	15.56	090
43831		A	Place gastrostomy tube	7.83	NA	4.51	0.99	NA	13.33	090
43832		A	Place gastrostomy tube	15.58	NA	6.84	1.93	NA	24.35	090
43840		A	Repair of stomach lesion	15.54	NA	6.76	2.02	NA	24.32	090
43842		A	V-band gastroplasty	18.44	NA	7.79	2.42	NA	28.65	090
43843		A	Gastroplasty w/o v-band	18.62	NA	7.76	2.43	NA	28.81	090
43845		C	Gastroplasty duodenal switch	0.00	0.00	0.00	0.00	0.00	0.00	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43846		A	Gastric bypass for obesity	24.01	NA	10.02	3.13	NA	37.16	090
43847		A	Gastric bypass incl small i	26.88	NA	10.89	3.51	NA	41.28	090
43848		A	Revision gastroplasty	29.35	NA	11.81	3.83	NA	44.99	090
43850		A	Revise stomach-bowel fusion	24.68	NA	9.81	3.18	NA	37.67	090
43855		A	Revise stomach-bowel fusion	26.12	NA	10.32	3.43	NA	39.87	090
43860		A	Revise stomach-bowel fusion	24.96	NA	9.96	3.25	NA	38.17	090
43865		A	Revise stomach-bowel fusion	26.48	NA	10.50	3.44	NA	40.42	090
43870		A	Repair stomach opening	9.68	NA	4.51	1.23	NA	15.42	090
43880		A	Repair stomach-bowel fistula	24.61	NA	9.89	3.18	NA	37.68	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	16.21	NA	6.71	2.08	NA	25.00	090
44010		A	Incision of small bowel	12.50	NA	5.44	1.60	NA	19.54	090
44015		A	Insert needle cath bowel	2.62	NA	0.88	0.34	NA	3.84	ZZZ
44020		A	Explore small intestine	13.97	NA	5.93	1.79	NA	21.69	090
44021		A	Decompress small bowel	14.06	NA	5.96	1.79	NA	21.81	090
44025		A	Incision of large bowel	14.26	NA	6.02	1.79	NA	22.07	090
44050		A	Reduce bowel obstruction	14.01	NA	5.95	1.81	NA	21.77	090
44055		A	Correct malrotation of bowel	21.97	NA	8.72	2.81	NA	33.50	090
44100		A	Biopsy of bowel	2.01	NA	0.71	0.17	NA	2.89	000
44110		A	Excise intestine lesion(s)	11.79	NA	5.22	1.51	NA	18.52	090
44111		A	Excision of bowel lesion(s)	14.27	NA	6.10	1.83	NA	22.20	090
44120		A	Removal of small intestine	16.97	NA	7.07	2.19	NA	26.23	090
44121		A	Removal of small intestine	4.44	NA	1.52	0.57	NA	6.53	ZZZ
44125		A	Removal of small intestine	17.51	NA	7.25	2.23	NA	26.99	090
44126		A	Enterectomy w/o taper, cong	35.45	NA	14.11	4.66	NA	54.22	090
44127		A	Enterectomy w/taper, cong	40.94	NA	15.71	5.70	NA	62.35	090
44128		A	Enterectomy cong, add-on	4.44	NA	1.53	0.61	NA	6.58	ZZZ
44130		A	Bowel to bowel fusion	14.47	NA	6.21	1.84	NA	22.52	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	0.76	0.28	NA	3.27	ZZZ
44140		A	Partial removal of colon	20.97	NA	8.64	2.67	NA	32.28	090
44141		A	Partial removal of colon	19.48	NA	10.04	2.49	NA	32.01	090
44143		A	Partial removal of colon	22.96	NA	10.68	2.95	NA	36.59	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44144		A	Partial removal of colon	21.50	NA	9.61	2.77	NA	33.88	090
44145		A	Partial removal of colon	26.38	NA	10.80	3.24	NA	40.42	090
44146		A	Partial removal of colon	27.50	NA	12.85	3.37	NA	43.72	090
44147		A	Partial removal of colon	20.68	NA	8.68	2.51	NA	31.87	090
44150		A	Removal of colon	23.91	NA	12.02	3.00	NA	38.93	090
44151		A	Removal of colon/ileostomy	26.84	NA	13.39	3.44	NA	43.67	090
44152		A	Removal of colon/ileostomy	27.79	NA	11.59	3.47	NA	42.85	090
44153		A	Removal of colon/ileostomy	30.54	NA	14.37	3.52	NA	48.43	090
44155		A	Removal of colon/ileostomy	27.82	NA	13.30	3.24	NA	44.36	090
44156		A	Removal of colon/ileostomy	30.74	NA	15.03	3.94	NA	49.71	090
44160		A	Removal of colon	18.59	NA	7.74	2.33	NA	28.66	090
44200		A	Laparoscopy, enterolysis	14.42	NA	6.19	1.85	NA	22.46	090
44201		A	Laparoscopy, jejunostomy	9.77	NA	4.66	1.27	NA	15.70	090
44202		A	Lap resect s/intestine singl	22.01	NA	8.92	2.81	NA	33.74	090
44203		A	Lap resect s/intestine, addl	4.44	NA	1.50	0.57	NA	6.51	ZZZ
44204		A	Laparo partial colectomy	25.04	NA	9.95	3.07	NA	38.06	090
44205		A	Lap colectomy part w/ileum	22.20	NA	8.84	2.71	NA	33.75	090
44206		A	Lap part colectomy w/stoma	26.96	NA	11.25	3.41	NA	41.62	090
44207		A	L colectomy/coloproctostomy	29.96	NA	11.48	3.63	NA	45.07	090
44208		A	L colectomy/coloproctostomy	31.95	NA	13.13	3.84	NA	48.92	090
44210		A	Laparo total proctocolectomy	27.96	NA	11.87	3.39	NA	43.22	090
44211		A	Laparo total proctocolectomy	34.95	NA	14.67	4.14	NA	53.76	090
44212		A	Laparo total proctocolectomy	32.45	NA	13.68	3.66	NA	49.79	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44239		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	12.09	NA	5.48	1.56	NA	19.13	090
44310		A	Ileostomy/jejunostomy	15.93	NA	6.69	1.95	NA	24.57	090
44312		A	Revision of ileostomy	8.01	NA	3.99	0.93	NA	12.93	090
44314		A	Revision of ileostomy	15.03	NA	6.55	1.73	NA	23.31	090
44316		A	Devise bowel pouch	21.06	NA	8.54	2.36	NA	31.96	090
44320		A	Colostomy	17.61	NA	7.65	2.23	NA	27.49	090
44322		A	Colostomy with biopsies	11.96	NA	8.57	1.53	NA	22.06	090
44340		A	Revision of colostomy	7.71	NA	4.26	0.98	NA	12.95	090
44345		A	Revision of colostomy	15.41	NA	6.88	1.94	NA	24.23	090
44346		A	Revision of colostomy	16.96	NA	7.38	2.09	NA	26.43	090
44360		A	Small bowel endoscopy	2.59	NA	1.10	0.19	NA	3.88	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	1.20	0.21	NA	4.28	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44363		A	Small bowel endoscopy	3.49	NA	1.38	0.27	NA	5.14	000
44364		A	Small bowel endoscopy	3.73	NA	1.49	0.27	NA	5.49	000
44365		A	Small bowel endoscopy	3.31	NA	1.36	0.24	NA	4.91	000
44366		A	Small bowel endoscopy	4.40	NA	1.73	0.32	NA	6.45	000
44369		A	Small bowel endoscopy	4.51	NA	1.73	0.33	NA	6.57	000
44370		A	Small bowel endoscopy/stent	4.79	NA	1.97	0.37	NA	7.13	000
44372		A	Small bowel endoscopy	4.40	NA	1.73	0.35	NA	6.48	000
44373		A	Small bowel endoscopy	3.49	NA	1.42	0.27	NA	5.18	000
44376		A	Small bowel endoscopy	5.25	NA	2.02	0.43	NA	7.70	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	2.13	0.40	NA	8.05	000
44378		A	Small bowel endoscopy	7.12	NA	2.69	0.53	NA	10.34	000
44379		A	S bowel endoscope w/stent	7.46	NA	2.91	0.62	NA	10.99	000
44380		A	Small bowel endoscopy	1.05	NA	0.55	0.08	NA	1.68	000
44382		A	Small bowel endoscopy	1.27	NA	0.63	0.12	NA	2.02	000
44383		A	Ileoscopy w/stent	2.94	NA	1.27	0.22	NA	4.43	000
44385		A	Endoscopy of bowel pouch	1.82	3.35	0.75	0.15	5.32	2.72	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.64	0.88	0.19	8.95	3.19	000
44388		A	Colonoscopy	2.82	5.08	1.15	0.26	8.16	4.23	000
44389		A	Colonoscopy with biopsy	3.13	6.62	1.27	0.27	10.02	4.67	000
44390		A	Colonoscopy for foreign body	3.82	7.11	1.49	0.32	11.25	5.63	000
44391		A	Colonoscopy for bleeding	4.31	8.72	1.69	0.34	13.37	6.34	000
44392		A	Colonoscopy & polypectomy	3.81	6.58	1.49	0.34	10.73	5.64	000
44393		A	Colonoscopy, lesion removal	4.83	6.90	1.86	0.42	12.15	7.11	000
44394		A	Colonoscopy w/snare	4.42	7.81	1.72	0.38	12.61	6.52	000
44397		A	Colonoscopy w/stent	4.70	NA	1.79	0.39	NA	6.88	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.16	0.03	NA	0.68	000
44602		A	Suture, small intestine	16.01	NA	6.39	2.05	NA	24.45	090
44603		A	Suture, small intestine	18.63	NA	7.27	2.38	NA	28.28	090
44604		A	Suture, large intestine	16.01	NA	6.45	2.04	NA	24.50	090
44605		A	Repair of bowel lesion	19.50	NA	8.39	2.48	NA	30.37	090
44615		A	Intestinal stricturoplasty	15.91	NA	6.67	2.01	NA	24.59	090
44620		A	Repair bowel opening	12.18	NA	5.32	1.51	NA	19.01	090
44625		A	Repair bowel opening	15.03	NA	6.30	1.83	NA	23.16	090
44626		A	Repair bowel opening	25.32	NA	9.81	3.22	NA	38.35	090
44640		A	Repair bowel-skin fistula	21.62	NA	8.57	2.72	NA	32.91	090
44650		A	Repair bowel fistula	22.54	NA	8.88	2.84	NA	34.26	090
44660		A	Repair bowel-bladder fistula	21.33	NA	8.34	2.12	NA	31.79	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
44661		A	Repair bowel-bladder fistula	24.77	NA	9.55	2.79	NA	37.11	090
44680		A	Surgical revision, intestine	15.38	NA	6.44	1.89	NA	23.71	090
44700		A	Suspend bowel w/prosthesis	16.09	NA	6.66	1.80	NA	24.55	090
44701		A	Intraop colon lavage add-on	3.10	NA	1.06	0.37	NA	4.53	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.71	0.37	NA	7.08	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.39	0.97	NA	10.36	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.21	NA	5.38	1.42	NA	18.01	090
44820		A	Excision of mesentery lesion	12.07	NA	5.48	1.53	NA	19.08	090
44850		A	Repair of mesentery	10.72	NA	5.00	1.37	NA	17.09	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	10.12	NA	4.69	1.29	NA	16.10	090
44901		A	Drain app abscess, percut	3.37	27.89	1.11	0.23	31.49	4.71	000
44950		A	Appendectomy	9.99	NA	4.31	1.30	NA	15.60	090
44955		A	Appendectomy add-on	1.53	NA	0.54	0.19	NA	2.26	ZZZ
44960		A	Appendectomy	12.32	NA	5.33	1.61	NA	19.26	090
44970		A	Laparoscopy, appendectomy	8.69	NA	4.08	1.13	NA	13.90	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	4.51	NA	2.96	0.51	NA	7.98	090
45005		A	Drainage of rectal abscess	1.99	4.05	1.58	0.24	6.28	3.81	010
45020		A	Drainage of rectal abscess	4.71	NA	3.27	0.54	NA	8.52	090
45100		A	Biopsy of rectum	3.67	NA	2.36	0.42	NA	6.45	090
45108		A	Removal of anorectal lesion	4.75	NA	2.77	0.58	NA	8.10	090
45110		A	Removal of rectum	27.96	NA	12.39	3.32	NA	43.67	090
45111		A	Partial removal of rectum	16.46	NA	7.16	2.04	NA	25.66	090
45112		A	Removal of rectum	30.49	NA	11.76	3.38	NA	45.63	090
45113		A	Partial proctectomy	30.53	NA	12.59	3.37	NA	46.49	090
45114		A	Partial removal of rectum	27.28	NA	10.87	3.31	NA	41.46	090
45116		A	Partial removal of rectum	24.54	NA	10.02	2.91	NA	37.47	090
45119		A	Remove rectum w/reservoir	30.79	NA	12.45	3.31	NA	46.55	090
45120		A	Removal of rectum	24.56	NA	10.12	2.86	NA	37.54	090
45121		A	Removal of rectum and colon	27.00	NA	11.10	3.21	NA	41.31	090
45123		A	Partial proctectomy	16.68	NA	6.85	1.83	NA	25.36	090
45126		A	Pelvic exenteration	45.09	NA	19.20	4.27	NA	68.56	090
45130		A	Excision of rectal prolapse	16.42	NA	6.76	1.76	NA	24.94	090
45135		A	Excision of rectal prolapse	19.25	NA	8.41	2.34	NA	30.00	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
45136		A	Excise ileoanal reservior	27.26	NA	12.51	2.71	NA	42.48	090
45150		A	Excision of rectal stricture	5.66	NA	2.96	0.59	NA	9.21	090
45160		A	Excision of rectal lesion	15.30	NA	6.64	1.66	NA	23.60	090
45170		A	Excision of rectal lesion	11.47	NA	5.23	1.34	NA	18.04	090
45190		A	Destruction, rectal tumor	9.73	NA	4.62	1.09	NA	15.44	090
45300		A	Proctosigmoidoscopy dx	0.38	1.53	0.28	0.04	1.95	0.70	000
45303		A	Proctosigmoidoscopy dilate	0.44	18.68	0.33	0.05	19.17	0.82	000
45305		A	Proctosigmoidoscopy w/bx	1.01	2.63	0.50	0.11	3.75	1.62	000
45307		A	Proctosigmoidoscopy fb	0.94	3.03	0.48	0.11	4.08	1.53	000
45308		A	Proctosigmoidoscopy removal	0.83	1.99	0.44	0.09	2.91	1.36	000
45309		A	Proctosigmoidoscopy removal	2.01	2.81	0.84	0.22	5.04	3.07	000
45315		A	Proctosigmoidoscopy removal	1.40	2.86	0.63	0.15	4.41	2.18	000
45317		A	Proctosigmoidoscopy bleed	1.50	2.43	0.66	0.15	4.08	2.31	000
45320		A	Proctosigmoidoscopy ablate	1.58	2.91	0.71	0.16	4.65	2.45	000
45321		A	Proctosigmoidoscopy volvul	1.17	NA	0.56	0.13	NA	1.86	000
45327		A	Proctosigmoidoscopy w/stent	1.65	NA	0.69	0.16	NA	2.50	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.27	0.50	0.08	3.31	1.54	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.07	0.59	0.09	4.31	1.83	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.00	0.80	0.16	6.95	2.75	000
45333		A	Sigmoidoscopy & polypectomy	1.79	4.87	0.80	0.15	6.81	2.74	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	1.14	0.21	NA	4.08	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	3.21	0.69	0.11	4.78	2.26	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	1.00	0.21	NA	3.57	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.21	1.00	0.19	7.74	3.53	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	3.46	1.28	0.26	6.86	4.68	000
45340		A	Sig w/balloon dilation	1.89	6.17	0.83	0.15	8.21	2.87	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	1.07	0.20	NA	3.87	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	1.54	0.30	NA	5.89	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	1.16	0.23	NA	4.31	000
45355		A	Surgical colonoscopy	3.51	NA	1.38	0.35	NA	5.24	000
45378		A	Diagnostic colonoscopy	3.69	6.14	1.47	0.30	10.13	5.46	000
45378	53	A	Diagnostic colonoscopy	0.96	2.27	0.50	0.08	3.31	1.54	000
45379		A	Colonoscopy w/fb removal	4.68	7.66	1.81	0.39	12.73	6.88	000
45380		A	Colonoscopy and biopsy	4.43	7.19	1.73	0.35	11.97	6.51	000
45381		A	Colonoscopy, submucous inj	4.19	7.11	1.65	0.32	11.62	6.16	000
45382		A	Colonoscopy/control bleeding	5.68	9.94	2.18	0.43	16.05	8.29	000
45383		A	Lesion removal colonoscopy	5.86	7.92	2.22	0.48	14.26	8.56	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
45384		A	Lesion remove colonoscopy	4.69	6.80	1.82	0.38	11.87	6.89	000
45385		A	Lesion removal colonoscopy	5.30	7.80	2.03	0.42	13.52	7.75	000
45386		A	Colonoscopy dilate stricture	4.57	12.40	1.78	0.39	17.36	6.74	000
45387		A	Colonoscopy w/stent	5.90	NA	2.33	0.48	NA	8.71	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	1.97	0.42	NA	7.48	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	2.48	0.42	NA	9.44	000
45500		A	Repair of rectum	7.28	NA	3.53	0.73	NA	11.54	090
45505		A	Repair of rectum	7.57	NA	3.85	0.85	NA	12.27	090
45520		A	Treatment of rectal prolapse	0.55	1.64	0.37	0.05	2.24	0.97	000
45540		A	Correct rectal prolapse	16.25	NA	6.79	1.82	NA	24.86	090
45541		A	Correct rectal prolapse	13.38	NA	5.94	1.55	NA	20.87	090
45550		A	Repair rectum/remove sigmoid	22.97	NA	9.21	2.58	NA	34.76	090
45560		A	Repair of rectocele	10.56	NA	5.05	1.13	NA	16.74	090
45562		A	Exploration/repair of rectum	15.36	NA	6.98	1.81	NA	24.15	090
45563		A	Exploration/repair of rectum	23.43	NA	10.51	3.04	NA	36.98	090
45800		A	Repair rect/bladder fistula	17.74	NA	7.42	1.83	NA	26.99	090
45805		A	Repair fistula w/colostomy	20.75	NA	9.50	2.06	NA	32.31	090
45820		A	Repair rectourethral fistula	18.45	NA	7.62	1.59	NA	27.66	090
45825		A	Repair fistula w/colostomy	21.22	NA	9.81	2.29	NA	33.32	090
45900		A	Reduction of rectal prolapse	2.61	NA	1.50	0.30	NA	4.41	010
45905		A	Dilation of anal sphincter	2.30	NA	1.43	0.27	NA	4.00	010
45910		A	Dilation of rectal narrowing	2.80	NA	1.66	0.29	NA	4.75	010
45915		A	Remove rectal obstruction	3.14	4.32	2.09	0.30	7.76	5.53	010
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.90	2.33	1.85	0.31	5.54	5.06	010
46030		A	Removal of rectal marker	1.23	1.35	0.71	0.13	2.71	2.07	010
46040		A	Incision of rectal abscess	4.95	5.49	3.58	0.60	11.04	9.13	090
46045		A	Incision of rectal abscess	4.31	NA	2.89	0.53	NA	7.73	090
46050		A	Incision of anal abscess	1.19	2.54	0.84	0.13	3.86	2.16	010
46060		A	Incision of rectal abscess	5.68	NA	3.24	0.66	NA	9.58	090
46070		A	Incision of anal septum	2.71	NA	1.83	0.35	NA	4.89	090
46080		A	Incision of anal sphincter	2.49	2.36	1.13	0.30	5.15	3.92	010
46083		A	Incise external hemorrhoid	1.40	2.52	0.92	0.15	4.07	2.47	010
46200		A	Removal of anal fissure	3.41	3.85	2.86	0.38	7.64	6.65	090
46210		A	Removal of anal crypt	2.67	5.11	2.62	0.31	8.09	5.60	090
46211		A	Removal of anal crypts	4.24	5.40	3.50	0.47	10.11	8.21	090
46220		A	Removal of anal tag	1.56	2.29	0.95	0.17	4.02	2.68	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
46221		A	Ligation of hemorrhoid(s)	2.04	2.64	1.74	0.22	4.90	4.00	010
46230		A	Removal of anal tags	2.57	3.07	1.29	0.29	5.93	4.15	010
46250		A	Hemorrhoidectomy	3.88	5.30	2.61	0.47	9.65	6.96	090
46255		A	Hemorrhoidectomy	4.59	5.83	2.83	0.56	10.98	7.98	090
46257		A	Remove hemorrhoids & fissure	5.39	NA	2.87	0.63	NA	8.89	090
46258		A	Remove hemorrhoids & fistula	5.72	NA	3.27	0.68	NA	9.67	090
46260		A	Hemorrhoidectomy	6.36	NA	3.18	0.75	NA	10.29	090
46261		A	Remove hemorrhoids & fissure	7.07	NA	3.60	0.79	NA	11.46	090
46262		A	Remove hemorrhoids & fistula	7.49	NA	3.73	0.82	NA	12.04	090
46270		A	Removal of anal fistula	3.71	4.99	2.83	0.46	9.16	7.00	090
46275		A	Removal of anal fistula	4.55	4.63	2.97	0.52	9.70	8.04	090
46280		A	Removal of anal fistula	5.97	NA	3.25	0.66	NA	9.88	090
46285		A	Removal of anal fistula	4.08	3.76	2.74	0.43	8.27	7.25	090
46288		A	Repair anal fistula	7.12	NA	3.67	0.79	NA	11.58	090
46320		A	Removal of hemorrhoid clot	1.61	2.12	0.85	0.18	3.91	2.64	010
46500		A	Injection into hemorrhoid(s)	1.61	2.11	1.15	0.16	3.88	2.92	010
46600		A	Diagnostic anoscopy	0.50	1.56	0.34	0.05	2.11	0.89	000
46604		A	Anoscopy and dilation	1.31	9.12	0.62	0.12	10.55	2.05	000
46606		A	Anoscopy and biopsy	0.81	3.78	0.43	0.09	4.68	1.33	000
46608		A	Anoscopy, remove for body	1.51	4.40	0.65	0.16	6.07	2.32	000
46610		A	Anoscopy, remove lesion	1.32	4.03	0.61	0.15	5.50	2.08	000
46611		A	Anoscopy	1.81	3.33	0.78	0.19	5.33	2.78	000
46612		A	Anoscopy, remove lesions	2.34	5.18	0.98	0.27	7.79	3.59	000
46614		A	Anoscopy, control bleeding	2.01	2.32	0.84	0.20	4.53	3.05	000
46615		A	Anoscopy	2.68	2.48	1.07	0.32	5.48	4.07	000
46700		A	Repair of anal stricture	9.12	NA	4.20	0.93	NA	14.25	090
46705		A	Repair of anal stricture	6.89	NA	3.68	0.90	NA	11.47	090
46706		A	Repr of anal fistula w/glue	2.39	NA	1.25	0.27	NA	3.91	010
46715		A	Rep perf anoper fistu	7.19	NA	3.57	0.92	NA	11.68	090
46716		A	Rep perf anoper/vestib fistu	15.05	NA	7.97	1.57	NA	24.59	090
46730		A	Construction of absent anus	26.71	NA	12.02	2.45	NA	41.18	090
46735		A	Construction of absent anus	32.12	NA	13.54	3.18	NA	48.84	090
46740		A	Construction of absent anus	29.96	NA	13.22	2.40	NA	45.58	090
46742		A	Repair of imperforated anus	35.75	NA	17.38	3.17	NA	56.30	090
46744		A	Repair of cloacal anomaly	52.55	NA	21.11	6.33	NA	79.99	090
46746		A	Repair of cloacal anomaly	58.13	NA	25.14	7.62	NA	90.89	090
46748		A	Repair of cloacal anomaly	64.11	NA	23.63	3.34	NA	91.08	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
46750		A	Repair of anal sphincter	10.23	NA	5.05	1.09	NA	16.37	090
46751		A	Repair of anal sphincter	8.76	NA	5.41	0.94	NA	15.11	090
46753		A	Reconstruction of anus	8.28	NA	3.84	0.94	NA	13.06	090
46754		A	Removal of suture from anus	2.20	3.59	1.67	0.19	5.98	4.06	010
46760		A	Repair of anal sphincter	14.41	NA	7.08	1.56	NA	23.05	090
46761		A	Repair of anal sphincter	13.82	NA	6.00	1.41	NA	21.23	090
46762		A	Implant artificial sphincter	12.69	NA	5.51	1.23	NA	19.43	090
46900		A	Destruction, anal lesion(s)	1.91	2.58	1.27	0.17	4.66	3.35	010
46910		A	Destruction, anal lesion(s)	1.86	2.90	1.06	0.18	4.94	3.10	010
46916		A	Cryosurgery, anal lesion(s)	1.86	3.15	1.39	0.11	5.12	3.36	010
46917		A	Laser surgery, anal lesions	1.86	9.12	1.12	0.21	11.19	3.19	010
46922		A	Excision of anal lesion(s)	1.86	3.27	1.07	0.21	5.34	3.14	010
46924		A	Destruction, anal lesion(s)	2.76	8.68	1.35	0.26	11.70	4.37	010
46934		A	Destruction of hemorrhoids	3.50	5.07	2.95	0.31	8.88	6.76	090
46935		A	Destruction of hemorrhoids	2.43	3.46	1.21	0.23	6.12	3.87	010
46936		A	Destruction of hemorrhoids	3.68	4.87	2.49	0.34	8.89	6.51	090
46937		A	Cryotherapy of rectal lesion	2.69	2.77	1.22	0.14	5.60	4.05	010
46938		A	Cryotherapy of rectal lesion	4.65	3.99	3.05	0.58	9.22	8.28	090
46940		A	Treatment of anal fissure	2.32	1.99	1.09	0.22	4.53	3.63	010
46942		A	Treatment of anal fissure	2.04	1.83	1.02	0.19	4.06	3.25	010
46945		A	Ligation of hemorrhoids	1.84	3.26	2.47	0.19	5.29	4.50	090
46946		A	Ligation of hemorrhoids	2.58	3.72	2.39	0.26	6.56	5.23	090
46947		A	Hemorrhoidopexy by stapling	5.20	NA	2.71	0.75	NA	8.66	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	3.07	0.63	0.12	5.09	2.65	000
47001		A	Needle biopsy, liver add-on	1.90	NA	0.65	0.24	NA	2.79	ZZZ
47010		A	Open drainage, liver lesion	15.99	NA	8.39	1.77	NA	26.15	090
47011		A	Percut drain, liver lesion	3.69	NA	1.21	0.22	NA	5.12	000
47015		A	Inject/aspirate liver cyst	15.09	NA	7.48	1.79	NA	24.36	090
47100		A	Wedge biopsy of liver	11.65	NA	6.03	1.50	NA	19.18	090
47120		A	Partial removal of liver	35.45	NA	15.14	4.54	NA	55.13	090
47122		A	Extensive removal of liver	55.05	NA	21.44	7.10	NA	83.59	090
47125		A	Partial removal of liver	49.12	NA	19.50	6.17	NA	74.79	090
47130		A	Partial removal of liver	53.27	NA	20.96	6.76	NA	80.99	090
47133		X	Removal of donor liver	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47135		R	Transplantation of liver	81.40	NA	31.50	9.65	NA	122.55	090
47136		R	Transplantation of liver	68.50	NA	27.01	8.36	NA	103.87	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
47140		A	Partial removal, donor liver	54.92	NA	22.27	5.13	NA	82.32	090
47141		A	Partial removal, donor liver	67.40	NA	26.90	5.13	NA	99.43	090
47142		A	Partial removal, donor liver	74.89	NA	29.46	5.13	NA	109.48	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	0.00	0.00	090
47146		A	Prep donor liver/venous	6.00	NA	2.05	0.83	NA	8.88	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.39	0.97	NA	10.36	XXX
47300		A	Surgery for liver lesion	15.06	NA	7.22	1.92	NA	24.20	090
47350		A	Repair liver wound	19.53	NA	8.86	2.51	NA	30.90	090
47360		A	Repair liver wound	26.88	NA	11.57	3.31	NA	41.76	090
47361		A	Repair liver wound	47.05	NA	18.51	5.79	NA	71.35	090
47362		A	Repair liver wound	18.48	NA	8.71	2.39	NA	29.58	090
47370		A	Laparo ablate liver tumor rf	19.66	NA	8.13	2.46	NA	30.25	090
47371		A	Laparo ablate liver cryosurg	19.66	NA	8.14	2.58	NA	30.38	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	22.97	NA	9.35	2.78	NA	35.10	090
47381		A	Open ablate liver tumor cryo	23.24	NA	9.58	2.81	NA	35.63	090
47382		A	Percut ablate liver rf	15.17	NA	6.07	0.97	NA	22.21	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	32.44	NA	13.43	3.11	NA	48.98	090
47420		A	Incision of bile duct	19.85	NA	8.75	2.59	NA	31.19	090
47425		A	Incision of bile duct	19.80	NA	8.80	2.57	NA	31.17	090
47460		A	Incise bile duct sphincter	18.01	NA	8.36	2.10	NA	28.47	090
47480		A	Incision of gallbladder	10.80	NA	5.90	1.39	NA	18.09	090
47490		A	Incision of gallbladder	7.22	NA	5.56	0.44	NA	13.22	090
47500		A	Injection for liver x-rays	1.96	NA	0.64	0.12	NA	2.72	000
47505		A	Injection for liver x-rays	0.76	NA	0.25	0.05	NA	1.06	000
47510		A	Insert catheter, bile duct	7.82	NA	5.01	0.48	NA	13.31	090
47511		A	Insert bile duct drain	10.48	NA	5.08	0.63	NA	16.19	090
47525		A	Change bile duct catheter	5.54	15.09	2.80	0.33	20.96	8.67	010
47530		A	Revise/reinsert bile tube	5.84	33.78	3.71	0.37	39.99	9.92	090
47550		A	Bile duct endoscopy add-on	3.02	NA	1.02	0.39	NA	4.43	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	2.37	0.43	NA	8.83	000
47553		A	Biliary endoscopy thru skin	6.34	NA	2.06	0.40	NA	8.80	000
47554		A	Biliary endoscopy thru skin	9.05	NA	3.35	0.95	NA	13.35	000
47555		A	Biliary endoscopy thru skin	7.55	NA	2.46	0.45	NA	10.46	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
47556		A	Biliary endoscopy thru skin	8.55	NA	2.78	0.51	NA	11.84	000
47560		A	Laparoscopy w/cholangio	4.88	NA	1.67	0.64	NA	7.19	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	1.91	0.64	NA	7.72	000
47562		A	Laparoscopic cholecystectomy	11.07	NA	4.98	1.44	NA	17.49	090
47563		A	Laparo cholecystectomy/graph	11.92	NA	5.29	1.56	NA	18.77	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	5.94	1.86	NA	22.01	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	5.36	1.63	NA	19.55	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	13.56	NA	6.12	1.77	NA	21.45	090
47605		A	Removal of gallbladder	14.67	NA	6.49	1.92	NA	23.08	090
47610		A	Removal of gallbladder	18.79	NA	7.92	2.45	NA	29.16	090
47612		A	Removal of gallbladder	18.75	NA	7.87	2.46	NA	29.08	090
47620		A	Removal of gallbladder	20.61	NA	8.51	2.70	NA	31.82	090
47630		A	Remove bile duct stone	9.10	NA	4.88	0.65	NA	14.63	090
47700		A	Exploration of bile ducts	15.60	NA	7.40	2.02	NA	25.02	090
47701		A	Bile duct revision	27.77	NA	11.47	3.64	NA	42.88	090
47711		A	Excision of bile duct tumor	23.00	NA	9.91	3.01	NA	35.92	090
47712		A	Excision of bile duct tumor	30.19	NA	12.40	3.87	NA	46.46	090
47715		A	Excision of bile duct cyst	18.77	NA	8.42	2.45	NA	29.64	090
47716		A	Fusion of bile duct cyst	16.42	NA	7.81	2.12	NA	26.35	090
47720		A	Fuse gallbladder & bowel	15.89	NA	7.46	2.08	NA	25.43	090
47721		A	Fuse upper gi structures	19.09	NA	8.55	2.48	NA	30.12	090
47740		A	Fuse gallbladder & bowel	18.45	NA	8.36	2.35	NA	29.16	090
47741		A	Fuse gallbladder & bowel	21.31	NA	9.27	2.81	NA	33.39	090
47760		A	Fuse bile ducts and bowel	25.81	NA	10.83	3.37	NA	40.01	090
47765		A	Fuse liver ducts & bowel	24.84	NA	10.78	3.24	NA	38.86	090
47780		A	Fuse bile ducts and bowel	26.46	NA	11.19	3.43	NA	41.08	090
47785		A	Fuse bile ducts and bowel	31.13	NA	12.89	3.99	NA	48.01	090
47800		A	Reconstruction of bile ducts	23.27	NA	10.04	2.98	NA	36.29	090
47801		A	Placement, bile duct support	15.15	NA	8.14	1.16	NA	24.45	090
47802		A	Fuse liver duct & intestine	21.52	NA	9.65	2.82	NA	33.99	090
47900		A	Suture bile duct injury	19.87	NA	8.85	2.63	NA	31.35	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	28.03	NA	11.49	3.37	NA	42.89	090
48001		A	Placement of drain, pancreas	35.40	NA	13.86	4.60	NA	53.86	090
48005		A	Resect/debride pancreas	42.11	NA	16.54	5.45	NA	64.10	090
48020		A	Removal of pancreatic stone	15.68	NA	7.29	2.10	NA	25.07	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
48100		A	Biopsy of pancreas, open	12.21	NA	5.58	1.56	NA	19.35	090
48102		A	Needle biopsy, pancreas	4.67	7.95	1.94	0.29	12.91	6.90	010
48120		A	Removal of pancreas lesion	15.83	NA	6.84	2.06	NA	24.73	090
48140		A	Partial removal of pancreas	22.91	NA	9.52	2.97	NA	35.40	090
48145		A	Partial removal of pancreas	23.98	NA	9.81	3.15	NA	36.94	090
48146		A	Pancreatectomy	26.36	NA	11.97	3.45	NA	41.78	090
48148		A	Removal of pancreatic duct	17.31	NA	7.59	2.22	NA	27.12	090
48150		A	Partial removal of pancreas	47.93	NA	19.48	6.23	NA	73.64	090
48152		A	Pancreatectomy	43.68	NA	18.18	5.77	NA	67.63	090
48153		A	Pancreatectomy	47.82	NA	19.52	6.26	NA	73.60	090
48154		A	Pancreatectomy	44.03	NA	18.21	5.77	NA	68.01	090
48155		A	Removal of pancreas	24.60	NA	11.65	3.20	NA	39.45	090
48160		N	Pancreas removal/transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48180		A	Fuse pancreas and bowel	24.68	NA	10.14	3.22	NA	38.04	090
48400		A	Injection, intraop add-on	1.95	NA	0.64	0.15	NA	2.74	ZZZ
48500		A	Surgery of pancreatic cyst	15.26	NA	7.32	2.00	NA	24.58	090
48510		A	Drain pancreatic pseudocyst	14.29	NA	7.43	1.78	NA	23.50	090
48511		A	Drain pancreatic pseudocyst	3.99	20.89	1.31	0.24	25.12	5.54	000
48520		A	Fuse pancreas cyst and bowel	15.57	NA	6.69	2.02	NA	24.28	090
48540		A	Fuse pancreas cyst and bowel	19.69	NA	8.10	2.53	NA	30.32	090
48545		A	Pancreatorrhaphy	18.15	NA	7.97	2.32	NA	28.44	090
48547		A	Duodenal exclusion	25.79	NA	10.47	3.33	NA	39.59	090
48550		X	Donor pancreatectomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.46	0.31	NA	6.07	XXX
48554		R	Transpl allograft pancreas	34.12	NA	18.25	4.13	NA	56.50	090
48556		A	Removal, allograft pancreas	15.69	NA	8.06	2.00	NA	25.75	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	11.66	NA	5.37	1.48	NA	18.51	090
49002		A	Reopening of abdomen	10.47	NA	5.01	1.34	NA	16.82	090
49010		A	Exploration behind abdomen	12.26	NA	5.89	1.51	NA	19.66	090
49020		A	Drain abdominal abscess	22.81	NA	10.18	2.75	NA	35.74	090
49021		A	Drain abdominal abscess	3.37	21.05	1.11	0.20	24.62	4.68	000
49040		A	Drain, open, abdom abscess	13.50	NA	6.41	1.65	NA	21.56	090
49041		A	Drain, percut, abdom abscess	3.99	19.51	1.31	0.24	23.74	5.54	000
49060		A	Drain, open, retrop abscess	15.84	NA	7.42	1.75	NA	25.01	090
49061		A	Drain, percut, retroper absc	3.69	19.62	1.21	0.22	23.53	5.12	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
49062		A	Drain to peritoneal cavity	11.34	NA	5.42	1.40	NA	18.16	090
49080		A	Puncture, peritoneal cavity	1.35	3.98	0.46	0.09	5.42	1.90	000
49081		A	Removal of abdominal fluid	1.26	2.58	0.43	0.09	3.93	1.78	000
49085		A	Remove abdomen foreign body	12.12	NA	5.49	1.55	NA	19.16	090
49180		A	Biopsy, abdominal mass	1.73	3.10	0.57	0.11	4.94	2.41	000
49200		A	Removal of abdominal lesion	10.23	NA	5.02	1.20	NA	16.45	090
49201		A	Remove abdom lesion, complex	14.82	NA	7.02	1.77	NA	23.61	090
49215		A	Excise sacral spine tumor	33.45	NA	14.04	4.24	NA	51.73	090
49220		A	Multiple surgery, abdomen	14.86	NA	6.62	1.88	NA	23.36	090
49250		A	Excision of umbilicus	8.34	NA	4.26	1.07	NA	13.67	090
49255		A	Removal of omentum	11.12	NA	5.60	1.40	NA	18.12	090
49320		A	Diag laparo separate proc	5.09	NA	2.63	0.63	NA	8.35	010
49321		A	Laparoscopy, biopsy	5.39	NA	2.64	0.69	NA	8.72	010
49322		A	Laparoscopy, aspiration	5.69	NA	2.99	0.71	NA	9.39	010
49323		A	Laparo drain lymphocele	9.47	NA	4.49	1.18	NA	15.14	090
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	3.07	0.62	0.15	5.10	2.65	000
49419		A	Insrt abdom cath for chemotx	6.64	NA	3.56	0.80	NA	11.00	090
49420		A	Insert abdom drain, temp	2.22	NA	1.09	0.21	NA	3.52	000
49421		A	Insert abdom drain, perm	5.53	NA	3.15	0.70	NA	9.38	090
49422		A	Remove perm cannula/catheter	6.24	NA	2.89	0.79	NA	9.92	010
49423		A	Exchange drainage catheter	1.46	14.07	0.52	0.09	15.62	2.07	000
49424		A	Assess cyst, contrast inject	0.76	3.71	0.29	0.05	4.52	1.10	000
49425		A	Insert abdomen-venous drain	11.35	NA	5.59	1.50	NA	18.44	090
49426		A	Revise abdomen-venous shunt	9.62	NA	4.76	1.25	NA	15.63	090
49427		A	Injection, abdominal shunt	0.89	NA	0.30	0.07	NA	1.26	000
49428		A	Ligation of shunt	6.05	NA	3.92	0.80	NA	10.77	010
49429		A	Removal of shunt	7.39	NA	3.42	1.00	NA	11.81	010
49491		A	Rpr hern preemie reduc	11.11	NA	5.05	1.40	NA	17.56	090
49492		A	Rpr ing hern premie, blocked	14.01	NA	6.10	1.78	NA	21.89	090
49495		A	Rpr ing hernia baby, reduc	5.88	NA	2.95	0.73	NA	9.56	090
49496		A	Rpr ing hernia baby, blocked	8.78	NA	4.27	1.07	NA	14.12	090
49500		A	Rpr ing hernia, init, reduce	5.47	NA	3.11	0.71	NA	9.29	090
49501		A	Rpr ing hernia, init blocked	8.87	NA	4.20	1.08	NA	14.15	090
49505		A	Prp i/hern init reduc >5 yr	7.59	NA	3.74	1.01	NA	12.34	090
49507		A	Prp i/hern init block >5 yr	9.56	NA	4.45	1.25	NA	15.26	090
49520		A	Rerepair ing hernia, reduce	9.62	NA	4.43	1.27	NA	15.32	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
49521		A	Rerepair ing hernia, blocked	11.95	NA	5.23	1.56	NA	18.74	090
49525		A	Repair ing hernia, sliding	8.56	NA	4.07	1.11	NA	13.74	090
49540		A	Repair lumbar hernia	10.37	NA	4.74	1.36	NA	16.47	090
49550		A	Rpr rem hernia, init, reduce	8.62	NA	4.12	1.13	NA	13.87	090
49553		A	Rpr fem hernia, init blocked	9.43	NA	4.41	1.23	NA	15.07	090
49555		A	Rerepair fem hernia, reduce	9.02	NA	4.26	1.18	NA	14.46	090
49557		A	Rerepair fem hernia, blocked	11.13	NA	4.98	1.46	NA	17.57	090
49560		A	Rpr ventral hern init, reduc	11.55	NA	5.14	1.50	NA	18.19	090
49561		A	Rpr ventral hern init, block	14.23	NA	6.05	1.85	NA	22.13	090
49565		A	Rerepair ventrl hern, reduce	11.55	NA	5.21	1.51	NA	18.27	090
49566		A	Rerepair ventrl hern, block	14.38	NA	6.12	1.87	NA	22.37	090
49568		A	Hernia repair w/mesh	4.88	NA	1.67	0.64	NA	7.19	ZZZ
49570		A	Rpr epigastric hern, reduce	5.68	NA	3.16	0.74	NA	9.58	090
49572		A	Rpr epigastric hern, blocked	6.72	NA	3.46	0.88	NA	11.06	090
49580		A	Rpr umbil hern, reduc < 5 yr	4.10	NA	2.59	0.50	NA	7.19	090
49582		A	Rpr umbil hern, block < 5 yr	6.64	NA	3.46	0.88	NA	10.98	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.22	NA	3.29	0.81	NA	10.32	090
49587		A	Rpr umbil hern, block > 5 yr	7.55	NA	3.73	0.98	NA	12.26	090
49590		A	Repair spigelian hernia	8.53	NA	4.08	1.11	NA	13.72	090
49600		A	Repair umbilical lesion	10.94	NA	5.32	1.32	NA	17.58	090
49605		A	Repair umbilical lesion	75.89	NA	28.50	9.29	NA	113.68	090
49606		A	Repair umbilical lesion	18.57	NA	7.68	2.42	NA	28.67	090
49610		A	Repair umbilical lesion	10.48	NA	5.19	1.07	NA	16.74	090
49611		A	Repair umbilical lesion	8.91	NA	6.97	0.78	NA	16.66	090
49650		A	Laparo hernia repair initial	6.26	NA	3.19	0.92	NA	10.37	090
49651		A	Laparo hernia repair recur	8.23	NA	4.04	1.13	NA	13.40	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.26	NA	6.22	1.55	NA	20.03	090
49904		A	Omental flap, extra-abdom	19.97	NA	15.21	2.63	NA	37.81	090
49905		A	Omental flap, intra-abdom	6.54	NA	2.29	0.77	NA	9.60	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	10.96	NA	5.21	0.94	NA	17.11	090
50020		A	Renal abscess, open drain	14.64	NA	7.74	1.28	NA	23.66	090
50021		A	Renal abscess, percut drain	3.37	21.65	1.10	0.20	25.22	4.67	000
50040		A	Drainage of kidney	14.92	NA	6.80	1.07	NA	22.79	090
50045		A	Exploration of kidney	15.44	NA	6.59	1.26	NA	23.29	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
50060		A	Removal of kidney stone	19.27	NA	7.82	1.36	NA	28.45	090
50065		A	Incision of kidney	20.76	NA	6.07	1.58	NA	28.41	090
50070		A	Incision of kidney	20.29	NA	8.21	1.43	NA	29.93	090
50075		A	Removal of kidney stone	25.30	NA	9.89	1.80	NA	36.99	090
50080		A	Removal of kidney stone	14.69	NA	6.27	1.04	NA	22.00	090
50081		A	Removal of kidney stone	21.77	NA	8.75	1.54	NA	32.06	090
50100		A	Revise kidney blood vessels	16.07	NA	7.78	2.02	NA	25.87	090
50120		A	Exploration of kidney	15.89	NA	6.76	1.22	NA	23.87	090
50125		A	Explore and drain kidney	16.50	NA	6.96	1.43	NA	24.89	090
50130		A	Removal of kidney stone	17.26	NA	7.16	1.22	NA	25.64	090
50135		A	Exploration of kidney	19.15	NA	7.77	1.37	NA	28.29	090
50200		A	Biopsy of kidney	2.63	NA	1.29	0.16	NA	4.08	000
50205		A	Biopsy of kidney	11.29	NA	5.01	1.30	NA	17.60	090
50220		A	Remove kidney, open	17.12	NA	7.23	1.38	NA	25.73	090
50225		A	Removal kidney open, complex	20.20	NA	8.14	1.50	NA	29.84	090
50230		A	Removal kidney open, radical	22.04	NA	8.57	1.59	NA	32.20	090
50234		A	Removal of kidney & ureter	22.37	NA	8.82	1.61	NA	32.80	090
50236		A	Removal of kidney & ureter	24.82	NA	10.24	1.75	NA	36.81	090
50240		A	Partial removal of kidney	21.97	NA	9.00	1.59	NA	32.56	090
50280		A	Removal of kidney lesion	15.65	NA	6.68	1.19	NA	23.52	090
50290		A	Removal of kidney lesion	14.71	NA	6.45	1.39	NA	22.55	090
50300		X	Remove cadaver donor kidney	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50320		A	Remove kidney, living donor	22.18	NA	10.65	2.36	NA	35.19	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.35	0.29	NA	5.64	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.18	0.26	NA	4.94	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.13	0.25	NA	4.72	XXX
50340		A	Removal of kidney	12.13	NA	6.49	1.64	NA	20.26	090
50360		A	Transplantation of kidney	31.48	NA	15.47	3.78	NA	50.73	090
50365		A	Transplantation of kidney	36.75	NA	18.19	4.39	NA	59.33	090
50370		A	Remove transplanted kidney	13.70	NA	7.14	1.65	NA	22.49	090
50380		A	Reimplantation of kidney	20.73	NA	12.02	2.41	NA	35.16	090
50390		A	Drainage of kidney lesion	1.96	NA	0.64	0.12	NA	2.72	000
50391		A	Instll rx agnt into rnal tub	1.96	1.58	0.63	0.14	3.68	2.73	000
50392		A	Insert kidney drain	3.37	NA	1.52	0.21	NA	5.10	000
50393		A	Insert ureteral tube	4.15	NA	1.78	0.25	NA	6.18	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
50394		A	Injection for kidney x-ray	0.76	2.68	0.66	0.05	3.49	1.47	000
50395		A	Create passage to kidney	3.37	NA	1.50	0.21	NA	5.08	000
50396		A	Measure kidney pressure	2.09	NA	1.08	0.13	NA	3.30	000
50398		A	Change kidney tube	1.46	16.31	0.52	0.09	17.86	2.07	000
50400		A	Revision of kidney/ureter	19.47	NA	7.87	1.40	NA	28.74	090
50405		A	Revision of kidney/ureter	23.89	NA	9.02	1.76	NA	34.67	090
50500		A	Repair of kidney wound	19.54	NA	8.38	2.00	NA	29.92	090
50520		A	Close kidney-skin fistula	17.20	NA	7.42	1.49	NA	26.11	090
50525		A	Repair renal-abdomen fistula	22.24	NA	8.99	1.82	NA	33.05	090
50526		A	Repair renal-abdomen fistula	23.98	NA	9.85	1.95	NA	35.78	090
50540		A	Revision of horseshoe kidney	19.90	NA	8.32	1.35	NA	29.57	090
50541		A	Laparo ablate renal cyst	15.98	NA	6.48	1.15	NA	23.61	090
50542		A	Laparo ablate renal mass	19.97	NA	8.13	1.39	NA	29.49	090
50543		A	Laparo partial nephrectomy	25.46	NA	10.19	1.84	NA	37.49	090
50544		A	Laparoscopy, pyeloplasty	22.37	NA	8.52	1.57	NA	32.46	090
50545		A	Laparo radical nephrectomy	23.96	NA	9.18	1.74	NA	34.88	090
50546		A	Laparoscopic nephrectomy	20.45	NA	8.36	1.56	NA	30.37	090
50547		A	Laparo removal donor kidney	25.46	NA	11.10	2.74	NA	39.30	090
50548		A	Laparo remove w/ureter	24.36	NA	9.17	1.74	NA	35.27	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	4.14	1.97	0.41	10.14	7.97	000
50553		A	Kidney endoscopy	5.98	4.36	2.17	0.39	10.73	8.54	000
50555		A	Kidney endoscopy & biopsy	6.52	4.81	2.33	0.46	11.79	9.31	000
50557		A	Kidney endoscopy & treatment	6.61	4.58	2.29	0.47	11.66	9.37	000
50561		A	Kidney endoscopy & treatment	7.58	5.08	2.64	0.54	13.20	10.76	000
50562		A	Renal scope w/tumor resect	10.90	NA	4.31	0.76	NA	15.97	090
50570		A	Kidney endoscopy	9.53	NA	3.21	0.68	NA	13.42	000
50572		A	Kidney endoscopy	10.33	NA	3.50	0.84	NA	14.67	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	3.74	0.79	NA	15.53	000
50575		A	Kidney endoscopy	13.96	NA	4.63	1.00	NA	19.59	000
50576		A	Kidney endoscopy & treatment	10.97	NA	3.66	0.78	NA	15.41	000
50580		A	Kidney endoscopy & treatment	11.84	NA	3.96	0.88	NA	16.68	000
50590		A	Fragmenting of kidney stone	9.08	12.39	4.11	0.65	22.12	13.84	090
50600		A	Exploration of ureter	15.82	NA	6.66	1.21	NA	23.69	090
50605		A	Insert ureteral support	15.44	NA	6.73	1.46	NA	23.63	090
50610		A	Removal of ureter stone	15.90	NA	6.96	1.38	NA	24.24	090
50620		A	Removal of ureter stone	15.14	NA	6.33	1.09	NA	22.56	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
50630		A	Removal of ureter stone	14.92	NA	6.27	1.11	NA	22.30	090
50650		A	Removal of ureter	17.38	NA	7.22	1.26	NA	25.86	090
50660		A	Removal of ureter	19.52	NA	7.95	1.43	NA	28.90	090
50684		A	Injection for ureter x-ray	0.76	4.97	0.47	0.05	5.78	1.28	000
50686		A	Measure ureter pressure	1.51	3.44	0.82	0.11	5.06	2.44	000
50688		A	Change of ureter tube	1.17	NA	1.06	0.07	NA	2.30	010
50690		A	Injection for ureter x-ray	1.16	1.82	0.72	0.07	3.05	1.95	000
50700		A	Revision of ureter	15.19	NA	7.11	1.28	NA	23.58	090
50715		A	Release of ureter	18.87	NA	8.73	2.11	NA	29.71	090
50722		A	Release of ureter	16.33	NA	7.80	1.88	NA	26.01	090
50725		A	Release/revise ureter	18.46	NA	8.04	1.51	NA	28.01	090
50727		A	Revise ureter	8.17	NA	4.27	0.62	NA	13.06	090
50728		A	Revise ureter	12.00	NA	5.55	1.01	NA	18.56	090
50740		A	Fusion of ureter & kidney	18.39	NA	7.73	1.96	NA	28.08	090
50750		A	Fusion of ureter & kidney	19.48	NA	7.98	1.38	NA	28.84	090
50760		A	Fusion of ureters	18.39	NA	7.67	1.58	NA	27.64	090
50770		A	Splicing of ureters	19.48	NA	7.97	1.48	NA	28.93	090
50780		A	Reimplant ureter in bladder	18.33	NA	7.58	1.53	NA	27.44	090
50782		A	Reimplant ureter in bladder	19.51	NA	8.76	1.58	NA	29.85	090
50783		A	Reimplant ureter in bladder	20.52	NA	8.21	1.97	NA	30.70	090
50785		A	Reimplant ureter in bladder	20.49	NA	8.29	1.56	NA	30.34	090
50800		A	Implant ureter in bowel	14.50	NA	6.46	1.20	NA	22.16	090
50810		A	Fusion of ureter & bowel	20.02	NA	9.08	2.30	NA	31.40	090
50815		A	Urine shunt to intestine	19.90	NA	8.44	1.60	NA	29.94	090
50820		A	Construct bowel bladder	21.86	NA	8.63	1.88	NA	32.37	090
50825		A	Construct bowel bladder	28.14	NA	11.12	2.08	NA	41.34	090
50830		A	Revise urine flow	31.23	NA	12.16	2.34	NA	45.73	090
50840		A	Replace ureter by bowel	19.97	NA	8.42	1.51	NA	29.90	090
50845		A	Appendico-vesicostomy	20.86	NA	8.89	1.53	NA	31.28	090
50860		A	Transplant ureter to skin	15.34	NA	6.61	1.30	NA	23.25	090
50900		A	Repair of ureter	13.60	NA	6.13	1.17	NA	20.90	090
50920		A	Closure ureter/skin fistula	14.31	NA	6.56	1.01	NA	21.88	090
50930		A	Closure ureter/bowel fistula	18.69	NA	7.96	1.28	NA	27.93	090
50940		A	Release of ureter	14.49	NA	6.39	1.26	NA	22.14	090
50945		A	Laparoscopy ureterolithotomy	16.97	NA	7.03	1.36	NA	25.36	090
50947		A	Laparo new ureter/bladder	24.46	NA	9.68	2.14	NA	36.28	090
50948		A	Laparo new ureter/bladder	22.47	NA	8.68	1.69	NA	32.84	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	4.29	2.05	0.42	10.54	8.30	000
50953		A	Endoscopy of ureter	6.23	4.40	2.36	0.44	11.07	9.03	000
50955		A	Ureter endoscopy & biopsy	6.74	6.41	2.68	0.48	13.63	9.90	000
50957		A	Ureter endoscopy & treatment	6.78	4.56	2.37	0.49	11.83	9.64	000
50961		A	Ureter endoscopy & treatment	6.04	4.36	2.18	0.41	10.81	8.63	000
50970		A	Ureter endoscopy	7.13	NA	2.46	0.52	NA	10.11	000
50972		A	Ureter endoscopy & catheter	6.88	NA	2.46	0.50	NA	9.84	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	3.10	0.64	NA	12.90	000
50976		A	Ureter endoscopy & treatment	9.03	NA	3.06	0.65	NA	12.74	000
50980		A	Ureter endoscopy & treatment	6.84	NA	2.37	0.50	NA	9.71	000
51000		A	Drainage of bladder	0.78	1.94	0.24	0.06	2.78	1.08	000
51005		A	Drainage of bladder	1.02	4.70	0.34	0.10	5.82	1.46	000
51010		A	Drainage of bladder	3.52	5.60	1.87	0.28	9.40	5.67	010
51020		A	Incise & treat bladder	6.70	NA	3.85	0.49	NA	11.04	090
51030		A	Incise & treat bladder	6.76	NA	3.97	0.58	NA	11.31	090
51040		A	Incise & drain bladder	4.39	NA	2.76	0.32	NA	7.47	090
51045		A	Incise bladder/drain ureter	6.76	NA	3.92	0.55	NA	11.23	090
51050		A	Removal of bladder stone	6.91	NA	3.64	0.49	NA	11.04	090
51060		A	Removal of ureter stone	8.84	NA	4.50	0.61	NA	13.95	090
51065		A	Remove ureter calculus	8.84	NA	4.35	0.64	NA	13.83	090
51080		A	Drainage of bladder abscess	5.95	NA	3.54	0.44	NA	9.93	090
51500		A	Removal of bladder cyst	10.12	NA	5.00	1.03	NA	16.15	090
51520		A	Removal of bladder lesion	9.28	NA	4.67	0.69	NA	14.64	090
51525		A	Removal of bladder lesion	13.95	NA	6.12	1.01	NA	21.08	090
51530		A	Removal of bladder lesion	12.36	NA	5.74	1.06	NA	19.16	090
51535		A	Repair of ureter lesion	12.55	NA	6.10	1.21	NA	19.86	090
51550		A	Partial removal of bladder	15.64	NA	6.72	1.34	NA	23.70	090
51555		A	Partial removal of bladder	21.20	NA	8.65	1.72	NA	31.57	090
51565		A	Revise bladder & ureter(s)	21.59	NA	8.95	1.66	NA	32.20	090
51570		A	Removal of bladder	24.20	NA	9.73	1.84	NA	35.77	090
51575		A	Removal of bladder & nodes	30.40	NA	12.02	2.16	NA	44.58	090
51580		A	Remove bladder/revise tract	31.03	NA	12.48	2.22	NA	45.73	090
51585		A	Removal of bladder & nodes	35.18	NA	13.69	2.48	NA	51.35	090
51590		A	Remove bladder/revise tract	32.61	NA	12.60	2.32	NA	47.53	090
51595		A	Remove bladder/revise tract	37.08	NA	14.12	2.62	NA	53.82	090
51596		A	Remove bladder/create pouch	39.46	NA	15.22	2.78	NA	57.46	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
51597		A	Removal of pelvic structures	38.29	NA	14.82	2.83	NA	55.94	090
51600		A	Injection for bladder x-ray	0.88	5.05	0.29	0.06	5.99	1.23	000
51605		A	Preparation for bladder xray	0.64	6.05	0.35	0.04	6.73	1.03	000
51610		A	Injection for bladder x-ray	1.05	2.28	0.60	0.07	3.40	1.72	000
51700		A	Irrigation of bladder	0.88	1.60	0.28	0.07	2.55	1.23	000
51701		A	Insert bladder catheter	0.50	1.58	0.19	0.04	2.12	0.73	000
51702		A	Insert temp bladder cath	0.50	2.08	0.24	0.04	2.62	0.78	000
51703		A	Insert bladder cath, complex	1.47	2.73	0.56	0.11	4.31	2.14	000
51705		A	Change of bladder tube	1.02	2.27	0.61	0.07	3.36	1.70	010
51710		A	Change of bladder tube	1.49	3.33	0.77	0.11	4.93	2.37	010
51715		A	Endoscopic injection/implant	3.73	3.90	1.35	0.29	7.92	5.37	000
51720		A	Treatment of bladder lesion	1.96	1.74	0.69	0.14	3.84	2.79	000
51725		A	Simple cystometrogram	1.51	5.59	NA	0.16	7.26	NA	000
51725	26	A	Simple cystometrogram	1.51	0.49	0.49	0.12	2.12	2.12	000
51725	TC	A	Simple cystometrogram	0.00	5.10	NA	0.04	5.14	NA	000
51726		A	Complex cystometrogram	1.71	7.50	NA	0.18	9.39	NA	000
51726	26	A	Complex cystometrogram	1.71	0.56	0.56	0.13	2.40	2.40	000
51726	TC	A	Complex cystometrogram	0.00	6.94	NA	0.05	6.99	NA	000
51736		A	Urine flow measurement	0.61	0.58	NA	0.06	1.25	NA	000
51736	26	A	Urine flow measurement	0.61	0.20	0.20	0.05	0.86	0.86	000
51736	TC	A	Urine flow measurement	0.00	0.38	NA	0.01	0.39	NA	000
51741		A	Electro-uroflowmetry, first	1.14	0.79	NA	0.11	2.04	NA	000
51741	26	A	Electro-uroflowmetry, first	1.14	0.37	0.37	0.09	1.60	1.60	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.42	NA	0.02	0.44	NA	000
51772		A	Urethra pressure profile	1.61	5.58	NA	0.19	7.38	NA	000
51772	26	A	Urethra pressure profile	1.61	0.55	0.55	0.14	2.30	2.30	000
51772	TC	A	Urethra pressure profile	0.00	5.03	NA	0.05	5.08	NA	000
51784		A	Anal/urinary muscle study	1.53	3.98	NA	0.16	5.67	NA	000
51784	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.12	2.15	2.15	000
51784	TC	A	Anal/urinary muscle study	0.00	3.48	NA	0.04	3.52	NA	000
51785		A	Anal/urinary muscle study	1.53	4.44	NA	0.15	6.12	NA	000
51785	26	A	Anal/urinary muscle study	1.53	0.50	0.50	0.11	2.14	2.14	000
51785	TC	A	Anal/urinary muscle study	0.00	3.94	NA	0.04	3.98	NA	000
51792		A	Urinary reflex study	1.10	5.99	NA	0.20	7.29	NA	000
51792	26	A	Urinary reflex study	1.10	0.41	0.41	0.07	1.58	1.58	000
51792	TC	A	Urinary reflex study	0.00	5.58	NA	0.13	5.71	NA	000
51795		A	Urine voiding pressure study	1.53	7.29	NA	0.22	9.04	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
51795	26	A	Urine voiding pressure study	1.53	0.50	0.50	0.12	2.15	2.15	000
51795	TC	A	Urine voiding pressure study	0.00	6.79	NA	0.10	6.89	NA	000
51797		A	Intraabdominal pressure test	1.60	5.78	NA	0.17	7.55	NA	000
51797	26	A	Intraabdominal pressure test	1.60	0.53	0.53	0.12	2.25	2.25	000
51797	TC	A	Intraabdominal pressure test	0.00	5.25	NA	0.05	5.30	NA	000
51798		A	Us urine capacity measure	0.00	0.34	NA	0.08	0.42	NA	XXX
51800		A	Revision of bladder/urethra	17.39	NA	7.56	1.35	NA	26.30	090
51820		A	Revision of urinary tract	17.86	NA	8.28	1.73	NA	27.87	090
51840		A	Attach bladder/urethra	10.69	NA	5.56	1.07	NA	17.32	090
51841		A	Attach bladder/urethra	13.01	NA	6.37	1.26	NA	20.64	090
51845		A	Repair bladder neck	9.72	NA	4.74	0.80	NA	15.26	090
51860		A	Repair of bladder wound	12.00	NA	5.75	1.16	NA	18.91	090
51865		A	Repair of bladder wound	15.02	NA	6.67	1.26	NA	22.95	090
51880		A	Repair of bladder opening	7.65	NA	3.95	0.72	NA	12.32	090
51900		A	Repair bladder/vagina lesion	12.95	NA	6.06	1.21	NA	20.22	090
51920		A	Close bladder-uterus fistula	11.79	NA	5.63	1.18	NA	18.60	090
51925		A	Hysterectomy/bladder repair	15.56	NA	8.61	2.02	NA	26.19	090
51940		A	Correction of bladder defect	28.39	NA	12.07	2.12	NA	42.58	090
51960		A	Revision of bladder & bowel	22.98	NA	9.63	1.65	NA	34.26	090
51980		A	Construct bladder opening	11.34	NA	5.37	0.86	NA	17.57	090
51990		A	Laparo urethral suspension	12.48	NA	6.14	1.40	NA	20.02	090
51992		A	Laparo sling operation	13.99	NA	6.20	1.40	NA	21.59	090
52000		A	Cystoscopy	2.01	3.30	0.76	0.14	5.45	2.91	000
52001		A	Cystoscopy, removal of clots	5.44	5.07	1.86	0.39	10.90	7.69	000
52005		A	Cystoscopy & ureter catheter	2.37	5.56	0.89	0.17	8.10	3.43	000
52007		A	Cystoscopy and biopsy	3.02	16.44	1.15	0.22	19.68	4.39	000
52010		A	Cystoscopy & duct catheter	3.02	10.75	1.15	0.22	13.99	4.39	000
52204		A	Cystoscopy	2.37	14.51	0.90	0.17	17.05	3.44	000
52214		A	Cystoscopy and treatment	3.70	38.10	1.33	0.26	42.06	5.29	000
52224		A	Cystoscopy and treatment	3.14	36.45	1.15	0.22	39.81	4.51	000
52234		A	Cystoscopy and treatment	4.62	NA	1.66	0.33	NA	6.61	000
52235		A	Cystoscopy and treatment	5.44	NA	1.93	0.39	NA	7.76	000
52240		A	Cystoscopy and treatment	9.71	NA	3.30	0.69	NA	13.70	000
52250		A	Cystoscopy and radiotracer	4.49	NA	1.65	0.32	NA	6.46	000
52260		A	Cystoscopy and treatment	3.91	NA	1.42	0.28	NA	5.61	000
52265		A	Cystoscopy and treatment	2.94	13.34	1.11	0.22	16.50	4.27	000
52270		A	Cystoscopy & revise urethra	3.36	11.03	1.24	0.24	14.63	4.84	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
52275		A	Cystoscopy & revise urethra	4.69	15.55	1.66	0.33	20.57	6.68	000
52276		A	Cystoscopy and treatment	4.99	NA	1.78	0.35	NA	7.12	000
52277		A	Cystoscopy and treatment	6.16	NA	2.22	0.44	NA	8.82	000
52281		A	Cystoscopy and treatment	2.80	7.09	1.08	0.20	10.09	4.08	000
52282		A	Cystoscopy, implant stent	6.39	NA	2.23	0.47	NA	9.09	000
52283		A	Cystoscopy and treatment	3.73	3.94	1.36	0.26	7.93	5.37	000
52285		A	Cystoscopy and treatment	3.60	4.01	1.33	0.26	7.87	5.19	000
52290		A	Cystoscopy and treatment	4.58	NA	1.65	0.32	NA	6.55	000
52300		A	Cystoscopy and treatment	5.30	NA	1.90	0.38	NA	7.58	000
52301		A	Cystoscopy and treatment	5.50	NA	1.98	0.46	NA	7.94	000
52305		A	Cystoscopy and treatment	5.30	NA	1.85	0.38	NA	7.53	000
52310		A	Cystoscopy and treatment	2.81	4.69	1.03	0.20	7.70	4.04	000
52315		A	Cystoscopy and treatment	5.20	8.66	1.83	0.37	14.23	7.40	000
52317		A	Remove bladder stone	6.71	28.94	2.28	0.48	36.13	9.47	000
52318		A	Remove bladder stone	9.18	NA	3.09	0.65	NA	12.92	000
52320		A	Cystoscopy and treatment	4.69	NA	1.63	0.34	NA	6.66	000
52325		A	Cystoscopy, stone removal	6.15	NA	2.11	0.44	NA	8.70	000
52327		A	Cystoscopy, inject material	5.18	31.81	1.81	0.38	37.37	7.37	000
52330		A	Cystoscopy and treatment	5.03	38.82	1.75	0.36	44.21	7.14	000
52332		A	Cystoscopy and treatment	2.83	5.74	1.05	0.21	8.78	4.09	000
52334		A	Create passage to kidney	4.82	NA	1.73	0.34	NA	6.89	000
52341		A	Cysto w/ureter stricture tx	5.99	NA	2.21	0.43	NA	8.63	000
52342		A	Cysto w/up stricture tx	6.49	NA	2.34	0.46	NA	9.29	000
52343		A	Cysto w/renal stricture tx	7.19	NA	2.58	0.52	NA	10.29	000
52344		A	Cysto/uretero, stricture tx	7.69	NA	2.79	0.55	NA	11.03	000
52345		A	Cysto/uretero w/up stricture	8.19	NA	2.95	0.58	NA	11.72	000
52346		A	Cystouretero w/renal strict	9.22	NA	3.28	0.67	NA	13.17	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	2.14	0.42	NA	8.41	000
52352		A	Cystouretero w/stone remove	6.87	NA	2.50	0.49	NA	9.86	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	2.85	0.57	NA	11.38	000
52354		A	Cystouretero w/biopsy	7.33	NA	2.67	0.52	NA	10.52	000
52355		A	Cystouretero w/excise tumor	8.81	NA	3.14	0.63	NA	12.58	000
52400		A	Cystouretero w/congen repr	9.67	NA	3.73	0.69	NA	14.09	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	1.70	0.40	NA	7.37	000
52450		A	Incision of prostate	7.63	NA	3.67	0.54	NA	11.84	090
52500		A	Revision of bladder neck	8.46	NA	3.92	0.60	NA	12.98	090
52510		A	Dilation prostatic urethra	6.71	NA	3.11	0.48	NA	10.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
52601		A	Prostatectomy (TURP)	12.35	NA	5.10	0.87	NA	18.32	090
52606		A	Control postop bleeding	8.12	NA	3.55	0.58	NA	12.25	090
52612		A	Prostatectomy, first stage	7.97	NA	3.73	0.57	NA	12.27	090
52614		A	Prostatectomy, second stage	6.83	NA	3.34	0.48	NA	10.65	090
52620		A	Remove residual prostate	6.60	NA	2.98	0.47	NA	10.05	090
52630		A	Remove prostate regrowth	7.25	NA	3.19	0.51	NA	10.95	090
52640		A	Relieve bladder contracture	6.61	NA	2.96	0.47	NA	10.04	090
52647		A	Laser surgery of prostate	10.34	73.94	4.53	0.73	85.01	15.60	090
52648		A	Laser surgery of prostate	11.19	NA	4.79	0.79	NA	16.77	090
52700		A	Drainage of prostate abscess	6.79	NA	3.18	0.48	NA	10.45	090
53000		A	Incision of urethra	2.28	NA	1.54	0.16	NA	3.98	010
53010		A	Incision of urethra	3.63	NA	2.91	0.25	NA	6.79	090
53020		A	Incision of urethra	1.77	3.00	0.67	0.13	4.90	2.57	000
53025		A	Incision of urethra	1.13	3.73	0.51	0.08	4.94	1.72	000
53040		A	Drainage of urethra abscess	6.39	NA	3.43	0.47	NA	10.29	090
53060		A	Drainage of urethra abscess	2.63	2.08	1.37	0.27	4.98	4.27	010
53080		A	Drainage of urinary leakage	6.28	NA	5.95	0.52	NA	12.75	090
53085		A	Drainage of urinary leakage	10.25	NA	7.40	0.91	NA	18.56	090
53200		A	Biopsy of urethra	2.59	1.32	0.98	0.21	4.12	3.78	000
53210		A	Removal of urethra	12.55	NA	5.83	0.93	NA	19.31	090
53215		A	Removal of urethra	15.56	NA	6.62	1.11	NA	23.29	090
53220		A	Treatment of urethra lesion	6.99	NA	3.71	0.53	NA	11.23	090
53230		A	Removal of urethra lesion	9.57	NA	4.71	0.73	NA	15.01	090
53235		A	Removal of urethra lesion	10.12	NA	4.90	0.73	NA	15.75	090
53240		A	Surgery for urethra pouch	6.44	NA	3.52	0.53	NA	10.49	090
53250		A	Removal of urethra gland	5.88	NA	3.29	0.49	NA	9.66	090
53260		A	Treatment of urethra lesion	2.98	2.24	1.42	0.26	5.48	4.66	010
53265		A	Treatment of urethra lesion	3.12	2.71	1.42	0.24	6.07	4.78	010
53270		A	Removal of urethra gland	3.09	2.20	1.54	0.30	5.59	4.93	010
53275		A	Repair of urethra defect	4.52	NA	2.25	0.33	NA	7.10	010
53400		A	Revise urethra, stage 1	12.75	NA	6.02	1.00	NA	19.77	090
53405		A	Revise urethra, stage 2	14.46	NA	6.31	1.09	NA	21.86	090
53410		A	Reconstruction of urethra	16.42	NA	7.05	1.19	NA	24.66	090
53415		A	Reconstruction of urethra	19.38	NA	7.33	1.38	NA	28.09	090
53420		A	Reconstruct urethra, stage 1	14.06	NA	6.28	1.01	NA	21.35	090
53425		A	Reconstruct urethra, stage 2	15.96	NA	6.88	1.13	NA	23.97	090
53430		A	Reconstruction of urethra	16.32	NA	6.99	1.20	NA	24.51	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
53431		A	Reconstruct urethra/bladder	19.86	NA	8.05	1.45	NA	29.36	090
53440		A	Male sling procedure	13.60	NA	5.97	0.97	NA	20.54	090
53442		A	Remove/revise male sling	11.55	NA	5.43	0.83	NA	17.81	090
53444		A	Insert tandem cuff	13.38	NA	5.87	0.94	NA	20.19	090
53445		A	Insert uro/ves nck sphincter	14.04	NA	7.08	1.00	NA	22.12	090
53446		A	Remove uro sphincter	10.21	NA	5.21	0.73	NA	16.15	090
53447		A	Remove/replace ur sphincter	13.47	NA	6.42	0.95	NA	20.84	090
53448		A	Remov/replc ur sphinctr comp	21.12	NA	9.04	1.52	NA	31.68	090
53449		A	Repair uro sphincter	9.69	NA	4.72	0.69	NA	15.10	090
53450		A	Revision of urethra	6.13	NA	3.29	0.43	NA	9.85	090
53460		A	Revision of urethra	7.11	NA	3.69	0.52	NA	11.32	090
53500		A	Urethrlys, transvag w/ scope	12.19	NA	6.20	0.91	NA	19.30	090
53502		A	Repair of urethra injury	7.62	NA	3.98	0.63	NA	12.23	090
53505		A	Repair of urethra injury	7.62	NA	3.86	0.54	NA	12.02	090
53510		A	Repair of urethra injury	10.09	NA	5.16	0.77	NA	16.02	090
53515		A	Repair of urethra injury	13.29	NA	5.92	1.05	NA	20.26	090
53520		A	Repair of urethra defect	8.67	NA	4.47	0.63	NA	13.77	090
53600		A	Dilate urethra stricture	1.21	1.14	0.43	0.09	2.44	1.73	000
53601		A	Dilate urethra stricture	0.98	1.27	0.37	0.07	2.32	1.42	000
53605		A	Dilate urethra stricture	1.28	NA	0.41	0.09	NA	1.78	000
53620		A	Dilate urethra stricture	1.62	1.99	0.59	0.12	3.73	2.33	000
53621		A	Dilate urethra stricture	1.35	2.07	0.49	0.10	3.52	1.94	000
53660		A	Dilation of urethra	0.71	1.31	0.31	0.05	2.07	1.07	000
53661		A	Dilation of urethra	0.72	1.30	0.29	0.05	2.07	1.06	000
53665		A	Dilation of urethra	0.76	NA	0.25	0.06	NA	1.07	000
53850		A	Prostatic microwave thermotx	9.44	94.06	3.94	0.67	104.17	14.05	090
53852		A	Prostatic rf thermotx	9.87	86.77	4.37	0.70	99.34	14.94	090
53853		A	Prostatic water thermother	5.23	55.34	2.85	0.37	60.94	8.45	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.54	2.91	0.93	0.11	4.56	2.58	010
54001		A	Slitting of prepuce	2.19	3.18	1.11	0.16	5.53	3.46	010
54015		A	Drain penis lesion	5.31	NA	2.55	0.38	NA	8.24	010
54050		A	Destruction, penis lesion(s)	1.24	1.66	1.03	0.08	2.98	2.35	010
54055		A	Destruction, penis lesion(s)	1.22	1.57	0.80	0.08	2.87	2.10	010
54056		A	Cryosurgery, penis lesion(s)	1.24	1.69	1.13	0.06	2.99	2.43	010
54057		A	Laser surg, penis lesion(s)	1.24	2.21	0.83	0.09	3.54	2.16	010
54060		A	Excision of penis lesion(s)	1.93	3.10	1.06	0.14	5.17	3.13	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54065		A	Destruction, penis lesion(s)	2.42	2.63	1.23	0.14	5.19	3.79	010
54100		A	Biopsy of penis	1.90	2.80	0.82	0.11	4.81	2.83	000
54105		A	Biopsy of penis	3.49	4.28	1.93	0.25	8.02	5.67	010
54110		A	Treatment of penis lesion	10.11	NA	4.75	0.74	NA	15.60	090
54111		A	Treat penis lesion, graft	13.55	NA	5.76	0.97	NA	20.28	090
54112		A	Treat penis lesion, graft	15.84	NA	6.79	1.12	NA	23.75	090
54115		A	Treatment of penis lesion	6.14	4.37	3.45	0.45	10.96	10.04	090
54120		A	Partial removal of penis	9.96	NA	4.67	0.68	NA	15.31	090
54125		A	Removal of penis	13.51	NA	5.82	0.98	NA	20.31	090
54130		A	Remove penis & nodes	20.11	NA	8.17	1.51	NA	29.79	090
54135		A	Remove penis & nodes	26.32	NA	10.16	1.86	NA	38.34	090
54150		A	Circumcision	1.81	4.35	0.70	0.16	6.32	2.67	XXX
54152		A	Circumcision	2.31	NA	1.20	0.19	NA	3.70	010
54160		A	Circumcision	2.48	4.14	1.09	0.19	6.81	3.76	010
54161		A	Circumcision	3.27	NA	1.56	0.24	NA	5.07	010
54162		A	Lysis penil circumic lesion	3.00	4.65	1.44	0.22	7.87	4.66	010
54163		A	Repair of circumcision	3.00	NA	2.00	0.22	NA	5.22	010
54164		A	Frenulotomy of penis	2.50	NA	1.83	0.19	NA	4.52	010
54200		A	Treatment of penis lesion	1.06	1.79	0.97	0.08	2.93	2.11	010
54205		A	Treatment of penis lesion	7.92	NA	4.68	0.56	NA	13.16	090
54220		A	Treatment of penis lesion	2.42	3.84	0.95	0.18	6.44	3.55	000
54230		A	Prepare penis study	1.34	1.08	0.63	0.09	2.51	2.06	000
54231		A	Dynamic cavernosometry	2.04	1.37	0.87	0.16	3.57	3.07	000
54235		A	Penile injection	1.19	0.96	0.58	0.09	2.24	1.86	000
54240		A	Penis study	1.31	1.03	NA	0.16	2.50	NA	000
54240	26	A	Penis study	1.31	0.43	0.43	0.10	1.84	1.84	000
54240	TC	A	Penis study	0.00	0.60	NA	0.06	0.66	NA	000
54250		A	Penis study	2.22	0.91	NA	0.18	3.31	NA	000
54250	26	A	Penis study	2.22	0.71	0.71	0.16	3.09	3.09	000
54250	TC	A	Penis study	0.00	0.20	NA	0.02	0.22	NA	000
54300		A	Revision of penis	10.39	NA	5.56	0.76	NA	16.71	090
54304		A	Revision of penis	12.47	NA	6.32	0.87	NA	19.66	090
54308		A	Reconstruction of urethra	11.81	NA	5.95	0.84	NA	18.60	090
54312		A	Reconstruction of urethra	13.55	NA	6.98	1.23	NA	21.76	090
54316		A	Reconstruction of urethra	16.79	NA	7.94	1.21	NA	25.94	090
54318		A	Reconstruction of urethra	11.23	NA	5.78	1.39	NA	18.40	090
54322		A	Reconstruction of urethra	12.99	NA	6.45	0.92	NA	20.36	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54324		A	Reconstruction of urethra	16.29	NA	7.95	1.13	NA	25.37	090
54326		A	Reconstruction of urethra	15.70	NA	7.77	1.11	NA	24.58	090
54328		A	Revise penis/urethra	15.63	NA	7.24	0.97	NA	23.84	090
54332		A	Revise penis/urethra	17.05	NA	7.72	1.20	NA	25.97	090
54336		A	Revise penis/urethra	20.01	NA	10.28	2.19	NA	32.48	090
54340		A	Secondary urethral surgery	8.90	NA	5.03	0.63	NA	14.56	090
54344		A	Secondary urethral surgery	15.92	NA	7.74	1.53	NA	25.19	090
54348		A	Secondary urethral surgery	17.12	NA	8.34	1.23	NA	26.69	090
54352		A	Reconstruct urethra/penis	24.70	NA	11.17	2.22	NA	38.09	090
54360		A	Penis plastic surgery	11.91	NA	6.02	0.85	NA	18.78	090
54380		A	Repair penis	13.16	NA	6.60	0.93	NA	20.69	090
54385		A	Repair penis	15.37	NA	8.25	0.86	NA	24.48	090
54390		A	Repair penis and bladder	21.58	NA	9.40	1.54	NA	32.52	090
54400		A	Insert semi-rigid prosthesis	8.98	NA	4.34	0.64	NA	13.96	090
54401		A	Insert self-contd prosthesis	10.26	NA	5.72	0.73	NA	16.71	090
54405		A	Insert multi-comp penis pros	13.41	NA	5.91	0.95	NA	20.27	090
54406		A	Remove muti-comp penis pros	12.08	NA	5.41	0.86	NA	18.35	090
54408		A	Repair multi-comp penis pros	12.73	NA	5.72	0.91	NA	19.36	090
54410		A	Remove/replace penis prosth	15.48	NA	6.61	1.10	NA	23.19	090
54411		A	Remov/replc penis pros, comp	15.98	NA	7.03	1.12	NA	24.13	090
54415		A	Remove self-contd penis pros	8.19	NA	4.19	0.58	NA	12.96	090
54416		A	Remv/repl penis contain pros	10.85	NA	5.36	0.77	NA	16.98	090
54417		A	Remv/replc penis pros, compl	14.17	NA	6.16	1.00	NA	21.33	090
54420		A	Revision of penis	11.40	NA	5.56	0.80	NA	17.76	090
54430		A	Revision of penis	10.13	NA	5.10	0.72	NA	15.95	090
54435		A	Revision of penis	6.11	NA	3.61	0.44	NA	10.16	090
54440		C	Repair of penis	0.00	0.00	0.00	0.00	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.95	0.44	0.08	2.15	1.64	000
54500		A	Biopsy of testis	1.31	0.61	0.56	0.09	2.01	1.96	000
54505		A	Biopsy of testis	3.45	NA	1.91	0.27	NA	5.63	010
54512		A	Excise lesion testis	8.57	NA	4.12	0.68	NA	13.37	090
54520		A	Removal of testis	5.22	NA	2.78	0.50	NA	8.50	090
54522		A	Orchiectomy, partial	9.49	NA	4.86	0.89	NA	15.24	090
54530		A	Removal of testis	8.57	NA	4.23	0.66	NA	13.46	090
54535		A	Extensive testis surgery	12.14	NA	5.53	0.98	NA	18.65	090
54550		A	Exploration for testis	7.77	NA	3.80	0.59	NA	12.16	090
54560		A	Exploration for testis	11.11	NA	5.15	0.90	NA	17.16	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
54600		A	Reduce testis torsion	7.00	NA	3.54	0.52	NA	11.06	090
54620		A	Suspension of testis	4.89	NA	2.43	0.37	NA	7.69	010
54640		A	Suspension of testis	6.89	NA	3.73	0.63	NA	11.25	090
54650		A	Orchiopexy (Fowler-Stephens)	11.43	NA	5.39	1.15	NA	17.97	090
54660		A	Revision of testis	5.10	NA	2.99	0.44	NA	8.53	090
54670		A	Repair testis injury	6.40	NA	3.53	0.46	NA	10.39	090
54680		A	Relocation of testis(es)	12.63	NA	6.14	1.16	NA	19.93	090
54690		A	Laparoscopy, orchiectomy	10.94	NA	4.93	1.01	NA	16.88	090
54692		A	Laparoscopy, orchiopexy	12.86	NA	5.42	1.30	NA	19.58	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.42	NA	1.93	0.28	NA	5.63	010
54800		A	Biopsy of epididymis	2.33	0.94	0.90	0.23	3.50	3.46	000
54820		A	Exploration of epididymis	5.13	NA	2.93	0.40	NA	8.46	090
54830		A	Remove epididymis lesion	5.37	NA	3.01	0.41	NA	8.79	090
54840		A	Remove epididymis lesion	5.19	NA	2.77	0.38	NA	8.34	090
54860		A	Removal of epididymis	6.31	NA	3.30	0.45	NA	10.06	090
54861		A	Removal of epididymis	8.89	NA	4.30	0.63	NA	13.82	090
54900		A	Fusion of spermatic ducts	13.18	NA	5.78	0.93	NA	19.89	090
54901		A	Fusion of spermatic ducts	17.91	NA	7.51	1.81	NA	27.23	090
55000		A	Drainage of hydrocele	1.43	2.06	0.65	0.11	3.60	2.19	000
55040		A	Removal of hydrocele	5.35	NA	2.89	0.43	NA	8.67	090
55041		A	Removal of hydroceles	7.73	NA	3.96	0.60	NA	12.29	090
55060		A	Repair of hydrocele	5.51	NA	3.07	0.46	NA	9.04	090
55100		A	Drainage of scrotum abscess	2.13	3.67	1.56	0.17	5.97	3.86	010
55110		A	Explore scrotum	5.69	NA	3.12	0.43	NA	9.24	090
55120		A	Removal of scrotum lesion	5.08	NA	2.94	0.39	NA	8.41	090
55150		A	Removal of scrotum	7.21	NA	3.83	0.57	NA	11.61	090
55175		A	Revision of scrotum	5.23	NA	3.00	0.39	NA	8.62	090
55180		A	Revision of scrotum	10.70	NA	5.35	0.90	NA	16.95	090
55200		A	Incision of sperm duct	4.23	12.31	2.37	0.32	16.86	6.92	090
55250		A	Removal of sperm duct(s)	3.29	11.47	2.21	0.26	15.02	5.76	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	1.31	0.25	NA	5.06	000
55400		A	Repair of sperm duct	8.48	NA	4.05	0.64	NA	13.17	090
55450		A	Ligation of sperm duct	4.11	6.99	1.86	0.29	11.39	6.26	010
55500		A	Removal of hydrocele	5.58	NA	3.08	0.56	NA	9.22	090
55520		A	Removal of sperm cord lesion	6.02	NA	3.24	0.74	NA	10.00	090
55530		A	Revise spermatic cord veins	5.65	NA	3.00	0.45	NA	9.10	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
55535		A	Revise spermatic cord veins	6.55	NA	3.39	0.49	NA	10.43	090
55540		A	Revise hernia & sperm veins	7.66	NA	3.79	0.94	NA	12.39	090
55550		A	Laparo ligate spermatic vein	6.56	NA	3.29	0.57	NA	10.42	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.37	NA	3.32	0.63	NA	10.32	090
55605		A	Incise sperm duct pouch	7.95	NA	4.28	0.64	NA	12.87	090
55650		A	Remove sperm duct pouch	11.78	NA	5.26	0.96	NA	18.00	090
55680		A	Remove sperm pouch lesion	5.18	NA	2.96	0.47	NA	8.61	090
55700		A	Biopsy of prostate	1.57	4.19	0.64	0.11	5.87	2.32	000
55705		A	Biopsy of prostate	4.56	NA	2.29	0.33	NA	7.18	010
55720		A	Drainage of prostate abscess	7.63	NA	3.81	0.94	NA	12.38	090
55725		A	Drainage of prostate abscess	8.67	NA	4.48	0.70	NA	13.85	090
55801		A	Removal of prostate	17.77	NA	7.60	1.34	NA	26.71	090
55810		A	Extensive prostate surgery	22.55	NA	8.92	1.59	NA	33.06	090
55812		A	Extensive prostate surgery	27.47	NA	10.96	2.03	NA	40.46	090
55815		A	Extensive prostate surgery	30.41	NA	11.87	2.16	NA	44.44	090
55821		A	Removal of prostate	14.23	NA	6.19	1.01	NA	21.43	090
55831		A	Removal of prostate	15.60	NA	6.64	1.11	NA	23.35	090
55840		A	Extensive prostate surgery	22.66	NA	9.26	1.61	NA	33.53	090
55842		A	Extensive prostate surgery	24.34	NA	9.82	1.70	NA	35.86	090
55845		A	Extensive prostate surgery	28.51	NA	10.91	2.02	NA	41.44	090
55859		A	Percut/needle insert, pros	12.50	NA	5.83	0.87	NA	19.20	090
55860		A	Surgical exposure, prostate	14.43	NA	6.39	1.02	NA	21.84	090
55862		A	Extensive prostate surgery	18.36	NA	7.83	1.48	NA	27.67	090
55865		A	Extensive prostate surgery	22.84	NA	9.24	1.61	NA	33.69	090
55866		A	Laparo radical prostatectomy	30.69	NA	11.70	2.15	NA	44.54	090
55870		A	Electroejaculation	2.58	1.53	1.08	0.16	4.27	3.82	000
55873		A	Cryoablate prostate	19.44	NA	8.93	1.37	NA	29.74	090
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
55970		N	Sex transformation, M to F	0.00	0.00	0.00	0.00	0.00	0.00	XXX
55980		N	Sex transformation, F to M	0.00	0.00	0.00	0.00	0.00	0.00	XXX
56405		A	I & D of vulva/perineum	1.44	1.33	1.14	0.17	2.94	2.75	010
56420		A	Drainage of gland abscess	1.39	2.27	1.04	0.16	3.82	2.59	010
56440		A	Surgery for vulva lesion	2.84	NA	1.71	0.34	NA	4.89	010
56441		A	Lysis of labial lesion(s)	1.97	1.81	1.41	0.20	3.98	3.58	010
56501		A	Destroy, vulva lesions, sim	1.53	1.78	1.24	0.17	3.48	2.94	010
56515		A	Destroy vulva lesion/s compl	2.76	2.54	1.81	0.32	5.62	4.89	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
56605		A	Biopsy of vulva/perineum	1.10	1.07	0.46	0.13	2.30	1.69	000
56606		A	Biopsy of vulva/perineum	0.55	0.49	0.22	0.07	1.11	0.84	ZZZ
56620		A	Partial removal of vulva	7.46	NA	4.79	0.89	NA	13.14	090
56625		A	Complete removal of vulva	8.39	NA	5.31	1.00	NA	14.70	090
56630		A	Extensive vulva surgery	12.34	NA	6.83	1.47	NA	20.64	090
56631		A	Extensive vulva surgery	16.18	NA	8.80	1.92	NA	26.90	090
56632		A	Extensive vulva surgery	20.26	NA	9.51	2.33	NA	32.10	090
56633		A	Extensive vulva surgery	16.45	NA	8.59	1.93	NA	26.97	090
56634		A	Extensive vulva surgery	17.85	NA	9.42	2.14	NA	29.41	090
56637		A	Extensive vulva surgery	21.94	NA	11.06	2.54	NA	35.54	090
56640		A	Extensive vulva surgery	22.14	NA	10.61	2.80	NA	35.55	090
56700		A	Partial removal of hymen	2.52	NA	1.83	0.30	NA	4.65	010
56720		A	Incision of hymen	0.68	NA	0.51	0.08	NA	1.27	000
56740		A	Remove vagina gland lesion	4.56	NA	2.56	0.54	NA	7.66	010
56800		A	Repair of vagina	3.88	NA	2.19	0.44	NA	6.51	010
56805		A	Repair clitoris	18.83	NA	9.41	2.13	NA	30.37	090
56810		A	Repair of perineum	4.12	NA	2.29	0.48	NA	6.89	010
56820		A	Exam of vulva w/scope	1.50	1.31	0.65	0.18	2.99	2.33	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.75	0.91	0.24	4.04	3.20	000
57000		A	Exploration of vagina	2.97	NA	1.72	0.31	NA	5.00	010
57010		A	Drainage of pelvic abscess	6.02	NA	3.80	0.68	NA	10.50	090
57020		A	Drainage of pelvic fluid	1.50	0.94	0.59	0.17	2.61	2.26	000
57022		A	I & d vaginal hematoma, pp	2.56	NA	1.49	0.26	NA	4.31	010
57023		A	I & d vag hematoma, non-ob	4.74	NA	2.57	0.55	NA	7.86	010
57061		A	Destroy vag lesions, simple	1.25	1.65	1.12	0.15	3.05	2.52	010
57065		A	Destroy vag lesions, complex	2.61	2.29	1.67	0.31	5.21	4.59	010
57100		A	Biopsy of vagina	1.20	1.08	0.48	0.14	2.42	1.82	000
57105		A	Biopsy of vagina	1.69	1.79	1.42	0.20	3.68	3.31	010
57106		A	Remove vagina wall, partial	6.35	NA	4.18	0.73	NA	11.26	090
57107		A	Remove vagina tissue, part	22.97	NA	10.46	2.65	NA	36.08	090
57109		A	Vaginectomy partial w/nodes	26.96	NA	11.24	3.14	NA	41.34	090
57110		A	Remove vagina wall, complete	14.27	NA	7.27	1.69	NA	23.23	090
57111		A	Remove vagina tissue, compl	26.96	NA	12.61	3.16	NA	42.73	090
57112		A	Vaginectomy w/nodes, compl	28.96	NA	12.09	3.04	NA	44.09	090
57120		A	Closure of vagina	7.40	NA	4.60	0.87	NA	12.87	090
57130		A	Remove vagina lesion	2.43	2.15	1.54	0.29	4.87	4.26	010
57135		A	Remove vagina lesion	2.67	2.26	1.65	0.31	5.24	4.63	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
57150		A	Treat vagina infection	0.55	1.10	0.21	0.06	1.71	0.82	000
57155		A	Insert uteri tandems/ovoids	6.26	NA	4.56	0.43	NA	11.25	090
57160		A	Insert pessary/other device	0.89	1.01	0.34	0.10	2.00	1.33	000
57170		A	Fitting of diaphragm/cap	0.91	1.48	0.33	0.11	2.50	1.35	000
57180		A	Treat vaginal bleeding	1.58	2.16	1.26	0.18	3.92	3.02	010
57200		A	Repair of vagina	3.93	NA	2.89	0.45	NA	7.27	090
57210		A	Repair vagina/perineum	5.16	NA	3.43	0.61	NA	9.20	090
57220		A	Revision of urethra	4.30	NA	3.10	0.50	NA	7.90	090
57230		A	Repair of urethral lesion	5.63	NA	3.40	0.55	NA	9.58	090
57240		A	Repair bladder & vagina	6.06	NA	3.81	0.62	NA	10.49	090
57250		A	Repair rectum & vagina	5.52	NA	3.57	0.65	NA	9.74	090
57260		A	Repair of vagina	8.26	NA	4.83	0.97	NA	14.06	090
57265		A	Extensive repair of vagina	11.32	NA	6.03	1.32	NA	18.67	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.97	0.64	NA	7.49	ZZZ
57268		A	Repair of bowel bulge	6.75	NA	4.19	0.78	NA	11.72	090
57270		A	Repair of bowel pouch	12.09	NA	6.24	1.41	NA	19.74	090
57280		A	Suspension of vagina	15.02	NA	7.36	1.66	NA	24.04	090
57282		A	Colpopexy, extraperitoneal	6.86	NA	4.50	1.02	NA	12.38	090
57283		A	Colpopexy, intraperitoneal	10.84	NA	5.91	1.02	NA	17.77	090
57284		A	Repair paravaginal defect	12.68	NA	7.14	1.41	NA	21.23	090
57287		A	Revise/remove sling repair	10.69	NA	5.47	0.91	NA	17.07	090
57288		A	Repair bladder defect	13.00	NA	5.90	1.12	NA	20.02	090
57289		A	Repair bladder & vagina	11.56	NA	6.03	1.21	NA	18.80	090
57291		A	Construction of vagina	7.94	NA	4.92	0.93	NA	13.79	090
57292		A	Construct vagina with graft	13.07	NA	6.93	1.56	NA	21.56	090
57300		A	Repair rectum-vagina fistula	7.60	NA	4.28	0.86	NA	12.74	090
57305		A	Repair rectum-vagina fistula	13.75	NA	6.26	1.69	NA	21.70	090
57307		A	Fistula repair & colostomy	15.91	NA	6.99	1.92	NA	24.82	090
57308		A	Fistula repair, transperine	9.93	NA	5.09	1.13	NA	16.15	090
57310		A	Repair urethrovaginal lesion	6.77	NA	3.83	0.54	NA	11.14	090
57311		A	Repair urethrovaginal lesion	7.97	NA	4.11	0.65	NA	12.73	090
57320		A	Repair bladder-vagina lesion	8.00	NA	4.36	0.68	NA	13.04	090
57330		A	Repair bladder-vagina lesion	12.33	NA	5.70	1.06	NA	19.09	090
57335		A	Repair vagina	18.70	NA	9.02	1.89	NA	29.61	090
57400		A	Dilation of vagina	2.27	NA	1.11	0.25	NA	3.63	000
57410		A	Pelvic examination	1.75	2.01	0.89	0.17	3.93	2.81	000
57415		A	Remove vaginal foreign body	2.17	NA	1.42	0.24	NA	3.83	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
57420		A	Exam of vagina w/scope	1.60	1.35	0.67	0.18	3.13	2.45	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.84	0.96	0.26	4.30	3.42	000
57425		A	Laparoscopy, surg, colpopexy	15.73	NA	6.63	1.74	NA	24.10	090
57452		A	Exam of cervix w/scope	1.50	1.28	0.76	0.17	2.95	2.43	000
57454		A	Bx/curett of cervix w/scope	2.33	1.64	1.15	0.28	4.25	3.76	000
57455		A	Biopsy of cervix w/scope	1.99	1.72	0.87	0.24	3.95	3.10	000
57456		A	Endocerv curettage w/scope	1.85	1.65	0.82	0.22	3.72	2.89	000
57460		A	Bx of cervix w/scope, leep	2.83	5.84	1.38	0.34	9.01	4.55	000
57461		A	Conz of cervix w/scope, leep	3.43	6.10	1.47	0.41	9.94	5.31	000
57500		A	Biopsy of cervix	0.97	2.54	0.63	0.11	3.62	1.71	000
57505		A	Endocervical curettage	1.14	1.46	1.10	0.13	2.73	2.37	010
57510		A	Cauterization of cervix	1.90	1.56	1.04	0.22	3.68	3.16	010
57511		A	Cryocautery of cervix	1.90	1.82	1.37	0.22	3.94	3.49	010
57513		A	Laser surgery of cervix	1.90	1.72	1.40	0.23	3.85	3.53	010
57520		A	Conization of cervix	4.03	3.93	2.87	0.48	8.44	7.38	090
57522		A	Conization of cervix	3.35	3.15	2.45	0.40	6.90	6.20	090
57530		A	Removal of cervix	4.78	NA	3.38	0.58	NA	8.74	090
57531		A	Removal of cervix, radical	27.96	NA	13.16	3.31	NA	44.43	090
57540		A	Removal of residual cervix	12.20	NA	6.23	1.48	NA	19.91	090
57545		A	Remove cervix/repair pelvis	13.01	NA	6.67	1.51	NA	21.19	090
57550		A	Removal of residual cervix	5.52	NA	3.82	0.66	NA	10.00	090
57555		A	Remove cervix/repair vagina	8.94	NA	5.08	1.07	NA	15.09	090
57556		A	Remove cervix, repair bowel	8.36	NA	4.85	0.93	NA	14.14	090
57700		A	Revision of cervix	3.54	NA	3.10	0.41	NA	7.05	090
57720		A	Revision of cervix	4.12	NA	3.10	0.48	NA	7.70	090
57800		A	Dilation of cervical canal	0.77	0.76	0.47	0.09	1.62	1.33	000
57820		A	D & c of residual cervix	1.67	1.47	1.14	0.20	3.34	3.01	010
58100		A	Biopsy of uterus lining	1.53	1.32	0.72	0.18	3.03	2.43	000
58120		A	Dilation and curettage	3.27	2.30	1.87	0.39	5.96	5.53	010
58140		A	Myomectomy abdom method	14.58	NA	7.10	1.78	NA	23.46	090
58145		A	Myomectomy vag method	8.03	NA	4.79	0.96	NA	13.78	090
58146		A	Myomectomy abdom complex	18.97	NA	9.00	2.27	NA	30.24	090
58150		A	Total hysterectomy	15.22	NA	7.48	1.81	NA	24.51	090
58152		A	Total hysterectomy	20.57	NA	9.85	2.41	NA	32.83	090
58180		A	Partial hysterectomy	15.27	NA	7.45	1.64	NA	24.36	090
58200		A	Extensive hysterectomy	21.56	NA	9.99	2.49	NA	34.04	090
58210		A	Extensive hysterectomy	28.81	NA	13.19	3.30	NA	45.30	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58240		A	Removal of pelvis contents	38.33	NA	17.61	4.15	NA	60.09	090
58260		A	Vaginal hysterectomy	12.96	NA	6.69	1.55	NA	21.20	090
58262		A	Vag hyst including t/o	14.75	NA	7.38	1.77	NA	23.90	090
58263		A	Vag hyst w/t/o & vag repair	16.04	NA	7.88	1.92	NA	25.84	090
58267		A	Vag hyst w/urinary repair	17.01	NA	8.37	2.04	NA	27.42	090
58270		A	Vag hyst w/enterocele repair	14.24	NA	7.06	1.70	NA	23.00	090
58275		A	Hysterectomy/revise vagina	15.74	NA	7.77	1.86	NA	25.37	090
58280		A	Hysterectomy/revise vagina	16.98	NA	8.25	1.99	NA	27.22	090
58285		A	Extensive hysterectomy	22.23	NA	9.94	2.68	NA	34.85	090
58290		A	Vag hyst complex	18.97	NA	9.12	2.28	NA	30.37	090
58291		A	Vag hyst incl t/o, complex	20.76	NA	9.87	2.48	NA	33.11	090
58292		A	Vag hyst t/o & repair, compl	22.05	NA	10.36	2.67	NA	35.08	090
58293		A	Vag hyst w/uro repair, compl	23.03	NA	10.65	2.75	NA	36.43	090
58294		A	Vag hyst w/enterocele, compl	20.25	NA	9.55	2.32	NA	32.12	090
58300		N	Insert intrauterine device	+1.01	1.42	0.38	0.12	2.55	1.51	XXX
58301		A	Remove intrauterine device	1.27	1.32	0.48	0.15	2.74	1.90	000
58321		A	Artificial insemination	0.92	1.15	0.37	0.10	2.17	1.39	000
58322		A	Artificial insemination	1.10	1.20	0.42	0.13	2.43	1.65	000
58323		A	Sperm washing	0.23	0.53	0.09	0.03	0.79	0.35	000
58340		A	Catheter for hysterography	0.88	3.16	0.65	0.09	4.13	1.62	000
58345		A	Reopen fallopian tube	4.65	NA	2.43	0.41	NA	7.49	010
58346		A	Insert heyman uteri capsule	6.74	NA	3.92	0.58	NA	11.24	090
58350		A	Reopen fallopian tube	1.01	1.49	0.92	0.12	2.62	2.05	010
58353		A	Endometr ablate, thermal	3.55	35.66	2.05	0.42	39.63	6.02	010
58356		A	Endometrial cryoablation	6.36	6.84	2.65	0.82	14.02	9.83	010
58400		A	Suspension of uterus	6.35	NA	3.93	0.74	NA	11.02	090
58410		A	Suspension of uterus	12.71	NA	6.43	1.45	NA	20.59	090
58520		A	Repair of ruptured uterus	11.90	NA	6.03	1.47	NA	19.40	090
58540		A	Revision of uterus	14.62	NA	6.95	1.76	NA	23.33	090
58545		A	Laparoscopic myomectomy	14.58	NA	7.18	1.76	NA	23.52	090
58546		A	Laparo-myomectomy, complex	18.97	NA	8.91	2.28	NA	30.16	090
58550		A	Laparo-asst vag hysterectomy	14.17	NA	7.29	1.70	NA	23.16	090
58552		A	Laparo-vag hyst incl t/o	15.98	NA	8.01	1.70	NA	25.69	090
58553		A	Laparo-vag hyst, complex	18.97	NA	8.91	2.29	NA	30.17	090
58554		A	Laparo-vag hyst w/t/o, compl	21.97	NA	10.39	2.24	NA	34.60	090
58555		A	Hysteroscopy, dx, sep proc	3.33	2.19	1.55	0.40	5.92	5.28	000
58558		A	Hysteroscopy, biopsy	4.74	NA	2.17	0.57	NA	7.48	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58559		A	Hysteroscopy, lysis	6.16	NA	2.73	0.73	NA	9.62	000
58560		A	Hysteroscopy, resect septum	6.99	NA	3.08	0.83	NA	10.90	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	4.28	1.19	NA	15.46	000
58562		A	Hysteroscopy, remove fb	5.20	NA	2.35	0.62	NA	8.17	000
58563		A	Hysteroscopy, ablation	6.16	56.19	2.75	0.74	63.09	9.65	000
58565		A	Hysteroscopy, sterilization	7.02	49.56	3.90	1.19	57.77	12.11	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.59	NA	3.33	0.65	NA	9.57	090
58605		A	Division of fallopian tube	4.99	NA	3.11	0.59	NA	8.69	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	0.57	0.17	NA	2.19	ZZZ
58615		A	Occlude fallopian tube(s)	3.89	NA	2.70	0.47	NA	7.06	010
58660		A	Laparoscopy, lysis	11.27	NA	5.25	1.38	NA	17.90	090
58661		A	Laparoscopy, remove adnexa	11.03	NA	5.12	1.33	NA	17.48	010
58662		A	Laparoscopy, excise lesions	11.77	NA	5.78	1.42	NA	18.97	090
58670		A	Laparoscopy, tubal cautery	5.59	NA	3.27	0.67	NA	9.53	090
58671		A	Laparoscopy, tubal block	5.59	NA	3.27	0.67	NA	9.53	090
58672		A	Laparoscopy, fimbrioplasty	12.86	NA	6.18	1.58	NA	20.62	090
58673		A	Laparoscopy, salpingostomy	13.72	NA	6.57	1.66	NA	21.95	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.03	NA	5.98	1.50	NA	19.51	090
58720		A	Removal of ovary/tube(s)	11.34	NA	5.77	1.37	NA	18.48	090
58740		A	Revise fallopian tube(s)	13.98	NA	7.13	1.67	NA	22.78	090
58750		A	Repair oviduct	14.82	NA	7.36	1.83	NA	24.01	090
58752		A	Revise ovarian tube(s)	14.82	NA	6.94	1.78	NA	23.54	090
58760		A	Remove tubal obstruction	13.11	NA	6.71	1.78	NA	21.60	090
58770		A	Create new tubal opening	13.95	NA	6.90	1.72	NA	22.57	090
58800		A	Drainage of ovarian cyst(s)	4.13	3.64	2.90	0.42	8.19	7.45	090
58805		A	Drainage of ovarian cyst(s)	5.87	NA	3.50	0.66	NA	10.03	090
58820		A	Drain ovary abscess, open	4.21	NA	3.29	0.52	NA	8.02	090
58822		A	Drain ovary abscess, percut	10.11	NA	5.21	1.15	NA	16.47	090
58823		A	Drain pelvic abscess, percut	3.37	21.32	1.12	0.25	24.94	4.74	000
58825		A	Transposition, ovary(s)	10.96	NA	5.79	1.32	NA	18.07	090
58900		A	Biopsy of ovary(s)	5.98	NA	3.57	0.68	NA	10.23	090
58920		A	Partial removal of ovary(s)	11.34	NA	5.57	1.41	NA	18.32	090
58925		A	Removal of ovarian cyst(s)	11.34	NA	5.68	1.39	NA	18.41	090
58940		A	Removal of ovary(s)	7.28	NA	4.10	0.89	NA	12.27	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
58943		A	Removal of ovary(s)	18.40	NA	8.64	2.20	NA	29.24	090
58950		A	Resect ovarian malignancy	16.90	NA	8.40	2.01	NA	27.31	090
58951		A	Resect ovarian malignancy	22.35	NA	10.44	2.59	NA	35.38	090
58952		A	Resect ovarian malignancy	24.97	NA	11.75	2.96	NA	39.68	090
58953		A	Tah, rad dissect for debulk	31.95	NA	14.54	3.75	NA	50.24	090
58954		A	Tah rad debulk/lymph remove	34.95	NA	15.70	4.11	NA	54.76	090
58956		A	Bso, omentectomy w/tah	20.78	NA	10.31	3.98	NA	35.07	090
58960		A	Exploration of abdomen	14.63	NA	7.35	1.76	NA	23.74	090
58970		A	Retrieval of oocyte	3.52	2.31	1.49	0.42	6.25	5.43	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.68	1.82	0.47	6.97	6.11	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	2.07	0.67	0.31	3.68	2.28	000
59001		A	Amniocentesis, therapeutic	3.00	NA	1.41	0.71	NA	5.12	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	1.54	0.81	NA	5.79	000
59015		A	Chorion biopsy	2.20	1.55	1.04	0.52	4.27	3.76	000
59020		A	Fetal contract stress test	0.66	0.78	NA	0.26	1.70	NA	000
59020	26	A	Fetal contract stress test	0.66	0.26	0.26	0.16	1.08	1.08	000
59020	TC	A	Fetal contract stress test	0.00	0.52	NA	0.10	0.62	NA	000
59025		A	Fetal non-stress test	0.53	0.44	NA	0.14	1.11	NA	000
59025	26	A	Fetal non-stress test	0.53	0.21	0.21	0.12	0.86	0.86	000
59025	TC	A	Fetal non-stress test	0.00	0.23	NA	0.02	0.25	NA	000
59030		A	Fetal scalp blood sample	1.99	NA	0.77	0.47	NA	3.23	000
59050		A	Fetal monitor w/report	0.89	NA	0.35	0.21	NA	1.45	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.29	0.17	NA	1.20	XXX
59070		A	Transabdom amnioinfus w/us	5.24	5.15	2.31	0.28	10.67	7.83	000
59072		A	Umbilical cord occlud w/us	8.99	NA	3.12	0.16	NA	12.27	000
59074		A	Fetal fluid drainage w/us	5.24	4.57	2.31	0.28	10.09	7.83	000
59076		A	Fetal shunt placement, w/us	8.99	NA	3.12	0.16	NA	12.27	000
59100		A	Remove uterus lesion	12.33	NA	6.45	2.91	NA	21.69	090
59120		A	Treat ectopic pregnancy	11.47	NA	6.24	2.66	NA	20.37	090
59121		A	Treat ectopic pregnancy	11.65	NA	6.32	2.75	NA	20.72	090
59130		A	Treat ectopic pregnancy	14.20	NA	4.79	3.35	NA	22.34	090
59135		A	Treat ectopic pregnancy	13.86	NA	7.22	3.27	NA	24.35	090
59136		A	Treat ectopic pregnancy	13.16	NA	6.60	3.11	NA	22.87	090
59140		A	Treat ectopic pregnancy	5.45	2.21	2.21	1.29	8.95	8.95	090
59150		A	Treat ectopic pregnancy	11.65	NA	5.99	2.75	NA	20.39	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
59151		A	Treat ectopic pregnancy	11.47	NA	6.05	2.71	NA	20.23	090
59160		A	D & c after delivery	2.71	3.29	2.13	0.64	6.64	5.48	010
59200		A	Insert cervical dilator	0.79	1.19	0.30	0.19	2.17	1.28	000
59300		A	Episiotomy or vaginal repair	2.41	2.17	0.96	0.57	5.15	3.94	000
59320		A	Revision of cervix	2.48	NA	1.24	0.58	NA	4.30	000
59325		A	Revision of cervix	4.06	NA	1.89	0.88	NA	6.83	000
59350		A	Repair of uterus	4.94	NA	1.87	1.17	NA	7.98	000
59400		A	Obstetrical care	23.03	NA	15.32	5.43	NA	43.78	MMM
59409		A	Obstetrical care	13.48	NA	5.30	3.18	NA	21.96	MMM
59410		A	Obstetrical care	14.76	NA	6.30	3.48	NA	24.54	MMM
59412		A	Antepartum manipulation	1.71	NA	0.81	0.40	NA	2.92	MMM
59414		A	Deliver placenta	1.61	NA	0.64	0.38	NA	2.63	MMM
59425		A	Antepartum care only	4.80	4.20	1.85	1.13	10.13	7.78	MMM
59426		A	Antepartum care only	8.27	7.54	3.22	1.95	17.76	13.44	MMM
59430		A	Care after delivery	2.13	1.23	0.94	0.50	3.86	3.57	MMM
59510		A	Cesarean delivery	26.18	NA	17.26	6.18	NA	49.62	MMM
59514		A	Cesarean delivery only	15.95	NA	6.21	3.76	NA	25.92	MMM
59515		A	Cesarean delivery	17.34	NA	7.83	4.09	NA	29.26	MMM
59525		A	Remove uterus after cesarean	8.53	NA	3.30	1.93	NA	13.76	ZZZ
59610		A	Vbac delivery	24.58	NA	15.86	5.80	NA	46.24	MMM
59612		A	Vbac delivery only	15.04	NA	6.05	3.55	NA	24.64	MMM
59614		A	Vbac care after delivery	16.32	NA	6.93	3.85	NA	27.10	MMM
59618		A	Attempted vbac delivery	27.74	NA	18.23	6.54	NA	52.51	MMM
59620		A	Attempted vbac delivery only	17.50	NA	6.76	4.13	NA	28.39	MMM
59622		A	Attempted vbac after care	18.90	NA	8.63	4.46	NA	31.99	MMM
59812		A	Treatment of miscarriage	4.00	NA	2.54	0.94	NA	7.48	090
59820		A	Care of miscarriage	4.00	4.42	3.56	0.94	9.36	8.50	090
59821		A	Treatment of miscarriage	4.46	4.27	3.40	1.05	9.78	8.91	090
59830		A	Treat uterus infection	6.10	NA	3.98	1.44	NA	11.52	090
59840		R	Abortion	3.01	NA	2.12	0.71	NA	5.84	010
59841		R	Abortion	5.23	3.49	2.97	1.23	9.95	9.43	010
59850		R	Abortion	5.90	NA	3.25	1.28	NA	10.43	090
59851		R	Abortion	5.92	NA	3.74	1.28	NA	10.94	090
59852		R	Abortion	8.23	NA	5.04	1.79	NA	15.06	090
59855		R	Abortion	6.11	NA	3.54	1.44	NA	11.09	090
59856		R	Abortion	7.47	NA	4.06	1.76	NA	13.29	090
59857		R	Abortion	9.28	NA	4.71	2.00	NA	15.99	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
59866		R	Abortion (mpr)	3.99	NA	1.89	0.87	NA	6.75	000
59870		A	Evacuate mole of uterus	6.00	NA	4.48	1.42	NA	11.90	090
59871		A	Remove cerclage suture	2.13	1.74	1.13	0.50	4.37	3.76	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.76	1.92	1.71	0.14	3.82	3.61	010
60001		A	Aspirate/inject thyriod cyst	0.97	1.41	0.33	0.07	2.45	1.37	000
60100		A	Biopsy of thyroid	1.56	1.40	0.53	0.10	3.06	2.19	000
60200		A	Remove thyroid lesion	9.54	NA	5.98	1.01	NA	16.53	090
60210		A	Partial thyroid excision	10.86	NA	5.63	1.23	NA	17.72	090
60212		A	Partial thyroid excision	16.01	NA	7.67	1.92	NA	25.60	090
60220		A	Partial removal of thyroid	11.88	NA	6.14	1.33	NA	19.35	090
60225		A	Partial removal of thyroid	14.17	NA	7.40	1.63	NA	23.20	090
60240		A	Removal of thyroid	16.04	NA	7.58	1.85	NA	25.47	090
60252		A	Removal of thyroid	20.54	NA	10.09	2.31	NA	32.94	090
60254		A	Extensive thyroid surgery	26.95	NA	14.14	2.63	NA	43.72	090
60260		A	Repeat thyroid surgery	17.44	NA	8.64	1.94	NA	28.02	090
60270		A	Removal of thyroid	20.24	NA	10.45	2.28	NA	32.97	090
60271		A	Removal of thyroid	16.80	NA	8.58	1.79	NA	27.17	090
60280		A	Remove thyroid duct lesion	5.86	NA	4.66	0.54	NA	11.06	090
60281		A	Remove thyroid duct lesion	8.52	NA	5.83	0.73	NA	15.08	090
60500		A	Explore parathyroid glands	16.21	NA	7.40	2.00	NA	25.61	090
60502		A	Re-explore parathyroids	20.32	NA	9.35	2.51	NA	32.18	090
60505		A	Explore parathyroid glands	21.46	NA	10.92	2.62	NA	35.00	090
60512		A	Autotransplant parathyroid	4.44	NA	1.62	0.54	NA	6.60	ZZZ
60520		A	Removal of thymus gland	16.78	NA	8.29	2.15	NA	27.22	090
60521		A	Removal of thymus gland	18.84	NA	9.54	2.75	NA	31.13	090
60522		A	Removal of thymus gland	23.06	NA	11.26	3.22	NA	37.54	090
60540		A	Explore adrenal gland	17.00	NA	7.58	1.76	NA	26.34	090
60545		A	Explore adrenal gland	19.85	NA	8.53	2.09	NA	30.47	090
60600		A	Remove carotid body lesion	17.90	NA	10.96	2.19	NA	31.05	090
60605		A	Remove carotid body lesion	20.21	NA	12.25	2.46	NA	34.92	090
60650		A	Laparoscopy adrenalectomy	19.97	NA	7.98	2.27	NA	30.22	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
61000		A	Remove cranial cavity fluid	1.58	NA	0.95	0.13	NA	2.66	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61001		A	Remove cranial cavity fluid	1.49	NA	1.06	0.16	NA	2.71	000
61020		A	Remove brain cavity fluid	1.51	NA	1.34	0.29	NA	3.14	000
61026		A	Injection into brain canal	1.69	NA	1.39	0.28	NA	3.36	000
61050		A	Remove brain canal fluid	1.51	NA	1.27	0.11	NA	2.89	000
61055		A	Injection into brain canal	2.10	NA	1.42	0.16	NA	3.68	000
61070		A	Brain canal shunt procedure	0.89	NA	1.01	0.15	NA	2.05	000
61105		A	Twist drill hole	5.13	NA	3.93	1.28	NA	10.34	090
61107		A	Drill skull for implantation	4.99	NA	2.53	1.23	NA	8.75	000
61108		A	Drill skull for drainage	10.17	NA	7.14	2.53	NA	19.84	090
61120		A	Burr hole for puncture	8.75	NA	5.99	1.91	NA	16.65	090
61140		A	Pierce skull for biopsy	15.88	NA	9.88	4.03	NA	29.79	090
61150		A	Pierce skull for drainage	17.54	NA	10.37	4.28	NA	32.19	090
61151		A	Pierce skull for drainage	12.40	NA	7.81	2.97	NA	23.18	090
61154		A	Pierce skull & remove clot	14.97	NA	9.48	4.07	NA	28.52	090
61156		A	Pierce skull for drainage	16.30	NA	9.83	4.05	NA	30.18	090
61210		A	Pierce skull, implant device	5.83	NA	2.91	1.45	NA	10.19	000
61215		A	Insert brain-fluid device	4.88	NA	4.00	1.20	NA	10.08	090
61250		A	Pierce skull & explore	10.40	NA	6.85	2.73	NA	19.98	090
61253		A	Pierce skull & explore	12.34	NA	7.72	2.59	NA	22.65	090
61304		A	Open skull for exploration	21.93	NA	12.83	5.19	NA	39.95	090
61305		A	Open skull for exploration	26.57	NA	15.31	5.78	NA	47.66	090
61312		A	Open skull for drainage	24.53	NA	15.04	6.14	NA	45.71	090
61313		A	Open skull for drainage	24.89	NA	14.80	6.26	NA	45.95	090
61314		A	Open skull for drainage	24.19	NA	13.03	6.12	NA	43.34	090
61315		A	Open skull for drainage	27.64	NA	16.01	6.91	NA	50.56	090
61316		A	Implt cran bone flap to abdo	1.39	NA	0.60	0.34	NA	2.33	ZZZ
61320		A	Open skull for drainage	25.58	NA	14.75	6.24	NA	46.57	090
61321		A	Open skull for drainage	28.46	NA	16.12	6.92	NA	51.50	090
61322		A	Decompressive craniotomy	29.46	NA	15.66	7.26	NA	52.38	090
61323		A	Decompressive lobectomy	30.95	NA	16.08	7.81	NA	54.84	090
61330		A	Decompress eye socket	23.29	NA	13.72	2.34	NA	39.35	090
61332		A	Explore/biopsy eye socket	27.24	NA	15.59	4.61	NA	47.44	090
61333		A	Explore orbit/remove lesion	27.91	NA	15.57	3.81	NA	47.29	090
61334		A	Explore orbit/remove object	18.24	NA	10.63	1.73	NA	30.60	090
61340		A	Subtemporal decompression	18.63	NA	11.12	4.59	NA	34.34	090
61343		A	Incise skull (press relief)	29.73	NA	16.80	7.40	NA	53.93	090
61345		A	Relieve cranial pressure	27.16	NA	15.39	6.68	NA	49.23	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61440		A	Incise skull for surgery	26.59	NA	14.20	6.83	NA	47.62	090
61450		A	Incise skull for surgery	25.91	NA	14.28	5.73	NA	45.92	090
61458		A	Incise skull for brain wound	27.25	NA	15.51	6.72	NA	49.48	090
61460		A	Incise skull for surgery	28.35	NA	16.41	5.88	NA	50.64	090
61470		A	Incise skull for surgery	26.02	NA	13.85	5.83	NA	45.70	090
61480		A	Incise skull for surgery	26.45	NA	15.27	6.68	NA	48.40	090
61490		A	Incise skull for surgery	25.62	NA	14.32	6.85	NA	46.79	090
61500		A	Removal of skull lesion	17.89	NA	10.80	3.93	NA	32.62	090
61501		A	Remove infected skull bone	14.82	NA	9.20	3.01	NA	27.03	090
61510		A	Removal of brain lesion	28.41	NA	16.69	7.09	NA	52.19	090
61512		A	Remove brain lining lesion	35.04	NA	19.67	8.76	NA	63.47	090
61514		A	Removal of brain abscess	25.22	NA	14.43	6.26	NA	45.91	090
61516		A	Removal of brain lesion	24.57	NA	14.26	6.19	NA	45.02	090
61517		A	Implt brain chemotx add-on	1.38	NA	0.64	0.34	NA	2.36	ZZZ
61518		A	Removal of brain lesion	37.26	NA	21.09	9.30	NA	67.65	090
61519		A	Remove brain lining lesion	41.33	NA	22.64	10.10	NA	74.07	090
61520		A	Removal of brain lesion	54.76	NA	30.32	10.72	NA	95.80	090
61521		A	Removal of brain lesion	44.41	NA	24.21	10.52	NA	79.14	090
61522		A	Removal of brain abscess	29.41	NA	16.41	7.43	NA	53.25	090
61524		A	Removal of brain lesion	27.82	NA	15.66	6.66	NA	50.14	090
61526		A	Removal of brain lesion	52.09	NA	29.48	6.82	NA	88.39	090
61530		A	Removal of brain lesion	43.79	NA	25.05	6.00	NA	74.84	090
61531		A	Implant brain electrodes	14.61	NA	9.12	3.71	NA	27.44	090
61533		A	Implant brain electrodes	19.68	NA	11.53	4.92	NA	36.13	090
61534		A	Removal of brain lesion	20.94	NA	12.08	5.33	NA	38.35	090
61535		A	Remove brain electrodes	11.61	NA	7.42	2.92	NA	21.95	090
61536		A	Removal of brain lesion	35.47	NA	19.78	8.68	NA	63.93	090
61537		A	Removal of brain tissue	24.96	NA	14.74	6.75	NA	46.45	090
61538		A	Removal of brain tissue	26.77	NA	15.31	6.75	NA	48.83	090
61539		A	Removal of brain tissue	32.03	NA	17.76	8.22	NA	58.01	090
61540		A	Removal of brain tissue	29.96	NA	17.24	8.22	NA	55.42	090
61541		A	Incision of brain tissue	28.81	NA	16.20	6.53	NA	51.54	090
61542		A	Removal of brain tissue	30.97	NA	17.82	7.95	NA	56.74	090
61543		A	Removal of brain tissue	29.18	NA	16.38	7.49	NA	53.05	090
61544		A	Remove & treat brain lesion	25.46	NA	13.82	5.92	NA	45.20	090
61545		A	Excision of brain tumor	43.73	NA	24.21	9.92	NA	77.86	090
61546		A	Removal of pituitary gland	31.25	NA	17.49	7.47	NA	56.21	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61548		A	Removal of pituitary gland	21.50	NA	12.78	3.34	NA	37.62	090
61550		A	Release of skull seams	14.63	NA	6.93	0.98	NA	22.54	090
61552		A	Release of skull seams	19.53	NA	9.11	1.06	NA	29.70	090
61556		A	Incise skull/sutures	22.23	NA	11.36	4.60	NA	38.19	090
61557		A	Incise skull/sutures	22.35	NA	13.62	5.74	NA	41.71	090
61558		A	Excision of skull/sutures	25.54	NA	14.19	1.35	NA	41.08	090
61559		A	Excision of skull/sutures	32.74	NA	19.31	8.40	NA	60.45	090
61563		A	Excision of skull tumor	26.79	NA	15.24	5.11	NA	47.14	090
61564		A	Excision of skull tumor	33.78	NA	18.28	8.67	NA	60.73	090
61566		A	Removal of brain tissue	30.95	NA	17.77	6.75	NA	55.47	090
61567		A	Incision of brain tissue	35.45	NA	20.67	6.49	NA	62.61	090
61570		A	Remove foreign body, brain	24.56	NA	13.91	5.32	NA	43.79	090
61571		A	Incise skull for brain wound	26.35	NA	15.14	6.72	NA	48.21	090
61575		A	Skull base/brainstem surgery	34.31	NA	19.63	5.10	NA	59.04	090
61576		A	Skull base/brainstem surgery	52.35	NA	34.73	5.51	NA	92.59	090
61580		A	Craniofacial approach, skull	30.30	NA	25.58	3.33	NA	59.21	090
61581		A	Craniofacial approach, skull	34.55	NA	23.44	3.87	NA	61.86	090
61582		A	Craniofacial approach, skull	31.61	NA	27.30	6.91	NA	65.82	090
61583		A	Craniofacial approach, skull	36.16	NA	25.11	8.32	NA	69.59	090
61584		A	Orbitocranial approach/skull	34.60	NA	24.52	7.69	NA	66.81	090
61585		A	Orbitocranial approach/skull	38.55	NA	26.49	6.96	NA	72.00	090
61586		A	Resect nasopharynx, skull	25.06	NA	22.58	4.32	NA	51.96	090
61590		A	Infratemporal approach/skull	41.72	NA	28.62	5.18	NA	75.52	090
61591		A	Infratemporal approach/skull	43.61	NA	29.52	5.48	NA	78.61	090
61592		A	Orbitocranial approach/skull	39.58	NA	26.50	9.31	NA	75.39	090
61595		A	Transtemporal approach/skull	29.53	NA	22.35	3.86	NA	55.74	090
61596		A	Transcochlear approach/skull	35.58	NA	24.44	3.36	NA	63.38	090
61597		A	Transcondylar approach/skull	37.90	NA	22.99	8.31	NA	69.20	090
61598		A	Transpetrosal approach/skull	33.36	NA	23.23	5.53	NA	62.12	090
61600		A	Resect/excise cranial lesion	25.81	NA	19.77	3.62	NA	49.20	090
61601		A	Resect/excise cranial lesion	27.85	NA	20.49	6.34	NA	54.68	090
61605		A	Resect/excise cranial lesion	29.29	NA	21.96	2.81	NA	54.06	090
61606		A	Resect/excise cranial lesion	38.77	NA	25.15	8.57	NA	72.49	090
61607		A	Resect/excise cranial lesion	36.22	NA	23.78	6.69	NA	66.69	090
61608		A	Resect/excise cranial lesion	42.04	NA	26.58	9.93	NA	78.55	090
61609		A	Transect artery, sinus	9.88	NA	4.85	2.53	NA	17.26	ZZZ
61610		A	Transect artery, sinus	29.63	NA	13.14	7.60	NA	50.37	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61611		A	Transect artery, sinus	7.41	NA	3.82	1.87	NA	13.10	ZZZ
61612		A	Transect artery, sinus	27.84	NA	13.31	4.28	NA	45.43	ZZZ
61613		A	Remove aneurysm, sinus	40.80	NA	26.26	8.34	NA	75.40	090
61615		A	Resect/excise lesion, skull	32.02	NA	22.72	4.65	NA	59.39	090
61616		A	Resect/excise lesion, skull	43.27	NA	28.65	7.89	NA	79.81	090
61618		A	Repair dura	16.96	NA	10.44	3.62	NA	31.02	090
61619		A	Repair dura	20.68	NA	12.24	3.89	NA	36.81	090
61623		A	Endovasc tempory vessel occl	9.95	NA	4.08	1.05	NA	15.08	000
61624		A	Transcath occlusion, cns	20.12	NA	6.89	1.92	NA	28.93	000
61626		A	Transcath occlusion, non-cns	16.60	NA	5.51	1.24	NA	23.35	000
61680		A	Intracranial vessel surgery	30.66	NA	17.43	7.60	NA	55.69	090
61682		A	Intracranial vessel surgery	61.48	NA	32.21	15.50	NA	109.19	090
61684		A	Intracranial vessel surgery	39.75	NA	22.00	10.20	NA	71.95	090
61686		A	Intracranial vessel surgery	64.39	NA	34.72	16.15	NA	115.26	090
61690		A	Intracranial vessel surgery	29.27	NA	16.72	6.87	NA	52.86	090
61692		A	Intracranial vessel surgery	51.79	NA	27.47	13.29	NA	92.55	090
61697		A	Brain aneurysm repr, complx	50.44	NA	28.01	12.44	NA	90.89	090
61698		A	Brain aneurysm repr, complx	48.34	NA	26.69	12.08	NA	87.11	090
61700		A	Brain aneurysm repr, simple	50.44	NA	27.80	12.59	NA	90.83	090
61702		A	Inner skull vessel surgery	48.34	NA	26.03	10.32	NA	84.69	090
61703		A	Clamp neck artery	17.44	NA	10.46	3.94	NA	31.84	090
61705		A	Revise circulation to head	36.15	NA	19.25	8.76	NA	64.16	090
61708		A	Revise circulation to head	35.25	NA	15.15	2.49	NA	52.89	090
61710		A	Revise circulation to head	29.63	NA	13.64	4.47	NA	47.74	090
61711		A	Fusion of skull arteries	36.28	NA	19.80	9.16	NA	65.24	090
61720		A	Incise skull/brain surgery	16.74	NA	9.97	2.72	NA	29.43	090
61735		A	Incise skull/brain surgery	20.40	NA	12.16	2.69	NA	35.25	090
61750		A	Incise skull/brain biopsy	18.17	NA	10.61	4.50	NA	33.28	090
61751		A	Brain biopsy w/ct/mr guide	17.59	NA	10.82	4.39	NA	32.80	090
61760		A	Implant brain electrodes	22.24	NA	8.71	5.07	NA	36.02	090
61770		A	Incise skull for treatment	21.41	NA	12.25	3.51	NA	37.17	090
61790		A	Treat trigeminal nerve	10.84	NA	5.91	2.68	NA	19.43	090
61791		A	Treat trigeminal tract	14.59	NA	8.91	3.07	NA	26.57	090
61793		A	Focus radiation beam	17.21	NA	10.12	4.24	NA	31.57	090
61795		A	Brain surgery using computer	4.03	NA	2.03	0.77	NA	6.83	ZZZ
61850		A	Implant neuroelectrodes	12.37	NA	7.67	3.18	NA	23.22	090
61860		A	Implant neuroelectrodes	20.84	NA	12.06	4.90	NA	37.80	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
61863		A	Implant neuroelectrode	18.97	NA	11.77	5.21	NA	35.95	090
61864		A	Implant neuroelectrde, add'l	4.49	NA	2.28	5.21	NA	11.98	ZZZ
61867		A	Implant neuroelectrode	31.29	NA	18.02	5.21	NA	54.52	090
61868		A	Implant neuroelectrde, add'l	7.91	NA	4.01	5.21	NA	17.13	ZZZ
61870		A	Implant neuroelectrodes	14.92	NA	9.70	3.83	NA	28.45	090
61875		A	Implant neuroelectrodes	15.04	NA	8.57	2.92	NA	26.53	090
61880		A	Revise/remove neuroelectrode	6.28	NA	4.57	1.58	NA	12.43	090
61885		A	Insrt/redo neurostim 1 array	5.84	NA	5.30	1.42	NA	12.56	090
61886		A	Implant neurostim arrays	7.99	NA	6.35	1.92	NA	16.26	090
61888		A	Revise/remove neuroreceiver	5.06	NA	3.67	1.23	NA	9.96	010
62000		A	Treat skull fracture	12.51	NA	5.51	1.04	NA	19.06	090
62005		A	Treat skull fracture	16.15	NA	8.79	3.74	NA	28.68	090
62010		A	Treatment of head injury	19.78	NA	11.71	4.80	NA	36.29	090
62100		A	Repair brain fluid leakage	22.00	NA	12.78	4.71	NA	39.49	090
62115		A	Reduction of skull defect	21.63	NA	11.64	5.46	NA	38.73	090
62116		A	Reduction of skull defect	23.55	NA	13.36	6.05	NA	42.96	090
62117		A	Reduction of skull defect	26.56	NA	15.37	4.48	NA	46.41	090
62120		A	Repair skull cavity lesion	23.31	NA	18.48	2.96	NA	44.75	090
62121		A	Incise skull repair	21.55	NA	15.45	4.08	NA	41.08	090
62140		A	Repair of skull defect	13.49	NA	8.32	3.22	NA	25.03	090
62141		A	Repair of skull defect	14.89	NA	9.04	3.49	NA	27.42	090
62142		A	Remove skull plate/flap	10.77	NA	6.99	2.55	NA	20.31	090
62143		A	Replace skull plate/flap	13.03	NA	8.04	3.18	NA	24.25	090
62145		A	Repair of skull & brain	18.79	NA	10.89	4.30	NA	33.98	090
62146		A	Repair of skull with graft	16.10	NA	9.63	3.52	NA	29.25	090
62147		A	Repair of skull with graft	19.31	NA	11.30	4.20	NA	34.81	090
62148		A	Retr bone flap to fix skull	2.00	NA	0.66	0.47	NA	3.33	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	1.53	0.75	NA	5.28	ZZZ
62161		A	Dissect brain w/scope	19.97	NA	12.09	5.02	NA	37.08	090
62162		A	Remove colloid cyst w/scope	25.21	NA	14.85	5.85	NA	45.91	090
62163		A	Neuroendoscopy w/fb removal	15.48	NA	9.92	3.97	NA	29.37	090
62164		A	Remove brain tumor w/scope	27.46	NA	14.95	5.31	NA	47.72	090
62165		A	Remove pituit tumor w/scope	21.97	NA	13.38	2.95	NA	38.30	090
62180		A	Establish brain cavity shunt	21.03	NA	12.28	4.77	NA	38.08	090
62190		A	Establish brain cavity shunt	11.05	NA	7.08	2.76	NA	20.89	090
62192		A	Establish brain cavity shunt	12.23	NA	7.62	2.93	NA	22.78	090
62194		A	Replace/irrigate catheter	5.02	NA	2.43	0.89	NA	8.34	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
62200		A	Establish brain cavity shunt	18.29	NA	10.84	4.49	NA	33.62	090
62201		A	Brain cavity shunt w/scope	14.84	NA	9.44	3.41	NA	27.69	090
62220		A	Establish brain cavity shunt	12.98	NA	7.98	3.06	NA	24.02	090
62223		A	Establish brain cavity shunt	12.85	NA	8.24	3.02	NA	24.11	090
62225		A	Replace/irrigate catheter	5.40	NA	4.09	1.33	NA	10.82	090
62230		A	Replace/revise brain shunt	10.52	NA	6.48	2.54	NA	19.54	090
62252		A	Csf shunt reprogram	0.74	1.47	NA	0.20	2.41	NA	XXX
62252	26	A	Csf shunt reprogram	0.74	0.37	0.37	0.18	1.29	1.29	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.10	NA	0.02	1.12	NA	XXX
62256		A	Remove brain cavity shunt	6.59	NA	4.69	1.65	NA	12.93	090
62258		A	Replace brain cavity shunt	14.52	NA	8.71	3.56	NA	26.79	090
62263		A	Epidural lysis mult sessions	6.13	12.69	3.19	0.42	19.24	9.74	010
62264		A	Epidural lysis on single day	4.42	7.73	1.42	0.27	12.42	6.11	010
62268		A	Drain spinal cord cyst	4.73	11.53	2.14	0.43	16.69	7.30	000
62269		A	Needle biopsy, spinal cord	5.01	14.68	1.97	0.39	20.08	7.37	000
62270		A	Spinal fluid tap, diagnostic	1.13	2.99	0.56	0.08	4.20	1.77	000
62272		A	Drain cerebro spinal fluid	1.35	3.61	0.71	0.17	5.13	2.23	000
62273		A	Inject epidural patch	2.15	2.71	0.71	0.14	5.00	3.00	000
62280		A	Treat spinal cord lesion	2.63	6.93	1.01	0.31	9.87	3.95	010
62281		A	Treat spinal cord lesion	2.66	5.65	0.89	0.18	8.49	3.73	010
62282		A	Treat spinal canal lesion	2.33	8.36	0.92	0.19	10.88	3.44	010
62284		A	Injection for myelogram	1.54	4.96	0.68	0.13	6.63	2.35	000
62287		A	Percutaneous diskectomy	8.07	NA	5.55	0.64	NA	14.26	090
62290		A	Inject for spine disk x-ray	3.00	7.13	1.38	0.25	10.38	4.63	000
62291		A	Inject for spine disk x-ray	2.91	5.93	1.23	0.26	9.10	4.40	000
62292		A	Injection into disk lesion	7.85	NA	4.47	0.81	NA	13.13	090
62294		A	Injection into spinal artery	11.81	NA	5.58	1.23	NA	18.62	090
62310		A	Inject spine c/t	1.91	4.81	0.65	0.12	6.84	2.68	000
62311		A	Inject spine l/s (cd)	1.54	4.92	0.59	0.10	6.56	2.23	000
62318		A	Inject spine w/cath, c/t	2.04	5.72	0.65	0.13	7.89	2.82	000
62319		A	Inject spine w/cath l/s (cd)	1.87	4.98	0.61	0.12	6.97	2.60	000
62350		A	Implant spinal canal cath	6.86	NA	3.94	0.98	NA	11.78	090
62351		A	Implant spinal canal cath	9.99	NA	7.12	2.17	NA	19.28	090
62355		A	Remove spinal canal catheter	5.44	NA	3.16	0.74	NA	9.34	090
62360		A	Insert spine infusion device	2.62	NA	2.68	0.36	NA	5.66	090
62361		A	Implant spine infusion pump	5.41	NA	3.92	0.77	NA	10.10	090
62362		A	Implant spine infusion pump	7.03	NA	4.36	1.15	NA	12.54	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
62365		A	Remove spine infusion device	5.41	NA	3.58	0.83	NA	9.82	090
62367		A	Analyze spine infusion pump	0.48	0.13	0.13	0.03	0.64	0.64	XXX
62368		A	Analyze spine infusion pump	0.75	0.19	0.19	0.06	1.00	1.00	XXX
63001		A	Removal of spinal lamina	15.80	NA	9.51	3.65	NA	28.96	090
63003		A	Removal of spinal lamina	15.93	NA	9.86	3.63	NA	29.42	090
63005		A	Removal of spinal lamina	14.90	NA	9.97	3.27	NA	28.14	090
63011		A	Removal of spinal lamina	14.50	NA	8.27	3.31	NA	26.08	090
63012		A	Removal of spinal lamina	15.38	NA	10.12	3.41	NA	28.91	090
63015		A	Removal of spinal lamina	19.32	NA	11.87	4.64	NA	35.83	090
63016		A	Removal of spinal lamina	19.17	NA	11.78	4.45	NA	35.40	090
63017		A	Removal of spinal lamina	15.92	NA	10.39	3.56	NA	29.87	090
63020		A	Neck spine disk surgery	14.79	NA	9.67	3.60	NA	28.06	090
63030		A	Low back disk surgery	11.98	NA	8.42	2.91	NA	23.31	090
63035		A	Spinal disk surgery add-on	3.15	NA	1.59	0.77	NA	5.51	ZZZ
63040		A	Laminotomy, single cervical	18.78	NA	11.50	4.49	NA	34.77	090
63042		A	Laminotomy, single lumbar	17.44	NA	11.34	4.08	NA	32.86	090
63043		C	Laminotomy, add'l cervical	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63044		C	Laminotomy, add'l lumbar	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	16.48	NA	10.35	3.89	NA	30.72	090
63046		A	Removal of spinal lamina	15.78	NA	10.18	3.47	NA	29.43	090
63047		A	Removal of spinal lamina	14.59	NA	9.89	3.15	NA	27.63	090
63048		A	Remove spinal lamina add-on	3.26	NA	1.66	0.71	NA	5.63	ZZZ
63050		A	Cervical laminoplasty	20.75	NA	11.84	4.64	NA	37.23	090
63051		A	C-laminoplasty w/graft/plate	24.25	NA	13.47	4.64	NA	42.36	090
63055		A	Decompress spinal cord	21.96	NA	13.13	5.13	NA	40.22	090
63056		A	Decompress spinal cord	20.33	NA	12.56	4.57	NA	37.46	090
63057		A	Decompress spine cord add-on	5.25	NA	2.63	1.18	NA	9.06	ZZZ
63064		A	Decompress spinal cord	24.57	NA	14.42	5.45	NA	44.44	090
63066		A	Decompress spine cord add-on	3.26	NA	1.66	0.67	NA	5.59	ZZZ
63075		A	Neck spine disk surgery	19.38	NA	12.08	4.49	NA	35.95	090
63076		A	Neck spine disk surgery	4.04	NA	2.05	0.93	NA	7.02	ZZZ
63077		A	Spine disk surgery, thorax	21.41	NA	12.79	3.70	NA	37.90	090
63078		A	Spine disk surgery, thorax	3.28	NA	1.64	0.63	NA	5.55	ZZZ
63081		A	Removal of vertebral body	23.69	NA	14.32	5.36	NA	43.37	090
63082		A	Remove vertebral body add-on	4.36	NA	2.22	1.00	NA	7.58	ZZZ
63085		A	Removal of vertebral body	26.88	NA	15.47	4.18	NA	46.53	090
63086		A	Remove vertebral body add-on	3.19	NA	1.59	0.55	NA	5.33	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
63087		A	Removal of vertebral body	35.52	NA	19.45	5.65	NA	60.62	090
63088		A	Remove vertebral body add-on	4.32	NA	2.17	0.78	NA	7.27	ZZZ
63090		A	Removal of vertebral body	28.12	NA	16.03	4.06	NA	48.21	090
63091		A	Remove vertebral body add-on	3.03	NA	1.46	0.47	NA	4.96	ZZZ
63101		A	Removal of vertebral body	31.95	NA	19.27	5.45	NA	56.67	090
63102		A	Removal of vertebral body	31.95	NA	19.27	5.45	NA	56.67	090
63103		A	Remove vertebral body add-on	4.82	NA	2.50	0.67	NA	7.99	ZZZ
63170		A	Incise spinal cord tract(s)	19.80	NA	11.86	4.81	NA	36.47	090
63172		A	Drainage of spinal cyst	17.63	NA	10.64	4.37	NA	32.64	090
63173		A	Drainage of spinal cyst	21.96	NA	12.80	5.64	NA	40.40	090
63180		A	Revise spinal cord ligaments	18.24	NA	10.98	3.92	NA	33.14	090
63182		A	Revise spinal cord ligaments	20.47	NA	10.95	5.25	NA	36.67	090
63185		A	Incise spinal column/nerves	15.02	NA	8.09	2.66	NA	25.77	090
63190		A	Incise spinal column/nerves	17.42	NA	10.13	3.21	NA	30.76	090
63191		A	Incise spinal column/nerves	17.51	NA	10.47	6.29	NA	34.27	090
63194		A	Incise spinal column & cord	19.16	NA	11.71	3.23	NA	34.10	090
63195		A	Incise spinal column & cord	18.81	NA	11.04	4.83	NA	34.68	090
63196		A	Incise spinal column & cord	22.27	NA	13.38	5.72	NA	41.37	090
63197		A	Incise spinal column & cord	21.08	NA	12.20	5.33	NA	38.61	090
63198		A	Incise spinal column & cord	25.34	NA	8.43	6.40	NA	40.17	090
63199		A	Incise spinal column & cord	26.85	NA	15.03	1.40	NA	43.28	090
63200		A	Release of spinal cord	19.15	NA	11.29	4.73	NA	35.17	090
63250		A	Revise spinal cord vessels	40.70	NA	19.92	8.93	NA	69.55	090
63251		A	Revise spinal cord vessels	41.14	NA	22.58	9.92	NA	73.64	090
63252		A	Revise spinal cord vessels	41.13	NA	22.23	10.07	NA	73.43	090
63265		A	Excise intraspinal lesion	21.53	NA	12.76	5.28	NA	39.57	090
63266		A	Excise intraspinal lesion	22.27	NA	13.17	5.37	NA	40.81	090
63267		A	Excise intraspinal lesion	17.92	NA	11.07	4.26	NA	33.25	090
63268		A	Excise intraspinal lesion	18.49	NA	10.36	3.61	NA	32.46	090
63270		A	Excise intraspinal lesion	26.76	NA	15.46	6.56	NA	48.78	090
63271		A	Excise intraspinal lesion	26.88	NA	15.56	6.47	NA	48.91	090
63272		A	Excise intraspinal lesion	25.28	NA	14.68	6.04	NA	46.00	090
63273		A	Excise intraspinal lesion	24.25	NA	14.33	5.69	NA	44.27	090
63275		A	Biopsy/excise spinal tumor	23.64	NA	13.76	5.61	NA	43.01	090
63276		A	Biopsy/excise spinal tumor	23.41	NA	13.67	5.60	NA	42.68	090
63277		A	Biopsy/excise spinal tumor	20.80	NA	12.51	4.86	NA	38.17	090
63278		A	Biopsy/excise spinal tumor	20.53	NA	12.38	4.40	NA	37.31	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
63280		A	Biopsy/excise spinal tumor	28.31	NA	16.30	7.01	NA	51.62	090
63281		A	Biopsy/excise spinal tumor	28.01	NA	16.16	6.90	NA	51.07	090
63282		A	Biopsy/excise spinal tumor	26.35	NA	15.32	6.40	NA	48.07	090
63283		A	Biopsy/excise spinal tumor	24.96	NA	14.65	6.22	NA	45.83	090
63285		A	Biopsy/excise spinal tumor	35.95	NA	19.93	8.98	NA	64.86	090
63286		A	Biopsy/excise spinal tumor	35.58	NA	19.89	8.87	NA	64.34	090
63287		A	Biopsy/excise spinal tumor	36.64	NA	20.41	8.81	NA	65.86	090
63290		A	Biopsy/excise spinal tumor	37.32	NA	20.58	8.74	NA	66.64	090
63295		A	Repair of laminectomy defect	5.25	NA	2.14	1.03	NA	8.42	ZZZ
63300		A	Removal of vertebral body	24.39	NA	14.29	5.56	NA	44.24	090
63301		A	Removal of vertebral body	27.56	NA	15.54	4.91	NA	48.01	090
63302		A	Removal of vertebral body	27.77	NA	15.84	5.22	NA	48.83	090
63303		A	Removal of vertebral body	30.45	NA	16.90	4.49	NA	51.84	090
63304		A	Removal of vertebral body	30.28	NA	17.26	6.36	NA	53.90	090
63305		A	Removal of vertebral body	31.98	NA	18.04	5.66	NA	55.68	090
63306		A	Removal of vertebral body	32.17	NA	17.79	8.26	NA	58.22	090
63307		A	Removal of vertebral body	31.58	NA	16.80	4.43	NA	52.81	090
63308		A	Remove vertebral body add-on	5.24	NA	2.60	1.26	NA	9.10	ZZZ
63600		A	Remove spinal cord lesion	14.00	NA	5.39	1.49	NA	20.88	090
63610		A	Stimulation of spinal cord	8.72	59.68	2.25	0.86	69.26	11.83	000
63615		A	Remove lesion of spinal cord	16.26	NA	9.26	2.64	NA	28.16	090
63650		A	Implant neuroelectrodes	6.73	NA	3.17	0.54	NA	10.44	090
63655		A	Implant neuroelectrodes	10.27	NA	6.89	2.33	NA	19.49	090
63660		A	Revise/remove neuroelectrode	6.15	NA	3.61	0.79	NA	10.55	090
63685		A	Insrt/redo spine n generator	7.03	NA	4.14	1.02	NA	12.19	090
63688		A	Revise/remove neuroreceiver	5.38	NA	3.55	0.85	NA	9.78	090
63700		A	Repair of spinal herniation	16.51	NA	10.30	3.42	NA	30.23	090
63702		A	Repair of spinal herniation	18.45	NA	11.03	4.09	NA	33.57	090
63704		A	Repair of spinal herniation	21.15	NA	12.91	4.54	NA	38.60	090
63706		A	Repair of spinal herniation	24.07	NA	13.57	6.18	NA	43.82	090
63707		A	Repair spinal fluid leakage	11.24	NA	7.70	2.41	NA	21.35	090
63709		A	Repair spinal fluid leakage	14.30	NA	9.39	3.02	NA	26.71	090
63710		A	Graft repair of spine defect	14.05	NA	9.03	3.34	NA	26.42	090
63740		A	Install spinal shunt	11.34	NA	7.34	2.68	NA	21.36	090
63741		A	Install spinal shunt	8.24	NA	4.75	1.59	NA	14.58	090
63744		A	Revision of spinal shunt	8.09	NA	5.25	1.76	NA	15.10	090
63746		A	Removal of spinal shunt	6.42	NA	3.77	1.49	NA	11.68	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64400		A	N block inj, trigeminal	1.11	1.89	0.43	0.09	3.09	1.63	000
64402		A	N block inj, facial	1.25	1.61	0.60	0.09	2.95	1.94	000
64405		A	N block inj, occipital	1.32	1.46	0.46	0.08	2.86	1.86	000
64408		A	N block inj, vagus	1.41	1.58	0.85	0.10	3.09	2.36	000
64410		A	N block inj, phrenic	1.43	2.50	0.46	0.10	4.03	1.99	000
64412		A	N block inj, spinal accessor	1.18	2.65	0.43	0.08	3.91	1.69	000
64413		A	N block inj, cervical plexus	1.40	1.84	0.50	0.09	3.33	1.99	000
64415		A	N block inj, brachial plexus	1.48	2.80	0.46	0.10	4.38	2.04	000
64416		A	N block cont infuse, b plex	3.49	NA	0.79	0.31	NA	4.59	010
64417		A	N block inj, axillary	1.44	3.03	0.49	0.11	4.58	2.04	000
64418		A	N block inj, suprascapular	1.32	2.62	0.44	0.08	4.02	1.84	000
64420		A	N block inj, intercost, sng	1.18	3.88	0.42	0.09	5.15	1.69	000
64421		A	N block inj, intercost, mlt	1.68	6.08	0.52	0.12	7.88	2.32	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.65	0.54	0.14	3.54	2.43	000
64430		A	N block inj, pudendal	1.46	2.51	0.55	0.11	4.08	2.12	000
64435		A	N block inj, paracervical	1.45	2.52	0.69	0.15	4.12	2.29	000
64445		A	N block inj, sciatic, sng	1.48	2.67	0.50	0.10	4.25	2.08	000
64446		A	N blk inj, sciatic, cont inf	3.25	NA	1.00	0.24	NA	4.49	010
64447		A	N block inj fem, single	1.50	NA	0.43	0.10	NA	2.03	000
64448		A	N block inj fem, cont inf	3.00	NA	0.81	0.21	NA	4.02	010
64449		A	N block inj, lumbar plexus	3.00	NA	0.96	0.16	NA	4.12	010
64450		A	N block, other peripheral	1.27	1.24	0.48	0.13	2.64	1.88	000
64470		A	Inj paravertebral c/t	1.85	7.23	0.71	0.13	9.21	2.69	000
64472		A	Inj paravertebral c/t add-on	1.29	2.33	0.34	0.09	3.71	1.72	ZZZ
64475		A	Inj paravertebral l/s	1.41	6.88	0.63	0.11	8.40	2.15	000
64476		A	Inj paravertebral l/s add-on	0.98	2.12	0.24	0.07	3.17	1.29	ZZZ
64479		A	Inj foramen epidural c/t	2.20	7.49	0.89	0.15	9.84	3.24	000
64480		A	Inj foramen epidural add-on	1.54	2.84	0.47	0.12	4.50	2.13	ZZZ
64483		A	Inj foramen epidural l/s	1.90	7.89	0.83	0.12	9.91	2.85	000
64484		A	Inj foramen epidural add-on	1.33	3.28	0.37	0.09	4.70	1.79	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.24	0.66	0.10	2.70	2.12	000
64508		A	N block, carotid sinus s/p	1.12	3.32	0.74	0.07	4.51	1.93	000
64510		A	N block, stellate ganglion	1.22	3.45	0.51	0.07	4.74	1.80	000
64517		A	N block inj, hypogas plxs	2.20	2.72	0.87	0.11	5.03	3.18	000
64520		A	N block, lumbar/thoracic	1.35	5.14	0.55	0.08	6.57	1.98	000
64530		A	N block inj, celiac pelus	1.58	4.45	0.65	0.10	6.13	2.33	000
64550		A	Apply neurostimulator	0.18	0.28	0.05	0.01	0.47	0.24	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
64553		A	Implant neuroelectrodes	2.31	2.83	1.85	0.19	5.33	4.35	010
64555		A	Implant neuroelectrodes	2.27	3.10	1.19	0.20	5.57	3.66	010
64560		A	Implant neuroelectrodes	2.36	2.63	1.28	0.21	5.20	3.85	010
64561		A	Implant neuroelectrodes	6.73	30.05	2.77	0.51	37.29	10.01	010
64565		A	Implant neuroelectrodes	1.76	3.28	1.26	0.13	5.17	3.15	010
64573		A	Implant neuroelectrodes	7.49	NA	5.24	1.53	NA	14.26	090
64575		A	Implant neuroelectrodes	4.34	NA	2.67	0.59	NA	7.60	090
64577		A	Implant neuroelectrodes	4.61	NA	3.28	1.04	NA	8.93	090
64580		A	Implant neuroelectrodes	4.11	NA	3.55	0.36	NA	8.02	090
64581		A	Implant neuroelectrodes	13.48	NA	5.37	1.05	NA	19.90	090
64585		A	Revise/remove neuroelectrode	2.06	11.28	2.13	0.20	13.54	4.39	010
64590		A	Insrt/redo perph n generator	2.40	7.14	2.28	0.21	9.75	4.89	010
64595		A	Revise/remove neuroreceiver	1.73	10.39	1.92	0.19	12.31	3.84	010
64600		A	Injection treatment of nerve	3.44	9.35	1.65	0.33	13.12	5.42	010
64605		A	Injection treatment of nerve	5.60	9.55	2.18	0.77	15.92	8.55	010
64610		A	Injection treatment of nerve	7.15	8.86	3.71	1.48	17.49	12.34	010
64612		A	Destroy nerve, face muscle	1.96	2.48	1.32	0.12	4.56	3.40	010
64613		A	Destroy nerve, spine muscle	1.96	2.93	1.22	0.11	5.00	3.29	010
64614		A	Destroy nerve, extrem musc	2.20	3.22	1.31	0.11	5.53	3.62	010
64620		A	Injection treatment of nerve	2.84	5.06	1.33	0.20	8.10	4.37	010
64622		A	Destr paravertebrl nerve l/s	3.00	7.76	1.37	0.21	10.97	4.58	010
64623		A	Destr paravertebral n add-on	0.99	2.96	0.22	0.07	4.02	1.28	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.28	7.78	1.96	0.22	11.28	5.46	010
64627		A	Destr paravertebral n add-on	1.16	4.53	0.27	0.08	5.77	1.51	ZZZ
64630		A	Injection treatment of nerve	3.00	2.73	1.41	0.23	5.96	4.64	010
64640		A	Injection treatment of nerve	2.76	4.18	1.84	0.28	7.22	4.88	010
64680		A	Injection treatment of nerve	2.62	6.71	1.43	0.18	9.51	4.23	010
64681		A	Injection treatment of nerve	3.54	9.29	2.06	0.28	13.11	5.88	010
64702		A	Revise finger/toe nerve	4.22	NA	3.86	0.61	NA	8.69	090
64704		A	Revise hand/foot nerve	4.56	NA	3.31	0.61	NA	8.48	090
64708		A	Revise arm/leg nerve	6.11	NA	4.86	0.94	NA	11.91	090
64712		A	Revision of sciatic nerve	7.74	NA	4.96	0.99	NA	13.69	090
64713		A	Revision of arm nerve(s)	10.98	NA	5.87	1.74	NA	18.59	090
64714		A	Revise low back nerve(s)	10.31	NA	4.20	1.19	NA	15.70	090
64716		A	Revision of cranial nerve	6.30	NA	5.97	0.65	NA	12.92	090
64718		A	Revise ulnar nerve at elbow	5.98	NA	5.99	1.04	NA	13.01	090
64719		A	Revise ulnar nerve at wrist	4.84	NA	4.52	0.77	NA	10.13	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64721		A	Carpal tunnel surgery	4.28	NA	5.36	0.72	NA	10.36	090
64722		A	Relieve pressure on nerve(s)	4.69	NA	3.04	0.52	NA	8.25	090
64726		A	Release foot/toe nerve	4.17	NA	2.79	0.55	NA	7.51	090
64727		A	Internal nerve revision	3.10	NA	1.50	0.47	NA	5.07	ZZZ
64732		A	Incision of brow nerve	4.40	NA	3.50	0.94	NA	8.84	090
64734		A	Incision of cheek nerve	4.91	NA	4.05	0.88	NA	9.84	090
64736		A	Incision of chin nerve	4.59	NA	4.02	0.52	NA	9.13	090
64738		A	Incision of jaw nerve	5.72	NA	4.61	1.07	NA	11.40	090
64740		A	Incision of tongue nerve	5.58	NA	5.12	0.69	NA	11.39	090
64742		A	Incision of facial nerve	6.21	NA	4.70	0.73	NA	11.64	090
64744		A	Incise nerve, back of head	5.23	NA	3.77	1.09	NA	10.09	090
64746		A	Incise diaphragm nerve	5.92	NA	4.50	0.82	NA	11.24	090
64752		A	Incision of vagus nerve	7.05	NA	4.28	0.92	NA	12.25	090
64755		A	Incision of stomach nerves	13.50	NA	5.63	1.81	NA	20.94	090
64760		A	Incision of vagus nerve	6.95	NA	3.45	0.78	NA	11.18	090
64761		A	Incision of pelvis nerve	6.40	NA	3.52	0.53	NA	10.45	090
64763		A	Incise hip/thigh nerve	6.92	NA	5.19	0.94	NA	13.05	090
64766		A	Incise hip/thigh nerve	8.66	NA	5.24	1.06	NA	14.96	090
64771		A	Sever cranial nerve	7.34	NA	5.55	1.22	NA	14.11	090
64772		A	Incision of spinal nerve	7.20	NA	4.92	1.29	NA	13.41	090
64774		A	Remove skin nerve lesion	5.16	NA	3.83	0.75	NA	9.74	090
64776		A	Remove digit nerve lesion	5.11	NA	3.68	0.73	NA	9.52	090
64778		A	Digit nerve surgery add-on	3.11	NA	1.50	0.45	NA	5.06	ZZZ
64782		A	Remove limb nerve lesion	6.22	NA	3.77	0.87	NA	10.86	090
64783		A	Limb nerve surgery add-on	3.71	NA	1.83	0.51	NA	6.05	ZZZ
64784		A	Remove nerve lesion	9.81	NA	6.59	1.42	NA	17.82	090
64786		A	Remove sciatic nerve lesion	15.44	NA	9.83	2.53	NA	27.80	090
64787		A	Implant nerve end	4.29	NA	2.12	0.58	NA	6.99	ZZZ
64788		A	Remove skin nerve lesion	4.60	NA	3.46	0.68	NA	8.74	090
64790		A	Removal of nerve lesion	11.29	NA	7.20	1.99	NA	20.48	090
64792		A	Removal of nerve lesion	14.90	NA	8.82	2.36	NA	26.08	090
64795		A	Biopsy of nerve	3.01	NA	1.56	0.50	NA	5.07	000
64802		A	Remove sympathetic nerves	9.14	NA	5.13	1.28	NA	15.55	090
64804		A	Remove sympathetic nerves	14.62	NA	7.16	2.09	NA	23.87	090
64809		A	Remove sympathetic nerves	13.65	NA	5.76	1.50	NA	20.91	090
64818		A	Remove sympathetic nerves	10.28	NA	5.28	1.32	NA	16.88	090
64820		A	Remove sympathetic nerves	10.35	NA	7.12	1.48	NA	18.95	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64821		A	Remove sympathetic nerves	8.74	NA	7.34	1.24	NA	17.32	090
64822		A	Remove sympathetic nerves	8.74	NA	7.23	1.27	NA	17.24	090
64823		A	Remove sympathetic nerves	10.35	NA	8.13	1.55	NA	20.03	090
64831		A	Repair of digit nerve	9.43	NA	7.07	1.39	NA	17.89	090
64832		A	Repair nerve add-on	5.65	NA	2.93	0.84	NA	9.42	ZZZ
64834		A	Repair of hand or foot nerve	10.17	NA	7.09	1.52	NA	18.78	090
64835		A	Repair of hand or foot nerve	10.92	NA	7.69	1.67	NA	20.28	090
64836		A	Repair of hand or foot nerve	10.92	NA	7.66	1.66	NA	20.24	090
64837		A	Repair nerve add-on	6.25	NA	3.23	0.96	NA	10.44	ZZZ
64840		A	Repair of leg nerve	13.00	NA	8.25	1.36	NA	22.61	090
64856		A	Repair/transpose nerve	13.78	NA	9.18	2.08	NA	25.04	090
64857		A	Repair arm/leg nerve	14.47	NA	9.63	2.22	NA	26.32	090
64858		A	Repair sciatic nerve	16.47	NA	10.77	3.30	NA	30.54	090
64859		A	Nerve surgery	4.25	NA	2.19	0.67	NA	7.11	ZZZ
64861		A	Repair of arm nerves	19.21	NA	11.77	4.05	NA	35.03	090
64862		A	Repair of low back nerves	19.41	NA	11.93	4.28	NA	35.62	090
64864		A	Repair of facial nerve	12.53	NA	8.76	1.30	NA	22.59	090
64865		A	Repair of facial nerve	15.22	NA	13.52	1.55	NA	30.29	090
64866		A	Fusion of facial/other nerve	15.72	NA	13.16	2.03	NA	30.91	090
64868		A	Fusion of facial/other nerve	14.02	NA	11.43	1.43	NA	26.88	090
64870		A	Fusion of facial/other nerve	15.97	NA	8.72	1.30	NA	25.99	090
64872		A	Subsequent repair of nerve	1.99	NA	1.08	0.29	NA	3.36	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	1.53	0.42	NA	4.93	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	1.74	0.47	NA	5.58	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	11.60	1.67	NA	30.77	090
64886		A	Nerve graft, head or neck	20.72	NA	13.54	2.10	NA	36.36	090
64890		A	Nerve graft, hand or foot	15.13	NA	9.99	2.28	NA	27.40	090
64891		A	Nerve graft, hand or foot	16.12	NA	7.58	1.62	NA	25.32	090
64892		A	Nerve graft, arm or leg	14.63	NA	8.86	2.45	NA	25.94	090
64893		A	Nerve graft, arm or leg	15.58	NA	9.86	2.60	NA	28.04	090
64895		A	Nerve graft, hand or foot	19.22	NA	9.65	2.55	NA	31.42	090
64896		A	Nerve graft, hand or foot	20.46	NA	10.98	3.13	NA	34.57	090
64897		A	Nerve graft, arm or leg	18.21	NA	10.69	2.52	NA	31.42	090
64898		A	Nerve graft, arm or leg	19.47	NA	11.79	2.74	NA	34.00	090
64901		A	Nerve graft add-on	10.20	NA	5.26	1.37	NA	16.83	ZZZ
64902		A	Nerve graft add-on	11.81	NA	5.96	1.54	NA	19.31	ZZZ
64905		A	Nerve pedicle transfer	14.00	NA	8.49	1.98	NA	24.47	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
64907		A	Nerve pedicle transfer	18.80	NA	12.52	3.13	NA	34.45	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	6.45	NA	8.35	0.32	NA	15.12	090
65093		A	Revise eye with implant	6.86	NA	8.71	0.36	NA	15.93	090
65101		A	Removal of eye	7.02	NA	9.52	0.37	NA	16.91	090
65103		A	Remove eye/insert implant	7.56	NA	9.73	0.38	NA	17.67	090
65105		A	Remove eye/attach implant	8.48	NA	10.46	0.43	NA	19.37	090
65110		A	Removal of eye	13.93	NA	13.67	0.84	NA	28.44	090
65112		A	Remove eye/revise socket	16.36	NA	16.13	1.38	NA	33.87	090
65114		A	Remove eye/revise socket	17.50	NA	16.34	1.02	NA	34.86	090
65125		A	Revise ocular implant	3.12	8.80	3.60	0.18	12.10	6.90	090
65130		A	Insert ocular implant	7.14	NA	9.16	0.35	NA	16.65	090
65135		A	Insert ocular implant	7.32	NA	9.31	0.38	NA	17.01	090
65140		A	Attach ocular implant	8.01	NA	9.87	0.43	NA	18.31	090
65150		A	Revise ocular implant	6.25	NA	7.97	0.33	NA	14.55	090
65155		A	Reinsert ocular implant	8.65	NA	10.48	0.50	NA	19.63	090
65175		A	Removal of ocular implant	6.27	NA	8.48	0.34	NA	15.09	090
65205		A	Remove foreign body from eye	0.71	0.64	0.29	0.04	1.39	1.04	000
65210		A	Remove foreign body from eye	0.84	0.81	0.38	0.04	1.69	1.26	000
65220		A	Remove foreign body from eye	0.71	0.64	0.28	0.05	1.40	1.04	000
65222		A	Remove foreign body from eye	0.93	0.89	0.38	0.05	1.87	1.36	000
65235		A	Remove foreign body from eye	7.56	NA	6.74	0.39	NA	14.69	090
65260		A	Remove foreign body from eye	10.94	NA	9.65	0.57	NA	21.16	090
65265		A	Remove foreign body from eye	12.57	NA	10.62	0.63	NA	23.82	090
65270		A	Repair of eye wound	1.90	5.22	1.39	0.10	7.22	3.39	010
65272		A	Repair of eye wound	3.81	7.71	3.29	0.20	11.72	7.30	090
65273		A	Repair of eye wound	4.35	NA	3.58	0.22	NA	8.15	090
65275		A	Repair of eye wound	5.33	6.31	3.94	0.29	11.93	9.56	090
65280		A	Repair of eye wound	7.65	NA	6.23	0.38	NA	14.26	090
65285		A	Repair of eye wound	12.88	NA	9.21	0.64	NA	22.73	090
65286		A	Repair of eye wound	5.50	11.14	4.62	0.27	16.91	10.39	090
65290		A	Repair of eye socket wound	5.40	NA	4.74	0.32	NA	10.46	090
65400		A	Removal of eye lesion	6.05	8.33	6.12	0.30	14.68	12.47	090
65410		A	Biopsy of cornea	1.47	2.11	0.97	0.07	3.65	2.51	000
65420		A	Removal of eye lesion	4.16	8.85	4.44	0.21	13.22	8.81	090
65426		A	Removal of eye lesion	5.24	10.17	4.92	0.26	15.67	10.42	090
65430		A	Corneal smear	1.47	1.29	0.98	0.07	2.83	2.52	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
65435		A	Curette/treat cornea	0.92	1.00	0.71	0.05	1.97	1.68	000
65436		A	Curette/treat cornea	4.18	4.09	3.67	0.21	8.48	8.06	090
65450		A	Treatment of corneal lesion	3.27	4.07	3.94	0.16	7.50	7.37	090
65600		A	Revision of cornea	3.39	5.01	3.35	0.17	8.57	6.91	090
65710		A	Corneal transplant	12.33	NA	11.20	0.60	NA	24.13	090
65730		A	Corneal transplant	14.23	NA	12.02	0.70	NA	26.95	090
65750		A	Corneal transplant	14.98	NA	11.97	0.74	NA	27.69	090
65755		A	Corneal transplant	14.87	NA	11.89	0.73	NA	27.49	090
65760		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65765		N	Revision of cornea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65767		N	Corneal tissue transplant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65770		A	Revise cornea with implant	17.53	NA	13.20	0.86	NA	31.59	090
65771		N	Radial keratotomy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
65772		A	Correction of astigmatism	4.28	5.53	4.13	0.21	10.02	8.62	090
65775		A	Correction of astigmatism	5.78	NA	5.95	0.28	NA	12.01	090
65780		A	Ocular reconst, transplant	10.23	NA	10.29	0.44	NA	20.96	090
65781		A	Ocular reconst, transplant	17.64	NA	13.67	0.44	NA	31.75	090
65782		A	Ocular reconst, transplant	14.98	NA	11.99	0.44	NA	27.41	090
65800		A	Drainage of eye	1.91	1.79	1.18	0.09	3.79	3.18	000
65805		A	Drainage of eye	1.91	2.17	1.19	0.09	4.17	3.19	000
65810		A	Drainage of eye	4.86	NA	4.70	0.24	NA	9.80	090
65815		A	Drainage of eye	5.04	10.00	4.81	0.25	15.29	10.10	090
65820		A	Relieve inner eye pressure	8.12	NA	9.05	0.40	NA	17.57	090
65850		A	Incision of eye	10.50	NA	8.44	0.52	NA	19.46	090
65855		A	Laser surgery of eye	3.84	4.31	3.10	0.19	8.34	7.13	010
65860		A	Incise inner eye adhesions	3.54	4.04	2.50	0.18	7.76	6.22	090
65865		A	Incise inner eye adhesions	5.59	NA	5.62	0.28	NA	11.49	090
65870		A	Incise inner eye adhesions	6.26	NA	6.41	0.31	NA	12.98	090
65875		A	Incise inner eye adhesions	6.53	NA	6.79	0.32	NA	13.64	090
65880		A	Incise inner eye adhesions	7.08	NA	7.03	0.35	NA	14.46	090
65900		A	Remove eye lesion	10.91	NA	10.25	0.57	NA	21.73	090
65920		A	Remove implant of eye	8.39	NA	8.17	0.41	NA	16.97	090
65930		A	Remove blood clot from eye	7.43	NA	6.83	0.37	NA	14.63	090
66020		A	Injection treatment of eye	1.59	3.12	1.44	0.08	4.79	3.11	010
66030		A	Injection treatment of eye	1.25	2.96	1.28	0.06	4.27	2.59	010
66130		A	Remove eye lesion	7.68	9.62	5.61	0.38	17.68	13.67	090
66150		A	Glaucoma surgery	8.29	NA	9.40	0.46	NA	18.15	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
66155		A	Glaucoma surgery	8.28	NA	9.35	0.41	NA	18.04	090
66160		A	Glaucoma surgery	10.15	NA	10.19	0.50	NA	20.84	090
66165		A	Glaucoma surgery	8.00	NA	9.24	0.40	NA	17.64	090
66170		A	Glaucoma surgery	12.14	NA	12.22	0.59	NA	24.95	090
66172		A	Incision of eye	15.02	NA	15.20	0.74	NA	30.96	090
66180		A	Implant eye shunt	14.53	NA	10.76	0.71	NA	26.00	090
66185		A	Revise eye shunt	8.13	NA	7.38	0.40	NA	15.91	090
66220		A	Repair eye lesion	7.76	NA	7.10	0.42	NA	15.28	090
66225		A	Repair/graft eye lesion	11.03	NA	8.73	0.54	NA	20.30	090
66250		A	Follow-up surgery of eye	5.97	11.69	5.48	0.30	17.96	11.75	090
66500		A	Incision of iris	3.70	NA	4.64	0.18	NA	8.52	090
66505		A	Incision of iris	4.07	NA	4.99	0.20	NA	9.26	090
66600		A	Remove iris and lesion	8.67	NA	8.22	0.44	NA	17.33	090
66605		A	Removal of iris	12.77	NA	10.02	0.77	NA	23.56	090
66625		A	Removal of iris	5.12	NA	4.73	0.25	NA	10.10	090
66630		A	Removal of iris	6.15	NA	5.71	0.30	NA	12.16	090
66635		A	Removal of iris	6.24	NA	5.74	0.31	NA	12.29	090
66680		A	Repair iris & ciliary body	5.43	NA	5.27	0.27	NA	10.97	090
66682		A	Repair iris & ciliary body	6.20	NA	6.61	0.31	NA	13.12	090
66700		A	Destruction, ciliary body	4.77	5.24	3.93	0.24	10.25	8.94	090
66710		A	Ciliary transscleral therapy	4.77	5.17	3.84	0.23	10.17	8.84	090
66711		A	Ciliary endoscopic ablation	6.60	NA	6.47	0.30	NA	13.37	090
66720		A	Destruction, ciliary body	4.77	5.79	4.72	0.26	10.82	9.75	090
66740		A	Destruction, ciliary body	4.77	5.09	3.97	0.23	10.09	8.97	090
66761		A	Revision of iris	4.06	5.59	4.31	0.20	9.85	8.57	090
66762		A	Revision of iris	4.57	5.65	4.29	0.23	10.45	9.09	090
66770		A	Removal of inner eye lesion	5.17	6.08	4.80	0.26	11.51	10.23	090
66820		A	Incision, secondary cataract	3.88	NA	5.81	0.19	NA	9.88	090
66821		A	After cataract laser surgery	2.35	4.09	3.62	0.11	6.55	6.08	090
66825		A	Reposition intraocular lens	8.22	NA	9.06	0.40	NA	17.68	090
66830		A	Removal of lens lesion	8.19	NA	6.95	0.38	NA	15.52	090
66840		A	Removal of lens material	7.90	NA	6.86	0.38	NA	15.14	090
66850		A	Removal of lens material	9.10	NA	7.64	0.44	NA	17.18	090
66852		A	Removal of lens material	9.96	NA	8.10	0.49	NA	18.55	090
66920		A	Extraction of lens	8.85	NA	7.30	0.44	NA	16.59	090
66930		A	Extraction of lens	10.16	NA	8.14	0.48	NA	18.78	090
66940		A	Extraction of lens	8.92	NA	7.60	0.43	NA	16.95	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
66982		A	Cataract surgery, complex	13.48	NA	9.86	0.61	NA	23.95	090
66983		A	Cataract surg w/iol, 1 stage	8.98	NA	6.11	0.22	NA	15.31	090
66984		A	Cataract surg w/iol, 1 stage	10.21	NA	7.42	0.42	NA	18.05	090
66985		A	Insert lens prosthesis	8.38	NA	7.45	0.38	NA	16.21	090
66986		A	Exchange lens prosthesis	12.26	NA	9.17	0.59	NA	22.02	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	0.69	0.08	NA	2.28	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.69	NA	4.86	0.28	NA	10.83	090
67010		A	Partial removal of eye fluid	6.86	NA	5.41	0.34	NA	12.61	090
67015		A	Release of eye fluid	6.91	NA	6.45	0.34	NA	13.70	090
67025		A	Replace eye fluid	6.83	9.22	6.22	0.34	16.39	13.39	090
67027		A	Implant eye drug system	10.83	NA	8.00	0.54	NA	19.37	090
67028		A	Injection eye drug	2.52	2.70	1.46	0.12	5.34	4.10	000
67030		A	Incise inner eye strands	4.83	NA	5.85	0.24	NA	10.92	090
67031		A	Laser surgery, eye strands	3.66	4.60	3.64	0.18	8.44	7.48	090
67036		A	Removal of inner eye fluid	11.87	NA	9.12	0.58	NA	21.57	090
67038		A	Strip retinal membrane	21.21	NA	15.49	1.04	NA	37.74	090
67039		A	Laser treatment of retina	14.50	NA	12.18	0.71	NA	27.39	090
67040		A	Laser treatment of retina	17.20	NA	13.68	0.85	NA	31.73	090
67101		A	Repair detached retina	7.52	9.12	6.53	0.37	17.01	14.42	090
67105		A	Repair detached retina	7.40	8.08	6.15	0.37	15.85	13.92	090
67107		A	Repair detached retina	14.82	NA	11.30	0.73	NA	26.85	090
67108		A	Repair detached retina	20.79	NA	14.42	1.02	NA	36.23	090
67110		A	Repair detached retina	8.80	10.23	7.39	0.44	19.47	16.63	090
67112		A	Rerepair detached retina	16.83	NA	11.81	0.83	NA	29.47	090
67115		A	Release encircling material	4.98	NA	5.08	0.25	NA	10.31	090
67120		A	Remove eye implant material	5.97	8.58	5.53	0.30	14.85	11.80	090
67121		A	Remove eye implant material	10.65	NA	8.53	0.53	NA	19.71	090
67141		A	Treatment of retina	5.19	5.85	4.86	0.26	11.30	10.31	090
67145		A	Treatment of retina	5.36	5.72	4.93	0.27	11.35	10.56	090
67208		A	Treatment of retinal lesion	6.69	6.12	5.51	0.33	13.14	12.53	090
67210		A	Treatment of retinal lesion	8.81	6.57	5.88	0.44	15.82	15.13	090
67218		A	Treatment of retinal lesion	18.50	NA	12.15	0.92	NA	31.57	090
67220		A	Treatment of choroid lesion	13.11	10.42	9.01	0.65	24.18	22.77	090
67221		R	Ocular photodynamic ther	4.00	4.33	1.80	0.20	8.53	6.00	000
67225		A	Eye photodynamic ther add-on	0.47	0.25	0.21	0.02	0.74	0.70	ZZZ
67227		A	Treatment of retinal lesion	6.57	6.58	5.52	0.33	13.48	12.42	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
67228		A	Treatment of retinal lesion	12.72	11.48	8.54	0.63	24.83	21.89	090
67250		A	Reinforce eye wall	8.65	NA	9.17	0.47	NA	18.29	090
67255		A	Reinforce/graft eye wall	8.89	NA	9.89	0.44	NA	19.22	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	6.64	NA	6.02	0.37	NA	13.03	090
67312		A	Revise two eye muscles	8.53	NA	6.75	0.43	NA	15.71	090
67314		A	Revise eye muscle	7.51	NA	6.55	0.39	NA	14.45	090
67316		A	Revise two eye muscles	9.65	NA	7.50	0.49	NA	17.64	090
67318		A	Revise eye muscle(s)	7.84	NA	6.93	0.41	NA	15.18	090
67320		A	Revise eye muscle(s) add-on	4.32	NA	1.95	0.23	NA	6.50	ZZZ
67331		A	Eye surgery follow-up add-on	4.05	NA	1.83	0.21	NA	6.09	ZZZ
67332		A	Rerevise eye muscles add-on	4.48	NA	2.02	0.24	NA	6.74	ZZZ
67334		A	Revise eye muscle w/suture	3.97	NA	1.79	0.20	NA	5.96	ZZZ
67335		A	Eye suture during surgery	2.49	NA	1.12	0.13	NA	3.74	ZZZ
67340		A	Revise eye muscle add-on	4.92	NA	2.20	0.25	NA	7.37	ZZZ
67343		A	Release eye tissue	7.34	NA	6.51	0.37	NA	14.22	090
67345		A	Destroy nerve of eye muscle	2.96	2.58	2.01	0.17	5.71	5.14	010
67350		A	Biopsy eye muscle	2.87	NA	1.87	0.16	NA	4.90	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	9.75	NA	11.26	0.57	NA	21.58	090
67405		A	Explore/drain eye socket	7.92	NA	9.77	0.46	NA	18.15	090
67412		A	Explore/treat eye socket	9.49	NA	10.93	0.53	NA	20.95	090
67413		A	Explore/treat eye socket	9.99	NA	10.77	0.54	NA	21.30	090
67414		A	Explr/decompress eye socket	11.11	NA	12.04	0.66	NA	23.81	090
67415		A	Aspiration, orbital contents	1.76	NA	0.76	0.10	NA	2.62	000
67420		A	Explore/treat eye socket	20.03	NA	17.39	1.22	NA	38.64	090
67430		A	Explore/treat eye socket	13.37	NA	14.89	0.91	NA	29.17	090
67440		A	Explore/drain eye socket	13.07	NA	14.26	0.77	NA	28.10	090
67445		A	Explr/decompress eye socket	14.40	NA	13.91	0.93	NA	29.24	090
67450		A	Explore/biopsy eye socket	13.49	NA	14.69	0.73	NA	28.91	090
67500		A	Inject/treat eye socket	0.79	0.67	0.29	0.06	1.52	1.14	000
67505		A	Inject/treat eye socket	0.82	0.69	0.31	0.05	1.56	1.18	000
67515		A	Inject/treat eye socket	0.61	0.59	0.38	0.03	1.23	1.02	000
67550		A	Insert eye socket implant	10.17	NA	11.30	0.73	NA	22.20	090
67560		A	Revise eye socket implant	10.58	NA	11.37	0.59	NA	22.54	090
67570		A	Decompress optic nerve	13.56	NA	13.58	0.79	NA	27.93	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
67700		A	Drainage of eyelid abscess	1.35	6.02	1.27	0.07	7.44	2.69	010
67710		A	Incision of eyelid	1.02	5.37	1.21	0.05	6.44	2.28	010
67715		A	Incision of eyelid fold	1.22	5.37	1.29	0.06	6.65	2.57	010
67800		A	Remove eyelid lesion	1.38	1.62	1.04	0.07	3.07	2.49	010
67801		A	Remove eyelid lesions	1.88	1.96	1.26	0.09	3.93	3.23	010
67805		A	Remove eyelid lesions	2.22	2.52	1.65	0.11	4.85	3.98	010
67808		A	Remove eyelid lesion(s)	3.79	NA	3.77	0.21	NA	7.77	090
67810		A	Biopsy of eyelid	1.48	3.33	0.68	0.07	4.88	2.23	000
67820		A	Revise eyelashes	0.89	0.60	0.56	0.04	1.53	1.49	000
67825		A	Revise eyelashes	1.38	1.73	1.41	0.07	3.18	2.86	010
67830		A	Revise eyelashes	1.70	5.53	1.50	0.09	7.32	3.29	010
67835		A	Revise eyelashes	5.55	NA	4.62	0.29	NA	10.46	090
67840		A	Remove eyelid lesion	2.04	5.47	1.65	0.10	7.61	3.79	010
67850		A	Treat eyelid lesion	1.69	3.37	1.47	0.08	5.14	3.24	010
67875		A	Closure of eyelid by suture	1.35	3.30	0.94	0.08	4.73	2.37	000
67880		A	Revision of eyelid	3.79	6.61	3.80	0.20	10.60	7.79	090
67882		A	Revision of eyelid	5.06	7.63	4.81	0.27	12.96	10.14	090
67900		A	Repair brow defect	6.13	9.06	5.25	0.38	15.57	11.76	090
67901		A	Repair eyelid defect	6.96	NA	5.40	0.51	NA	12.87	090
67902		A	Repair eyelid defect	7.02	NA	5.46	0.45	NA	12.93	090
67903		A	Repair eyelid defect	6.36	9.56	5.51	0.47	16.39	12.34	090
67904		A	Repair eyelid defect	6.25	9.63	5.23	0.41	16.29	11.89	090
67906		A	Repair eyelid defect	6.78	5.37	5.03	0.46	12.61	12.27	090
67908		A	Repair eyelid defect	5.12	6.63	5.34	0.29	12.04	10.75	090
67909		A	Revise eyelid defect	5.39	8.03	4.95	0.31	13.73	10.65	090
67911		A	Revise eyelid defect	5.26	NA	4.78	0.31	NA	10.35	090
67912		A	Correction eyelid w/implant	5.67	18.93	5.53	0.28	24.88	11.48	090
67914		A	Repair eyelid defect	3.67	6.34	3.05	0.21	10.22	6.93	090
67915		A	Repair eyelid defect	3.18	5.98	2.80	0.17	9.33	6.15	090
67916		A	Repair eyelid defect	5.30	8.05	4.76	0.30	13.65	10.36	090
67917		A	Repair eyelid defect	6.01	8.46	5.07	0.36	14.83	11.44	090
67921		A	Repair eyelid defect	3.39	6.19	2.89	0.18	9.76	6.46	090
67922		A	Repair eyelid defect	3.06	5.91	2.75	0.15	9.12	5.96	090
67923		A	Repair eyelid defect	5.87	8.12	4.97	0.32	14.31	11.16	090
67924		A	Repair eyelid defect	5.78	8.92	4.68	0.32	15.02	10.78	090
67930		A	Repair eyelid wound	3.60	5.71	2.17	0.21	9.52	5.98	010
67935		A	Repair eyelid wound	6.21	8.52	4.41	0.39	15.12	11.01	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
67938		A	Remove eyelid foreign body	1.33	5.38	1.26	0.07	6.78	2.66	010
67950		A	Revision of eyelid	5.81	8.63	5.21	0.36	14.80	11.38	090
67961		A	Revision of eyelid	5.68	8.68	5.03	0.33	14.69	11.04	090
67966		A	Revision of eyelid	6.56	9.13	5.56	0.37	16.06	12.49	090
67971		A	Reconstruction of eyelid	9.78	NA	7.28	0.53	NA	17.59	090
67973		A	Reconstruction of eyelid	12.85	NA	9.31	0.75	NA	22.91	090
67974		A	Reconstruction of eyelid	12.82	NA	9.23	0.75	NA	22.80	090
67975		A	Reconstruction of eyelid	9.12	NA	6.95	0.50	NA	16.57	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.37	1.41	1.21	0.07	2.85	2.65	010
68040		A	Treatment of eyelid lesions	0.85	0.71	0.43	0.04	1.60	1.32	000
68100		A	Biopsy of eyelid lining	1.35	3.25	0.95	0.07	4.67	2.37	000
68110		A	Remove eyelid lining lesion	1.77	4.10	1.65	0.09	5.96	3.51	010
68115		A	Remove eyelid lining lesion	2.36	5.96	1.91	0.12	8.44	4.39	010
68130		A	Remove eyelid lining lesion	4.92	8.71	4.60	0.25	13.88	9.77	090
68135		A	Remove eyelid lining lesion	1.84	1.81	1.65	0.09	3.74	3.58	010
68200		A	Treat eyelid by injection	0.49	0.54	0.33	0.02	1.05	0.84	000
68320		A	Revise/graft eyelid lining	5.36	11.28	5.52	0.28	16.92	11.16	090
68325		A	Revise/graft eyelid lining	7.35	NA	6.54	0.44	NA	14.33	090
68326		A	Revise/graft eyelid lining	7.14	NA	6.41	0.38	NA	13.93	090
68328		A	Revise/graft eyelid lining	8.17	NA	7.29	0.54	NA	16.00	090
68330		A	Revise eyelid lining	4.82	9.41	4.72	0.25	14.48	9.79	090
68335		A	Revise/graft eyelid lining	7.18	NA	6.38	0.36	NA	13.92	090
68340		A	Separate eyelid adhesions	4.16	8.87	4.10	0.21	13.24	8.47	090
68360		A	Revise eyelid lining	4.36	8.04	4.18	0.22	12.62	8.76	090
68362		A	Revise eyelid lining	7.33	NA	6.40	0.36	NA	14.09	090
68371		A	Harvest eye tissue, alograft	4.89	NA	4.73	0.44	NA	10.06	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.69	5.90	1.82	0.09	7.68	3.60	010
68420		A	Incise/drain tear sac	2.30	6.19	2.10	0.12	8.61	4.52	010
68440		A	Incise tear duct opening	0.94	2.08	1.27	0.05	3.07	2.26	010
68500		A	Removal of tear gland	11.00	NA	9.73	0.55	NA	21.28	090
68505		A	Partial removal, tear gland	10.92	NA	10.65	0.57	NA	22.14	090
68510		A	Biopsy of tear gland	4.60	7.33	2.09	0.24	12.17	6.93	000
68520		A	Removal of tear sac	7.50	NA	7.42	0.41	NA	15.33	090
68525		A	Biopsy of tear sac	4.42	NA	2.02	0.23	NA	6.67	000
68530		A	Clearance of tear duct	3.65	8.17	2.64	0.20	12.02	6.49	010

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
68540		A	Remove tear gland lesion	10.58	NA	9.39	0.61	NA	20.58	090
68550		A	Remove tear gland lesion	13.24	NA	11.35	0.79	NA	25.38	090
68700		A	Repair tear ducts	6.59	NA	5.98	0.35	NA	12.92	090
68705		A	Revise tear duct opening	2.06	4.17	1.79	0.10	6.33	3.95	010
68720		A	Create tear sac drain	8.95	NA	7.86	0.49	NA	17.30	090
68745		A	Create tear duct drain	8.62	NA	7.86	0.51	NA	16.99	090
68750		A	Create tear duct drain	8.65	NA	8.27	0.47	NA	17.39	090
68760		A	Close tear duct opening	1.73	3.54	1.63	0.09	5.36	3.45	010
68761		A	Close tear duct opening	1.36	2.27	1.32	0.07	3.70	2.75	010
68770		A	Close tear system fistula	7.01	3.18	3.18	0.35	10.54	10.54	090
68801		A	Dilate tear duct opening	0.94	1.94	1.48	0.05	2.93	2.47	010
68810		A	Probe nasolacrimal duct	1.90	3.66	2.67	0.11	5.67	4.68	010
68811		A	Probe nasolacrimal duct	2.35	NA	2.41	0.14	NA	4.90	010
68815		A	Probe nasolacrimal duct	3.20	8.24	2.81	0.18	11.62	6.19	010
68840		A	Explore/irrigate tear ducts	1.25	1.60	1.12	0.06	2.91	2.43	010
68850		A	Injection for tear sac x-ray	0.80	0.88	0.68	0.04	1.72	1.52	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.45	2.88	1.36	0.12	4.45	2.93	010
69005		A	Drain external ear lesion	2.11	2.93	1.83	0.18	5.22	4.12	010
69020		A	Drain outer ear canal lesion	1.48	3.99	2.06	0.12	5.59	3.66	010
69090		N	Pierce earlobes	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69100		A	Biopsy of external ear	0.81	1.71	0.39	0.04	2.56	1.24	000
69105		A	Biopsy of external ear canal	0.85	2.34	0.77	0.07	3.26	1.69	000
69110		A	Remove external ear, partial	3.43	6.74	4.47	0.30	10.47	8.20	090
69120		A	Removal of external ear	4.04	NA	6.18	0.38	NA	10.60	090
69140		A	Remove ear canal lesion(s)	7.96	NA	13.28	0.67	NA	21.91	090
69145		A	Remove ear canal lesion(s)	2.62	5.78	3.30	0.22	8.62	6.14	090
69150		A	Extensive ear canal surgery	13.41	NA	13.40	1.25	NA	28.06	090
69155		A	Extensive ear/neck surgery	20.77	NA	19.54	1.98	NA	42.29	090
69200		A	Clear outer ear canal	0.77	2.38	0.55	0.06	3.21	1.38	000
69205		A	Clear outer ear canal	1.20	NA	1.36	0.10	NA	2.66	010
69210		A	Remove impacted ear wax	0.61	0.63	0.23	0.05	1.29	0.89	000
69220		A	Clean out mastoid cavity	0.83	2.36	0.73	0.07	3.26	1.63	000
69222		A	Clean out mastoid cavity	1.40	3.85	2.06	0.12	5.37	3.58	010
69300		R	Revise external ear	6.35	NA	4.22	0.72	NA	11.29	YYY
69310		A	Rebuild outer ear canal	10.77	NA	16.28	0.86	NA	27.91	090
69320		A	Rebuild outer ear canal	16.93	NA	21.84	1.40	NA	40.17	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.16	0.67	0.07	3.06	1.57	000
69401		A	Inflate middle ear canal	0.63	1.24	0.65	0.05	1.92	1.33	000
69405		A	Catheterize middle ear canal	2.63	3.50	2.31	0.22	6.35	5.16	010
69410		A	Inset middle ear (baffle)	0.33	2.10	0.48	0.03	2.46	0.84	000
69420		A	Incision of eardrum	1.33	3.15	1.59	0.11	4.59	3.03	010
69421		A	Incision of eardrum	1.73	NA	2.16	0.15	NA	4.04	010
69424		A	Remove ventilating tube	0.85	2.18	0.68	0.07	3.10	1.60	000
69433		A	Create eardrum opening	1.52	3.09	1.64	0.13	4.74	3.29	010
69436		A	Create eardrum opening	1.96	NA	2.29	0.19	NA	4.44	010
69440		A	Exploration of middle ear	7.56	NA	8.77	0.61	NA	16.94	090
69450		A	Eardrum revision	5.56	NA	7.03	0.45	NA	13.04	090
69501		A	Mastoidectomy	9.06	NA	9.00	0.77	NA	18.83	090
69502		A	Mastoidectomy	12.36	NA	11.59	1.00	NA	24.95	090
69505		A	Remove mastoid structures	12.97	NA	17.19	1.08	NA	31.24	090
69511		A	Extensive mastoid surgery	13.50	NA	17.47	1.09	NA	32.06	090
69530		A	Extensive mastoid surgery	19.16	NA	21.63	1.52	NA	42.31	090
69535		A	Remove part of temporal bone	36.09	NA	31.96	2.86	NA	70.91	090
69540		A	Remove ear lesion	1.20	3.74	1.97	0.10	5.04	3.27	010
69550		A	Remove ear lesion	10.97	NA	14.86	0.90	NA	26.73	090
69552		A	Remove ear lesion	19.43	NA	20.67	1.57	NA	41.67	090
69554		A	Remove ear lesion	33.11	NA	30.33	2.89	NA	66.33	090
69601		A	Mastoid surgery revision	13.22	NA	12.67	1.05	NA	26.94	090
69602		A	Mastoid surgery revision	13.56	NA	13.23	1.10	NA	27.89	090
69603		A	Mastoid surgery revision	14.00	NA	18.36	1.15	NA	33.51	090
69604		A	Mastoid surgery revision	14.00	NA	13.69	1.12	NA	28.81	090
69605		A	Mastoid surgery revision	18.46	NA	20.95	1.49	NA	40.90	090
69610		A	Repair of eardrum	4.42	5.55	3.27	0.36	10.33	8.05	010
69620		A	Repair of eardrum	5.88	11.12	6.29	0.47	17.47	12.64	090
69631		A	Repair eardrum structures	9.85	NA	11.20	0.80	NA	21.85	090
69632		A	Rebuild eardrum structures	12.73	NA	13.47	1.04	NA	27.24	090
69633		A	Rebuild eardrum structures	12.08	NA	13.05	0.98	NA	26.11	090
69635		A	Repair eardrum structures	13.31	NA	16.74	1.09	NA	31.14	090
69636		A	Rebuild eardrum structures	15.20	NA	19.30	1.24	NA	35.74	090
69637		A	Rebuild eardrum structures	15.09	NA	19.22	1.23	NA	35.54	090
69641		A	Revise middle ear & mastoid	12.69	NA	12.78	1.04	NA	26.51	090
69642		A	Revise middle ear & mastoid	16.81	NA	16.28	1.37	NA	34.46	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69643		A	Revise middle ear & mastoid	15.30	NA	14.82	1.24	NA	31.36	090
69644		A	Revise middle ear & mastoid	16.94	NA	20.40	1.37	NA	38.71	090
69645		A	Revise middle ear & mastoid	16.36	NA	20.02	1.33	NA	37.71	090
69646		A	Revise middle ear & mastoid	17.96	NA	20.76	1.46	NA	40.18	090
69650		A	Release middle ear bone	9.65	NA	9.91	0.78	NA	20.34	090
69660		A	Revise middle ear bone	11.88	NA	11.18	0.96	NA	24.02	090
69661		A	Revise middle ear bone	15.72	NA	14.70	1.27	NA	31.69	090
69662		A	Revise middle ear bone	15.42	NA	13.75	1.25	NA	30.42	090
69666		A	Repair middle ear structures	9.74	NA	9.97	0.79	NA	20.50	090
69667		A	Repair middle ear structures	9.75	NA	9.98	0.79	NA	20.52	090
69670		A	Remove mastoid air cells	11.49	NA	11.71	0.92	NA	24.12	090
69676		A	Remove middle ear nerve	9.51	NA	10.75	0.80	NA	21.06	090
69700		A	Close mastoid fistula	8.22	NA	9.24	0.67	NA	18.13	090
69710		N	Implant/replace hearing aid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
69711		A	Remove/repair hearing aid	10.42	NA	10.79	0.83	NA	22.04	090
69714		A	Implant temple bone w/stimul	13.98	NA	12.66	1.13	NA	27.77	090
69715		A	Temple bne implnt w/stimulat	16.22	NA	15.03	1.47	NA	34.72	090
69717		A	Temple bone implant revision	14.96	NA	14.47	0.90	NA	30.33	090
69718		A	Revise temple bone implant	18.47	NA	15.30	3.18	NA	36.95	090
69720		A	Release facial nerve	14.36	NA	14.52	1.18	NA	30.06	090
69725		A	Release facial nerve	25.34	NA	20.13	2.42	NA	47.89	090
69740		A	Repair facial nerve	15.94	NA	13.41	1.27	NA	30.62	090
69745		A	Repair facial nerve	16.66	NA	14.97	1.14	NA	32.77	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.55	NA	9.46	0.69	NA	18.70	090
69802		A	Incise inner ear	13.08	NA	12.32	1.06	NA	26.46	090
69805		A	Explore inner ear	13.80	NA	11.88	1.12	NA	26.80	090
69806		A	Explore inner ear	12.33	NA	11.04	1.01	NA	24.38	090
69820		A	Establish inner ear window	10.32	NA	11.22	0.90	NA	22.44	090
69840		A	Revise inner ear window	10.24	NA	13.17	0.79	NA	24.20	090
69905		A	Remove inner ear	11.08	NA	11.35	1.02	NA	23.45	090
69910		A	Remove inner ear & mastoid	13.61	NA	11.92	1.06	NA	26.59	090
69915		A	Incise inner ear nerve	21.20	NA	16.46	1.67	NA	39.33	090
69930		A	Implant cochlear device	16.78	NA	14.75	1.36	NA	32.89	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	25.60	NA	18.90	2.26	NA	46.76	090
69955		A	Release facial nerve	27.00	NA	21.38	2.46	NA	50.84	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
69960		A	Release inner ear canal	27.00	NA	20.05	2.15	NA	49.20	090
69970		A	Remove inner ear lesion	29.99	NA	23.27	2.59	NA	55.85	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	1.79	0.83	NA	6.08	ZZZ
70010		A	Contrast x-ray of brain	1.19	4.72	NA	0.28	6.19	NA	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.06	1.64	1.64	XXX
70010	TC	A	Contrast x-ray of brain	0.00	4.33	NA	0.22	4.55	NA	XXX
70015		A	Contrast x-ray of brain	1.19	1.74	NA	0.16	3.09	NA	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.39	0.39	0.08	1.66	1.66	XXX
70015	TC	A	Contrast x-ray of brain	0.00	1.35	NA	0.08	1.43	NA	XXX
70030		A	X-ray eye for foreign body	0.17	0.48	NA	0.03	0.68	NA	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.42	NA	0.02	0.44	NA	XXX
70100		A	X-ray exam of jaw	0.18	0.58	NA	0.03	0.79	NA	XXX
70100	26	A	X-ray exam of jaw	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.52	NA	0.02	0.54	NA	XXX
70110		A	X-ray exam of jaw	0.25	0.70	NA	0.05	1.00	NA	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.62	NA	0.04	0.66	NA	XXX
70120		A	X-ray exam of mastoids	0.18	0.68	NA	0.05	0.91	NA	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.62	NA	0.04	0.66	NA	XXX
70130		A	X-ray exam of mastoids	0.34	0.89	NA	0.07	1.30	NA	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.78	NA	0.05	0.83	NA	XXX
70134		A	X-ray exam of middle ear	0.34	0.84	NA	0.07	1.25	NA	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.73	NA	0.05	0.78	NA	XXX
70140		A	X-ray exam of facial bones	0.19	0.68	NA	0.05	0.92	NA	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.62	NA	0.04	0.66	NA	XXX
70150		A	X-ray exam of facial bones	0.26	0.86	NA	0.06	1.18	NA	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.08	0.08	0.01	0.35	0.35	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.78	NA	0.05	0.83	NA	XXX
70160		A	X-ray exam of nasal bones	0.17	0.58	NA	0.03	0.78	NA	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.52	NA	0.02	0.54	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
70170		A	X-ray exam of tear duct	0.30	1.05	NA	0.07	1.42	NA	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.10	0.10	0.01	0.41	0.41	XXX
70170	TC	A	X-ray exam of tear duct	0.00	0.95	NA	0.06	1.01	NA	XXX
70190		A	X-ray exam of eye sockets	0.21	0.69	NA	0.05	0.95	NA	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.07	0.07	0.01	0.29	0.29	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.62	NA	0.04	0.66	NA	XXX
70200		A	X-ray exam of eye sockets	0.28	0.87	NA	0.06	1.21	NA	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.09	0.09	0.01	0.38	0.38	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.78	NA	0.05	0.83	NA	XXX
70210		A	X-ray exam of sinuses	0.17	0.68	NA	0.05	0.90	NA	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.62	NA	0.04	0.66	NA	XXX
70220		A	X-ray exam of sinuses	0.25	0.86	NA	0.06	1.17	NA	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	0.34	0.34	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.78	NA	0.05	0.83	NA	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.48	NA	0.03	0.70	NA	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	0.26	0.26	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.42	NA	0.02	0.44	NA	XXX
70250		A	X-ray exam of skull	0.24	0.70	NA	0.05	0.99	NA	XXX
70250	26	A	X-ray exam of skull	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70250	TC	A	X-ray exam of skull	0.00	0.62	NA	0.04	0.66	NA	XXX
70260		A	X-ray exam of skull	0.34	1.00	NA	0.08	1.42	NA	XXX
70260	26	A	X-ray exam of skull	0.34	0.11	0.11	0.02	0.47	0.47	XXX
70260	TC	A	X-ray exam of skull	0.00	0.89	NA	0.06	0.95	NA	XXX
70300		A	X-ray exam of teeth	0.10	0.31	NA	0.03	0.44	NA	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.01	0.16	0.16	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.26	NA	0.02	0.28	NA	XXX
70310		A	X-ray exam of teeth	0.16	0.50	NA	0.03	0.69	NA	XXX
70310	26	A	X-ray exam of teeth	0.16	0.08	0.08	0.01	0.25	0.25	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.42	NA	0.02	0.44	NA	XXX
70320		A	Full mouth x-ray of teeth	0.22	0.86	NA	0.06	1.14	NA	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.08	0.08	0.01	0.31	0.31	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.78	NA	0.05	0.83	NA	XXX
70328		A	X-ray exam of jaw joint	0.18	0.55	NA	0.03	0.76	NA	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	0.25	0.25	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.49	NA	0.02	0.51	NA	XXX
70330		A	X-ray exam of jaw joints	0.24	0.92	NA	0.06	1.22	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70330	26	A	X-ray exam of jaw joints	0.24	0.08	0.08	0.01	0.33	0.33	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.84	NA	0.05	0.89	NA	XXX
70332		A	X-ray exam of jaw joint	0.54	2.30	NA	0.15	2.99	NA	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.03	0.77	0.77	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	2.10	NA	0.12	2.22	NA	XXX
70336		A	Magnetic image, jaw joint	1.48	11.69	NA	0.66	13.83	NA	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	11.20	NA	0.59	11.79	NA	XXX
70350		A	X-ray head for orthodontia	0.17	0.45	NA	0.03	0.65	NA	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.07	0.07	0.01	0.25	0.25	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.38	NA	0.02	0.40	NA	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.64	NA	0.05	0.89	NA	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.07	0.07	0.01	0.28	0.28	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.57	NA	0.04	0.61	NA	XXX
70360		A	X-ray exam of neck	0.17	0.48	NA	0.03	0.68	NA	XXX
70360	26	A	X-ray exam of neck	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70360	TC	A	X-ray exam of neck	0.00	0.42	NA	0.02	0.44	NA	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.41	NA	0.08	1.81	NA	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.10	0.10	0.01	0.43	0.43	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.31	NA	0.07	1.38	NA	XXX
70371		A	Speech evaluation, complex	0.84	2.38	NA	0.16	3.38	NA	XXX
70371	26	A	Speech evaluation, complex	0.84	0.28	0.28	0.04	1.16	1.16	XXX
70371	TC	A	Speech evaluation, complex	0.00	2.10	NA	0.12	2.22	NA	XXX
70373		A	Contrast x-ray of larynx	0.44	1.92	NA	0.13	2.49	NA	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.14	0.14	0.02	0.60	0.60	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.78	NA	0.11	1.89	NA	XXX
70380		A	X-ray exam of salivary gland	0.17	0.73	NA	0.05	0.95	NA	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.06	0.06	0.01	0.24	0.24	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.67	NA	0.04	0.71	NA	XXX
70390		A	X-ray exam of salivary duct	0.38	1.90	NA	0.13	2.41	NA	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.02	0.52	0.52	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.78	NA	0.11	1.89	NA	XXX
70450		A	Ct head/brain w/o dye	0.85	5.00	NA	0.29	6.14	NA	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.28	0.28	0.04	1.17	1.17	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70460		A	Ct head/brain w/dye	1.13	6.03	NA	0.35	7.51	NA	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.37	0.37	0.05	1.55	1.55	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
70460	TC	A	Ct head/brain w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	7.49	NA	0.43	9.19	NA	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	5.14	NA	0.31	6.73	NA	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	6.11	NA	0.36	7.85	NA	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	7.55	NA	0.43	9.43	NA	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.48	0.48	0.06	1.99	1.99	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70486		A	Ct maxillofacial w/o dye	1.14	5.09	NA	0.30	6.53	NA	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.37	0.37	0.05	1.56	1.56	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70487		A	Ct maxillofacial w/dye	1.30	6.09	NA	0.36	7.75	NA	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.43	0.43	0.06	1.79	1.79	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	7.53	NA	0.43	9.38	NA	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.46	0.46	0.06	1.94	1.94	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	5.14	NA	0.31	6.73	NA	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.42	0.42	0.06	1.76	1.76	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	4.72	NA	0.25	4.97	NA	XXX
70491		A	Ct soft tissue neck w/dye	1.38	6.11	NA	0.36	7.85	NA	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	5.66	NA	0.30	5.96	NA	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	7.54	NA	0.43	9.42	NA	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.47	0.47	0.06	1.98	1.98	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
70496		A	Ct angiography, head	1.75	11.17	NA	0.66	13.58	NA	XXX
70496	26	A	Ct angiography, head	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70496	TC	A	Ct angiography, head	0.00	10.60	NA	0.58	11.18	NA	XXX
70498		A	Ct angiography, neck	1.75	11.17	NA	0.66	13.58	NA	XXX
70498	26	A	Ct angiography, neck	1.75	0.57	0.57	0.08	2.40	2.40	XXX
70498	TC	A	Ct angiography, neck	0.00	10.60	NA	0.58	11.18	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70540		A	Mri orbit/face/neck w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
70542		A	Mri orbit/face/neck w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
70544		A	Mr angiography head w/o dye	1.20	11.60	NA	0.64	13.44	NA	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.40	0.40	0.05	1.65	1.65	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70545		A	Mr angiography head w/dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70545	TC	A	Mr angiography head w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	23.00	NA	0.67	25.47	NA	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	22.41	NA	0.59	23.00	NA	XXX
70547		A	Mr angiography neck w/o dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70548		A	Mr angiography neck w/dye	1.20	11.59	NA	0.64	13.43	NA	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.39	0.39	0.05	1.64	1.64	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	23.00	NA	0.67	25.47	NA	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	22.41	NA	0.59	23.00	NA	XXX
70551		A	Mri brain w/o dye	1.48	11.69	NA	0.66	13.83	NA	XXX
70551	26	A	Mri brain w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
70551	TC	A	Mri brain w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
70552		A	Mri brain w/dye	1.78	14.03	NA	0.78	16.59	NA	XXX
70552	26	A	Mri brain w/dye	1.78	0.59	0.59	0.08	2.45	2.45	XXX
70552	TC	A	Mri brain w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
70553		A	Mri brain w/o & w/dye	2.36	25.66	NA	1.42	29.44	NA	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.78	0.78	0.11	3.25	3.25	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
70557		C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
70557	26	A	Mri brain w/o dye	2.90	1.13	1.13	0.08	4.11	4.11	XXX
70557	TC	C	Mri brain w/o dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558		C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	1.24	1.24	0.10	4.54	4.54	XXX
70558	TC	C	Mri brain w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559		C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.24	1.24	0.12	4.56	4.56	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	0.00	0.00	0.00	0.00	0.00	XXX
71010		A	Chest x-ray	0.18	0.53	NA	0.03	0.74	NA	XXX
71010	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71010	TC	A	Chest x-ray	0.00	0.47	NA	0.02	0.49	NA	XXX
71015		A	Chest x-ray	0.21	0.59	NA	0.03	0.83	NA	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	0.29	0.29	XXX
71015	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71020		A	Chest x-ray	0.22	0.69	NA	0.05	0.96	NA	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71020	TC	A	Chest x-ray	0.00	0.62	NA	0.04	0.66	NA	XXX
71021		A	Chest x-ray	0.27	0.82	NA	0.06	1.15	NA	XXX
71021	26	A	Chest x-ray	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71021	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71022		A	Chest x-ray	0.31	0.83	NA	0.06	1.20	NA	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71022	TC	A	Chest x-ray	0.00	0.73	NA	0.05	0.78	NA	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	0.91	NA	0.07	1.36	NA	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	0.53	0.53	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	0.78	NA	0.05	0.83	NA	XXX
71030		A	Chest x-ray	0.31	0.88	NA	0.06	1.25	NA	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.01	0.42	0.42	XXX
71030	TC	A	Chest x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.60	NA	0.10	2.16	NA	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.16	0.16	0.02	0.64	0.64	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.44	NA	0.08	1.52	NA	XXX
71035		A	Chest x-ray	0.18	0.58	NA	0.03	0.79	NA	XXX
71035	26	A	Chest x-ray	0.18	0.06	0.06	0.01	0.25	0.25	XXX
71035	TC	A	Chest x-ray	0.00	0.52	NA	0.02	0.54	NA	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.65	NA	0.11	2.34	NA	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.19	0.19	0.03	0.80	0.80	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
71040	TC	A	Contrast x-ray of bronchi	0.00	1.46	NA	0.08	1.54	NA	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.44	NA	0.17	3.35	NA	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.04	1.02	1.02	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.20	NA	0.13	2.33	NA	XXX
71090		A	X-ray & pacemaker insertion	0.54	1.89	NA	0.13	2.56	NA	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.21	0.21	0.02	0.77	0.77	XXX
71090	TC	A	X-ray & pacemaker insertion	0.00	1.68	NA	0.11	1.79	NA	XXX
71100		A	X-ray exam of ribs	0.22	0.64	NA	0.05	0.91	NA	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.57	NA	0.04	0.61	NA	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.76	NA	0.05	1.08	NA	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.67	NA	0.04	0.71	NA	XXX
71110		A	X-ray exam of ribs	0.27	0.87	NA	0.06	1.20	NA	XXX
71110	26	A	X-ray exam of ribs	0.27	0.09	0.09	0.01	0.37	0.37	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.78	NA	0.05	0.83	NA	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.99	NA	0.07	1.38	NA	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.10	0.10	0.01	0.43	0.43	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.89	NA	0.06	0.95	NA	XXX
71120		A	X-ray exam of breastbone	0.20	0.72	NA	0.05	0.97	NA	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.07	0.07	0.01	0.28	0.28	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.65	NA	0.04	0.69	NA	XXX
71130		A	X-ray exam of breastbone	0.22	0.78	NA	0.05	1.05	NA	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.01	0.30	0.30	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.71	NA	0.04	0.75	NA	XXX
71250		A	Ct thorax w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
71250	TC	A	Ct thorax w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
71260		A	Ct thorax w/dye	1.24	7.48	NA	0.43	9.15	NA	XXX
71260	26	A	Ct thorax w/dye	1.24	0.41	0.41	0.06	1.71	1.71	XXX
71260	TC	A	Ct thorax w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
71270		A	Ct thorax w/o & w/dye	1.38	9.30	NA	0.52	11.20	NA	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.45	0.45	0.06	1.89	1.89	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
71275		A	Ct angiography, chest	1.92	13.01	NA	0.48	15.41	NA	XXX
71275	26	A	Ct angiography, chest	1.92	0.63	0.63	0.09	2.64	2.64	XXX
71275	TC	A	Ct angiography, chest	0.00	12.38	NA	0.39	12.77	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
71550		A	Mri chest w/o dye	1.46	11.68	NA	0.51	13.65	NA	XXX
71550	26	A	Mri chest w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
71550	TC	A	Mri chest w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
71551		A	Mri chest w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
71551	26	A	Mri chest w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
71551	TC	A	Mri chest w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
71552		A	Mri chest w/o & w/dye	2.26	25.62	NA	0.78	28.66	NA	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	24.88	NA	0.68	25.56	NA	XXX
71555		R	Mri angio chest w or w/o dye	1.81	11.80	NA	0.67	14.28	NA	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72010		A	X-ray exam of spine	0.45	1.17	NA	0.08	1.70	NA	XXX
72010	26	A	X-ray exam of spine	0.45	0.15	0.15	0.02	0.62	0.62	XXX
72010	TC	A	X-ray exam of spine	0.00	1.02	NA	0.06	1.08	NA	XXX
72020		A	X-ray exam of spine	0.15	0.47	NA	0.03	0.65	NA	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	0.21	0.21	XXX
72020	TC	A	X-ray exam of spine	0.00	0.42	NA	0.02	0.44	NA	XXX
72040		A	X-ray exam of neck spine	0.22	0.67	NA	0.05	0.94	NA	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.60	NA	0.04	0.64	NA	XXX
72050		A	X-ray exam of neck spine	0.31	0.99	NA	0.07	1.37	NA	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72052		A	X-ray exam of neck spine	0.36	1.25	NA	0.08	1.69	NA	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.13	NA	0.06	1.19	NA	XXX
72069		A	X-ray exam of trunk spine	0.22	0.57	NA	0.03	0.82	NA	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.01	0.31	0.31	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.49	NA	0.02	0.51	NA	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.72	NA	0.05	0.99	NA	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.65	NA	0.04	0.69	NA	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.80	NA	0.06	1.08	NA	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.73	NA	0.05	0.78	NA	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.98	NA	0.07	1.27	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72080		A	X-ray exam of trunk spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72090		A	X-ray exam of trunk spine	0.28	0.76	NA	0.05	1.09	NA	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.09	0.09	0.01	0.38	0.38	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72100		A	X-ray exam of lower spine	0.22	0.74	NA	0.05	1.01	NA	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.67	NA	0.04	0.71	NA	XXX
72110		A	X-ray exam of lower spine	0.31	1.01	NA	0.07	1.39	NA	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.01	0.42	0.42	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.91	NA	0.06	0.97	NA	XXX
72114		A	X-ray exam of lower spine	0.36	1.31	NA	0.08	1.75	NA	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.12	0.12	0.02	0.50	0.50	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.19	NA	0.06	1.25	NA	XXX
72120		A	X-ray exam of lower spine	0.22	0.96	NA	0.07	1.25	NA	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.07	0.07	0.01	0.30	0.30	XXX
72120	TC	A	X-ray exam of lower spine	0.00	0.89	NA	0.06	0.95	NA	XXX
72125		A	Ct neck spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72126		A	Ct neck spine w/dye	1.22	7.47	NA	0.42	9.11	NA	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72126	TC	A	Ct neck spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72128		A	Ct chest spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72129		A	Ct chest spine w/dye	1.22	7.47	NA	0.43	9.12	NA	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
72129	TC	A	Ct chest spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72130	TC	A	Ct chest spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72131		A	Ct lumbar spine w/o dye	1.16	6.29	NA	0.36	7.81	NA	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72132		A	Ct lumbar spine w/dye	1.22	7.47	NA	0.42	9.11	NA	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	7.07	NA	0.37	7.44	NA	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	9.27	NA	0.52	11.06	NA	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	8.85	NA	0.46	9.31	NA	XXX
72141		A	Mri neck spine w/o dye	1.60	11.73	NA	0.66	13.99	NA	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72142		A	Mri neck spine w/dye	1.92	14.08	NA	0.79	16.79	NA	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.64	0.64	0.09	2.65	2.65	XXX
72142	TC	A	Mri neck spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72146		A	Mri chest spine w/o dye	1.60	12.97	NA	0.71	15.28	NA	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	12.44	NA	0.64	13.08	NA	XXX
72147		A	Mri chest spine w/dye	1.92	14.07	NA	0.79	16.78	NA	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.63	0.63	0.09	2.64	2.64	XXX
72147	TC	A	Mri chest spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72148		A	Mri lumbar spine w/o dye	1.48	12.93	NA	0.71	15.12	NA	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.49	0.49	0.07	2.04	2.04	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	12.44	NA	0.64	13.08	NA	XXX
72149		A	Mri lumbar spine w/dye	1.78	14.04	NA	0.78	16.60	NA	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.60	0.60	0.08	2.46	2.46	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	13.44	NA	0.70	14.14	NA	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	25.73	NA	1.43	29.73	NA	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.85	0.85	0.12	3.54	3.54	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	25.72	NA	1.42	29.71	NA	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.84	0.84	0.11	3.52	3.52	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	25.66	NA	1.42	29.44	NA	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.78	0.78	0.11	3.25	3.25	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	24.88	NA	1.31	26.19	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
72159		N	Mr angio spine w/o&w/dye	+1.80	12.92	12.92	0.74	15.46	15.46	XXX
72159	26	N	Mr angio spine w/o&w/dye	+1.80	0.69	0.69	0.10	2.59	2.59	XXX
72159	TC	N	Mr angio spine w/o&w/dye	+0.00	12.23	12.23	0.64	12.87	12.87	XXX
72170		A	X-ray exam of pelvis	0.17	0.58	NA	0.03	0.78	NA	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.52	NA	0.02	0.54	NA	XXX
72190		A	X-ray exam of pelvis	0.21	0.74	NA	0.05	1.00	NA	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.07	0.07	0.01	0.29	0.29	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.67	NA	0.04	0.71	NA	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	12.63	NA	0.47	14.91	NA	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.60	0.60	0.08	2.49	2.49	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	12.03	NA	0.39	12.42	NA	XXX
72192		A	Ct pelvis w/o dye	1.09	6.27	NA	0.36	7.72	NA	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	5.91	NA	0.31	6.22	NA	XXX
72193		A	Ct pelvis w/dye	1.16	7.22	NA	0.41	8.79	NA	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
72193	TC	A	Ct pelvis w/dye	0.00	6.84	NA	0.36	7.20	NA	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	8.89	NA	0.48	10.59	NA	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	8.49	NA	0.43	8.92	NA	XXX
72195		A	Mri pelvis w/o dye	1.46	11.68	NA	0.52	13.66	NA	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.48	0.48	0.07	2.01	2.01	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
72196		A	Mri pelvis w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
72196	TC	A	Mri pelvis w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
72197		A	Mri pelvis w/o & w/dye	2.26	25.62	NA	1.02	28.90	NA	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	24.88	NA	0.92	25.80	NA	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	11.79	NA	0.67	14.26	NA	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.58	NA	0.03	0.78	NA	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.52	NA	0.02	0.54	NA	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.68	NA	0.05	0.92	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	0.26	0.26	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.62	NA	0.04	0.66	NA	XXX
72220		A	X-ray exam of tailbone	0.17	0.63	NA	0.05	0.85	NA	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.06	0.06	0.01	0.24	0.24	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.57	NA	0.04	0.61	NA	XXX
72240		A	Contrast x-ray of neck spine	0.91	5.04	NA	0.29	6.24	NA	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.29	0.29	0.04	1.24	1.24	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	4.75	NA	0.25	5.00	NA	XXX
72255		A	Contrast x-ray, thorax spine	0.91	4.60	NA	0.26	5.77	NA	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.27	0.27	0.04	1.22	1.22	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	4.33	NA	0.22	4.55	NA	XXX
72265		A	Contrast x-ray, lower spine	0.83	4.32	NA	0.26	5.41	NA	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.25	0.25	0.04	1.12	1.12	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	4.07	NA	0.22	4.29	NA	XXX
72270		A	Contrast x-ray, spine	1.33	6.52	NA	0.39	8.24	NA	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.06	1.81	1.81	XXX
72270	TC	A	Contrast x-ray, spine	0.00	6.10	NA	0.33	6.43	NA	XXX
72275		A	Epidurography	0.76	2.30	NA	0.26	3.32	NA	XXX
72275	26	A	Epidurography	0.76	0.20	0.20	0.04	1.00	1.00	XXX
72275	TC	A	Epidurography	0.00	2.10	NA	0.22	2.32	NA	XXX
72285		A	X-ray c/t spine disk	1.16	8.74	NA	0.50	10.40	NA	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.36	0.36	0.07	1.59	1.59	XXX
72285	TC	A	X-ray c/t spine disk	0.00	8.38	NA	0.43	8.81	NA	XXX
72295		A	X-ray of lower spine disk	0.83	8.13	NA	0.46	9.42	NA	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.27	0.27	0.06	1.16	1.16	XXX
72295	TC	A	X-ray of lower spine disk	0.00	7.86	NA	0.40	8.26	NA	XXX
73000		A	X-ray exam of collar bone	0.16	0.57	NA	0.03	0.76	NA	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.52	NA	0.02	0.54	NA	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.58	NA	0.03	0.78	NA	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.52	NA	0.02	0.54	NA	XXX
73020		A	X-ray exam of shoulder	0.15	0.52	NA	0.03	0.70	NA	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.47	NA	0.02	0.49	NA	XXX
73030		A	X-ray exam of shoulder	0.18	0.63	NA	0.05	0.86	NA	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.06	0.06	0.01	0.25	0.25	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73030	TC	A	X-ray exam of shoulder	0.00	0.57	NA	0.04	0.61	NA	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.28	NA	0.14	2.96	NA	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.02	0.74	0.74	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	2.10	NA	0.12	2.22	NA	XXX
73050		A	X-ray exam of shoulders	0.20	0.74	NA	0.05	0.99	NA	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.67	NA	0.04	0.71	NA	XXX
73060		A	X-ray exam of humerus	0.17	0.63	NA	0.05	0.85	NA	XXX
73060	26	A	X-ray exam of humerus	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.57	NA	0.04	0.61	NA	XXX
73070		A	X-ray exam of elbow	0.15	0.57	NA	0.03	0.75	NA	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.01	0.21	0.21	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.52	NA	0.02	0.54	NA	XXX
73080		A	X-ray exam of elbow	0.17	0.63	NA	0.05	0.85	NA	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.57	NA	0.04	0.61	NA	XXX
73085		A	Contrast x-ray of elbow	0.54	2.29	NA	0.15	2.98	NA	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.19	0.19	0.03	0.76	0.76	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	2.10	NA	0.12	2.22	NA	XXX
73090		A	X-ray exam of forearm	0.16	0.57	NA	0.03	0.76	NA	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.52	NA	0.02	0.54	NA	XXX
73092		A	X-ray exam of arm, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73100		A	X-ray exam of wrist	0.16	0.54	NA	0.03	0.73	NA	XXX
73100	26	A	X-ray exam of wrist	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.49	NA	0.02	0.51	NA	XXX
73110		A	X-ray exam of wrist	0.17	0.59	NA	0.03	0.79	NA	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.53	NA	0.02	0.55	NA	XXX
73115		A	Contrast x-ray of wrist	0.54	1.76	NA	0.13	2.43	NA	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	1.58	NA	0.10	1.68	NA	XXX
73120		A	X-ray exam of hand	0.16	0.54	NA	0.03	0.73	NA	XXX
73120	26	A	X-ray exam of hand	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73120	TC	A	X-ray exam of hand	0.00	0.49	NA	0.02	0.51	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73130		A	X-ray exam of hand	0.17	0.59	NA	0.03	0.79	NA	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73130	TC	A	X-ray exam of hand	0.00	0.53	NA	0.02	0.55	NA	XXX
73140		A	X-ray exam of finger(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73200		A	Ct upper extremity w/o dye	1.09	5.32	NA	0.30	6.71	NA	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	4.96	NA	0.25	5.21	NA	XXX
73201		A	Ct upper extremity w/dye	1.16	6.29	NA	0.36	7.81	NA	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	5.91	NA	0.31	6.22	NA	XXX
73202		A	Ct uppr extremity w/o&w/dye	1.22	7.82	NA	0.45	9.49	NA	XXX
73202	26	A	Ct uppr extremity w/o&w/dye	1.22	0.40	0.40	0.06	1.68	1.68	XXX
73202	TC	A	Ct uppr extremity w/o&w/dye	0.00	7.42	NA	0.39	7.81	NA	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	11.55	NA	0.47	13.83	NA	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.59	0.59	0.08	2.48	2.48	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	10.96	NA	0.39	11.35	NA	XXX
73218		A	Mri upper extremity w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73219		A	Mri upper extremity w/dye	1.62	13.98	NA	0.54	16.14	NA	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.54	0.54	0.07	2.23	2.23	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73220		A	Mri uppr extremity w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73220	26	A	Mri uppr extremity w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73220	TC	A	Mri uppr extremity w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73222		A	Mri joint upr extrem w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73225		N	Mr angio upr extr w/o&w/dye	+1.73	11.68	11.68	0.69	14.10	14.10	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73225	26	N	Mr angio upr extr w/o&w/dye	+1.73	0.67	0.67	0.10	2.50	2.50	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	+0.00	11.01	11.01	0.59	11.60	11.60	XXX
73500		A	X-ray exam of hip	0.17	0.53	NA	0.03	0.73	NA	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73500	TC	A	X-ray exam of hip	0.00	0.47	NA	0.02	0.49	NA	XXX
73510		A	X-ray exam of hip	0.21	0.64	NA	0.05	0.90	NA	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.01	0.29	0.29	XXX
73510	TC	A	X-ray exam of hip	0.00	0.57	NA	0.04	0.61	NA	XXX
73520		A	X-ray exam of hips	0.26	0.76	NA	0.05	1.07	NA	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.01	0.36	0.36	XXX
73520	TC	A	X-ray exam of hips	0.00	0.67	NA	0.04	0.71	NA	XXX
73525		A	Contrast x-ray of hip	0.54	2.28	NA	0.15	2.97	NA	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73525	TC	A	Contrast x-ray of hip	0.00	2.10	NA	0.12	2.22	NA	XXX
73530		A	X-ray exam of hip	0.29	0.62	NA	0.03	0.94	NA	XXX
73530	26	A	X-ray exam of hip	0.29	0.10	0.10	0.01	0.40	0.40	XXX
73530	TC	A	X-ray exam of hip	0.00	0.52	NA	0.02	0.54	NA	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.64	NA	0.05	0.89	NA	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.07	0.07	0.01	0.28	0.28	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.57	NA	0.04	0.61	NA	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	2.26	NA	0.16	3.01	NA	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.16	0.16	0.04	0.79	0.79	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	2.10	NA	0.12	2.22	NA	XXX
73550		A	X-ray exam of thigh	0.17	0.63	NA	0.05	0.85	NA	XXX
73550	26	A	X-ray exam of thigh	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.57	NA	0.04	0.61	NA	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.58	NA	0.03	0.78	NA	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.02	0.54	NA	XXX
73562		A	X-ray exam of knee, 3	0.18	0.63	NA	0.05	0.86	NA	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.06	0.06	0.01	0.25	0.25	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.57	NA	0.04	0.61	NA	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.69	NA	0.05	0.96	NA	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.07	0.07	0.01	0.30	0.30	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.62	NA	0.04	0.66	NA	XXX
73565		A	X-ray exam of knees	0.17	0.55	NA	0.03	0.75	NA	XXX
73565	26	A	X-ray exam of knees	0.17	0.06	0.06	0.01	0.24	0.24	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
73565	TC	A	X-ray exam of knees	0.00	0.49	NA	0.02	0.51	NA	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.79	NA	0.17	3.50	NA	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.17	0.17	0.03	0.74	0.74	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.62	NA	0.14	2.76	NA	XXX
73590		A	X-ray exam of lower leg	0.17	0.58	NA	0.03	0.78	NA	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.52	NA	0.02	0.54	NA	XXX
73592		A	X-ray exam of leg, infant	0.16	0.54	NA	0.03	0.73	NA	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.49	NA	0.02	0.51	NA	XXX
73600		A	X-ray exam of ankle	0.16	0.54	NA	0.03	0.73	NA	XXX
73600	26	A	X-ray exam of ankle	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.49	NA	0.02	0.51	NA	XXX
73610		A	X-ray exam of ankle	0.17	0.59	NA	0.03	0.79	NA	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.53	NA	0.02	0.55	NA	XXX
73615		A	Contrast x-ray of ankle	0.54	2.28	NA	0.15	2.97	NA	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.18	0.18	0.03	0.75	0.75	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	2.10	NA	0.12	2.22	NA	XXX
73620		A	X-ray exam of foot	0.16	0.54	NA	0.03	0.73	NA	XXX
73620	26	A	X-ray exam of foot	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.02	0.51	NA	XXX
73630		A	X-ray exam of foot	0.17	0.59	NA	0.03	0.79	NA	XXX
73630	26	A	X-ray exam of foot	0.17	0.06	0.06	0.01	0.24	0.24	XXX
73630	TC	A	X-ray exam of foot	0.00	0.53	NA	0.02	0.55	NA	XXX
73650		A	X-ray exam of heel	0.16	0.52	NA	0.03	0.71	NA	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.01	0.22	0.22	XXX
73650	TC	A	X-ray exam of heel	0.00	0.47	NA	0.02	0.49	NA	XXX
73660		A	X-ray exam of toe(s)	0.13	0.46	NA	0.03	0.62	NA	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	0.18	0.18	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.42	NA	0.02	0.44	NA	XXX
73700		A	Ct lower extremity w/o dye	1.09	5.32	NA	0.30	6.71	NA	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.36	0.36	0.05	1.50	1.50	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	4.96	NA	0.25	5.21	NA	XXX
73701		A	Ct lower extremity w/dye	1.16	6.29	NA	0.36	7.81	NA	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.38	0.38	0.05	1.59	1.59	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	5.91	NA	0.31	6.22	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
73702		A	Ct lwr extremity w/o&w/dye	1.22	7.82	NA	0.44	9.48	NA	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.40	0.40	0.05	1.67	1.67	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	7.42	NA	0.39	7.81	NA	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	11.58	NA	0.48	13.96	NA	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.62	0.62	0.09	2.61	2.61	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	10.96	NA	0.39	11.35	NA	XXX
73718		A	Mri lower extremity w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73719		A	Mri lower extremity w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	25.58	NA	0.94	28.67	NA	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.70	0.70	0.10	2.95	2.95	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	11.64	NA	0.45	13.44	NA	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.06	1.85	1.85	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	11.20	NA	0.39	11.59	NA	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	13.97	NA	0.54	16.13	NA	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.53	0.53	0.07	2.22	2.22	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	13.44	NA	0.47	13.91	NA	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	25.59	NA	0.94	28.68	NA	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.71	0.71	0.10	2.96	2.96	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	24.88	NA	0.84	25.72	NA	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	11.80	NA	0.67	14.29	NA	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.60	0.60	0.08	2.50	2.50	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
74000		A	X-ray exam of abdomen	0.18	0.58	NA	0.03	0.79	NA	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.06	0.06	0.01	0.25	0.25	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.52	NA	0.02	0.54	NA	XXX
74010		A	X-ray exam of abdomen	0.23	0.65	NA	0.05	0.93	NA	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.08	0.08	0.01	0.32	0.32	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.57	NA	0.04	0.61	NA	XXX
74020		A	X-ray exam of abdomen	0.27	0.71	NA	0.05	1.03	NA	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.09	0.09	0.01	0.37	0.37	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.62	NA	0.04	0.66	NA	XXX
74022		A	X-ray exam series, abdomen	0.32	0.83	NA	0.06	1.21	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.73	NA	0.05	0.78	NA	XXX
74150		A	Ct abdomen w/o dye	1.19	6.05	NA	0.35	7.59	NA	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.39	0.39	0.05	1.63	1.63	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	5.66	NA	0.30	5.96	NA	XXX
74160		A	Ct abdomen w/dye	1.27	7.26	NA	0.42	8.95	NA	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.42	0.42	0.06	1.75	1.75	XXX
74160	TC	A	Ct abdomen w/dye	0.00	6.84	NA	0.36	7.20	NA	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	8.95	NA	0.49	10.84	NA	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.46	0.46	0.06	1.92	1.92	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	8.49	NA	0.43	8.92	NA	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	12.65	NA	0.47	15.02	NA	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.62	0.62	0.08	2.60	2.60	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	12.03	NA	0.39	12.42	NA	XXX
74181		A	Mri abdomen w/o dye	1.46	11.68	NA	0.51	13.65	NA	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.48	0.48	0.06	2.00	2.00	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	11.20	NA	0.45	11.65	NA	XXX
74182		A	Mri abdomen w/dye	1.73	14.01	NA	0.60	16.34	NA	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.57	0.57	0.08	2.38	2.38	XXX
74182	TC	A	Mri abdomen w/dye	0.00	13.44	NA	0.52	13.96	NA	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	25.62	NA	1.02	28.90	NA	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.74	0.74	0.10	3.10	3.10	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	24.88	NA	0.92	25.80	NA	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	11.79	NA	0.67	14.26	NA	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.59	0.59	0.08	2.47	2.47	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
74190		A	X-ray exam of peritoneum	0.48	1.47	NA	0.09	2.04	NA	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.16	0.16	0.02	0.66	0.66	XXX
74190	TC	A	X-ray exam of peritoneum	0.00	1.31	NA	0.07	1.38	NA	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.31	NA	0.08	1.75	NA	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.19	NA	0.06	1.25	NA	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.34	NA	0.08	1.88	NA	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.15	0.15	0.02	0.63	0.63	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.19	NA	0.06	1.25	NA	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.48	NA	0.09	2.10	NA	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.17	0.17	0.02	0.72	0.72	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.31	NA	0.07	1.38	NA	XXX
74235		A	Remove esophagus obstruction	1.19	3.01	NA	0.20	4.40	NA	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.39	0.39	0.06	1.64	1.64	XXX
74235	TC	A	Remove esophagus obstruction	0.00	2.62	NA	0.14	2.76	NA	XXX
74240		A	X-ray exam, upper gi tract	0.69	1.69	NA	0.11	2.49	NA	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.46	NA	0.08	1.54	NA	XXX
74241		A	X-ray exam, upper gi tract	0.69	1.72	NA	0.11	2.52	NA	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	1.49	NA	0.08	1.57	NA	XXX
74245		A	X-ray exam, upper gi tract	0.91	2.68	NA	0.17	3.76	NA	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	2.38	NA	0.13	2.51	NA	XXX
74246		A	Contrst x-ray uppr gi tract	0.69	1.87	NA	0.13	2.69	NA	XXX
74246	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74246	TC	A	Contrst x-ray uppr gi tract	0.00	1.64	NA	0.10	1.74	NA	XXX
74247		A	Contrst x-ray uppr gi tract	0.69	1.91	NA	0.14	2.74	NA	XXX
74247	26	A	Contrst x-ray uppr gi tract	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74247	TC	A	Contrst x-ray uppr gi tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74249		A	Contrst x-ray uppr gi tract	0.91	2.87	NA	0.18	3.96	NA	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.30	0.30	0.04	1.25	1.25	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	2.57	NA	0.14	2.71	NA	XXX
74250		A	X-ray exam of small bowel	0.47	1.46	NA	0.09	2.02	NA	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.15	0.15	0.02	0.64	0.64	XXX
74250	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74251		A	X-ray exam of small bowel	0.69	1.54	NA	0.10	2.33	NA	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74251	TC	A	X-ray exam of small bowel	0.00	1.31	NA	0.07	1.38	NA	XXX
74260		A	X-ray exam of small bowel	0.50	1.65	NA	0.10	2.25	NA	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.16	0.16	0.02	0.68	0.68	XXX
74260	TC	A	X-ray exam of small bowel	0.00	1.49	NA	0.08	1.57	NA	XXX
74270		A	Contrast x-ray exam of colon	0.69	1.93	NA	0.14	2.76	NA	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.23	0.23	0.03	0.95	0.95	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	1.70	NA	0.11	1.81	NA	XXX
74280		A	Contrast x-ray exam of colon	0.99	2.55	NA	0.17	3.71	NA	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.32	0.32	0.04	1.35	1.35	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	2.23	NA	0.13	2.36	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74283		A	Contrast x-ray exam of colon	2.02	3.22	NA	0.23	5.47	NA	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.66	0.66	0.09	2.77	2.77	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.56	NA	0.14	2.70	NA	XXX
74290		A	Contrast x-ray, gallbladder	0.32	0.83	NA	0.06	1.21	NA	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.01	0.43	0.43	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	0.73	NA	0.05	0.78	NA	XXX
74291		A	Contrast x-rays, gallbladder	0.20	0.49	NA	0.03	0.72	NA	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	0.28	0.28	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	0.42	NA	0.02	0.44	NA	XXX
74300		C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	0.00	0.00	0.00	0.00	0.00	XXX
74301		C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.01	0.29	0.29	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
74305		A	X-ray bile ducts/pancreas	0.42	0.92	NA	0.07	1.41	NA	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.14	0.14	0.02	0.58	0.58	XXX
74305	TC	A	X-ray bile ducts/pancreas	0.00	0.78	NA	0.05	0.83	NA	XXX
74320		A	Contrast x-ray of bile ducts	0.54	3.33	NA	0.19	4.06	NA	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	3.15	NA	0.17	3.32	NA	XXX
74327		A	X-ray bile stone removal	0.70	1.99	NA	0.14	2.83	NA	XXX
74327	26	A	X-ray bile stone removal	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.76	NA	0.11	1.87	NA	XXX
74328		A	X-ray bile duct endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74328	TC	A	X-ray bile duct endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74329		A	X-ray for pancreas endoscopy	0.70	3.38	NA	0.20	4.28	NA	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.03	0.96	0.96	XXX
74329	TC	A	X-ray for pancreas endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74330		A	X-ray bile/panc endoscopy	0.90	3.44	NA	0.21	4.55	NA	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.04	1.23	1.23	XXX
74330	TC	A	X-ray bile/panc endoscopy	0.00	3.15	NA	0.17	3.32	NA	XXX
74340		A	X-ray guide for GI tube	0.54	2.80	NA	0.16	3.50	NA	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74340	TC	A	X-ray guide for GI tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74350		A	X-ray guide, stomach tube	0.76	3.40	NA	0.20	4.36	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
74350	26	A	X-ray guide, stomach tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74350	TC	A	X-ray guide, stomach tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74355		A	X-ray guide, intestinal tube	0.76	2.87	NA	0.17	3.80	NA	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.03	1.04	1.04	XXX
74355	TC	A	X-ray guide, intestinal tube	0.00	2.62	NA	0.14	2.76	NA	XXX
74360		A	X-ray guide, GI dilation	0.54	3.34	NA	0.20	4.08	NA	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.19	0.19	0.03	0.76	0.76	XXX
74360	TC	A	X-ray guide, GI dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74363		A	X-ray, bile duct dilation	0.88	6.39	NA	0.37	7.64	NA	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.29	0.29	0.04	1.21	1.21	XXX
74363	TC	A	X-ray, bile duct dilation	0.00	6.10	NA	0.33	6.43	NA	XXX
74400		A	Contrst x-ray, urinary tract	0.49	1.84	NA	0.13	2.46	NA	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	1.68	NA	0.11	1.79	NA	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.11	NA	0.13	2.73	NA	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	1.95	NA	0.11	2.06	NA	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.28	NA	0.14	2.91	NA	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.16	0.16	0.02	0.67	0.67	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.12	NA	0.12	2.24	NA	XXX
74420		A	Contrst x-ray, urinary tract	0.36	2.74	NA	0.16	3.26	NA	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74420	TC	A	Contrst x-ray, urinary tract	0.00	2.62	NA	0.14	2.76	NA	XXX
74425		A	Contrst x-ray, urinary tract	0.36	1.43	NA	0.09	1.88	NA	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.12	0.12	0.02	0.50	0.50	XXX
74425	TC	A	Contrst x-ray, urinary tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74430		A	Contrast x-ray, bladder	0.32	1.15	NA	0.08	1.55	NA	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	0.44	0.44	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.05	NA	0.06	1.11	NA	XXX
74440		A	X-ray, male genital tract	0.38	1.25	NA	0.08	1.71	NA	XXX
74440	26	A	X-ray, male genital tract	0.38	0.12	0.12	0.02	0.52	0.52	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.13	NA	0.06	1.19	NA	XXX
74445		A	X-ray exam of penis	1.14	1.50	NA	0.13	2.77	NA	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.07	1.58	1.58	XXX
74445	TC	A	X-ray exam of penis	0.00	1.13	NA	0.06	1.19	NA	XXX
74450		A	X-ray, urethra/bladder	0.33	1.57	NA	0.10	2.00	NA	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
74450	TC	A	X-ray, urethra/bladder	0.00	1.46	NA	0.08	1.54	NA	XXX
74455		A	X-ray, urethra/bladder	0.33	1.69	NA	0.12	2.14	NA	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	0.46	0.46	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.58	NA	0.10	1.68	NA	XXX
74470		A	X-ray exam of kidney lesion	0.54	1.43	NA	0.09	2.06	NA	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74470	TC	A	X-ray exam of kidney lesion	0.00	1.25	NA	0.07	1.32	NA	XXX
74475		A	X-ray control, cath insert	0.54	4.25	NA	0.24	5.03	NA	XXX
74475	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74475	TC	A	X-ray control, cath insert	0.00	4.07	NA	0.22	4.29	NA	XXX
74480		A	X-ray control, cath insert	0.54	4.25	NA	0.24	5.03	NA	XXX
74480	26	A	X-ray control, cath insert	0.54	0.18	0.18	0.02	0.74	0.74	XXX
74480	TC	A	X-ray control, cath insert	0.00	4.07	NA	0.22	4.29	NA	XXX
74485		A	X-ray guide, GU dilation	0.54	3.32	NA	0.20	4.06	NA	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.03	0.74	0.74	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	3.15	NA	0.17	3.32	NA	XXX
74710		A	X-ray measurement of pelvis	0.34	1.16	NA	0.08	1.58	NA	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.11	0.11	0.02	0.47	0.47	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	1.05	NA	0.06	1.11	NA	XXX
74740		A	X-ray, female genital tract	0.38	1.44	NA	0.09	1.91	NA	XXX
74740	26	A	X-ray, female genital tract	0.38	0.13	0.13	0.02	0.53	0.53	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.31	NA	0.07	1.38	NA	XXX
74742		A	X-ray, fallopian tube	0.61	3.35	NA	0.20	4.16	NA	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.20	0.20	0.03	0.84	0.84	XXX
74742	TC	A	X-ray, fallopian tube	0.00	3.15	NA	0.17	3.32	NA	XXX
74775		A	X-ray exam of perineum	0.62	1.67	NA	0.11	2.40	NA	XXX
74775	26	A	X-ray exam of perineum	0.62	0.21	0.21	0.03	0.86	0.86	XXX
74775	TC	A	X-ray exam of perineum	0.00	1.46	NA	0.08	1.54	NA	XXX
75552		A	Heart mri for morph w/o dye	1.60	11.73	NA	0.66	13.99	NA	XXX
75552	26	A	Heart mri for morph w/o dye	1.60	0.53	0.53	0.07	2.20	2.20	XXX
75552	TC	A	Heart mri for morph w/o dye	0.00	11.20	NA	0.59	11.79	NA	XXX
75553		A	Heart mri for morph w/dye	2.00	11.85	NA	0.66	14.51	NA	XXX
75553	26	A	Heart mri for morph w/dye	2.00	0.65	0.65	0.07	2.72	2.72	XXX
75553	TC	A	Heart mri for morph w/dye	0.00	11.20	NA	0.59	11.79	NA	XXX
75554		A	Cardiac MRI/function	1.83	11.84	NA	0.66	14.33	NA	XXX
75554	26	A	Cardiac MRI/function	1.83	0.64	0.64	0.07	2.54	2.54	XXX
75554	TC	A	Cardiac MRI/function	0.00	11.20	NA	0.59	11.79	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
75555		A	Cardiac MRI/limited study	1.74	11.84	NA	0.66	14.24	NA	XXX
75555	26	A	Cardiac MRI/limited study	1.74	0.64	0.64	0.07	2.45	2.45	XXX
75555	TC	A	Cardiac MRI/limited study	0.00	11.20	NA	0.59	11.79	NA	XXX
75556		N	Cardiac MRI/flow mapping	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75600		A	Contrast x-ray exam of aorta	0.49	12.79	NA	0.67	13.95	NA	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.19	0.19	0.02	0.70	0.70	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75605		A	Contrast x-ray exam of aorta	1.14	13.00	NA	0.70	14.84	NA	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.40	0.40	0.05	1.59	1.59	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75625		A	Contrast x-ray exam of aorta	1.14	12.98	NA	0.71	14.83	NA	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	12.60	NA	0.65	13.25	NA	XXX
75630		A	X-ray aorta, leg arteries	1.79	13.74	NA	0.80	16.33	NA	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.61	0.61	0.11	2.51	2.51	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	13.13	NA	0.69	13.82	NA	XXX
75635		A	Ct angio abdominal arteries	2.40	16.70	NA	0.50	19.60	NA	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.79	0.79	0.11	3.30	3.30	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	15.91	NA	0.39	16.30	NA	XXX
75650		A	Artery x-rays, head & neck	1.49	13.09	NA	0.73	15.31	NA	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.49	0.49	0.08	2.06	2.06	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75658		A	Artery x-rays, arm	1.31	13.07	NA	0.72	15.10	NA	XXX
75658	26	A	Artery x-rays, arm	1.31	0.47	0.47	0.07	1.85	1.85	XXX
75658	TC	A	Artery x-rays, arm	0.00	12.60	NA	0.65	13.25	NA	XXX
75660		A	Artery x-rays, head & neck	1.31	13.04	NA	0.73	15.08	NA	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.08	1.83	1.83	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75662		A	Artery x-rays, head & neck	1.66	13.19	NA	0.73	15.58	NA	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.59	0.59	0.08	2.33	2.33	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75665		A	Artery x-rays, head & neck	1.31	13.04	NA	0.74	15.09	NA	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75671		A	Artery x-rays, head & neck	1.66	13.15	NA	0.74	15.55	NA	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.55	0.55	0.09	2.30	2.30	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	12.60	NA	0.65	13.25	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75676		A	Artery x-rays, neck	1.31	13.04	NA	0.74	15.09	NA	XXX
75676	26	A	Artery x-rays, neck	1.31	0.44	0.44	0.09	1.84	1.84	XXX
75676	TC	A	Artery x-rays, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75680		A	Artery x-rays, neck	1.66	13.15	NA	0.74	15.55	NA	XXX
75680	26	A	Artery x-rays, neck	1.66	0.55	0.55	0.09	2.30	2.30	XXX
75680	TC	A	Artery x-rays, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75685		A	Artery x-rays, spine	1.31	13.03	NA	0.72	15.06	NA	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75685	TC	A	Artery x-rays, spine	0.00	12.60	NA	0.65	13.25	NA	XXX
75705		A	Artery x-rays, spine	2.18	13.33	NA	0.78	16.29	NA	XXX
75705	26	A	Artery x-rays, spine	2.18	0.73	0.73	0.13	3.04	3.04	XXX
75705	TC	A	Artery x-rays, spine	0.00	12.60	NA	0.65	13.25	NA	XXX
75710		A	Artery x-rays, arm/leg	1.14	12.99	NA	0.72	14.85	NA	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.39	0.39	0.07	1.60	1.60	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	12.60	NA	0.65	13.25	NA	XXX
75716		A	Artery x-rays, arms/legs	1.31	13.03	NA	0.72	15.06	NA	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.43	0.43	0.07	1.81	1.81	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	12.60	NA	0.65	13.25	NA	XXX
75722		A	Artery x-rays, kidney	1.14	13.00	NA	0.71	14.85	NA	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.40	0.40	0.06	1.60	1.60	XXX
75722	TC	A	Artery x-rays, kidney	0.00	12.60	NA	0.65	13.25	NA	XXX
75724		A	Artery x-rays, kidneys	1.49	13.16	NA	0.71	15.36	NA	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.56	0.56	0.06	2.11	2.11	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	12.60	NA	0.65	13.25	NA	XXX
75726		A	Artery x-rays, abdomen	1.14	12.97	NA	0.70	14.81	NA	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	12.60	NA	0.65	13.25	NA	XXX
75731		A	Artery x-rays, adrenal gland	1.14	12.97	NA	0.71	14.82	NA	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	12.60	NA	0.65	13.25	NA	XXX
75733		A	Artery x-rays, adrenals	1.31	13.04	NA	0.71	15.06	NA	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.44	0.06	1.81	1.81	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	12.60	NA	0.65	13.25	NA	XXX
75736		A	Artery x-rays, pelvis	1.14	12.98	NA	0.71	14.83	NA	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.38	0.38	0.06	1.58	1.58	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	12.60	NA	0.65	13.25	NA	XXX
75741		A	Artery x-rays, lung	1.31	13.03	NA	0.71	15.05	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75741	26	A	Artery x-rays, lung	1.31	0.43	0.43	0.06	1.80	1.80	XXX
75741	TC	A	Artery x-rays, lung	0.00	12.60	NA	0.65	13.25	NA	XXX
75743		A	Artery x-rays, lungs	1.66	13.14	NA	0.72	15.52	NA	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.54	0.54	0.07	2.27	2.27	XXX
75743	TC	A	Artery x-rays, lungs	0.00	12.60	NA	0.65	13.25	NA	XXX
75746		A	Artery x-rays, lung	1.14	12.98	NA	0.70	14.82	NA	XXX
75746	26	A	Artery x-rays, lung	1.14	0.38	0.38	0.05	1.57	1.57	XXX
75746	TC	A	Artery x-rays, lung	0.00	12.60	NA	0.65	13.25	NA	XXX
75756		A	Artery x-rays, chest	1.14	13.05	NA	0.69	14.88	NA	XXX
75756	26	A	Artery x-rays, chest	1.14	0.45	0.45	0.04	1.63	1.63	XXX
75756	TC	A	Artery x-rays, chest	0.00	12.60	NA	0.65	13.25	NA	XXX
75774		A	Artery x-ray, each vessel	0.36	12.72	NA	0.67	13.75	NA	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	12.60	NA	0.65	13.25	NA	ZZZ
75790		A	Visualize A-V shunt	1.84	1.95	NA	0.18	3.97	NA	XXX
75790	26	A	Visualize A-V shunt	1.84	0.60	0.60	0.10	2.54	2.54	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.35	NA	0.08	1.43	NA	XXX
75801		A	Lymph vessel x-ray, arm/leg	0.81	5.68	NA	0.36	6.85	NA	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.27	0.27	0.07	1.15	1.15	XXX
75801	TC	A	Lymph vessel x-ray, arm/leg	0.00	5.41	NA	0.29	5.70	NA	XXX
75803		A	Lymph vessel x-ray,arms/legs	1.17	5.79	NA	0.34	7.30	NA	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75803	TC	A	Lymph vessel x-ray,arms/legs	0.00	5.41	NA	0.29	5.70	NA	XXX
75805		A	Lymph vessel x-ray, trunk	0.81	6.37	NA	0.38	7.56	NA	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.27	0.27	0.05	1.13	1.13	XXX
75805	TC	A	Lymph vessel x-ray, trunk	0.00	6.10	NA	0.33	6.43	NA	XXX
75807		A	Lymph vessel x-ray, trunk	1.17	6.48	NA	0.38	8.03	NA	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.38	0.38	0.05	1.60	1.60	XXX
75807	TC	A	Lymph vessel x-ray, trunk	0.00	6.10	NA	0.33	6.43	NA	XXX
75809		A	Nonvascular shunt, x-ray	0.47	0.93	NA	0.07	1.47	NA	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.02	0.64	0.64	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	0.78	NA	0.05	0.83	NA	XXX
75810		A	Vein x-ray, spleen/liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75810	TC	A	Vein x-ray, spleen/liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.18	NA	0.10	1.98	NA	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.23	0.23	0.04	0.97	0.97	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75820	TC	A	Vein x-ray, arm/leg	0.00	0.95	NA	0.06	1.01	NA	XXX
75822		A	Vein x-ray, arms/legs	1.06	1.83	NA	0.13	3.02	NA	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.35	0.35	0.05	1.46	1.46	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.48	NA	0.08	1.56	NA	XXX
75825		A	Vein x-ray, trunk	1.14	12.97	NA	0.72	14.83	NA	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75825	TC	A	Vein x-ray, trunk	0.00	12.60	NA	0.65	13.25	NA	XXX
75827		A	Vein x-ray, chest	1.14	12.97	NA	0.71	14.82	NA	XXX
75827	26	A	Vein x-ray, chest	1.14	0.37	0.37	0.06	1.57	1.57	XXX
75827	TC	A	Vein x-ray, chest	0.00	12.60	NA	0.65	13.25	NA	XXX
75831		A	Vein x-ray, kidney	1.14	12.97	NA	0.72	14.83	NA	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.37	0.37	0.07	1.58	1.58	XXX
75831	TC	A	Vein x-ray, kidney	0.00	12.60	NA	0.65	13.25	NA	XXX
75833		A	Vein x-ray, kidneys	1.49	13.09	NA	0.74	15.32	NA	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.49	0.49	0.09	2.07	2.07	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	12.60	NA	0.65	13.25	NA	XXX
75840		A	Vein x-ray, adrenal gland	1.14	12.98	NA	0.72	14.84	NA	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.38	0.38	0.07	1.59	1.59	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	12.60	NA	0.65	13.25	NA	XXX
75842		A	Vein x-ray, adrenal glands	1.49	13.08	NA	0.72	15.29	NA	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.48	0.48	0.07	2.04	2.04	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	12.60	NA	0.65	13.25	NA	XXX
75860		A	Vein x-ray, neck	1.14	12.99	NA	0.70	14.83	NA	XXX
75860	26	A	Vein x-ray, neck	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75860	TC	A	Vein x-ray, neck	0.00	12.60	NA	0.65	13.25	NA	XXX
75870		A	Vein x-ray, skull	1.14	12.99	NA	0.70	14.83	NA	XXX
75870	26	A	Vein x-ray, skull	1.14	0.39	0.39	0.05	1.58	1.58	XXX
75870	TC	A	Vein x-ray, skull	0.00	12.60	NA	0.65	13.25	NA	XXX
75872		A	Vein x-ray, skull	1.14	12.97	NA	0.78	14.89	NA	XXX
75872	26	A	Vein x-ray, skull	1.14	0.37	0.37	0.13	1.64	1.64	XXX
75872	TC	A	Vein x-ray, skull	0.00	12.60	NA	0.65	13.25	NA	XXX
75880		A	Vein x-ray, eye socket	0.70	1.18	NA	0.09	1.97	NA	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.23	0.23	0.03	0.96	0.96	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	0.95	NA	0.06	1.01	NA	XXX
75885		A	Vein x-ray, liver	1.44	13.07	NA	0.72	15.23	NA	XXX
75885	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.07	1.98	1.98	XXX
75885	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75887		A	Vein x-ray, liver	1.44	13.07	NA	0.71	15.22	NA	XXX
75887	26	A	Vein x-ray, liver	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75887	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75889		A	Vein x-ray, liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75889	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75889	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75891		A	Vein x-ray, liver	1.14	12.97	NA	0.70	14.81	NA	XXX
75891	26	A	Vein x-ray, liver	1.14	0.37	0.37	0.05	1.56	1.56	XXX
75891	TC	A	Vein x-ray, liver	0.00	12.60	NA	0.65	13.25	NA	XXX
75893		A	Venous sampling by catheter	0.54	12.78	NA	0.68	14.00	NA	XXX
75893	26	A	Venous sampling by catheter	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75893	TC	A	Venous sampling by catheter	0.00	12.60	NA	0.65	13.25	NA	XXX
75894		A	X-rays, transcath therapy	1.31	24.56	NA	1.35	27.22	NA	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.43	0.43	0.08	1.82	1.82	XXX
75894	TC	A	X-rays, transcath therapy	0.00	24.13	NA	1.27	25.40	NA	XXX
75896		A	X-rays, transcath therapy	1.31	21.44	NA	1.17	23.92	NA	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.45	0.45	0.07	1.83	1.83	XXX
75896	TC	A	X-rays, transcath therapy	0.00	20.99	NA	1.10	22.09	NA	XXX
75898		A	Follow-up angiography	1.65	1.60	NA	0.14	3.39	NA	XXX
75898	26	A	Follow-up angiography	1.65	0.55	0.55	0.08	2.28	2.28	XXX
75898	TC	A	Follow-up angiography	0.00	1.05	NA	0.06	1.11	NA	XXX
75900		A	Arterial catheter exchange	0.49	21.13	NA	1.14	22.76	NA	XXX
75900	26	A	Arterial catheter exchange	0.49	0.16	0.16	0.03	0.68	0.68	XXX
75900	TC	A	Arterial catheter exchange	0.00	20.97	NA	1.11	22.08	NA	XXX
75901		A	Remove cva device obstruct	0.49	1.47	NA	0.85	2.81	NA	XXX
75901	26	A	Remove cva device obstruct	0.49	0.16	0.16	0.02	0.67	0.67	XXX
75901	TC	A	Remove cva device obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75902		A	Remove cva lumen obstruct	0.39	1.44	NA	0.85	2.68	NA	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.13	0.13	0.02	0.54	0.54	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.31	NA	0.83	2.14	NA	XXX
75940		A	X-ray placement, vein filter	0.54	12.78	NA	0.69	14.01	NA	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75940	TC	A	X-ray placement, vein filter	0.00	12.60	NA	0.65	13.25	NA	XXX
75945		A	Intravascular us	0.40	4.70	NA	0.28	5.38	NA	XXX
75945	26	A	Intravascular us	0.40	0.14	0.14	0.04	0.58	0.58	XXX
75945	TC	A	Intravascular us	0.00	4.56	NA	0.24	4.80	NA	XXX
75946		A	Intravascular us add-on	0.40	2.43	NA	0.18	3.01	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
75946	26	A	Intravascular us add-on	0.40	0.14	0.14	0.05	0.59	0.59	ZZZ
75946	TC	A	Intravascular us add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.49	1.49	0.44	6.42	6.42	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.45	0.45	0.13	1.94	1.94	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.78	0.78	0.15	3.18	3.18	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
75960		A	Transcath iv stent rs&i	0.82	15.18	NA	0.82	16.82	NA	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.28	0.28	0.05	1.15	1.15	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	14.90	NA	0.77	15.67	NA	XXX
75961		A	Retrieval, broken catheter	4.24	11.89	NA	0.77	16.90	NA	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.39	1.39	0.22	5.85	5.85	XXX
75961	TC	A	Retrieval, broken catheter	0.00	10.50	NA	0.55	11.05	NA	XXX
75962		A	Repair arterial blockage	0.54	15.92	NA	0.87	17.33	NA	XXX
75962	26	A	Repair arterial blockage	0.54	0.18	0.18	0.04	0.76	0.76	XXX
75962	TC	A	Repair arterial blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75964		A	Repair artery blockage, each	0.36	8.51	NA	0.46	9.33	NA	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.12	0.12	0.03	0.51	0.51	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75966		A	Repair arterial blockage	1.31	16.20	NA	0.90	18.41	NA	XXX
75966	26	A	Repair arterial blockage	1.31	0.46	0.46	0.07	1.84	1.84	XXX
75966	TC	A	Repair arterial blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75968		A	Repair artery blockage, each	0.36	8.52	NA	0.45	9.33	NA	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75970		A	Vascular biopsy	0.83	11.82	NA	0.64	13.29	NA	XXX
75970	26	A	Vascular biopsy	0.83	0.28	0.28	0.04	1.15	1.15	XXX
75970	TC	A	Vascular biopsy	0.00	11.54	NA	0.60	12.14	NA	XXX
75978		A	Repair venous blockage	0.54	15.92	NA	0.86	17.32	NA	XXX
75978	26	A	Repair venous blockage	0.54	0.18	0.18	0.03	0.75	0.75	XXX
75978	TC	A	Repair venous blockage	0.00	15.74	NA	0.83	16.57	NA	XXX
75980		A	Contrast xray exam bile duct	1.44	5.88	NA	0.35	7.67	NA	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
75980	TC	A	Contrast xray exam bile duct	0.00	5.41	NA	0.29	5.70	NA	XXX
75982		A	Contrast xray exam bile duct	1.44	6.57	NA	0.39	8.40	NA	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.47	0.47	0.06	1.97	1.97	XXX
75982	TC	A	Contrast xray exam bile duct	0.00	6.10	NA	0.33	6.43	NA	XXX
75984		A	Xray control catheter change	0.72	2.18	NA	0.14	3.04	NA	XXX
75984	26	A	Xray control catheter change	0.72	0.23	0.23	0.03	0.98	0.98	XXX
75984	TC	A	Xray control catheter change	0.00	1.95	NA	0.11	2.06	NA	XXX
75989		A	Abscess drainage under x-ray	1.19	3.54	NA	0.22	4.95	NA	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.39	0.39	0.05	1.63	1.63	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	3.15	NA	0.17	3.32	NA	XXX
75992		A	Atherectomy, x-ray exam	0.54	15.93	NA	0.86	17.33	NA	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.19	0.19	0.03	0.76	0.76	XXX
75992	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75993		A	Atherectomy, x-ray exam	0.36	8.52	NA	0.45	9.33	NA	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.13	0.13	0.02	0.51	0.51	ZZZ
75993	TC	A	Atherectomy, x-ray exam	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75994		A	Atherectomy, x-ray exam	1.31	16.20	NA	0.90	18.41	NA	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.46	0.46	0.07	1.84	1.84	XXX
75994	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75995		A	Atherectomy, x-ray exam	1.31	16.21	NA	0.88	18.40	NA	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.47	0.47	0.05	1.83	1.83	XXX
75995	TC	A	Atherectomy, x-ray exam	0.00	15.74	NA	0.83	16.57	NA	XXX
75996		A	Atherectomy, x-ray exam	0.36	8.51	NA	0.45	9.32	NA	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.12	0.12	0.02	0.50	0.50	ZZZ
75996	TC	A	Atherectomy, x-ray exam	0.00	8.39	NA	0.43	8.82	NA	ZZZ
75998		A	Fluoroguide for vein device	0.38	1.44	NA	0.11	1.93	NA	ZZZ
75998	26	A	Fluoroguide for vein device	0.38	0.13	0.13	0.01	0.52	0.52	ZZZ
75998	TC	A	Fluoroguide for vein device	0.00	1.31	NA	0.10	1.41	NA	ZZZ
76000		A	Fluoroscope examination	0.17	1.36	NA	0.08	1.61	NA	XXX
76000	26	A	Fluoroscope examination	0.17	0.05	0.05	0.01	0.23	0.23	XXX
76000	TC	A	Fluoroscope examination	0.00	1.31	NA	0.07	1.38	NA	XXX
76001		A	Fluoroscope exam, extensive	0.67	2.84	NA	0.19	3.70	NA	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.22	0.22	0.05	0.94	0.94	XXX
76001	TC	A	Fluoroscope exam, extensive	0.00	2.62	NA	0.14	2.76	NA	XXX
76003		A	Needle localization by x-ray	0.54	1.48	NA	0.10	2.12	NA	XXX
76003	26	A	Needle localization by x-ray	0.54	0.17	0.17	0.03	0.74	0.74	XXX
76003	TC	A	Needle localization by x-ray	0.00	1.31	NA	0.07	1.38	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76005		A	Fluoroguide for spine inject	0.60	1.46	NA	0.11	2.17	NA	XXX
76005	26	A	Fluoroguide for spine inject	0.60	0.15	0.15	0.04	0.79	0.79	XXX
76005	TC	A	Fluoroguide for spine inject	0.00	1.31	NA	0.07	1.38	NA	XXX
76006		A	X-ray stress view	0.41	0.18	0.18	0.06	0.65	0.65	XXX
76010		A	X-ray, nose to rectum	0.18	0.58	NA	0.03	0.79	NA	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.06	0.06	0.01	0.25	0.25	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.52	NA	0.02	0.54	NA	XXX
76012		C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76012	26	A	Percut vertebroplasty fluor	1.31	0.47	0.47	0.10	1.88	1.88	XXX
76012	TC	C	Percut vertebroplasty fluor	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013		C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76013	26	A	Percut vertebroplasty, ct	1.38	0.48	0.48	0.08	1.94	1.94	XXX
76013	TC	C	Percut vertebroplasty, ct	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76020		A	X-rays for bone age	0.19	0.58	NA	0.03	0.80	NA	XXX
76020	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	0.26	0.26	XXX
76020	TC	A	X-rays for bone age	0.00	0.52	NA	0.02	0.54	NA	XXX
76040		A	X-rays, bone evaluation	0.27	0.87	NA	0.06	1.20	NA	XXX
76040	26	A	X-rays, bone evaluation	0.27	0.09	0.09	0.01	0.37	0.37	XXX
76040	TC	A	X-rays, bone evaluation	0.00	0.78	NA	0.05	0.83	NA	XXX
76061		A	X-rays, bone survey	0.45	1.15	NA	0.08	1.68	NA	XXX
76061	26	A	X-rays, bone survey	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76061	TC	A	X-rays, bone survey	0.00	1.00	NA	0.06	1.06	NA	XXX
76062		A	X-rays, bone survey	0.54	1.62	NA	0.10	2.26	NA	XXX
76062	26	A	X-rays, bone survey	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76062	TC	A	X-rays, bone survey	0.00	1.44	NA	0.08	1.52	NA	XXX
76065		A	X-rays, bone evaluation	0.70	0.96	NA	0.08	1.74	NA	XXX
76065	26	A	X-rays, bone evaluation	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76065	TC	A	X-rays, bone evaluation	0.00	0.73	NA	0.05	0.78	NA	XXX
76066		A	Joint survey, single view	0.31	1.21	NA	0.08	1.60	NA	XXX
76066	26	A	Joint survey, single view	0.31	0.10	0.10	0.02	0.43	0.43	XXX
76066	TC	A	Joint survey, single view	0.00	1.11	NA	0.06	1.17	NA	XXX
76070		A	Ct bone density, axial	0.25	3.03	NA	0.17	3.45	NA	XXX
76070	26	A	Ct bone density, axial	0.25	0.08	0.08	0.01	0.34	0.34	XXX
76070	TC	A	Ct bone density, axial	0.00	2.95	NA	0.16	3.11	NA	XXX
76071		A	Ct bone density, peripheral	0.22	3.02	NA	0.06	3.30	NA	XXX
76071	26	A	Ct bone density, peripheral	0.22	0.07	0.07	0.01	0.30	0.30	XXX
76071	TC	A	Ct bone density, peripheral	0.00	2.95	NA	0.05	3.00	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76075		A	Dxa bone density, axial	0.30	3.19	NA	0.18	3.67	NA	XXX
76075	26	A	Dxa bone density, axial	0.30	0.10	0.10	0.01	0.41	0.41	XXX
76075	TC	A	Dxa bone density, axial	0.00	3.09	NA	0.17	3.26	NA	XXX
76076		A	Dxa bone density/peripheral	0.22	0.83	NA	0.06	1.11	NA	XXX
76076	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76076	TC	A	Dxa bone density/peripheral	0.00	0.75	NA	0.05	0.80	NA	XXX
76077		A	Dxa bone density/v-fracture	0.17	0.81	NA	0.06	1.04	NA	XXX
76077	26	A	Dxa bone density/v-fracture	0.17	0.06	0.06	0.01	0.24	0.24	XXX
76077	TC	A	Dxa bone density/v-fracture	0.00	0.75	NA	0.05	0.80	NA	XXX
76078		A	Radiographic absorptiometry	0.20	0.82	NA	0.06	1.08	NA	XXX
76078	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	0.28	0.28	XXX
76078	TC	A	Radiographic absorptiometry	0.00	0.75	NA	0.05	0.80	NA	XXX
76080		A	X-ray exam of fistula	0.54	1.23	NA	0.08	1.85	NA	XXX
76080	26	A	X-ray exam of fistula	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76080	TC	A	X-ray exam of fistula	0.00	1.05	NA	0.06	1.11	NA	XXX
76082		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76082	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76082	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76083		A	Computer mammogram add-on	0.06	0.44	NA	0.02	0.52	NA	ZZZ
76083	26	A	Computer mammogram add-on	0.06	0.02	0.02	0.01	0.09	0.09	ZZZ
76083	TC	A	Computer mammogram add-on	0.00	0.42	NA	0.01	0.43	NA	ZZZ
76086		A	X-ray of mammary duct	0.36	2.74	NA	0.16	3.26	NA	XXX
76086	26	A	X-ray of mammary duct	0.36	0.12	0.12	0.02	0.50	0.50	XXX
76086	TC	A	X-ray of mammary duct	0.00	2.62	NA	0.14	2.76	NA	XXX
76088		A	X-ray of mammary ducts	0.45	3.81	NA	0.21	4.47	NA	XXX
76088	26	A	X-ray of mammary ducts	0.45	0.15	0.15	0.02	0.62	0.62	XXX
76088	TC	A	X-ray of mammary ducts	0.00	3.66	NA	0.19	3.85	NA	XXX
76090		A	Mammogram, one breast	0.70	1.28	NA	0.09	2.07	NA	XXX
76090	26	A	Mammogram, one breast	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76090	TC	A	Mammogram, one breast	0.00	1.05	NA	0.06	1.11	NA	XXX
76091		A	Mammogram, both breasts	0.87	1.59	NA	0.11	2.57	NA	XXX
76091	26	A	Mammogram, both breasts	0.87	0.28	0.28	0.04	1.19	1.19	XXX
76091	TC	A	Mammogram, both breasts	0.00	1.31	NA	0.07	1.38	NA	XXX
76092		A	Mammogram, screening	0.70	1.46	NA	0.10	2.26	NA	XXX
76092	26	A	Mammogram, screening	0.70	0.23	0.23	0.03	0.96	0.96	XXX
76092	TC	A	Mammogram, screening	0.00	1.23	NA	0.07	1.30	NA	XXX
76093		A	Magnetic image, breast	1.63	18.15	NA	0.99	20.77	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76093	26	A	Magnetic image, breast	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76093	TC	A	Magnetic image, breast	0.00	17.62	NA	0.92	18.54	NA	XXX
76094		A	Magnetic image, both breasts	1.63	24.44	NA	1.31	27.38	NA	XXX
76094	26	A	Magnetic image, both breasts	1.63	0.53	0.53	0.07	2.23	2.23	XXX
76094	TC	A	Magnetic image, both breasts	0.00	23.91	NA	1.24	25.15	NA	XXX
76095		A	Stereotactic breast biopsy	1.59	7.68	NA	0.46	9.73	NA	XXX
76095	26	A	Stereotactic breast biopsy	1.59	0.52	0.52	0.09	2.20	2.20	XXX
76095	TC	A	Stereotactic breast biopsy	0.00	7.16	NA	0.37	7.53	NA	XXX
76096		A	X-ray of needle wire, breast	0.56	1.49	NA	0.10	2.15	NA	XXX
76096	26	A	X-ray of needle wire, breast	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76096	TC	A	X-ray of needle wire, breast	0.00	1.31	NA	0.07	1.38	NA	XXX
76098		A	X-ray exam, breast specimen	0.16	0.47	NA	0.03	0.66	NA	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.42	NA	0.02	0.44	NA	XXX
76100		A	X-ray exam of body section	0.58	1.44	NA	0.10	2.12	NA	XXX
76100	26	A	X-ray exam of body section	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76100	TC	A	X-ray exam of body section	0.00	1.25	NA	0.07	1.32	NA	XXX
76101		A	Complex body section x-ray	0.58	1.61	NA	0.11	2.30	NA	XXX
76101	26	A	Complex body section x-ray	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76101	TC	A	Complex body section x-ray	0.00	1.42	NA	0.08	1.50	NA	XXX
76102		A	Complex body section x-rays	0.58	1.92	NA	0.14	2.64	NA	XXX
76102	26	A	Complex body section x-rays	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76102	TC	A	Complex body section x-rays	0.00	1.73	NA	0.11	1.84	NA	XXX
76120		A	Cine/video x-rays	0.38	1.18	NA	0.08	1.64	NA	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76120	TC	A	Cine/video x-rays	0.00	1.05	NA	0.06	1.11	NA	XXX
76125		A	Cine/video x-rays add-on	0.27	0.87	NA	0.06	1.20	NA	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.01	0.37	0.37	ZZZ
76125	TC	A	Cine/video x-rays add-on	0.00	0.78	NA	0.05	0.83	NA	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.42	NA	0.02	0.44	NA	XXX
76350		C	Special x-ray contrast study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76355		A	Ct scan for localization	1.21	8.66	NA	0.48	10.35	NA	XXX
76355	26	A	Ct scan for localization	1.21	0.40	0.40	0.06	1.67	1.67	XXX
76355	TC	A	Ct scan for localization	0.00	8.26	NA	0.42	8.68	NA	XXX
76360		A	Ct scan for needle biopsy	1.16	8.64	NA	0.47	10.27	NA	XXX
76360	26	A	Ct scan for needle biopsy	1.16	0.38	0.38	0.05	1.59	1.59	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76360	TC	A	Ct scan for needle biopsy	0.00	8.26	NA	0.42	8.68	NA	XXX
76362		A	Ct guide for tissue ablation	3.99	9.56	NA	1.65	15.20	NA	XXX
76362	26	A	Ct guide for tissue ablation	3.99	1.30	1.30	0.19	5.48	5.48	XXX
76362	TC	A	Ct guide for tissue ablation	0.00	8.26	NA	1.46	9.72	NA	XXX
76370		A	Ct scan for therapy guide	0.85	3.23	NA	0.20	4.28	NA	XXX
76370	26	A	Ct scan for therapy guide	0.85	0.28	0.28	0.04	1.17	1.17	XXX
76370	TC	A	Ct scan for therapy guide	0.00	2.95	NA	0.16	3.11	NA	XXX
76375		A	3d/holograph reconstr add-on	0.16	3.59	NA	0.19	3.94	NA	XXX
76375	26	A	3d/holograph reconstr add-on	0.16	0.05	0.05	0.01	0.22	0.22	XXX
76375	TC	A	3d/holograph reconstr add-on	0.00	3.54	NA	0.18	3.72	NA	XXX
76380		A	CAT scan follow-up study	0.98	3.82	NA	0.22	5.02	NA	XXX
76380	26	A	CAT scan follow-up study	0.98	0.32	0.32	0.04	1.34	1.34	XXX
76380	TC	A	CAT scan follow-up study	0.00	3.50	NA	0.18	3.68	NA	XXX
76390		N	Mr spectroscopy	+1.40	11.48	11.48	0.66	13.54	13.54	XXX
76390	26	N	Mr spectroscopy	+1.40	0.47	0.47	0.07	1.94	1.94	XXX
76390	TC	N	Mr spectroscopy	+0.00	11.01	11.01	0.59	11.60	11.60	XXX
76393		A	Mr guidance for needle place	1.50	11.70	NA	0.64	13.84	NA	XXX
76393	26	A	Mr guidance for needle place	1.50	0.50	0.50	0.09	2.09	2.09	XXX
76393	TC	A	Mr guidance for needle place	0.00	11.20	NA	0.55	11.75	NA	XXX
76394		A	Mri for tissue ablation	4.24	12.58	NA	1.80	18.62	NA	XXX
76394	26	A	Mri for tissue ablation	4.24	1.38	1.38	0.24	5.86	5.86	XXX
76394	TC	A	Mri for tissue ablation	0.00	11.20	NA	1.56	12.76	NA	XXX
76400		A	Magnetic image, bone marrow	1.60	11.72	NA	0.66	13.98	NA	XXX
76400	26	A	Magnetic image, bone marrow	1.60	0.52	0.52	0.07	2.19	2.19	XXX
76400	TC	A	Magnetic image, bone marrow	0.00	11.20	NA	0.59	11.79	NA	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76506		A	Echo exam of head	0.63	1.66	NA	0.13	2.42	NA	XXX
76506	26	A	Echo exam of head	0.63	0.24	0.24	0.05	0.92	0.92	XXX
76506	TC	A	Echo exam of head	0.00	1.42	NA	0.08	1.50	NA	XXX
76510		A	Ophth us, b & quant a	1.55	2.86	NA	0.10	4.51	NA	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.68	0.68	0.03	2.26	2.26	XXX
76510	TC	A	Ophth us, b & quant a	0.00	2.18	NA	0.07	2.25	NA	XXX
76511		A	Ophth us, quant a only	0.94	2.43	NA	0.10	3.47	NA	XXX
76511	26	A	Ophth us, quant a only	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76511	TC	A	Ophth us, quant a only	0.00	2.03	NA	0.07	2.10	NA	XXX
76512		A	Ophth us, b w/non-quant a	0.94	2.23	NA	0.12	3.29	NA	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.42	0.42	0.02	1.38	1.38	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	1.81	NA	0.10	1.91	NA	XXX
76513		A	Echo exam of eye, water bath	0.66	1.81	NA	0.12	2.59	NA	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.52	NA	0.10	1.62	NA	XXX
76514		A	Echo exam of eye, thickness	0.17	0.13	NA	0.02	0.32	NA	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.05	NA	0.01	0.06	NA	XXX
76516		A	Echo exam of eye	0.54	1.46	NA	0.08	2.08	NA	XXX
76516	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76516	TC	A	Echo exam of eye	0.00	1.22	NA	0.07	1.29	NA	XXX
76519		A	Echo exam of eye	0.54	1.55	NA	0.08	2.17	NA	XXX
76519	26	A	Echo exam of eye	0.54	0.24	0.24	0.01	0.79	0.79	XXX
76519	TC	A	Echo exam of eye	0.00	1.31	NA	0.07	1.38	NA	XXX
76529		A	Echo exam of eye	0.57	1.37	NA	0.10	2.04	NA	XXX
76529	26	A	Echo exam of eye	0.57	0.24	0.24	0.02	0.83	0.83	XXX
76529	TC	A	Echo exam of eye	0.00	1.13	NA	0.08	1.21	NA	XXX
76536		A	Us exam of head and neck	0.56	1.60	NA	0.11	2.27	NA	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.03	0.77	0.77	XXX
76536	TC	A	Us exam of head and neck	0.00	1.42	NA	0.08	1.50	NA	XXX
76604		A	Us exam, chest, b-scan	0.55	1.49	NA	0.09	2.13	NA	XXX
76604	26	A	Us exam, chest, b-scan	0.55	0.18	0.18	0.02	0.75	0.75	XXX
76604	TC	A	Us exam, chest, b-scan	0.00	1.31	NA	0.07	1.38	NA	XXX
76645		A	Us exam, breast(s)	0.54	1.23	NA	0.08	1.85	NA	XXX
76645	26	A	Us exam, breast(s)	0.54	0.18	0.18	0.02	0.74	0.74	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.05	NA	0.06	1.11	NA	XXX
76700		A	Us exam, abdom, complete	0.81	2.24	NA	0.15	3.20	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76700	26	A	Us exam, abdom, complete	0.81	0.27	0.27	0.04	1.12	1.12	XXX
76700	TC	A	Us exam, abdom, complete	0.00	1.97	NA	0.11	2.08	NA	XXX
76705		A	Echo exam of abdomen	0.59	1.61	NA	0.11	2.31	NA	XXX
76705	26	A	Echo exam of abdomen	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.42	NA	0.08	1.50	NA	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.21	NA	0.14	3.09	NA	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	1.97	NA	0.11	2.08	NA	XXX
76775		A	Us exam abdo back wall, lim	0.58	1.61	NA	0.11	2.30	NA	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.42	NA	0.08	1.50	NA	XXX
76778		A	Us exam kidney transplant	0.74	2.21	NA	0.14	3.09	NA	XXX
76778	26	A	Us exam kidney transplant	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76778	TC	A	Us exam kidney transplant	0.00	1.97	NA	0.11	2.08	NA	XXX
76800		A	Us exam, spinal canal	1.13	1.76	NA	0.13	3.02	NA	XXX
76800	26	A	Us exam, spinal canal	1.13	0.34	0.34	0.05	1.52	1.52	XXX
76800	TC	A	Us exam, spinal canal	0.00	1.42	NA	0.08	1.50	NA	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.44	NA	0.16	3.59	NA	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	2.10	NA	0.12	2.22	NA	XXX
76802		A	Ob us < 14 wks, add'l fetus	0.83	1.34	NA	0.16	2.33	NA	ZZZ
76802	26	A	Ob us < 14 wks, add'l fetus	0.83	0.29	0.29	0.04	1.16	1.16	ZZZ
76802	TC	A	Ob us < 14 wks, add'l fetus	0.00	1.05	NA	0.12	1.17	NA	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.44	NA	0.16	3.59	NA	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.04	1.37	1.37	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.10	NA	0.12	2.22	NA	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.39	NA	0.26	2.63	NA	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.04	1.36	1.36	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.05	NA	0.22	1.27	NA	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	4.24	NA	0.52	6.66	NA	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.09	2.70	2.70	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	3.53	NA	0.43	3.96	NA	XXX
76812		A	Ob us, detailed, addl fetus	1.78	1.71	NA	0.49	3.98	NA	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.66	0.66	0.08	2.52	2.52	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	1.05	NA	0.41	1.46	NA	ZZZ
76815		A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.11	2.41	NA	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.23	0.23	0.03	0.91	0.91	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.42	NA	0.08	1.50	NA	XXX
76816		A	Ob us, follow-up, per fetus	0.85	1.43	NA	0.10	2.38	NA	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.32	0.32	0.04	1.21	1.21	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.11	NA	0.06	1.17	NA	XXX
76817		A	Transvaginal us, obstetric	0.75	1.78	NA	0.09	2.62	NA	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	1.04	1.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.52	NA	0.06	1.58	NA	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.00	NA	0.15	3.20	NA	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	1.49	1.49	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.89	NA	0.13	2.79	NA	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.28	0.28	0.03	1.08	1.08	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.61	NA	0.10	1.71	NA	XXX
76820		A	Umbilical artery echo	0.50	1.80	NA	0.15	2.45	NA	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.03	0.72	0.72	XXX
76820	TC	A	Umbilical artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76821		A	Middle cerebral artery echo	0.70	1.88	NA	0.15	2.73	NA	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.27	0.27	0.03	1.00	1.00	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.61	NA	0.12	1.73	NA	XXX
76825		A	Echo exam of fetal heart	1.67	2.57	NA	0.18	4.42	NA	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.60	0.60	0.07	2.34	2.34	XXX
76825	TC	A	Echo exam of fetal heart	0.00	1.97	NA	0.11	2.08	NA	XXX
76826		A	Echo exam of fetal heart	0.83	1.00	NA	0.08	1.91	NA	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.29	0.29	0.03	1.15	1.15	XXX
76826	TC	A	Echo exam of fetal heart	0.00	0.71	NA	0.05	0.76	NA	XXX
76827		A	Echo exam of fetal heart	0.58	1.93	NA	0.15	2.66	NA	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	0.82	0.82	XXX
76827	TC	A	Echo exam of fetal heart	0.00	1.72	NA	0.12	1.84	NA	XXX
76828		A	Echo exam of fetal heart	0.56	1.33	NA	0.11	2.00	NA	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.03	0.81	0.81	XXX
76828	TC	A	Echo exam of fetal heart	0.00	1.11	NA	0.08	1.19	NA	XXX
76830		A	Transvaginal us, non-ob	0.69	1.75	NA	0.13	2.57	NA	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	1.52	NA	0.10	1.62	NA	XXX
76831		A	Echo exam, uterus	0.72	1.77	NA	0.13	2.62	NA	XXX
76831	26	A	Echo exam, uterus	0.72	0.25	0.25	0.03	1.00	1.00	XXX
76831	TC	A	Echo exam, uterus	0.00	1.52	NA	0.10	1.62	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76856		A	Us exam, pelvic, complete	0.69	1.75	NA	0.13	2.57	NA	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.23	0.23	0.03	0.95	0.95	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	1.52	NA	0.10	1.62	NA	XXX
76857		A	Us exam, pelvic, limited	0.38	1.83	NA	0.08	2.29	NA	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.02	0.52	0.52	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.71	NA	0.06	1.77	NA	XXX
76870		A	Us exam, scrotum	0.64	1.73	NA	0.13	2.50	NA	XXX
76870	26	A	Us exam, scrotum	0.64	0.21	0.21	0.03	0.88	0.88	XXX
76870	TC	A	Us exam, scrotum	0.00	1.52	NA	0.10	1.62	NA	XXX
76872		A	Us, transrectal	0.69	2.24	NA	0.14	3.07	NA	XXX
76872	26	A	Us, transrectal	0.69	0.22	0.22	0.04	0.95	0.95	XXX
76872	TC	A	Us, transrectal	0.00	2.02	NA	0.10	2.12	NA	XXX
76873		A	Echograp trans r, pros study	1.55	2.60	NA	0.25	4.40	NA	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.50	0.50	0.09	2.14	2.14	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.10	NA	0.16	2.26	NA	XXX
76880		A	Us exam, extremity	0.59	1.61	NA	0.11	2.31	NA	XXX
76880	26	A	Us exam, extremity	0.59	0.19	0.19	0.03	0.81	0.81	XXX
76880	TC	A	Us exam, extremity	0.00	1.42	NA	0.08	1.50	NA	XXX
76885		A	Us exam infant hips, dynamic	0.74	1.76	NA	0.13	2.63	NA	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.24	0.24	0.03	1.01	1.01	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	1.52	NA	0.10	1.62	NA	XXX
76886		A	Us exam infant hips, static	0.62	1.62	NA	0.11	2.35	NA	XXX
76886	26	A	Us exam infant hips, static	0.62	0.20	0.20	0.03	0.85	0.85	XXX
76886	TC	A	Us exam infant hips, static	0.00	1.42	NA	0.08	1.50	NA	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.77	NA	0.12	2.56	NA	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76932		A	Echo guide for heart biopsy	0.67	1.77	NA	0.12	2.56	NA	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.25	0.25	0.02	0.94	0.94	XXX
76932	TC	A	Echo guide for heart biopsy	0.00	1.52	NA	0.10	1.62	NA	XXX
76936		A	Echo guide for artery repair	1.99	6.95	NA	0.47	9.41	NA	XXX
76936	26	A	Echo guide for artery repair	1.99	0.66	0.66	0.13	2.78	2.78	XXX
76936	TC	A	Echo guide for artery repair	0.00	6.29	NA	0.34	6.63	NA	XXX
76937		A	Us guide, vascular access	0.30	0.48	NA	0.13	0.91	NA	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.10	0.10	0.03	0.43	0.43	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.38	NA	0.10	0.48	NA	ZZZ
76940		A	Us guide, tissue ablation	2.00	2.17	NA	0.58	4.75	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76940	26	A	Us guide, tissue ablation	2.00	0.65	0.65	0.29	2.94	2.94	XXX
76940	TC	A	Us guide, tissue ablation	0.00	1.52	NA	0.29	1.81	NA	XXX
76941		A	Echo guide for transfusion	1.34	2.00	NA	0.15	3.49	NA	XXX
76941	26	A	Echo guide for transfusion	1.34	0.47	0.47	0.07	1.88	1.88	XXX
76941	TC	A	Echo guide for transfusion	0.00	1.53	NA	0.08	1.61	NA	XXX
76942		A	Echo guide for biopsy	0.67	3.03	NA	0.13	3.83	NA	XXX
76942	26	A	Echo guide for biopsy	0.67	0.22	0.22	0.03	0.92	0.92	XXX
76942	TC	A	Echo guide for biopsy	0.00	2.81	NA	0.10	2.91	NA	XXX
76945		A	Echo guide, villus sampling	0.67	1.75	NA	0.12	2.54	NA	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.22	0.22	0.04	0.93	0.93	XXX
76945	TC	A	Echo guide, villus sampling	0.00	1.53	NA	0.08	1.61	NA	XXX
76946		A	Echo guide for amniocentesis	0.38	1.66	NA	0.12	2.16	NA	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	0.54	0.54	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	1.52	NA	0.10	1.62	NA	XXX
76948		A	Echo guide, ova aspiration	0.38	1.65	NA	0.12	2.15	NA	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.13	0.13	0.02	0.53	0.53	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	1.52	NA	0.10	1.62	NA	XXX
76950		A	Echo guidance radiotherapy	0.58	1.50	NA	0.10	2.18	NA	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.19	0.19	0.03	0.80	0.80	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	1.31	NA	0.07	1.38	NA	XXX
76965		A	Echo guidance radiotherapy	1.34	6.00	NA	0.37	7.71	NA	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.43	0.43	0.08	1.85	1.85	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	5.57	NA	0.29	5.86	NA	XXX
76970		A	Ultrasound exam follow-up	0.40	1.18	NA	0.08	1.66	NA	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.13	0.13	0.02	0.55	0.55	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	1.05	NA	0.06	1.11	NA	XXX
76975		A	GI endoscopic ultrasound	0.81	1.80	NA	0.14	2.75	NA	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.28	0.28	0.04	1.13	1.13	XXX
76975	TC	A	GI endoscopic ultrasound	0.00	1.52	NA	0.10	1.62	NA	XXX
76977		A	Us bone density measure	0.05	0.84	NA	0.06	0.95	NA	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.01	0.08	0.08	XXX
76977	TC	A	Us bone density measure	0.00	0.82	NA	0.05	0.87	NA	XXX
76986		A	Ultrasound guide intraoper	1.20	3.02	NA	0.26	4.48	NA	XXX
76986	26	A	Ultrasound guide intraoper	1.20	0.40	0.40	0.12	1.72	1.72	XXX
76986	TC	A	Ultrasound guide intraoper	0.00	2.62	NA	0.14	2.76	NA	XXX
76999		C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
76999	TC	C	Echo examination procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77261		A	Radiation therapy planning	1.39	0.51	0.51	0.07	1.97	1.97	XXX
77262		A	Radiation therapy planning	2.11	0.75	0.75	0.11	2.97	2.97	XXX
77263		A	Radiation therapy planning	3.14	1.11	1.11	0.16	4.41	4.41	XXX
77280		A	Set radiation therapy field	0.70	3.69	NA	0.22	4.61	NA	XXX
77280	26	A	Set radiation therapy field	0.70	0.22	0.22	0.04	0.96	0.96	XXX
77280	TC	A	Set radiation therapy field	0.00	3.47	NA	0.18	3.65	NA	XXX
77285		A	Set radiation therapy field	1.05	5.91	NA	0.35	7.31	NA	XXX
77285	26	A	Set radiation therapy field	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77285	TC	A	Set radiation therapy field	0.00	5.57	NA	0.30	5.87	NA	XXX
77290		A	Set radiation therapy field	1.56	7.01	NA	0.43	9.00	NA	XXX
77290	26	A	Set radiation therapy field	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77290	TC	A	Set radiation therapy field	0.00	6.51	NA	0.35	6.86	NA	XXX
77295		A	Set radiation therapy field	4.56	29.39	NA	1.72	35.67	NA	XXX
77295	26	A	Set radiation therapy field	4.56	1.46	1.46	0.24	6.26	6.26	XXX
77295	TC	A	Set radiation therapy field	0.00	27.93	NA	1.48	29.41	NA	XXX
77299		C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.54	NA	0.10	2.26	NA	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.20	0.20	0.03	0.85	0.85	XXX
77300	TC	A	Radiation therapy dose plan	0.00	1.34	NA	0.07	1.41	NA	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	30.49	NA	1.88	40.36	NA	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	2.56	2.56	0.40	10.95	10.95	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	27.93	NA	1.48	29.41	NA	XXX
77305		A	Teletx isodose plan simple	0.70	2.09	NA	0.15	2.94	NA	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.23	0.23	0.04	0.97	0.97	XXX
77305	TC	A	Teletx isodose plan simple	0.00	1.86	NA	0.11	1.97	NA	XXX
77310		A	Teletx isodose plan intermed	1.05	2.67	NA	0.18	3.90	NA	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	2.33	NA	0.13	2.46	NA	XXX
77315		A	Teletx isodose plan complex	1.56	3.16	NA	0.22	4.94	NA	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77315	TC	A	Teletx isodose plan complex	0.00	2.66	NA	0.14	2.80	NA	XXX
77321		A	Special teletx port plan	0.95	4.34	NA	0.26	5.55	NA	XXX
77321	26	A	Special teletx port plan	0.95	0.30	0.30	0.05	1.30	1.30	XXX
77321	TC	A	Special teletx port plan	0.00	4.04	NA	0.21	4.25	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
77326		A	Brachytx isodose calc simp	0.93	2.66	NA	0.18	3.77	NA	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.30	0.30	0.05	1.28	1.28	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.36	NA	0.13	2.49	NA	XXX
77327		A	Brachytx isodose calc interm	1.39	3.91	NA	0.25	5.55	NA	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.44	0.44	0.07	1.90	1.90	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.47	NA	0.18	3.65	NA	XXX
77328		A	Brachytx isodose plan compl	2.09	5.63	NA	0.36	8.08	NA	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	4.96	NA	0.25	5.21	NA	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.06	1.71	NA	XXX
77331	26	A	Special radiation dosimetry	0.87	0.28	0.28	0.04	1.19	1.19	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.50	NA	0.02	0.52	NA	XXX
77332		A	Radiation treatment aid(s)	0.54	1.51	NA	0.10	2.15	NA	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.17	0.17	0.03	0.74	0.74	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.34	NA	0.07	1.41	NA	XXX
77333		A	Radiation treatment aid(s)	0.84	2.16	NA	0.15	3.15	NA	XXX
77333	26	A	Radiation treatment aid(s)	0.84	0.27	0.27	0.04	1.15	1.15	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	1.89	NA	0.11	2.00	NA	XXX
77334		A	Radiation treatment aid(s)	1.24	3.65	NA	0.23	5.12	NA	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.40	0.40	0.06	1.70	1.70	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	3.25	NA	0.17	3.42	NA	XXX
77336		A	Radiation physics consult	0.00	2.98	NA	0.16	3.14	NA	XXX
77370		A	Radiation physics consult	0.00	3.49	NA	0.18	3.67	NA	XXX
77399		C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77402		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77403		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77404		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77406		A	Radiation treatment delivery	0.00	1.77	NA	0.11	1.88	NA	XXX
77407		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77408		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77409		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77411		A	Radiation treatment delivery	0.00	2.09	NA	0.12	2.21	NA	XXX
77412		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77413		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
77414		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77416		A	Radiation treatment delivery	0.00	2.33	NA	0.13	2.46	NA	XXX
77417		A	Radiology port film(s)	0.00	0.59	NA	0.04	0.63	NA	XXX
77418		A	Radiation tx delivery, imrt	0.00	17.98	NA	0.13	18.11	NA	XXX
77427		A	Radiation tx management, x5	3.31	1.06	1.06	0.17	4.54	4.54	XXX
77431		A	Radiation therapy management	1.81	0.68	0.68	0.09	2.58	2.58	XXX
77432		A	Stereotactic radiation trmt	7.92	2.90	2.90	0.41	11.23	11.23	XXX
77470		A	Special radiation treatment	2.09	11.82	NA	0.70	14.61	NA	XXX
77470	26	A	Special radiation treatment	2.09	0.67	0.67	0.11	2.87	2.87	XXX
77470	TC	A	Special radiation treatment	0.00	11.15	NA	0.59	11.74	NA	XXX
77499		C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	3.55	NA	0.24	5.35	NA	XXX
77600	26	R	Hyperthermia treatment	1.56	0.50	0.50	0.08	2.14	2.14	XXX
77600	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77605		R	Hyperthermia treatment	2.09	4.72	NA	0.38	7.19	NA	XXX
77605	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.16	2.91	2.91	XXX
77605	TC	R	Hyperthermia treatment	0.00	4.06	NA	0.22	4.28	NA	XXX
77610		R	Hyperthermia treatment	1.56	3.56	NA	0.24	5.36	NA	XXX
77610	26	R	Hyperthermia treatment	1.56	0.51	0.51	0.08	2.15	2.15	XXX
77610	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77615		R	Hyperthermia treatment	2.09	4.72	NA	0.33	7.14	NA	XXX
77615	26	R	Hyperthermia treatment	2.09	0.66	0.66	0.11	2.86	2.86	XXX
77615	TC	R	Hyperthermia treatment	0.00	4.06	NA	0.22	4.28	NA	XXX
77620		R	Hyperthermia treatment	1.56	3.57	NA	0.36	5.49	NA	XXX
77620	26	R	Hyperthermia treatment	1.56	0.52	0.52	0.20	2.28	2.28	XXX
77620	TC	R	Hyperthermia treatment	0.00	3.05	NA	0.16	3.21	NA	XXX
77750		A	Infuse radioactive materials	4.90	2.91	NA	0.32	8.13	NA	090
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
77750	TC	A	Infuse radioactive materials	0.00	1.33	NA	0.07	1.40	NA	090
77761		A	Apply intrcav radiat simple	3.80	3.59	NA	0.33	7.72	NA	090
77761	26	A	Apply intrcav radiat simple	3.80	1.09	1.09	0.19	5.08	5.08	090

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
77761	TC	A	Apply intrcav radiat simple	0.00	2.50	NA	0.14	2.64	NA	090
77762		A	Apply intrcav radiat interm	5.71	5.44	NA	0.49	11.64	NA	090
77762	26	A	Apply intrcav radiat interm	5.71	1.83	1.83	0.30	7.84	7.84	090
77762	TC	A	Apply intrcav radiat interm	0.00	3.61	NA	0.19	3.80	NA	090
77763		A	Apply intrcav radiat compl	8.56	7.23	NA	0.68	16.47	NA	090
77763	26	A	Apply intrcav radiat compl	8.56	2.74	2.74	0.45	11.75	11.75	090
77763	TC	A	Apply intrcav radiat compl	0.00	4.49	NA	0.23	4.72	NA	090
77776		A	Apply interstit radiat simpl	4.65	3.13	NA	0.56	8.34	NA	090
77776	26	A	Apply interstit radiat simpl	4.65	0.95	0.95	0.43	6.03	6.03	090
77776	TC	A	Apply interstit radiat simpl	0.00	2.18	NA	0.13	2.31	NA	090
77777		A	Apply interstit radiat inter	7.47	6.60	NA	0.63	14.70	NA	090
77777	26	A	Apply interstit radiat inter	7.47	2.37	2.37	0.41	10.25	10.25	090
77777	TC	A	Apply interstit radiat inter	0.00	4.23	NA	0.22	4.45	NA	090
77778		A	Apply interstit radiat compl	11.17	8.70	NA	0.84	20.71	NA	090
77778	26	A	Apply interstit radiat compl	11.17	3.57	3.57	0.57	15.31	15.31	090
77778	TC	A	Apply interstit radiat compl	0.00	5.13	NA	0.27	5.40	NA	090
77781		A	High intensity brachytherapy	1.66	20.83	NA	1.14	23.63	NA	090
77781	26	A	High intensity brachytherapy	1.66	0.53	0.53	0.08	2.27	2.27	090
77781	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77782		A	High intensity brachytherapy	2.49	21.10	NA	1.19	24.78	NA	090
77782	26	A	High intensity brachytherapy	2.49	0.80	0.80	0.13	3.42	3.42	090
77782	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77783		A	High intensity brachytherapy	3.72	21.49	NA	1.25	26.46	NA	090
77783	26	A	High intensity brachytherapy	3.72	1.19	1.19	0.19	5.10	5.10	090
77783	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77784		A	High intensity brachytherapy	5.60	22.09	NA	1.35	29.04	NA	090
77784	26	A	High intensity brachytherapy	5.60	1.79	1.79	0.29	7.68	7.68	090
77784	TC	A	High intensity brachytherapy	0.00	20.30	NA	1.06	21.36	NA	090
77789		A	Apply surface radiation	1.12	0.82	NA	0.07	2.01	NA	000
77789	26	A	Apply surface radiation	1.12	0.37	0.37	0.05	1.54	1.54	000
77789	TC	A	Apply surface radiation	0.00	0.45	NA	0.02	0.47	NA	000
77790		A	Radiation handling	1.05	0.84	NA	0.07	1.96	NA	XXX
77790	26	A	Radiation handling	1.05	0.34	0.34	0.05	1.44	1.44	XXX
77790	TC	A	Radiation handling	0.00	0.50	NA	0.02	0.52	NA	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78000		A	Thyroid, single uptake	0.19	1.03	NA	0.07	1.29	NA	XXX
78000	26	A	Thyroid, single uptake	0.19	0.06	0.06	0.01	0.26	0.26	XXX
78000	TC	A	Thyroid, single uptake	0.00	0.97	NA	0.06	1.03	NA	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.40	NA	0.08	1.74	NA	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.09	0.09	0.01	0.36	0.36	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.31	NA	0.07	1.38	NA	XXX
78003		A	Thyroid suppress/stimul	0.33	1.08	NA	0.07	1.48	NA	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.11	0.11	0.01	0.45	0.45	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	0.97	NA	0.06	1.03	NA	XXX
78006		A	Thyroid imaging with uptake	0.49	2.54	NA	0.15	3.18	NA	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	2.38	NA	0.13	2.51	NA	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.74	NA	0.16	3.40	NA	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.17	0.17	0.02	0.69	0.69	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.57	NA	0.14	2.71	NA	XXX
78010		A	Thyroid imaging	0.39	1.95	NA	0.13	2.47	NA	XXX
78010	26	A	Thyroid imaging	0.39	0.13	0.13	0.02	0.54	0.54	XXX
78010	TC	A	Thyroid imaging	0.00	1.82	NA	0.11	1.93	NA	XXX
78011		A	Thyroid imaging with flow	0.45	2.56	NA	0.15	3.16	NA	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78011	TC	A	Thyroid imaging with flow	0.00	2.41	NA	0.13	2.54	NA	XXX
78015		A	Thyroid met imaging	0.67	2.80	NA	0.17	3.64	NA	XXX
78015	26	A	Thyroid met imaging	0.67	0.23	0.23	0.03	0.93	0.93	XXX
78015	TC	A	Thyroid met imaging	0.00	2.57	NA	0.14	2.71	NA	XXX
78016		A	Thyroid met imaging/studies	0.82	3.76	NA	0.22	4.80	NA	XXX
78016	26	A	Thyroid met imaging/studies	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	3.48	NA	0.18	3.66	NA	XXX
78018		A	Thyroid met imaging, body	0.86	5.72	NA	0.33	6.91	NA	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.30	0.30	0.04	1.20	1.20	XXX
78018	TC	A	Thyroid met imaging, body	0.00	5.42	NA	0.29	5.71	NA	XXX
78020		A	Thyroid met uptake	0.60	1.52	NA	0.16	2.28	NA	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.21	0.21	0.02	0.83	0.83	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.31	NA	0.14	1.45	NA	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	4.55	NA	0.15	5.52	NA	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.28	0.28	0.04	1.14	1.14	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	4.27	NA	0.11	4.38	NA	XXX
78075		A	Adrenal nuclear imaging	0.74	5.68	NA	0.32	6.74	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78075	26	A	Adrenal nuclear imaging	0.74	0.26	0.26	0.03	1.03	1.03	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	5.42	NA	0.29	5.71	NA	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	2.23	NA	0.14	2.92	NA	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.19	0.19	0.02	0.76	0.76	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	2.04	NA	0.12	2.16	NA	XXX
78103		A	Bone marrow imaging, mult	0.75	3.43	NA	0.20	4.38	NA	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.26	0.26	0.03	1.04	1.04	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	3.17	NA	0.17	3.34	NA	XXX
78104		A	Bone marrow imaging, body	0.80	4.34	NA	0.25	5.39	NA	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78104	TC	A	Bone marrow imaging, body	0.00	4.07	NA	0.22	4.29	NA	XXX
78110		A	Plasma volume, single	0.19	1.02	NA	0.07	1.28	NA	XXX
78110	26	A	Plasma volume, single	0.19	0.07	0.07	0.01	0.27	0.27	XXX
78110	TC	A	Plasma volume, single	0.00	0.95	NA	0.06	1.01	NA	XXX
78111		A	Plasma volume, multiple	0.22	2.65	NA	0.15	3.02	NA	XXX
78111	26	A	Plasma volume, multiple	0.22	0.08	0.08	0.01	0.31	0.31	XXX
78111	TC	A	Plasma volume, multiple	0.00	2.57	NA	0.14	2.71	NA	XXX
78120		A	Red cell mass, single	0.23	1.81	NA	0.12	2.16	NA	XXX
78120	26	A	Red cell mass, single	0.23	0.08	0.08	0.01	0.32	0.32	XXX
78120	TC	A	Red cell mass, single	0.00	1.73	NA	0.11	1.84	NA	XXX
78121		A	Red cell mass, multiple	0.32	3.02	NA	0.15	3.49	NA	XXX
78121	26	A	Red cell mass, multiple	0.32	0.11	0.11	0.01	0.44	0.44	XXX
78121	TC	A	Red cell mass, multiple	0.00	2.91	NA	0.14	3.05	NA	XXX
78122		A	Blood volume	0.45	4.76	NA	0.26	5.47	NA	XXX
78122	26	A	Blood volume	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78122	TC	A	Blood volume	0.00	4.60	NA	0.24	4.84	NA	XXX
78130		A	Red cell survival study	0.61	3.06	NA	0.17	3.84	NA	XXX
78130	26	A	Red cell survival study	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78130	TC	A	Red cell survival study	0.00	2.85	NA	0.14	2.99	NA	XXX
78135		A	Red cell survival kinetics	0.64	5.09	NA	0.28	6.01	NA	XXX
78135	26	A	Red cell survival kinetics	0.64	0.22	0.22	0.03	0.89	0.89	XXX
78135	TC	A	Red cell survival kinetics	0.00	4.87	NA	0.25	5.12	NA	XXX
78140		A	Red cell sequestration	0.61	4.13	NA	0.24	4.98	NA	XXX
78140	26	A	Red cell sequestration	0.61	0.20	0.20	0.03	0.84	0.84	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78140	TC	A	Red cell sequestration	0.00	3.93	NA	0.21	4.14	NA	XXX
78160		A	Plasma iron turnover	0.33	3.78	NA	0.23	4.34	NA	XXX
78160	26	A	Plasma iron turnover	0.33	0.12	0.12	0.04	0.49	0.49	XXX
78160	TC	A	Plasma iron turnover	0.00	3.66	NA	0.19	3.85	NA	XXX
78162		A	Radioiron absorption exam	0.45	3.39	NA	0.19	4.03	NA	XXX
78162	26	A	Radioiron absorption exam	0.45	0.19	0.19	0.02	0.66	0.66	XXX
78162	TC	A	Radioiron absorption exam	0.00	3.20	NA	0.17	3.37	NA	XXX
78170		A	Red cell iron utilization	0.41	5.45	NA	0.30	6.16	NA	XXX
78170	26	A	Red cell iron utilization	0.41	0.14	0.14	0.02	0.57	0.57	XXX
78170	TC	A	Red cell iron utilization	0.00	5.31	NA	0.28	5.59	NA	XXX
78172		C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78172	26	A	Total body iron estimation	0.53	0.17	0.17	0.02	0.72	0.72	XXX
78172	TC	C	Total body iron estimation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78185		A	Spleen imaging	0.40	2.50	NA	0.15	3.05	NA	XXX
78185	26	A	Spleen imaging	0.40	0.14	0.14	0.02	0.56	0.56	XXX
78185	TC	A	Spleen imaging	0.00	2.36	NA	0.13	2.49	NA	XXX
78190		A	Platelet survival, kinetics	1.09	6.10	NA	0.38	7.57	NA	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.39	0.39	0.08	1.56	1.56	XXX
78190	TC	A	Platelet survival, kinetics	0.00	5.71	NA	0.30	6.01	NA	XXX
78191		A	Platelet survival	0.61	7.54	NA	0.40	8.55	NA	XXX
78191	26	A	Platelet survival	0.61	0.20	0.20	0.03	0.84	0.84	XXX
78191	TC	A	Platelet survival	0.00	7.34	NA	0.37	7.71	NA	XXX
78195		A	Lymph system imaging	1.20	4.48	NA	0.28	5.96	NA	XXX
78195	26	A	Lymph system imaging	1.20	0.41	0.41	0.06	1.67	1.67	XXX
78195	TC	A	Lymph system imaging	0.00	4.07	NA	0.22	4.29	NA	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	2.51	NA	0.15	3.10	NA	XXX
78201	26	A	Liver imaging	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78201	TC	A	Liver imaging	0.00	2.36	NA	0.13	2.49	NA	XXX
78202		A	Liver imaging with flow	0.51	3.05	NA	0.16	3.72	NA	XXX
78202	26	A	Liver imaging with flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78202	TC	A	Liver imaging with flow	0.00	2.88	NA	0.14	3.02	NA	XXX
78205		A	Liver imaging (3D)	0.71	6.15	NA	0.34	7.20	NA	XXX
78205	26	A	Liver imaging (3D)	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78205	TC	A	Liver imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78206		A	Liver image (3d) with flow	0.96	6.24	NA	0.15	7.35	NA	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.33	0.33	0.04	1.33	1.33	XXX
78206	TC	A	Liver image (3d) with flow	0.00	5.91	NA	0.11	6.02	NA	XXX
78215		A	Liver and spleen imaging	0.49	3.10	NA	0.16	3.75	NA	XXX
78215	26	A	Liver and spleen imaging	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78215	TC	A	Liver and spleen imaging	0.00	2.94	NA	0.14	3.08	NA	XXX
78216		A	Liver & spleen image/flow	0.57	3.67	NA	0.20	4.44	NA	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78216	TC	A	Liver & spleen image/flow	0.00	3.48	NA	0.18	3.66	NA	XXX
78220		A	Liver function study	0.49	3.88	NA	0.21	4.58	NA	XXX
78220	26	A	Liver function study	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78220	TC	A	Liver function study	0.00	3.72	NA	0.19	3.91	NA	XXX
78223		A	Hepatobiliary imaging	0.84	3.94	NA	0.23	5.01	NA	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.28	0.28	0.04	1.16	1.16	XXX
78223	TC	A	Hepatobiliary imaging	0.00	3.66	NA	0.19	3.85	NA	XXX
78230		A	Salivary gland imaging	0.45	2.33	NA	0.15	2.93	NA	XXX
78230	26	A	Salivary gland imaging	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78230	TC	A	Salivary gland imaging	0.00	2.18	NA	0.13	2.31	NA	XXX
78231		A	Serial salivary imaging	0.52	3.35	NA	0.19	4.06	NA	XXX
78231	26	A	Serial salivary imaging	0.52	0.18	0.18	0.02	0.72	0.72	XXX
78231	TC	A	Serial salivary imaging	0.00	3.17	NA	0.17	3.34	NA	XXX
78232		A	Salivary gland function exam	0.47	3.70	NA	0.20	4.37	NA	XXX
78232	26	A	Salivary gland function exam	0.47	0.16	0.16	0.02	0.65	0.65	XXX
78232	TC	A	Salivary gland function exam	0.00	3.54	NA	0.18	3.72	NA	XXX
78258		A	Esophageal motility study	0.74	3.13	NA	0.17	4.04	NA	XXX
78258	26	A	Esophageal motility study	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78258	TC	A	Esophageal motility study	0.00	2.88	NA	0.14	3.02	NA	XXX
78261		A	Gastric mucosa imaging	0.69	4.34	NA	0.25	5.28	NA	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78261	TC	A	Gastric mucosa imaging	0.00	4.10	NA	0.22	4.32	NA	XXX
78262		A	Gastroesophageal reflux exam	0.68	4.48	NA	0.25	5.41	NA	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	4.25	NA	0.22	4.47	NA	XXX
78264		A	Gastric emptying study	0.78	4.39	NA	0.25	5.42	NA	XXX
78264	26	A	Gastric emptying study	0.78	0.26	0.26	0.03	1.07	1.07	XXX
78264	TC	A	Gastric emptying study	0.00	4.13	NA	0.22	4.35	NA	XXX
78267		X	Breath tst attain/anal c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78268		X	Breath test analysis, c-14	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78270		A	Vit B-12 absorption exam	0.20	1.62	NA	0.11	1.93	NA	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.55	NA	0.10	1.65	NA	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	1.71	NA	0.11	2.02	NA	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	0.28	0.28	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.64	NA	0.10	1.74	NA	XXX
78272		A	Vit B-12 absorp, combined	0.27	2.41	NA	0.14	2.82	NA	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.09	0.09	0.01	0.37	0.37	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	2.32	NA	0.13	2.45	NA	XXX
78278		A	Acute GI blood loss imaging	0.99	5.20	NA	0.29	6.48	NA	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	4.87	NA	0.25	5.12	NA	XXX
78282		C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78290		A	Meckel's divert exam	0.68	3.28	NA	0.19	4.15	NA	XXX
78290	26	A	Meckel's divert exam	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78290	TC	A	Meckel's divert exam	0.00	3.05	NA	0.16	3.21	NA	XXX
78291		A	Leveen/shunt patency exam	0.88	3.36	NA	0.20	4.44	NA	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.30	0.30	0.04	1.22	1.22	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	3.06	NA	0.16	3.22	NA	XXX
78299		C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	2.69	NA	0.17	3.48	NA	XXX
78300	26	A	Bone imaging, limited area	0.62	0.21	0.21	0.03	0.86	0.86	XXX
78300	TC	A	Bone imaging, limited area	0.00	2.48	NA	0.14	2.62	NA	XXX
78305		A	Bone imaging, multiple areas	0.83	3.94	NA	0.23	5.00	NA	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.28	0.28	0.04	1.15	1.15	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	3.66	NA	0.19	3.85	NA	XXX
78306		A	Bone imaging, whole body	0.86	4.56	NA	0.26	5.68	NA	XXX
78306	26	A	Bone imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78306	TC	A	Bone imaging, whole body	0.00	4.27	NA	0.22	4.49	NA	XXX
78315		A	Bone imaging, 3 phase	1.02	5.12	NA	0.29	6.43	NA	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.34	0.34	0.04	1.40	1.40	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	4.78	NA	0.25	5.03	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78320		A	Bone imaging (3D)	1.04	6.27	NA	0.35	7.66	NA	XXX
78320	26	A	Bone imaging (3D)	1.04	0.36	0.36	0.04	1.44	1.44	XXX
78320	TC	A	Bone imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX
78350		A	Bone mineral, single photon	0.22	0.82	NA	0.06	1.10	NA	XXX
78350	26	A	Bone mineral, single photon	0.22	0.07	0.07	0.01	0.30	0.30	XXX
78350	TC	A	Bone mineral, single photon	0.00	0.75	NA	0.05	0.80	NA	XXX
78351		N	Bone mineral, dual photon	+0.30	1.72	0.12	0.01	2.03	0.43	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.16	0.16	0.02	0.63	0.63	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78428		A	Cardiac shunt imaging	0.78	2.54	NA	0.16	3.48	NA	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.29	0.29	0.03	1.10	1.10	XXX
78428	TC	A	Cardiac shunt imaging	0.00	2.25	NA	0.13	2.38	NA	XXX
78445		A	Vascular flow imaging	0.49	2.03	NA	0.13	2.65	NA	XXX
78445	26	A	Vascular flow imaging	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78445	TC	A	Vascular flow imaging	0.00	1.86	NA	0.11	1.97	NA	XXX
78455		A	Venous thrombosis study	0.73	4.23	NA	0.24	5.20	NA	XXX
78455	26	A	Venous thrombosis study	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78455	TC	A	Venous thrombosis study	0.00	3.98	NA	0.21	4.19	NA	XXX
78456		A	Acute venous thrombus image	1.00	4.32	NA	0.33	5.65	NA	XXX
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.04	1.38	1.38	XXX
78456	TC	A	Acute venous thrombus image	0.00	3.98	NA	0.29	4.27	NA	XXX
78457		A	Venous thrombosis imaging	0.77	2.92	NA	0.18	3.87	NA	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.26	0.26	0.04	1.07	1.07	XXX
78457	TC	A	Venous thrombosis imaging	0.00	2.66	NA	0.14	2.80	NA	XXX
78458		A	Ven thrombosis images, bilat	0.90	4.34	NA	0.25	5.49	NA	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.32	0.32	0.04	1.26	1.26	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	4.02	NA	0.21	4.23	NA	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78459	26	R	Heart muscle imaging (PET)	1.50	0.57	0.57	0.05	2.12	2.12	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78460		A	Heart muscle blood, single	0.86	2.65	NA	0.17	3.68	NA	XXX
78460	26	A	Heart muscle blood, single	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78460	TC	A	Heart muscle blood, single	0.00	2.36	NA	0.13	2.49	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78461		A	Heart muscle blood, multiple	1.23	5.15	NA	0.30	6.68	NA	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	4.72	NA	0.25	4.97	NA	XXX
78464		A	Heart image (3d), single	1.09	7.45	NA	0.41	8.95	NA	XXX
78464	26	A	Heart image (3d), single	1.09	0.38	0.38	0.04	1.51	1.51	XXX
78464	TC	A	Heart image (3d), single	0.00	7.07	NA	0.37	7.44	NA	XXX
78465		A	Heart image (3d), multiple	1.46	12.31	NA	0.68	14.45	NA	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.52	0.52	0.06	2.04	2.04	XXX
78465	TC	A	Heart image (3d), multiple	0.00	11.79	NA	0.62	12.41	NA	XXX
78466		A	Heart infarct image	0.69	2.86	NA	0.17	3.72	NA	XXX
78466	26	A	Heart infarct image	0.69	0.24	0.24	0.03	0.96	0.96	XXX
78466	TC	A	Heart infarct image	0.00	2.62	NA	0.14	2.76	NA	XXX
78468		A	Heart infarct image (ef)	0.80	3.93	NA	0.22	4.95	NA	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.27	0.27	0.03	1.10	1.10	XXX
78468	TC	A	Heart infarct image (ef)	0.00	3.66	NA	0.19	3.85	NA	XXX
78469		A	Heart infarct image (3D)	0.92	5.53	NA	0.31	6.76	NA	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.03	1.26	1.26	XXX
78469	TC	A	Heart infarct image (3D)	0.00	5.22	NA	0.28	5.50	NA	XXX
78472		A	Gated heart, planar, single	0.98	5.85	NA	0.34	7.17	NA	XXX
78472	26	A	Gated heart, planar, single	0.98	0.34	0.34	0.04	1.36	1.36	XXX
78472	TC	A	Gated heart, planar, single	0.00	5.51	NA	0.30	5.81	NA	XXX
78473		A	Gated heart, multiple	1.47	8.77	NA	0.48	10.72	NA	XXX
78473	26	A	Gated heart, multiple	1.47	0.51	0.51	0.06	2.04	2.04	XXX
78473	TC	A	Gated heart, multiple	0.00	8.26	NA	0.42	8.68	NA	XXX
78478		A	Heart wall motion add-on	0.62	1.79	NA	0.12	2.53	NA	XXX
78478	26	A	Heart wall motion add-on	0.62	0.23	0.23	0.02	0.87	0.87	XXX
78478	TC	A	Heart wall motion add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78480		A	Heart function add-on	0.62	1.78	NA	0.12	2.52	NA	XXX
78480	26	A	Heart function add-on	0.62	0.22	0.22	0.02	0.86	0.86	XXX
78480	TC	A	Heart function add-on	0.00	1.56	NA	0.10	1.66	NA	XXX
78481		A	Heart first pass, single	0.98	5.58	NA	0.32	6.88	NA	XXX
78481	26	A	Heart first pass, single	0.98	0.36	0.36	0.04	1.38	1.38	XXX
78481	TC	A	Heart first pass, single	0.00	5.22	NA	0.28	5.50	NA	XXX
78483		A	Heart first pass, multiple	1.47	8.41	NA	0.46	10.34	NA	XXX
78483	26	A	Heart first pass, multiple	1.47	0.54	0.54	0.05	2.06	2.06	XXX
78483	TC	A	Heart first pass, multiple	0.00	7.87	NA	0.41	8.28	NA	XXX
78491		I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78491	26	I	Heart image (pet), single	+1.50	0.59	0.59	0.06	2.15	2.15	XXX
78491	TC	I	Heart image (pet), single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492		I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78492	26	I	Heart image (pet), multiple	+1.87	0.74	0.74	0.07	2.68	2.68	XXX
78492	TC	I	Heart image (pet), multiple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78494		A	Heart image, spect	1.19	7.49	NA	0.35	9.03	NA	XXX
78494	26	A	Heart image, spect	1.19	0.42	0.42	0.05	1.66	1.66	XXX
78494	TC	A	Heart image, spect	0.00	7.07	NA	0.30	7.37	NA	XXX
78496		A	Heart first pass add-on	0.50	7.25	NA	0.32	8.07	NA	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.18	0.18	0.02	0.70	0.70	ZZZ
78496	TC	A	Heart first pass add-on	0.00	7.07	NA	0.30	7.37	NA	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	3.68	NA	0.21	4.63	NA	XXX
78580	26	A	Lung perfusion imaging	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78580	TC	A	Lung perfusion imaging	0.00	3.43	NA	0.18	3.61	NA	XXX
78584		A	Lung V/Q image single breath	0.99	3.53	NA	0.21	4.73	NA	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.33	0.33	0.04	1.36	1.36	XXX
78584	TC	A	Lung V/Q image single breath	0.00	3.20	NA	0.17	3.37	NA	XXX
78585		A	Lung V/Q imaging	1.09	6.00	NA	0.35	7.44	NA	XXX
78585	26	A	Lung V/Q imaging	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78585	TC	A	Lung V/Q imaging	0.00	5.64	NA	0.30	5.94	NA	XXX
78586		A	Aerosol lung image, single	0.40	2.72	NA	0.16	3.28	NA	XXX
78586	26	A	Aerosol lung image, single	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78586	TC	A	Aerosol lung image, single	0.00	2.59	NA	0.14	2.73	NA	XXX
78587		A	Aerosol lung image, multiple	0.49	2.97	NA	0.16	3.62	NA	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.17	0.17	0.02	0.68	0.68	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	2.80	NA	0.14	2.94	NA	XXX
78588		A	Perfusion lung image	1.09	3.56	NA	0.23	4.88	NA	XXX
78588	26	A	Perfusion lung image	1.09	0.36	0.36	0.05	1.50	1.50	XXX
78588	TC	A	Perfusion lung image	0.00	3.20	NA	0.18	3.38	NA	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	2.98	NA	0.16	3.54	NA	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.13	0.13	0.02	0.55	0.55	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	2.85	NA	0.14	2.99	NA	XXX
78593		A	Vent image, 1 proj, gas	0.49	3.61	NA	0.20	4.30	NA	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.16	0.16	0.02	0.67	0.67	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78593	TC	A	Vent image, 1 proj, gas	0.00	3.45	NA	0.18	3.63	NA	XXX
78594		A	Vent image, mult proj, gas	0.53	5.16	NA	0.27	5.96	NA	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.98	NA	0.25	5.23	NA	XXX
78596		A	Lung differential function	1.27	7.49	NA	0.42	9.18	NA	XXX
78596	26	A	Lung differential function	1.27	0.42	0.42	0.05	1.74	1.74	XXX
78596	TC	A	Lung differential function	0.00	7.07	NA	0.37	7.44	NA	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78600		A	Brain imaging, ltd static	0.44	3.03	NA	0.16	3.63	NA	XXX
78600	26	A	Brain imaging, ltd static	0.44	0.15	0.15	0.02	0.61	0.61	XXX
78600	TC	A	Brain imaging, ltd static	0.00	2.88	NA	0.14	3.02	NA	XXX
78601		A	Brain imaging, ltd w/flow	0.51	3.57	NA	0.20	4.28	NA	XXX
78601	26	A	Brain imaging, ltd w/flow	0.51	0.17	0.17	0.02	0.70	0.70	XXX
78601	TC	A	Brain imaging, ltd w/flow	0.00	3.40	NA	0.18	3.58	NA	XXX
78605		A	Brain imaging, complete	0.53	3.58	NA	0.20	4.31	NA	XXX
78605	26	A	Brain imaging, complete	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78605	TC	A	Brain imaging, complete	0.00	3.40	NA	0.18	3.58	NA	XXX
78606		A	Brain imaging, compl w/flow	0.64	4.08	NA	0.24	4.96	NA	XXX
78606	26	A	Brain imaging, compl w/flow	0.64	0.21	0.21	0.03	0.88	0.88	XXX
78606	TC	A	Brain imaging, compl w/flow	0.00	3.87	NA	0.21	4.08	NA	XXX
78607		A	Brain imaging (3D)	1.23	6.98	NA	0.40	8.61	NA	XXX
78607	26	A	Brain imaging (3D)	1.23	0.43	0.43	0.05	1.71	1.71	XXX
78607	TC	A	Brain imaging (3D)	0.00	6.55	NA	0.35	6.90	NA	XXX
78608		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78609		N	Brain imaging (PET)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78610		A	Brain flow imaging only	0.30	1.69	NA	0.11	2.10	NA	XXX
78610	26	A	Brain flow imaging only	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78610	TC	A	Brain flow imaging only	0.00	1.58	NA	0.10	1.68	NA	XXX
78615		A	Cerebral vascular flow image	0.42	4.00	NA	0.23	4.65	NA	XXX
78615	26	A	Cerebral vascular flow image	0.42	0.15	0.15	0.02	0.59	0.59	XXX
78615	TC	A	Cerebral vascular flow image	0.00	3.85	NA	0.21	4.06	NA	XXX
78630		A	Cerebrospinal fluid scan	0.68	5.27	NA	0.30	6.25	NA	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.23	0.23	0.03	0.94	0.94	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	5.04	NA	0.27	5.31	NA	XXX
78635		A	CSF ventriculography	0.61	2.77	NA	0.16	3.54	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78635	26	A	CSF ventriculography	0.61	0.23	0.23	0.02	0.86	0.86	XXX
78635	TC	A	CSF ventriculography	0.00	2.54	NA	0.14	2.68	NA	XXX
78645		A	CSF shunt evaluation	0.57	3.62	NA	0.20	4.39	NA	XXX
78645	26	A	CSF shunt evaluation	0.57	0.19	0.19	0.02	0.78	0.78	XXX
78645	TC	A	CSF shunt evaluation	0.00	3.43	NA	0.18	3.61	NA	XXX
78647		A	Cerebrospinal fluid scan	0.90	6.22	NA	0.35	7.47	NA	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.31	0.31	0.04	1.25	1.25	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.91	NA	0.31	6.22	NA	XXX
78650		A	CSF leakage imaging	0.61	4.85	NA	0.27	5.73	NA	XXX
78650	26	A	CSF leakage imaging	0.61	0.21	0.21	0.03	0.85	0.85	XXX
78650	TC	A	CSF leakage imaging	0.00	4.64	NA	0.24	4.88	NA	XXX
78660		A	Nuclear exam of tear flow	0.53	2.30	NA	0.14	2.97	NA	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.18	0.18	0.02	0.73	0.73	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	2.12	NA	0.12	2.24	NA	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, static	0.45	3.20	NA	0.18	3.83	NA	XXX
78700	26	A	Kidney imaging, static	0.45	0.15	0.15	0.02	0.62	0.62	XXX
78700	TC	A	Kidney imaging, static	0.00	3.05	NA	0.16	3.21	NA	XXX
78701		A	Kidney imaging with flow	0.49	3.72	NA	0.20	4.41	NA	XXX
78701	26	A	Kidney imaging with flow	0.49	0.16	0.16	0.02	0.67	0.67	XXX
78701	TC	A	Kidney imaging with flow	0.00	3.56	NA	0.18	3.74	NA	XXX
78704		A	Imaging renogram	0.74	4.20	NA	0.24	5.18	NA	XXX
78704	26	A	Imaging renogram	0.74	0.25	0.25	0.03	1.02	1.02	XXX
78704	TC	A	Imaging renogram	0.00	3.95	NA	0.21	4.16	NA	XXX
78707		A	Kidney flow/function image	0.96	4.79	NA	0.27	6.02	NA	XXX
78707	26	A	Kidney flow/function image	0.96	0.32	0.32	0.04	1.32	1.32	XXX
78707	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78708		A	Kidney flow/function image	1.21	4.88	NA	0.28	6.37	NA	XXX
78708	26	A	Kidney flow/function image	1.21	0.41	0.41	0.05	1.67	1.67	XXX
78708	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78709		A	Kidney flow/function image	1.41	4.94	NA	0.29	6.64	NA	XXX
78709	26	A	Kidney flow/function image	1.41	0.47	0.47	0.06	1.94	1.94	XXX
78709	TC	A	Kidney flow/function image	0.00	4.47	NA	0.23	4.70	NA	XXX
78710		A	Kidney imaging (3D)	0.66	6.13	NA	0.34	7.13	NA	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.22	0.22	0.03	0.91	0.91	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
78710	TC	A	Kidney imaging (3D)	0.00	5.91	NA	0.31	6.22	NA	XXX
78715		A	Renal vascular flow exam	0.30	1.69	NA	0.11	2.10	NA	XXX
78715	26	A	Renal vascular flow exam	0.30	0.11	0.11	0.01	0.42	0.42	XXX
78715	TC	A	Renal vascular flow exam	0.00	1.58	NA	0.10	1.68	NA	XXX
78725		A	Kidney function study	0.38	1.91	NA	0.13	2.42	NA	XXX
78725	26	A	Kidney function study	0.38	0.13	0.13	0.02	0.53	0.53	XXX
78725	TC	A	Kidney function study	0.00	1.78	NA	0.11	1.89	NA	XXX
78730		A	Urinary bladder retention	0.36	1.58	NA	0.10	2.04	NA	XXX
78730	26	A	Urinary bladder retention	0.36	0.12	0.12	0.02	0.50	0.50	XXX
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.08	1.54	NA	XXX
78740		A	Ureteral reflux study	0.57	2.31	NA	0.15	3.03	NA	XXX
78740	26	A	Ureteral reflux study	0.57	0.19	0.19	0.03	0.79	0.79	XXX
78740	TC	A	Ureteral reflux study	0.00	2.12	NA	0.12	2.24	NA	XXX
78760		A	Testicular imaging	0.66	2.90	NA	0.17	3.73	NA	XXX
78760	26	A	Testicular imaging	0.66	0.22	0.22	0.03	0.91	0.91	XXX
78760	TC	A	Testicular imaging	0.00	2.68	NA	0.14	2.82	NA	XXX
78761		A	Testicular imaging/flow	0.71	3.44	NA	0.20	4.35	NA	XXX
78761	26	A	Testicular imaging/flow	0.71	0.24	0.24	0.03	0.98	0.98	XXX
78761	TC	A	Testicular imaging/flow	0.00	3.20	NA	0.17	3.37	NA	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.62	NA	0.22	4.50	NA	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.22	0.22	0.04	0.92	0.92	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.40	NA	0.18	3.58	NA	XXX
78801		A	Tumor imaging, mult areas	0.79	4.49	NA	0.27	5.55	NA	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.27	0.27	0.05	1.11	1.11	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	4.22	NA	0.22	4.44	NA	XXX
78802		A	Tumor imaging, whole body	0.86	5.82	NA	0.34	7.02	NA	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78802	TC	A	Tumor imaging, whole body	0.00	5.53	NA	0.30	5.83	NA	XXX
78803		A	Tumor imaging (3D)	1.09	6.93	NA	0.40	8.42	NA	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.38	0.38	0.05	1.52	1.52	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.55	NA	0.35	6.90	NA	XXX
78804		A	Tumor imaging, whole body	1.07	11.43	NA	0.34	12.84	NA	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.37	0.37	0.04	1.48	1.48	XXX
78804	TC	A	Tumor imaging, whole body	0.00	11.06	NA	0.30	11.36	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
78805		A	Abscess imaging, ltd area	0.73	3.65	NA	0.21	4.59	NA	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.25	0.25	0.03	1.01	1.01	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.40	NA	0.18	3.58	NA	XXX
78806		A	Abscess imaging, whole body	0.86	6.72	NA	0.39	7.97	NA	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.29	0.29	0.04	1.19	1.19	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.43	NA	0.35	6.78	NA	XXX
78807		A	Nuclear localization/abscess	1.09	6.94	NA	0.39	8.42	NA	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.39	0.39	0.04	1.52	1.52	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.55	NA	0.35	6.90	NA	XXX
78811		I	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78811	26	I	Tumor imaging (pet), limited	+1.54	0.00	0.00	0.11	1.65	1.65	XXX
78811	TC	I	Tumor imaging (pet), limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812		I	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78812	26	I	Tumor image (pet)/skul-thigh	+1.93	0.00	0.00	0.11	2.04	2.04	XXX
78812	TC	I	Tumor image (pet)/skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813		I	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78813	26	I	Tumor image (pet) full body	+2.00	0.00	0.00	0.11	2.11	2.11	XXX
78813	TC	I	Tumor image (pet) full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814		I	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78814	26	I	Tumor image pet/ct, limited	+2.20	0.00	0.00	0.11	2.31	2.31	XXX
78814	TC	I	Tumor image pet/ct, limited	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815		I	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78815	26	I	Tumorimage pet/ct skul-thigh	+2.44	0.00	0.00	0.11	2.55	2.55	XXX
78815	TC	I	Tumorimage pet/ct skul-thigh	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816		I	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78816	26	I	Tumor image pet/ct full body	+2.50	0.00	0.00	0.11	2.61	2.61	XXX
78816	TC	I	Tumor image pet/ct full body	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78890		B	Nuclear medicine data proc	+0.05	1.33	NA	0.07	1.45	NA	XXX
78890	26	B	Nuclear medicine data proc	+0.05	0.02	0.02	0.01	0.08	0.08	XXX
78890	TC	B	Nuclear medicine data proc	+0.00	1.31	NA	0.06	1.37	NA	XXX
78891		B	Nuclear med data proc	+0.10	2.66	NA	0.14	2.90	NA	XXX
78891	26	B	Nuclear med data proc	+0.10	0.04	0.04	0.01	0.15	0.15	XXX
78891	TC	B	Nuclear med data proc	+0.00	2.62	NA	0.13	2.75	NA	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	3.22	NA	0.22	5.24	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
79005	26	A	Nuclear rx, oral admin	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79101		A	Nuclear rx, iv admin	1.96	3.29	NA	0.22	5.47	NA	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.67	0.67	0.08	2.71	2.71	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79200		A	Nuclear rx, intracav admin	1.99	3.31	NA	0.23	5.53	NA	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	2.62	NA	0.14	2.76	NA	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.56	0.56	0.13	2.29	2.29	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79403		A	Hematopoietic nuclear tx	2.25	5.16	NA	0.24	7.65	NA	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.89	0.89	0.10	3.24	3.24	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	4.27	NA	0.14	4.41	NA	XXX
79440		A	Nuclear rx, intra-articular	1.99	3.34	NA	0.22	5.55	NA	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.08	2.79	2.79	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	2.62	NA	0.14	2.76	NA	XXX
79445		A	Nuclear rx, intra-arterial	2.40	3.44	NA	0.28	6.12	NA	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.82	0.82	0.12	3.34	3.34	XXX
79445	TC	A	Nuclear rx, intra-arterial	0.00	2.62	NA	0.16	2.78	NA	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.21	0.16	0.01	0.59	0.54	XXX
80502		A	Lab pathology consultation	1.33	0.54	0.54	0.06	1.93	1.93	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
83912	26	A	Genetic examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84181	26	A	Western blot test	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84182	26	A	Protein, western blot test	0.37	0.16	0.16	0.02	0.55	0.55	XXX
85060		A	Blood smear interpretation	0.45	0.18	0.18	0.02	0.65	0.65	XXX
85097		A	Bone marrow interpretation	0.94	1.91	0.41	0.04	2.89	1.39	XXX
85390	26	A	Fibrinolysins screen	0.37	0.13	0.13	0.01	0.51	0.51	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.16	0.04	NA	0.57	XXX
85576	26	A	Blood platelet aggregation	0.37	0.16	0.16	0.01	0.54	0.54	XXX
86077		A	Physician blood bank service	0.94	0.39	0.39	0.04	1.37	1.37	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
86078		A	Physician blood bank service	0.94	0.46	0.40	0.04	1.44	1.38	XXX
86079		A	Physician blood bank service	0.94	0.45	0.41	0.03	1.42	1.38	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.13	0.13	0.01	0.51	0.51	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.18	0.18	0.02	0.62	0.62	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
86485		C	Skin test, candida	0.00	0.00	0.00	0.00	0.00	0.00	XXX
86490		A	Coccidioidomycosis skin test	0.00	0.29	NA	0.02	0.31	NA	XXX
86510		A	Histoplasmosis skin test	0.00	0.32	NA	0.02	0.34	NA	XXX
86580		A	TB intradermal test	0.00	0.25	NA	0.02	0.27	NA	XXX
86585		A	TB tine test	0.00	0.20	NA	0.01	0.21	NA	XXX
86586		C	Skin test, unlisted	0.00	0.00	0.00	0.00	0.00	0.00	XXX
87164	26	A	Dark field examination	0.37	0.12	0.12	0.01	0.50	0.50	XXX
87207	26	A	Smear, special stain	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88104		A	Cytopathology, fluids	0.56	0.85	NA	0.04	1.45	NA	XXX
88104	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88104	TC	A	Cytopathology, fluids	0.00	0.61	NA	0.02	0.63	NA	XXX
88106		A	Cytopathology, fluids	0.56	1.35	NA	0.04	1.95	NA	XXX
88106	26	A	Cytopathology, fluids	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88106	TC	A	Cytopathology, fluids	0.00	1.11	NA	0.02	1.13	NA	XXX
88107		A	Cytopathology, fluids	0.76	1.54	NA	0.05	2.35	NA	XXX
88107	26	A	Cytopathology, fluids	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88107	TC	A	Cytopathology, fluids	0.00	1.21	NA	0.02	1.23	NA	XXX
88108		A	Cytopath, concentrate tech	0.56	1.21	NA	0.04	1.81	NA	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.24	0.24	0.02	0.82	0.82	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	0.97	NA	0.02	0.99	NA	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.97	NA	0.04	3.19	NA	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.51	0.51	0.02	1.71	1.71	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.46	NA	0.02	1.48	NA	XXX
88125		A	Forensic cytopathology	0.26	0.25	NA	0.02	0.53	NA	XXX
88125	26	A	Forensic cytopathology	0.26	0.11	0.11	0.01	0.38	0.38	XXX
88125	TC	A	Forensic cytopathology	0.00	0.14	NA	0.01	0.15	NA	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.15	0.15	0.02	0.59	0.59	XXX
88160		A	Cytopath smear, other source	0.50	0.83	NA	0.04	1.37	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88160	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.62	NA	0.02	0.64	NA	XXX
88161		A	Cytopath smear, other source	0.50	0.94	NA	0.04	1.48	NA	XXX
88161	26	A	Cytopath smear, other source	0.50	0.21	0.21	0.02	0.73	0.73	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.73	NA	0.02	0.75	NA	XXX
88162		A	Cytopath smear, other source	0.76	1.02	NA	0.05	1.83	NA	XXX
88162	26	A	Cytopath smear, other source	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.69	NA	0.02	0.71	NA	XXX
88172		A	Cytopathology eval of fna	0.60	0.73	NA	0.04	1.37	NA	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.26	0.26	0.02	0.88	0.88	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.47	NA	0.02	0.49	NA	XXX
88173		A	Cytopath eval, fna, report	1.39	2.14	NA	0.07	3.60	NA	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.59	0.59	0.05	2.03	2.03	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.55	NA	0.02	1.57	NA	XXX
88182		A	Cell marker study	0.77	1.98	NA	0.07	2.82	NA	XXX
88182	26	A	Cell marker study	0.77	0.33	0.33	0.03	1.13	1.13	XXX
88182	TC	A	Cell marker study	0.00	1.65	NA	0.04	1.69	NA	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.32	NA	0.02	1.34	NA	XXX
88185		A	Flowcytometry/tc, add-on	0.00	0.64	NA	0.02	0.66	NA	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.45	0.45	0.01	1.82	1.82	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.57	0.57	0.01	2.27	2.27	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.75	0.75	0.01	2.99	2.99	XXX
88199		C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88291		A	Cyto/molecular report	0.52	0.17	0.17	0.02	0.71	0.71	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.45	NA	0.02	0.55	NA	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.01	0.12	0.12	XXX
88300	TC	A	Surgical path, gross	0.00	0.42	NA	0.01	0.43	NA	XXX
88302		A	Tissue exam by pathologist	0.13	1.03	NA	0.03	1.19	NA	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.06	0.06	0.01	0.20	0.20	XXX
88302	TC	A	Tissue exam by pathologist	0.00	0.97	NA	0.02	0.99	NA	XXX
88304		A	Tissue exam by pathologist	0.22	1.32	NA	0.03	1.57	NA	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.09	0.09	0.01	0.32	0.32	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.23	NA	0.02	1.25	NA	XXX
88305		A	Tissue exam by pathologist	0.75	1.91	NA	0.07	2.73	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88305	26	A	Tissue exam by pathologist	0.75	0.33	0.33	0.03	1.11	1.11	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.58	NA	0.04	1.62	NA	XXX
88307		A	Tissue exam by pathologist	1.59	3.15	NA	0.12	4.86	NA	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.68	0.68	0.06	2.33	2.33	XXX
88307	TC	A	Tissue exam by pathologist	0.00	2.47	NA	0.06	2.53	NA	XXX
88309		A	Tissue exam by pathologist	2.28	4.39	NA	0.14	6.81	NA	XXX
88309	26	A	Tissue exam by pathologist	2.28	0.97	0.97	0.08	3.33	3.33	XXX
88309	TC	A	Tissue exam by pathologist	0.00	3.42	NA	0.06	3.48	NA	XXX
88311		A	Decalcify tissue	0.24	0.23	NA	0.02	0.49	NA	XXX
88311	26	A	Decalcify tissue	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88311	TC	A	Decalcify tissue	0.00	0.13	NA	0.01	0.14	NA	XXX
88312		A	Special stains	0.54	1.52	NA	0.03	2.09	NA	XXX
88312	26	A	Special stains	0.54	0.23	0.23	0.02	0.79	0.79	XXX
88312	TC	A	Special stains	0.00	1.29	NA	0.01	1.30	NA	XXX
88313		A	Special stains	0.24	1.25	NA	0.02	1.51	NA	XXX
88313	26	A	Special stains	0.24	0.10	0.10	0.01	0.35	0.35	XXX
88313	TC	A	Special stains	0.00	1.15	NA	0.01	1.16	NA	XXX
88314		A	Histochemical stain	0.45	2.06	NA	0.04	2.55	NA	XXX
88314	26	A	Histochemical stain	0.45	0.19	0.19	0.02	0.66	0.66	XXX
88314	TC	A	Histochemical stain	0.00	1.87	NA	0.02	1.89	NA	XXX
88318		A	Chemical histochemistry	0.42	1.65	NA	0.03	2.10	NA	XXX
88318	26	A	Chemical histochemistry	0.42	0.18	0.18	0.02	0.62	0.62	XXX
88318	TC	A	Chemical histochemistry	0.00	1.47	NA	0.01	1.48	NA	XXX
88319		A	Enzyme histochemistry	0.53	3.41	NA	0.04	3.98	NA	XXX
88319	26	A	Enzyme histochemistry	0.53	0.22	0.22	0.02	0.77	0.77	XXX
88319	TC	A	Enzyme histochemistry	0.00	3.19	NA	0.02	3.21	NA	XXX
88321		A	Microslide consultation	1.30	0.79	0.56	0.05	2.14	1.91	XXX
88323		A	Microslide consultation	1.35	1.78	NA	0.07	3.20	NA	XXX
88323	26	A	Microslide consultation	1.35	0.57	0.57	0.05	1.97	1.97	XXX
88323	TC	A	Microslide consultation	0.00	1.21	NA	0.02	1.23	NA	XXX
88325		A	Comprehensive review of data	2.22	2.93	0.95	0.09	5.24	3.26	XXX
88329		A	Path consult introp	0.67	0.65	0.29	0.03	1.35	0.99	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.10	NA	0.08	2.37	NA	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.51	0.51	0.04	1.74	1.74	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.59	NA	0.04	0.63	NA	XXX
88332		A	Path consult intraop, add'l	0.59	0.46	NA	0.04	1.09	NA	XXX
88332	26	A	Path consult intraop, add'l	0.59	0.25	0.25	0.02	0.86	0.86	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88332	TC	A	Path consult intraop, add'l	0.00	0.21	NA	0.02	0.23	NA	XXX
88342		A	Immunohistochemistry	0.85	1.46	NA	0.05	2.36	NA	XXX
88342	26	A	Immunohistochemistry	0.85	0.36	0.36	0.03	1.24	1.24	XXX
88342	TC	A	Immunohistochemistry	0.00	1.10	NA	0.02	1.12	NA	XXX
88346		A	Immunofluorescent study	0.86	1.57	NA	0.05	2.48	NA	XXX
88346	26	A	Immunofluorescent study	0.86	0.36	0.36	0.03	1.25	1.25	XXX
88346	TC	A	Immunofluorescent study	0.00	1.21	NA	0.02	1.23	NA	XXX
88347		A	Immunofluorescent study	0.86	1.26	NA	0.05	2.17	NA	XXX
88347	26	A	Immunofluorescent study	0.86	0.35	0.35	0.03	1.24	1.24	XXX
88347	TC	A	Immunofluorescent study	0.00	0.91	NA	0.02	0.93	NA	XXX
88348		A	Electron microscopy	1.51	9.35	NA	0.13	10.99	NA	XXX
88348	26	A	Electron microscopy	1.51	0.64	0.64	0.06	2.21	2.21	XXX
88348	TC	A	Electron microscopy	0.00	8.71	NA	0.07	8.78	NA	XXX
88349		A	Scanning electron microscopy	0.76	3.56	NA	0.09	4.41	NA	XXX
88349	26	A	Scanning electron microscopy	0.76	0.33	0.33	0.03	1.12	1.12	XXX
88349	TC	A	Scanning electron microscopy	0.00	3.23	NA	0.06	3.29	NA	XXX
88355		A	Analysis, skeletal muscle	1.85	8.77	NA	0.13	10.75	NA	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.79	0.79	0.07	2.71	2.71	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	7.98	NA	0.06	8.04	NA	XXX
88356		A	Analysis, nerve	3.02	4.18	NA	0.19	7.39	NA	XXX
88356	26	A	Analysis, nerve	3.02	1.26	1.26	0.12	4.40	4.40	XXX
88356	TC	A	Analysis, nerve	0.00	2.92	NA	0.07	2.99	NA	XXX
88358		A	Analysis, tumor	0.95	0.84	NA	0.18	1.97	NA	XXX
88358	26	A	Analysis, tumor	0.95	0.40	0.40	0.11	1.46	1.46	XXX
88358	TC	A	Analysis, tumor	0.00	0.44	NA	0.07	0.51	NA	XXX
88360		A	Tumor immunohistochem/manual	1.10	1.73	NA	0.08	2.91	NA	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.47	0.47	0.06	1.63	1.63	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.26	NA	0.02	1.28	NA	XXX
88361		A	Tumor immunohistochem/comput	1.18	3.02	NA	0.18	4.38	NA	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.49	0.49	0.11	1.78	1.78	XXX
88361	TC	A	Tumor immunohistochem/comput	0.00	2.53	NA	0.07	2.60	NA	XXX
88362		A	Nerve teasing preparations	2.17	4.69	NA	0.16	7.02	NA	XXX
88362	26	A	Nerve teasing preparations	2.17	0.92	0.92	0.10	3.19	3.19	XXX
88362	TC	A	Nerve teasing preparations	0.00	3.77	NA	0.06	3.83	NA	XXX
88365		A	Insitu hybridization (fish)	1.20	2.13	NA	0.05	3.38	NA	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.51	0.51	0.03	1.74	1.74	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	1.62	NA	0.02	1.64	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
88367		A	Insitu hybridization, auto	1.30	4.11	NA	0.12	5.53	NA	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.54	0.54	0.06	1.90	1.90	XXX
88367	TC	A	Insitu hybridization, auto	0.00	3.57	NA	0.06	3.63	NA	XXX
88368		A	Insitu hybridization, manual	1.40	3.50	NA	0.12	5.02	NA	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.60	0.60	0.06	2.06	2.06	XXX
88368	TC	A	Insitu hybridization, manual	0.00	2.90	NA	0.06	2.96	NA	XXX
88371	26	A	Protein, western blot tissue	0.37	0.13	0.13	0.01	0.51	0.51	XXX
88372	26	A	Protein analysis w/probe	0.37	0.16	0.16	0.01	0.54	0.54	XXX
88380		C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	26	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88380	TC	C	Microdissection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399		C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.16	0.16	0.01	0.54	0.54	XXX
89100		A	Sample intestinal contents	0.60	1.83	0.21	0.03	2.46	0.84	XXX
89105		A	Sample intestinal contents	0.50	2.22	0.17	0.02	2.74	0.69	XXX
89130		A	Sample stomach contents	0.45	1.74	0.13	0.02	2.21	0.60	XXX
89132		A	Sample stomach contents	0.19	1.55	0.06	0.01	1.75	0.26	XXX
89135		A	Sample stomach contents	0.79	1.89	0.25	0.04	2.72	1.08	XXX
89136		A	Sample stomach contents	0.21	1.73	0.09	0.01	1.95	0.31	XXX
89140		A	Sample stomach contents	0.94	2.08	0.27	0.04	3.06	1.25	XXX
89141		A	Sample stomach contents	0.85	2.79	0.33	0.03	3.67	1.21	XXX
89220		A	Sputum specimen collection	0.00	0.39	NA	0.02	0.41	NA	XXX
89230		A	Collect sweat for test	0.00	0.11	NA	0.02	0.13	NA	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90296		E	Diphtheria antitoxin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90371		E	Hep b ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90375		E	Rabies ig, im/sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90376		E	Rabies ig, heat treated	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90378		X	Rsv ig, im, 50mg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90385		E	Rh ig, minidose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90393		E	Vaccina ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90396		E	Varicella-zoster ig, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.31	NA	0.01	0.49	NA	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90468		R	Immune admin o/n, addl < 8 y	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
90471		A	Immunization admin	0.17	0.31	NA	0.01	0.49	NA	XXX
90472		A	Immunization admin, each add	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90473		R	Immune admin oral/nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90474		R	Immune admin oral/nasal addl	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
90476		E	Adenovirus vaccine, type 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90477		E	Adenovirus vaccine, type 7	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90581		E	Anthrax vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90585		E	Bcg vaccine, percut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90586		E	Bcg vaccine, intravesical	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90632		E	Hep a vaccine, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90633		E	Hep a vacc, ped/adol, 2 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90634		E	Hep a vacc, ped/adol, 3 dose	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90636		E	Hep a/hep b vacc, adult im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90645		E	Hib vaccine, hboc, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90646		E	Hib vaccine, prp-d, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90647		E	Hib vaccine, prp-omp, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90648		E	Hib vaccine, prp-t, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90655		X	Flu vaccine no preserv 6-35m	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90656		E	Flu vaccine no preserv 3 & >	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90657		X	Flu vaccine, 3 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90658		X	Flu vaccine, 3 yrs & >, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90660		X	Flu vaccine, nasal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90665		E	Lyme disease vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90669		N	Pneumococcal vacc, ped <5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90675		E	Rabies vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90676		E	Rabies vaccine, id	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90680		E	Rotovirus vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90690		E	Typhoid vaccine, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90691		E	Typhoid vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90692		E	Typhoid vaccine, h-p, sc/id	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90693		E	Typhoid vaccine, akd, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90698		E	Dtap-hib-ip vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90700		E	Dtap vaccine, < 7 yrs, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90701		E	Dtp vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90702		E	Dt vaccine < 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90703		E	Tetanus vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90704		E	Mumps vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90705		E	Measles vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90706		E	Rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90707		E	Mmr vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90708		E	Measles-rubella vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90710		E	Mmrv vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90712		E	Oral poliovirus vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90713		E	Poliovirus, ipv, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90715		E	Tdap vaccine >7 im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90716		E	Chicken pox vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90717		E	Yellow fever vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90718		E	Td vaccine > 7, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90719		E	Diphtheria vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90720		E	Dtp/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90721		E	Dtap/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90725		E	Cholera vaccine, injectable	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90727		E	Plague vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90732		X	Pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90733		E	Meningococcal vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90734		E	Meningococcal vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90735		E	Encephalitis vaccine, sc	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90740		X	Hepb vacc, ill pat 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90743		X	Hep b vacc, adol, 2 dose, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90744		X	Hepb vacc ped/adol 3 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90746		X	Hep b vaccine, adult, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90747		X	Hepb vacc, ill pat 4 dose im	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90749		E	Vaccine toxoid	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90780		I	IV infusion therapy, 1 hour	+0.17	2.15	2.15	0.07	2.39	2.39	XXX
90781		I	IV infusion, additional hour	+0.17	0.46	0.46	0.04	0.67	0.67	ZZZ
90782		I	Injection, sc/im	+0.17	0.32	0.32	0.01	0.50	0.50	XXX
90783		A	Injection, ia	0.17	0.31	NA	0.02	0.50	NA	XXX
90784		I	Injection, iv	+0.17	0.80	0.80	0.04	1.01	1.01	XXX
90788		A	Injection of antibiotic	0.17	0.26	NA	0.01	0.44	NA	XXX
90799		C	Ther/prophylactic/dx inject	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.17	0.93	0.07	4.04	3.80	XXX
90802		A	Intac psy dx interview	3.01	1.20	0.98	0.08	4.29	4.07	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.49	0.38	0.03	1.73	1.62	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.50	0.42	0.03	1.90	1.82	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.70	0.60	0.05	2.61	2.51	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.70	0.63	0.05	2.77	2.70	XXX
90808		A	Psytx, office, 75-80 min	2.79	1.03	0.90	0.07	3.89	3.76	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	1.00	0.92	0.08	4.03	3.95	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.51	0.42	0.04	1.87	1.78	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.57	0.46	0.04	2.09	1.98	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.79	0.64	0.05	2.81	2.66	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.77	0.67	0.05	2.95	2.85	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	1.10	0.98	0.07	4.07	3.95	XXX
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.05	0.95	0.08	4.19	4.09	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.46	0.03	NA	1.74	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.46	0.04	NA	1.91	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.69	0.05	NA	2.63	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.65	0.05	NA	2.75	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	1.01	0.07	NA	3.91	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.95	0.08	NA	4.02	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.48	0.03	NA	1.87	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.49	0.04	NA	2.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.72	0.05	NA	2.78	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.68	0.05	NA	2.89	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	1.06	0.07	NA	4.07	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.98	0.08	NA	4.16	XXX
90845		A	Psychoanalysis	1.79	0.58	0.55	0.04	2.41	2.38	XXX
90846		R	Family psytx w/o patient	1.83	0.65	0.65	0.05	2.53	2.53	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
90847		R	Family psytx w/patient	2.21	0.82	0.76	0.05	3.08	3.02	XXX
90849		R	Multiple family group psytx	0.59	0.27	0.24	0.02	0.88	0.85	XXX
90853		A	Group psychotherapy	0.59	0.25	0.23	0.02	0.86	0.84	XXX
90857		A	Intac group psytx	0.63	0.29	0.25	0.02	0.94	0.90	XXX
90862		A	Medication management	0.95	0.40	0.32	0.02	1.37	1.29	XXX
90865		A	Narcosynthesis	2.84	1.36	0.91	0.11	4.31	3.86	XXX
90870		A	Electroconvulsive therapy	1.88	1.93	0.59	0.05	3.86	2.52	000
90871		N	Electroconvulsive therapy	+2.72	1.07	1.07	0.07	3.86	3.86	000
90875		N	Psychophysiological therapy	+1.20	0.90	0.46	0.04	2.14	1.70	XXX
90876		N	Psychophysiological therapy	+1.90	1.16	0.73	0.05	3.11	2.68	XXX
90880		A	Hypnotherapy	2.19	1.04	0.69	0.06	3.29	2.94	XXX
90882		N	Environmental manipulation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90885		B	Psy evaluation of records	+0.97	0.37	0.37	0.02	1.36	1.36	XXX
90887		B	Consultation with family	+1.48	0.82	0.56	0.04	2.34	2.08	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.65	0.14	0.02	1.08	0.57	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.56	0.31	0.05	2.50	1.25	000
90918		I	ESRD related services, month	+11.16	6.11	6.11	0.36	17.63	17.63	XXX
90919		I	ESRD related services, month	+8.53	4.00	4.00	0.29	12.82	12.82	XXX
90920		I	ESRD related services, month	+7.26	3.75	3.75	0.23	11.24	11.24	XXX
90921		I	ESRD related services, month	+4.46	2.44	2.44	0.14	7.04	7.04	XXX
90922		I	ESRD related services, day	+0.37	0.21	0.21	0.01	0.59	0.59	XXX
90923		I	Esrd related services, day	+0.28	0.13	0.13	0.01	0.42	0.42	XXX
90924		I	Esrd related services, day	+0.24	0.12	0.12	0.01	0.37	0.37	XXX
90925		I	Esrd related services, day	+0.15	0.08	0.08	0.01	0.24	0.24	XXX
90935		A	Hemodialysis, one evaluation	1.22	NA	0.67	0.04	NA	1.93	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.97	0.07	NA	3.15	000
90939		X	Hemodialysis study, transcut	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90940		X	Hemodialysis access study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	0.69	0.04	NA	2.01	000
90947		A	Dialysis, repeated eval	2.16	NA	0.99	0.07	NA	3.22	000
90989		X	Dialysis training, complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90993		X	Dialysis training, incompl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
90997		A	Hemoperfusion	1.84	NA	0.66	0.06	NA	2.56	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	0.33	NA	0.04	1.10	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
91000	26	A	Esophageal intubation	0.73	0.25	0.25	0.03	1.01	1.01	000
91000	TC	A	Esophageal intubation	0.00	0.08	NA	0.01	0.09	NA	000
91010		A	Esophagus motility study	1.25	4.41	NA	0.12	5.78	NA	000
91010	26	A	Esophagus motility study	1.25	0.44	0.44	0.06	1.75	1.75	000
91010	TC	A	Esophagus motility study	0.00	3.97	NA	0.06	4.03	NA	000
91011		A	Esophagus motility study	1.50	5.23	NA	0.13	6.86	NA	000
91011	26	A	Esophagus motility study	1.50	0.53	0.53	0.07	2.10	2.10	000
91011	TC	A	Esophagus motility study	0.00	4.70	NA	0.06	4.76	NA	000
91012		A	Esophagus motility study	1.46	5.75	NA	0.14	7.35	NA	000
91012	26	A	Esophagus motility study	1.46	0.51	0.51	0.07	2.04	2.04	000
91012	TC	A	Esophagus motility study	0.00	5.24	NA	0.07	5.31	NA	000
91020		A	Gastric motility	1.44	4.52	NA	0.13	6.09	NA	000
91020	26	A	Gastric motility	1.44	0.49	0.49	0.07	2.00	2.00	000
91020	TC	A	Gastric motility	0.00	4.03	NA	0.06	4.09	NA	000
91030		A	Acid perfusion of esophagus	0.91	2.43	NA	0.06	3.40	NA	000
91030	26	A	Acid perfusion of esophagus	0.91	0.32	0.32	0.04	1.27	1.27	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.11	NA	0.02	2.13	NA	000
91034		A	Gastroesophageal reflux test	0.97	5.24	NA	0.12	6.33	NA	XXX
91034	26	A	Gastroesophageal reflux test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91034	TC	A	Gastroesophageal reflux test	0.00	4.90	NA	0.06	4.96	NA	XXX
91035		A	G-esoph reflx tst w/electrod	1.59	10.80	NA	0.12	12.51	NA	XXX
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.56	0.56	0.06	2.21	2.21	XXX
91035	TC	A	G-esoph reflx tst w/electrod	0.00	10.24	NA	0.06	10.30	NA	XXX
91037		A	Esoph imped function test	0.97	2.93	NA	0.12	4.02	NA	XXX
91037	26	A	Esoph imped function test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91037	TC	A	Esoph imped function test	0.00	2.59	NA	0.06	2.65	NA	XXX
91038		A	Esoph imped funct test > 1h	1.10	2.22	NA	0.12	3.44	NA	XXX
91038	26	A	Esoph imped funct test > 1h	1.10	0.39	0.39	0.06	1.55	1.55	XXX
91038	TC	A	Esoph imped funct test > 1h	0.00	1.83	NA	0.06	1.89	NA	XXX
91040		A	Esoph balloon distension tst	0.97	11.13	NA	0.12	12.22	NA	XXX
91040	26	A	Esoph balloon distension tst	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91040	TC	A	Esoph balloon distension tst	0.00	10.79	NA	0.06	10.85	NA	XXX
91052		A	Gastric analysis test	0.79	2.45	NA	0.06	3.30	NA	000
91052	26	A	Gastric analysis test	0.79	0.28	0.28	0.04	1.11	1.11	000
91052	TC	A	Gastric analysis test	0.00	2.17	NA	0.02	2.19	NA	000
91055		A	Gastric intubation for smear	0.94	2.94	NA	0.07	3.95	NA	000
91055	26	A	Gastric intubation for smear	0.94	0.27	0.27	0.05	1.26	1.26	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
91055	TC	A	Gastric intubation for smear	0.00	2.67	NA	0.02	2.69	NA	000
91060		A	Gastric saline load test	0.45	1.96	NA	0.05	2.46	NA	000
91060	26	A	Gastric saline load test	0.45	0.14	0.14	0.03	0.62	0.62	000
91060	TC	A	Gastric saline load test	0.00	1.82	NA	0.02	1.84	NA	000
91065		A	Breath hydrogen test	0.20	1.46	NA	0.03	1.69	NA	000
91065	26	A	Breath hydrogen test	0.20	0.07	0.07	0.01	0.28	0.28	000
91065	TC	A	Breath hydrogen test	0.00	1.39	NA	0.02	1.41	NA	000
91100		A	Pass intestine bleeding tube	1.08	2.79	0.28	0.07	3.94	1.43	000
91105		A	Gastric intubation treatment	0.37	2.10	0.09	0.03	2.50	0.49	000
91110		A	Gi tract capsule endoscopy	3.64	22.18	NA	0.16	25.98	NA	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.28	1.28	0.09	5.01	5.01	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	20.90	NA	0.07	20.97	NA	XXX
91120		A	Rectal sensation test	0.97	10.98	NA	0.11	12.06	NA	XXX
91120	26	A	Rectal sensation test	0.97	0.34	0.34	0.07	1.38	1.38	XXX
91120	TC	A	Rectal sensation test	0.00	10.64	NA	0.04	10.68	NA	XXX
91122		A	Anal pressure record	1.77	5.10	NA	0.20	7.07	NA	000
91122	26	A	Anal pressure record	1.77	0.60	0.60	0.12	2.49	2.49	000
91122	TC	A	Anal pressure record	0.00	4.50	NA	0.08	4.58	NA	000
91123		B	Irrigate fecal impaction	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.18	0.18	0.03	0.73	0.73	XXX
91132	TC	C	Electrogastrography	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133		C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.23	0.23	0.03	0.92	0.92	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299		C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	0.97	0.34	0.02	1.87	1.24	XXX
92004		A	Eye exam, new patient	1.67	1.70	0.68	0.04	3.41	2.39	XXX
92012		A	Eye exam established pat	0.67	1.03	0.29	0.02	1.72	0.98	XXX
92014		A	Eye exam & treatment	1.10	1.41	0.47	0.03	2.54	1.60	XXX
92015		N	Refraction	+0.38	1.49	0.15	0.01	1.88	0.54	XXX
92018		A	New eye exam & treatment	2.50	NA	1.07	0.07	NA	3.64	XXX
92019		A	Eye exam & treatment	1.31	NA	0.56	0.03	NA	1.90	XXX
92020		A	Special eye evaluation	0.37	0.34	0.16	0.01	0.72	0.54	XXX
92060		A	Special eye evaluation	0.69	0.73	NA	0.03	1.45	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92060	26	A	Special eye evaluation	0.69	0.29	0.29	0.02	1.00	1.00	XXX
92060	TC	A	Special eye evaluation	0.00	0.44	NA	0.01	0.45	NA	XXX
92065		A	Orthoptic/pleoptic training	0.37	0.53	NA	0.02	0.92	NA	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.15	0.15	0.01	0.53	0.53	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.38	NA	0.01	0.39	NA	XXX
92070		A	Fitting of contact lens	0.70	1.07	0.32	0.02	1.79	1.04	XXX
92081		A	Visual field examination(s)	0.36	0.94	NA	0.02	1.32	NA	XXX
92081	26	A	Visual field examination(s)	0.36	0.15	0.15	0.01	0.52	0.52	XXX
92081	TC	A	Visual field examination(s)	0.00	0.79	NA	0.01	0.80	NA	XXX
92082		A	Visual field examination(s)	0.44	1.23	NA	0.02	1.69	NA	XXX
92082	26	A	Visual field examination(s)	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92082	TC	A	Visual field examination(s)	0.00	1.04	NA	0.01	1.05	NA	XXX
92083		A	Visual field examination(s)	0.50	1.43	NA	0.02	1.95	NA	XXX
92083	26	A	Visual field examination(s)	0.50	0.22	0.22	0.01	0.73	0.73	XXX
92083	TC	A	Visual field examination(s)	0.00	1.21	NA	0.01	1.22	NA	XXX
92100		A	Serial tonometry exam(s)	0.92	1.35	0.36	0.02	2.29	1.30	XXX
92120		A	Tonography & eye evaluation	0.81	1.07	0.32	0.02	1.90	1.15	XXX
92130		A	Water provocation tonography	0.81	1.28	0.37	0.02	2.11	1.20	XXX
92135		A	Opthalmic dx imaging	0.35	0.79	NA	0.02	1.16	NA	XXX
92135	26	A	Opthalmic dx imaging	0.35	0.15	0.15	0.01	0.51	0.51	XXX
92135	TC	A	Opthalmic dx imaging	0.00	0.64	NA	0.01	0.65	NA	XXX
92136		A	Ophthalmic biometry	0.54	1.65	NA	0.08	2.27	NA	XXX
92136	26	A	Ophthalmic biometry	0.54	0.24	0.24	0.01	0.79	0.79	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.41	NA	0.07	1.48	NA	XXX
92140		A	Glaucoma provocative tests	0.50	0.99	0.21	0.01	1.50	0.72	XXX
92225		A	Special eye exam, initial	0.38	0.22	0.16	0.01	0.61	0.55	XXX
92226		A	Special eye exam, subsequent	0.33	0.21	0.14	0.01	0.55	0.48	XXX
92230		A	Eye exam with photos	0.60	1.53	0.20	0.02	2.15	0.82	XXX
92235		A	Eye exam with photos	0.81	2.61	NA	0.08	3.50	NA	XXX
92235	26	A	Eye exam with photos	0.81	0.37	0.37	0.02	1.20	1.20	XXX
92235	TC	A	Eye exam with photos	0.00	2.24	NA	0.06	2.30	NA	XXX
92240		A	Icg angiography	1.10	6.10	NA	0.09	7.29	NA	XXX
92240	26	A	Icg angiography	1.10	0.50	0.50	0.03	1.63	1.63	XXX
92240	TC	A	Icg angiography	0.00	5.60	NA	0.06	5.66	NA	XXX
92250		A	Eye exam with photos	0.44	1.53	NA	0.02	1.99	NA	XXX
92250	26	A	Eye exam with photos	0.44	0.19	0.19	0.01	0.64	0.64	XXX
92250	TC	A	Eye exam with photos	0.00	1.34	NA	0.01	1.35	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92260		A	Ophthalmoscopy/dynamometry	0.20	0.26	0.09	0.01	0.47	0.30	XXX
92265		A	Eye muscle evaluation	0.81	1.49	NA	0.06	2.36	NA	XXX
92265	26	A	Eye muscle evaluation	0.81	0.28	0.28	0.04	1.13	1.13	XXX
92265	TC	A	Eye muscle evaluation	0.00	1.21	NA	0.02	1.23	NA	XXX
92270		A	Electro-oculography	0.81	1.53	NA	0.05	2.39	NA	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	1.17	1.17	XXX
92270	TC	A	Electro-oculography	0.00	1.20	NA	0.02	1.22	NA	XXX
92275		A	Electroretinography	1.01	1.94	NA	0.05	3.00	NA	XXX
92275	26	A	Electroretinography	1.01	0.43	0.43	0.03	1.47	1.47	XXX
92275	TC	A	Electroretinography	0.00	1.51	NA	0.02	1.53	NA	XXX
92283		A	Color vision examination	0.17	0.84	NA	0.02	1.03	NA	XXX
92283	26	A	Color vision examination	0.17	0.07	0.07	0.01	0.25	0.25	XXX
92283	TC	A	Color vision examination	0.00	0.77	NA	0.01	0.78	NA	XXX
92284		A	Dark adaptation eye exam	0.24	1.88	NA	0.02	2.14	NA	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.08	0.08	0.01	0.33	0.33	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.80	NA	0.01	1.81	NA	XXX
92285		A	Eye photography	0.20	0.99	NA	0.02	1.21	NA	XXX
92285	26	A	Eye photography	0.20	0.09	0.09	0.01	0.30	0.30	XXX
92285	TC	A	Eye photography	0.00	0.90	NA	0.01	0.91	NA	XXX
92286		A	Internal eye photography	0.66	3.05	NA	0.04	3.75	NA	XXX
92286	26	A	Internal eye photography	0.66	0.29	0.29	0.02	0.97	0.97	XXX
92286	TC	A	Internal eye photography	0.00	2.76	NA	0.02	2.78	NA	XXX
92287		A	Internal eye photography	0.81	2.38	0.31	0.02	3.21	1.14	XXX
92310		N	Contact lens fitting	+1.17	1.12	0.45	0.04	2.33	1.66	XXX
92311		A	Contact lens fitting	1.08	1.09	0.35	0.03	2.20	1.46	XXX
92312		A	Contact lens fitting	1.26	1.08	0.50	0.03	2.37	1.79	XXX
92313		A	Contact lens fitting	0.92	1.06	0.29	0.02	2.00	1.23	XXX
92314		N	Prescription of contact lens	+0.69	0.94	0.27	0.01	1.64	0.97	XXX
92315		A	Prescription of contact lens	0.45	0.85	0.16	0.01	1.31	0.62	XXX
92316		A	Prescription of contact lens	0.68	0.91	0.29	0.02	1.61	0.99	XXX
92317		A	Prescription of contact lens	0.45	0.94	0.15	0.01	1.40	0.61	XXX
92325		A	Modification of contact lens	0.00	0.40	NA	0.01	0.41	NA	XXX
92326		A	Replacement of contact lens	0.00	1.63	NA	0.06	1.69	NA	XXX
92330		A	Fitting of artificial eye	1.08	0.99	0.32	0.03	2.10	1.43	XXX
92335		A	Fitting of artificial eye	0.45	0.90	0.16	0.01	1.36	0.62	XXX
92340		N	Fitting of spectacles	+0.37	0.70	0.14	0.01	1.08	0.52	XXX
92341		N	Fitting of spectacles	+0.47	0.74	0.18	0.01	1.22	0.66	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
92342		N	Fitting of spectacles	+0.53	0.76	0.21	0.01	1.30	0.75	XXX
92352		B	Special spectacles fitting	+0.37	0.68	0.14	0.01	1.06	0.52	XXX
92353		B	Special spectacles fitting	+0.50	0.73	0.19	0.02	1.25	0.71	XXX
92354		B	Special spectacles fitting	+0.00	8.86	NA	0.10	8.96	NA	XXX
92355		B	Special spectacles fitting	+0.00	4.33	NA	0.01	4.34	NA	XXX
92358		B	Eye prosthesis service	+0.00	0.97	NA	0.05	1.02	NA	XXX
92370		N	Repair & adjust spectacles	+0.32	0.55	0.13	0.02	0.89	0.47	XXX
92371		B	Repair & adjust spectacles	+0.00	0.62	NA	0.02	0.64	NA	XXX
92390		N	Supply of spectacles	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92391		N	Supply of contact lenses	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92392		I	Supply of low vision aids	+0.00	3.79	3.79	0.02	3.81	3.81	XXX
92393		I	Supply of artificial eye	+0.00	11.76	11.76	0.57	12.33	12.33	XXX
92395		I	Supply of spectacles	+0.00	1.28	1.28	0.10	1.38	1.38	XXX
92396		I	Supply of contact lenses	+0.00	2.16	2.16	0.07	2.23	2.23	XXX
92499		C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	1.11	0.05	NA	2.67	000
92504		A	Ear microscopy examination	0.18	0.50	0.09	0.01	0.69	0.28	XXX
92506		A	Speech/hearing evaluation	0.86	2.59	0.40	0.03	3.48	1.29	XXX
92507		A	Speech/hearing therapy	0.52	1.11	0.23	0.02	1.65	0.77	XXX
92508		A	Speech/hearing therapy	0.26	0.51	0.12	0.01	0.78	0.39	XXX
92510		I	Rehab for ear implant	+1.50	2.08	0.82	0.07	3.65	2.39	XXX
92511		A	Nasopharyngoscopy	0.84	3.31	0.78	0.03	4.18	1.65	000
92512		A	Nasal function studies	0.55	1.14	0.18	0.02	1.71	0.75	XXX
92516		A	Facial nerve function test	0.43	1.20	0.22	0.01	1.64	0.66	XXX
92520		A	Laryngeal function studies	0.76	0.51	0.39	0.03	1.30	1.18	XXX
92526		A	Oral function therapy	0.55	1.64	0.20	0.02	2.21	0.77	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.03	NA	0.04	1.47	NA	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.19	0.19	0.02	0.61	0.61	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	0.84	NA	0.02	0.86	NA	XXX
92542		A	Positional nystagmus test	0.33	1.14	NA	0.03	1.50	NA	XXX
92542	26	A	Positional nystagmus test	0.33	0.16	0.16	0.01	0.50	0.50	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92542	TC	A	Positional nystagmus test	0.00	0.98	NA	0.02	1.00	NA	XXX
92543		A	Caloric vestibular test	0.10	0.57	NA	0.02	0.69	NA	XXX
92543	26	A	Caloric vestibular test	0.10	0.05	0.05	0.01	0.16	0.16	XXX
92543	TC	A	Caloric vestibular test	0.00	0.52	NA	0.01	0.53	NA	XXX
92544		A	Optokinetic nystagmus test	0.26	0.90	NA	0.03	1.19	NA	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.12	0.12	0.01	0.39	0.39	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	0.78	NA	0.02	0.80	NA	XXX
92545		A	Oscillating tracking test	0.23	0.80	NA	0.03	1.06	NA	XXX
92545	26	A	Oscillating tracking test	0.23	0.11	0.11	0.01	0.35	0.35	XXX
92545	TC	A	Oscillating tracking test	0.00	0.69	NA	0.02	0.71	NA	XXX
92546		A	Sinusoidal rotational test	0.29	1.98	NA	0.03	2.30	NA	XXX
92546	26	A	Sinusoidal rotational test	0.29	0.13	0.13	0.01	0.43	0.43	XXX
92546	TC	A	Sinusoidal rotational test	0.00	1.85	NA	0.02	1.87	NA	XXX
92547		A	Supplemental electrical test	0.00	0.08	NA	0.06	0.14	NA	ZZZ
92548		A	Posturography	0.50	2.25	NA	0.15	2.90	NA	XXX
92548	26	A	Posturography	0.50	0.26	0.26	0.02	0.78	0.78	XXX
92548	TC	A	Posturography	0.00	1.99	NA	0.13	2.12	NA	XXX
92551		N	Pure tone hearing test, air	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92552		A	Pure tone audiometry, air	0.00	0.44	NA	0.04	0.48	NA	XXX
92553		A	Audiometry, air & bone	0.00	0.66	NA	0.06	0.72	NA	XXX
92555		A	Speech threshold audiometry	0.00	0.38	NA	0.04	0.42	NA	XXX
92556		A	Speech audiometry, complete	0.00	0.57	NA	0.06	0.63	NA	XXX
92557		A	Comprehensive hearing test	0.00	1.19	NA	0.12	1.31	NA	XXX
92559		N	Group audiometric testing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92560		N	Bekesy audiometry, screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.72	NA	0.06	0.78	NA	XXX
92562		A	Loudness balance test	0.00	0.41	NA	0.04	0.45	NA	XXX
92563		A	Tone decay hearing test	0.00	0.38	NA	0.04	0.42	NA	XXX
92564		A	Sisi hearing test	0.00	0.47	NA	0.05	0.52	NA	XXX
92565		A	Stenger test, pure tone	0.00	0.40	NA	0.04	0.44	NA	XXX
92567		A	Tympanometry	0.00	0.52	NA	0.06	0.58	NA	XXX
92568		A	Acoustic reflex testing	0.00	0.38	NA	0.04	0.42	NA	XXX
92569		A	Acoustic reflex decay test	0.00	0.41	NA	0.04	0.45	NA	XXX
92571		A	Filtered speech hearing test	0.00	0.39	NA	0.04	0.43	NA	XXX
92572		A	Staggered spondaic word test	0.00	0.09	NA	0.01	0.10	NA	XXX
92573		A	Lombard test	0.00	0.35	NA	0.04	0.39	NA	XXX
92575		A	Sensorineural acuity test	0.00	0.30	NA	0.02	0.32	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
92576		A	Synthetic sentence test	0.00	0.44	NA	0.05	0.49	NA	XXX
92577		A	Stenger test, speech	0.00	0.72	NA	0.07	0.79	NA	XXX
92579		A	Visual audiometry (vra)	0.00	0.73	NA	0.06	0.79	NA	XXX
92582		A	Conditioning play audiometry	0.00	0.73	NA	0.06	0.79	NA	XXX
92583		A	Select picture audiometry	0.00	0.89	NA	0.08	0.97	NA	XXX
92584		A	Electrocochleography	0.00	2.47	NA	0.21	2.68	NA	XXX
92585		A	Auditor evoke potent, compre	0.50	2.06	NA	0.17	2.73	NA	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.03	0.74	0.74	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	1.85	NA	0.14	1.99	NA	XXX
92586		A	Auditor evoke potent, limit	0.00	1.85	NA	0.14	1.99	NA	XXX
92587		A	Evoked auditory test	0.13	1.37	NA	0.12	1.62	NA	XXX
92587	26	A	Evoked auditory test	0.13	0.06	0.06	0.01	0.20	0.20	XXX
92587	TC	A	Evoked auditory test	0.00	1.31	NA	0.11	1.42	NA	XXX
92588		A	Evoked auditory test	0.36	1.63	NA	0.14	2.13	NA	XXX
92588	26	A	Evoked auditory test	0.36	0.16	0.16	0.01	0.53	0.53	XXX
92588	TC	A	Evoked auditory test	0.00	1.47	NA	0.13	1.60	NA	XXX
92590		N	Hearing aid exam, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92591		N	Hearing aid exam, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92592		N	Hearing aid check, one ear	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92593		N	Hearing aid check, both ears	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92594		N	Electro hearng aid test, one	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92595		N	Electro hearng aid tst, both	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92596		A	Ear protector evaluation	0.00	0.59	NA	0.06	0.65	NA	XXX
92597		A	Oral speech device eval	0.86	1.69	0.45	0.03	2.58	1.34	XXX
92601		A	Cochlear implt f/up exam < 7	0.00	3.50	NA	0.07	3.57	NA	XXX
92602		A	Reprogram cochlear implt < 7	0.00	2.38	NA	0.07	2.45	NA	XXX
92603		A	Cochlear implt f/up exam 7 >	0.00	2.14	NA	0.07	2.21	NA	XXX
92604		A	Reprogram cochlear implt 7 >	0.00	1.35	NA	0.07	1.42	NA	XXX
92605		B	Eval for nonspeech device rx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92606		B	Non-speech device service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	3.08	NA	0.05	3.13	NA	XXX
92608		A	Ex for speech device rx addl	0.00	0.55	NA	0.05	0.60	NA	XXX
92609		A	Use of speech device service	0.00	1.59	NA	0.04	1.63	NA	XXX
92610		A	Evaluate swallowing function	0.00	3.43	NA	0.08	3.51	NA	XXX
92611		A	Motion fluoroscopy/swallow	0.00	3.43	NA	0.08	3.51	NA	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	2.74	0.66	0.04	4.05	1.97	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.40	0.39	0.05	1.16	1.15	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
92614		A	Laryngoscopic sensory test	1.27	2.50	0.66	0.04	3.81	1.97	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.35	0.35	0.05	1.03	1.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.39	0.99	0.06	5.33	2.93	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.44	0.44	0.05	1.28	1.28	XXX
92620		A	Auditory function, 60 min	0.00	1.14	NA	0.06	1.20	NA	XXX
92621		A	Auditory function, + 15 min	0.00	0.25	NA	0.06	0.31	NA	ZZZ
92625		A	Tinnitus assessment	0.00	1.12	NA	0.06	1.18	NA	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	4.20	0.97	0.26	8.25	5.02	000
92953		A	Temporary external pacing	0.23	NA	0.07	0.02	NA	0.32	000
92960		A	Cardioversion electric, ext	2.25	6.31	1.17	0.08	8.64	3.50	000
92961		A	Cardioversion, electric, int	4.59	NA	2.08	0.29	NA	6.96	000
92970		A	Cardioassist, internal	3.51	NA	1.06	0.19	NA	4.76	000
92971		A	Cardioassist, external	1.77	NA	0.85	0.06	NA	2.68	000
92973		A	Percut coronary thrombectomy	3.28	NA	1.29	0.23	NA	4.80	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	1.18	0.21	NA	4.39	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	2.81	0.23	NA	10.28	000
92977		A	Dissolve clot, heart vessel	0.00	8.05	NA	0.46	8.51	NA	XXX
92978		A	Intravasc us, heart add-on	1.80	5.27	NA	0.30	7.37	NA	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.71	0.71	0.06	2.57	2.57	ZZZ
92978	TC	A	Intravasc us, heart add-on	0.00	4.56	NA	0.24	4.80	NA	ZZZ
92979		A	Intravasc us, heart add-on	1.44	2.85	NA	0.19	4.48	NA	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.56	0.56	0.06	2.06	2.06	ZZZ
92979	TC	A	Intravasc us, heart add-on	0.00	2.29	NA	0.13	2.42	NA	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	6.05	0.48	NA	21.35	000
92981		A	Insert intracoronary stent	4.16	NA	1.63	0.13	NA	5.92	ZZZ
92982		A	Coronary artery dilation	10.96	NA	4.53	0.35	NA	15.84	000
92984		A	Coronary artery dilation	2.97	NA	1.16	0.09	NA	4.22	ZZZ
92986		A	Revision of aortic valve	21.77	NA	11.83	0.70	NA	34.30	090
92987		A	Revision of mitral valve	22.67	NA	12.21	0.72	NA	35.60	090
92990		A	Revision of pulmonary valve	17.31	NA	9.79	0.79	NA	27.89	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	4.96	0.39	NA	17.42	000
92996		A	Coronary atherectomy add-on	3.26	NA	1.27	0.10	NA	4.63	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	4.82	0.46	NA	17.26	000
92998		A	Pul art balloon repr, percut	5.99	NA	2.20	0.28	NA	8.47	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93000		A	Electrocardiogram, complete	0.17	0.51	NA	0.03	0.71	NA	XXX
93005		A	Electrocardiogram, tracing	0.00	0.45	NA	0.02	0.47	NA	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	0.24	0.24	XXX
93012		A	Transmission of ecg	0.00	6.01	NA	0.18	6.19	NA	XXX
93014		A	Report on transmitted ecg	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93015		A	Cardiovascular stress test	0.75	1.96	NA	0.14	2.85	NA	XXX
93016		A	Cardiovascular stress test	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93017		A	Cardiovascular stress test	0.00	1.68	NA	0.11	1.79	NA	XXX
93018		A	Cardiovascular stress test	0.30	0.11	0.11	0.01	0.42	0.42	XXX
93024		A	Cardiac drug stress test	1.17	1.57	NA	0.13	2.87	NA	XXX
93024	26	A	Cardiac drug stress test	1.17	0.45	0.45	0.05	1.67	1.67	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.12	NA	0.08	1.20	NA	XXX
93025		A	Microvolt t-wave assess	0.75	7.59	NA	0.14	8.48	NA	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.29	0.29	0.03	1.07	1.07	XXX
93025	TC	A	Microvolt t-wave assess	0.00	7.30	NA	0.11	7.41	NA	XXX
93040		A	Rhythm ECG with report	0.16	0.20	NA	0.02	0.38	NA	XXX
93041		A	Rhythm ECG, tracing	0.00	0.15	NA	0.01	0.16	NA	XXX
93042		A	Rhythm ECG, report	0.16	0.05	0.05	0.01	0.22	0.22	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	3.61	NA	0.24	4.37	NA	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	1.24	NA	0.08	1.32	NA	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	2.18	NA	0.14	2.32	NA	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	3.89	NA	0.26	4.67	NA	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	1.52	NA	0.11	1.63	NA	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	2.18	NA	0.13	2.31	NA	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93235		A	ECG monitor/report, 24 hrs	0.45	2.78	NA	0.16	3.39	NA	XXX
93236		A	ECG monitor/report, 24 hrs	0.00	2.62	NA	0.14	2.76	NA	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.16	0.16	0.02	0.63	0.63	XXX
93268		A	ECG record/review	0.52	7.44	NA	0.28	8.24	NA	XXX
93270		A	ECG recording	0.00	1.24	NA	0.08	1.32	NA	XXX
93271		A	Ecg/monitoring and analysis	0.00	6.01	NA	0.18	6.19	NA	XXX
93272		A	Ecg/review, interpret only	0.52	0.19	0.19	0.02	0.73	0.73	XXX
93278		A	ECG/signal-averaged	0.25	1.25	NA	0.12	1.62	NA	XXX
93278	26	A	ECG/signal-averaged	0.25	0.10	0.10	0.01	0.36	0.36	XXX
93278	TC	A	ECG/signal-averaged	0.00	1.15	NA	0.11	1.26	NA	XXX
93303		A	Echo transthoracic	1.30	4.34	NA	0.27	5.91	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93303	26	A	Echo transthoracic	1.30	0.48	0.48	0.04	1.82	1.82	XXX
93303	TC	A	Echo transthoracic	0.00	3.86	NA	0.23	4.09	NA	XXX
93304		A	Echo transthoracic	0.75	2.22	NA	0.16	3.13	NA	XXX
93304	26	A	Echo transthoracic	0.75	0.28	0.28	0.03	1.06	1.06	XXX
93304	TC	A	Echo transthoracic	0.00	1.94	NA	0.13	2.07	NA	XXX
93307		A	Echo exam of heart	0.92	4.21	NA	0.26	5.39	NA	XXX
93307	26	A	Echo exam of heart	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93307	TC	A	Echo exam of heart	0.00	3.86	NA	0.23	4.09	NA	XXX
93308		A	Echo exam of heart	0.53	2.14	NA	0.15	2.82	NA	XXX
93308	26	A	Echo exam of heart	0.53	0.20	0.20	0.02	0.75	0.75	XXX
93308	TC	A	Echo exam of heart	0.00	1.94	NA	0.13	2.07	NA	XXX
93312		A	Echo transesophageal	2.20	4.57	NA	0.37	7.14	NA	XXX
93312	26	A	Echo transesophageal	2.20	0.79	0.79	0.08	3.07	3.07	XXX
93312	TC	A	Echo transesophageal	0.00	3.78	NA	0.29	4.07	NA	XXX
93313		A	Echo transesophageal	0.95	NA	0.21	0.06	NA	1.22	XXX
93314		A	Echo transesophageal	1.25	4.25	NA	0.34	5.84	NA	XXX
93314	26	A	Echo transesophageal	1.25	0.47	0.47	0.05	1.77	1.77	XXX
93314	TC	A	Echo transesophageal	0.00	3.78	NA	0.29	4.07	NA	XXX
93315		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93315	26	A	Echo transesophageal	2.78	1.01	1.01	0.11	3.90	3.90	XXX
93315	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93316		A	Echo transesophageal	0.95	NA	0.24	0.05	NA	1.24	XXX
93317		C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93317	26	A	Echo transesophageal	1.83	0.67	0.67	0.08	2.58	2.58	XXX
93317	TC	C	Echo transesophageal	0.00	0.00	NA	0.00	0.00	NA	XXX
93318		C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.48	0.48	0.14	2.82	2.82	XXX
93318	TC	C	Echo transesophageal intraop	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93320		A	Doppler echo exam, heart	0.38	1.86	NA	0.13	2.37	NA	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.15	0.15	0.01	0.54	0.54	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.71	NA	0.12	1.83	NA	ZZZ
93321		A	Doppler echo exam, heart	0.15	1.17	NA	0.09	1.41	NA	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.06	0.06	0.01	0.22	0.22	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	1.11	NA	0.08	1.19	NA	ZZZ
93325		A	Doppler color flow add-on	0.07	2.93	NA	0.22	3.22	NA	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.03	0.03	0.01	0.11	0.11	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	2.90	NA	0.21	3.11	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93350		A	Echo transthoracic	1.48	2.33	NA	0.18	3.99	NA	XXX
93350	26	A	Echo transthoracic	1.48	0.57	0.57	0.05	2.10	2.10	XXX
93350	TC	A	Echo transthoracic	0.00	1.76	NA	0.13	1.89	NA	XXX
93501		A	Right heart catheterization	3.02	18.05	NA	1.26	22.33	NA	000
93501	26	A	Right heart catheterization	3.02	1.15	1.15	0.21	4.38	4.38	000
93501	TC	A	Right heart catheterization	0.00	16.90	NA	1.05	17.95	NA	000
93503		A	Insert/place heart catheter	2.91	NA	0.68	0.20	NA	3.79	000
93505		A	Biopsy of heart lining	4.37	3.66	NA	0.48	8.51	NA	000
93505	26	A	Biopsy of heart lining	4.37	1.68	1.68	0.32	6.37	6.37	000
93505	TC	A	Biopsy of heart lining	0.00	1.98	NA	0.16	2.14	NA	000
93508		A	Cath placement, angiography	4.09	14.68	NA	0.93	19.70	NA	000
93508	26	A	Cath placement, angiography	4.09	2.08	2.08	0.28	6.45	6.45	000
93508	TC	A	Cath placement, angiography	0.00	12.60	NA	0.65	13.25	NA	000
93510		A	Left heart catheterization	4.32	39.12	NA	2.60	46.04	NA	000
93510	26	A	Left heart catheterization	4.32	2.17	2.17	0.30	6.79	6.79	000
93510	TC	A	Left heart catheterization	0.00	36.95	NA	2.30	39.25	NA	000
93511		A	Left heart catheterization	5.02	38.41	NA	2.58	46.01	NA	000
93511	26	A	Left heart catheterization	5.02	2.44	2.44	0.35	7.81	7.81	000
93511	TC	A	Left heart catheterization	0.00	35.97	NA	2.23	38.20	NA	000
93514		A	Left heart catheterization	7.04	39.09	NA	2.72	48.85	NA	000
93514	26	A	Left heart catheterization	7.04	3.12	3.12	0.49	10.65	10.65	000
93514	TC	A	Left heart catheterization	0.00	35.97	NA	2.23	38.20	NA	000
93524		A	Left heart catheterization	6.94	50.17	NA	3.41	60.52	NA	000
93524	26	A	Left heart catheterization	6.94	3.17	3.17	0.48	10.59	10.59	000
93524	TC	A	Left heart catheterization	0.00	47.00	NA	2.93	49.93	NA	000
93526		A	Rt & Lt heart catheters	5.98	51.10	NA	3.43	60.51	NA	000
93526	26	A	Rt & Lt heart catheters	5.98	2.81	2.81	0.41	9.20	9.20	000
93526	TC	A	Rt & Lt heart catheters	0.00	48.29	NA	3.02	51.31	NA	000
93527		A	Rt & Lt heart catheters	7.27	50.31	NA	3.43	61.01	NA	000
93527	26	A	Rt & Lt heart catheters	7.27	3.31	3.31	0.50	11.08	11.08	000
93527	TC	A	Rt & Lt heart catheters	0.00	47.00	NA	2.93	49.93	NA	000
93528		A	Rt & Lt heart catheters	8.99	51.03	NA	3.55	63.57	NA	000
93528	26	A	Rt & Lt heart catheters	8.99	4.03	4.03	0.62	13.64	13.64	000
93528	TC	A	Rt & Lt heart catheters	0.00	47.00	NA	2.93	49.93	NA	000
93529		A	Rt, lt heart catheterization	4.79	49.27	NA	3.26	57.32	NA	000
93529	26	A	Rt, lt heart catheterization	4.79	2.27	2.27	0.33	7.39	7.39	000
93529	TC	A	Rt, lt heart catheterization	0.00	47.00	NA	2.93	49.93	NA	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93530		A	Rt heart cath, congenital	4.22	18.83	NA	1.34	24.39	NA	000
93530	26	A	Rt heart cath, congenital	4.22	1.93	1.93	0.29	6.44	6.44	000
93530	TC	A	Rt heart cath, congenital	0.00	16.90	NA	1.05	17.95	NA	000
93531		A	R & I heart cath, congenital	8.34	51.87	NA	3.60	63.81	NA	000
93531	26	A	R & I heart cath, congenital	8.34	3.58	3.58	0.58	12.50	12.50	000
93531	TC	A	R & I heart cath, congenital	0.00	48.29	NA	3.02	51.31	NA	000
93532		A	R & I heart cath, congenital	9.99	51.25	NA	3.62	64.86	NA	000
93532	26	A	R & I heart cath, congenital	9.99	4.25	4.25	0.69	14.93	14.93	000
93532	TC	A	R & I heart cath, congenital	0.00	47.00	NA	2.93	49.93	NA	000
93533		A	R & I heart cath, congenital	6.69	49.79	NA	3.39	59.87	NA	000
93533	26	A	R & I heart cath, congenital	6.69	2.79	2.79	0.46	9.94	9.94	000
93533	TC	A	R & I heart cath, congenital	0.00	47.00	NA	2.93	49.93	NA	000
93539		A	Injection, cardiac cath	0.40	NA	0.16	0.01	NA	0.57	000
93540		A	Injection, cardiac cath	0.43	NA	0.17	0.01	NA	0.61	000
93541		A	Injection for lung angiogram	0.29	NA	0.11	0.01	NA	0.41	000
93542		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93543		A	Injection for heart x-rays	0.29	NA	0.11	0.01	NA	0.41	000
93544		A	Injection for aortography	0.25	NA	0.10	0.01	NA	0.36	000
93545		A	Inject for coronary x-rays	0.40	NA	0.16	0.01	NA	0.57	000
93555		A	Imaging, cardiac cath	0.81	6.59	NA	0.37	7.77	NA	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.32	0.32	0.03	1.16	1.16	XXX
93555	TC	A	Imaging, cardiac cath	0.00	6.27	NA	0.34	6.61	NA	XXX
93556		A	Imaging, cardiac cath	0.83	10.21	NA	0.54	11.58	NA	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.32	0.32	0.03	1.18	1.18	XXX
93556	TC	A	Imaging, cardiac cath	0.00	9.89	NA	0.51	10.40	NA	XXX
93561		A	Cardiac output measurement	0.50	0.68	NA	0.09	1.27	NA	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.03	0.69	0.69	000
93561	TC	A	Cardiac output measurement	0.00	0.52	NA	0.06	0.58	NA	000
93562		A	Cardiac output measurement	0.16	0.37	NA	0.05	0.58	NA	000
93562	26	A	Cardiac output measurement	0.16	0.05	0.05	0.01	0.22	0.22	000
93562	TC	A	Cardiac output measurement	0.00	0.32	NA	0.04	0.36	NA	000
93571		A	Heart flow reserve measure	1.80	5.24	NA	0.30	7.34	NA	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.68	0.68	0.06	2.54	2.54	ZZZ
93571	TC	A	Heart flow reserve measure	0.00	4.56	NA	0.24	4.80	NA	ZZZ
93572		A	Heart flow reserve measure	1.44	2.79	NA	0.18	4.41	NA	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.50	0.50	0.05	1.99	1.99	ZZZ
93572	TC	A	Heart flow reserve measure	0.00	2.29	NA	0.13	2.42	NA	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93580		A	Transcath closure of asd	17.97	NA	7.38	1.25	NA	26.60	000
93581		A	Transcath closure of vsd	24.39	NA	9.39	1.69	NA	35.47	000
93600		A	Bundle of His recording	2.12	2.78	NA	0.29	5.19	NA	000
93600	26	A	Bundle of His recording	2.12	0.83	0.83	0.16	3.11	3.11	000
93600	TC	A	Bundle of His recording	0.00	1.95	NA	0.13	2.08	NA	000
93602		A	Intra-atrial recording	2.12	1.93	NA	0.24	4.29	NA	000
93602	26	A	Intra-atrial recording	2.12	0.82	0.82	0.17	3.11	3.11	000
93602	TC	A	Intra-atrial recording	0.00	1.11	NA	0.07	1.18	NA	000
93603		A	Right ventricular recording	2.12	2.49	NA	0.29	4.90	NA	000
93603	26	A	Right ventricular recording	2.12	0.81	0.81	0.18	3.11	3.11	000
93603	TC	A	Right ventricular recording	0.00	1.68	NA	0.11	1.79	NA	000
93609		A	Map tachycardia, add-on	4.99	4.67	NA	0.52	10.18	NA	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.95	1.95	0.35	7.29	7.29	ZZZ
93609	TC	A	Map tachycardia, add-on	0.00	2.72	NA	0.17	2.89	NA	ZZZ
93610		A	Intra-atrial pacing	3.02	2.51	NA	0.35	5.88	NA	000
93610	26	A	Intra-atrial pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93610	TC	A	Intra-atrial pacing	0.00	1.35	NA	0.10	1.45	NA	000
93612		A	Intraventricular pacing	3.02	2.77	NA	0.36	6.15	NA	000
93612	26	A	Intraventricular pacing	3.02	1.16	1.16	0.25	4.43	4.43	000
93612	TC	A	Intraventricular pacing	0.00	1.61	NA	0.11	1.72	NA	000
93613		A	Electrophys map 3d, add-on	6.99	NA	2.76	0.48	NA	10.23	ZZZ
93615		A	Esophageal recording	0.99	0.59	NA	0.05	1.63	NA	000
93615	26	A	Esophageal recording	0.99	0.27	0.27	0.03	1.29	1.29	000
93615	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93616		A	Esophageal recording	1.49	0.75	NA	0.11	2.35	NA	000
93616	26	A	Esophageal recording	1.49	0.43	0.43	0.09	2.01	2.01	000
93616	TC	A	Esophageal recording	0.00	0.32	NA	0.02	0.34	NA	000
93618		A	Heart rhythm pacing	4.25	5.63	NA	0.38	10.26	NA	000
93618	26	A	Heart rhythm pacing	4.25	1.67	1.67	0.14	6.06	6.06	000
93618	TC	A	Heart rhythm pacing	0.00	3.96	NA	0.24	4.20	NA	000
93619		A	Electrophysiology evaluation	7.31	10.88	NA	0.71	18.90	NA	000
93619	26	A	Electrophysiology evaluation	7.31	3.18	3.18	0.24	10.73	10.73	000
93619	TC	A	Electrophysiology evaluation	0.00	7.70	NA	0.47	8.17	NA	000
93620		C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93620	26	A	Electrophysiology evaluation	11.57	4.84	4.84	0.38	16.79	16.79	000
93620	TC	C	Electrophysiology evaluation	0.00	0.00	NA	0.00	0.00	NA	000
93621		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93621	26	A	Electrophysiology evaluation	2.10	0.82	0.82	0.07	2.99	2.99	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622		C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.21	1.21	0.10	4.41	4.41	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623		C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	1.11	1.11	0.09	4.05	4.05	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93624		A	Electrophysiologic study	4.80	4.17	NA	0.28	9.25	NA	000
93624	26	A	Electrophysiologic study	4.80	2.19	2.19	0.15	7.14	7.14	000
93624	TC	A	Electrophysiologic study	0.00	1.98	NA	0.13	2.11	NA	000
93631		A	Heart pacing, mapping	7.59	8.92	NA	1.49	18.00	NA	000
93631	26	A	Heart pacing, mapping	7.59	2.77	2.77	0.87	11.23	11.23	000
93631	TC	A	Heart pacing, mapping	0.00	6.15	NA	0.62	6.77	NA	000
93640		A	Evaluation heart device	3.51	8.53	NA	0.54	12.58	NA	000
93640	26	A	Evaluation heart device	3.51	1.36	1.36	0.12	4.99	4.99	000
93640	TC	A	Evaluation heart device	0.00	7.17	NA	0.42	7.59	NA	000
93641		A	Electrophysiology evaluation	5.92	9.48	NA	0.62	16.02	NA	000
93641	26	A	Electrophysiology evaluation	5.92	2.31	2.31	0.20	8.43	8.43	000
93641	TC	A	Electrophysiology evaluation	0.00	7.17	NA	0.42	7.59	NA	000
93642		A	Electrophysiology evaluation	4.88	9.38	NA	0.58	14.84	NA	000
93642	26	A	Electrophysiology evaluation	4.88	2.21	2.21	0.16	7.25	7.25	000
93642	TC	A	Electrophysiology evaluation	0.00	7.17	NA	0.42	7.59	NA	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	4.43	0.73	NA	15.65	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	6.32	1.12	NA	23.67	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	6.88	1.22	NA	25.75	000
93660		A	Tilt table evaluation	1.89	2.42	NA	0.08	4.39	NA	000
93660	26	A	Tilt table evaluation	1.89	0.74	0.74	0.06	2.69	2.69	000
93660	TC	A	Tilt table evaluation	0.00	1.68	NA	0.02	1.70	NA	000
93662		C	Intracardiac ecg (ice)	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	1.11	1.11	0.09	4.00	4.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	0.00	NA	0.00	0.00	NA	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93701		A	Bioimpedance, thoracic	0.17	0.98	NA	0.02	1.17	NA	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.91	NA	0.01	0.92	NA	XXX
93720		A	Total body plethysmography	0.17	0.76	NA	0.07	1.00	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93721		A	Plethysmography tracing	0.00	0.71	NA	0.06	0.77	NA	XXX
93722		A	Plethysmography report	0.17	0.05	0.05	0.01	0.23	0.23	XXX
93724		A	Analyze pacemaker system	4.88	5.87	NA	0.40	11.15	NA	000
93724	26	A	Analyze pacemaker system	4.88	1.91	1.91	0.16	6.95	6.95	000
93724	TC	A	Analyze pacemaker system	0.00	3.96	NA	0.24	4.20	NA	000
93727		A	Analyze ilr system	0.52	0.20	0.20	0.02	0.74	0.74	XXX
93731		A	Analyze pacemaker system	0.45	0.66	NA	0.06	1.17	NA	XXX
93731	26	A	Analyze pacemaker system	0.45	0.17	0.17	0.02	0.64	0.64	XXX
93731	TC	A	Analyze pacemaker system	0.00	0.49	NA	0.04	0.53	NA	XXX
93732		A	Analyze pacemaker system	0.92	0.86	NA	0.07	1.85	NA	XXX
93732	26	A	Analyze pacemaker system	0.92	0.35	0.35	0.03	1.30	1.30	XXX
93732	TC	A	Analyze pacemaker system	0.00	0.51	NA	0.04	0.55	NA	XXX
93733		A	Telephone analy, pacemaker	0.17	0.80	NA	0.07	1.04	NA	XXX
93733	26	A	Telephone analy, pacemaker	0.17	0.07	0.07	0.01	0.25	0.25	XXX
93733	TC	A	Telephone analy, pacemaker	0.00	0.73	NA	0.06	0.79	NA	XXX
93734		A	Analyze pacemaker system	0.38	0.50	NA	0.03	0.91	NA	XXX
93734	26	A	Analyze pacemaker system	0.38	0.15	0.15	0.01	0.54	0.54	XXX
93734	TC	A	Analyze pacemaker system	0.00	0.35	NA	0.02	0.37	NA	XXX
93735		A	Analyze pacemaker system	0.74	0.72	NA	0.07	1.53	NA	XXX
93735	26	A	Analyze pacemaker system	0.74	0.28	0.28	0.03	1.05	1.05	XXX
93735	TC	A	Analyze pacemaker system	0.00	0.44	NA	0.04	0.48	NA	XXX
93736		A	Telephonic analy, pacemaker	0.15	0.69	NA	0.07	0.91	NA	XXX
93736	26	A	Telephonic analy, pacemaker	0.15	0.06	0.06	0.01	0.22	0.22	XXX
93736	TC	A	Telephonic analy, pacemaker	0.00	0.63	NA	0.06	0.69	NA	XXX
93740		B	Temperature gradient studies	+0.16	0.19	NA	0.02	0.37	NA	XXX
93740	26	B	Temperature gradient studies	+0.16	0.04	0.04	0.01	0.21	0.21	XXX
93740	TC	B	Temperature gradient studies	+0.00	0.15	NA	0.01	0.16	NA	XXX
93741		A	Analyze ht pace device sngl	0.80	0.98	NA	0.07	1.85	NA	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93741	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93742		A	Analyze ht pace device sngl	0.91	1.03	NA	0.07	2.01	NA	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93742	TC	A	Analyze ht pace device sngl	0.00	0.67	NA	0.04	0.71	NA	XXX
93743		A	Analyze ht pace device dual	1.03	1.13	NA	0.08	2.24	NA	XXX
93743	26	A	Analyze ht pace device dual	1.03	0.40	0.40	0.04	1.47	1.47	XXX
93743	TC	A	Analyze ht pace device dual	0.00	0.73	NA	0.04	0.77	NA	XXX
93744		A	Analyze ht pace device dual	1.18	1.13	NA	0.08	2.39	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93744	26	A	Analyze ht pace device dual	1.18	0.46	0.46	0.04	1.68	1.68	XXX
93744	TC	A	Analyze ht pace device dual	0.00	0.67	NA	0.04	0.71	NA	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93760		N	Cephalic thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93762		N	Peripheral thermogram	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	+0.16	0.08	NA	0.02	0.26	NA	XXX
93770	26	B	Measure venous pressure	+0.16	0.05	0.05	0.01	0.22	0.22	XXX
93770	TC	B	Measure venous pressure	+0.00	0.03	NA	0.01	0.04	NA	XXX
93784		A	Ambulatory BP monitoring	0.38	1.55	NA	0.03	1.96	NA	XXX
93786		A	Ambulatory BP recording	0.00	0.91	NA	0.01	0.92	NA	XXX
93788		A	Ambulatory BP analysis	0.00	0.51	NA	0.01	0.52	NA	XXX
93790		A	Review/report BP recording	0.38	0.13	0.13	0.01	0.52	0.52	XXX
93797		A	Cardiac rehab	0.18	0.30	0.07	0.01	0.49	0.26	000
93798		A	Cardiac rehab/monitor	0.28	0.46	0.11	0.01	0.75	0.40	000
93799		C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.33	NA	0.12	2.67	NA	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	0.31	0.31	XXX
93875	TC	A	Extracranial study	0.00	2.25	NA	0.11	2.36	NA	XXX
93880		A	Extracranial study	0.60	5.55	NA	0.39	6.54	NA	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.04	0.84	0.84	XXX
93880	TC	A	Extracranial study	0.00	5.35	NA	0.35	5.70	NA	XXX
93882		A	Extracranial study	0.40	3.50	NA	0.26	4.16	NA	XXX
93882	26	A	Extracranial study	0.40	0.14	0.14	0.04	0.58	0.58	XXX
93882	TC	A	Extracranial study	0.00	3.36	NA	0.22	3.58	NA	XXX
93886		A	Intracranial study	0.94	6.74	NA	0.45	8.13	NA	XXX
93886	26	A	Intracranial study	0.94	0.37	0.37	0.06	1.37	1.37	XXX
93886	TC	A	Intracranial study	0.00	6.37	NA	0.39	6.76	NA	XXX
93888		A	Intracranial study	0.62	4.24	NA	0.32	5.18	NA	XXX
93888	26	A	Intracranial study	0.62	0.23	0.23	0.05	0.90	0.90	XXX
93888	TC	A	Intracranial study	0.00	4.01	NA	0.27	4.28	NA	XXX
93890		A	Tcd, vasoreactivity study	1.00	4.90	NA	0.45	6.35	NA	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.40	0.40	0.06	1.46	1.46	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	4.50	NA	0.39	4.89	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
93892		A	Tcd, emboli detect w/o inj	1.15	5.16	NA	0.45	6.76	NA	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	4.70	NA	0.39	5.09	NA	XXX
93893		A	Tcd, emboli detect w/inj	1.15	5.03	NA	0.45	6.63	NA	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	4.57	NA	0.39	4.96	NA	XXX
93922		A	Extremity study	0.25	2.68	NA	0.15	3.08	NA	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	0.35	0.35	XXX
93922	TC	A	Extremity study	0.00	2.60	NA	0.13	2.73	NA	XXX
93923		A	Extremity study	0.45	4.03	NA	0.26	4.74	NA	XXX
93923	26	A	Extremity study	0.45	0.15	0.15	0.04	0.64	0.64	XXX
93923	TC	A	Extremity study	0.00	3.88	NA	0.22	4.10	NA	XXX
93924		A	Extremity study	0.50	4.79	NA	0.30	5.59	NA	XXX
93924	26	A	Extremity study	0.50	0.17	0.17	0.05	0.72	0.72	XXX
93924	TC	A	Extremity study	0.00	4.62	NA	0.25	4.87	NA	XXX
93925		A	Lower extremity study	0.58	6.78	NA	0.39	7.75	NA	XXX
93925	26	A	Lower extremity study	0.58	0.20	0.20	0.04	0.82	0.82	XXX
93925	TC	A	Lower extremity study	0.00	6.58	NA	0.35	6.93	NA	XXX
93926		A	Lower extremity study	0.39	4.05	NA	0.27	4.71	NA	XXX
93926	26	A	Lower extremity study	0.39	0.13	0.13	0.04	0.56	0.56	XXX
93926	TC	A	Lower extremity study	0.00	3.92	NA	0.23	4.15	NA	XXX
93930		A	Upper extremity study	0.46	5.35	NA	0.41	6.22	NA	XXX
93930	26	A	Upper extremity study	0.46	0.16	0.16	0.04	0.66	0.66	XXX
93930	TC	A	Upper extremity study	0.00	5.19	NA	0.37	5.56	NA	XXX
93931		A	Upper extremity study	0.31	3.48	NA	0.27	4.06	NA	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	0.44	0.44	XXX
93931	TC	A	Upper extremity study	0.00	3.38	NA	0.24	3.62	NA	XXX
93965		A	Extremity study	0.35	2.79	NA	0.14	3.28	NA	XXX
93965	26	A	Extremity study	0.35	0.12	0.12	0.02	0.49	0.49	XXX
93965	TC	A	Extremity study	0.00	2.67	NA	0.12	2.79	NA	XXX
93970		A	Extremity study	0.68	5.25	NA	0.45	6.38	NA	XXX
93970	26	A	Extremity study	0.68	0.23	0.23	0.05	0.96	0.96	XXX
93970	TC	A	Extremity study	0.00	5.02	NA	0.40	5.42	NA	XXX
93971		A	Extremity study	0.45	3.59	NA	0.30	4.34	NA	XXX
93971	26	A	Extremity study	0.45	0.15	0.15	0.03	0.63	0.63	XXX
93971	TC	A	Extremity study	0.00	3.44	NA	0.27	3.71	NA	XXX
93975		A	Vascular study	1.80	7.63	NA	0.56	9.99	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
93975	26	A	Vascular study	1.80	0.60	0.60	0.13	2.53	2.53	XXX
93975	TC	A	Vascular study	0.00	7.03	NA	0.43	7.46	NA	XXX
93976		A	Vascular study	1.21	4.33	NA	0.36	5.90	NA	XXX
93976	26	A	Vascular study	1.21	0.40	0.40	0.06	1.67	1.67	XXX
93976	TC	A	Vascular study	0.00	3.93	NA	0.30	4.23	NA	XXX
93978		A	Vascular study	0.65	4.51	NA	0.43	5.59	NA	XXX
93978	26	A	Vascular study	0.65	0.22	0.22	0.06	0.93	0.93	XXX
93978	TC	A	Vascular study	0.00	4.29	NA	0.37	4.66	NA	XXX
93979		A	Vascular study	0.44	3.21	NA	0.27	3.92	NA	XXX
93979	26	A	Vascular study	0.44	0.15	0.15	0.03	0.62	0.62	XXX
93979	TC	A	Vascular study	0.00	3.06	NA	0.24	3.30	NA	XXX
93980		A	Penile vascular study	1.25	2.85	NA	0.42	4.52	NA	XXX
93980	26	A	Penile vascular study	1.25	0.41	0.41	0.08	1.74	1.74	XXX
93980	TC	A	Penile vascular study	0.00	2.44	NA	0.34	2.78	NA	XXX
93981		A	Penile vascular study	0.44	2.87	NA	0.33	3.64	NA	XXX
93981	26	A	Penile vascular study	0.44	0.14	0.14	0.02	0.60	0.60	XXX
93981	TC	A	Penile vascular study	0.00	2.73	NA	0.31	3.04	NA	XXX
93990		A	Doppler flow testing	0.25	3.99	NA	0.26	4.50	NA	XXX
93990	26	A	Doppler flow testing	0.25	0.09	0.09	0.03	0.37	0.37	XXX
93990	TC	A	Doppler flow testing	0.00	3.90	NA	0.23	4.13	NA	XXX
94010		A	Breathing capacity test	0.17	0.67	NA	0.03	0.87	NA	XXX
94010	26	A	Breathing capacity test	0.17	0.05	0.05	0.01	0.23	0.23	XXX
94010	TC	A	Breathing capacity test	0.00	0.62	NA	0.02	0.64	NA	XXX
94014		A	Patient recorded spirometry	0.52	0.76	NA	0.03	1.31	NA	XXX
94015		A	Patient recorded spirometry	0.00	0.59	NA	0.01	0.60	NA	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	0.71	0.71	XXX
94060		A	Evaluation of wheezing	0.31	1.07	NA	0.07	1.45	NA	XXX
94060	26	A	Evaluation of wheezing	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94060	TC	A	Evaluation of wheezing	0.00	0.98	NA	0.06	1.04	NA	XXX
94070		A	Evaluation of wheezing	0.60	0.82	NA	0.13	1.55	NA	XXX
94070	26	A	Evaluation of wheezing	0.60	0.18	0.18	0.03	0.81	0.81	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.64	NA	0.10	0.74	NA	XXX
94150		B	Vital capacity test	+0.07	0.47	NA	0.02	0.56	NA	XXX
94150	26	B	Vital capacity test	+0.07	0.03	0.03	0.01	0.11	0.11	XXX
94150	TC	B	Vital capacity test	+0.00	0.44	NA	0.01	0.45	NA	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.44	NA	0.03	0.58	NA	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	0.15	0.15	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.41	NA	0.02	0.43	NA	XXX
94240		A	Residual lung capacity	0.26	0.66	NA	0.06	0.98	NA	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94240	TC	A	Residual lung capacity	0.00	0.58	NA	0.05	0.63	NA	XXX
94250		A	Expired gas collection	0.11	0.64	NA	0.02	0.77	NA	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	0.15	0.15	XXX
94250	TC	A	Expired gas collection	0.00	0.61	NA	0.01	0.62	NA	XXX
94260		A	Thoracic gas volume	0.13	0.58	NA	0.05	0.76	NA	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	0.18	0.18	XXX
94260	TC	A	Thoracic gas volume	0.00	0.54	NA	0.04	0.58	NA	XXX
94350		A	Lung nitrogen washout curve	0.26	0.76	NA	0.05	1.07	NA	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.68	NA	0.04	0.72	NA	XXX
94360		A	Measure airflow resistance	0.26	0.70	NA	0.07	1.03	NA	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94360	TC	A	Measure airflow resistance	0.00	0.62	NA	0.06	0.68	NA	XXX
94370		A	Breath airway closing volume	0.26	0.72	NA	0.03	1.01	NA	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94370	TC	A	Breath airway closing volume	0.00	0.64	NA	0.02	0.66	NA	XXX
94375		A	Respiratory flow volume loop	0.31	0.60	NA	0.03	0.94	NA	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.09	0.09	0.01	0.41	0.41	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.51	NA	0.02	0.53	NA	XXX
94400		A	CO2 breathing response curve	0.40	0.84	NA	0.09	1.33	NA	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.03	0.55	0.55	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.72	NA	0.06	0.78	NA	XXX
94450		A	Hypoxia response curve	0.40	0.85	NA	0.04	1.29	NA	XXX
94450	26	A	Hypoxia response curve	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94450	TC	A	Hypoxia response curve	0.00	0.73	NA	0.02	0.75	NA	XXX
94452		A	Hast w/report	0.31	1.02	NA	0.04	1.37	NA	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	0.42	0.42	XXX
94452	TC	A	Hast w/report	0.00	0.93	NA	0.02	0.95	NA	XXX
94453		A	Hast w/oxygen titrate	0.40	1.51	NA	0.04	1.95	NA	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.12	0.12	0.02	0.54	0.54	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.39	NA	0.02	1.41	NA	XXX
94620		A	Pulmonary stress test/simple	0.64	2.49	NA	0.13	3.26	NA	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	0.87	0.87	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	2.29	NA	0.10	2.39	NA	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
94621		A	Pulm stress test/complex	1.42	2.20	NA	0.16	3.78	NA	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.44	0.06	1.92	1.92	XXX
94621	TC	A	Pulm stress test/complex	0.00	1.76	NA	0.10	1.86	NA	XXX
94640		A	Airway inhalation treatment	0.00	0.30	NA	0.02	0.32	NA	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94656		A	Initial ventilator mgmt	1.22	1.16	0.32	0.07	2.45	1.61	XXX
94657		A	Continued ventilator mgmt	0.83	0.98	0.25	0.04	1.85	1.12	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.65	0.23	0.04	1.45	1.03	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.23	0.03	NA	1.02	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.31	NA	0.04	0.35	NA	XXX
94667		A	Chest wall manipulation	0.00	0.52	NA	0.05	0.57	NA	XXX
94668		A	Chest wall manipulation	0.00	0.45	NA	0.02	0.47	NA	XXX
94680		A	Exhaled air analysis, o2	0.26	1.86	NA	0.07	2.19	NA	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.78	NA	0.06	1.84	NA	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	2.52	NA	0.13	2.85	NA	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.06	0.06	0.01	0.27	0.27	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	2.46	NA	0.12	2.58	NA	XXX
94690		A	Exhaled air analysis	0.07	1.99	NA	0.05	2.11	NA	XXX
94690	26	A	Exhaled air analysis	0.07	0.02	0.02	0.01	0.10	0.10	XXX
94690	TC	A	Exhaled air analysis	0.00	1.97	NA	0.04	2.01	NA	XXX
94720		A	Monoxide diffusing capacity	0.26	1.00	NA	0.07	1.33	NA	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.92	NA	0.06	0.98	NA	XXX
94725		A	Membrane diffusion capacity	0.26	2.91	NA	0.13	3.30	NA	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	0.35	0.35	XXX
94725	TC	A	Membrane diffusion capacity	0.00	2.83	NA	0.12	2.95	NA	XXX
94750		A	Pulmonary compliance study	0.23	1.34	NA	0.05	1.62	NA	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	0.31	0.31	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.27	NA	0.04	1.31	NA	XXX
94760		T	Measure blood oxygen level	0.00	0.04	NA	0.02	0.06	NA	XXX
94761		T	Measure blood oxygen level	0.00	0.07	NA	0.06	0.13	NA	XXX
94762		A	Measure blood oxygen level	0.00	0.47	NA	0.10	0.57	NA	XXX
94770		A	Exhaled carbon dioxide test	0.15	0.75	NA	0.08	0.98	NA	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.04	0.04	0.01	0.20	0.20	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	0.71	NA	0.07	0.78	NA	XXX
94772		C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799		C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.00	0.10	NA	0.01	0.11	NA	XXX
95010		A	Percut allergy titrate test	0.15	0.32	0.06	0.01	0.48	0.22	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.14	0.06	0.01	0.30	0.22	XXX
95024		A	Id allergy test, drug/bug	0.00	0.15	NA	0.01	0.16	NA	XXX
95027		A	Id allergy titrate-airborne	0.00	0.15	NA	0.01	0.16	NA	XXX
95028		A	Id allergy test-delayed type	0.00	0.23	NA	0.01	0.24	NA	XXX
95044		A	Allergy patch tests	0.00	0.20	NA	0.01	0.21	NA	XXX
95052		A	Photo patch test	0.00	0.25	NA	0.01	0.26	NA	XXX
95056		A	Photosensitivity tests	0.00	0.17	NA	0.01	0.18	NA	XXX
95060		A	Eye allergy tests	0.00	0.35	NA	0.02	0.37	NA	XXX
95065		A	Nose allergy test	0.00	0.20	NA	0.01	0.21	NA	XXX
95070		A	Bronchial allergy tests	0.00	2.28	NA	0.02	2.30	NA	XXX
95071		A	Bronchial allergy tests	0.00	2.92	NA	0.02	2.94	NA	XXX
95075		A	Ingestion challenge test	0.95	0.82	0.38	0.03	1.80	1.36	XXX
95078		A	Provocative testing	0.00	0.25	NA	0.02	0.27	NA	XXX
95115		A	Immunotherapy, one injection	0.00	0.39	NA	0.02	0.41	NA	000
95117		A	Immunotherapy injections	0.00	0.50	NA	0.02	0.52	NA	000
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	000
95145		A	Antigen therapy services	0.06	0.32	0.02	0.01	0.39	0.09	000
95146		A	Antigen therapy services	0.06	0.44	0.03	0.01	0.51	0.10	000
95147		A	Antigen therapy services	0.06	0.42	0.02	0.01	0.49	0.09	000
95148		A	Antigen therapy services	0.06	0.56	0.03	0.01	0.65	0.10	000
95149		A	Antigen therapy services	0.06	0.80	0.03	0.01	0.87	0.10	000
95165		A	Antigen therapy services	0.06	0.19	0.02	0.01	0.26	0.09	000
95170		A	Antigen therapy services	0.06	0.13	0.03	0.01	0.20	0.10	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95180		A	Rapid desensitization	2.01	2.03	0.93	0.05	4.09	2.99	000
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	0.00	0.00	000
95250		A	Glucose monitoring, cont	0.00	4.10	NA	0.01	4.11	NA	XXX
95805		A	Multiple sleep latency test	1.88	17.26	NA	0.43	19.57	NA	XXX
95805	26	A	Multiple sleep latency test	1.88	0.66	0.66	0.09	2.63	2.63	XXX
95805	TC	A	Multiple sleep latency test	0.00	16.60	NA	0.34	16.94	NA	XXX
95806		A	Sleep study, unattended	1.66	3.33	NA	0.38	5.37	NA	XXX
95806	26	A	Sleep study, unattended	1.66	0.54	0.54	0.07	2.27	2.27	XXX
95806	TC	A	Sleep study, unattended	0.00	2.79	NA	0.31	3.10	NA	XXX
95807		A	Sleep study, attended	1.66	11.85	NA	0.50	14.01	NA	XXX
95807	26	A	Sleep study, attended	1.66	0.53	0.53	0.08	2.27	2.27	XXX
95807	TC	A	Sleep study, attended	0.00	11.32	NA	0.42	11.74	NA	XXX
95808		A	Polysomnography, 1-3	2.65	13.19	NA	0.55	16.39	NA	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.92	0.92	0.13	3.70	3.70	XXX
95808	TC	A	Polysomnography, 1-3	0.00	12.27	NA	0.42	12.69	NA	XXX
95810		A	Polysomnography, 4 or more	3.52	17.49	NA	0.59	21.60	NA	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.18	1.18	0.17	4.87	4.87	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	16.31	NA	0.42	16.73	NA	XXX
95811		A	Polysomnography w/cpap	3.79	19.19	NA	0.61	23.59	NA	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.27	1.27	0.18	5.24	5.24	XXX
95811	TC	A	Polysomnography w/cpap	0.00	17.92	NA	0.43	18.35	NA	XXX
95812		A	Eeg, 41-60 minutes	1.08	4.03	NA	0.17	5.28	NA	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.45	0.45	0.06	1.59	1.59	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	3.58	NA	0.11	3.69	NA	XXX
95813		A	Eeg, over 1 hour	1.73	5.02	NA	0.21	6.96	NA	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.70	0.70	0.10	2.53	2.53	XXX
95813	TC	A	Eeg, over 1 hour	0.00	4.32	NA	0.11	4.43	NA	XXX
95816		A	Eeg, awake and drowsy	1.08	3.71	NA	0.16	4.95	NA	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	3.25	NA	0.10	3.35	NA	XXX
95819		A	Eeg, awake and asleep	1.08	2.98	NA	0.16	4.22	NA	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95819	TC	A	Eeg, awake and asleep	0.00	2.52	NA	0.10	2.62	NA	XXX
95822		A	Eeg, coma or sleep only	1.08	4.60	NA	0.19	5.87	NA	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.46	0.46	0.06	1.60	1.60	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	4.14	NA	0.13	4.27	NA	XXX
95824		C	Eeg, cerebral death only	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95824	26	A	Eeg, cerebral death only	0.74	0.31	0.31	0.04	1.09	1.09	XXX
95824	TC	C	Eeg, cerebral death only	0.00	0.00	NA	0.00	0.00	NA	XXX
95827		A	Eeg, all night recording	1.08	2.70	NA	0.19	3.97	NA	XXX
95827	26	A	Eeg, all night recording	1.08	0.41	0.41	0.05	1.54	1.54	XXX
95827	TC	A	Eeg, all night recording	0.00	2.29	NA	0.14	2.43	NA	XXX
95829		A	Surgery electrocorticogram	6.20	31.00	NA	0.50	37.70	NA	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.31	2.31	0.48	8.99	8.99	XXX
95829	TC	A	Surgery electrocorticogram	0.00	28.69	NA	0.02	28.71	NA	XXX
95830		A	Insert electrodes for EEG	1.70	3.29	0.73	0.11	5.10	2.54	XXX
95831		A	Limb muscle testing, manual	0.28	0.46	0.13	0.01	0.75	0.42	XXX
95832		A	Hand muscle testing, manual	0.29	0.33	0.12	0.02	0.64	0.43	XXX
95833		A	Body muscle testing, manual	0.47	0.58	0.23	0.02	1.07	0.72	XXX
95834		A	Body muscle testing, manual	0.60	0.63	0.28	0.03	1.26	0.91	XXX
95851		A	Range of motion measurements	0.16	0.36	0.08	0.01	0.53	0.25	XXX
95852		A	Range of motion measurements	0.11	0.26	0.05	0.01	0.38	0.17	XXX
95857		A	Tensilon test	0.53	0.60	0.23	0.02	1.15	0.78	XXX
95858		A	Tensilon test & myogram	1.56	1.07	NA	0.12	2.75	NA	XXX
95858	26	A	Tensilon test & myogram	1.56	0.67	0.67	0.08	2.31	2.31	XXX
95858	TC	A	Tensilon test & myogram	0.00	0.40	NA	0.04	0.44	NA	XXX
95860		A	Muscle test, one limb	0.96	1.42	NA	0.07	2.45	NA	XXX
95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	1.43	1.43	XXX
95860	TC	A	Muscle test, one limb	0.00	1.00	NA	0.02	1.02	NA	XXX
95861		A	Muscle test, 2 limbs	1.54	1.41	NA	0.14	3.09	NA	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.68	0.68	0.08	2.30	2.30	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	0.73	NA	0.06	0.79	NA	XXX
95863		A	Muscle test, 3 limbs	1.87	1.74	NA	0.15	3.76	NA	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.80	0.80	0.09	2.76	2.76	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	0.94	NA	0.06	1.00	NA	XXX
95864		A	Muscle test, 4 limbs	1.99	2.65	NA	0.22	4.86	NA	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.87	0.87	0.10	2.96	2.96	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	1.78	NA	0.12	1.90	NA	XXX
95867		A	Muscle test cran nerv unilat	0.79	0.93	NA	0.07	1.79	NA	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.35	0.35	0.03	1.17	1.17	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	0.58	NA	0.04	0.62	NA	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.21	NA	0.11	2.50	NA	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.51	0.51	0.06	1.75	1.75	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	0.70	NA	0.05	0.75	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95869		A	Muscle test, thor paraspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95870		A	Muscle test, nonparaspinal	0.37	0.37	NA	0.04	0.78	NA	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	0.55	0.55	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	0.21	NA	0.02	0.23	NA	XXX
95872		A	Muscle test, one fiber	1.50	1.23	NA	0.13	2.86	NA	XXX
95872	26	A	Muscle test, one fiber	1.50	0.63	0.63	0.08	2.21	2.21	XXX
95872	TC	A	Muscle test, one fiber	0.00	0.60	NA	0.05	0.65	NA	XXX
95875		A	Limb exercise test	1.10	1.45	NA	0.11	2.66	NA	XXX
95875	26	A	Limb exercise test	1.10	0.47	0.47	0.05	1.62	1.62	XXX
95875	TC	A	Limb exercise test	0.00	0.98	NA	0.06	1.04	NA	XXX
95900		A	Motor nerve conduction test	0.42	1.26	NA	0.04	1.72	NA	XXX
95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	0.62	0.62	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.02	1.10	NA	XXX
95903		A	Motor nerve conduction test	0.60	1.19	NA	0.05	1.84	NA	XXX
95903	26	A	Motor nerve conduction test	0.60	0.26	0.26	0.03	0.89	0.89	XXX
95903	TC	A	Motor nerve conduction test	0.00	0.93	NA	0.02	0.95	NA	XXX
95904		A	Sense nerve conduction test	0.34	1.09	NA	0.04	1.47	NA	XXX
95904	26	A	Sense nerve conduction test	0.34	0.15	0.15	0.02	0.51	0.51	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.94	NA	0.02	0.96	NA	XXX
95920		A	Intraop nerve test add-on	2.11	2.24	NA	0.23	4.58	NA	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.93	0.93	0.16	3.20	3.20	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95921		A	Autonomic nerv function test	0.90	0.71	NA	0.06	1.67	NA	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	1.27	1.27	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95922		A	Autonomic nerv function test	0.96	0.78	NA	0.07	1.81	NA	XXX
95922	26	A	Autonomic nerv function test	0.96	0.40	0.40	0.05	1.41	1.41	XXX
95922	TC	A	Autonomic nerv function test	0.00	0.38	NA	0.02	0.40	NA	XXX
95923		A	Autonomic nerv function test	0.90	1.94	NA	0.07	2.91	NA	XXX
95923	26	A	Autonomic nerv function test	0.90	0.38	0.38	0.05	1.33	1.33	XXX
95923	TC	A	Autonomic nerv function test	0.00	1.56	NA	0.02	1.58	NA	XXX
95925		A	Somatosensory testing	0.54	1.13	NA	0.10	1.77	NA	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.04	0.80	0.80	XXX
95925	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95926		A	Somatosensory testing	0.54	1.14	NA	0.09	1.77	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95926	26	A	Somatosensory testing	0.54	0.23	0.23	0.03	0.80	0.80	XXX
95926	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95927		A	Somatosensory testing	0.54	1.16	NA	0.09	1.79	NA	XXX
95927	26	A	Somatosensory testing	0.54	0.25	0.25	0.03	0.82	0.82	XXX
95927	TC	A	Somatosensory testing	0.00	0.91	NA	0.06	0.97	NA	XXX
95928		A	C motor evoked, uppr limbs	1.50	3.02	NA	0.09	4.61	NA	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	2.37	NA	0.03	2.40	NA	XXX
95929		A	C motor evoked, lwr limbs	1.50	3.21	NA	0.09	4.80	NA	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	2.56	NA	0.03	2.59	NA	XXX
95930		A	Visual evoked potential test	0.35	2.24	NA	0.03	2.62	NA	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	0.52	0.52	XXX
95930	TC	A	Visual evoked potential test	0.00	2.09	NA	0.01	2.10	NA	XXX
95933		A	Blink reflex test	0.59	1.02	NA	0.10	1.71	NA	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.04	0.87	0.87	XXX
95933	TC	A	Blink reflex test	0.00	0.78	NA	0.06	0.84	NA	XXX
95934		A	H-reflex test	0.51	0.43	NA	0.04	0.98	NA	XXX
95934	26	A	H-reflex test	0.51	0.22	0.22	0.02	0.75	0.75	XXX
95934	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95936		A	H-reflex test	0.55	0.45	NA	0.05	1.05	NA	XXX
95936	26	A	H-reflex test	0.55	0.24	0.24	0.03	0.82	0.82	XXX
95936	TC	A	H-reflex test	0.00	0.21	NA	0.02	0.23	NA	XXX
95937		A	Neuromuscular junction test	0.65	0.61	NA	0.09	1.35	NA	XXX
95937	26	A	Neuromuscular junction test	0.65	0.27	0.27	0.07	0.99	0.99	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.34	NA	0.02	0.36	NA	XXX
95950		A	Ambulatory eeg monitoring	1.51	3.93	NA	0.51	5.95	NA	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.64	0.64	0.08	2.23	2.23	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	3.29	NA	0.43	3.72	NA	XXX
95951		C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.55	2.55	0.33	8.87	8.87	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	0.00	NA	0.00	0.00	NA	XXX
95953		A	EEG monitoring/computer	3.08	7.62	NA	0.60	11.30	NA	XXX
95953	26	A	EEG monitoring/computer	3.08	1.29	1.29	0.17	4.54	4.54	XXX
95953	TC	A	EEG monitoring/computer	0.00	6.33	NA	0.43	6.76	NA	XXX
95954		A	EEG monitoring/giving drugs	2.45	4.22	NA	0.19	6.86	NA	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	1.04	1.04	0.13	3.62	3.62	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95954	TC	A	EEG monitoring/giving drugs	0.00	3.18	NA	0.06	3.24	NA	XXX
95955		A	EEG during surgery	1.01	2.32	NA	0.23	3.56	NA	XXX
95955	26	A	EEG during surgery	1.01	0.36	0.36	0.06	1.43	1.43	XXX
95955	TC	A	EEG during surgery	0.00	1.96	NA	0.17	2.13	NA	XXX
95956		A	Eeg monitoring, cable/radio	3.08	15.41	NA	0.59	19.08	NA	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.30	1.30	0.16	4.54	4.54	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	14.11	NA	0.43	14.54	NA	XXX
95957		A	EEG digital analysis	1.98	2.55	NA	0.23	4.76	NA	XXX
95957	26	A	EEG digital analysis	1.98	0.85	0.85	0.11	2.94	2.94	XXX
95957	TC	A	EEG digital analysis	0.00	1.70	NA	0.12	1.82	NA	XXX
95958		A	EEG monitoring/function test	4.24	3.48	NA	0.37	8.09	NA	XXX
95958	26	A	EEG monitoring/function test	4.24	1.74	1.74	0.24	6.22	6.22	XXX
95958	TC	A	EEG monitoring/function test	0.00	1.74	NA	0.13	1.87	NA	XXX
95961		A	Electrode stimulation, brain	2.97	2.63	NA	0.54	6.14	NA	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.32	1.32	0.47	4.76	4.76	XXX
95961	TC	A	Electrode stimulation, brain	0.00	1.31	NA	0.07	1.38	NA	XXX
95962		A	Electrode stim, brain add-on	3.21	2.70	NA	0.39	6.30	NA	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.39	1.39	0.32	4.92	4.92	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.31	NA	0.07	1.38	NA	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.42	3.42	0.45	11.86	11.86	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966		C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95966	26	A	Meg, evoked, single	3.99	1.71	1.71	0.19	5.89	5.89	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
95967		C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95967	26	A	Meg, evoked, each add'l	3.49	1.18	1.18	0.15	4.82	4.82	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
95970		A	Analyze neurostim, no prog	0.45	0.85	0.14	0.03	1.33	0.62	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973		A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95974		A	Cranial neurostim, complex	3.00	1.70	1.30	0.17	4.87	4.47	XXX
95975		A	Cranial neurostim, complex	1.70	0.89	0.73	0.12	2.71	2.55	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.93	1.30	0.18	5.61	4.98	XXX
95979		A	Analyz neurostim brain addon	1.64	0.87	0.69	0.08	2.59	2.41	ZZZ
95990		A	Spin/brain pump refil & main	0.00	1.50	NA	0.06	1.56	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
95991		A	Spin/brain pump refil & main	0.77	1.46	0.17	0.06	2.29	1.00	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	0.53	0.11	NA	2.44	XXX
96001		A	Motion test w/ft press meas	2.15	NA	0.66	0.10	NA	2.91	XXX
96002		A	Dynamic surface emg	0.41	NA	0.15	0.02	NA	0.58	XXX
96003		A	Dynamic fine wire emg	0.37	NA	0.12	0.02	NA	0.51	XXX
96004		A	Phys review of motion tests	2.14	0.94	0.94	0.11	3.19	3.19	XXX
96100		A	Psychological testing	0.00	1.76	NA	0.18	1.94	NA	XXX
96105		A	Assessment of aphasia	0.00	1.76	NA	0.18	1.94	NA	XXX
96110		A	Developmental test, lim	0.00	0.18	NA	0.18	0.36	NA	XXX
96111		A	Developmental test, extend	2.60	1.05	NA	0.18	3.83	NA	XXX
96115		A	Neurobehavior status exam	0.00	1.76	NA	0.18	1.94	NA	XXX
96117		A	Neuropsych test battery	0.00	1.76	NA	0.18	1.94	NA	XXX
96150		A	Assess hlth/behave, init	0.50	0.18	0.18	0.01	0.69	0.69	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.18	0.17	0.01	0.67	0.66	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.17	0.16	0.01	0.64	0.63	XXX
96153		A	Intervene hlth/behave, group	0.10	0.04	0.03	0.01	0.15	0.14	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.17	0.16	0.01	0.63	0.62	XXX
96155		N	Interv hlth/behav fam no pt	+0.44	0.18	0.17	0.02	0.64	0.63	XXX
96400		I	Chemotherapy, sc/im	+0.17	1.12	1.12	0.01	1.30	1.30	XXX
96405		A	Intralesional chemo admin	0.52	2.30	0.24	0.03	2.85	0.79	000
96406		A	Intralesional chemo admin	0.80	3.01	0.29	0.03	3.84	1.12	000
96408		I	Chemotherapy, push technique	+0.17	2.91	2.91	0.06	3.14	3.14	XXX
96410		I	Chemotherapy,infusion method	+0.17	4.16	4.16	0.08	4.41	4.41	XXX
96412		I	Chemo, infuse method add-on	+0.17	0.74	0.74	0.07	0.98	0.98	ZZZ
96414		I	Chemo, infuse method add-on	+0.17	5.22	5.22	0.08	5.47	5.47	XXX
96420		A	Chemotherapy, push technique	0.17	2.65	NA	0.08	2.90	NA	XXX
96422		A	Chemotherapy,infusion method	0.17	4.83	NA	0.08	5.08	NA	XXX
96423		A	Chemo, infuse method add-on	0.17	1.88	NA	0.02	2.07	NA	ZZZ
96425		A	Chemotherapy,infusion method	0.17	4.47	NA	0.08	4.72	NA	XXX
96440		A	Chemotherapy, intracavitary	2.37	7.93	1.23	0.16	10.46	3.76	000
96445		A	Chemotherapy, intracavitary	2.20	8.03	1.18	0.14	10.37	3.52	000
96450		A	Chemotherapy, into CNS	1.89	6.94	1.09	0.09	8.92	3.07	000
96520		A	Port pump refill & main	0.21	3.76	NA	0.06	4.03	NA	XXX
96530		A	Syst pump refill & main	0.21	2.64	NA	0.06	2.91	NA	XXX
96542		A	Chemotherapy injection	1.42	4.23	0.66	0.07	5.72	2.15	XXX
96545		B	Provide chemotherapy agent	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	0.96	NA	0.04	1.00	NA	XXX
96570		A	Photodynamic tx, 30 min	1.10	NA	0.37	0.11	NA	1.58	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	NA	0.19	0.03	NA	0.77	ZZZ
96900		A	Ultraviolet light therapy	0.00	0.44	NA	0.02	0.46	NA	XXX
96902		B	Trichogram	+0.41	0.18	0.16	0.01	0.60	0.58	XXX
96910		A	Photochemotherapy with UV-B	0.00	0.99	NA	0.04	1.03	NA	XXX
96912		A	Photochemotherapy with UV-A	0.00	1.26	NA	0.05	1.31	NA	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	1.68	NA	0.10	1.78	NA	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	2.53	0.56	0.03	3.71	1.74	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	2.60	0.57	0.03	3.80	1.77	000
96922		A	Laser tx, skin > 500 sq cm	2.10	3.48	0.62	0.05	5.63	2.77	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.75	0.45	0.05	2.00	1.70	XXX
97002		A	Pt re-evaluation	0.60	0.44	0.23	0.02	1.06	0.85	XXX
97003		A	Ot evaluation	1.20	0.88	0.40	0.06	2.14	1.66	XXX
97004		A	Ot re-evaluation	0.60	0.67	0.19	0.02	1.29	0.81	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	+0.06	0.05	NA	0.01	0.12	NA	XXX
97012		A	Mechanical traction therapy	0.25	0.13	NA	0.01	0.39	NA	XXX
97014		I	Electric stimulation therapy	+0.18	0.19	0.19	0.01	0.38	0.38	XXX
97016		A	Vasopneumatic device therapy	0.18	0.18	NA	0.01	0.37	NA	XXX
97018		A	Paraffin bath therapy	0.06	0.10	NA	0.01	0.17	NA	XXX
97020		A	Microwave therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97022		A	Whirlpool therapy	0.17	0.21	NA	0.01	0.39	NA	XXX
97024		A	Diathermy treatment	0.06	0.07	NA	0.01	0.14	NA	XXX
97026		A	Infrared therapy	0.06	0.06	NA	0.01	0.13	NA	XXX
97028		A	Ultraviolet therapy	0.08	0.07	NA	0.01	0.16	NA	XXX
97032		A	Electrical stimulation	0.25	0.16	NA	0.01	0.42	NA	XXX
97033		A	Electric current therapy	0.26	0.27	NA	0.01	0.54	NA	XXX
97034		A	Contrast bath therapy	0.21	0.15	NA	0.01	0.37	NA	XXX
97035		A	Ultrasound therapy	0.21	0.10	NA	0.01	0.32	NA	XXX
97036		A	Hydrotherapy	0.28	0.32	NA	0.01	0.61	NA	XXX
97039		A	Physical therapy treatment	0.20	0.10	NA	0.01	0.31	NA	XXX
97110		A	Therapeutic exercises	0.45	0.27	NA	0.02	0.74	NA	XXX
97112		A	Neuromuscular reeducation	0.45	0.31	NA	0.02	0.78	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
97113		A	Aquatic therapy/exercises	0.44	0.39	NA	0.02	0.85	NA	XXX
97116		A	Gait training therapy	0.40	0.24	NA	0.01	0.65	NA	XXX
97124		A	Massage therapy	0.35	0.23	NA	0.01	0.59	NA	XXX
97139		A	Physical medicine procedure	0.21	0.20	NA	0.01	0.42	NA	XXX
97140		A	Manual therapy	0.43	0.25	NA	0.02	0.70	NA	XXX
97150		A	Group therapeutic procedures	0.27	0.18	NA	0.01	0.46	NA	XXX
97504		A	Orthotic training	0.45	0.33	NA	0.03	0.81	NA	XXX
97520		A	Prosthetic training	0.45	0.27	NA	0.02	0.74	NA	XXX
97530		A	Therapeutic activities	0.44	0.32	NA	0.02	0.78	NA	XXX
97532		A	Cognitive skills development	0.44	0.20	NA	0.01	0.65	NA	XXX
97533		A	Sensory integration	0.44	0.24	NA	0.01	0.69	NA	XXX
97535		A	Self care mngment training	0.45	0.33	NA	0.01	0.79	NA	XXX
97537		A	Community/work reintegration	0.45	0.26	NA	0.01	0.72	NA	XXX
97542		A	Wheelchair mngment training	0.45	0.28	NA	0.01	0.74	NA	XXX
97545		R	Work hardening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	0.66	NA	0.05	1.29	NA	XXX
97598		A	Active wound care > 20 cm	0.80	0.79	NA	0.05	1.64	NA	XXX
97602		B	Wound(s) care non-selective	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97605		B	Neg press wound tx, < 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97606		B	Neg press wound tx, > 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97703		A	Prosthetic checkout	0.25	0.41	NA	0.02	0.68	NA	XXX
97750		A	Physical performance test	0.45	0.32	NA	0.02	0.79	NA	XXX
97755		A	Assistive technology assess	0.62	0.28	NA	0.02	0.92	NA	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.00	0.47	NA	0.01	0.48	NA	XXX
97803		A	Med nutrition, indiv, subseq	0.00	0.47	NA	0.01	0.48	NA	XXX
97804		A	Medical nutrition, group	0.00	0.18	NA	0.01	0.19	NA	XXX
97810		N	Acupunct w/o stimul 15 min	+0.60	0.00	0.00	0.03	0.63	0.63	XXX
97811		N	Acupunct w/o stimul addl 15m	+0.50	0.00	0.00	0.03	0.53	0.53	ZZZ
97813		N	Acupunct w/stimul 15 min	+0.65	0.00	0.00	0.03	0.68	0.68	XXX
97814		N	Acupunct w/stimul addl 15m	+0.55	0.00	0.00	0.03	0.58	0.58	ZZZ
98925		A	Osteopathic manipulation	0.45	0.32	0.14	0.02	0.79	0.61	000
98926		A	Osteopathic manipulation	0.65	0.41	0.25	0.03	1.09	0.93	000
98927		A	Osteopathic manipulation	0.87	0.50	0.29	0.03	1.40	1.19	000
98928		A	Osteopathic manipulation	1.03	0.59	0.34	0.04	1.66	1.41	000
98929		A	Osteopathic manipulation	1.19	0.67	0.37	0.05	1.91	1.61	000

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/[2] HCPCS	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
98940		A	Chiropractic manipulation	0.45	0.23	0.12	0.01	0.69	0.58	000
98941		A	Chiropractic manipulation	0.65	0.30	0.17	0.02	0.97	0.84	000
98942		A	Chiropractic manipulation	0.87	0.36	0.23	0.02	1.25	1.12	000
98943		N	Chiropractic manipulation	+0.40	0.24	0.16	0.01	0.65	0.57	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99026		N	In-hospital on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99027		N	Out-of-hosp on call service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99052		B	Medical services at night	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99054		B	Medical servcs, unusual hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99056		B	Non-office medical services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99075		N	Medical testimony	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99100		B	Special anesthesia service	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99141		B	Sedation, iv/im or inhalant	+0.80	1.87	0.38	0.05	2.72	1.23	XXX
99142		B	Sedation, oral/rectal/nasal	+0.60	0.95	0.30	0.04	1.59	0.94	XXX
99170		A	Anogenital exam, child	1.75	1.76	0.55	0.08	3.59	2.38	000
99172		N	Ocular function screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99173		N	Visual acuity screen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99175		A	Induction of vomiting	0.00	1.39	NA	0.10	1.49	NA	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.24	0.72	0.16	5.74	3.22	XXX
99185		A	Regional hypothermia	0.00	0.64	NA	0.04	0.68	NA	XXX
99186		A	Total body hypothermia	0.00	1.78	NA	0.45	2.23	NA	XXX
99190		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
99191		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99192		X	Special pump services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99195		A	Phlebotomy	0.00	0.44	NA	0.02	0.46	NA	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.45	0.49	0.15	0.03	0.97	0.63	XXX
99202		A	Office/outpatient visit, new	0.88	0.79	0.31	0.05	1.72	1.24	XXX
99203		A	Office/outpatient visit, new	1.34	1.13	0.48	0.09	2.56	1.91	XXX
99204		A	Office/outpatient visit, new	2.00	1.50	0.71	0.12	3.62	2.83	XXX
99205		A	Office/outpatient visit, new	2.67	1.77	0.95	0.14	4.58	3.76	XXX
99211		A	Office/outpatient visit, est	0.17	0.39	0.06	0.01	0.57	0.24	XXX
99212		A	Office/outpatient visit, est	0.45	0.54	0.16	0.03	1.02	0.64	XXX
99213		A	Office/outpatient visit, est	0.67	0.69	0.24	0.03	1.39	0.94	XXX
99214		A	Office/outpatient visit, est	1.10	1.03	0.41	0.05	2.18	1.56	XXX
99215		A	Office/outpatient visit, est	1.77	1.32	0.65	0.08	3.17	2.50	XXX
99217		A	Observation care discharge	1.28	NA	0.53	0.06	NA	1.87	XXX
99218		A	Observation care	1.28	NA	0.44	0.06	NA	1.78	XXX
99219		A	Observation care	2.14	NA	0.72	0.10	NA	2.96	XXX
99220		A	Observation care	2.99	NA	1.03	0.14	NA	4.16	XXX
99221		A	Initial hospital care	1.28	NA	0.45	0.07	NA	1.80	XXX
99222		A	Initial hospital care	2.14	NA	0.74	0.10	NA	2.98	XXX
99223		A	Initial hospital care	2.99	NA	1.03	0.13	NA	4.15	XXX
99231		A	Subsequent hospital care	0.64	NA	0.23	0.03	NA	0.90	XXX
99232		A	Subsequent hospital care	1.06	NA	0.37	0.04	NA	1.47	XXX
99233		A	Subsequent hospital care	1.51	NA	0.52	0.06	NA	2.09	XXX
99234		A	Observ/hosp same date	2.56	NA	0.89	0.13	NA	3.58	XXX
99235		A	Observ/hosp same date	3.41	NA	1.15	0.16	NA	4.72	XXX
99236		A	Observ/hosp same date	4.26	NA	1.44	0.19	NA	5.89	XXX
99238		A	Hospital discharge day	1.28	NA	0.54	0.05	NA	1.87	XXX
99239		A	Hospital discharge day	1.75	NA	0.73	0.07	NA	2.55	XXX
99241		A	Office consultation	0.64	0.64	0.22	0.05	1.33	0.91	XXX
99242		A	Office consultation	1.29	1.04	0.46	0.10	2.43	1.85	XXX
99243		A	Office consultation	1.72	1.39	0.63	0.13	3.24	2.48	XXX
99244		A	Office consultation	2.58	1.82	0.92	0.16	4.56	3.66	XXX
99245		A	Office consultation	3.42	2.27	1.24	0.21	5.90	4.87	XXX
99251		A	Initial inpatient consult	0.66	NA	0.24	0.05	NA	0.95	XXX
99252		A	Initial inpatient consult	1.32	NA	0.50	0.09	NA	1.91	XXX
99253		A	Initial inpatient consult	1.82	NA	0.68	0.11	NA	2.61	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99254		A	Initial inpatient consult	2.64	NA	0.98	0.13	NA	3.75	XXX
99255		A	Initial inpatient consult	3.64	NA	1.35	0.18	NA	5.17	XXX
99261		A	Follow-up inpatient consult	0.42	NA	0.15	0.02	NA	0.59	XXX
99262		A	Follow-up inpatient consult	0.85	NA	0.31	0.04	NA	1.20	XXX
99263		A	Follow-up inpatient consult	1.27	NA	0.45	0.06	NA	1.78	XXX
99271		A	Confirmatory consultation	0.45	0.55	0.16	0.03	1.03	0.64	XXX
99272		A	Confirmatory consultation	0.84	0.83	0.31	0.06	1.73	1.21	XXX
99273		A	Confirmatory consultation	1.19	1.11	0.45	0.10	2.40	1.74	XXX
99274		A	Confirmatory consultation	1.73	1.37	0.64	0.12	3.22	2.49	XXX
99275		A	Confirmatory consultation	2.31	1.65	0.84	0.14	4.10	3.29	XXX
99281		A	Emergency dept visit	0.33	NA	0.09	0.02	NA	0.44	XXX
99282		A	Emergency dept visit	0.55	NA	0.14	0.04	NA	0.73	XXX
99283		A	Emergency dept visit	1.24	NA	0.31	0.09	NA	1.64	XXX
99284		A	Emergency dept visit	1.95	NA	0.47	0.14	NA	2.56	XXX
99285		A	Emergency dept visit	3.06	NA	0.72	0.23	NA	4.01	XXX
99288		B	Direct advanced life support	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99289		A	Ped crit care transport	4.79	NA	1.45	0.24	NA	6.48	XXX
99290		A	Ped crit care transport addl	2.40	NA	0.81	0.12	NA	3.33	ZZZ
99291		A	Critical care, first hour	3.99	2.57	1.28	0.21	6.77	5.48	XXX
99292		A	Critical care, add'l 30 min	2.00	0.90	0.64	0.10	3.00	2.74	ZZZ
99293		A	Ped critical care, initial	15.98	NA	4.75	1.09	NA	21.82	XXX
99294		A	Ped critical care, subseq	7.99	NA	2.40	0.45	NA	10.84	XXX
99295		A	Neonate crit care, initial	18.46	NA	5.37	1.15	NA	24.98	XXX
99296		A	Neonate critical care subseq	7.99	NA	2.54	0.32	NA	10.85	XXX
99298		A	Ic for lbw infant < 1500 gm	2.75	NA	0.93	0.16	NA	3.84	XXX
99299		A	Ic, lbw infant 1500-2500 gm	2.50	NA	0.86	0.16	NA	3.52	XXX
99301		A	Nursing facility care	1.20	0.50	0.50	0.05	1.75	1.75	XXX
99302		A	Nursing facility care	1.61	0.64	0.64	0.07	2.32	2.32	XXX
99303		A	Nursing facility care	2.01	0.76	0.76	0.09	2.86	2.86	XXX
99311		A	Nursing fac care, subseq	0.60	0.27	0.27	0.03	0.90	0.90	XXX
99312		A	Nursing fac care, subseq	1.00	0.45	0.45	0.04	1.49	1.49	XXX
99313		A	Nursing fac care, subseq	1.42	0.62	0.62	0.06	2.10	2.10	XXX
99315		A	Nursing fac discharge day	1.13	0.45	0.45	0.05	1.63	1.63	XXX
99316		A	Nursing fac discharge day	1.50	0.59	0.59	0.07	2.16	2.16	XXX
99321		A	Rest home visit, new patient	0.71	0.34	NA	0.03	1.08	NA	XXX
99322		A	Rest home visit, new patient	1.01	0.46	NA	0.05	1.52	NA	XXX
99323		A	Rest home visit, new patient	1.28	0.55	NA	0.05	1.88	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99331		A	Rest home visit, est pat	0.60	0.32	NA	0.03	0.95	NA	XXX
99332		A	Rest home visit, est pat	0.80	0.38	NA	0.03	1.21	NA	XXX
99333		A	Rest home visit, est pat	1.00	0.46	NA	0.04	1.50	NA	XXX
99341		A	Home visit, new patient	1.01	0.48	NA	0.05	1.54	NA	XXX
99342		A	Home visit, new patient	1.52	0.68	NA	0.07	2.27	NA	XXX
99343		A	Home visit, new patient	2.27	0.94	NA	0.10	3.31	NA	XXX
99344		A	Home visit, new patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99345		A	Home visit, new patient	3.78	1.43	NA	0.16	5.37	NA	XXX
99347		A	Home visit, est patient	0.76	0.40	NA	0.04	1.20	NA	XXX
99348		A	Home visit, est patient	1.26	0.58	NA	0.06	1.90	NA	XXX
99349		A	Home visit, est patient	2.02	0.83	NA	0.09	2.94	NA	XXX
99350		A	Home visit, est patient	3.03	1.18	NA	0.13	4.34	NA	XXX
99354		A	Prolonged service, office	1.77	0.77	0.66	0.08	2.62	2.51	ZZZ
99355		A	Prolonged service, office	1.77	0.75	0.62	0.07	2.59	2.46	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	0.62	0.07	NA	2.40	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	0.63	0.08	NA	2.42	ZZZ
99358		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99359		B	Prolonged serv, w/o contact	0.00	0.00	0.00	0.00	0.00	0.00	ZZZ
99360		X	Physician standby services	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99361		B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99362		B	Physician/team conference	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99371		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99372		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99373		B	Physician phone consultation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99374		B	Home health care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99375		I	Home health care supervision	+1.73	1.55	1.55	0.07	3.35	3.35	XXX
99377		B	Hospice care supervision	+1.10	0.70	0.42	0.05	1.85	1.57	XXX
99378		I	Hospice care supervision	+1.73	1.94	1.94	0.07	3.74	3.74	XXX
99379		B	Nursing fac care supervision	+1.10	0.70	0.42	0.04	1.84	1.56	XXX
99380		B	Nursing fac care supervision	+1.73	0.99	0.66	0.06	2.78	2.45	XXX
99381		N	Prev visit, new, infant	+1.19	1.50	0.45	0.05	2.74	1.69	XXX
99382		N	Prev visit, new, age 1-4	+1.36	1.54	0.52	0.05	2.95	1.93	XXX
99383		N	Prev visit, new, age 5-11	+1.36	1.48	0.52	0.05	2.89	1.93	XXX
99384		N	Prev visit, new, age 12-17	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99385		N	Prev visit, new, age 18-39	+1.53	1.55	0.59	0.06	3.14	2.18	XXX
99386		N	Prev visit, new, age 40-64	+1.88	1.74	0.72	0.07	3.69	2.67	XXX
99387		N	Prev visit, new, 65 & over	+2.06	1.87	0.79	0.07	4.00	2.92	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99391		N	Prev visit, est, infant	+1.02	1.02	0.39	0.04	2.08	1.45	XXX
99392		N	Prev visit, est, age 1-4	+1.19	1.09	0.45	0.05	2.33	1.69	XXX
99393		N	Prev visit, est, age 5-11	+1.19	1.06	0.45	0.05	2.30	1.69	XXX
99394		N	Prev visit, est, age 12-17	+1.36	1.13	0.52	0.05	2.54	1.93	XXX
99395		N	Prev visit, est, age 18-39	+1.36	1.16	0.52	0.05	2.57	1.93	XXX
99396		N	Prev visit, est, age 40-64	+1.53	1.25	0.59	0.06	2.84	2.18	XXX
99397		N	Prev visit, est, 65 & over	+1.71	1.36	0.66	0.06	3.13	2.43	XXX
99401		N	Preventive counseling, indiv	+0.48	0.62	0.19	0.01	1.11	0.68	XXX
99402		N	Preventive counseling, indiv	+0.98	0.87	0.37	0.02	1.87	1.37	XXX
99403		N	Preventive counseling, indiv	+1.46	1.09	0.56	0.04	2.59	2.06	XXX
99404		N	Preventive counseling, indiv	+1.95	1.32	0.75	0.05	3.32	2.75	XXX
99411		N	Preventive counseling, group	+0.15	0.18	0.06	0.01	0.34	0.22	XXX
99412		N	Preventive counseling, group	+0.25	0.25	0.10	0.01	0.51	0.36	XXX
99420		N	Health risk assessment test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99429		N	Unlisted preventive service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99431		A	Initial care, normal newborn	1.17	NA	0.38	0.05	NA	1.60	XXX
99432		A	Newborn care, not in hosp	1.26	0.93	0.40	0.07	2.26	1.73	XXX
99433		A	Normal newborn care/hospital	0.62	NA	0.20	0.02	NA	0.84	XXX
99435		A	Newborn discharge day hosp	1.50	NA	0.59	0.06	NA	2.15	XXX
99436		A	Attendance, birth	1.50	NA	0.47	0.06	NA	2.03	XXX
99440		A	Newborn resuscitation	2.93	NA	0.93	0.12	NA	3.98	XXX
99450		N	Life/disability evaluation	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99455		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99456		R	Disability examination	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sing/m/fam couns	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
99600		I	Home visit nos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0150		R	Comprehensve oral evaluation	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0240		R	Intraoral occlusal film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0250		R	Extraoral first film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0260		R	Extraoral ea additional film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0270		R	Dental bitewing single film	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0272		R	Dental bitewings two films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0274		R	Dental bitewings four films	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0277		R	Vert bitewings-sev to eight	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0416		R	Viral culture	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0421		R	Gen tst suscept oral disease	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0431		R	Diag tst detect mucos abnorm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0460		R	Pulp vitality test	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0472		R	Gross exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0473		R	Micro exam, prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0474		R	Micro w exam of surg margins	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0475		R	Decalcification procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0476		R	Spec stains for microorganis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0477		R	Spec stains not for microorg	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0478		R	Immunohistochemical stains	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0479		R	Tissue in-situ hybridization	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0480		R	Cytopath smear prep & report	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0481		R	Electron microscopy diagnost	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0482		R	Direct immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0483		R	Indirect immunofluorescence	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0484		R	Consult slides prep elsewher	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0485		R	Consult inc prep of slides	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D0502		R	Other oral pathology procedu	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D0999		R	Unspecified diagnostic proce	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1510		R	Space maintainer fxd unilat	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1515		R	Fixed bilat space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1520		R	Remove unilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1525		R	Remove bilat space maintain	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D1550		R	Recement space maintainer	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
D2999		R	Dental unspec restorative pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3460		R	Endodontic endosseous implan	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D3999		R	Endodontic procedure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4260		R	Osseous surgery per quadrant	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4263		R	Bone replce graft first site	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4264		R	Bone replce graft each add	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4268		R	Surgical revision procedure	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D4270		R	Pedicle soft tissue graft pr	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4271		R	Free soft tissue graft proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4273		R	Subepithelial tissue graft	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4355		R	Full mouth debridement	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D4381		R	Localized delivery antimicro	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5911		R	Facial moulage sectional	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5912		R	Facial moulage complete	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5951		R	Feeding aid	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5983		R	Radiation applicator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5984		R	Radiation shield	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5985		R	Radiation cone locator	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D5987		R	Commissure splint	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D6920		R	Dental connector bar	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7111		R	Extraction coronal remnants	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7140		R	Extraction erupted tooth/exr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7210		R	Rem imp tooth w mucoper flp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7220		R	Impact tooth remov soft tiss	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7230		R	Impact tooth remov part bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7240		R	Impact tooth remov comp bony	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7241		R	Impact tooth rem bony w/comp	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7250		R	Tooth root removal	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7260		R	Oral antral fistula closure	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7261		R	Primary closure sinus perf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7283		R	Place device impacted tooth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7288		R	Brush biopsy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7291		R	Transseptal fiberotomy	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D7321		R	Alveoloplasty not w/extracts	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7511		R	Incision/drain abscess intra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7521		R	Incision/drain abscess extra	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D7940		R	Reshaping bone orthognathic	0.00	0.00	0.00	0.00	0.00	0.00	YYY

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
D9110		R	Tx dental pain minor proc	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9230		R	Analgesia	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9248		R	Sedation (non-iv)	0.00	0.00	0.00	0.00	0.00	0.00	XXX
D9630		R	Other drugs/medicaments	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9930		R	Treatment of complications	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9940		R	Dental occlusal guard	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9950		R	Occlusion analysis	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9951		R	Limited occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
D9952		R	Complete occlusal adjustment	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0027		X	Semen analysis	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0030		C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0030	26	A	PET imaging prev PET single	1.50	0.58	0.58	0.06	2.14	2.14	XXX
G0030	TC	C	PET imaging prev PET single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031		C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0031	26	A	PET imaging prev PET multple	1.87	0.72	0.72	0.07	2.66	2.66	XXX
G0031	TC	C	PET imaging prev PET multple	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032		C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0032	26	A	PET follow SPECT 78464 singl	1.50	0.54	0.54	0.06	2.10	2.10	XXX
G0032	TC	C	PET follow SPECT 78464 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033		C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0033	26	A	PET follow SPECT 78464 mult	1.87	0.74	0.74	0.07	2.68	2.68	XXX
G0033	TC	C	PET follow SPECT 78464 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034		C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0034	26	A	PET follow SPECT 76865 singl	1.50	0.57	0.57	0.05	2.12	2.12	XXX
G0034	TC	C	PET follow SPECT 76865 singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035		C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0035	26	A	PET follow SPECT 78465 mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0035	TC	C	PET follow SPECT 78465 mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036		C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0036	26	A	PET follow comry angio sing	1.50	0.56	0.56	0.05	2.11	2.11	XXX
G0036	TC	C	PET follow comry angio sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037		C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0037	26	A	PET follow comry angio mult	1.87	0.71	0.71	0.06	2.64	2.64	XXX
G0037	TC	C	PET follow comry angio mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0038		C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0038	26	A	PET follow myocard perf sing	1.50	0.52	0.52	0.07	2.09	2.09	XXX
G0038	TC	C	PET follow myocard perf sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039		C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0039	26	A	PET follow myocard perf mult	1.87	0.71	0.71	0.07	2.65	2.65	XXX
G0039	TC	C	PET follow myocard perf mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040		C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0040	26	A	PET follow stress echo singl	1.50	0.59	0.59	0.06	2.15	2.15	XXX
G0040	TC	C	PET follow stress echo singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041		C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0041	26	A	PET follow stress echo mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0041	TC	C	PET follow stress echo mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042		C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0042	26	A	PET follow ventriculogm sing	1.50	0.61	0.61	0.05	2.16	2.16	XXX
G0042	TC	C	PET follow ventriculogm sing	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0043		C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0043	26	A	PET follow ventriculogm mult	1.87	0.75	0.75	0.07	2.69	2.69	XXX
G0043	TC	C	PET follow ventriculogm mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044		C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0044	26	A	PET following rest ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0044	TC	C	PET following rest ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045		C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0045	26	A	PET following rest ECG mult	1.87	0.72	0.72	0.06	2.65	2.65	XXX
G0045	TC	C	PET following rest ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046		C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0046	26	A	PET follow stress ECG singl	1.50	0.59	0.59	0.05	2.14	2.14	XXX
G0046	TC	C	PET follow stress ECG singl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047		C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0047	26	A	PET follow stress ECG mult	1.87	0.73	0.73	0.06	2.66	2.66	XXX
G0047	TC	C	PET follow stress ECG mult	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.52	0.17	0.02	0.99	0.64	XXX
G0102		A	Prostate ca screening; dre	0.17	0.39	0.06	0.01	0.57	0.24	XXX
G0103		X	Psa, total screening	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.27	0.50	0.08	3.31	1.54	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.14	1.47	0.30	10.13	5.46	000
G0105	53	A	Colorectal scrn; hi risk ind	0.96	2.27	0.50	0.08	3.31	1.54	000
G0106		A	Colon CA screen;barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0106	26	A	Colon CA screen;barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0107		X	CA screen; fecal blood test	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0108		A	Diab manage trn per indiv	0.00	0.83	NA	0.01	0.84	NA	XXX
G0109		A	Diab manage trn ind/group	0.00	0.48	NA	0.01	0.49	NA	XXX
G0110		R	Nett pulm-rehab educ; ind	0.90	0.68	0.29	0.04	1.62	1.23	XXX
G0111		R	Nett pulm-rehab educ; group	0.27	0.29	0.13	0.01	0.57	0.41	XXX
G0112		R	Nett;nutrition guid, initial	1.72	1.21	0.65	0.05	2.98	2.42	XXX
G0113		R	Nett;nutrition guid,subseqnt	1.29	0.81	0.41	0.05	2.15	1.75	XXX
G0114		R	Nett; psychosocial consult	1.20	0.48	0.37	0.05	1.73	1.62	XXX
G0115		R	Nett; psychological testing	1.20	0.82	0.37	0.03	2.05	1.60	XXX
G0116		R	Nett; psychosocial counsel	1.11	0.95	0.33	0.05	2.11	1.49	XXX
G0117		T	Glaucoma scrn hgh risk direc	0.45	0.72	0.19	0.01	1.18	0.65	XXX
G0118		T	Glaucoma scrn hgh risk direc	0.17	0.53	0.06	0.01	0.71	0.24	XXX
G0120		A	Colon ca scrn; barium enema	0.99	2.55	NA	0.17	3.71	NA	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.32	0.32	0.04	1.35	1.35	XXX
G0120	TC	A	Colon ca scrn; barium enema	0.00	2.23	NA	0.13	2.36	NA	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.14	1.47	0.30	10.13	5.46	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.27	0.50	0.08	3.31	1.54	000
G0122		N	Colon ca scrn; barium enema	+0.99	2.57	2.57	0.18	3.74	3.74	XXX
G0122	26	N	Colon ca scrn; barium enema	+0.99	0.38	0.38	0.05	1.42	1.42	XXX
G0122	TC	N	Colon ca scrn; barium enema	+0.00	2.19	2.19	0.13	2.32	2.32	XXX
G0123		X	Screen cerv/vag thin layer	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0125		C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0125	26	A	PET image pulmonary nodule	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0125	TC	C	PET image pulmonary nodule	0.00	0.00	NA	0.00	0.00	NA	XXX
G0127		R	Trim nail(s)	0.17	0.25	0.07	0.01	0.43	0.25	000
G0128		R	CORF skilled nursing service	0.08	0.03	0.03	0.01	0.12	0.12	XXX
G0130		A	Single energy x-ray study	0.22	0.87	NA	0.06	1.15	NA	XXX
G0130	26	A	Single energy x-ray study	0.22	0.07	0.07	0.01	0.30	0.30	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.80	NA	0.05	0.85	NA	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.15	0.15	0.02	0.59	0.59	XXX
G0143		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0144		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0145		X	Scr c/v cyto,thinlayer,rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0147		X	Scr c/v cyto, automated sys	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0148		X	Scr c/v cyto, autosys, rescr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.57	0.03	0.01	3.65	0.11	XXX
G0168		A	Wound closure by adhesive	0.45	1.93	0.22	0.03	2.41	0.70	000
G0173		X	Linear acc stereo radsur com	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0175		X	OPPS Service,sched team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0176		X	OPPS/PHP;activity therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0177		X	OPPS/PHP; train & educ serv	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0179		A	MD recertification HHA PT	0.45	1.03	NA	0.02	1.50	NA	XXX
G0180		A	MD certification HHA patient	0.67	1.26	NA	0.03	1.96	NA	XXX
G0181		A	Home health care supervision	1.73	1.48	NA	0.07	3.28	NA	XXX
G0182		A	Hospice care supervision	1.73	1.66	NA	0.07	3.46	NA	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.77	NA	0.10	3.57	NA	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.54	NA	0.07	2.61	NA	XXX
G0204		A	Diagnosticmammographydigital	0.87	2.78	NA	0.11	3.76	NA	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.28	0.28	0.04	1.19	1.19	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	2.50	NA	0.07	2.57	NA	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.25	NA	0.09	3.04	NA	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.23	0.23	0.03	0.96	0.96	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.02	NA	0.06	2.08	NA	XXX
G0210		C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0210	26	A	PET img wholebody dxlung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0210	TC	C	PET img wholebody dxlung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211		C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0211	26	A	PET img wholbody init lung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0211	TC	C	PET img wholbody init lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212		C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0212	26	A	PET img wholebod restag lung	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0212	TC	C	PET img wholebod restag lung	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213		C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0213	26	A	PET img wholbody dx	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0213	TC	C	PET img wholbody dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214		C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0214	26	A	PET img wholebod init	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0214	TC	C	PET img wholebod init	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0215		C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0215	26	A	PETimg wholebod restag	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0215	TC	C	PETimg wholebod restag	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216		C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0216	26	A	PET img wholebod dx melanoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0216	TC	C	PET img wholebod dx melanoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217		C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0217	26	A	PET img wholebod init melan	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0217	TC	C	PET img wholebod init melan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218		C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0218	26	A	PET img wholebod restag mela	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0218	TC	C	PET img wholebod restag mela	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219		N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	26	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0219	TC	N	PET img wholbod melano nonco	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220		C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0220	26	A	PET img wholebod dx lymphoma	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0220	TC	C	PET img wholebod dx lymphoma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221		C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0221	26	A	PET imag wholbod init lympho	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0221	TC	C	PET imag wholbod init lympho	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222		C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0222	26	A	PET imag wholbod resta lymph	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0222	TC	C	PET imag wholbod resta lymph	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223		C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0223	26	A	PET imag wholbod reg dx head	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0223	TC	C	PET imag wholbod reg dx head	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224		C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0224	26	A	PET imag wholbod reg ini hea	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0224	TC	C	PET imag wholbod reg ini hea	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225		C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0225	26	A	PET whol restag headneckonly	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0225	TC	C	PET whol restag headneckonly	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226		C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0226	26	A	PET img wholbody dx esophagl	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0226	TC	C	PET img wholbody dx esophagl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227		C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0227	26	A	PET img wholbod ini esophage	1.50	0.52	0.52	0.06	2.08	2.08	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0227	TC	C	PET img wholbod ini esophage	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228		C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0228	26	A	PET img wholbod restg esopha	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0228	TC	C	PET img wholbod restg esopha	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229		C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0229	26	A	PET img metaboloc brain pres	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0229	TC	C	PET img metaboloc brain pres	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230		C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0230	26	A	PET myocard viability post	1.50	0.53	0.53	0.06	2.09	2.09	XXX
G0230	TC	C	PET myocard viability post	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231		C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0231	26	A	PET WhBD colorec; gamma cam	1.50	0.51	0.51	0.06	2.07	2.07	XXX
G0231	TC	C	PET WhBD colorec; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232		C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0232	26	A	PET whbd lymphoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0232	TC	C	PET whbd lymphoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0233		C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0233	26	A	PET whbd melanoma; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0233	TC	C	PET whbd melanoma; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234		C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0234	26	A	PET WhBD pulm nod; gamma cam	1.50	0.52	0.52	0.06	2.08	2.08	XXX
G0234	TC	C	PET WhBD pulm nod; gamma cam	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.47	NA	0.02	0.49	NA	XXX
G0238		A	Oth resp proc, indiv	0.00	0.49	NA	0.02	0.51	NA	XXX
G0239		A	Oth resp proc, group	0.00	0.33	NA	0.02	0.35	NA	XXX
G0242		X	Multisource photon ster plan	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0243		X	Multisour photon stero treat	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0244		E	Observ care by facility topt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0245		R	Initial foot exam pt lops	0.88	0.79	0.31	0.04	1.71	1.23	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.54	0.16	0.02	1.01	0.63	XXX
G0247		R	Routine footcare pt w lops	0.50	0.52	0.21	0.02	1.04	0.73	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	6.61	NA	0.01	6.62	NA	XXX
G0249		R	Provide test material,equipm	0.00	3.96	NA	0.01	3.97	NA	XXX
G0250		R	MD review interpret of test	0.18	0.06	0.06	0.01	0.25	0.25	XXX
G0251		E	Linear acc based stero radio	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252		N	PET imaging initial dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0252	26	N	PET imaging initial dx	+1.50	0.60	0.60	0.04	2.14	2.14	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0252	TC	N	PET imaging initial dx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253		C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0253	26	A	PET image brst dection recur	1.87	0.63	0.63	0.08	2.58	2.58	XXX
G0253	TC	C	PET image brst dection recur	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254		C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0254	26	A	PET image brst eval to tx	1.87	0.65	0.65	0.08	2.60	2.60	XXX
G0254	TC	C	PET image brst eval to tx	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255		N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	26	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0255	TC	N	Current percep threshold tst	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0257		E	Unsched dialysis ESRD pt hos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0258		E	IV infusion during obs stay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0259		E	Inject for sacroiliac joint	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0260		E	Inj for sacroiliac jt anesth	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0263		E	Adm with CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0264		E	Assmt otr CHF, CP, asthma	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0265		X	Cryopresevation Freeze+stora	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0266		X	Thawing + expansion froz cel	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0267		X	Bone marrow or psc harvest	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0268		A	Removal of impacted wax md	0.61	0.63	0.24	0.02	1.26	0.87	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0270		A	MNT subs tx for change dx	0.00	0.47	NA	0.01	0.48	NA	XXX
G0271		A	Group MNT 2 or more 30 mins	0.00	0.18	NA	0.01	0.19	NA	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.10	0.01	NA	0.36	ZZZ
G0279		C	Excorp shock tx, elbow epi	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0280		C	Excorp shock tx other than	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0281		A	Elec stim unattend for press	0.18	0.11	NA	0.01	0.30	NA	XXX
G0282		N	Elect stim wound care not pd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.11	NA	0.01	0.30	NA	XXX
G0288		A	Recon, CTA for surg plan	0.00	10.61	NA	0.18	10.79	NA	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	0.80	0.25	NA	2.53	ZZZ
G0290		E	Drug-eluting stents, single	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0291		E	Drug-eluting stents,each add	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0293		E	Non-cov surg proc,clin trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0294		E	Non-cov proc, clinical trial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0295		N	Electromagnetic therapy onc	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non-facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0296		C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0296	26	A	PET imge restag thyrod cance	1.87	0.71	0.71	0.08	2.66	2.66	XXX
G0296	TC	C	PET imge restag thyrod cance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0297		X	Insert single chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0298		X	Insert dual chamber/cd	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0299		X	Inser/repos single icd+leads	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0300		X	Insert reposit lead dual+gen	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0302		X	Pre-op service LVRS complete	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0303		X	Pre-op service LVRS 10-15dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0304		X	Pre-op service LVRS 1-9 dos	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0305		X	Post op service LVRS min 6	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0306		X	CBC/diffwbc w/o platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0307		X	CBC without platelet	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0308		A	ESRD related svc 4+mo < 2yrs	12.74	8.54	8.54	0.42	21.70	21.70	XXX
G0309		A	ESRD related svc 2-3mo <2yrs	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0310		A	ESRD related svc 1 vst <2yrs	8.49	5.68	5.68	0.28	14.45	14.45	XXX
G0311		A	ESRD related svs 4+mo 2-11yr	9.73	4.72	4.72	0.34	14.79	14.79	XXX
G0312		A	ESRD relate svs 2-3 mo 2-11y	8.11	3.92	3.92	0.29	12.32	12.32	XXX
G0313		A	ESRD related svs 1 mon 2-11y	6.49	3.14	3.14	0.22	9.85	9.85	XXX
G0314		A	ESRD related svs 4+ mo 12-19	8.28	4.42	4.42	0.27	12.97	12.97	XXX
G0315		A	ESRD related svs 2-3mo/12-19	6.90	3.67	3.67	0.23	10.80	10.80	XXX
G0316		A	ESRD related svs 1vis/12-19y	5.52	2.94	2.94	0.17	8.63	8.63	XXX
G0317		A	ESRD related svs 4+mo 20+yrs	5.09	2.86	2.86	0.17	8.12	8.12	XXX
G0318		A	ESRD related svs 2-3 mo 20+y	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0319		A	ESRD related svs 1visit 20+y	3.39	1.90	1.90	0.11	5.40	5.40	XXX
G0320		A	ESD related svs home undr 2	10.61	7.10	7.10	0.36	18.07	18.07	XXX
G0321		A	ESRDrelatedsvs home mo 2-11y	8.11	3.92	3.92	0.29	12.32	12.32	XXX
G0322		A	ESRD related svs hom mo12-19	6.90	3.67	3.67	0.23	10.80	10.80	XXX
G0323		A	ESRD related svs home mo 20+	4.24	2.38	2.38	0.14	6.76	6.76	XXX
G0324		A	ESRD relate svs home/dy <2yr	0.35	0.24	0.24	0.01	0.60	0.60	XXX
G0325		A	ESRD relate home/day/ 2-11yr	0.23	0.12	0.12	0.01	0.36	0.36	XXX
G0326		A	ESRD relate home/dy 12-19yr	0.27	0.13	0.13	0.01	0.41	0.41	XXX
G0327		A	ESRD relate home/dy 20+yrs	0.14	0.08	0.08	0.01	0.23	0.23	XXX
G0328		X	Fecal blood scrn immunoassay	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0329		A	Electromagntic tx for ulcers	0.06	0.14	0.02	0.01	0.21	0.09	XXX
G0336		C	PET imaging brain alzheimers	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0336	26	A	PET imaging brain alzheimers	1.50	0.49	0.49	0.05	2.04	2.04	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
G0336	TC	C	PET imaging brain alzheimers	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0337		X	Hospice evaluation preelecti	+1.34	0.51	0.51	0.09	1.94	1.94	XXX
G0338		X	Linear accelerator stero pln	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0339		X	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0340		X	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	5.73	2.59	0.48	13.19	10.05	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	5.29	1.46	NA	18.67	090
G0343		A	Laparotomy islet cell transp	19.85	NA	8.75	2.05	NA	30.65	090
G0344		A	Initial preventive exam	1.34	1.13	0.48	0.10	2.57	1.92	XXX
G0345		A	IV infuse hydration, initial	0.17	1.42	NA	0.07	1.66	NA	XXX
G0346		A	Each additional infuse hour	0.09	0.40	NA	0.04	0.53	NA	ZZZ
G0347		A	IV infusion therapy/diagnost	0.21	1.75	NA	0.07	2.03	NA	XXX
G0348		A	Each additional hr up to 8hr	0.18	0.46	NA	0.04	0.68	NA	ZZZ
G0349		A	Additional sequential infuse	0.19	0.89	NA	0.04	1.12	NA	ZZZ
G0350		A	Concurrent infusion	0.17	0.44	NA	0.04	0.65	NA	XXX
G0351		A	Therapeutic/diagnostic injec	0.17	0.31	NA	0.01	0.49	NA	XXX
G0353		A	IV push,single orinitial dru	0.18	1.29	NA	0.04	1.51	NA	XXX
G0354		A	Each addition sequential IV	0.10	0.57	NA	0.04	0.71	NA	XXX
G0355		A	Chemo adminisrate subcut/IM	0.21	1.14	NA	0.01	1.36	NA	XXX
G0356		A	Hormonal anti-neoplastic	0.19	0.74	NA	0.01	0.94	NA	XXX
G0357		A	IV push single/initial subst	0.24	2.92	NA	0.06	3.22	NA	XXX
G0358		A	IV push each additional drug	0.20	1.61	NA	0.06	1.87	NA	XXX
G0359		A	Chemotherapy IV one hr initi	0.28	4.19	NA	0.08	4.55	NA	XXX
G0360		A	Each additional hr 1-8 hrs	0.19	0.77	NA	0.07	1.03	NA	ZZZ
G0361		A	Prolong chemo infuse>8hrs pu	0.21	4.60	NA	0.08	4.89	NA	XXX
G0362		A	Each add sequential infusion	0.21	1.94	NA	0.07	2.22	NA	ZZZ
G0363		A	Irrigate implanted venous de	0.04	0.69	NA	0.01	0.74	NA	XXX
G0364		A	Bone marrow aspirate &biopsy	0.16	0.14	0.06	0.04	0.34	0.26	ZZZ
G0365		A	Vessel mapping hemo access	0.25	3.99	NA	0.25	4.49	NA	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.02	0.36	0.36	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	3.90	NA	0.23	4.13	NA	XXX
G0366		A	EKG for initial prevent exam	0.17	0.51	NA	0.03	0.71	NA	XXX
G0367		A	EKG tracing for initial prev	0.00	0.45	NA	0.02	0.47	NA	XXX
G0368		A	EKG interpret & report preve	0.17	0.06	0.06	0.01	0.24	0.24	XXX
G3001		X	Admin + supply, tositumomab	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9001		X	MCCD, initial rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9002		X	MCCD,maintenance rate	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM B. - RELATIVE VALUE UNITS(RVUs) AND RELATED INFORMATION -

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
G9003		X	MCCD, risk adj hi, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9004		X	MCCD, risk adj lo, initial	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9005		X	MCCD, risk adj, maintenance	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9006		X	MCCD, Home monitoring	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9007		X	MCCD, sch team conf	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9008		X	Mccd,phys coor-care ovrsght	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9009		X	MCCD, risk adj, level 3	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9010		X	MCCD, risk adj, level 4	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9011		X	MCCD, risk adj, level 5	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9012		X	Other Specified Case Mgmt	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9013		N	ESRD demo bundle level I	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9014		N	ESRD demo bundle-level II	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9016		N	Demo-smoking cessation coun	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9017		X	Amantadine HCL, oral	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9018		X	Zanamivir, inh pwdr	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9019		X	Oseltamivir phosp	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G9020		X	Rimantadine HCL	0.00	0.00	0.00	0.00	0.00	0.00	XXX
M0064		A	Visit for drug monitoring	0.37	0.34	0.12	0.01	0.72	0.50	XXX
P3001		A	Screening pap smear by phys	0.42	0.15	0.15	0.02	0.59	0.59	XXX
Q0035		A	Cardiokymography	0.17	0.45	NA	0.03	0.65	NA	XXX
Q0035	26	A	Cardiokymography	0.17	0.06	0.06	0.01	0.24	0.24	XXX
Q0035	TC	A	Cardiokymography	0.00	0.39	NA	0.02	0.41	NA	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.67	0.14	0.02	1.06	0.53	XXX
Q0092		A	Set up port xray equipment	0.00	0.32	NA	0.01	0.33	NA	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	0.00	0.00	XXX
Q3014		X	Telehealth facility fee	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	0.00	0.00	0.00	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	0.00	0.00	0.00	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
0073T		A	Delivery, comp imrt	0.00	18.02	NA	0.13	18.15	NA	XXX
11004		A	Debride genitalia & perineum	10.31	NA	3.90	0.67	NA	14.88	000
11005		A	Debride abdom wall	13.75	NA	5.56	0.96	NA	20.27	000
11006		A	Debride genit/per/abdom wall	12.61	NA	4.85	1.28	NA	18.74	000
11008		A	Remove mesh from abd wall	5.00	NA	2.02	0.61	NA	7.63	ZZZ
19296		A	Place po breast cath for rad	3.63	125.39	1.53	0.36	129.38	5.52	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.17	NA	2.53	ZZZ
19298		A	Place breast rad tube/caths	6.00	42.16	2.41	0.43	48.59	8.84	000
27412		A	Autochondrocyte implant knee	23.23	NA	14.80	4.33	NA	42.36	090
27415		A	Osteochondral knee allograft	18.49	NA	12.55	4.33	NA	35.37	090
29866		A	Autgrft implnt, knee w/scope	13.88	NA	11.35	2.38	NA	27.61	090
29867		A	Allgrft implnt, knee w/scope	17.00	NA	13.22	2.76	NA	32.98	090
29868		A	Meniscal trnspl, knee w/scpe	23.59	NA	16.79	4.33	NA	44.71	090
31545		A	Remove vc lesion w/scope	6.30	NA	3.47	0.37	NA	10.14	000
31546		A	Remove vc lesion scope/graft	9.73	NA	4.97	0.78	NA	15.48	000
31620		A	Endobronchial us add-on	1.40	5.64	0.55	0.11	7.15	2.06	ZZZ
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.72	0.34	NA	5.87	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.76	0.36	NA	6.48	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.76	0.31	NA	6.37	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.56	0.13	NA	2.27	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.97	0.22	NA	7.07	000
32019		A	Insert pleural catheter	4.17	19.96	1.65	0.42	24.55	6.24	000
34803		A	Endovas aaa repr w/3-p part	24.00	NA	10.21	1.99	NA	36.20	090
36475		A	Endovenous rf, 1st vein	6.72	51.39	2.53	0.37	58.48	9.62	000
36476		A	Endovenous rf, vein add-on	3.38	7.88	1.14	0.18	11.44	4.70	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	46.77	2.53	0.37	53.86	9.62	000
36479		A	Endovenous laser vein addon	3.38	7.99	1.14	0.18	11.55	4.70	ZZZ
36818		A	Av fuse, uppr arm, cephalic	11.52	NA	6.03	1.88	NA	19.43	090
36819		A	Av fuse, uppr arm, basilic	13.98	NA	6.37	1.92	NA	22.27	090
37205		A	Transcath iv stent, percut	8.27	NA	3.75	0.61	NA	12.63	000
37206		A	Transcath iv stent/perc addl	4.12	NA	1.43	0.32	NA	5.87	ZZZ
37215		R	Transcath stent, cca w/eps	18.71	NA	9.09	1.09	NA	28.89	090
37216		R	Transcath stent, cca w/o eps	17.98	NA	8.81	1.04	NA	27.83	090
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.20	0.36	NA	8.06	000

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal-practice RVUs	Non-facility Total	Facility Total	Global
43644		A	Lap gastric bypass/roux-en-y	27.83	NA	11.21	3.13	NA	42.17	090
43645		A	Lap gastr bypass incl smll i	29.96	NA	12.01	3.51	NA	45.48	090
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.71	0.37	NA	7.08	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.39	0.97	NA	10.36	XXX
45391		A	Colonoscopy w/endoscope us	5.09	NA	1.97	0.42	NA	7.48	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	2.48	0.42	NA	9.44	000
46947		A	Hemorrhoidopexy by stapling	5.20	NA	2.71	0.75	NA	8.66	090
47140		A	Partial removal, donor liver	54.92	NA	22.27	5.13	NA	82.32	090
47141		A	Partial removal, donor liver	67.40	NA	26.90	5.13	NA	99.43	090
47142		A	Partial removal, donor liver	74.89	NA	29.46	5.13	NA	109.48	090
47146		A	Prep donor liver/venous	6.00	NA	2.05	0.83	NA	8.88	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.39	0.97	NA	10.36	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.46	0.31	NA	6.07	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.35	0.29	NA	5.64	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.18	0.26	NA	4.94	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.13	0.25	NA	4.72	XXX
50360		A	Transplantation of kidney	31.48	NA	15.47	3.78	NA	50.73	090
50365		A	Transplantation of kidney	36.75	NA	18.19	4.39	NA	59.33	090
50391		A	Instll rx agnt into rnal tub	1.96	1.58	0.63	0.14	3.68	2.73	000
50547		A	Laparo removal donor kidney	25.46	NA	11.10	2.74	NA	39.30	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.97	0.64	NA	7.49	ZZZ
57282		A	Colpopexy, extraperitoneal	6.86	NA	4.50	1.02	NA	12.38	090
57283		A	Colpopexy, intraperitoneal	10.84	NA	5.91	1.02	NA	17.77	090
58356		A	Endometrial cryoablation	6.36	6.84	2.65	0.82	14.02	9.83	010
58565		A	Hysteroscopy, sterilization	7.02	49.56	3.90	1.19	57.77	12.11	090
58956		A	Bso, omentectomy w/tah	20.78	NA	10.31	3.98	NA	35.07	090
63050		A	Cervical laminoplasty	20.75	NA	11.84	4.64	NA	37.23	090
63051		A	C-laminoplasty w/graft/plate	24.25	NA	13.47	4.64	NA	42.36	090
63295		A	Repair of laminectomy defect	5.25	NA	2.14	1.03	NA	8.42	ZZZ
66710		A	Ciliary transsleral therapy	4.77	5.17	3.84	0.23	10.17	8.84	090
66711		A	Ciliary endoscopic ablation	6.60	NA	6.47	0.30	NA	13.37	090
75960	26	A	Transcath iv stent rs&i	0.82	0.28	0.28	0.05	1.15	1.15	XXX
76075	26	A	Dxa bone density, axial	0.30	0.10	0.10	0.01	0.41	0.41	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
76076	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	0.31	0.31	XXX
76077	26	A	Dxa bone density/v-fracture	0.17	0.06	0.06	0.01	0.24	0.24	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.68	0.68	0.03	2.26	2.26	XXX
76511	26	A	Ophth us, quant a only	0.94	0.40	0.40	0.03	1.37	1.37	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.42	0.42	0.02	1.38	1.38	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.29	0.29	0.02	0.97	0.97	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.08	0.08	0.01	0.26	0.26	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.03	0.72	0.72	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.27	0.27	0.03	1.00	1.00	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	0.82	0.82	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.22	0.22	0.03	0.81	0.81	XXX
77750	26	A	Infuse radioactive materials	4.90	1.58	1.58	0.25	6.73	6.73	090
78811	26	I	Tumor imaging (pet), limited	+1.54	0.00	0.00	0.11	1.65	1.65	XXX
78812	26	I	Tumor image (pet)/skul-thigh	+1.93	0.00	0.00	0.11	2.04	2.04	XXX
78813	26	I	Tumor image (pet) full body	+2.00	0.00	0.00	0.11	2.11	2.11	XXX
78814	26	I	Tumor image pet/ct, limited	+2.20	0.00	0.00	0.11	2.31	2.31	XXX
78815	26	I	Tumorimage pet/ct skul-thigh	+2.44	0.00	0.00	0.11	2.55	2.55	XXX
78816	26	I	Tumor image pet/ct full body	+2.50	0.00	0.00	0.11	2.61	2.61	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.60	0.60	0.08	2.48	2.48	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.67	0.67	0.08	2.71	2.71	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.69	0.69	0.09	2.77	2.77	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.56	0.56	0.13	2.29	2.29	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.72	0.72	0.08	2.79	2.79	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.82	0.82	0.12	3.34	3.34	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	0.00	0.00	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.01	0.52	0.52	XXX
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.15	0.15	0.01	0.53	0.53	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.14	0.14	0.01	0.52	0.52	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	1.32	NA	0.02	1.34	NA	XXX
88185		A	Flowcytometry/tc, add-on	0.00	0.64	NA	0.02	0.66	NA	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.45	0.45	0.01	1.82	1.82	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.57	0.57	0.01	2.27	2.27	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.75	0.75	0.01	2.99	2.99	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
88360	26	A	Tumor immunohistochem/manual	1.10	0.47	0.47	0.06	1.63	1.63	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.49	0.49	0.11	1.78	1.78	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.51	0.51	0.03	1.74	1.74	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.54	0.54	0.06	1.90	1.90	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.60	0.60	0.06	2.06	2.06	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.31	NA	0.01	0.49	NA	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.13	NA	0.01	0.29	NA	ZZZ
90471		A	Immunization admin	0.17	0.31	NA	0.01	0.49	NA	XXX
90472		A	Immunization admin, each add	0.15	0.13	NA	0.01	0.29	NA	ZZZ
91034	26	A	Gastroesophageal reflux test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.56	0.56	0.06	2.21	2.21	XXX
91037	26	A	Esoph imped function test	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91038	26	A	Esoph imped funct test > 1h	1.10	0.39	0.39	0.06	1.55	1.55	XXX
91040	26	A	Esoph balloon distension tst	0.97	0.34	0.34	0.06	1.37	1.37	XXX
91120	26	A	Rectal sensation test	0.97	0.34	0.34	0.07	1.38	1.38	XXX
93741	26	A	Analyze ht pace device sngl	0.80	0.31	0.31	0.03	1.14	1.14	XXX
93742	26	A	Analyze ht pace device sngl	0.91	0.36	0.36	0.03	1.30	1.30	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.40	0.40	0.06	1.46	1.46	XXX
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.46	0.46	0.06	1.67	1.67	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	0.42	0.42	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.12	0.12	0.02	0.54	0.54	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.65	0.65	0.06	2.21	2.21	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.22	0.07	1.53	1.07	XXX
95972		A	Analyze neurostim, complex	1.50	1.21	0.49	0.14	2.85	2.13	XXX
95973		A	Analyze neurostim, complex	0.92	0.62	0.34	0.07	1.61	1.33	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	1.93	1.30	0.18	5.61	4.98	XXX
95979		A	Analyz neurostim brain addon	1.64	0.87	0.69	0.08	2.59	2.41	ZZZ
96520		A	Port pump refill & main	0.21	3.76	NA	0.06	4.03	NA	XXX
96530		A	Syst pump refill & main	0.21	2.64	NA	0.06	2.91	NA	XXX
97597		A	Active wound care/20 cm or <	0.58	0.66	NA	0.05	1.29	NA	XXX
97598		A	Active wound care > 20 cm	0.80	0.79	NA	0.05	1.64	NA	XXX
97605		B	Neg press wound tx, < 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C. - CODES WITH INTERIM RVUs

CPT[1]/ HCPCS[2]	Mod	Status	Description	Physician work RVUs[3]	Non- facility PE RVUs	Facility PE RVUs	Mal- practice RVUs	Non-facility Total	Facility Total	Global
97606		B	Neg press wound tx, > 50 cm	0.00	0.00	0.00	0.00	0.00	0.00	XXX
G0344		A	Initial preventive exam	1.34	1.13	0.48	0.10	2.57	1.92	XXX
G0345		A	IV infuse hydration, initial	0.17	1.42	NA	0.07	1.66	NA	XXX
G0346		A	Each additional infuse hour	0.09	0.40	NA	0.04	0.53	NA	ZZZ
G0347		A	IV infusion therapy/diagnost	0.21	1.75	NA	0.07	2.03	NA	XXX
G0348		A	Each additional hr up to 8hr	0.18	0.46	NA	0.04	0.68	NA	ZZZ
G0349		A	Additional sequential infuse	0.19	0.89	NA	0.04	1.12	NA	ZZZ
G0350		A	Concurrent infusion	0.17	0.44	NA	0.04	0.65	NA	XXX
G0351		A	Therapeutic/diagnostic injec	0.17	0.31	NA	0.01	0.49	NA	XXX
G0353		A	IV push,single orinitial dru	0.18	1.29	NA	0.04	1.51	NA	XXX
G0354		A	Each addition sequential IV	0.10	0.57	NA	0.04	0.71	NA	XXX
G0355		A	Chemo administrate subcut/IM	0.21	1.14	NA	0.01	1.36	NA	XXX
G0356		A	Hormonal anti-neoplastic	0.19	0.74	NA	0.01	0.94	NA	XXX
G0357		A	IV push single/initial subst	0.24	2.92	NA	0.06	3.22	NA	XXX
G0358		A	IV push each additional drug	0.20	1.61	NA	0.06	1.87	NA	XXX
G0359		A	Chemotherapy IV one hr initi	0.28	4.19	NA	0.08	4.55	NA	XXX
G0360		A	Each additional hr 1-8 hrs	0.19	0.77	NA	0.07	1.03	NA	ZZZ
G0361		A	Prolong chemo infuse>8hrs pu	0.21	4.60	NA	0.08	4.89	NA	XXX
G0362		A	Each add sequential infusion	0.21	1.94	NA	0.07	2.22	NA	ZZZ
G0363		A	Irngate implanted venous de	0.04	0.69	NA	0.01	0.74	NA	XXX
G0364		A	Bone marrow aspirate &biopsy	0.16	0.14	0.06	0.04	0.34	0.26	ZZZ
G0365	26	A	Vessel mapping hemo access	0.25	0.09	0.09	0.02	0.36	0.36	XXX
G0366		A	EKG for initial prevent exam	0.17	0.51	NA	0.03	0.71	NA	XXX
G0367		A	EKG tracing for initial prev	0.00	0.45	NA	0.02	0.47	NA	XXX
G0368		A	EKG interpret & report preve	0.17	0.06	0.06	0.01	0.24	0.24	XXX

3 +Indicates RVUs are not used for Medicare payment.

ADDENDUM D -- 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.858	0.752
00831	01	[2]Alaska	1.670	1.670	1.670
00832	00	Arizona	1.000	0.985	1.069
00520	13	Arkansas	1.000	0.839	0.438
31146	26	Anaheim/Santa Ana, CA	1.036	1.210	0.954
31146	18	Los Angeles, CA	1.049	1.147	0.954
31140	03	Marin/Napa/Solano, CA	1.025	1.294	0.651
31140	07	Oakland/Berkley, CA	1.048	1.303	0.651
31140	05	San Francisco, CA	1.064	1.501	0.651
31140	06	San Mateo, CA	1.061	1.484	0.639
31140	09	Santa Clara, CA	1.073	1.460	0.604
31146	17	Ventura, CA	1.028	1.152	0.744
31146	99	Rest of California*	1.007	1.043	0.733
31140	99	Rest of California*	1.007	1.043	0.733
00824	01	Colorado	1.000	1.003	0.803
00591	00	Connecticut	1.044	1.163	0.900
00902	01	Delaware	1.016	1.026	0.892
00903	01	DC + MD/VA Suburbs	1.049	1.208	0.926
00590	03	Fort Lauderdale, FL	1.000	1.003	1.703
00590	04	Miami, FL	1.008	1.049	2.269
00590	99	Rest of Florida	1.000	0.940	1.272
00511	01	Atlanta, GA	1.008	1.074	0.966
00511	99	Rest of Georgia	1.000	0.882	0.966
00833	01	Hawaii/Guam	1.001	1.118	0.800
05130	00	Idaho	1.000	0.874	0.459
00952	16	Chicago, IL	1.027	1.109	1.867
00952	12	East St. Louis, IL	1.000	0.931	1.750
00952	15	Suburban Chicago, IL	1.012	1.093	1.652
00952	99	Rest of Illinois	1.000	0.881	1.193
00630	00	Indiana	1.000	0.914	0.436
00826	00	Iowa	1.000	0.872	0.589
00650	00	Kansas*	1.000	0.887	0.721
00740	04	Kansas*	1.000	0.887	0.721
00660	00	Kentucky	1.000	0.860	0.873
00528	01	New Orleans, LA	1.000	0.945	1.197
00528	99	Rest of Louisiana	1.000	0.858	1.058
31142	03	Southern Maine	1.000	1.006	0.637
31142	99	Rest of Maine	1.000	0.898	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.017	1.058	0.947
00901	99	Rest of Maryland	1.000	0.976	0.760
31143	01	Metropolitan Boston	1.036	1.284	0.823
31143	99	Rest of Massachusetts	1.009	1.116	0.823
00953	01	Detroit, MI	1.040	1.046	2.744
00953	99	Rest of Michigan	1.000	0.929	1.518
00954	00	Minnesota	1.000	0.990	0.410
00512	00	Mississippi	1.000	0.838	0.722

[1] 1.0 Floor on Work GPCI set by MMA.

[2] 1.67 Floor on all indices set by MMA.

GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.

* States are served by more than one carrier.

ADDENDUM D -- 2005 GEOGRAPHIC PRACTICE COST INDICES BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00740	02	Metropolitan Kansas City, MO	1.000	0.971	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.946	0.941
00523	99	Rest of Missouri*	1.000	0.813	0.892
00740	99	Rest of Missouri*	1.000	0.813	0.892
00751	01	Montana	1.000	0.860	0.904
00655	00	Nebraska	1.000	0.876	0.454
00834	00	Nevada	1.004	1.041	1.068
31144	40	New Hampshire	1.000	1.029	0.942
00805	01	Northern NJ	1.058	1.207	0.973
00805	99	Rest of New Jersey	1.036	1.115	0.973
00521	05	New Mexico	1.000	0.893	0.895
00803	01	Manhattan, NY	1.079	1.324	1.504
00803	02	NYC Suburbs/Long I., NY	1.060	1.266	1.785
00803	03	Poughkpsie/N NYC Suburbs, NY	1.013	1.074	1.167
14330	04	Queens, NY	1.045	1.228	1.710
00801	99	Rest of New York	1.000	0.930	0.677
05535	00	North Carolina	1.000	0.925	0.640
00820	01	North Dakota	1.000	0.870	0.602
00883	00	Ohio	1.000	0.938	0.976
00522	00	Oklahoma	1.000	0.865	0.382
00835	01	Portland, OR	1.000	1.053	0.441
00835	99	Rest of Oregon	1.000	0.929	0.441
00865	01	Metropolitan Philadelphia, PA	1.020	1.098	1.386
00865	99	Rest of Pennsylvania	1.000	0.916	0.806
00973	20	Puerto Rico	1.000	0.705	0.261
00870	01	Rhode Island	1.031	1.027	0.909
00880	01	South Carolina	1.000	0.898	0.394
00820	02	South Dakota	1.000	0.877	0.365
05440	35	Tennessee	1.000	0.890	0.631
00900	31	Austin, TX	1.000	1.021	0.986
00900	20	Beaumont, TX	1.000	0.875	1.298
00900	09	Brazoria, TX	1.006	0.970	1.298
00900	11	Dallas, TX	1.010	1.063	1.061
00900	28	Fort Worth, TX	1.000	0.985	1.061
00900	15	Galveston, TX	1.000	0.960	1.298
00900	18	Houston, TX	1.018	1.011	1.297
00900	99	Rest of Texas	1.000	0.873	1.138
00910	09	Utah	1.000	0.939	0.662
31145	50	Vermont	1.000	0.977	0.514
00973	50	Virgin Islands	1.000	1.018	1.003
00904	00	Virginia	1.000	0.939	0.579
00836	02	Seattle (King Cnty), WA	1.010	1.115	0.819
00836	99	Rest of Washington	1.000	0.975	0.819
00884	16	West Virginia	1.000	0.835	1.547
00951	00	Wisconsin	1.000	0.924	0.790
00825	21	Wyoming	1.000	0.874	0.935

[1] 1.0 Floor on Work GPCI set by MMA.

[2] 1.67 Floor on all indices set by MMA.

GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.

* States are served by more than one carrier.

ADDENDUM E -- 2006 GEOGRAPHIC PRACTICE COST INDICES
BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00510	00	Alabama	1.000	0.846	0.752
00831	01	Alaska	1.017	1.103	1.029
00832	00	Arizona	1.000	0.992	1.069
00520	13	Arkansas	1.000	0.831	0.438
31146	26	Anaheim/Santa Ana, CA	1.034	1.236	0.954
31146	18	Los Angeles, CA	1.041	1.156	0.954
31140	03	Marin/Napa/Solano, CA	1.035	1.340	0.651
31140	07	Oakland/Berkley, CA	1.054	1.371	0.651
31140	05	San Francisco, CA	1.060	1.543	0.651
31140	06	San Mateo, CA	1.073	1.536	0.639
31140	09	Santa Clara, CA	1.083	1.540	0.604
31146	17	Ventura, CA	1.028	1.179	0.744
31140	99	Rest of California*	1.007	1.053	0.733
31146	99	Rest of California*	1.007	1.053	0.733
00824	01	Colorado	1.000	1.014	0.803
00591	00	Connecticut	1.038	1.170	0.900
00902	01	Delaware	1.012	1.018	0.892
00903	01	DC + MD/VA Suburbs	1.048	1.250	0.926
00590	03	Fort Lauderdale, FL	1.000	0.988	1.703
00590	04	Miami, FL	1.000	1.046	2.269
00590	99	Rest of Florida	1.000	0.934	1.272
00511	01	Atlanta, GA	1.010	1.089	0.966
00511	99	Rest of Georgia	1.000	0.872	0.966
00833	01	Hawaii/Guam	1.005	1.111	0.800
05130	00	Idaho	1.000	0.868	0.459
00952	16	Chicago, IL	1.025	1.126	1.867
00952	12	East St. Louis, IL	1.000	0.939	1.750
00952	15	Suburban Chicago, IL	1.018	1.115	1.652
00952	99	Rest of Illinois	1.000	0.872	1.193
00630	00	Indiana	1.000	0.906	0.436
00826	00	Iowa	1.000	0.868	0.589
00650	00	Kansas*	1.000	0.878	0.721
00740	04	Kansas*	1.000	0.878	0.721
00660	00	Kentucky	1.000	0.854	0.873
00528	01	New Orleans, LA	1.000	0.946	1.197
00528	99	Rest of Louisiana	1.000	0.847	1.058
31142	03	Southern Maine	1.000	1.013	0.637
31142	99	Rest of Maine	1.000	0.886	0.637
00901	01	Baltimore/Surr. Cntys, MD	1.012	1.078	0.947
00901	99	Rest of Maryland	1.000	0.980	0.760
31143	01	Metropolitan Boston	1.030	1.329	0.823
31143	99	Rest of Massachusetts	1.007	1.103	0.823
00953	01	Detroit, MI	1.037	1.054	2.744
00953	99	Rest of Michigan	1.000	0.921	1.518
00954	00	Minnesota	1.000	1.005	0.410
00512	00	Mississippi	1.000	0.839	0.722
00740	02	Metropolitan Kansas City, MO	1.000	0.975	0.946
00523	01	Metropolitan St. Louis, MO	1.000	0.955	0.941
00523	99	Rest of Missouri*	1.000	0.802	0.892

[1] 1.0 Floor on Work GPCI set by MMA.
GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.
* States are served by more than one carrier.

ADDENDUM E -- 2006 GEOGRAPHIC PRACTICE COST INDICES
BY MEDICARE CARRIER AND LOCALITY

Carrier Number	Locality Number	Locality Name	[1]Work GPCI	PE GPCI	MP GPCI
00740	99	Rest of Missouri*	1.000	0.802	0.892
00751	01	Montana	1.000	0.844	0.904
00655	00	Nebraska	1.000	0.875	0.454
00834	00	Nevada	1.003	1.043	1.068
31144	40	New Hampshire	1.000	1.027	0.942
00805	01	Northern NJ	1.058	1.220	0.973
00805	99	Rest of New Jersey	1.043	1.119	0.973
00521	05	New Mexico	1.000	0.887	0.895
00803	01	Manhattan, NY	1.065	1.298	1.504
00803	02	NYC Suburbs/Long I., NY	1.052	1.280	1.785
00803	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.074	1.167
14330	04	Queens, NY	1.032	1.228	1.710
00801	99	Rest of New York	1.000	0.917	0.677
05535	00	North Carolina	1.000	0.920	0.640
00820	01	North Dakota	1.000	0.860	0.602
00883	00	Ohio	1.000	0.933	0.976
00522	00	Oklahoma	1.000	0.854	0.382
00835	01	Portland, OR	1.002	1.057	0.441
00835	99	Rest of Oregon	1.000	0.925	0.441
00865	01	Metropolitan Philadelphia, PA	1.016	1.104	1.386
00865	99	Rest of Pennsylvania	1.000	0.902	0.806
00973	20	Puerto Rico	1.000	0.698	0.261
00870	01	Rhode Island	1.045	0.989	0.909
00880	01	South Carolina	1.000	0.893	0.394
00820	02	South Dakota	1.000	0.876	0.365
05440	35	Tennessee	1.000	0.879	0.631
00900	31	Austin, TX	1.000	1.046	0.986
00900	20	Beaumont, TX	1.000	0.860	1.298
00900	09	Brazoria, TX	1.020	0.961	1.298
00900	11	Dallas, TX	1.009	1.062	1.061
00900	28	Fort Worth, TX	1.000	0.989	1.061
00900	15	Galveston, TX	1.000	0.952	1.298
00900	18	Houston, TX	1.016	1.014	1.297
00900	99	Rest of Texas	1.000	0.865	1.138
00910	09	Utah	1.000	0.937	0.662
31145	50	Vermont	1.000	0.968	0.514
00973	50	Virgin Islands	1.000	1.014	1.003
00904	00	Virginia	1.000	0.940	0.579
00836	02	Seattle (King Cnty), WA	1.014	1.131	0.819
00836	99	Rest of Washington	1.000	0.978	0.819
00884	16	West Virginia	1.000	0.819	1.547
00951	00	Wisconsin	1.000	0.918	0.790
00825	21	Wyoming	1.000	0.853	0.935

[1] 1.0 Floor on Work GPCI set by MMA.
GPCIs scaled by following factors: Work = 0.9965, Practice Expense = 0.9929, Malpractice = 1.0021.
* States are served by more than one carrier.

ADDENDUM F -- COMPARISON OF 2004 GAFs TO 2005 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2005 GAF	Difference	Percent Difference
31140	09	Santa Clara, CA	1.184	1.224	0.040	0.034
31140	07	Oakland/Berkley, CA	1.111	1.144	0.033	0.030
31140	06	San Mateo, CA	1.201	1.230	0.029	0.024
31140	03	Marin/Napa/Solano, CA	1.103	1.128	0.025	0.023
00903	01	DC + MD/VA Suburbs	1.096	1.114	0.019	0.017
31143	01	Metropolitan Boston	1.118	1.136	0.018	0.016
31140	05	San Francisco, CA	1.223	1.239	0.016	0.013
00900	31	Austin, TX	0.995	1.009	0.014	0.014
00952	15	Suburban Chicago, IL	1.059	1.072	0.013	0.012
31146	17	Ventura, CA	1.060	1.072	0.011	0.011
31146	26	Anaheim/Santa Ana, CA	1.098	1.109	0.011	0.010
00836	02	Seattle (King Cnty), WA	1.039	1.049	0.010	0.010
00805	01	Northern NJ	1.111	1.120	0.009	0.008
00952	16	Chicago, IL	1.087	1.096	0.009	0.008
00511	01	Atlanta, GA	1.027	1.036	0.009	0.008
00805	99	Rest of New Jersey	1.060	1.068	0.008	0.008
00901	01	Baltimore/Surr. Cntys, MD	1.025	1.033	0.008	0.007
00954	00	Minnesota	0.967	0.973	0.006	0.007
00523	01	Metropolitan St. Louis, MO	0.969	0.974	0.006	0.006
00820	01	North Dakota	0.923	0.928	0.005	0.006
00900	28	Fort Worth, TX	0.992	0.996	0.005	0.005
00952	12	East St. Louis, IL	0.995	0.999	0.004	0.005
00824	01	Colorado	0.990	0.994	0.004	0.004
31146	99	Rest of California*	1.008	1.012	0.004	0.004
31140	99	Rest of California*	1.008	1.012	0.004	0.004
00740	02	Metropolitan Kansas City, MO	0.982	0.986	0.004	0.004
31142	03	Southern Maine	0.986	0.989	0.003	0.003
00832	00	Arizona	0.994	0.996	0.003	0.003
00953	01	Detroit, MI	1.106	1.109	0.002	0.002
00904	00	Virginia	0.955	0.957	0.002	0.002
00836	99	Rest of Washington	0.980	0.982	0.002	0.002
00835	01	Portland, OR	1.000	1.002	0.002	0.002
31144	40	New Hampshire	1.009	1.011	0.002	0.002
00900	11	Dallas, TX	1.033	1.035	0.002	0.002
00901	99	Rest of Maryland	0.979	0.981	0.002	0.002
00865	01	Metropolitan Philadelphia, PA	1.068	1.069	0.001	0.001
00900	99	Rest of Texas	0.949	0.950	0.001	0.001
00655	00	Nebraska	0.925	0.925	0.000	0.000
00900	18	Houston, TX	1.026	1.026	0.000	0.000
31146	18	Los Angeles, CA	1.088	1.088	0.000	0.000
00831	01	Alaska	1.670	1.670	0.000	0.000
00880	01	South Carolina	0.932	0.932	0.000	0.000
00910	09	Utah	0.961	0.961	0.000	0.000
00512	00	Mississippi	0.919	0.919	0.000	0.000
00803	02	NYC Suburbs/Long I., NY	1.179	1.178	-0.001	0.000
00900	09	Brazoria, TX	1.003	1.002	-0.001	-0.001
00591	00	Connecticut	1.092	1.091	-0.001	-0.001
00803	03	Poughkpsie/N NYC Suburbs, NY	1.047	1.046	-0.001	-0.001
00520	13	Arkansas	0.910	0.908	-0.001	-0.001

* States are served by more than one carrier.

ADDENDUM F -- COMPARISON OF 2004 GAFs TO 2005 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2005 GAF	Difference	Percent Difference
00835	99	Rest of Oregon	0.949	0.948	-0.001	-0.001
00528	01	New Orleans, LA	0.985	0.984	-0.001	-0.001
05535	00	North Carolina	0.955	0.954	-0.001	-0.002
00826	00	Iowa	0.930	0.928	-0.002	-0.002
00902	01	Delaware	1.018	1.016	-0.002	-0.002
00973	50	Virgin Islands	1.010	1.008	-0.002	-0.002
00883	00	Ohio	0.974	0.972	-0.002	-0.002
00834	00	Nevada	1.025	1.023	-0.002	-0.002
00590	99	Rest of Florida	0.987	0.985	-0.002	-0.002
00833	01	Hawaii/Guam	1.047	1.045	-0.002	-0.002
00660	00	Kentucky	0.937	0.934	-0.002	-0.003
00952	99	Rest of Illinois	0.958	0.956	-0.003	-0.003
00521	05	New Mexico	0.952	0.949	-0.003	-0.003
00884	16	West Virginia	0.952	0.949	-0.003	-0.003
00740	99	Rest of Missouri*	0.917	0.914	-0.003	-0.003
00523	99	Rest of Missouri*	0.917	0.914	-0.003	-0.003
00973	20	Puerto Rico	0.846	0.843	-0.003	-0.004
00751	01	Montana	0.939	0.935	-0.003	-0.004
05440	35	Tennessee	0.941	0.938	-0.003	-0.004
00511	99	Rest of Georgia	0.951	0.947	-0.004	-0.004
05130	00	Idaho	0.928	0.924	-0.004	-0.004
00740	04	Kansas*	0.944	0.940	-0.004	-0.004
00650	00	Kansas*	0.944	0.940	-0.004	-0.004
00630	00	Indiana	0.945	0.941	-0.004	-0.004
31145	50	Vermont	0.976	0.971	-0.004	-0.004
00900	15	Galveston, TX	0.999	0.994	-0.004	-0.004
00953	99	Rest of Michigan	0.994	0.989	-0.005	-0.005
00865	99	Rest of Pennsylvania	0.961	0.956	-0.005	-0.005
00951	00	Wisconsin	0.964	0.959	-0.005	-0.005
31143	99	Rest of Massachusetts	1.054	1.049	-0.005	-0.005
00528	99	Rest of Louisiana	0.946	0.940	-0.005	-0.006
31142	99	Rest of Maine	0.947	0.942	-0.006	-0.006
00522	00	Oklahoma	0.923	0.917	-0.006	-0.006
00510	00	Alabama	0.935	0.929	-0.006	-0.006
00900	20	Beaumont, TX	0.964	0.957	-0.007	-0.007
00801	99	Rest of New York	0.965	0.957	-0.007	-0.008
00870	01	Rhode Island	1.033	1.025	-0.008	-0.008
14330	04	Queens, NY	1.161	1.151	-0.010	-0.008
00590	03	Fort Lauderdale, FL	1.038	1.029	-0.010	-0.009
00590	04	Miami, FL	1.085	1.075	-0.010	-0.009
00825	21	Wyoming	0.953	0.943	-0.010	-0.011
00820	02	South Dakota	0.933	0.922	-0.011	-0.012
00803	01	Manhattan, NY	1.225	1.203	-0.022	-0.018

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ADDENDUM G -- COMPARISON OF 2004 GAFs TO 2006 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2006 GAF	Difference	Percent Difference
31140	09	Santa Clara, CA	1.184	1.265	0.080	0.068
31140	07	Oakland/Berkley, CA	1.111	1.177	0.066	0.059
31140	06	San Mateo, CA	1.201	1.259	0.058	0.048
31140	03	Marin/Napa/Solano, CA	1.103	1.154	0.050	0.046
00903	01	DC + MD/VA Suburbs	1.096	1.132	0.036	0.033
31143	01	Metropolitan Boston	1.118	1.153	0.035	0.031
31140	05	San Francisco, CA	1.223	1.256	0.033	0.027
00900	31	Austin, TX	0.995	1.020	0.025	0.025
00952	15	Suburban Chicago, IL	1.059	1.085	0.026	0.025
31146	17	Ventura, CA	1.060	1.083	0.023	0.022
31146	26	Anaheim/Santa Ana, CA	1.098	1.119	0.021	0.020
00836	02	Seattle (King Cnty), WA	1.039	1.058	0.019	0.019
00511	01	Atlanta, GA	1.027	1.043	0.016	0.016
00952	16	Chicago, IL	1.087	1.102	0.015	0.014
00954	00	Minnesota	0.967	0.980	0.013	0.013
00901	01	Baltimore/Surr. Cntys, MD	1.025	1.039	0.014	0.013
00805	99	Rest of New Jersey	1.060	1.074	0.014	0.013
00805	01	Northern NJ	1.111	1.126	0.014	0.013
00523	01	Metropolitan St. Louis, MO	0.969	0.978	0.010	0.010
00824	01	Colorado	0.990	0.999	0.009	0.009
31146	99	Rest of California*	1.008	1.017	0.008	0.008
31140	99	Rest of California*	1.008	1.017	0.008	0.008
00952	12	East St. Louis, IL	0.995	1.003	0.008	0.008
00900	28	Fort Worth, TX	0.992	0.998	0.006	0.006
31142	03	Southern Maine	0.986	0.992	0.006	0.006
00740	02	Metropolitan Kansas City, MO	0.982	0.987	0.006	0.006
00832	00	Arizona	0.994	0.999	0.006	0.006
00835	01	Portland, OR	1.000	1.005	0.005	0.005
00953	01	Detroit, MI	1.106	1.111	0.004	0.004
00836	99	Rest of Washington	0.980	0.984	0.004	0.004
00901	99	Rest of Maryland	0.979	0.982	0.004	0.004
00904	00	Virginia	0.955	0.958	0.003	0.003
00900	09	Brazoria, TX	1.003	1.005	0.003	0.003
00865	01	Metropolitan Philadelphia, PA	1.068	1.069	0.001	0.001
31144	40	New Hampshire	1.009	1.010	0.001	0.001
00803	02	NYC Suburbs/Long I., NY	1.179	1.180	0.001	0.001
00900	11	Dallas, TX	1.033	1.034	0.001	0.001
00820	01	North Dakota	0.923	0.924	0.001	0.001
00900	18	Houston, TX	1.026	1.026	0.001	0.001
00512	00	Mississippi	0.919	0.919	0.000	0.000
31146	18	Los Angeles, CA	1.088	1.088	0.000	0.000
00655	00	Nebraska	0.925	0.925	0.000	0.000
00803	03	Poughkpsie/N NYC Suburbs, NY	1.047	1.046	-0.001	-0.001
00528	01	New Orleans, LA	0.985	0.984	-0.001	-0.001
00591	00	Connecticut	1.092	1.091	-0.001	-0.001
00910	09	Utah	0.961	0.960	-0.001	-0.001
00834	00	Nevada	1.025	1.023	-0.002	-0.002
00880	01	South Carolina	0.932	0.930	-0.002	-0.002
00900	99	Rest of Texas	0.949	0.947	-0.003	-0.003

Note: The Percent Difference in the GAF for Alaska is the result of the termination of the favorable 2-Year MMA provision for the state of Alaska.

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ADDENDUM G -- COMPARISON OF 2004 GAFs TO 2006 GAFs

Carrier Number	Locality Number	Locality Name	2004 GAF	2006 GAF	Difference	Percent Difference
00833	01	Hawaii/Guam	1.047	1.044	-0.003	-0.003
00835	99	Rest of Oregon	0.949	0.946	-0.003	-0.003
00973	50	Virgin Islands	1.010	1.007	-0.004	-0.004
00826	00	Iowa	0.930	0.927	-0.003	-0.004
05535	00	North Carolina	0.955	0.951	-0.004	-0.004
00883	00	Ohio	0.974	0.970	-0.004	-0.004
00590	99	Rest of Florida	0.987	0.982	-0.005	-0.005
00520	13	Arkansas	0.910	0.905	-0.005	-0.005
00660	00	Kentucky	0.937	0.932	-0.005	-0.005
00521	05	New Mexico	0.952	0.947	-0.006	-0.006
05130	00	Idaho	0.928	0.922	-0.006	-0.007
00952	99	Rest of Illinois	0.958	0.952	-0.006	-0.007
00902	01	Delaware	1.018	1.010	-0.007	-0.007
00973	20	Puerto Rico	0.846	0.840	-0.006	-0.007
00951	00	Wisconsin	0.964	0.956	-0.007	-0.008
00900	15	Galveston, TX	0.999	0.991	-0.008	-0.008
00630	00	Indiana	0.945	0.937	-0.008	-0.008
00953	99	Rest of Michigan	0.994	0.986	-0.008	-0.008
31145	50	Vermont	0.976	0.968	-0.008	-0.008
00740	04	Kansas*	0.944	0.936	-0.008	-0.008
00650	00	Kansas*	0.944	0.936	-0.008	-0.008
00511	99	Rest of Georgia	0.951	0.943	-0.008	-0.008
00740	99	Rest of Missouri*	0.917	0.910	-0.008	-0.009
00523	99	Rest of Missouri*	0.917	0.910	-0.008	-0.009
05440	35	Tennessee	0.941	0.933	-0.008	-0.009
00884	16	West Virginia	0.952	0.942	-0.010	-0.011
00528	99	Rest of Louisiana	0.946	0.936	-0.010	-0.011
00751	01	Montana	0.939	0.928	-0.010	-0.011
31143	99	Rest of Massachusetts	1.054	1.042	-0.012	-0.011
00865	99	Rest of Pennsylvania	0.961	0.950	-0.011	-0.011
31142	99	Rest of Maine	0.947	0.936	-0.011	-0.011
00522	00	Oklahoma	0.923	0.913	-0.011	-0.011
00510	00	Alabama	0.935	0.923	-0.011	-0.012
00820	02	South Dakota	0.933	0.922	-0.012	-0.013
00801	99	Rest of New York	0.965	0.952	-0.013	-0.014
00590	04	Miami, FL	1.085	1.069	-0.015	-0.014
00900	20	Beaumont, TX	0.964	0.951	-0.014	-0.014
14330	04	Queens, NY	1.161	1.144	-0.016	-0.014
00590	03	Fort Lauderdale, FL	1.038	1.022	-0.016	-0.016
00870	01	Rhode Island	1.033	1.016	-0.018	-0.017
00825	21	Wyoming	0.953	0.934	-0.019	-0.020
00803	01	Manhattan, NY	1.225	1.184	-0.041	-0.034
00831	01	Alaska	1.670	1.055	-0.615	-0.368

Note: The Percent Difference in the GAF for Alaska is the result of the termination of the favorable 2-Year MMA provision for the state of Alaska.

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ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
00601	PR	00766	PR	04290	ME	04654	ME
00606	PR	00767	PR	04292	ME	04655	ME
00610	PR	00769	PR	04406	ME	04657	ME
00611	PR	00771	PR	04413	ME	04658	ME
00617	PR	00772	PR	04414	ME	04666	ME
00624	PR	00777	PR	04415	ME	04667	ME
00627	PR	00782	PR	04424	ME	04668	ME
00631	PR	00783	PR	04426	ME	04671	ME
00637	PR	00794	PR	04430	ME	04680	ME
00638	PR	00795	PR	04441	ME	04686	ME
00641	PR	00953	PR	04442	ME	04691	ME
00647	PR	00954	PR	04443	ME	04694	ME
00650	PR	04010	ME	04448	ME	04765	ME
00653	PR	04016	ME	04451	ME	04777	ME
00659	PR	04022	ME	04454	ME	04782	ME
00660	PR	04037	ME	04455	ME	04911	ME
00662	PR	04041	ME	04457	ME	04912	ME
00664	PR	04051	ME	04459	ME	04920	ME
00667	PR	04068	ME	04460	ME	04923	ME
00669	PR	04088	ME	04462	ME	04924	ME
00670	PR	04216	ME	04463	ME	04925	ME
00676	PR	04217	ME	04464	ME	04928	ME
00677	PR	04219	ME	04478	ME	04929	ME
00678	PR	04220	ME	04479	ME	04930	ME
00685	PR	04221	ME	04481	ME	04933	ME
00687	PR	04222	ME	04485	ME	04937	ME
00692	PR	04224	ME	04487	ME	04942	ME
00693	PR	04226	ME	04490	ME	04943	ME
00694	PR	04228	ME	04491	ME	04944	ME
00703	PR	04231	ME	04492	ME	04945	ME
00707	PR	04237	ME	04493	ME	04950	ME
00714	PR	04238	ME	04495	ME	04953	ME
00718	PR	04254	ME	04606	ME	04954	ME
00719	PR	04255	ME	04611	ME	04957	ME
00720	PR	04257	ME	04619	ME	04958	ME
00721	PR	04261	ME	04622	ME	04961	ME
00723	PR	04267	ME	04623	ME	04965	ME
00729	PR	04268	ME	04626	ME	04967	ME
00735	PR	04270	ME	04628	ME	04971	ME
00742	PR	04271	ME	04630	ME	04975	ME
00744	PR	04275	ME	04631	ME	04976	ME
00745	PR	04276	ME	04637	ME	04978	ME
00751	PR	04278	ME	04643	ME	04979	ME
00754	PR	04281	ME	04648	ME	04985	ME
00757	PR	04286	ME	04649	ME	05444	VT
00765	PR	04289	ME	04652	ME	05824	VT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
05837	VT	12032	NY	12427	NY	12843	NY
05840	VT	12035	NY	12430	NY	12845	NY
05846	VT	12036	NY	12431	NY	12848	NY
05858	VT	12040	NY	12434	NY	12849	NY
05901	VT	12042	NY	12436	NY	12851	NY
05902	VT	12043	NY	12438	NY	12852	NY
05903	VT	12051	NY	12439	NY	12853	NY
05904	VT	12057	NY	12442	NY	12854	NY
05905	VT	12058	NY	12444	NY	12855	NY
05906	VT	12066	NY	12450	NY	12856	NY
05907	VT	12071	NY	12451	NY	12857	NY
08001	NJ	12073	NY	12452	NY	12858	NY
08023	NJ	12076	NY	12454	NY	12860	NY
08038	NJ	12078	NY	12455	NY	12861	NY
08067	NJ	12083	NY	12459	NY	12862	NY
08069	NJ	12087	NY	12460	NY	12865	NY
08070	NJ	12089	NY	12463	NY	12870	NY
08072	NJ	12090	NY	12468	NY	12872	NY
08098	NJ	12092	NY	12470	NY	12873	NY
08202	NJ	12093	NY	12473	NY	12874	NY
08204	NJ	12095	NY	12474	NY	12878	NY
08210	NJ	12117	NY	12482	NY	12879	NY
08212	NJ	12122	NY	12485	NY	12883	NY
08214	NJ	12124	NY	12492	NY	12885	NY
08218	NJ	12131	NY	12496	NY	12886	NY
08219	NJ	12133	NY	12808	NY	12887	NY
08242	NJ	12134	NY	12809	NY	12913	NY
08243	NJ	12149	NY	12810	NY	12928	NY
08247	NJ	12157	NY	12811	NY	12932	NY
08251	NJ	12160	NY	12814	NY	12936	NY
08252	NJ	12167	NY	12815	NY	12941	NY
08260	NJ	12175	NY	12816	NY	12942	NY
08270	NJ	12176	NY	12817	NY	12943	NY
08318	NJ	12187	NY	12819	NY	12946	NY
08343	NJ	12192	NY	12821	NY	12950	NY
08347	NJ	12194	NY	12823	NY	12956	NY
08530	NJ	12405	NY	12824	NY	12960	NY
08556	NJ	12406	NY	12827	NY	12961	NY
08557	NJ	12407	NY	12828	NY	12964	NY
08559	NJ	12413	NY	12832	NY	12974	NY
12015	NY	12414	NY	12834	NY	12975	NY
12022	NY	12418	NY	12836	NY	12977	NY
12024	NY	12421	NY	12837	NY	12987	NY
12025	NY	12422	NY	12838	NY	12993	NY
12028	NY	12423	NY	12839	NY	12996	NY
12031	NY	12424	NY	12841	NY	12997	NY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
12998	NY	13343	NY	13751	NY	14414	NY
13028	NY	13345	NY	13752	NY	14415	NY
13032	NY	13350	NY	13753	NY	14416	NY
13033	NY	13357	NY	13754	NY	14418	NY
13035	NY	13361	NY	13755	NY	14422	NY
13036	NY	13364	NY	13756	NY	14423	NY
13037	NY	13365	NY	13757	NY	14429	NY
13042	NY	13367	NY	13758	NY	14433	NY
13043	NY	13368	NY	13774	NY	14435	NY
13044	NY	13404	NY	13775	NY	14441	NY
13064	NY	13406	NY	13778	NY	14449	NY
13065	NY	13407	NY	13780	NY	14452	NY
13076	NY	13409	NY	13782	NY	14466	NY
13103	NY	13411	NY	13783	NY	14470	NY
13111	NY	13416	NY	13786	NY	14476	NY
13113	NY	13418	NY	13788	NY	14477	NY
13122	NY	13420	NY	13801	NY	14478	NY
13124	NY	13431	NY	13804	NY	14480	NY
13131	NY	13433	NY	13806	NY	14485	NY
13132	NY	13454	NY	13809	NY	14486	NY
13134	NY	13459	NY	13811	NY	14487	NY
13135	NY	13460	NY	13812	NY	14488	NY
13136	NY	13461	NY	13814	NY	14489	NY
13143	NY	13464	NY	13815	NY	14502	NY
13146	NY	13470	NY	13827	NY	14505	NY
13148	NY	13472	NY	13830	NY	14507	NY
13154	NY	13473	NY	13832	NY	14513	NY
13155	NY	13475	NY	13835	NY	14516	NY
13156	NY	13489	NY	13837	NY	14519	NY
13165	NY	13491	NY	13838	NY	14520	NY
13166	NY	13493	NY	13839	NY	14521	NY
13167	NY	13620	NY	13840	NY	14522	NY
13301	NY	13626	NY	13841	NY	14527	NY
13302	NY	13627	NY	13842	NY	14533	NY
13305	NY	13631	NY	13843	NY	14538	NY
13309	NY	13648	NY	13844	NY	14539	NY
13312	NY	13730	NY	13845	NY	14541	NY
13314	NY	13731	NY	13846	NY	14542	NY
13316	NY	13732	NY	13847	NY	14544	NY
13324	NY	13733	NY	13856	NY	14551	NY
13325	NY	13734	NY	13860	NY	14555	NY
13327	NY	13736	NY	13864	NY	14557	NY
13329	NY	13739	NY	14029	NY	14558	NY
13331	NY	13740	NY	14098	NY	14560	NY
13332	NY	13743	NY	14143	NY	14563	NY
13340	NY	13750	NY	14413	NY	14568	NY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
14571	NY	15325	PA	15446	PA	15534	PA
14588	NY	15327	PA	15447	PA	15535	PA
14589	NY	15334	PA	15449	PA	15536	PA
14590	NY	15337	PA	15450	PA	15537	PA
14592	NY	15338	PA	15451	PA	15538	PA
14707	NY	15341	PA	15454	PA	15539	PA
14708	NY	15344	PA	15455	PA	15540	PA
14709	NY	15346	PA	15456	PA	15541	PA
14711	NY	15348	PA	15458	PA	15542	PA
14714	NY	15349	PA	15459	PA	15544	PA
14715	NY	15351	PA	15460	PA	15545	PA
14717	NY	15352	PA	15461	PA	15546	PA
14721	NY	15353	PA	15462	PA	15547	PA
14727	NY	15354	PA	15463	PA	15548	PA
14735	NY	15357	PA	15464	PA	15549	PA
14739	NY	15359	PA	15465	PA	15550	PA
14744	NY	15362	PA	15466	PA	15551	PA
14745	NY	15364	PA	15467	PA	15552	PA
14754	NY	15370	PA	15468	PA	15553	PA
14774	NY	15380	PA	15469	PA	15554	PA
14777	NY	15401	PA	15470	PA	15555	PA
14786	NY	15410	PA	15472	PA	15557	PA
14802	NY	15411	PA	15473	PA	15558	PA
14803	NY	15413	PA	15474	PA	15559	PA
14804	NY	15415	PA	15475	PA	15560	PA
14806	NY	15416	PA	15476	PA	15561	PA
14813	NY	15417	PA	15478	PA	15562	PA
14822	NY	15420	PA	15480	PA	15563	PA
14837	NY	15421	PA	15482	PA	15564	PA
14842	NY	15422	PA	15484	PA	15565	PA
14847	NY	15424	PA	15485	PA	15630	PA
14857	NY	15425	PA	15486	PA	15631	PA
14859	NY	15428	PA	15488	PA	15656	PA
14860	NY	15430	PA	15489	PA	15673	PA
14880	NY	15431	PA	15490	PA	15682	PA
14883	NY	15433	PA	15492	PA	15686	PA
14884	NY	15435	PA	15501	PA	15714	PA
14892	NY	15436	PA	15502	PA	15722	PA
14895	NY	15437	PA	15510	PA	15736	PA
14897	NY	15438	PA	15520	PA	15737	PA
15012	PA	15439	PA	15521	PA	15738	PA
15310	PA	15440	PA	15522	PA	15760	PA
15315	PA	15442	PA	15530	PA	15762	PA
15316	PA	15443	PA	15531	PA	15773	PA
15320	PA	15444	PA	15532	PA	15775	PA
15322	PA	15445	PA	15533	PA	15828	PA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
15832	PA	16215	PA	16375	PA	16693	PA
15834	PA	16217	PA	16401	PA	16694	PA
15861	PA	16218	PA	16407	PA	16695	PA
15924	PA	16220	PA	16412	PA	16699	PA
15926	PA	16221	PA	16413	PA	16822	PA
15927	PA	16222	PA	16423	PA	16848	PA
15928	PA	16223	PA	16438	PA	16877	PA
15931	PA	16224	PA	16444	PA	16901	PA
15935	PA	16225	PA	16475	PA	16911	PA
15936	PA	16226	PA	16611	PA	16912	PA
15937	PA	16228	PA	16614	PA	16917	PA
15940	PA	16229	PA	16621	PA	16918	PA
15943	PA	16230	PA	16622	PA	16920	PA
15948	PA	16232	PA	16623	PA	16921	PA
15953	PA	16233	PA	16624	PA	16928	PA
15959	PA	16234	PA	16630	PA	16929	PA
15961	PA	16235	PA	16631	PA	16930	PA
15963	PA	16236	PA	16633	PA	16932	PA
16028	PA	16238	PA	16634	PA	16933	PA
16036	PA	16239	PA	16636	PA	16935	PA
16049	PA	16240	PA	16638	PA	16936	PA
16054	PA	16242	PA	16646	PA	16938	PA
16058	PA	16244	PA	16647	PA	16939	PA
16101	PA	16245	PA	16650	PA	16940	PA
16102	PA	16248	PA	16652	PA	16942	PA
16103	PA	16249	PA	16654	PA	16943	PA
16105	PA	16250	PA	16655	PA	16946	PA
16107	PA	16253	PA	16657	PA	16950	PA
16108	PA	16254	PA	16659	PA	17003	PA
16112	PA	16255	PA	16660	PA	17006	PA
16116	PA	16257	PA	16662	PA	17010	PA
16117	PA	16258	PA	16664	PA	17014	PA
16120	PA	16259	PA	16667	PA	17017	PA
16132	PA	16260	PA	16668	PA	17020	PA
16140	PA	16261	PA	16669	PA	17021	PA
16142	PA	16262	PA	16670	PA	17024	PA
16143	PA	16263	PA	16672	PA	17031	PA
16155	PA	16321	PA	16673	PA	17035	PA
16156	PA	16322	PA	16674	PA	17037	PA
16157	PA	16326	PA	16675	PA	17038	PA
16160	PA	16331	PA	16678	PA	17040	PA
16201	PA	16332	PA	16679	PA	17041	PA
16210	PA	16334	PA	16683	PA	17045	PA
16212	PA	16353	PA	16685	PA	17047	PA
16213	PA	16361	PA	16689	PA	17048	PA
16214	PA	16370	PA	16691	PA	17049	PA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
17052	PA	17320	PA	17751	PA	17870	PA
17053	PA	17324	PA	17752	PA	17872	PA
17056	PA	17325	PA	17756	PA	17876	PA
17058	PA	17326	PA	17758	PA	17877	PA
17059	PA	17337	PA	17760	PA	17881	PA
17060	PA	17340	PA	17762	PA	17882	PA
17062	PA	17343	PA	17764	PA	17901	PA
17066	PA	17344	PA	17765	PA	17921	PA
17068	PA	17350	PA	17767	PA	17922	PA
17069	PA	17353	PA	17768	PA	17923	PA
17071	PA	17372	PA	17769	PA	17925	PA
17074	PA	17375	PA	17772	PA	17929	PA
17076	PA	17503	PA	17773	PA	17930	PA
17077	PA	17506	PA	17774	PA	17931	PA
17078	PA	17507	PA	17777	PA	17932	PA
17082	PA	17509	PA	17778	PA	17933	PA
17086	PA	17517	PA	17779	PA	17934	PA
17090	PA	17519	PA	17801	PA	17935	PA
17091	PA	17522	PA	17812	PA	17936	PA
17094	PA	17527	PA	17813	PA	17938	PA
17097	PA	17528	PA	17823	PA	17941	PA
17098	PA	17529	PA	17824	PA	17942	PA
17211	PA	17534	PA	17825	PA	17943	PA
17212	PA	17535	PA	17827	PA	17944	PA
17213	PA	17536	PA	17830	PA	17945	PA
17215	PA	17549	PA	17831	PA	17946	PA
17223	PA	17555	PA	17832	PA	17948	PA
17228	PA	17557	PA	17833	PA	17949	PA
17229	PA	17566	PA	17834	PA	17951	PA
17233	PA	17567	PA	17836	PA	17952	PA
17238	PA	17569	PA	17840	PA	17953	PA
17239	PA	17578	PA	17842	PA	17954	PA
17243	PA	17581	PA	17843	PA	17957	PA
17249	PA	17721	PA	17847	PA	17959	PA
17253	PA	17726	PA	17850	PA	17960	PA
17255	PA	17730	PA	17851	PA	17961	PA
17260	PA	17731	PA	17853	PA	17963	PA
17264	PA	17737	PA	17857	PA	17964	PA
17267	PA	17738	PA	17860	PA	17965	PA
17301	PA	17740	PA	17861	PA	17966	PA
17303	PA	17742	PA	17862	PA	17967	PA
17304	PA	17745	PA	17864	PA	17968	PA
17306	PA	17747	PA	17865	PA	17970	PA
17307	PA	17748	PA	17866	PA	17972	PA
17310	PA	17749	PA	17867	PA	17974	PA
17316	PA	17750	PA	17868	PA	17976	PA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
17978	PA	18419	PA	19311	PA	21656	MD
17979	PA	18421	PA	19362	PA	21657	MD
17980	PA	18425	PA	19363	PA	21658	MD
17981	PA	18426	PA	19374	PA	21660	MD
17982	PA	18428	PA	19501	PA	21666	MD
17983	PA	18430	PA	19507	PA	21668	MD
17985	PA	18435	PA	19543	PA	21670	MD
18010	PA	18441	PA	19544	PA	21681	MD
18012	PA	18446	PA	19549	PA	21682	MD
18013	PA	18451	PA	19559	PA	21683	MD
18030	PA	18457	PA	20106	VA	21684	MD
18050	PA	18458	PA	20113	VA	21685	MD
18071	PA	18464	PA	20130	VA	21686	MD
18210	PA	18465	PA	20135	VA	21687	MD
18211	PA	18470	PA	20137	VA	21688	MD
18212	PA	18614	PA	20140	VA	21690	MD
18214	PA	18615	PA	20184	VA	21727	MD
18216	PA	18616	PA	20185	VA	21750	MD
18218	PA	18619	PA	20188	VA	21759	MD
18220	PA	18624	PA	20198	VA	21811	MD
18229	PA	18625	PA	20682	MD	21813	MD
18230	PA	18626	PA	21520	MD	21822	MD
18231	PA	18628	PA	21522	MD	21829	MD
18232	PA	18632	PA	21523	MD	21841	MD
18235	PA	18636	PA	21531	MD	21842	MD
18237	PA	18801	PA	21536	MD	21843	MD
18240	PA	18812	PA	21538	MD	21851	MD
18241	PA	18813	PA	21541	MD	21862	MD
18242	PA	18816	PA	21550	MD	21863	MD
18244	PA	18818	PA	21561	MD	21864	MD
18245	PA	18820	PA	21607	MD	21872	MD
18248	PA	18821	PA	21609	MD	22002	VA
18250	PA	18822	PA	21617	MD	22134	VA
18252	PA	18823	PA	21619	MD	22427	VA
18254	PA	18824	PA	21623	MD	22428	VA
18255	PA	18825	PA	21628	MD	22432	VA
18324	PA	18826	PA	21629	MD	22433	VA
18328	PA	18827	PA	21632	MD	22435	VA
18336	PA	18828	PA	21636	MD	22442	VA
18337	PA	18830	PA	21638	MD	22443	VA
18340	PA	18834	PA	21639	MD	22446	VA
18343	PA	18839	PA	21640	MD	22448	VA
18351	PA	18842	PA	21641	MD	22451	VA
18371	PA	18843	PA	21644	MD	22456	VA
18373	PA	18844	PA	21649	MD	22460	VA
18413	PA	18847	PA	21655	MD	22469	VA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
22472	VA	22652	VA	22846	VA	23050	VA
22473	VA	22654	VA	22847	VA	23055	VA
22481	VA	22655	VA	22848	VA	23056	VA
22485	VA	22656	VA	22849	VA	23061	VA
22488	VA	22657	VA	22850	VA	23062	VA
22501	VA	22660	VA	22851	VA	23064	VA
22508	VA	22664	VA	22853	VA	23066	VA
22511	VA	22709	VA	22923	VA	23068	VA
22514	VA	22711	VA	22935	VA	23070	VA
22520	VA	22715	VA	22942	VA	23071	VA
22524	VA	22716	VA	22948	VA	23072	VA
22526	VA	22719	VA	22953	VA	23076	VA
22529	VA	22721	VA	22957	VA	23079	VA
22530	VA	22722	VA	22960	VA	23083	VA
22535	VA	22723	VA	22963	VA	23084	VA
22538	VA	22725	VA	22965	VA	23085	VA
22539	VA	22727	VA	22968	VA	23086	VA
22542	VA	22730	VA	22972	VA	23089	VA
22544	VA	22731	VA	22973	VA	23091	VA
22546	VA	22732	VA	22974	VA	23092	VA
22547	VA	22735	VA	22989	VA	23093	VA
22548	VA	22738	VA	23001	VA	23101	VA
22552	VA	22740	VA	23002	VA	23105	VA
22558	VA	22743	VA	23003	VA	23106	VA
22567	VA	22747	VA	23004	VA	23107	VA
22570	VA	22748	VA	23005	VA	23108	VA
22572	VA	22749	VA	23009	VA	23109	VA
22577	VA	22810	VA	23011	VA	23110	VA
22579	VA	22811	VA	23015	VA	23117	VA
22580	VA	22812	VA	23017	VA	23119	VA
22581	VA	22815	VA	23018	VA	23123	VA
22602	VA	22820	VA	23021	VA	23124	VA
22603	VA	22821	VA	23022	VA	23125	VA
22622	VA	22824	VA	23023	VA	23126	VA
22623	VA	22827	VA	23024	VA	23128	VA
22624	VA	22830	VA	23025	VA	23130	VA
22625	VA	22831	VA	23027	VA	23131	VA
22626	VA	22832	VA	23030	VA	23138	VA
22627	VA	22833	VA	23031	VA	23139	VA
22637	VA	22834	VA	23032	VA	23140	VA
22640	VA	22835	VA	23035	VA	23141	VA
22641	VA	22840	VA	23038	VA	23147	VA
22642	VA	22841	VA	23040	VA	23148	VA
22644	VA	22842	VA	23043	VA	23149	VA
22645	VA	22844	VA	23045	VA	23154	VA
22650	VA	22845	VA	23047	VA	23155	VA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
23156	VA	23418	VA	23875	VA	23968	VA
23161	VA	23420	VA	23876	VA	23970	VA
23163	VA	23421	VA	23878	VA	23974	VA
23169	VA	23422	VA	23879	VA	23976	VA
23170	VA	23423	VA	23881	VA	24053	VA
23175	VA	23424	VA	23882	VA	24054	VA
23176	VA	23426	VA	23883	VA	24055	VA
23177	VA	23427	VA	23884	VA	24064	VA
23178	VA	23430	VA	23885	VA	24065	VA
23180	VA	23431	VA	23887	VA	24066	VA
23181	VA	23440	VA	23888	VA	24067	VA
23183	VA	23441	VA	23889	VA	24069	VA
23184	VA	23442	VA	23890	VA	24072	VA
23190	VA	23480	VA	23891	VA	24076	VA
23191	VA	23483	VA	23893	VA	24077	VA
23301	VA	23487	VA	23894	VA	24078	VA
23302	VA	23488	VA	23897	VA	24079	VA
23303	VA	23801	VA	23898	VA	24082	VA
23304	VA	23821	VA	23899	VA	24083	VA
23306	VA	23822	VA	23915	VA	24085	VA
23308	VA	23824	VA	23917	VA	24086	VA
23314	VA	23827	VA	23919	VA	24088	VA
23315	VA	23828	VA	23920	VA	24089	VA
23336	VA	23829	VA	23921	VA	24090	VA
23337	VA	23830	VA	23922	VA	24091	VA
23341	VA	23833	VA	23923	VA	24092	VA
23345	VA	23837	VA	23924	VA	24093	VA
23356	VA	23839	VA	23927	VA	24094	VA
23357	VA	23840	VA	23930	VA	24101	VA
23358	VA	23841	VA	23934	VA	24102	VA
23359	VA	23842	VA	23936	VA	24104	VA
23389	VA	23843	VA	23937	VA	24105	VA
23395	VA	23844	VA	23938	VA	24120	VA
23396	VA	23845	VA	23939	VA	24121	VA
23397	VA	23846	VA	23941	VA	24124	VA
23399	VA	23847	VA	23944	VA	24127	VA
23401	VA	23850	VA	23947	VA	24128	VA
23404	VA	23856	VA	23950	VA	24130	VA
23407	VA	23857	VA	23952	VA	24131	VA
23409	VA	23866	VA	23955	VA	24133	VA
23410	VA	23867	VA	23958	VA	24134	VA
23412	VA	23868	VA	23959	VA	24136	VA
23414	VA	23870	VA	23962	VA	24137	VA
23415	VA	23872	VA	23963	VA	24139	VA
23416	VA	23873	VA	23964	VA	24146	VA
23417	VA	23874	VA	23967	VA	24147	VA

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24148	VA	24271	VA	24441	VA	24594	VA
24150	VA	24272	VA	24442	VA	24595	VA
24151	VA	24277	VA	24445	VA	24599	VA
24161	VA	24279	VA	24458	VA	24603	VA
24165	VA	24280	VA	24460	VA	24607	VA
24167	VA	24281	VA	24465	VA	24614	VA
24168	VA	24282	VA	24468	VA	24618	VA
24171	VA	24283	VA	24471	VA	24620	VA
24174	VA	24285	VA	24472	VA	24624	VA
24175	VA	24289	VA	24473	VA	24627	VA
24176	VA	24290	VA	24483	VA	24628	VA
24177	VA	24292	VA	24484	VA	24631	VA
24184	VA	24293	VA	24487	VA	24634	VA
24185	VA	24311	VA	24517	VA	24639	VA
24201	VA	24314	VA	24521	VA	24646	VA
24202	VA	24315	VA	24522	VA	24647	VA
24203	VA	24317	VA	24523	VA	24649	VA
24209	VA	24318	VA	24526	VA	24656	VA
24215	VA	24319	VA	24527	VA	24657	VA
24216	VA	24325	VA	24528	VA	24658	VA
24217	VA	24326	VA	24529	VA	24716	WV
24218	VA	24328	VA	24530	VA	24719	WV
24219	VA	24330	VA	24531	VA	24726	WV
24220	VA	24343	VA	24533	VA	24801	WV
24221	VA	24348	VA	24538	VA	24808	WV
24224	VA	24351	VA	24549	VA	24811	WV
24225	VA	24352	VA	24550	VA	24813	WV
24226	VA	24354	VA	24554	VA	24815	WV
24228	VA	24363	VA	24555	VA	24816	WV
24230	VA	24366	VA	24557	VA	24817	WV
24237	VA	24370	VA	24562	VA	24818	WV
24239	VA	24373	VA	24563	VA	24820	WV
24243	VA	24375	VA	24565	VA	24821	WV
24244	VA	24378	VA	24566	VA	24822	WV
24245	VA	24379	VA	24569	VA	24823	WV
24246	VA	24380	VA	24570	VA	24824	WV
24248	VA	24381	VA	24571	VA	24825	WV
24250	VA	24412	VA	24572	VA	24826	WV
24251	VA	24413	VA	24574	VA	24827	WV
24256	VA	24415	VA	24576	VA	24828	WV
24258	VA	24416	VA	24578	VA	24829	WV
24260	VA	24426	VA	24579	VA	24830	WV
24263	VA	24433	VA	24580	VA	24831	WV
24265	VA	24435	VA	24586	VA	24832	WV
24266	VA	24438	VA	24588	VA	24834	WV
24269	VA	24439	VA	24593	VA	24836	WV

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24839	WV	24897	WV	25063	WV	25231	WV
24841	WV	24898	WV	25081	WV	25234	WV
24842	WV	24899	WV	25085	WV	25235	WV
24843	WV	24915	WV	25088	WV	25239	WV
24844	WV	24918	WV	25090	WV	25241	WV
24845	WV	24919	WV	25093	WV	25243	WV
24846	WV	24920	WV	25095	WV	25244	WV
24847	WV	24924	WV	25106	WV	25245	WV
24848	WV	24927	WV	25108	WV	25247	WV
24849	WV	24934	WV	25111	WV	25248	WV
24850	WV	24935	WV	25113	WV	25250	WV
24851	WV	24941	WV	25114	WV	25251	WV
24852	WV	24942	WV	25115	WV	25252	WV
24853	WV	24944	WV	25118	WV	25253	WV
24854	WV	24945	WV	25119	WV	25256	WV
24855	WV	24946	WV	25123	WV	25258	WV
24856	WV	24951	WV	25125	WV	25259	WV
24857	WV	24954	WV	25130	WV	25260	WV
24859	WV	24962	WV	25133	WV	25261	WV
24860	WV	24963	WV	25136	WV	25262	WV
24861	WV	24974	WV	25139	WV	25264	WV
24862	WV	24976	WV	25141	WV	25265	WV
24866	WV	24981	WV	25142	WV	25266	WV
24867	WV	24983	WV	25148	WV	25267	WV
24868	WV	24984	WV	25149	WV	25268	WV
24869	WV	24985	WV	25150	WV	25270	WV
24870	WV	24993	WV	25152	WV	25271	WV
24871	WV	25002	WV	25154	WV	25275	WV
24872	WV	25005	WV	25161	WV	25276	WV
24873	WV	25009	WV	25164	WV	25279	WV
24874	WV	25010	WV	25165	WV	25281	WV
24877	WV	25018	WV	25169	WV	25283	WV
24878	WV	25019	WV	25173	WV	25285	WV
24879	WV	25021	WV	25180	WV	25286	WV
24880	WV	25024	WV	25181	WV	25287	WV
24881	WV	25028	WV	25185	WV	25410	WV
24882	WV	25030	WV	25186	WV	25411	WV
24883	WV	25031	WV	25187	WV	25414	WV
24884	WV	25036	WV	25193	WV	25419	WV
24887	WV	25040	WV	25203	WV	25422	WV
24888	WV	25043	WV	25204	WV	25423	WV
24889	WV	25049	WV	25205	WV	25425	WV
24892	WV	25051	WV	25206	WV	25429	WV
24894	WV	25053	WV	25208	WV	25430	WV
24895	WV	25057	WV	25209	WV	25431	WV
24896	WV	25059	WV	25211	WV	25432	WV

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
25434	WV	25666	WV	25880	WV	26135	WV
25437	WV	25667	WV	25882	WV	26136	WV
25438	WV	25669	WV	25901	WV	26137	WV
25441	WV	25670	WV	25904	WV	26138	WV
25442	WV	25671	WV	25907	WV	26141	WV
25443	WV	25672	WV	25912	WV	26143	WV
25444	WV	25674	WV	25913	WV	26146	WV
25446	WV	25676	WV	25914	WV	26147	WV
25501	WV	25678	WV	25916	WV	26148	WV
25502	WV	25682	WV	25917	WV	26149	WV
25503	WV	25685	WV	25928	WV	26151	WV
25506	WV	25686	WV	25931	WV	26152	WV
25507	WV	25687	WV	25936	WV	26155	WV
25511	WV	25688	WV	25938	WV	26159	WV
25512	WV	25690	WV	25942	WV	26160	WV
25514	WV	25691	WV	25943	WV	26161	WV
25515	WV	25692	WV	25951	WV	26162	WV
25517	WV	25694	WV	25965	WV	26164	WV
25519	WV	25696	WV	25966	WV	26167	WV
25520	WV	25697	WV	25969	WV	26170	WV
25521	WV	25699	WV	25976	WV	26173	WV
25523	WV	25704	WV	25977	WV	26175	WV
25524	WV	25770	WV	25978	WV	26178	WV
25529	WV	25771	WV	25979	WV	26186	WV
25530	WV	25810	WV	25985	WV	26187	WV
25534	WV	25811	WV	25986	WV	26201	WV
25535	WV	25812	WV	25988	WV	26202	WV
25540	WV	25826	WV	26030	WV	26203	WV
25544	WV	25831	WV	26031	WV	26205	WV
25550	WV	25833	WV	26032	WV	26206	WV
25555	WV	25837	WV	26033	WV	26208	WV
25557	WV	25840	WV	26034	WV	26209	WV
25562	WV	25845	WV	26035	WV	26210	WV
25564	WV	25846	WV	26036	WV	26215	WV
25565	WV	25848	WV	26037	WV	26217	WV
25567	WV	25854	WV	26038	WV	26218	WV
25570	WV	25855	WV	26039	WV	26219	WV
25571	WV	25859	WV	26040	WV	26222	WV
25573	WV	25862	WV	26041	WV	26228	WV
25608	WV	25864	WV	26050	WV	26229	WV
25621	WV	25866	WV	26055	WV	26234	WV
25623	WV	25868	WV	26056	WV	26236	WV
25650	WV	25870	WV	26058	WV	26237	WV
25651	WV	25875	WV	26070	WV	26238	WV
25661	WV	25876	WV	26075	WV	26250	WV
25665	WV	25879	WV	26134	WV	26254	WV

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
26260	WV	26419	WV	26651	WV	26812	WV
26261	WV	26421	WV	26656	WV	26814	WV
26264	WV	26424	WV	26660	WV	26815	WV
26266	WV	26425	WV	26662	WV	26817	WV
26269	WV	26430	WV	26667	WV	26818	WV
26271	WV	26434	WV	26671	WV	26823	WV
26275	WV	26435	WV	26674	WV	26824	WV
26287	WV	26436	WV	26675	WV	26833	WV
26288	WV	26437	WV	26676	WV	26836	WV
26289	WV	26440	WV	26678	WV	26838	WV
26291	WV	26443	WV	26679	WV	26845	WV
26292	WV	26444	WV	26680	WV	26847	WV
26298	WV	26447	WV	26681	WV	26851	WV
26320	WV	26452	WV	26684	WV	26852	WV
26321	WV	26456	WV	26690	WV	26855	WV
26325	WV	26519	WV	26691	WV	26865	WV
26327	WV	26520	WV	26704	WV	26866	WV
26328	WV	26524	WV	26705	WV	26884	WV
26334	WV	26525	WV	26707	WV	26886	WV
26335	WV	26535	WV	26710	WV	27007	NC
26337	WV	26537	WV	26711	WV	27011	NC
26338	WV	26542	WV	26714	WV	27014	NC
26339	WV	26547	WV	26716	WV	27016	NC
26342	WV	26561	WV	26717	WV	27017	NC
26343	WV	26562	WV	26719	WV	27018	NC
26346	WV	26575	WV	26720	WV	27019	NC
26347	WV	26581	WV	26722	WV	27020	NC
26348	WV	26601	WV	26726	WV	27021	NC
26349	WV	26610	WV	26731	WV	27022	NC
26350	WV	26611	WV	26734	WV	27024	NC
26351	WV	26612	WV	26739	WV	27025	NC
26354	WV	26615	WV	26743	WV	27027	NC
26362	WV	26617	WV	26750	WV	27028	NC
26372	WV	26618	WV	26753	WV	27030	NC
26374	WV	26619	WV	26755	WV	27031	NC
26376	WV	26621	WV	26757	WV	27041	NC
26377	WV	26623	WV	26761	WV	27042	NC
26378	WV	26624	WV	26763	WV	27043	NC
26384	WV	26627	WV	26764	WV	27046	NC
26405	WV	26629	WV	26767	WV	27047	NC
26407	WV	26631	WV	26801	WV	27048	NC
26410	WV	26634	WV	26802	WV	27049	NC
26411	WV	26636	WV	26804	WV	27052	NC
26412	WV	26638	WV	26807	WV	27053	NC
26415	WV	26639	WV	26808	WV	27055	NC
26416	WV	26641	WV	26810	WV	27207	NC

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27208	NC	27520	NC	27832	NC	27921	NC
27209	NC	27521	NC	27838	NC	27922	NC
27212	NC	27522	NC	27839	NC	27923	NC
27213	NC	27524	NC	27840	NC	27924	NC
27228	NC	27525	NC	27841	NC	27925	NC
27229	NC	27541	NC	27842	NC	27926	NC
27247	NC	27542	NC	27843	NC	27927	NC
27252	NC	27543	NC	27844	NC	27928	NC
27256	NC	27546	NC	27845	NC	27929	NC
27288	NC	27551	NC	27846	NC	27930	NC
27289	NC	27552	NC	27847	NC	27932	NC
27291	NC	27555	NC	27849	NC	27935	NC
27292	NC	27559	NC	27850	NC	27936	NC
27293	NC	27563	NC	27852	NC	27937	NC
27294	NC	27564	NC	27853	NC	27938	NC
27295	NC	27565	NC	27854	NC	27939	NC
27299	NC	27568	NC	27855	NC	27941	NC
27305	NC	27569	NC	27857	NC	27942	NC
27306	NC	27570	NC	27861	NC	27943	NC
27311	NC	27573	NC	27862	NC	27944	NC
27312	NC	27574	NC	27864	NC	27946	NC
27314	NC	27576	NC	27866	NC	27947	NC
27315	NC	27577	NC	27867	NC	27948	NC
27316	NC	27581	NC	27869	NC	27949	NC
27320	NC	27582	NC	27870	NC	27950	NC
27321	NC	27583	NC	27871	NC	27953	NC
27322	NC	27586	NC	27872	NC	27954	NC
27323	NC	27589	NC	27874	NC	27956	NC
27326	NC	27593	NC	27875	NC	27957	NC
27343	NC	27594	NC	27876	NC	27958	NC
27344	NC	27596	NC	27877	NC	27959	NC
27350	NC	27801	NC	27881	NC	27960	NC
27351	NC	27802	NC	27882	NC	27962	NC
27355	NC	27805	NC	27885	NC	27964	NC
27356	NC	27807	NC	27886	NC	27965	NC
27370	NC	27809	NC	27887	NC	27966	NC
27371	NC	27816	NC	27888	NC	27967	NC
27374	NC	27818	NC	27890	NC	27968	NC
27375	NC	27819	NC	27892	NC	27969	NC
27379	NC	27820	NC	27897	NC	27970	NC
27501	NC	27823	NC	27910	NC	27972	NC
27504	NC	27824	NC	27915	NC	27973	NC
27506	NC	27825	NC	27916	NC	27974	NC
27507	NC	27826	NC	27917	NC	27976	NC
27508	NC	27828	NC	27919	NC	27978	NC
27509	NC	27831	NC	27920	NC	27979	NC

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27980	NC	28337	NC	28432	NC	28537	NC
27981	NC	28338	NC	28433	NC	28538	NC
27982	NC	28339	NC	28434	NC	28552	NC
27983	NC	28340	NC	28435	NC	28554	NC
27985	NC	28341	NC	28436	NC	28555	NC
27986	NC	28344	NC	28438	NC	28556	NC
28001	NC	28345	NC	28439	NC	28571	NC
28002	NC	28347	NC	28441	NC	28573	NC
28007	NC	28349	NC	28442	NC	28580	NC
28009	NC	28357	NC	28443	NC	28583	NC
28021	NC	28358	NC	28444	NC	28585	NC
28023	NC	28359	NC	28446	NC	28587	NC
28037	NC	28360	NC	28447	NC	28604	NC
28079	NC	28361	NC	28448	NC	28606	NC
28080	NC	28362	NC	28450	NC	28612	NC
28088	NC	28363	NC	28451	NC	28615	NC
28091	NC	28364	NC	28452	NC	28616	NC
28097	NC	28366	NC	28453	NC	28617	NC
28102	NC	28367	NC	28454	NC	28621	NC
28104	NC	28368	NC	28455	NC	28622	NC
28108	NC	28369	NC	28456	NC	28623	NC
28109	NC	28371	NC	28457	NC	28624	NC
28119	NC	28372	NC	28458	NC	28626	NC
28127	NC	28375	NC	28459	NC	28627	NC
28128	NC	28376	NC	28461	NC	28629	NC
28129	NC	28377	NC	28462	NC	28630	NC
28133	NC	28378	NC	28463	NC	28631	NC
28135	NC	28379	NC	28464	NC	28635	NC
28137	NC	28380	NC	28465	NC	28636	NC
28163	NC	28382	NC	28466	NC	28637	NC
28168	NC	28383	NC	28467	NC	28640	NC
28170	NC	28384	NC	28468	NC	28642	NC
28173	NC	28385	NC	28469	NC	28643	NC
28261	NC	28386	NC	28470	NC	28644	NC
28318	NC	28392	NC	28471	NC	28646	NC
28319	NC	28393	NC	28472	NC	28649	NC
28320	NC	28398	NC	28478	NC	28651	NC
28323	NC	28399	NC	28479	NC	28652	NC
28325	NC	28420	NC	28508	NC	28653	NC
28326	NC	28421	NC	28509	NC	28654	NC
28328	NC	28422	NC	28510	NC	28656	NC
28329	NC	28423	NC	28515	NC	28657	NC
28330	NC	28424	NC	28518	NC	28659	NC
28332	NC	28425	NC	28521	NC	28662	NC
28334	NC	28430	NC	28522	NC	28663	NC
28335	NC	28431	NC	28529	NC	28664	NC

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
28665	NC	28904	NC	29180	SC	29484	SC
28666	NC	28905	NC	29321	SC	29485	SC
28667	NC	28906	NC	29325	SC	29488	SC
28668	NC	28909	NC	29332	SC	29492	SC
28669	NC	29001	SC	29340	SC	29493	SC
28670	NC	29003	SC	29341	SC	29512	SC
28672	NC	29006	SC	29342	SC	29516	SC
28674	NC	29010	SC	29351	SC	29518	SC
28675	NC	29014	SC	29353	SC	29519	SC
28676	NC	29015	SC	29355	SC	29520	SC
28678	NC	29030	SC	29360	SC	29525	SC
28681	NC	29031	SC	29364	SC	29532	SC
28683	NC	29037	SC	29370	SC	29536	SC
28684	NC	29041	SC	29379	SC	29540	SC
28685	NC	29042	SC	29384	SC	29542	SC
28693	NC	29046	SC	29395	SC	29543	SC
28694	NC	29051	SC	29410	SC	29546	SC
28697	NC	29055	SC	29420	SC	29547	SC
28702	NC	29056	SC	29430	SC	29550	SC
28705	NC	29065	SC	29431	SC	29551	SC
28713	NC	29069	SC	29433	SC	29554	SC
28714	NC	29075	SC	29434	SC	29556	SC
28719	NC	29079	SC	29435	SC	29560	SC
28722	NC	29080	SC	29436	SC	29563	SC
28733	NC	29081	SC	29437	SC	29564	SC
28737	NC	29082	SC	29438	SC	29565	SC
28740	NC	29101	SC	29445	SC	29567	SC
28743	NC	29102	SC	29446	SC	29570	SC
28749	NC	29106	SC	29447	SC	29571	SC
28750	NC	29108	SC	29448	SC	29573	SC
28752	NC	29111	SC	29450	SC	29574	SC
28753	NC	29122	SC	29452	SC	29580	SC
28754	NC	29126	SC	29453	SC	29584	SC
28755	NC	29127	SC	29456	SC	29589	SC
28756	NC	29129	SC	29461	SC	29590	SC
28761	NC	29130	SC	29468	SC	29592	SC
28762	NC	29132	SC	29469	SC	29593	SC
28765	NC	29135	SC	29471	SC	29594	SC
28771	NC	29138	SC	29472	SC	29596	SC
28773	NC	29143	SC	29474	SC	29620	SC
28777	NC	29145	SC	29475	SC	29628	SC
28781	NC	29148	SC	29476	SC	29638	SC
28782	NC	29162	SC	29477	SC	29639	SC
28901	NC	29166	SC	29479	SC	29642	SC
28902	NC	29176	SC	29481	SC	29645	SC
28903	NC	29178	SC	29483	SC	29659	SC

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
29697	SC	29929	SC	30222	GA	30457	GA
29702	SC	29932	SC	30229	GA	30464	GA
29706	SC	29933	SC	30233	GA	30467	GA
29709	SC	29934	SC	30234	GA	30470	GA
29712	SC	29936	SC	30251	GA	30471	GA
29714	SC	29939	SC	30256	GA	30473	GA
29717	SC	29943	SC	30257	GA	30477	GA
29718	SC	29944	SC	30258	GA	30499	GA
29724	SC	29945	SC	30265	GA	30510	GA
29727	SC	30011	GA	30276	GA	30511	GA
29728	SC	30016	GA	30277	GA	30512	GA
29729	SC	30052	GA	30284	GA	30513	GA
29741	SC	30055	GA	30289	GA	30514	GA
29742	SC	30103	GA	30292	GA	30516	GA
29743	SC	30104	GA	30293	GA	30517	GA
29810	SC	30110	GA	30295	GA	30520	GA
29812	SC	30113	GA	30401	GA	30521	GA
29813	SC	30120	GA	30410	GA	30522	GA
29817	SC	30121	GA	30411	GA	30523	GA
29821	SC	30123	GA	30412	GA	30525	GA
29824	SC	30125	GA	30413	GA	30528	GA
29826	SC	30132	GA	30414	GA	30529	GA
29827	SC	30137	GA	30417	GA	30530	GA
29832	SC	30138	GA	30420	GA	30531	GA
29835	SC	30140	GA	30421	GA	30534	GA
29836	SC	30141	GA	30423	GA	30535	GA
29838	SC	30143	GA	30424	GA	30537	GA
29840	SC	30145	GA	30425	GA	30539	GA
29843	SC	30148	GA	30426	GA	30540	GA
29844	SC	30153	GA	30427	GA	30541	GA
29845	SC	30157	GA	30428	GA	30544	GA
29846	SC	30171	GA	30429	GA	30545	GA
29847	SC	30175	GA	30434	GA	30546	GA
29849	SC	30176	GA	30438	GA	30547	GA
29853	SC	30177	GA	30439	GA	30548	GA
29899	SC	30178	GA	30441	GA	30549	GA
29911	SC	30179	GA	30442	GA	30552	GA
29912	SC	30180	GA	30445	GA	30553	GA
29913	SC	30182	GA	30446	GA	30555	GA
29916	SC	30184	GA	30447	GA	30558	GA
29918	SC	30204	GA	30448	GA	30559	GA
29921	SC	30206	GA	30449	GA	30560	GA
29922	SC	30216	GA	30451	GA	30562	GA
29923	SC	30217	GA	30453	GA	30563	GA
29924	SC	30218	GA	30455	GA	30565	GA
29927	SC	30219	GA	30456	GA	30567	GA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
30568	GA	30707	GA	31020	GA	31089	GA
30571	GA	30708	GA	31024	GA	31090	GA
30572	GA	30711	GA	31025	GA	31091	GA
30573	GA	30724	GA	31026	GA	31092	GA
30575	GA	30725	GA	31029	GA	31094	GA
30576	GA	30728	GA	31030	GA	31096	GA
30580	GA	30730	GA	31031	GA	31303	GA
30581	GA	30731	GA	31032	GA	31304	GA
30582	GA	30738	GA	31033	GA	31305	GA
30596	GA	30739	GA	31035	GA	31307	GA
30599	GA	30741	GA	31037	GA	31312	GA
30619	GA	30747	GA	31038	GA	31316	GA
30620	GA	30750	GA	31039	GA	31318	GA
30623	GA	30751	GA	31041	GA	31319	GA
30624	GA	30752	GA	31042	GA	31326	GA
30625	GA	30753	GA	31044	GA	31327	GA
30627	GA	30757	GA	31045	GA	31329	GA
30628	GA	30803	GA	31046	GA	31331	GA
30629	GA	30806	GA	31049	GA	31510	GA
30630	GA	30807	GA	31050	GA	31513	GA
30631	GA	30808	GA	31051	GA	31515	GA
30633	GA	30810	GA	31052	GA	31516	GA
30634	GA	30811	GA	31054	GA	31518	GA
30635	GA	30816	GA	31055	GA	31532	GA
30639	GA	30817	GA	31057	GA	31537	GA
30642	GA	30818	GA	31058	GA	31539	GA
30643	GA	30819	GA	31060	GA	31542	GA
30645	GA	30820	GA	31063	GA	31543	GA
30646	GA	30821	GA	31064	GA	31544	GA
30647	GA	30822	GA	31066	GA	31549	GA
30648	GA	30823	GA	31067	GA	31551	GA
30650	GA	30824	GA	31068	GA	31553	GA
30660	GA	30828	GA	31069	GA	31556	GA
30662	GA	30830	GA	31070	GA	31557	GA
30663	GA	30833	GA	31071	GA	31562	GA
30664	GA	31001	GA	31072	GA	31563	GA
30665	GA	31002	GA	31076	GA	31566	GA
30666	GA	31003	GA	31078	GA	31620	GA
30667	GA	31004	GA	31079	GA	31622	GA
30668	GA	31006	GA	31081	GA	31623	GA
30669	GA	31007	GA	31082	GA	31624	GA
30671	GA	31008	GA	31083	GA	31625	GA
30673	GA	31014	GA	31084	GA	31627	GA
30678	GA	31016	GA	31085	GA	31629	GA
30680	GA	31017	GA	31086	GA	31630	GA
30705	GA	31018	GA	31087	GA	31631	GA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
31634	GA	31774	GA	32052	FL	32327	FL
31635	GA	31777	GA	32053	FL	32328	FL
31637	GA	31779	GA	32058	FL	32329	FL
31638	GA	31781	GA	32059	FL	32330	FL
31639	GA	31783	GA	32060	FL	32331	FL
31642	GA	31784	GA	32062	FL	32332	FL
31643	GA	31785	GA	32064	FL	32333	FL
31645	GA	31786	GA	32066	FL	32334	FL
31646	GA	31787	GA	32071	FL	32335	FL
31647	GA	31789	GA	32091	FL	32336	FL
31648	GA	31790	GA	32094	FL	32337	FL
31649	GA	31791	GA	32096	FL	32340	FL
31650	GA	31796	GA	32097	FL	32341	FL
31713	GA	31797	GA	32102	FL	32343	FL
31714	GA	31798	GA	32110	FL	32344	FL
31716	GA	31801	GA	32112	FL	32345	FL
31720	GA	31803	GA	32131	FL	32346	FL
31723	GA	31804	GA	32135	FL	32347	FL
31724	GA	31805	GA	32136	FL	32348	FL
31726	GA	31806	GA	32137	FL	32350	FL
31728	GA	31807	GA	32138	FL	32351	FL
31729	GA	31810	GA	32139	FL	32352	FL
31730	GA	31811	GA	32140	FL	32353	FL
31732	GA	31812	GA	32142	FL	32355	FL
31736	GA	31814	GA	32147	FL	32356	FL
31737	GA	31815	GA	32148	FL	32357	FL
31739	GA	31816	GA	32149	FL	32358	FL
31740	GA	31821	GA	32151	FL	32359	FL
31741	GA	31822	GA	32157	FL	32360	FL
31742	GA	31823	GA	32158	FL	32361	FL
31745	GA	31824	GA	32159	FL	32420	FL
31746	GA	31825	GA	32162	FL	32421	FL
31749	GA	31826	GA	32164	FL	32422	FL
31750	GA	31827	GA	32177	FL	32423	FL
31751	GA	31830	GA	32178	FL	32424	FL
31754	GA	31831	GA	32181	FL	32425	FL
31759	GA	31832	GA	32185	FL	32426	FL
31760	GA	31836	GA	32187	FL	32427	FL
31761	GA	32007	FL	32189	FL	32428	FL
31762	GA	32008	FL	32193	FL	32430	FL
31763	GA	32009	FL	32320	FL	32431	FL
31766	GA	32011	FL	32321	FL	32432	FL
31767	GA	32013	FL	32322	FL	32433	FL
31769	GA	32041	FL	32323	FL	32434	FL
31770	GA	32042	FL	32324	FL	32435	FL
31772	GA	32044	FL	32326	FL	32437	FL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
32439	FL	32767	FL	33935	FL	34731	FL
32440	FL	32776	FL	33944	FL	34736	FL
32442	FL	32778	FL	33957	FL	34737	FL
32443	FL	32784	FL	33960	FL	34748	FL
32445	FL	33440	FL	33975	FL	34749	FL
32446	FL	33471	FL	34140	FL	34753	FL
32447	FL	33513	FL	34145	FL	34755	FL
32448	FL	33514	FL	34146	FL	34756	FL
32449	FL	33521	FL	34449	FL	34762	FL
32452	FL	33538	FL	34484	FL	34785	FL
32454	FL	33543	FL	34498	FL	34788	FL
32455	FL	33544	FL	34601	FL	34789	FL
32456	FL	33574	FL	34602	FL	34797	FL
32457	FL	33585	FL	34603	FL	34956	FL
32459	FL	33597	FL	34604	FL	35004	AL
32460	FL	33825	FL	34605	FL	35013	AL
32461	FL	33826	FL	34606	FL	35014	AL
32462	FL	33827	FL	34607	FL	35016	AL
32463	FL	33830	FL	34608	FL	35031	AL
32464	FL	33831	FL	34609	FL	35032	AL
32465	FL	33834	FL	34610	FL	35034	AL
32538	FL	33841	FL	34611	FL	35035	AL
32550	FL	33843	FL	34613	FL	35038	AL
32619	FL	33844	FL	34614	FL	35042	AL
32621	FL	33845	FL	34636	FL	35044	AL
32622	FL	33847	FL	34639	FL	35045	AL
32625	FL	33852	FL	34652	FL	35046	AL
32626	FL	33854	FL	34653	FL	35049	AL
32628	FL	33855	FL	34654	FL	35051	AL
32639	FL	33856	FL	34655	FL	35052	AL
32644	FL	33857	FL	34656	FL	35054	AL
32648	FL	33859	FL	34661	FL	35063	AL
32666	FL	33862	FL	34667	FL	35072	AL
32668	FL	33865	FL	34668	FL	35074	AL
32680	FL	33867	FL	34669	FL	35079	AL
32683	FL	33870	FL	34673	FL	35082	AL
32692	FL	33871	FL	34674	FL	35085	AL
32693	FL	33872	FL	34679	FL	35089	AL
32696	FL	33873	FL	34680	FL	35096	AL
32702	FL	33875	FL	34690	FL	35097	AL
32726	FL	33876	FL	34691	FL	35112	AL
32727	FL	33890	FL	34705	FL	35120	AL
32735	FL	33924	FL	34711	FL	35121	AL
32736	FL	33930	FL	34712	FL	35125	AL
32756	FL	33931	FL	34713	FL	35128	AL
32757	FL	33932	FL	34729	FL	35130	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
35131	AL	35546	AL	35651	AL	35978	AL
35133	AL	35548	AL	35652	AL	35979	AL
35135	AL	35549	AL	35653	AL	35980	AL
35136	AL	35550	AL	35654	AL	35981	AL
35143	AL	35551	AL	35671	AL	35983	AL
35146	AL	35552	AL	35672	AL	35984	AL
35148	AL	35553	AL	35739	AL	35986	AL
35149	AL	35554	AL	35740	AL	35987	AL
35150	AL	35555	AL	35742	AL	35988	AL
35151	AL	35559	AL	35744	AL	35989	AL
35160	AL	35560	AL	35745	AL	36003	AL
35161	AL	35563	AL	35746	AL	36005	AL
35171	AL	35564	AL	35747	AL	36006	AL
35175	AL	35565	AL	35751	AL	36008	AL
35182	AL	35570	AL	35752	AL	36009	AL
35183	AL	35571	AL	35755	AL	36010	AL
35184	AL	35572	AL	35756	AL	36015	AL
35188	AL	35573	AL	35764	AL	36016	AL
35441	AL	35574	AL	35765	AL	36017	AL
35442	AL	35575	AL	35766	AL	36020	AL
35443	AL	35576	AL	35768	AL	36022	AL
35447	AL	35577	AL	35769	AL	36024	AL
35448	AL	35578	AL	35771	AL	36025	AL
35459	AL	35579	AL	35772	AL	36026	AL
35460	AL	35580	AL	35774	AL	36027	AL
35461	AL	35581	AL	35776	AL	36028	AL
35462	AL	35582	AL	35950	AL	36029	AL
35464	AL	35584	AL	35951	AL	36030	AL
35466	AL	35585	AL	35953	AL	36031	AL
35469	AL	35586	AL	35956	AL	36032	AL
35470	AL	35587	AL	35957	AL	36033	AL
35471	AL	35592	AL	35958	AL	36034	AL
35474	AL	35593	AL	35959	AL	36035	AL
35477	AL	35594	AL	35960	AL	36037	AL
35481	AL	35610	AL	35961	AL	36038	AL
35491	AL	35611	AL	35962	AL	36039	AL
35501	AL	35612	AL	35963	AL	36040	AL
35502	AL	35613	AL	35964	AL	36041	AL
35503	AL	35614	AL	35966	AL	36042	AL
35504	AL	35615	AL	35967	AL	36045	AL
35540	AL	35618	AL	35968	AL	36047	AL
35541	AL	35620	AL	35971	AL	36048	AL
35542	AL	35643	AL	35973	AL	36049	AL
35543	AL	35647	AL	35974	AL	36051	AL
35544	AL	35649	AL	35975	AL	36053	AL
35545	AL	35650	AL	35976	AL	36054	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36061	AL	36323	AL	36467	AL	36732	AL
36062	AL	36330	AL	36470	AL	36736	AL
36066	AL	36331	AL	36471	AL	36738	AL
36067	AL	36340	AL	36473	AL	36740	AL
36068	AL	36344	AL	36474	AL	36741	AL
36071	AL	36345	AL	36475	AL	36742	AL
36072	AL	36346	AL	36476	AL	36744	AL
36075	AL	36349	AL	36477	AL	36745	AL
36078	AL	36350	AL	36480	AL	36748	AL
36079	AL	36351	AL	36481	AL	36749	AL
36080	AL	36352	AL	36482	AL	36750	AL
36081	AL	36353	AL	36483	AL	36751	AL
36082	AL	36360	AL	36501	AL	36752	AL
36083	AL	36361	AL	36502	AL	36753	AL
36087	AL	36362	AL	36503	AL	36754	AL
36088	AL	36371	AL	36504	AL	36756	AL
36089	AL	36373	AL	36509	AL	36762	AL
36091	AL	36374	AL	36513	AL	36763	AL
36092	AL	36375	AL	36515	AL	36764	AL
36093	AL	36401	AL	36518	AL	36765	AL
36251	AL	36420	AL	36522	AL	36766	AL
36255	AL	36425	AL	36524	AL	36768	AL
36258	AL	36426	AL	36529	AL	36769	AL
36261	AL	36427	AL	36538	AL	36776	AL
36262	AL	36429	AL	36539	AL	36778	AL
36263	AL	36431	AL	36540	AL	36779	AL
36264	AL	36432	AL	36543	AL	36782	AL
36266	AL	36435	AL	36545	AL	36783	AL
36267	AL	36436	AL	36548	AL	36784	AL
36268	AL	36439	AL	36553	AL	36785	AL
36269	AL	36441	AL	36556	AL	36786	AL
36270	AL	36442	AL	36558	AL	36790	AL
36273	AL	36444	AL	36569	AL	36792	AL
36274	AL	36445	AL	36570	AL	36793	AL
36275	AL	36446	AL	36581	AL	36851	AL
36276	AL	36449	AL	36583	AL	36856	AL
36278	AL	36451	AL	36584	AL	36858	AL
36280	AL	36453	AL	36585	AL	36859	AL
36310	AL	36454	AL	36586	AL	36860	AL
36311	AL	36455	AL	36720	AL	36866	AL
36313	AL	36456	AL	36721	AL	36867	AL
36314	AL	36457	AL	36722	AL	36868	AL
36316	AL	36458	AL	36723	AL	36869	AL
36317	AL	36460	AL	36726	AL	36871	AL
36318	AL	36461	AL	36727	AL	36872	AL
36322	AL	36462	AL	36728	AL	36875	AL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36901	AL	37095	TN	37328	TN	37691	TN
36904	AL	37096	TN	37332	TN	37692	TN
36906	AL	37097	TN	37333	TN	37694	TN
36907	AL	37098	TN	37334	TN	37707	TN
36908	AL	37101	TN	37335	TN	37708	TN
36910	AL	37110	TN	37336	TN	37709	TN
36912	AL	37111	TN	37337	TN	37711	TN
36913	AL	37121	TN	37338	TN	37713	TN
36915	AL	37122	TN	37339	TN	37714	TN
36916	AL	37134	TN	37348	TN	37715	TN
36919	AL	37137	TN	37352	TN	37719	TN
36921	AL	37140	TN	37354	TN	37722	TN
36922	AL	37143	TN	37356	TN	37724	TN
36925	AL	37144	TN	37357	TN	37725	TN
37012	TN	37145	TN	37359	TN	37726	TN
37015	TN	37146	TN	37360	TN	37727	TN
37016	TN	37147	TN	37361	TN	37729	TN
37019	TN	37149	TN	37362	TN	37730	TN
37020	TN	37150	TN	37365	TN	37731	TN
37023	TN	37151	TN	37366	TN	37732	TN
37025	TN	37152	TN	37367	TN	37733	TN
37026	TN	37160	TN	37369	TN	37738	TN
37028	TN	37161	TN	37378	TN	37742	TN
37029	TN	37162	TN	37380	TN	37743	TN
37030	TN	37166	TN	37381	TN	37744	TN
37032	TN	37167	TN	37385	TN	37745	TN
37033	TN	37175	TN	37387	TN	37748	TN
37034	TN	37178	TN	37391	TN	37752	TN
37035	TN	37180	TN	37394	TN	37753	TN
37047	TN	37183	TN	37395	TN	37754	TN
37049	TN	37185	TN	37397	TN	37755	TN
37050	TN	37187	TN	37616	TN	37756	TN
37057	TN	37188	TN	37640	TN	37757	TN
37058	TN	37190	TN	37641	TN	37760	TN
37059	TN	37301	TN	37642	TN	37762	TN
37061	TN	37305	TN	37643	TN	37763	TN
37071	TN	37307	TN	37644	TN	37764	TN
37073	TN	37313	TN	37645	TN	37765	TN
37074	TN	37314	TN	37650	TN	37766	TN
37078	TN	37316	TN	37657	TN	37770	TN
37079	TN	37317	TN	37658	TN	37771	TN
37082	TN	37321	TN	37680	TN	37772	TN
37083	TN	37322	TN	37682	TN	37773	TN
37086	TN	37325	TN	37683	TN	37774	TN
37089	TN	37326	TN	37687	TN	37779	TN
37091	TN	37327	TN	37688	TN	37807	TN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
37809	TN	38004	TN	38223	TN	38345	TN
37810	TN	38006	TN	38224	TN	38346	TN
37811	TN	38008	TN	38231	TN	38347	TN
37818	TN	38010	TN	38232	TN	38348	TN
37819	TN	38011	TN	38233	TN	38351	TN
37820	TN	38012	TN	38235	TN	38352	TN
37821	TN	38021	TN	38236	TN	38355	TN
37822	TN	38023	TN	38240	TN	38357	TN
37824	TN	38034	TN	38242	TN	38358	TN
37825	TN	38036	TN	38251	TN	38359	TN
37829	TN	38037	TN	38253	TN	38361	TN
37840	TN	38039	TN	38254	TN	38363	TN
37841	TN	38040	TN	38256	TN	38365	TN
37843	TN	38041	TN	38257	TN	38367	TN
37845	TN	38042	TN	38258	TN	38368	TN
37846	TN	38043	TN	38260	TN	38369	TN
37847	TN	38044	TN	38261	TN	38370	TN
37848	TN	38045	TN	38271	TN	38371	TN
37851	TN	38046	TN	38281	TN	38372	TN
37852	TN	38048	TN	38310	TN	38374	TN
37854	TN	38050	TN	38311	TN	38375	TN
37857	TN	38052	TN	38315	TN	38376	TN
37861	TN	38053	TN	38316	TN	38377	TN
37862	TN	38054	TN	38317	TN	38379	TN
37863	TN	38055	TN	38318	TN	38380	TN
37864	TN	38057	TN	38320	TN	38381	TN
37865	TN	38058	TN	38321	TN	38382	TN
37866	TN	38060	TN	38324	TN	38387	TN
37867	TN	38061	TN	38326	TN	38388	TN
37868	TN	38063	TN	38327	TN	38389	TN
37869	TN	38066	TN	38328	TN	38390	TN
37870	TN	38067	TN	38329	TN	38393	TN
37871	TN	38068	TN	38330	TN	38425	TN
37872	TN	38069	TN	38331	TN	38449	TN
37873	TN	38071	TN	38332	TN	38450	TN
37874	TN	38074	TN	38333	TN	38452	TN
37876	TN	38075	TN	38334	TN	38453	TN
37879	TN	38076	TN	38336	TN	38454	TN
37880	TN	38077	TN	38337	TN	38455	TN
37881	TN	38079	TN	38338	TN	38456	TN
37885	TN	38080	TN	38339	TN	38457	TN
37887	TN	38083	TN	38340	TN	38459	TN
37888	TN	38201	TN	38341	TN	38460	TN
37890	TN	38220	TN	38342	TN	38462	TN
37892	TN	38221	TN	38343	TN	38463	TN
38001	TN	38222	TN	38344	TN	38464	TN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38468	TN	38589	TN	38676	MS	38843	MS
38469	TN	38602	MS	38679	MS	38844	MS
38471	TN	38603	MS	38680	MS	38847	MS
38472	TN	38606	MS	38683	MS	38848	MS
38473	TN	38609	MS	38685	MS	38850	MS
38475	TN	38610	MS	38686	MS	38851	MS
38476	TN	38611	MS	38720	MS	38852	MS
38477	TN	38618	MS	38721	MS	38854	MS
38478	TN	38619	MS	38725	MS	38855	MS
38481	TN	38620	MS	38726	MS	38856	MS
38483	TN	38621	MS	38730	MS	38858	MS
38485	TN	38622	MS	38732	MS	38859	MS
38486	TN	38623	MS	38733	MS	38860	MS
38488	TN	38625	MS	38736	MS	38863	MS
38504	TN	38626	MS	38737	MS	38864	MS
38541	TN	38627	MS	38738	MS	38869	MS
38542	TN	38628	MS	38740	MS	38870	MS
38543	TN	38629	MS	38745	MS	38871	MS
38547	TN	38632	MS	38746	MS	38873	MS
38549	TN	38633	MS	38749	MS	38875	MS
38550	TN	38634	MS	38751	MS	38876	MS
38551	TN	38635	MS	38753	MS	38877	MS
38552	TN	38637	MS	38754	MS	38878	MS
38553	TN	38638	MS	38759	MS	38880	MS
38554	TN	38641	MS	38761	MS	38901	MS
38556	TN	38642	MS	38762	MS	38902	MS
38559	TN	38643	MS	38764	MS	38912	MS
38560	TN	38646	MS	38765	MS	38913	MS
38562	TN	38647	MS	38768	MS	38914	MS
38563	TN	38649	MS	38769	MS	38915	MS
38564	TN	38650	MS	38771	MS	38916	MS
38565	TN	38651	MS	38772	MS	38917	MS
38567	TN	38652	MS	38773	MS	38920	MS
38568	TN	38654	MS	38774	MS	38921	MS
38569	TN	38658	MS	38778	MS	38922	MS
38570	TN	38659	MS	38781	MS	38923	MS
38573	TN	38661	MS	38820	MS	38924	MS
38575	TN	38663	MS	38821	MS	38925	MS
38577	TN	38664	MS	38825	MS	38926	MS
38579	TN	38665	MS	38827	MS	38927	MS
38580	TN	38666	MS	38828	MS	38928	MS
38581	TN	38668	MS	38829	MS	38929	MS
38583	TN	38670	MS	38833	MS	38940	MS
38585	TN	38671	MS	38838	MS	38943	MS
38587	TN	38672	MS	38839	MS	38947	MS
38588	TN	38674	MS	38841	MS	38948	MS

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38950	MS	39098	MS	39341	MS	39556	MS
38951	MS	39107	MS	39345	MS	39561	MS
38953	MS	39108	MS	39346	MS	39573	MS
38954	MS	39109	MS	39347	MS	39577	MS
38955	MS	39111	MS	39348	MS	39630	MS
38957	MS	39112	MS	39350	MS	39631	MS
38958	MS	39113	MS	39352	MS	39633	MS
38960	MS	39114	MS	39354	MS	39638	MS
38961	MS	39115	MS	39355	MS	39641	MS
38962	MS	39116	MS	39356	MS	39643	MS
38963	MS	39117	MS	39358	MS	39645	MS
38964	MS	39119	MS	39359	MS	39647	MS
38965	MS	39140	MS	39360	MS	39653	MS
38966	MS	39144	MS	39361	MS	39654	MS
38967	MS	39146	MS	39362	MS	39656	MS
39038	MS	39149	MS	39363	MS	39661	MS
39039	MS	39150	MS	39365	MS	39663	MS
39040	MS	39152	MS	39366	MS	39664	MS
39044	MS	39153	MS	39367	MS	39665	MS
39046	MS	39159	MS	39421	MS	39667	MS
39051	MS	39160	MS	39422	MS	39668	MS
39054	MS	39162	MS	39423	MS	39669	MS
39057	MS	39163	MS	39426	MS	39730	MS
39059	MS	39166	MS	39427	MS	39735	MS
39061	MS	39168	MS	39428	MS	39737	MS
39062	MS	39169	MS	39429	MS	39739	MS
39063	MS	39171	MS	39439	MS	39740	MS
39067	MS	39173	MS	39451	MS	39741	MS
39069	MS	39176	MS	39452	MS	39744	MS
39074	MS	39177	MS	39455	MS	39745	MS
39077	MS	39179	MS	39456	MS	39746	MS
39078	MS	39189	MS	39457	MS	39747	MS
39079	MS	39191	MS	39460	MS	39750	MS
39080	MS	39192	MS	39461	MS	39751	MS
39081	MS	39194	MS	39462	MS	39752	MS
39082	MS	39322	MS	39463	MS	39754	MS
39083	MS	39323	MS	39466	MS	39755	MS
39086	MS	39324	MS	39470	MS	39756	MS
39087	MS	39327	MS	39474	MS	39767	MS
39088	MS	39328	MS	39475	MS	39771	MS
39090	MS	39330	MS	39476	MS	39772	MS
39092	MS	39332	MS	39478	MS	39773	MS
39094	MS	39336	MS	39479	MS	39776	MS
39095	MS	39337	MS	39481	MS	39813	GA
39096	MS	39338	MS	39482	MS	39823	GA
39097	MS	39339	MS	39483	MS	39824	GA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
39826	GA	40109	KY	40359	KY	40807	KY
39827	GA	40110	KY	40360	KY	40808	KY
39828	GA	40111	KY	40361	KY	40810	KY
39829	GA	40115	KY	40362	KY	40815	KY
39832	GA	40117	KY	40363	KY	40816	KY
39836	GA	40119	KY	40366	KY	40818	KY
39837	GA	40129	KY	40371	KY	40819	KY
39840	GA	40140	KY	40372	KY	40820	KY
39841	GA	40142	KY	40374	KY	40823	KY
39842	GA	40143	KY	40376	KY	40824	KY
39845	GA	40144	KY	40380	KY	40826	KY
39846	GA	40145	KY	40383	KY	40827	KY
39851	GA	40146	KY	40384	KY	40828	KY
39854	GA	40150	KY	40386	KY	40829	KY
39859	GA	40152	KY	40387	KY	40830	KY
39861	GA	40153	KY	40402	KY	40831	KY
39862	GA	40155	KY	40409	KY	40840	KY
39866	GA	40157	KY	40410	KY	40843	KY
39867	GA	40161	KY	40419	KY	40844	KY
39870	GA	40164	KY	40421	KY	40847	KY
39877	GA	40165	KY	40434	KY	40849	KY
39885	GA	40170	KY	40437	KY	40854	KY
39886	GA	40171	KY	40442	KY	40855	KY
39897	GA	40176	KY	40444	KY	40858	KY
40006	KY	40178	KY	40445	KY	40862	KY
40007	KY	40310	KY	40446	KY	40863	KY
40011	KY	40311	KY	40447	KY	40865	KY
40019	KY	40312	KY	40448	KY	40868	KY
40036	KY	40316	KY	40456	KY	40870	KY
40040	KY	40322	KY	40460	KY	40873	KY
40045	KY	40330	KY	40461	KY	40874	KY
40046	KY	40334	KY	40467	KY	40903	KY
40047	KY	40336	KY	40472	KY	40906	KY
40050	KY	40337	KY	40473	KY	40914	KY
40055	KY	40339	KY	40481	KY	40915	KY
40057	KY	40340	KY	40484	KY	40921	KY
40058	KY	40342	KY	40486	KY	40923	KY
40061	KY	40346	KY	40488	KY	40927	KY
40068	KY	40347	KY	40489	KY	40930	KY
40069	KY	40348	KY	40492	KY	40931	KY
40070	KY	40350	KY	40495	KY	40932	KY
40071	KY	40353	KY	40734	KY	40935	KY
40075	KY	40355	KY	40771	KY	40941	KY
40078	KY	40356	KY	40801	KY	40943	KY
40104	KY	40357	KY	40803	KY	40944	KY
40108	KY	40358	KY	40806	KY	40946	KY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
40949	KY	41128	KY	41255	KY	41477	KY
40951	KY	41132	KY	41256	KY	41517	KY
40953	KY	41135	KY	41257	KY	41537	KY
40962	KY	41137	KY	41260	KY	41632	KY
40964	KY	41139	KY	41262	KY	41714	KY
40972	KY	41141	KY	41263	KY	41725	KY
40979	KY	41142	KY	41264	KY	41730	KY
40982	KY	41143	KY	41265	KY	41740	KY
40983	KY	41144	KY	41267	KY	41743	KY
40995	KY	41146	KY	41268	KY	41749	KY
40997	KY	41149	KY	41271	KY	41759	KY
40999	KY	41156	KY	41274	KY	41762	KY
41002	KY	41159	KY	41301	KY	41764	KY
41003	KY	41160	KY	41311	KY	41766	KY
41004	KY	41164	KY	41313	KY	41772	KY
41006	KY	41166	KY	41314	KY	41775	KY
41008	KY	41169	KY	41332	KY	41776	KY
41010	KY	41170	KY	41333	KY	41777	KY
41030	KY	41171	KY	41338	KY	41804	KY
41031	KY	41173	KY	41342	KY	41810	KY
41033	KY	41174	KY	41344	KY	41812	KY
41035	KY	41175	KY	41347	KY	41815	KY
41037	KY	41179	KY	41351	KY	41817	KY
41039	KY	41180	KY	41352	KY	41819	KY
41040	KY	41181	KY	41360	KY	41821	KY
41041	KY	41183	KY	41362	KY	41822	KY
41043	KY	41189	KY	41364	KY	41824	KY
41044	KY	41201	KY	41365	KY	41825	KY
41045	KY	41203	KY	41368	KY	41826	KY
41046	KY	41204	KY	41386	KY	41828	KY
41049	KY	41214	KY	41397	KY	41831	KY
41052	KY	41215	KY	41408	KY	41832	KY
41054	KY	41216	KY	41410	KY	41833	KY
41061	KY	41219	KY	41413	KY	41834	KY
41064	KY	41222	KY	41419	KY	41835	KY
41065	KY	41224	KY	41421	KY	41836	KY
41081	KY	41226	KY	41422	KY	41837	KY
41083	KY	41228	KY	41425	KY	41838	KY
41086	KY	41230	KY	41426	KY	41839	KY
41093	KY	41231	KY	41433	KY	41840	KY
41095	KY	41232	KY	41444	KY	41843	KY
41097	KY	41234	KY	41451	KY	41844	KY
41098	KY	41238	KY	41459	KY	41845	KY
41121	KY	41240	KY	41464	KY	41847	KY
41124	KY	41250	KY	41465	KY	41848	KY
41127	KY	41254	KY	41472	KY	41849	KY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
41855	KY	42088	KY	42286	KY	42455	KY
41858	KY	42120	KY	42287	KY	42456	KY
41859	KY	42124	KY	42288	KY	42459	KY
41861	KY	42129	KY	42320	KY	42460	KY
41862	KY	42133	KY	42321	KY	42461	KY
42021	KY	42134	KY	42322	KY	42462	KY
42022	KY	42135	KY	42323	KY	42463	KY
42023	KY	42140	KY	42324	KY	42516	KY
42024	KY	42150	KY	42325	KY	42528	KY
42025	KY	42151	KY	42326	KY	42539	KY
42027	KY	42153	KY	42327	KY	42541	KY
42028	KY	42154	KY	42328	KY	42565	KY
42029	KY	42157	KY	42330	KY	42566	KY
42031	KY	42163	KY	42332	KY	42602	KY
42032	KY	42164	KY	42333	KY	42603	KY
42033	KY	42166	KY	42337	KY	42629	KY
42035	KY	42167	KY	42338	KY	42631	KY
42037	KY	42201	KY	42339	KY	42632	KY
42038	KY	42202	KY	42343	KY	42633	KY
42039	KY	42203	KY	42344	KY	42634	KY
42040	KY	42204	KY	42345	KY	42635	KY
42041	KY	42206	KY	42347	KY	42638	KY
42044	KY	42207	KY	42348	KY	42642	KY
42045	KY	42209	KY	42349	KY	42647	KY
42047	KY	42210	KY	42350	KY	42649	KY
42048	KY	42211	KY	42351	KY	42653	KY
42050	KY	42214	KY	42352	KY	42711	KY
42051	KY	42215	KY	42354	KY	42712	KY
42055	KY	42216	KY	42361	KY	42713	KY
42056	KY	42219	KY	42364	KY	42715	KY
42058	KY	42220	KY	42365	KY	42716	KY
42060	KY	42234	KY	42367	KY	42717	KY
42061	KY	42251	KY	42368	KY	42718	KY
42063	KY	42252	KY	42369	KY	42719	KY
42064	KY	42256	KY	42370	KY	42720	KY
42066	KY	42257	KY	42371	KY	42721	KY
42069	KY	42259	KY	42372	KY	42722	KY
42070	KY	42261	KY	42374	KY	42726	KY
42078	KY	42265	KY	42403	KY	42728	KY
42079	KY	42267	KY	42404	KY	42729	KY
42081	KY	42273	KY	42409	KY	42731	KY
42082	KY	42275	KY	42411	KY	42733	KY
42083	KY	42276	KY	42437	KY	42735	KY
42084	KY	42280	KY	42444	KY	42741	KY
42085	KY	42283	KY	42445	KY	42742	KY
42087	KY	42285	KY	42450	KY	42743	KY

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
42746	KY	43140	OH	43456	OH	43754	OH
42748	KY	43142	OH	43458	OH	43756	OH
42749	KY	43143	OH	43468	OH	43757	OH
42753	KY	43144	OH	43501	OH	43758	OH
42754	KY	43145	OH	43502	OH	43759	OH
42755	KY	43146	OH	43505	OH	43760	OH
42757	KY	43149	OH	43506	OH	43761	OH
42758	KY	43151	OH	43510	OH	43764	OH
42759	KY	43152	OH	43515	OH	43766	OH
42761	KY	43153	OH	43516	OH	43779	OH
42762	KY	43156	OH	43517	OH	43782	OH
42764	KY	43158	OH	43518	OH	43783	OH
42765	KY	43160	OH	43521	OH	43786	OH
42782	KY	43162	OH	43523	OH	43787	OH
42786	KY	43164	OH	43524	OH	43788	OH
43005	OH	43315	OH	43527	OH	43789	OH
43006	OH	43316	OH	43531	OH	43793	OH
43009	OH	43317	OH	43532	OH	43803	OH
43011	OH	43320	OH	43533	OH	43804	OH
43014	OH	43321	OH	43534	OH	43805	OH
43019	OH	43323	OH	43535	OH	43811	OH
43022	OH	43325	OH	43540	OH	43812	OH
43028	OH	43326	OH	43543	OH	43824	OH
43037	OH	43330	OH	43545	OH	43828	OH
43044	OH	43334	OH	43548	OH	43832	OH
43047	OH	43338	OH	43550	OH	43836	OH
43048	OH	43340	OH	43553	OH	43837	OH
43050	OH	43345	OH	43554	OH	43840	OH
43060	OH	43346	OH	43555	OH	43843	OH
43064	OH	43349	OH	43557	OH	43844	OH
43070	OH	43350	OH	43558	OH	43845	OH
43072	OH	43351	OH	43567	OH	43902	OH
43076	OH	43359	OH	43570	OH	43905	OH
43078	OH	43408	OH	43711	OH	43906	OH
43083	OH	43412	OH	43716	OH	43907	OH
43084	OH	43416	OH	43717	OH	43909	OH
43103	OH	43430	OH	43718	OH	43912	OH
43106	OH	43432	OH	43719	OH	43914	OH
43111	OH	43433	OH	43724	OH	43915	OH
43113	OH	43436	OH	43728	OH	43916	OH
43116	OH	43439	OH	43730	OH	43927	OH
43117	OH	43440	OH	43731	OH	43928	OH
43127	OH	43445	OH	43739	OH	43931	OH
43128	OH	43446	OH	43747	OH	43933	OH
43135	OH	43449	OH	43748	OH	43934	OH
43138	OH	43452	OH	43752	OH	43935	OH

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
43937	OH	44612	OH	44844	OH	45311	OH
43940	OH	44615	OH	44847	OH	45314	OH
43942	OH	44617	OH	44849	OH	45320	OH
43946	OH	44619	OH	44850	OH	45321	OH
43947	OH	44620	OH	44851	OH	45328	OH
43950	OH	44621	OH	44854	OH	45330	OH
43951	OH	44622	OH	44855	OH	45331	OH
43967	OH	44624	OH	44856	OH	45332	OH
43972	OH	44625	OH	44857	OH	45333	OH
43973	OH	44628	OH	44860	OH	45334	OH
43974	OH	44629	OH	44865	OH	45336	OH
43976	OH	44631	OH	44881	OH	45337	OH
43977	OH	44633	OH	44882	OH	45338	OH
43981	OH	44637	OH	44887	OH	45339	OH
43984	OH	44638	OH	44888	OH	45340	OH
43985	OH	44639	OH	44889	OH	45346	OH
43986	OH	44644	OH	44890	OH	45347	OH
43988	OH	44651	OH	45036	OH	45348	OH
44003	OH	44653	OH	45070	OH	45350	OH
44004	OH	44654	OH	45101	OH	45351	OH
44005	OH	44656	OH	45105	OH	45352	OH
44010	OH	44660	OH	45110	OH	45353	OH
44030	OH	44661	OH	45115	OH	45358	OH
44032	OH	44663	OH	45118	OH	45360	OH
44041	OH	44671	OH	45119	OH	45361	OH
44047	OH	44672	OH	45121	OH	45362	OH
44048	OH	44675	OH	45123	OH	45363	OH
44068	OH	44678	OH	45130	OH	45365	OH
44076	OH	44679	OH	45131	OH	45367	OH
44082	OH	44680	OH	45132	OH	45371	OH
44084	OH	44681	OH	45133	OH	45378	OH
44085	OH	44682	OH	45135	OH	45380	OH
44088	OH	44683	OH	45142	OH	45381	OH
44093	OH	44687	OH	45144	OH	45382	OH
44099	OH	44690	OH	45154	OH	45383	OH
44231	OH	44693	OH	45155	OH	45387	OH
44234	OH	44695	OH	45165	OH	45388	OH
44288	OH	44697	OH	45167	OH	45389	OH
44408	OH	44699	OH	45168	OH	45390	OH
44431	OH	44811	OH	45171	OH	45613	OH
44490	OH	44820	OH	45172	OH	45616	OH
44493	OH	44825	OH	45302	OH	45618	OH
44607	OH	44826	OH	45303	OH	45619	OH
44609	OH	44827	OH	45304	OH	45621	OH
44610	OH	44833	OH	45306	OH	45622	OH
44611	OH	44837	OH	45310	OH	45624	OH

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
45634	OH	45779	OH	45876	OH	46148	IN
45638	OH	45783	OH	45877	OH	46150	IN
45640	OH	45784	OH	45879	OH	46155	IN
45642	OH	45806	OH	45880	OH	46156	IN
45645	OH	45810	OH	45882	OH	46157	IN
45646	OH	45812	OH	45883	OH	46158	IN
45650	OH	45813	OH	45884	OH	46160	IN
45651	OH	45815	OH	45885	OH	46161	IN
45654	OH	45817	OH	45886	OH	46166	IN
45656	OH	45819	OH	45888	OH	46170	IN
45659	OH	45821	OH	45891	OH	46171	IN
45660	OH	45822	OH	45893	OH	46172	IN
45661	OH	45826	OH	45894	OH	46173	IN
45669	OH	45827	OH	45895	OH	46175	IN
45672	OH	45828	OH	45896	OH	46176	IN
45675	OH	45830	OH	45898	OH	46182	IN
45678	OH	45831	OH	45899	OH	46310	IN
45679	OH	45832	OH	46035	IN	46349	IN
45680	OH	45835	OH	46036	IN	46366	IN
45683	OH	45836	OH	46039	IN	46372	IN
45684	OH	45837	OH	46041	IN	46374	IN
45687	OH	45838	OH	46045	IN	46379	IN
45688	OH	45843	OH	46049	IN	46380	IN
45690	OH	45844	OH	46050	IN	46381	IN
45692	OH	45845	OH	46057	IN	46392	IN
45693	OH	45846	OH	46058	IN	46501	IN
45695	OH	45848	OH	46065	IN	46502	IN
45696	OH	45849	OH	46067	IN	46504	IN
45697	OH	45851	OH	46068	IN	46506	IN
45698	OH	45853	OH	46104	IN	46508	IN
45712	OH	45855	OH	46105	IN	46510	IN
45713	OH	45856	OH	46110	IN	46511	IN
45714	OH	45859	OH	46111	IN	46513	IN
45720	OH	45860	OH	46113	IN	46524	IN
45724	OH	45861	OH	46115	IN	46531	IN
45727	OH	45862	OH	46120	IN	46532	IN
45729	OH	45863	OH	46121	IN	46534	IN
45741	OH	45864	OH	46125	IN	46537	IN
45742	OH	45865	OH	46126	IN	46538	IN
45743	OH	45866	OH	46127	IN	46539	IN
45760	OH	45869	OH	46128	IN	46542	IN
45769	OH	45870	OH	46130	IN	46550	IN
45770	OH	45871	OH	46133	IN	46555	IN
45771	OH	45873	OH	46135	IN	46562	IN
45772	OH	45874	OH	46144	IN	46563	IN
45775	OH	45875	OH	46146	IN	46565	IN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
46566	IN	46782	IN	46977	IN	47135	IN
46567	IN	46783	IN	46980	IN	47136	IN
46570	IN	46784	IN	46982	IN	47137	IN
46571	IN	46785	IN	46984	IN	47138	IN
46572	IN	46786	IN	46985	IN	47139	IN
46574	IN	46787	IN	46990	IN	47140	IN
46580	IN	46789	IN	46992	IN	47142	IN
46581	IN	46791	IN	46996	IN	47145	IN
46582	IN	46792	IN	47003	IN	47160	IN
46590	IN	46793	IN	47006	IN	47161	IN
46701	IN	46794	IN	47010	IN	47164	IN
46702	IN	46795	IN	47011	IN	47165	IN
46703	IN	46796	IN	47012	IN	47166	IN
46705	IN	46910	IN	47016	IN	47167	IN
46706	IN	46911	IN	47017	IN	47170	IN
46710	IN	46912	IN	47019	IN	47174	IN
46711	IN	46913	IN	47020	IN	47175	IN
46713	IN	46914	IN	47021	IN	47177	IN
46720	IN	46915	IN	47023	IN	47220	IN
46721	IN	46916	IN	47024	IN	47223	IN
46723	IN	46917	IN	47030	IN	47225	IN
46725	IN	46919	IN	47031	IN	47227	IN
46730	IN	46920	IN	47033	IN	47228	IN
46732	IN	46921	IN	47034	IN	47229	IN
46733	IN	46922	IN	47035	IN	47234	IN
46737	IN	46923	IN	47036	IN	47235	IN
46738	IN	46926	IN	47037	IN	47240	IN
46740	IN	46929	IN	47038	IN	47245	IN
46742	IN	46931	IN	47039	IN	47249	IN
46746	IN	46935	IN	47040	IN	47260	IN
46747	IN	46939	IN	47041	IN	47261	IN
46750	IN	46940	IN	47042	IN	47263	IN
46755	IN	46941	IN	47043	IN	47264	IN
46760	IN	46943	IN	47102	IN	47265	IN
46761	IN	46945	IN	47107	IN	47270	IN
46763	IN	46946	IN	47108	IN	47272	IN
46764	IN	46951	IN	47110	IN	47273	IN
46767	IN	46958	IN	47112	IN	47274	IN
46769	IN	46959	IN	47114	IN	47281	IN
46770	IN	46960	IN	47115	IN	47282	IN
46771	IN	46962	IN	47116	IN	47283	IN
46772	IN	46968	IN	47117	IN	47322	IN
46776	IN	46970	IN	47118	IN	47325	IN
46777	IN	46971	IN	47120	IN	47326	IN
46779	IN	46974	IN	47123	IN	47331	IN
46780	IN	46975	IN	47125	IN	47336	IN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47337	IN	47455	IN	47617	IN	47865	IN
47340	IN	47456	IN	47620	IN	47868	IN
47344	IN	47457	IN	47631	IN	47872	IN
47348	IN	47459	IN	47633	IN	47874	IN
47351	IN	47460	IN	47634	IN	47875	IN
47352	IN	47465	IN	47635	IN	47879	IN
47353	IN	47469	IN	47638	IN	47881	IN
47354	IN	47471	IN	47639	IN	47882	IN
47355	IN	47501	IN	47640	IN	47884	IN
47356	IN	47514	IN	47647	IN	47917	IN
47358	IN	47515	IN	47648	IN	47918	IN
47359	IN	47519	IN	47649	IN	47921	IN
47360	IN	47520	IN	47654	IN	47922	IN
47361	IN	47522	IN	47660	IN	47923	IN
47362	IN	47523	IN	47665	IN	47925	IN
47366	IN	47525	IN	47666	IN	47926	IN
47368	IN	47529	IN	47670	IN	47928	IN
47369	IN	47531	IN	47683	IN	47929	IN
47371	IN	47536	IN	47830	IN	47932	IN
47373	IN	47537	IN	47831	IN	47942	IN
47380	IN	47550	IN	47832	IN	47943	IN
47381	IN	47551	IN	47833	IN	47944	IN
47382	IN	47552	IN	47834	IN	47946	IN
47384	IN	47553	IN	47836	IN	47948	IN
47385	IN	47556	IN	47837	IN	47949	IN
47386	IN	47558	IN	47838	IN	47950	IN
47387	IN	47562	IN	47840	IN	47951	IN
47388	IN	47564	IN	47841	IN	47952	IN
47390	IN	47567	IN	47842	IN	47957	IN
47394	IN	47568	IN	47845	IN	47958	IN
47424	IN	47574	IN	47846	IN	47959	IN
47427	IN	47576	IN	47847	IN	47960	IN
47431	IN	47577	IN	47848	IN	47963	IN
47432	IN	47579	IN	47849	IN	47964	IN
47433	IN	47581	IN	47850	IN	47966	IN
47435	IN	47584	IN	47852	IN	47969	IN
47438	IN	47585	IN	47853	IN	47970	IN
47439	IN	47586	IN	47854	IN	47971	IN
47441	IN	47588	IN	47855	IN	47974	IN
47443	IN	47590	IN	47856	IN	47975	IN
47445	IN	47598	IN	47857	IN	47977	IN
47448	IN	47601	IN	47859	IN	47978	IN
47449	IN	47611	IN	47860	IN	47980	IN
47452	IN	47612	IN	47861	IN	47982	IN
47453	IN	47615	IN	47862	IN	47984	IN
47454	IN	47616	IN	47864	IN	47986	IN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47987	IN	48471	MI	48741	MI	48850	MI
47988	IN	48472	MI	48742	MI	48851	MI
47991	IN	48475	MI	48743	MI	48852	MI
47993	IN	48610	MI	48744	MI	48853	MI
47995	IN	48611	MI	48745	MI	48860	MI
47997	IN	48612	MI	48746	MI	48861	MI
48032	MI	48616	MI	48748	MI	48865	MI
48039	MI	48617	MI	48749	MI	48866	MI
48097	MI	48619	MI	48750	MI	48870	MI
48110	MI	48621	MI	48754	MI	48873	MI
48117	MI	48622	MI	48755	MI	48875	MI
48131	MI	48624	MI	48757	MI	48876	MI
48133	MI	48625	MI	48758	MI	48879	MI
48140	MI	48627	MI	48759	MI	48881	MI
48144	MI	48629	MI	48760	MI	48884	MI
48157	MI	48630	MI	48762	MI	48885	MI
48159	MI	48632	MI	48763	MI	48886	MI
48160	MI	48633	MI	48764	MI	48888	MI
48166	MI	48636	MI	48765	MI	48890	MI
48177	MI	48647	MI	48766	MI	48891	MI
48179	MI	48651	MI	48767	MI	48894	MI
48182	MI	48652	MI	48768	MI	48897	MI
48401	MI	48653	MI	48769	MI	48907	MI
48410	MI	48656	MI	48770	MI	48908	MI
48413	MI	48658	MI	48787	MI	48913	MI
48416	MI	48659	MI	48808	MI	48917	MI
48419	MI	48701	MI	48809	MI	48950	MI
48422	MI	48703	MI	48811	MI	48980	MI
48426	MI	48705	MI	48812	MI	49010	MI
48427	MI	48720	MI	48813	MI	49013	MI
48432	MI	48721	MI	48815	MI	49021	MI
48434	MI	48723	MI	48818	MI	49026	MI
48435	MI	48725	MI	48820	MI	49027	MI
48441	MI	48726	MI	48821	MI	49030	MI
48444	MI	48728	MI	48822	MI	49031	MI
48445	MI	48729	MI	48827	MI	49032	MI
48450	MI	48730	MI	48829	MI	49035	MI
48453	MI	48731	MI	48831	MI	49040	MI
48454	MI	48733	MI	48833	MI	49042	MI
48456	MI	48734	MI	48834	MI	49043	MI
48465	MI	48735	MI	48835	MI	49045	MI
48466	MI	48736	MI	48837	MI	49046	MI
48467	MI	48737	MI	48838	MI	49047	MI
48468	MI	48738	MI	48845	MI	49050	MI
48469	MI	48739	MI	48846	MI	49055	MI
48470	MI	48740	MI	48849	MI	49056	MI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49057	MI	49305	MI	49612	MI	49679	MI
49058	MI	49307	MI	49613	MI	49680	MI
49060	MI	49309	MI	49614	MI	49682	MI
49061	MI	49311	MI	49615	MI	49683	MI
49062	MI	49312	MI	49616	MI	49688	MI
49063	MI	49314	MI	49617	MI	49689	MI
49064	MI	49320	MI	49619	MI	49701	MI
49065	MI	49322	MI	49621	MI	49705	MI
49066	MI	49323	MI	49622	MI	49709	MI
49067	MI	49325	MI	49623	MI	49711	MI
49068	MI	49327	MI	49625	MI	49712	MI
49069	MI	49328	MI	49626	MI	49713	MI
49070	MI	49329	MI	49627	MI	49717	MI
49071	MI	49332	MI	49628	MI	49719	MI
49072	MI	49333	MI	49629	MI	49720	MI
49073	MI	49335	MI	49630	MI	49721	MI
49075	MI	49336	MI	49631	MI	49727	MI
49076	MI	49337	MI	49632	MI	49729	MI
49078	MI	49338	MI	49633	MI	49743	MI
49079	MI	49339	MI	49634	MI	49745	MI
49080	MI	49340	MI	49635	MI	49746	MI
49090	MI	49342	MI	49636	MI	49749	MI
49091	MI	49344	MI	49639	MI	49756	MI
49092	MI	49346	MI	49640	MI	49757	MI
49093	MI	49347	MI	49642	MI	49759	MI
49095	MI	49348	MI	49644	MI	49760	MI
49096	MI	49349	MI	49645	MI	49761	MI
49099	MI	49406	MI	49646	MI	49762	MI
49104	MI	49408	MI	49648	MI	49765	MI
49107	MI	49412	MI	49650	MI	49775	MI
49112	MI	49413	MI	49651	MI	49776	MI
49117	MI	49416	MI	49653	MI	49777	MI
49130	MI	49419	MI	49654	MI	49779	MI
49224	MI	49420	MI	49655	MI	49781	MI
49229	MI	49421	MI	49656	MI	49782	MI
49233	MI	49436	MI	49657	MI	49791	MI
49236	MI	49446	MI	49659	MI	49792	MI
49238	MI	49449	MI	49660	MI	49796	MI
49245	MI	49450	MI	49664	MI	49799	MI
49265	MI	49452	MI	49665	MI	49805	MI
49267	MI	49453	MI	49667	MI	49806	MI
49270	MI	49455	MI	49670	MI	49807	MI
49275	MI	49459	MI	49674	MI	49812	MI
49276	MI	49461	MI	49675	MI	49813	MI
49287	MI	49463	MI	49676	MI	49816	MI
49304	MI	49611	MI	49677	MI	49817	MI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49818	MI	49918	MI	50047	IA	50132	IA
49820	MI	49919	MI	50048	IA	50133	IA
49821	MI	49920	MI	50049	IA	50135	IA
49822	MI	49925	MI	50050	IA	50136	IA
49825	MI	49927	MI	50052	IA	50137	IA
49826	MI	49929	MI	50054	IA	50138	IA
49827	MI	49935	MI	50057	IA	50139	IA
49829	MI	49938	MI	50058	IA	50140	IA
49835	MI	49946	MI	50059	IA	50143	IA
49836	MI	49947	MI	50060	IA	50144	IA
49837	MI	49948	MI	50061	IA	50145	IA
49838	MI	49950	MI	50062	IA	50146	IA
49839	MI	49953	MI	50063	IA	50147	IA
49840	MI	49959	MI	50064	IA	50149	IA
49845	MI	49960	MI	50065	IA	50150	IA
49847	MI	49962	MI	50066	IA	50151	IA
49848	MI	49964	MI	50067	IA	50152	IA
49853	MI	49967	MI	50068	IA	50153	IA
49854	MI	49968	MI	50069	IA	50155	IA
49858	MI	49969	MI	50070	IA	50156	IA
49862	MI	49970	MI	50071	IA	50160	IA
49863	MI	49971	MI	50072	IA	50163	IA
49864	MI	50001	IA	50074	IA	50164	IA
49868	MI	50002	IA	50075	IA	50165	IA
49872	MI	50003	IA	50076	IA	50166	IA
49873	MI	50006	IA	50101	IA	50167	IA
49874	MI	50008	IA	50102	IA	50168	IA
49878	MI	50020	IA	50103	IA	50170	IA
49880	MI	50022	IA	50104	IA	50173	IA
49883	MI	50025	IA	50107	IA	50174	IA
49884	MI	50026	IA	50108	IA	50197	IA
49886	MI	50027	IA	50109	IA	50198	IA
49887	MI	50028	IA	50110	IA	50206	IA
49891	MI	50029	IA	50115	IA	50207	IA
49893	MI	50031	IA	50116	IA	50208	IA
49894	MI	50033	IA	50117	IA	50210	IA
49895	MI	50034	IA	50118	IA	50211	IA
49896	MI	50036	IA	50119	IA	50212	IA
49901	MI	50037	IA	50122	IA	50213	IA
49902	MI	50038	IA	50123	IA	50214	IA
49903	MI	50039	IA	50125	IA	50216	IA
49908	MI	50040	IA	50126	IA	50217	IA
49910	MI	50041	IA	50127	IA	50218	IA
49911	MI	50042	IA	50128	IA	50219	IA
49912	MI	50043	IA	50129	IA	50220	IA
49915	MI	50044	IA	50130	IA	50222	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50223	IA	50434	IA	50526	IA	50592	IA
50225	IA	50435	IA	50527	IA	50593	IA
50227	IA	50436	IA	50528	IA	50595	IA
50228	IA	50438	IA	50529	IA	50597	IA
50229	IA	50439	IA	50531	IA	50598	IA
50230	IA	50440	IA	50533	IA	50599	IA
50231	IA	50441	IA	50535	IA	50601	IA
50232	IA	50444	IA	50536	IA	50602	IA
50233	IA	50446	IA	50538	IA	50603	IA
50235	IA	50447	IA	50539	IA	50604	IA
50238	IA	50448	IA	50540	IA	50605	IA
50240	IA	50449	IA	50541	IA	50606	IA
50241	IA	50450	IA	50542	IA	50607	IA
50246	IA	50451	IA	50545	IA	50608	IA
50249	IA	50452	IA	50546	IA	50609	IA
50250	IA	50453	IA	50548	IA	50611	IA
50251	IA	50454	IA	50551	IA	50612	IA
50252	IA	50455	IA	50552	IA	50616	IA
50254	IA	50456	IA	50554	IA	50619	IA
50255	IA	50458	IA	50556	IA	50620	IA
50256	IA	50459	IA	50558	IA	50621	IA
50257	IA	50460	IA	50559	IA	50622	IA
50258	IA	50461	IA	50560	IA	50624	IA
50259	IA	50465	IA	50561	IA	50625	IA
50261	IA	50466	IA	50562	IA	50627	IA
50262	IA	50468	IA	50563	IA	50628	IA
50263	IA	50470	IA	50565	IA	50629	IA
50264	IA	50471	IA	50567	IA	50630	IA
50268	IA	50472	IA	50568	IA	50631	IA
50269	IA	50473	IA	50570	IA	50632	IA
50271	IA	50475	IA	50571	IA	50633	IA
50272	IA	50476	IA	50573	IA	50635	IA
50273	IA	50478	IA	50574	IA	50636	IA
50274	IA	50480	IA	50575	IA	50638	IA
50275	IA	50481	IA	50576	IA	50641	IA
50276	IA	50483	IA	50577	IA	50642	IA
50277	IA	50484	IA	50578	IA	50644	IA
50420	IA	50510	IA	50579	IA	50645	IA
50421	IA	50511	IA	50581	IA	50647	IA
50423	IA	50514	IA	50582	IA	50648	IA
50424	IA	50515	IA	50583	IA	50649	IA
50426	IA	50517	IA	50585	IA	50650	IA
50427	IA	50519	IA	50586	IA	50652	IA
50430	IA	50520	IA	50588	IA	50653	IA
50431	IA	50522	IA	50590	IA	50654	IA
50432	IA	50525	IA	50591	IA	50655	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50657	IA	50861	IA	51234	IA	51446	IA
50658	IA	50862	IA	51235	IA	51447	IA
50659	IA	50863	IA	51237	IA	51448	IA
50660	IA	50864	IA	51238	IA	51449	IA
50661	IA	51001	IA	51239	IA	51450	IA
50662	IA	51002	IA	51240	IA	51451	IA
50664	IA	51003	IA	51241	IA	51452	IA
50665	IA	51004	IA	51242	IA	51453	IA
50666	IA	51006	IA	51243	IA	51454	IA
50668	IA	51008	IA	51244	IA	51455	IA
50669	IA	51009	IA	51245	IA	51458	IA
50670	IA	51010	IA	51246	IA	51459	IA
50671	IA	51011	IA	51247	IA	51460	IA
50672	IA	51016	IA	51248	IA	51461	IA
50673	IA	51017	IA	51249	IA	51462	IA
50674	IA	51018	IA	51250	IA	51463	IA
50675	IA	51019	IA	51331	IA	51465	IA
50676	IA	51020	IA	51334	IA	51466	IA
50677	IA	51022	IA	51342	IA	51467	IA
50680	IA	51023	IA	51344	IA	51520	IA
50681	IA	51024	IA	51345	IA	51523	IA
50682	IA	51025	IA	51346	IA	51525	IA
50801	IA	51027	IA	51347	IA	51527	IA
50830	IA	51028	IA	51349	IA	51528	IA
50831	IA	51031	IA	51350	IA	51529	IA
50833	IA	51033	IA	51351	IA	51530	IA
50835	IA	51034	IA	51354	IA	51531	IA
50836	IA	51036	IA	51355	IA	51532	IA
50837	IA	51038	IA	51358	IA	51533	IA
50839	IA	51040	IA	51360	IA	51534	IA
50840	IA	51041	IA	51363	IA	51535	IA
50841	IA	51045	IA	51364	IA	51536	IA
50842	IA	51046	IA	51365	IA	51537	IA
50843	IA	51048	IA	51401	IA	51540	IA
50845	IA	51050	IA	51430	IA	51541	IA
50846	IA	51051	IA	51431	IA	51543	IA
50847	IA	51053	IA	51432	IA	51544	IA
50848	IA	51058	IA	51433	IA	51545	IA
50849	IA	51059	IA	51436	IA	51546	IA
50851	IA	51060	IA	51439	IA	51549	IA
50853	IA	51062	IA	51440	IA	51550	IA
50854	IA	51063	IA	51441	IA	51551	IA
50857	IA	51201	IA	51442	IA	51552	IA
50858	IA	51230	IA	51443	IA	51554	IA
50859	IA	51231	IA	51444	IA	51555	IA
50860	IA	51232	IA	51445	IA	51556	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
51557	IA	52038	IA	52157	IA	52305	IA
51558	IA	52040	IA	52158	IA	52306	IA
51560	IA	52041	IA	52159	IA	52307	IA
51561	IA	52042	IA	52160	IA	52308	IA
51562	IA	52043	IA	52161	IA	52309	IA
51563	IA	52044	IA	52162	IA	52310	IA
51564	IA	52047	IA	52163	IA	52312	IA
51565	IA	52048	IA	52164	IA	52313	IA
51566	IA	52049	IA	52165	IA	52314	IA
51570	IA	52050	IA	52166	IA	52315	IA
51571	IA	52052	IA	52168	IA	52316	IA
51572	IA	52053	IA	52169	IA	52318	IA
51573	IA	52054	IA	52170	IA	52320	IA
51574	IA	52055	IA	52171	IA	52321	IA
51578	IA	52056	IA	52172	IA	52323	IA
51579	IA	52057	IA	52175	IA	52325	IA
51591	IA	52060	IA	52201	IA	52326	IA
51593	IA	52064	IA	52203	IA	52327	IA
51601	IA	52065	IA	52204	IA	52329	IA
51602	IA	52066	IA	52205	IA	52330	IA
51603	IA	52069	IA	52206	IA	52332	IA
51630	IA	52070	IA	52207	IA	52334	IA
51631	IA	52071	IA	52208	IA	52335	IA
51632	IA	52072	IA	52209	IA	52337	IA
51636	IA	52074	IA	52210	IA	52339	IA
51637	IA	52075	IA	52212	IA	52342	IA
51638	IA	52076	IA	52215	IA	52345	IA
51639	IA	52077	IA	52216	IA	52346	IA
51640	IA	52078	IA	52217	IA	52347	IA
51645	IA	52079	IA	52220	IA	52348	IA
51646	IA	52101	IA	52223	IA	52349	IA
51647	IA	52132	IA	52224	IA	52351	IA
51648	IA	52133	IA	52225	IA	52353	IA
51649	IA	52134	IA	52229	IA	52354	IA
51650	IA	52135	IA	52231	IA	52355	IA
51651	IA	52136	IA	52236	IA	52356	IA
51652	IA	52140	IA	52237	IA	52358	IA
51653	IA	52141	IA	52247	IA	52359	IA
51654	IA	52142	IA	52248	IA	52361	IA
51656	IA	52144	IA	52249	IA	52362	IA
52030	IA	52146	IA	52251	IA	52531	IA
52031	IA	52147	IA	52252	IA	52534	IA
52032	IA	52151	IA	52253	IA	52535	IA
52033	IA	52154	IA	52255	IA	52537	IA
52035	IA	52155	IA	52257	IA	52538	IA
52036	IA	52156	IA	52301	IA	52540	IA

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
52542	IA	52652	IA	53088	WI	53556	WI
52543	IA	52653	IA	53091	WI	53557	WI
52544	IA	52654	IA	53094	WI	53561	WI
52549	IA	52659	IA	53098	WI	53565	WI
52550	IA	52720	IA	53099	WI	53569	WI
52551	IA	52721	IA	53114	WI	53573	WI
52552	IA	52737	IA	53115	WI	53577	WI
52555	IA	52738	IA	53120	WI	53578	WI
52560	IA	52739	IA	53121	WI	53579	WI
52561	IA	52747	IA	53125	WI	53580	WI
52562	IA	52749	IA	53128	WI	53581	WI
52563	IA	52752	IA	53137	WI	53582	WI
52565	IA	52754	IA	53138	WI	53583	WI
52568	IA	52759	IA	53147	WI	53584	WI
52569	IA	52760	IA	53148	WI	53585	WI
52570	IA	52761	IA	53156	WI	53586	WI
52571	IA	52766	IA	53157	WI	53587	WI
52572	IA	52769	IA	53176	WI	53588	WI
52573	IA	52772	IA	53178	WI	53594	WI
52574	IA	52776	IA	53184	WI	53595	WI
52576	IA	52778	IA	53190	WI	53599	WI
52577	IA	53003	WI	53191	WI	53801	WI
52581	IA	53006	WI	53195	WI	53802	WI
52583	IA	53014	WI	53503	WI	53803	WI
52584	IA	53016	WI	53504	WI	53804	WI
52585	IA	53017	WI	53506	WI	53805	WI
52586	IA	53022	WI	53507	WI	53806	WI
52588	IA	53032	WI	53510	WI	53807	WI
52590	IA	53033	WI	53516	WI	53808	WI
52591	IA	53034	WI	53518	WI	53809	WI
52593	IA	53035	WI	53525	WI	53810	WI
52594	IA	53036	WI	53526	WI	53811	WI
52595	IA	53037	WI	53530	WI	53812	WI
52620	IA	53038	WI	53533	WI	53813	WI
52621	IA	53039	WI	53535	WI	53816	WI
52626	IA	53047	WI	53536	WI	53817	WI
52630	IA	53048	WI	53538	WI	53818	WI
52640	IA	53050	WI	53540	WI	53820	WI
52641	IA	53059	WI	53541	WI	53821	WI
52642	IA	53061	WI	53543	WI	53824	WI
52644	IA	53062	WI	53544	WI	53825	WI
52645	IA	53073	WI	53549	WI	53826	WI
52646	IA	53075	WI	53551	WI	53827	WI
52647	IA	53076	WI	53553	WI	53901	WI
52649	IA	53078	WI	53554	WI	53910	WI
52651	IA	53086	WI	53555	WI	53911	WI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
53913	WI	54004	WI	54143	WI	54446	WI
53916	WI	54005	WI	54149	WI	54447	WI
53917	WI	54006	WI	54150	WI	54448	WI
53920	WI	54007	WI	54151	WI	54450	WI
53922	WI	54009	WI	54152	WI	54451	WI
53923	WI	54010	WI	54153	WI	54452	WI
53924	WI	54011	WI	54154	WI	54456	WI
53925	WI	54012	WI	54156	WI	54459	WI
53927	WI	54013	WI	54157	WI	54460	WI
53928	WI	54014	WI	54159	WI	54462	WI
53929	WI	54015	WI	54160	WI	54464	WI
53930	WI	54016	WI	54161	WI	54465	WI
53932	WI	54017	WI	54165	WI	54470	WI
53933	WI	54020	WI	54166	WI	54479	WI
53934	WI	54021	WI	54169	WI	54480	WI
53935	WI	54022	WI	54171	WI	54484	WI
53936	WI	54023	WI	54174	WI	54485	WI
53937	WI	54024	WI	54175	WI	54486	WI
53940	WI	54025	WI	54177	WI	54487	WI
53941	WI	54026	WI	54182	WI	54488	WI
53942	WI	54027	WI	54201	WI	54490	WI
53943	WI	54028	WI	54205	WI	54491	WI
53944	WI	54082	WI	54216	WI	54493	WI
53948	WI	54101	WI	54217	WI	54498	WI
53949	WI	54102	WI	54405	WI	54499	WI
53950	WI	54103	WI	54409	WI	54511	WI
53951	WI	54104	WI	54411	WI	54512	WI
53952	WI	54107	WI	54414	WI	54513	WI
53953	WI	54110	WI	54416	WI	54515	WI
53954	WI	54111	WI	54418	WI	54519	WI
53955	WI	54112	WI	54420	WI	54520	WI
53956	WI	54114	WI	54421	WI	54521	WI
53957	WI	54119	WI	54422	WI	54524	WI
53958	WI	54120	WI	54424	WI	54525	WI
53959	WI	54121	WI	54425	WI	54526	WI
53960	WI	54123	WI	54426	WI	54530	WI
53961	WI	54124	WI	54428	WI	54532	WI
53962	WI	54125	WI	54430	WI	54534	WI
53963	WI	54127	WI	54433	WI	54536	WI
53964	WI	54128	WI	54434	WI	54537	WI
53965	WI	54129	WI	54435	WI	54538	WI
53968	WI	54135	WI	54436	WI	54540	WI
53969	WI	54137	WI	54437	WI	54541	WI
54001	WI	54138	WI	54439	WI	54542	WI
54002	WI	54139	WI	54442	WI	54545	WI
54003	WI	54141	WI	54444	WI	54547	WI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54550	WI	54649	WI	54761	WI	54848	WI
54552	WI	54651	WI	54762	WI	54849	WI
54554	WI	54652	WI	54763	WI	54853	WI
54555	WI	54654	WI	54764	WI	54854	WI
54556	WI	54655	WI	54765	WI	54856	WI
54557	WI	54656	WI	54766	WI	54857	WI
54558	WI	54657	WI	54767	WI	54858	WI
54559	WI	54658	WI	54768	WI	54859	WI
54560	WI	54659	WI	54769	WI	54862	WI
54561	WI	54660	WI	54770	WI	54864	WI
54563	WI	54661	WI	54771	WI	54865	WI
54565	WI	54662	WI	54772	WI	54867	WI
54566	WI	54664	WI	54773	WI	54868	WI
54610	WI	54665	WI	54801	WI	54870	WI
54611	WI	54666	WI	54805	WI	54871	WI
54612	WI	54667	WI	54810	WI	54872	WI
54613	WI	54670	WI	54812	WI	54873	WI
54615	WI	54721	WI	54813	WI	54874	WI
54616	WI	54722	WI	54814	WI	54875	WI
54618	WI	54723	WI	54816	WI	54876	WI
54619	WI	54724	WI	54817	WI	54880	WI
54620	WI	54725	WI	54818	WI	54888	WI
54621	WI	54728	WI	54819	WI	54889	WI
54622	WI	54730	WI	54820	WI	54890	WI
54623	WI	54731	WI	54821	WI	54891	WI
54624	WI	54733	WI	54822	WI	54893	WI
54625	WI	54734	WI	54824	WI	54895	WI
54626	WI	54735	WI	54826	WI	54896	WI
54627	WI	54736	WI	54827	WI	54922	WI
54628	WI	54737	WI	54828	WI	54926	WI
54629	WI	54738	WI	54829	WI	54928	WI
54630	WI	54739	WI	54830	WI	54929	WI
54631	WI	54740	WI	54832	WI	54930	WI
54632	WI	54741	WI	54834	WI	54933	WI
54634	WI	54743	WI	54835	WI	54940	WI
54635	WI	54746	WI	54836	WI	54943	WI
54637	WI	54747	WI	54837	WI	54945	WI
54638	WI	54749	WI	54838	WI	54946	WI
54639	WI	54750	WI	54839	WI	54948	WI
54640	WI	54751	WI	54840	WI	54949	WI
54641	WI	54754	WI	54841	WI	54950	WI
54642	WI	54755	WI	54842	WI	54960	WI
54643	WI	54756	WI	54843	WI	54961	WI
54645	WI	54758	WI	54844	WI	54962	WI
54646	WI	54759	WI	54845	WI	54965	WI
54648	WI	54760	WI	54847	WI	54966	WI

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54967	WI	55307	MN	55398	MN	55730	MN
54969	WI	55308	MN	55561	MN	55731	MN
54970	WI	55309	MN	55563	MN	55733	MN
54975	WI	55310	MN	55565	MN	55734	MN
54976	WI	55312	MN	55575	MN	55735	MN
54977	WI	55313	MN	55580	MN	55741	MN
54978	WI	55314	MN	55581	MN	55742	MN
54981	WI	55319	MN	55582	MN	55744	MN
54982	WI	55320	MN	55584	MN	55745	MN
54983	WI	55321	MN	55585	MN	55746	MN
54984	WI	55324	MN	55586	MN	55747	MN
54990	WI	55325	MN	55587	MN	55748	MN
55002	MN	55328	MN	55588	MN	55749	MN
55007	MN	55329	MN	55589	MN	55750	MN
55012	MN	55330	MN	55590	MN	55751	MN
55013	MN	55332	MN	55591	MN	55752	MN
55019	MN	55333	MN	55601	MN	55753	MN
55021	MN	55334	MN	55603	MN	55756	MN
55030	MN	55335	MN	55604	MN	55757	MN
55032	MN	55336	MN	55605	MN	55758	MN
55036	MN	55338	MN	55606	MN	55760	MN
55037	MN	55341	MN	55607	MN	55764	MN
55040	MN	55342	MN	55609	MN	55767	MN
55041	MN	55349	MN	55612	MN	55768	MN
55045	MN	55350	MN	55613	MN	55769	MN
55046	MN	55352	MN	55614	MN	55771	MN
55049	MN	55354	MN	55615	MN	55772	MN
55051	MN	55355	MN	55616	MN	55775	MN
55052	MN	55358	MN	55703	MN	55777	MN
55053	MN	55362	MN	55704	MN	55780	MN
55056	MN	55363	MN	55705	MN	55781	MN
55057	MN	55365	MN	55706	MN	55782	MN
55060	MN	55366	MN	55707	MN	55783	MN
55063	MN	55370	MN	55708	MN	55784	MN
55067	MN	55371	MN	55709	MN	55785	MN
55069	MN	55373	MN	55710	MN	55786	MN
55072	MN	55376	MN	55712	MN	55787	MN
55074	MN	55377	MN	55716	MN	55790	MN
55078	MN	55380	MN	55718	MN	55792	MN
55079	MN	55381	MN	55719	MN	55793	MN
55084	MN	55382	MN	55720	MN	55795	MN
55087	MN	55385	MN	55721	MN	55796	MN
55088	MN	55389	MN	55722	MN	55797	MN
55092	MN	55390	MN	55723	MN	55798	MN
55301	MN	55395	MN	55725	MN	55909	MN
55302	MN	55396	MN	55726	MN	55912	MN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
55917	MN	56007	MN	56085	MN	56157	MN
55918	MN	56009	MN	56087	MN	56158	MN
55919	MN	56011	MN	56089	MN	56159	MN
55921	MN	56013	MN	56091	MN	56160	MN
55922	MN	56014	MN	56093	MN	56161	MN
55923	MN	56016	MN	56096	MN	56164	MN
55924	MN	56017	MN	56097	MN	56165	MN
55926	MN	56019	MN	56098	MN	56166	MN
55927	MN	56020	MN	56101	MN	56167	MN
55931	MN	56022	MN	56110	MN	56168	MN
55932	MN	56023	MN	56111	MN	56169	MN
55933	MN	56025	MN	56113	MN	56170	MN
55935	MN	56026	MN	56114	MN	56172	MN
55936	MN	56027	MN	56115	MN	56173	MN
55939	MN	56028	MN	56116	MN	56174	MN
55940	MN	56029	MN	56117	MN	56175	MN
55941	MN	56030	MN	56118	MN	56177	MN
55943	MN	56032	MN	56119	MN	56178	MN
55944	MN	56033	MN	56120	MN	56180	MN
55945	MN	56035	MN	56122	MN	56183	MN
55947	MN	56036	MN	56123	MN	56185	MN
55949	MN	56041	MN	56125	MN	56186	MN
55950	MN	56042	MN	56128	MN	56187	MN
55951	MN	56043	MN	56129	MN	56207	MN
55953	MN	56044	MN	56131	MN	56208	MN
55954	MN	56045	MN	56132	MN	56210	MN
55955	MN	56046	MN	56134	MN	56211	MN
55956	MN	56047	MN	56136	MN	56212	MN
55957	MN	56048	MN	56137	MN	56214	MN
55961	MN	56050	MN	56138	MN	56215	MN
55962	MN	56051	MN	56139	MN	56218	MN
55964	MN	56052	MN	56140	MN	56219	MN
55965	MN	56056	MN	56141	MN	56220	MN
55967	MN	56057	MN	56142	MN	56221	MN
55968	MN	56058	MN	56143	MN	56222	MN
55970	MN	56060	MN	56144	MN	56223	MN
55971	MN	56062	MN	56145	MN	56224	MN
55973	MN	56068	MN	56146	MN	56225	MN
55974	MN	56069	MN	56147	MN	56226	MN
55975	MN	56071	MN	56149	MN	56227	MN
55977	MN	56072	MN	56150	MN	56228	MN
55981	MN	56073	MN	56151	MN	56229	MN
55982	MN	56076	MN	56152	MN	56230	MN
55985	MN	56081	MN	56153	MN	56231	MN
55990	MN	56083	MN	56155	MN	56232	MN
55991	MN	56084	MN	56156	MN	56235	MN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56236	MN	56314	MN	56430	MN	56536	MN
56237	MN	56316	MN	56431	MN	56540	MN
56239	MN	56317	MN	56433	MN	56541	MN
56240	MN	56318	MN	56434	MN	56542	MN
56241	MN	56320	MN	56435	MN	56543	MN
56243	MN	56323	MN	56436	MN	56544	MN
56244	MN	56325	MN	56437	MN	56545	MN
56245	MN	56328	MN	56438	MN	56546	MN
56248	MN	56329	MN	56440	MN	56547	MN
56249	MN	56330	MN	56443	MN	56548	MN
56252	MN	56331	MN	56446	MN	56549	MN
56255	MN	56333	MN	56452	MN	56550	MN
56256	MN	56334	MN	56453	MN	56552	MN
56257	MN	56335	MN	56458	MN	56553	MN
56258	MN	56336	MN	56461	MN	56554	MN
56260	MN	56338	MN	56464	MN	56556	MN
56262	MN	56339	MN	56466	MN	56557	MN
56263	MN	56340	MN	56467	MN	56560	MN
56264	MN	56342	MN	56469	MN	56561	MN
56265	MN	56344	MN	56470	MN	56565	MN
56266	MN	56345	MN	56473	MN	56566	MN
56267	MN	56347	MN	56474	MN	56568	MN
56270	MN	56349	MN	56475	MN	56569	MN
56271	MN	56350	MN	56477	MN	56570	MN
56274	MN	56352	MN	56478	MN	56574	MN
56276	MN	56353	MN	56479	MN	56575	MN
56277	MN	56356	MN	56481	MN	56577	MN
56278	MN	56357	MN	56482	MN	56578	MN
56280	MN	56358	MN	56484	MN	56579	MN
56283	MN	56359	MN	56501	MN	56580	MN
56284	MN	56362	MN	56502	MN	56581	MN
56285	MN	56363	MN	56510	MN	56583	MN
56287	MN	56364	MN	56511	MN	56584	MN
56291	MN	56367	MN	56513	MN	56585	MN
56292	MN	56368	MN	56514	MN	56589	MN
56293	MN	56371	MN	56516	MN	56590	MN
56294	MN	56373	MN	56517	MN	56591	MN
56295	MN	56376	MN	56519	MN	56592	MN
56296	MN	56378	MN	56520	MN	56593	MN
56297	MN	56379	MN	56521	MN	56594	MN
56304	MN	56381	MN	56522	MN	56621	MN
56307	MN	56382	MN	56523	MN	56623	MN
56309	MN	56384	MN	56525	MN	56626	MN
56311	MN	56385	MN	56529	MN	56627	MN
56312	MN	56386	MN	56531	MN	56628	MN
56313	MN	56389	MN	56535	MN	56629	MN

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56631	MN	56727	MN	57047	SD	57248	SD
56633	MN	56728	MN	57048	SD	57249	SD
56634	MN	56729	MN	57050	SD	57251	SD
56636	MN	56731	MN	57051	SD	57252	SD
56637	MN	56732	MN	57052	SD	57253	SD
56639	MN	56733	MN	57053	SD	57255	SD
56641	MN	56734	MN	57054	SD	57256	SD
56644	MN	56735	MN	57057	SD	57257	SD
56646	MN	56736	MN	57058	SD	57258	SD
56649	MN	56737	MN	57059	SD	57259	SD
56651	MN	56738	MN	57061	SD	57260	SD
56652	MN	56741	MN	57062	SD	57261	SD
56653	MN	56742	MN	57063	SD	57262	SD
56654	MN	56744	MN	57065	SD	57264	SD
56655	MN	56748	MN	57066	SD	57265	SD
56657	MN	56750	MN	57070	SD	57266	SD
56658	MN	56751	MN	57071	SD	57268	SD
56659	MN	56755	MN	57075	SD	57269	SD
56660	MN	56756	MN	57076	SD	57270	SD
56661	MN	56757	MN	57212	SD	57271	SD
56662	MN	56758	MN	57213	SD	57273	SD
56668	MN	56759	MN	57214	SD	57274	SD
56669	MN	56760	MN	57216	SD	57276	SD
56672	MN	56761	MN	57217	SD	57278	SD
56673	MN	56762	MN	57218	SD	57279	SD
56676	MN	56763	MN	57219	SD	57311	SD
56678	MN	57002	SD	57220	SD	57312	SD
56679	MN	57006	SD	57221	SD	57313	SD
56680	MN	57007	SD	57223	SD	57314	SD
56681	MN	57012	SD	57224	SD	57315	SD
56684	MN	57013	SD	57225	SD	57317	SD
56686	MN	57014	SD	57226	SD	57319	SD
56688	MN	57015	SD	57227	SD	57321	SD
56710	MN	57016	SD	57231	SD	57322	SD
56711	MN	57017	SD	57232	SD	57323	SD
56712	MN	57021	SD	57233	SD	57324	SD
56713	MN	57024	SD	57234	SD	57325	SD
56714	MN	57026	SD	57236	SD	57326	SD
56715	MN	57027	SD	57237	SD	57328	SD
56716	MN	57028	SD	57238	SD	57329	SD
56720	MN	57029	SD	57239	SD	57330	SD
56721	MN	57034	SD	57241	SD	57331	SD
56722	MN	57036	SD	57242	SD	57332	SD
56723	MN	57042	SD	57244	SD	57335	SD
56724	MN	57043	SD	57246	SD	57337	SD
56726	MN	57045	SD	57247	SD	57339	SD

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57340	SD	57435	SD	57548	SD	57650	SD
57341	SD	57436	SD	57551	SD	57651	SD
57342	SD	57437	SD	57552	SD	57652	SD
57344	SD	57438	SD	57553	SD	57653	SD
57345	SD	57440	SD	57557	SD	57656	SD
57346	SD	57442	SD	57559	SD	57657	SD
57348	SD	57448	SD	57560	SD	57658	SD
57349	SD	57450	SD	57562	SD	57659	SD
57350	SD	57451	SD	57564	SD	57660	SD
57353	SD	57452	SD	57567	SD	57661	SD
57354	SD	57454	SD	57568	SD	57706	SD
57355	SD	57455	SD	57569	SD	57714	SD
57356	SD	57456	SD	57571	SD	57716	SD
57358	SD	57457	SD	57574	SD	57717	SD
57359	SD	57461	SD	57576	SD	57718	SD
57361	SD	57462	SD	57577	SD	57720	SD
57362	SD	57465	SD	57578	SD	57722	SD
57364	SD	57466	SD	57579	SD	57724	SD
57365	SD	57467	SD	57580	SD	57725	SD
57366	SD	57468	SD	57584	SD	57729	SD
57367	SD	57469	SD	57585	SD	57730	SD
57368	SD	57470	SD	57601	SD	57732	SD
57369	SD	57471	SD	57620	SD	57735	SD
57370	SD	57472	SD	57621	SD	57736	SD
57371	SD	57473	SD	57622	SD	57737	SD
57373	SD	57475	SD	57623	SD	57738	SD
57374	SD	57476	SD	57625	SD	57741	SD
57375	SD	57477	SD	57626	SD	57742	SD
57376	SD	57520	SD	57629	SD	57744	SD
57379	SD	57521	SD	57630	SD	57747	SD
57380	SD	57523	SD	57631	SD	57748	SD
57381	SD	57526	SD	57632	SD	57750	SD
57382	SD	57528	SD	57633	SD	57752	SD
57383	SD	57529	SD	57634	SD	57754	SD
57384	SD	57531	SD	57636	SD	57755	SD
57385	SD	57532	SD	57638	SD	57756	SD
57386	SD	57533	SD	57639	SD	57758	SD
57399	SD	57534	SD	57640	SD	57759	SD
57420	SD	57537	SD	57641	SD	57760	SD
57421	SD	57538	SD	57642	SD	57761	SD
57422	SD	57540	SD	57644	SD	57762	SD
57424	SD	57541	SD	57645	SD	57763	SD
57428	SD	57542	SD	57646	SD	57764	SD
57429	SD	57543	SD	57647	SD	57765	SD
57430	SD	57544	SD	57648	SD	57766	SD
57434	SD	57547	SD	57649	SD	57767	SD

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57769	SD	58041	ND	58231	ND	58329	ND
57770	SD	58043	ND	58233	ND	58330	ND
57772	SD	58045	ND	58236	ND	58331	ND
57773	SD	58046	ND	58237	ND	58332	ND
57774	SD	58048	ND	58238	ND	58335	ND
57775	SD	58049	ND	58239	ND	58337	ND
57776	SD	58053	ND	58240	ND	58338	ND
57777	SD	58054	ND	58241	ND	58339	ND
57779	SD	58056	ND	58243	ND	58341	ND
57780	SD	58057	ND	58249	ND	58343	ND
57782	SD	58058	ND	58250	ND	58344	ND
57783	SD	58060	ND	58251	ND	58345	ND
57785	SD	58061	ND	58254	ND	58346	ND
57787	SD	58062	ND	58255	ND	58348	ND
57788	SD	58063	ND	58257	ND	58351	ND
57790	SD	58064	ND	58258	ND	58352	ND
57791	SD	58065	ND	58259	ND	58353	ND
57792	SD	58067	ND	58260	ND	58355	ND
57793	SD	58068	ND	58261	ND	58356	ND
57794	SD	58069	ND	58262	ND	58357	ND
58001	ND	58071	ND	58265	ND	58359	ND
58002	ND	58072	ND	58266	ND	58361	ND
58004	ND	58074	ND	58267	ND	58362	ND
58005	ND	58075	ND	58269	ND	58363	ND
58006	ND	58076	ND	58270	ND	58365	ND
58007	ND	58077	ND	58271	ND	58366	ND
58008	ND	58079	ND	58272	ND	58367	ND
58009	ND	58081	ND	58273	ND	58368	ND
58011	ND	58204	ND	58274	ND	58369	ND
58012	ND	58205	ND	58276	ND	58370	ND
58013	ND	58207	ND	58277	ND	58372	ND
58015	ND	58210	ND	58281	ND	58374	ND
58016	ND	58212	ND	58282	ND	58377	ND
58017	ND	58213	ND	58301	ND	58379	ND
58018	ND	58214	ND	58310	ND	58380	ND
58027	ND	58216	ND	58311	ND	58381	ND
58029	ND	58218	ND	58313	ND	58382	ND
58030	ND	58219	ND	58316	ND	58384	ND
58031	ND	58220	ND	58317	ND	58385	ND
58032	ND	58222	ND	58318	ND	58386	ND
58033	ND	58223	ND	58319	ND	58413	ND
58035	ND	58224	ND	58321	ND	58415	ND
58036	ND	58225	ND	58323	ND	58416	ND
58038	ND	58227	ND	58324	ND	58418	ND
58039	ND	58229	ND	58325	ND	58421	ND
58040	ND	58230	ND	58327	ND	58422	ND

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
58423	ND	58523	ND	58640	ND	58778	ND
58425	ND	58524	ND	58642	ND	58782	ND
58428	ND	58528	ND	58643	ND	58783	ND
58429	ND	58529	ND	58644	ND	58784	ND
58430	ND	58530	ND	58645	ND	58787	ND
58431	ND	58531	ND	58646	ND	58788	ND
58433	ND	58533	ND	58647	ND	58789	ND
58436	ND	58535	ND	58650	ND	58790	ND
58438	ND	58538	ND	58651	ND	58792	ND
58439	ND	58540	ND	58653	ND	58793	ND
58440	ND	58541	ND	58654	ND	58794	ND
58441	ND	58542	ND	58710	ND	58831	ND
58442	ND	58544	ND	58711	ND	58833	ND
58443	ND	58545	ND	58712	ND	58835	ND
58444	ND	58549	ND	58713	ND	58838	ND
58445	ND	58552	ND	58716	ND	58844	ND
58448	ND	58554	ND	58721	ND	58847	ND
58451	ND	58559	ND	58723	ND	58854	ND
58452	ND	58561	ND	58727	ND	59001	MT
58454	ND	58562	ND	58730	ND	59003	MT
58456	ND	58563	ND	58731	ND	59004	MT
58458	ND	58564	ND	58736	ND	59007	MT
58460	ND	58565	ND	58737	ND	59008	MT
58461	ND	58566	ND	58740	ND	59010	MT
58463	ND	58568	ND	58741	ND	59011	MT
58464	ND	58569	ND	58744	ND	59012	MT
58466	ND	58570	ND	58747	ND	59013	MT
58474	ND	58571	ND	58748	ND	59014	MT
58475	ND	58573	ND	58750	ND	59016	MT
58477	ND	58575	ND	58752	ND	59018	MT
58478	ND	58576	ND	58757	ND	59019	MT
58479	ND	58577	ND	58758	ND	59020	MT
58480	ND	58579	ND	58759	ND	59022	MT
58481	ND	58580	ND	58760	ND	59025	MT
58482	ND	58581	ND	58761	ND	59026	MT
58484	ND	58620	ND	58762	ND	59027	MT
58486	ND	58621	ND	58763	ND	59028	MT
58487	ND	58623	ND	58765	ND	59029	MT
58488	ND	58625	ND	58768	ND	59030	MT
58489	ND	58626	ND	58769	ND	59031	MT
58490	ND	58627	ND	58770	ND	59032	MT
58492	ND	58631	ND	58771	ND	59033	MT
58494	ND	58632	ND	58772	ND	59034	MT
58495	ND	58634	ND	58773	ND	59035	MT
58520	ND	58636	ND	58775	ND	59036	MT
58521	ND	58638	ND	58776	ND	59038	MT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59039	MT	59221	MT	59348	MT	59482	MT
59041	MT	59222	MT	59349	MT	59484	MT
59043	MT	59226	MT	59353	MT	59486	MT
59046	MT	59242	MT	59354	MT	59489	MT
59047	MT	59243	MT	59411	MT	59501	MT
59050	MT	59245	MT	59416	MT	59520	MT
59052	MT	59247	MT	59417	MT	59521	MT
59053	MT	59252	MT	59418	MT	59523	MT
59054	MT	59253	MT	59419	MT	59524	MT
59055	MT	59254	MT	59420	MT	59525	MT
59058	MT	59255	MT	59422	MT	59526	MT
59059	MT	59256	MT	59424	MT	59527	MT
59061	MT	59257	MT	59425	MT	59528	MT
59062	MT	59258	MT	59427	MT	59529	MT
59063	MT	59259	MT	59430	MT	59530	MT
59065	MT	59261	MT	59432	MT	59532	MT
59066	MT	59262	MT	59433	MT	59535	MT
59067	MT	59263	MT	59434	MT	59537	MT
59068	MT	59270	MT	59435	MT	59538	MT
59069	MT	59274	MT	59436	MT	59540	MT
59070	MT	59275	MT	59440	MT	59542	MT
59071	MT	59276	MT	59441	MT	59544	MT
59072	MT	59311	MT	59442	MT	59546	MT
59073	MT	59312	MT	59444	MT	59547	MT
59074	MT	59313	MT	59445	MT	59631	MT
59075	MT	59314	MT	59446	MT	59632	MT
59076	MT	59315	MT	59447	MT	59634	MT
59077	MT	59316	MT	59448	MT	59638	MT
59078	MT	59317	MT	59450	MT	59641	MT
59081	MT	59318	MT	59451	MT	59642	MT
59082	MT	59319	SD	59452	MT	59643	MT
59083	MT	59322	MT	59453	MT	59644	MT
59084	MT	59323	MT	59454	MT	59645	MT
59085	MT	59324	MT	59456	MT	59647	MT
59086	MT	59326	MT	59457	MT	59710	MT
59087	MT	59327	MT	59460	MT	59713	MT
59089	MT	59330	MT	59462	MT	59720	MT
59201	MT	59332	MT	59464	MT	59721	MT
59211	MT	59333	MT	59466	MT	59722	MT
59212	MT	59337	MT	59467	MT	59724	MT
59213	MT	59339	MT	59468	MT	59725	MT
59214	MT	59341	MT	59469	MT	59728	MT
59215	MT	59343	MT	59471	MT	59729	MT
59217	MT	59344	MT	59473	MT	59731	MT
59218	MT	59345	MT	59474	MT	59732	MT
59219	MT	59347	MT	59479	MT	59733	MT

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59735	MT	59871	MT	60928	IL	61049	IL
59736	MT	59872	MT	60929	IL	61051	IL
59739	MT	59873	MT	60930	IL	61052	IL
59740	MT	59874	MT	60931	IL	61053	IL
59745	MT	59875	MT	60933	IL	61054	IL
59746	MT	59910	MT	60934	IL	61059	IL
59747	MT	59914	MT	60936	IL	61061	IL
59749	MT	59915	MT	60938	IL	61064	IL
59751	MT	59917	MT	60939	IL	61065	IL
59754	MT	59918	MT	60945	IL	61068	IL
59755	MT	59923	MT	60946	IL	61071	IL
59759	MT	59929	MT	60948	IL	61074	IL
59761	MT	59930	MT	60951	IL	61075	IL
59762	MT	59931	MT	60952	IL	61078	IL
59820	MT	59933	MT	60953	IL	61081	IL
59821	MT	59934	MT	60954	IL	61084	IL
59824	MT	59935	MT	60955	IL	61085	IL
59827	MT	60113	IL	60956	IL	61087	IL
59828	MT	60416	IL	60957	IL	61091	IL
59829	MT	60420	IL	60959	IL	61230	IL
59830	MT	60447	IL	60962	IL	61231	IL
59831	MT	60460	IL	60966	IL	61233	IL
59832	MT	60470	IL	60967	IL	61234	IL
59833	MT	60512	IL	60968	IL	61235	IL
59835	MT	60518	IL	60970	IL	61238	IL
59837	MT	60531	IL	60973	IL	61241	IL
59840	MT	60536	IL	60974	IL	61243	IL
59841	MT	60537	IL	61001	IL	61250	IL
59842	MT	60538	IL	61007	IL	61251	IL
59843	MT	60541	IL	61008	IL	61252	IL
59844	MT	60543	IL	61010	IL	61254	IL
59845	MT	60545	IL	61011	IL	61258	IL
59848	MT	60549	IL	61012	IL	61260	IL
59853	MT	60551	IL	61014	IL	61261	IL
59854	MT	60557	IL	61015	IL	61262	IL
59855	MT	60560	IL	61020	IL	61263	IL
59856	MT	60911	IL	61025	IL	61270	IL
59858	MT	60912	IL	61028	IL	61272	IL
59859	MT	60918	IL	61030	IL	61273	IL
59860	MT	60919	IL	61036	IL	61274	IL
59863	MT	60920	IL	61037	IL	61276	IL
59864	MT	60921	IL	61038	IL	61277	IL
59865	MT	60922	IL	61041	IL	61281	IL
59866	MT	60924	IL	61043	IL	61283	IL
59867	MT	60926	IL	61046	IL	61285	IL
59870	MT	60927	IL	61047	IL	61301	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61311	IL	61371	IL	61478	IL	61727	IL
61312	IL	61372	IL	61479	IL	61729	IL
61313	IL	61373	IL	61480	IL	61733	IL
61314	IL	61374	IL	61482	IL	61734	IL
61315	IL	61375	IL	61483	IL	61735	IL
61316	IL	61376	IL	61484	IL	61738	IL
61317	IL	61377	IL	61486	IL	61739	IL
61319	IL	61379	IL	61490	IL	61740	IL
61320	IL	61412	IL	61491	IL	61741	IL
61321	IL	61413	IL	61501	IL	61742	IL
61322	IL	61415	IL	61516	IL	61743	IL
61323	IL	61417	IL	61519	IL	61747	IL
61325	IL	61418	IL	61520	IL	61749	IL
61326	IL	61419	IL	61524	IL	61750	IL
61327	IL	61421	IL	61530	IL	61751	IL
61328	IL	61423	IL	61531	IL	61755	IL
61329	IL	61424	IL	61532	IL	61759	IL
61330	IL	61425	IL	61534	IL	61760	IL
61332	IL	61426	IL	61535	IL	61764	IL
61333	IL	61427	IL	61537	IL	61769	IL
61334	IL	61431	IL	61540	IL	61771	IL
61335	IL	61432	IL	61541	IL	61773	IL
61336	IL	61433	IL	61542	IL	61775	IL
61337	IL	61434	IL	61543	IL	61777	IL
61338	IL	61435	IL	61544	IL	61778	IL
61340	IL	61437	IL	61545	IL	61813	IL
61341	IL	61441	IL	61546	IL	61818	IL
61342	IL	61442	IL	61548	IL	61830	IL
61344	IL	61443	IL	61550	IL	61839	IL
61345	IL	61447	IL	61553	IL	61842	IL
61346	IL	61449	IL	61554	IL	61854	IL
61348	IL	61450	IL	61555	IL	61855	IL
61349	IL	61452	IL	61558	IL	61856	IL
61350	IL	61453	IL	61560	IL	61866	IL
61354	IL	61454	IL	61561	IL	61882	IL
61356	IL	61459	IL	61563	IL	61884	IL
61358	IL	61460	IL	61564	IL	61910	IL
61359	IL	61462	IL	61565	IL	61911	IL
61360	IL	61465	IL	61567	IL	61913	IL
61361	IL	61466	IL	61568	IL	61914	IL
61362	IL	61468	IL	61570	IL	61917	IL
61363	IL	61469	IL	61571	IL	61919	IL
61364	IL	61471	IL	61610	IL	61924	IL
61368	IL	61473	IL	61611	IL	61925	IL
61369	IL	61476	IL	61721	IL	61928	IL
61370	IL	61477	IL	61723	IL	61929	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61930	IL	62065	IL	62261	IL	62355	IL
61932	IL	62069	IL	62262	IL	62356	IL
61933	IL	62070	IL	62263	IL	62357	IL
61936	IL	62075	IL	62265	IL	62358	IL
61937	IL	62076	IL	62266	IL	62361	IL
61940	IL	62077	IL	62268	IL	62362	IL
61941	IL	62078	IL	62271	IL	62363	IL
61942	IL	62079	IL	62272	IL	62366	IL
61944	IL	62080	IL	62273	IL	62367	IL
61949	IL	62081	IL	62274	IL	62370	IL
61951	IL	62082	IL	62275	IL	62373	IL
61953	IL	62083	IL	62277	IL	62375	IL
61955	IL	62085	IL	62278	IL	62378	IL
61956	IL	62086	IL	62279	IL	62379	IL
61957	IL	62088	IL	62280	IL	62380	IL
62006	IL	62089	IL	62283	IL	62410	IL
62009	IL	62091	IL	62284	IL	62413	IL
62011	IL	62092	IL	62286	IL	62415	IL
62012	IL	62093	IL	62288	IL	62417	IL
62013	IL	62094	IL	62292	IL	62418	IL
62014	IL	62098	IL	62293	IL	62420	IL
62015	IL	62214	IL	62295	IL	62422	IL
62016	IL	62215	IL	62297	IL	62423	IL
62017	IL	62216	IL	62298	IL	62427	IL
62019	IL	62217	IL	62310	IL	62428	IL
62022	IL	62218	IL	62311	IL	62431	IL
62023	IL	62219	IL	62312	IL	62432	IL
62027	IL	62230	IL	62313	IL	62433	IL
62028	IL	62231	IL	62314	IL	62434	IL
62030	IL	62233	IL	62316	IL	62435	IL
62031	IL	62236	IL	62318	IL	62436	IL
62032	IL	62237	IL	62319	IL	62438	IL
62033	IL	62238	IL	62321	IL	62439	IL
62036	IL	62241	IL	62323	IL	62441	IL
62037	IL	62242	IL	62329	IL	62442	IL
62044	IL	62244	IL	62330	IL	62444	IL
62045	IL	62245	IL	62334	IL	62446	IL
62047	IL	62246	IL	62336	IL	62447	IL
62049	IL	62247	IL	62340	IL	62448	IL
62050	IL	62248	IL	62341	IL	62449	IL
62051	IL	62249	IL	62343	IL	62451	IL
62052	IL	62250	IL	62344	IL	62454	IL
62053	IL	62252	IL	62345	IL	62458	IL
62054	IL	62253	IL	62352	IL	62459	IL
62056	IL	62256	IL	62353	IL	62460	IL
62063	IL	62259	IL	62354	IL	62462	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62463	IL	62617	IL	62815	IL	62877	IL
62464	IL	62618	IL	62817	IL	62878	IL
62465	IL	62621	IL	62818	IL	62879	IL
62466	IL	62622	IL	62819	IL	62880	IL
62468	IL	62624	IL	62820	IL	62884	IL
62471	IL	62626	IL	62821	IL	62885	IL
62474	IL	62627	IL	62822	IL	62886	IL
62475	IL	62630	IL	62823	IL	62887	IL
62476	IL	62633	IL	62824	IL	62888	IL
62477	IL	62634	IL	62825	IL	62890	IL
62478	IL	62635	IL	62827	IL	62891	IL
62479	IL	62639	IL	62828	IL	62895	IL
62480	IL	62640	IL	62829	IL	62896	IL
62481	IL	62642	IL	62831	IL	62897	IL
62510	IL	62643	IL	62832	IL	62899	IL
62511	IL	62644	IL	62833	IL	62905	IL
62512	IL	62649	IL	62834	IL	62906	IL
62517	IL	62655	IL	62835	IL	62908	IL
62518	IL	62656	IL	62836	IL	62909	IL
62519	IL	62659	IL	62837	IL	62910	IL
62531	IL	62662	IL	62838	IL	62912	IL
62533	IL	62663	IL	62839	IL	62913	IL
62534	IL	62664	IL	62840	IL	62914	IL
62538	IL	62666	IL	62842	IL	62917	IL
62540	IL	62667	IL	62843	IL	62919	IL
62541	IL	62671	IL	62844	IL	62920	IL
62543	IL	62672	IL	62847	IL	62923	IL
62546	IL	62673	IL	62848	IL	62926	IL
62547	IL	62674	IL	62850	IL	62928	IL
62548	IL	62675	IL	62851	IL	62930	IL
62550	IL	62681	IL	62852	IL	62931	IL
62553	IL	62682	IL	62855	IL	62934	IL
62555	IL	62683	IL	62856	IL	62935	IL
62556	IL	62685	IL	62857	IL	62938	IL
62557	IL	62686	IL	62858	IL	62939	IL
62560	IL	62688	IL	62859	IL	62941	IL
62565	IL	62690	IL	62860	IL	62943	IL
62567	IL	62691	IL	62861	IL	62944	IL
62568	IL	62694	IL	62862	IL	62946	IL
62570	IL	62803	IL	62863	IL	62947	IL
62571	IL	62805	IL	62865	IL	62952	IL
62572	IL	62806	IL	62867	IL	62953	IL
62610	IL	62808	IL	62869	IL	62954	IL
62611	IL	62809	IL	62871	IL	62955	IL
62612	IL	62811	IL	62874	IL	62956	IL
62613	IL	62812	IL	62876	IL	62957	IL

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62960	IL	63052	MO	63431	MO	63543	MO
62961	IL	63053	MO	63432	MO	63544	MO
62962	IL	63056	MO	63433	MO	63545	MO
62963	IL	63057	MO	63434	MO	63547	MO
62964	IL	63060	MO	63435	MO	63548	MO
62965	IL	63061	MO	63436	MO	63549	MO
62967	IL	63065	MO	63437	MO	63551	MO
62969	IL	63066	MO	63438	MO	63552	MO
62970	IL	63069	MO	63439	MO	63555	MO
62972	IL	63070	MO	63440	MO	63556	MO
62973	IL	63071	MO	63441	MO	63557	MO
62976	IL	63072	MO	63442	MO	63558	MO
62977	IL	63079	MO	63443	MO	63560	MO
62979	IL	63087	MO	63445	MO	63561	MO
62982	IL	63091	MO	63446	MO	63563	MO
62983	IL	63330	MO	63447	MO	63565	MO
62984	IL	63333	MO	63448	MO	63566	MO
62985	IL	63334	MO	63450	MO	63567	MO
62987	IL	63336	MO	63451	MO	63601	MO
62988	IL	63339	MO	63452	MO	63620	MO
62990	IL	63342	MO	63453	MO	63621	MO
62991	IL	63343	MO	63456	MO	63622	MO
62992	IL	63344	MO	63457	MO	63623	MO
62993	IL	63347	MO	63458	MO	63624	MO
62995	IL	63349	MO	63459	MO	63625	MO
62996	IL	63350	MO	63460	MO	63626	MO
62997	IL	63351	MO	63462	MO	63627	MO
62998	IL	63353	MO	63464	MO	63628	MO
62999	IL	63357	MO	63465	MO	63629	MO
63010	MO	63359	MO	63466	MO	63630	MO
63012	MO	63361	MO	63467	MO	63631	MO
63015	MO	63362	MO	63468	MO	63632	MO
63016	MO	63363	MO	63469	MO	63633	MO
63019	MO	63369	MO	63472	MO	63636	MO
63020	MO	63370	MO	63473	MO	63637	MO
63023	MO	63377	MO	63474	MO	63638	MO
63028	MO	63378	MO	63530	MO	63640	MO
63030	MO	63379	MO	63531	MO	63645	MO
63036	MO	63381	MO	63532	MO	63646	MO
63037	MO	63383	MO	63534	MO	63648	MO
63041	MO	63384	MO	63535	MO	63650	MO
63047	MO	63387	MO	63536	MO	63651	MO
63048	MO	63388	MO	63537	MO	63653	MO
63049	MO	63389	MO	63538	MO	63654	MO
63050	MO	63390	MO	63539	MO	63655	MO
63051	MO	63430	MO	63541	MO	63656	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
63660	MO	63841	MO	63953	MO	64430	MO
63661	MO	63845	MO	63955	MO	64431	MO
63662	MO	63846	MO	63956	MO	64432	MO
63663	MO	63847	MO	63957	MO	64433	MO
63664	MO	63848	MO	63960	MO	64434	MO
63665	MO	63849	MO	63963	MO	64436	MO
63666	MO	63850	MO	63964	MO	64437	MO
63670	MO	63851	MO	63965	MO	64438	MO
63673	MO	63852	MO	63966	MO	64441	MO
63674	MO	63853	MO	63967	MO	64442	MO
63675	MO	63855	MO	64001	MO	64445	MO
63730	MO	63857	MO	64011	MO	64446	MO
63735	MO	63860	MO	64012	MO	64447	MO
63737	MO	63862	MO	64017	MO	64449	MO
63738	MO	63863	MO	64020	MO	64451	MO
63746	MO	63866	MO	64021	MO	64453	MO
63748	MO	63867	MO	64022	MO	64454	MO
63750	MO	63868	MO	64035	MO	64455	MO
63751	MO	63869	MO	64036	MO	64456	MO
63753	MO	63870	MO	64037	MO	64457	MO
63760	MO	63871	MO	64062	MO	64458	MO
63763	MO	63873	MO	64067	MO	64459	MO
63764	MO	63874	MO	64071	MO	64461	MO
63772	MO	63875	MO	64074	MO	64463	MO
63775	MO	63876	MO	64076	MO	64465	MO
63776	MO	63877	MO	64077	MO	64466	MO
63781	MO	63878	MO	64078	MO	64467	MO
63782	MO	63879	MO	64079	MO	64468	MO
63783	MO	63880	MO	64080	MO	64469	MO
63787	MO	63881	MO	64083	MO	64470	MO
63820	MO	63882	MO	64084	MO	64471	MO
63821	MO	63931	MO	64085	MO	64473	MO
63822	MO	63933	MO	64090	MO	64474	MO
63823	MO	63934	MO	64096	MO	64475	MO
63825	MO	63935	MO	64097	MO	64476	MO
63826	MO	63936	MO	64098	MO	64477	MO
63827	MO	63937	MO	64402	MO	64478	MO
63828	MO	63939	MO	64420	MO	64479	MO
63829	MO	63941	MO	64421	MO	64480	MO
63830	MO	63942	MO	64422	MO	64481	MO
63833	MO	63943	MO	64423	MO	64482	MO
63834	MO	63944	MO	64424	MO	64483	MO
63837	MO	63947	MO	64426	MO	64485	MO
63838	MO	63950	MO	64427	MO	64486	MO
63839	MO	63951	MO	64428	MO	64487	MO
63840	MO	63952	MO	64429	MO	64489	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
64490	MO	64661	MO	64770	MO	65034	MO
64491	MO	64664	MO	64776	MO	65035	MO
64492	MO	64667	MO	64777	MO	65036	MO
64493	MO	64668	MO	64779	MO	65037	MO
64494	MO	64670	MO	64780	MO	65038	MO
64496	MO	64671	MO	64781	MO	65041	MO
64497	MO	64672	MO	64788	MO	65042	MO
64498	MO	64673	MO	64789	MO	65043	MO
64499	MO	64674	MO	64831	MO	65046	MO
64601	MO	64676	MO	64832	MO	65047	MO
64620	MO	64679	MO	64833	MO	65048	MO
64622	MO	64680	MO	64836	MO	65050	MO
64623	MO	64681	MO	64840	MO	65051	MO
64624	MO	64682	MO	64842	MO	65054	MO
64625	MO	64683	MO	64843	MO	65055	MO
64628	MO	64686	MO	64844	MO	65058	MO
64630	MO	64687	MO	64847	MO	65059	MO
64631	MO	64688	MO	64848	MO	65061	MO
64632	MO	64689	MO	64850	MO	65062	MO
64633	MO	64701	MO	64853	MO	65063	MO
64635	MO	64720	MO	64854	MO	65064	MO
64636	MO	64722	MO	64856	MO	65066	MO
64637	MO	64723	MO	64858	MO	65067	MO
64638	MO	64724	MO	64859	MO	65068	MO
64639	MO	64725	MO	64861	MO	65069	MO
64640	MO	64726	MO	64862	MO	65072	MO
64641	MO	64730	MO	64863	MO	65075	MO
64642	MO	64734	MO	64864	MO	65077	MO
64643	MO	64735	MO	64865	MO	65078	MO
64644	MO	64738	MO	64866	MO	65080	MO
64645	MO	64739	MO	64867	MO	65081	MO
64646	MO	64740	MO	64868	MO	65082	MO
64647	MO	64742	MO	64873	MO	65083	MO
64648	MO	64743	MO	64874	MO	65084	MO
64649	MO	64744	MO	65001	MO	65085	MO
64650	MO	64745	MO	65011	MO	65230	MO
64651	MO	64746	MO	65013	MO	65231	MO
64652	MO	64747	MO	65014	MO	65233	MO
64653	MO	64748	MO	65016	MO	65236	MO
64654	MO	64752	MO	65017	MO	65237	MO
64655	MO	64756	MO	65018	MO	65239	MO
64656	MO	64759	MO	65022	MO	65240	MO
64657	MO	64762	MO	65024	MO	65243	MO
64658	MO	64763	MO	65025	MO	65244	MO
64659	MO	64766	MO	65026	MO	65246	MO
64660	MO	64769	MO	65031	MO	65247	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65248	MO	65441	MO	65584	MO	65659	MO
65250	MO	65443	MO	65586	MO	65660	MO
65251	MO	65444	MO	65588	MO	65661	MO
65254	MO	65446	MO	65589	MO	65662	MO
65257	MO	65449	MO	65590	MO	65663	MO
65258	MO	65452	MO	65601	MO	65664	MO
65259	MO	65453	MO	65603	MO	65666	MO
65260	MO	65456	MO	65605	MO	65667	MO
65261	MO	65457	MO	65606	MO	65668	MO
65262	MO	65459	MO	65608	MO	65669	MO
65263	MO	65463	MO	65609	MO	65674	MO
65270	MO	65464	MO	65610	MO	65675	MO
65274	MO	65466	MO	65611	MO	65676	MO
65275	MO	65468	MO	65613	MO	65681	MO
65276	MO	65470	MO	65617	MO	65682	MO
65278	MO	65473	MO	65618	MO	65685	MO
65281	MO	65479	MO	65620	MO	65686	MO
65282	MO	65483	MO	65622	MO	65688	MO
65283	MO	65484	MO	65623	MO	65689	MO
65286	MO	65486	MO	65624	MO	65690	MO
65287	MO	65501	MO	65625	MO	65692	MO
65320	MO	65532	MO	65626	MO	65701	MO
65321	MO	65534	MO	65629	MO	65702	MO
65322	MO	65535	MO	65630	MO	65704	MO
65323	MO	65536	MO	65631	MO	65705	MO
65325	MO	65540	MO	65632	MO	65706	MO
65326	MO	65541	MO	65633	MO	65707	MO
65327	MO	65542	MO	65634	MO	65708	MO
65329	MO	65543	MO	65635	MO	65710	MO
65330	MO	65546	MO	65636	MO	65711	MO
65335	MO	65548	MO	65637	MO	65712	MO
65338	MO	65552	MO	65638	MO	65714	MO
65339	MO	65555	MO	65640	MO	65715	MO
65340	MO	65556	MO	65641	MO	65717	MO
65344	MO	65557	MO	65644	MO	65720	MO
65347	MO	65560	MO	65645	MO	65721	MO
65348	MO	65564	MO	65646	MO	65722	MO
65349	MO	65565	MO	65647	MO	65723	MO
65351	MO	65566	MO	65649	MO	65724	MO
65354	MO	65567	MO	65650	MO	65725	MO
65355	MO	65570	MO	65652	MO	65727	MO
65360	MO	65571	MO	65654	MO	65728	MO
65433	MO	65572	MO	65655	MO	65729	MO
65438	MO	65580	MO	65656	MO	65730	MO
65439	MO	65582	MO	65657	MO	65732	MO
65440	MO	65583	MO	65658	MO	65734	MO

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65735	MO	66026	KS	66413	KS	66538	KS
65737	MO	66032	KS	66414	KS	66540	KS
65741	MO	66033	KS	66415	KS	66541	KS
65745	MO	66035	KS	66416	KS	66543	KS
65746	MO	66036	KS	66417	KS	66544	KS
65747	MO	66039	KS	66418	KS	66547	KS
65752	MO	66040	KS	66419	KS	66548	KS
65753	MO	66041	KS	66422	KS	66549	KS
65754	MO	66042	KS	66423	KS	66550	KS
65755	MO	66052	KS	66424	KS	66551	KS
65756	MO	66053	KS	66425	KS	66552	KS
65760	MO	66054	KS	66426	KS	66555	KS
65761	MO	66056	KS	66427	KS	66701	KS
65762	MO	66058	KS	66428	KS	66710	KS
65764	MO	66060	KS	66429	KS	66711	KS
65766	MO	66064	KS	66431	KS	66712	KS
65767	MO	66066	KS	66432	KS	66713	KS
65768	MO	66067	KS	66434	KS	66714	KS
65769	MO	66070	KS	66436	KS	66716	KS
65772	MO	66071	KS	66438	KS	66717	KS
65773	MO	66072	KS	66439	KS	66720	KS
65774	MO	66073	KS	66440	KS	66724	KS
65775	MO	66075	KS	66450	KS	66725	KS
65776	MO	66076	KS	66451	KS	66727	KS
65777	MO	66077	KS	66501	KS	66728	KS
65778	MO	66078	KS	66507	KS	66732	KS
65779	MO	66079	KS	66508	KS	66733	KS
65783	MO	66080	KS	66509	KS	66734	KS
65784	MO	66086	KS	66510	KS	66735	KS
65785	MO	66087	KS	66512	KS	66736	KS
65788	MO	66088	KS	66515	KS	66738	KS
65789	MO	66090	KS	66516	KS	66739	KS
65790	MO	66091	KS	66518	KS	66740	KS
65791	MO	66092	KS	66520	KS	66741	KS
65793	MO	66093	KS	66521	KS	66742	KS
66002	KS	66094	KS	66522	KS	66743	KS
66007	KS	66095	KS	66523	KS	66746	KS
66008	KS	66097	KS	66524	KS	66748	KS
66010	KS	66401	KS	66526	KS	66749	KS
66013	KS	66403	KS	66527	KS	66751	KS
66014	KS	66404	KS	66528	KS	66753	KS
66015	KS	66406	KS	66532	KS	66754	KS
66016	KS	66407	KS	66534	KS	66755	KS
66017	KS	66408	KS	66535	KS	66756	KS
66023	KS	66411	KS	66536	KS	66757	KS
66024	KS	66412	KS	66537	KS	66758	KS

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
66759	KS	66872	KS	67018	KS	67131	KS
66760	KS	66873	KS	67019	KS	67132	KS
66761	KS	66901	KS	67022	KS	67133	KS
66762	KS	66930	KS	67023	KS	67137	KS
66763	KS	66932	KS	67024	KS	67138	KS
66767	KS	66933	KS	67029	KS	67140	KS
66769	KS	66935	KS	67031	KS	67142	KS
66770	KS	66936	KS	67035	KS	67143	KS
66771	KS	66937	KS	67036	KS	67144	KS
66772	KS	66938	KS	67038	KS	67146	KS
66773	KS	66939	KS	67039	KS	67150	KS
66775	KS	66940	KS	67041	KS	67152	KS
66776	KS	66941	KS	67042	KS	67154	KS
66777	KS	66942	KS	67045	KS	67155	KS
66778	KS	66943	KS	67047	KS	67156	KS
66779	KS	66944	KS	67049	KS	67159	KS
66780	KS	66945	KS	67051	KS	67301	KS
66781	KS	66946	KS	67053	KS	67333	KS
66782	KS	66948	KS	67054	KS	67334	KS
66783	KS	66949	KS	67057	KS	67335	KS
66834	KS	66951	KS	67058	KS	67337	KS
66838	KS	66952	KS	67059	KS	67340	KS
66839	KS	66953	KS	67061	KS	67344	KS
66840	KS	66955	KS	67063	KS	67345	KS
66842	KS	66956	KS	67065	KS	67346	KS
66843	KS	66958	KS	67068	KS	67347	KS
66845	KS	66959	KS	67070	KS	67349	KS
66846	KS	66960	KS	67071	KS	67351	KS
66849	KS	66961	KS	67072	KS	67352	KS
66850	KS	66962	KS	67073	KS	67353	KS
66851	KS	66963	KS	67074	KS	67355	KS
66852	KS	66964	KS	67102	KS	67360	KS
66853	KS	66966	KS	67103	KS	67361	KS
66855	KS	66967	KS	67104	KS	67363	KS
66856	KS	66968	KS	67105	KS	67364	KS
66857	KS	66970	KS	67106	KS	67410	KS
66858	KS	67002	KS	67107	KS	67417	KS
66859	KS	67003	KS	67109	KS	67418	KS
66860	KS	67004	KS	67111	KS	67420	KS
66861	KS	67005	KS	67112	KS	67422	KS
66862	KS	67008	KS	67118	KS	67423	KS
66863	KS	67009	KS	67119	KS	67427	KS
66866	KS	67010	KS	67120	KS	67428	KS
66869	KS	67012	KS	67122	KS	67430	KS
66870	KS	67013	KS	67123	KS	67431	KS
66871	KS	67017	KS	67127	KS	67432	KS

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Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
67436	KS	67520	KS	67651	KS	67837	KS
67437	KS	67521	KS	67653	KS	67838	KS
67438	KS	67524	KS	67654	KS	67839	KS
67439	KS	67545	KS	67656	KS	67840	KS
67441	KS	67546	KS	67657	KS	67841	KS
67443	KS	67547	KS	67658	KS	67844	KS
67444	KS	67548	KS	67659	KS	67849	KS
67445	KS	67552	KS	67661	KS	67850	KS
67446	KS	67553	KS	67663	KS	67853	KS
67447	KS	67554	KS	67664	KS	67854	KS
67449	KS	67556	KS	67665	KS	67855	KS
67450	KS	67557	KS	67669	KS	67857	KS
67451	KS	67559	KS	67672	KS	67860	KS
67452	KS	67560	KS	67673	KS	67861	KS
67454	KS	67563	KS	67675	KS	67862	KS
67455	KS	67565	KS	67701	KS	67863	KS
67456	KS	67572	KS	67730	KS	67864	KS
67457	KS	67573	KS	67731	KS	67865	KS
67458	KS	67575	KS	67732	KS	67867	KS
67459	KS	67576	KS	67733	KS	67869	KS
67460	KS	67578	KS	67734	KS	67870	KS
67464	KS	67579	KS	67735	KS	67871	KS
67466	KS	67584	KS	67736	KS	67877	KS
67467	KS	67621	KS	67737	KS	67878	KS
67468	KS	67622	KS	67738	KS	67879	KS
67473	KS	67623	KS	67739	KS	67880	KS
67474	KS	67625	KS	67740	KS	67951	KS
67475	KS	67626	KS	67741	KS	67952	KS
67476	KS	67628	KS	67743	KS	68001	NE
67478	KS	67629	KS	67744	KS	68002	NE
67480	KS	67631	KS	67745	KS	68003	NE
67481	KS	67632	KS	67747	KS	68004	NE
67482	KS	67634	KS	67748	KS	68008	NE
67483	KS	67635	KS	67749	KS	68009	NE
67484	KS	67638	KS	67751	KS	68014	NE
67485	KS	67639	KS	67752	KS	68015	NE
67487	KS	67640	KS	67753	KS	68016	NE
67490	KS	67642	KS	67756	KS	68017	NE
67491	KS	67643	KS	67757	KS	68018	NE
67492	KS	67644	KS	67758	KS	68019	NE
67512	KS	67645	KS	67761	KS	68020	NE
67513	KS	67646	KS	67762	KS	68023	NE
67515	KS	67647	KS	67764	KS	68029	NE
67516	KS	67648	KS	67831	KS	68030	NE
67518	KS	67649	KS	67835	KS	68033	NE
67519	KS	67650	KS	67836	KS	68034	NE

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68036	NE	68331	NE	68410	NE	68623	NE
68037	NE	68332	NE	68413	NE	68624	NE
68038	NE	68333	NE	68414	NE	68626	NE
68039	NE	68335	NE	68415	NE	68627	NE
68040	NE	68337	NE	68416	NE	68628	NE
68041	NE	68338	NE	68417	NE	68629	NE
68042	NE	68340	NE	68418	NE	68631	NE
68045	NE	68341	NE	68420	NE	68632	NE
68047	NE	68342	NE	68421	NE	68634	NE
68048	NE	68343	NE	68422	NE	68635	NE
68050	NE	68344	NE	68423	NE	68636	NE
68055	NE	68345	NE	68424	NE	68637	NE
68058	NE	68346	NE	68429	NE	68638	NE
68061	NE	68347	NE	68431	NE	68640	NE
68062	NE	68348	NE	68433	NE	68641	NE
68065	NE	68349	NE	68434	NE	68642	NE
68066	NE	68350	NE	68436	NE	68643	NE
68067	NE	68351	NE	68437	NE	68644	NE
68068	NE	68352	NE	68439	NE	68647	NE
68070	NE	68354	NE	68440	NE	68648	NE
68071	NE	68355	NE	68441	NE	68651	NE
68073	NE	68357	NE	68442	NE	68652	NE
68301	NE	68359	NE	68443	NE	68653	NE
68303	NE	68360	NE	68444	NE	68654	NE
68304	NE	68361	NE	68445	NE	68655	NE
68305	NE	68362	NE	68446	NE	68658	NE
68307	NE	68364	NE	68447	NE	68659	NE
68309	NE	68365	NE	68448	NE	68660	NE
68310	NE	68366	NE	68450	NE	68661	NE
68313	NE	68367	NE	68452	NE	68662	NE
68314	NE	68370	NE	68453	NE	68663	NE
68315	NE	68371	NE	68454	NE	68665	NE
68316	NE	68374	NE	68455	NE	68666	NE
68318	NE	68375	NE	68456	NE	68667	NE
68319	NE	68376	NE	68457	NE	68669	NE
68320	NE	68377	NE	68458	NE	68710	NE
68321	NE	68378	NE	68460	NE	68711	NE
68322	NE	68380	NE	68463	NE	68713	NE
68323	NE	68381	NE	68464	NE	68714	NE
68324	NE	68382	NE	68465	NE	68716	NE
68325	NE	68401	NE	68466	NE	68717	NE
68326	NE	68403	NE	68467	NE	68718	NE
68327	NE	68405	NE	68601	NE	68719	NE
68328	NE	68406	NE	68602	NE	68720	NE
68329	NE	68407	NE	68620	NE	68722	NE
68330	NE	68409	NE	68622	NE	68723	NE

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68724	NE	68778	NE	68860	NE	68959	NE
68725	NE	68779	NE	68862	NE	68960	NE
68726	NE	68780	NE	68863	NE	68961	NE
68727	NE	68783	NE	68864	NE	68963	NE
68728	NE	68784	NE	68865	NE	68964	NE
68729	NE	68785	NE	68871	NE	68966	NE
68730	NE	68786	NE	68872	NE	68967	NE
68731	NE	68787	NE	68873	NE	68969	NE
68732	NE	68788	NE	68874	NE	68970	NE
68733	NE	68789	NE	68875	NE	68971	NE
68734	NE	68790	NE	68878	NE	68972	NE
68735	NE	68791	NE	68879	NE	68974	NE
68736	NE	68792	NE	68880	NE	68975	NE
68737	NE	68813	NE	68881	NE	68976	NE
68738	NE	68814	NE	68882	NE	68977	NE
68739	NE	68815	NE	68920	NE	68978	NE
68740	NE	68816	NE	68922	NE	68979	NE
68741	NE	68817	NE	68923	NE	68980	NE
68742	NE	68818	NE	68924	NE	68981	NE
68743	NE	68819	NE	68926	NE	68982	NE
68745	NE	68820	NE	68927	NE	69001	NE
68746	NE	68821	NE	68928	NE	69020	NE
68747	NE	68822	NE	68929	NE	69022	NE
68749	NE	68823	NE	68930	NE	69023	NE
68751	NE	68825	NE	68932	NE	69024	NE
68753	NE	68826	NE	68933	NE	69025	NE
68755	NE	68827	NE	68934	NE	69026	NE
68756	NE	68828	NE	68935	NE	69027	NE
68757	NE	68831	NE	68936	NE	69028	NE
68759	NE	68833	NE	68937	NE	69029	NE
68760	NE	68834	NE	68938	NE	69031	NE
68761	NE	68835	NE	68939	NE	69032	NE
68763	NE	68837	NE	68940	NE	69033	NE
68764	NE	68838	NE	68941	NE	69034	NE
68765	NE	68841	NE	68942	NE	69036	NE
68766	NE	68842	NE	68943	NE	69038	NE
68767	NE	68843	NE	68944	NE	69039	NE
68768	NE	68844	NE	68945	NE	69040	NE
68769	NE	68846	NE	68946	NE	69042	NE
68770	NE	68850	NE	68947	NE	69043	NE
68771	NE	68852	NE	68948	NE	69044	NE
68772	NE	68853	NE	68949	NE	69045	NE
68773	NE	68854	NE	68952	NE	69046	NE
68774	NE	68855	NE	68954	NE	69120	NE
68776	NE	68856	NE	68957	NE	69121	NE
68777	NE	68859	NE	68958	NE	69122	NE

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
69125	NE	69301	NE	70086	LA	70538	LA
69127	NE	69331	NE	70087	LA	70540	LA
69128	NE	69333	NE	70090	LA	70542	LA
69129	NE	69334	NE	70091	LA	70543	LA
69130	NE	69335	NE	70339	LA	70546	LA
69131	NE	69336	NE	70340	LA	70548	LA
69133	NE	69337	NE	70341	LA	70549	LA
69134	NE	69339	NE	70342	LA	70554	LA
69135	NE	69340	NE	70372	LA	70555	LA
69138	NE	69343	NE	70380	LA	70556	LA
69140	NE	69345	NE	70381	LA	70559	LA
69141	NE	69346	NE	70390	LA	70575	LA
69142	NE	69347	NE	70391	LA	70576	LA
69144	NE	69348	NE	70392	LA	70578	LA
69145	NE	69350	NE	70393	LA	70580	LA
69146	NE	69351	NE	70426	LA	70581	LA
69147	NE	69354	NE	70427	LA	70582	LA
69148	NE	69360	NE	70429	LA	70584	LA
69149	NE	69365	NE	70438	LA	70585	LA
69150	NE	69366	NE	70441	LA	70586	LA
69152	NE	69367	NE	70449	LA	70591	LA
69153	NE	70030	LA	70450	LA	70631	LA
69154	NE	70031	LA	70453	LA	70632	LA
69155	NE	70037	LA	70462	LA	70634	LA
69156	NE	70038	LA	70467	LA	70637	LA
69157	NE	70039	LA	70510	LA	70638	LA
69160	NE	70040	LA	70511	LA	70640	LA
69161	NE	70041	LA	70512	LA	70643	LA
69162	NE	70042	LA	70514	LA	70644	LA
69163	NE	70046	LA	70515	LA	70645	LA
69166	NE	70047	LA	70516	LA	70648	LA
69167	NE	70050	LA	70517	LA	70650	LA
69168	NE	70051	LA	70519	LA	70651	LA
69171	NE	70052	LA	70521	LA	70652	LA
69190	NE	70057	LA	70522	LA	70653	LA
69201	NE	70066	LA	70523	LA	70654	LA
69210	NE	70070	LA	70524	LA	70655	LA
69211	NE	70071	LA	70525	LA	70657	LA
69212	NE	70076	LA	70526	LA	70658	LA
69214	NE	70078	LA	70527	LA	70660	LA
69216	NE	70079	LA	70528	LA	70662	LA
69217	NE	70080	LA	70531	LA	70706	LA
69218	NE	70081	LA	70532	LA	70710	LA
69219	NE	70082	LA	70533	LA	70711	LA
69220	NE	70083	LA	70534	LA	70712	LA
69221	NE	70084	LA	70537	LA	70715	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
70716	LA	70785	LA	71082	LA	71329	LA
70717	LA	70786	LA	71218	LA	71330	LA
70719	LA	70787	LA	71219	LA	71331	LA
70720	LA	70788	LA	71220	LA	71333	LA
70721	LA	70789	LA	71221	LA	71334	LA
70722	LA	71001	LA	71222	LA	71336	LA
70723	LA	71002	LA	71223	LA	71339	LA
70726	LA	71003	LA	71226	LA	71340	LA
70727	LA	71008	LA	71229	LA	71341	LA
70728	LA	71016	LA	71230	LA	71342	LA
70729	LA	71018	LA	71232	LA	71343	LA
70730	LA	71019	LA	71233	LA	71350	LA
70732	LA	71021	LA	71234	LA	71351	LA
70733	LA	71023	LA	71237	LA	71354	LA
70736	LA	71024	LA	71241	LA	71355	LA
70740	LA	71025	LA	71242	LA	71357	LA
70743	LA	71027	LA	71243	LA	71362	LA
70744	LA	71028	LA	71247	LA	71363	LA
70747	LA	71030	LA	71249	LA	71366	LA
70748	LA	71031	LA	71250	LA	71367	LA
70749	LA	71032	LA	71251	LA	71368	LA
70752	LA	71034	LA	71253	LA	71369	LA
70753	LA	71036	LA	71254	LA	71371	LA
70754	LA	71038	LA	71256	LA	71373	LA
70755	LA	71039	LA	71259	LA	71375	LA
70756	LA	71040	LA	71260	LA	71377	LA
70757	LA	71045	LA	71261	LA	71378	LA
70759	LA	71046	LA	71263	LA	71401	LA
70760	LA	71048	LA	71264	LA	71404	LA
70761	LA	71049	LA	71266	LA	71406	LA
70762	LA	71050	LA	71268	LA	71407	LA
70763	LA	71052	LA	71269	LA	71410	LA
70764	LA	71055	LA	71276	LA	71411	LA
70765	LA	71058	LA	71277	LA	71414	LA
70767	LA	71063	LA	71279	LA	71415	LA
70769	LA	71065	LA	71282	LA	71416	LA
70772	LA	71066	LA	71284	LA	71417	LA
70773	LA	71068	LA	71286	LA	71418	LA
70775	LA	71070	LA	71295	LA	71419	LA
70776	LA	71071	LA	71316	LA	71422	LA
70777	LA	71072	LA	71320	LA	71423	LA
70780	LA	71073	LA	71322	LA	71425	LA
70781	LA	71075	LA	71323	LA	71426	LA
70782	LA	71078	LA	71324	LA	71428	LA
70783	LA	71079	LA	71326	LA	71429	LA
70784	LA	71080	LA	71327	LA	71432	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
71434	LA	71661	AR	71832	AR	71953	AR
71435	LA	71662	AR	71833	AR	71957	AR
71440	LA	71663	AR	71834	AR	71958	AR
71441	LA	71665	AR	71835	AR	71959	AR
71449	LA	71666	AR	71836	AR	71960	AR
71450	LA	71667	AR	71837	AR	71961	AR
71452	LA	71670	AR	71838	AR	71962	AR
71454	LA	71671	AR	71839	AR	71965	AR
71456	LA	71674	AR	71840	AR	71966	AR
71457	LA	71675	AR	71841	AR	71969	AR
71458	LA	71676	AR	71842	AR	71970	AR
71460	LA	71677	AR	71844	AR	71971	AR
71462	LA	71678	AR	71845	AR	71972	AR
71463	LA	71701	AR	71846	AR	71973	AR
71465	LA	71711	AR	71847	AR	71998	AR
71467	LA	71720	AR	71851	AR	72001	AR
71468	LA	71721	AR	71852	AR	72002	AR
71469	LA	71722	AR	71853	AR	72003	AR
71471	LA	71725	AR	71854	AR	72006	AR
71473	LA	71726	AR	71855	AR	72007	AR
71479	LA	71728	AR	71857	AR	72011	AR
71480	LA	71740	AR	71858	AR	72013	AR
71483	LA	71742	AR	71859	AR	72015	AR
71486	LA	71743	AR	71860	AR	72016	AR
71497	LA	71744	AR	71861	AR	72017	AR
71630	AR	71745	AR	71862	AR	72018	AR
71631	AR	71748	AR	71864	AR	72021	AR
71635	AR	71751	AR	71865	AR	72022	AR
71638	AR	71752	AR	71866	AR	72023	AR
71639	AR	71753	AR	71920	AR	72024	AR
71640	AR	71754	AR	71921	AR	72025	AR
71642	AR	71763	AR	71922	AR	72026	AR
71643	AR	71764	AR	71923	AR	72027	AR
71644	AR	71766	AR	71929	AR	72028	AR
71646	AR	71770	AR	71932	AR	72029	AR
71647	AR	71772	AR	71933	AR	72030	AR
71651	AR	71801	AR	71935	AR	72031	AR
71652	AR	71802	AR	71937	AR	72036	AR
71653	AR	71820	AR	71940	AR	72037	AR
71654	AR	71822	AR	71941	AR	72038	AR
71655	AR	71823	AR	71942	AR	72040	AR
71656	AR	71825	AR	71943	AR	72041	AR
71657	AR	71826	AR	71944	AR	72042	AR
71658	AR	71827	AR	71945	AR	72044	AR
71659	AR	71828	AR	71950	AR	72046	AR
71660	AR	71831	AR	71952	AR	72048	AR

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72051	AR	72160	AR	72368	AR	72453	AR
72055	AR	72166	AR	72369	AR	72454	AR
72057	AR	72167	AR	72370	AR	72455	AR
72059	AR	72168	AR	72372	AR	72456	AR
72063	AR	72170	AR	72373	AR	72457	AR
72064	AR	72176	AR	72374	AR	72458	AR
72065	AR	72179	AR	72377	AR	72459	AR
72066	AR	72189	AR	72379	AR	72460	AR
72067	AR	72310	AR	72383	AR	72461	AR
72069	AR	72311	AR	72385	AR	72462	AR
72070	AR	72312	AR	72386	AR	72464	AR
72071	AR	72313	AR	72387	AR	72465	AR
72072	AR	72315	AR	72389	AR	72466	AR
72073	AR	72316	AR	72390	AR	72469	AR
72074	AR	72319	AR	72391	AR	72470	AR
72080	AR	72320	AR	72392	AR	72472	AR
72083	AR	72321	AR	72394	AR	72474	AR
72084	AR	72322	AR	72395	AR	72475	AR
72086	AR	72324	AR	72396	AR	72476	AR
72088	AR	72326	AR	72410	AR	72478	AR
72089	AR	72328	AR	72412	AR	72479	AR
72101	AR	72329	AR	72413	AR	72482	AR
72103	AR	72330	AR	72415	AR	72512	AR
72104	AR	72331	AR	72422	AR	72513	AR
72105	AR	72333	AR	72424	AR	72515	AR
72107	AR	72335	AR	72425	AR	72517	AR
72108	AR	72336	AR	72426	AR	72519	AR
72110	AR	72338	AR	72428	AR	72520	AR
72122	AR	72340	AR	72429	AR	72521	AR
72123	AR	72341	AR	72430	AR	72523	AR
72125	AR	72342	AR	72432	AR	72525	AR
72126	AR	72346	AR	72433	AR	72528	AR
72127	AR	72347	AR	72434	AR	72529	AR
72128	AR	72348	AR	72435	AR	72530	AR
72129	AR	72350	AR	72436	AR	72531	AR
72130	AR	72351	AR	72438	AR	72532	AR
72131	AR	72352	AR	72439	AR	72533	AR
72133	AR	72353	AR	72440	AR	72536	AR
72134	AR	72354	AR	72441	AR	72538	AR
72140	AR	72355	AR	72442	AR	72539	AR
72141	AR	72358	AR	72443	AR	72540	AR
72150	AR	72359	AR	72444	AR	72542	AR
72153	AR	72360	AR	72445	AR	72543	AR
72156	AR	72365	AR	72449	AR	72545	AR
72157	AR	72366	AR	72450	AR	72546	AR
72158	AR	72367	AR	72451	AR	72554	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72555	AR	72675	AR	72834	AR	73006	OK
72556	AR	72677	AR	72835	AR	73009	OK
72560	AR	72680	AR	72838	AR	73010	OK
72561	AR	72683	AR	72839	AR	73011	OK
72565	AR	72685	AR	72840	AR	73012	OK
72566	AR	72686	AR	72841	AR	73014	OK
72567	AR	72687	AR	72842	AR	73015	OK
72569	AR	72711	AR	72845	AR	73016	OK
72572	AR	72712	AR	72846	AR	73017	OK
72573	AR	72714	AR	72851	AR	73018	OK
72576	AR	72715	AR	72852	AR	73021	OK
72577	AR	72716	AR	72853	AR	73022	OK
72578	AR	72718	AR	72854	AR	73023	OK
72581	AR	72719	AR	72855	AR	73024	OK
72583	AR	72721	AR	72856	AR	73027	OK
72584	AR	72722	AR	72857	AR	73028	OK
72585	AR	72732	AR	72860	AR	73029	OK
72587	AR	72733	AR	72863	AR	73030	OK
72610	AR	72734	AR	72865	AR	73031	OK
72613	AR	72736	AR	72921	AR	73032	OK
72616	AR	72738	AR	72924	AR	73033	OK
72619	AR	72739	AR	72926	AR	73036	OK
72624	AR	72740	AR	72927	AR	73038	OK
72628	AR	72742	AR	72928	AR	73040	OK
72629	AR	72745	AR	72930	AR	73041	OK
72631	AR	72747	AR	72932	AR	73042	OK
72632	AR	72751	AR	72933	AR	73043	OK
72634	AR	72752	AR	72934	AR	73044	OK
72636	AR	72756	AR	72935	AR	73047	OK
72638	AR	72757	AR	72943	AR	73048	OK
72639	AR	72758	AR	72944	AR	73050	OK
72640	AR	72760	AR	72946	AR	73052	OK
72641	AR	72761	AR	72947	AR	73053	OK
72645	AR	72768	AR	72948	AR	73055	OK
72648	AR	72773	AR	72949	AR	73056	OK
72650	AR	72776	AR	72950	AR	73057	OK
72655	AR	72820	AR	72951	AR	73058	OK
72657	AR	72821	AR	72952	AR	73059	OK
72660	AR	72824	AR	72955	AR	73061	OK
72661	AR	72826	AR	72956	AR	73062	OK
72663	AR	72827	AR	72957	AR	73063	OK
72666	AR	72828	AR	72958	AR	73064	OK
72668	AR	72829	AR	73001	OK	73065	OK
72669	AR	72830	AR	73002	OK	73067	OK
72670	AR	72832	AR	73004	OK	73073	OK
72672	AR	72833	AR	73005	OK	73074	OK

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
73075	OK	73542	OK	73664	OK	73840	OK
73077	OK	73544	OK	73666	OK	73841	OK
73078	OK	73546	OK	73667	OK	73842	OK
73079	OK	73547	OK	73669	OK	73843	OK
73080	OK	73548	OK	73673	OK	73844	OK
73082	OK	73550	OK	73716	OK	73847	OK
73085	OK	73551	OK	73717	OK	73848	OK
73086	OK	73553	OK	73718	OK	73851	OK
73089	OK	73554	OK	73719	OK	73852	OK
73090	OK	73555	OK	73722	OK	73853	OK
73092	OK	73559	OK	73724	OK	73855	OK
73093	OK	73561	OK	73726	OK	73857	OK
73094	OK	73562	OK	73728	OK	73858	OK
73095	OK	73564	OK	73729	OK	73859	OK
73096	OK	73565	OK	73731	OK	73860	OK
73098	OK	73566	OK	73734	OK	73901	OK
73099	OK	73568	OK	73737	OK	73931	OK
73425	OK	73569	OK	73739	OK	73932	OK
73430	OK	73570	OK	73741	OK	73933	OK
73432	OK	73571	OK	73742	OK	73937	OK
73433	OK	73572	OK	73744	OK	73938	OK
73434	OK	73573	OK	73746	OK	73939	OK
73439	OK	73575	OK	73747	OK	73942	OK
73440	OK	73601	OK	73749	OK	73944	OK
73441	OK	73620	OK	73750	OK	73945	OK
73442	OK	73622	OK	73755	OK	73946	OK
73446	OK	73624	OK	73756	OK	73947	OK
73447	OK	73625	OK	73757	OK	73949	OK
73448	OK	73626	OK	73758	OK	73950	OK
73449	OK	73628	OK	73759	OK	73951	OK
73450	OK	73632	OK	73760	OK	74001	OK
73453	OK	73638	OK	73761	OK	74002	OK
73455	OK	73639	OK	73762	OK	74009	OK
73456	OK	73641	OK	73763	OK	74010	OK
73459	OK	73642	OK	73764	OK	74014	OK
73460	OK	73646	OK	73766	OK	74015	OK
73461	OK	73647	OK	73768	OK	74020	OK
73476	OK	73650	OK	73770	OK	74026	OK
73491	OK	73651	OK	73771	OK	74027	OK
73520	OK	73654	OK	73772	OK	74028	OK
73529	OK	73655	OK	73801	OK	74030	OK
73530	OK	73658	OK	73802	OK	74034	OK
73531	OK	73659	OK	73832	OK	74035	OK
73533	OK	73660	OK	73834	OK	74036	OK
73534	OK	73661	OK	73835	OK	74038	OK
73536	OK	73663	OK	73838	OK	74039	OK

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
74041	OK	74359	OK	74540	OK	74724	OK
74042	OK	74360	OK	74542	OK	74726	OK
74044	OK	74361	OK	74543	OK	74727	OK
74045	OK	74362	OK	74545	OK	74728	OK
74046	OK	74363	OK	74549	OK	74729	OK
74047	OK	74364	OK	74552	OK	74730	OK
74048	OK	74365	OK	74555	OK	74731	OK
74052	OK	74366	OK	74556	OK	74733	OK
74053	OK	74367	OK	74557	OK	74734	OK
74054	OK	74368	OK	74558	OK	74735	OK
74056	OK	74369	OK	74559	OK	74736	OK
74058	OK	74370	OK	74562	OK	74737	OK
74060	OK	74421	OK	74563	OK	74738	OK
74066	OK	74426	OK	74567	OK	74740	OK
74067	OK	74429	OK	74569	OK	74741	OK
74068	OK	74431	OK	74570	OK	74743	OK
74071	OK	74432	OK	74571	OK	74745	OK
74072	OK	74435	OK	74572	OK	74747	OK
74079	OK	74437	OK	74574	OK	74748	OK
74080	OK	74438	OK	74577	OK	74750	OK
74081	OK	74440	OK	74578	OK	74752	OK
74083	OK	74445	OK	74601	OK	74753	OK
74084	OK	74446	OK	74602	OK	74754	OK
74131	OK	74447	OK	74603	OK	74755	OK
74301	OK	74454	OK	74604	OK	74756	OK
74330	OK	74456	OK	74630	OK	74759	OK
74331	OK	74457	OK	74631	OK	74760	OK
74332	OK	74458	OK	74632	OK	74761	OK
74333	OK	74459	OK	74633	OK	74764	OK
74335	OK	74460	OK	74636	OK	74766	OK
74337	OK	74461	OK	74637	OK	74818	OK
74338	OK	74462	OK	74641	OK	74824	OK
74339	OK	74466	OK	74643	OK	74826	OK
74340	OK	74467	OK	74644	OK	74827	OK
74342	OK	74472	OK	74646	OK	74829	OK
74343	OK	74477	OK	74647	OK	74830	OK
74344	OK	74521	OK	74650	OK	74831	OK
74345	OK	74523	OK	74651	OK	74832	OK
74346	OK	74525	OK	74652	OK	74833	OK
74347	OK	74530	OK	74653	OK	74834	OK
74349	OK	74531	OK	74701	OK	74836	OK
74350	OK	74533	OK	74702	OK	74837	OK
74352	OK	74534	OK	74720	OK	74839	OK
74354	OK	74535	OK	74721	OK	74845	OK
74355	OK	74536	OK	74722	OK	74848	OK
74358	OK	74538	OK	74723	OK	74849	OK

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Specialty Physician PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
74850	OK	74965	OK	75440	TX	75571	TX
74855	OK	74966	OK	75441	TX	75572	TX
74856	OK	75102	TX	75443	TX	75574	TX
74859	OK	75103	TX	75444	TX	75630	TX
74860	OK	75105	TX	75446	TX	75631	TX
74864	OK	75109	TX	75447	TX	75633	TX
74867	OK	75110	TX	75448	TX	75636	TX
74868	OK	75114	TX	75449	TX	75637	TX
74869	OK	75117	TX	75450	TX	75638	TX
74872	OK	75118	TX	75451	TX	75639	TX
74875	OK	75124	TX	75452	TX	75640	TX
74878	OK	75125	TX	75457	TX	75643	TX
74880	OK	75126	TX	75469	TX	75644	TX
74881	OK	75127	TX	75471	TX	75645	TX
74883	OK	75140	TX	75472	TX	75650	TX
74884	OK	75142	TX	75474	TX	75652	TX
74901	OK	75143	TX	75475	TX	75653	TX
74902	OK	75144	TX	75476	TX	75654	TX
74930	OK	75147	TX	75478	TX	75656	TX
74931	OK	75151	TX	75479	TX	75657	TX
74932	OK	75152	TX	75480	TX	75658	TX
74935	OK	75153	TX	75481	TX	75659	TX
74936	OK	75154	TX	75482	TX	75661	TX
74937	OK	75155	TX	75483	TX	75662	TX
74939	OK	75156	TX	75487	TX	75663	TX
74940	OK	75157	TX	75488	TX	75666	TX
74941	OK	75158	TX	75490	TX	75667	TX
74942	OK	75161	TX	75492	TX	75668	TX
74943	OK	75163	TX	75494	TX	75669	TX
74944	OK	75167	TX	75497	TX	75680	TX
74945	OK	75169	TX	75550	TX	75681	TX
74946	OK	75410	TX	75551	TX	75682	TX
74947	OK	75412	TX	75554	TX	75683	TX
74948	OK	75413	TX	75555	TX	75684	TX
74949	OK	75415	TX	75556	TX	75685	TX
74951	OK	75417	TX	75559	TX	75686	TX
74953	OK	75418	TX	75560	TX	75687	TX
74954	OK	75420	TX	75561	TX	75689	TX
74955	OK	75426	TX	75562	TX	75691	TX
74956	OK	75431	TX	75563	TX	75692	TX
74957	OK	75432	TX	75564	TX	75754	TX
74959	OK	75433	TX	75565	TX	75755	TX
74960	OK	75436	TX	75566	TX	75756	TX
74962	OK	75437	TX	75567	TX	75758	TX
74963	OK	75438	TX	75568	TX	75765	TX
74964	OK	75439	TX	75570	TX	75770	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
75773	TX	75959	TX	76227	TX	76435	TX
75778	TX	75960	TX	76228	TX	76436	TX
75782	TX	75966	TX	76230	TX	76437	TX
75783	TX	75968	TX	76234	TX	76439	TX
75790	TX	75972	TX	76238	TX	76442	TX
75797	TX	75973	TX	76239	TX	76443	TX
75831	TX	75974	TX	76240	TX	76444	TX
75833	TX	75975	TX	76241	TX	76445	TX
75834	TX	75977	TX	76246	TX	76448	TX
75835	TX	75979	TX	76250	TX	76449	TX
75838	TX	75990	TX	76251	TX	76450	TX
75840	TX	76008	TX	76252	TX	76452	TX
75844	TX	76009	TX	76253	TX	76453	TX
75845	TX	76023	TX	76255	TX	76454	TX
75846	TX	76028	TX	76258	TX	76455	TX
75847	TX	76031	TX	76261	TX	76457	TX
75848	TX	76033	TX	76263	TX	76458	TX
75849	TX	76035	TX	76265	TX	76459	TX
75850	TX	76043	TX	76267	TX	76460	TX
75851	TX	76044	TX	76270	TX	76462	TX
75852	TX	76048	TX	76272	TX	76463	TX
75855	TX	76049	TX	76351	TX	76464	TX
75856	TX	76050	TX	76352	TX	76466	TX
75858	TX	76055	TX	76357	TX	76467	TX
75859	TX	76058	TX	76363	TX	76468	TX
75860	TX	76059	TX	76364	TX	76469	TX
75862	TX	76061	TX	76365	TX	76470	TX
75865	TX	76064	TX	76366	TX	76471	TX
75926	TX	76065	TX	76370	TX	76472	TX
75928	TX	76066	TX	76371	TX	76474	TX
75929	TX	76067	TX	76372	TX	76475	TX
75930	TX	76068	TX	76373	TX	76476	TX
75931	TX	76070	TX	76374	TX	76481	TX
75932	TX	76071	TX	76377	TX	76483	TX
75933	TX	76073	TX	76379	TX	76484	TX
75934	TX	76077	TX	76380	TX	76485	TX
75935	TX	76078	TX	76384	TX	76486	TX
75936	TX	76082	TX	76385	TX	76487	TX
75938	TX	76084	TX	76388	TX	76490	TX
75939	TX	76085	TX	76389	TX	76491	TX
75942	TX	76087	TX	76424	TX	76518	TX
75947	TX	76088	TX	76426	TX	76519	TX
75948	TX	76093	TX	76427	TX	76520	TX
75951	TX	76097	TX	76429	TX	76522	TX
75954	TX	76098	TX	76430	TX	76523	TX
75956	TX	76225	TX	76431	TX	76525	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
76526	TX	76666	TX	76866	TX	77351	TX
76528	TX	76667	TX	76867	TX	77358	TX
76531	TX	76671	TX	76869	TX	77359	TX
76538	TX	76673	TX	76870	TX	77360	TX
76539	TX	76675	TX	76871	TX	77363	TX
76550	TX	76676	TX	76872	TX	77364	TX
76555	TX	76677	TX	76873	TX	77367	TX
76556	TX	76678	TX	76874	TX	77368	TX
76558	TX	76679	TX	76875	TX	77369	TX
76561	TX	76680	TX	76877	TX	77371	TX
76565	TX	76681	TX	76878	TX	77374	TX
76566	TX	76685	TX	76880	TX	77376	TX
76567	TX	76686	TX	76882	TX	77399	TX
76570	TX	76687	TX	76883	TX	77404	TX
76577	TX	76689	TX	76884	TX	77412	TX
76596	TX	76690	TX	76885	TX	77414	TX
76597	TX	76691	TX	76887	TX	77415	TX
76598	TX	76692	TX	76888	TX	77418	TX
76599	TX	76693	TX	76930	TX	77419	TX
76621	TX	76820	TX	76932	TX	77423	TX
76622	TX	76821	TX	76933	TX	77426	TX
76626	TX	76824	TX	76936	TX	77428	TX
76627	TX	76825	TX	76937	TX	77434	TX
76628	TX	76828	TX	76941	TX	77440	TX
76629	TX	76831	TX	76943	TX	77442	TX
76631	TX	76832	TX	76945	TX	77445	TX
76632	TX	76834	TX	76949	TX	77446	TX
76634	TX	76836	TX	76950	TX	77452	TX
76635	TX	76837	TX	76951	TX	77456	TX
76636	TX	76841	TX	76953	TX	77457	TX
76637	TX	76842	TX	77320	TX	77458	TX
76639	TX	76844	TX	77326	TX	77460	TX
76641	TX	76845	TX	77327	TX	77465	TX
76642	TX	76848	TX	77328	TX	77466	TX
76644	TX	76849	TX	77331	TX	77468	TX
76645	TX	76852	TX	77332	TX	77470	TX
76648	TX	76853	TX	77334	TX	77473	TX
76649	TX	76854	TX	77335	TX	77474	TX
76650	TX	76855	TX	77340	TX	77475	TX
76652	TX	76856	TX	77341	TX	77482	TX
76653	TX	76858	TX	77342	TX	77483	TX
76656	TX	76859	TX	77343	TX	77484	TX
76657	TX	76861	TX	77344	TX	77485	TX
76660	TX	76862	TX	77348	TX	77514	TX
76661	TX	76864	TX	77349	TX	77519	TX
76665	TX	76865	TX	77350	TX	77533	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
77535	TX	77857	TX	77995	TX	78117	TX
77538	TX	77859	TX	78001	TX	78118	TX
77560	TX	77861	TX	78003	TX	78119	TX
77561	TX	77863	TX	78005	TX	78121	TX
77564	TX	77864	TX	78007	TX	78122	TX
77575	TX	77865	TX	78008	TX	78123	TX
77580	TX	77867	TX	78009	TX	78124	TX
77582	TX	77868	TX	78011	TX	78125	TX
77585	TX	77869	TX	78012	TX	78133	TX
77597	TX	77870	TX	78014	TX	78140	TX
77611	TX	77871	TX	78016	TX	78141	TX
77612	TX	77872	TX	78017	TX	78142	TX
77614	TX	77873	TX	78019	TX	78143	TX
77615	TX	77875	TX	78021	TX	78144	TX
77616	TX	77876	TX	78022	TX	78145	TX
77624	TX	77878	TX	78026	TX	78146	TX
77625	TX	77879	TX	78039	TX	78147	TX
77626	TX	77880	TX	78050	TX	78151	TX
77630	TX	77882	TX	78052	TX	78154	TX
77631	TX	77950	TX	78053	TX	78155	TX
77632	TX	77954	TX	78055	TX	78156	TX
77639	TX	77957	TX	78056	TX	78159	TX
77656	TX	77960	TX	78057	TX	78160	TX
77657	TX	77961	TX	78059	TX	78161	TX
77659	TX	77962	TX	78060	TX	78162	TX
77660	TX	77963	TX	78061	TX	78163	TX
77661	TX	77964	TX	78062	TX	78164	TX
77662	TX	77967	TX	78063	TX	78266	TX
77663	TX	77969	TX	78064	TX	78332	TX
77664	TX	77970	TX	78065	TX	78333	TX
77665	TX	77971	TX	78066	TX	78335	TX
77670	TX	77972	TX	78067	TX	78336	TX
77830	TX	77974	TX	78070	TX	78338	TX
77831	TX	77975	TX	78071	TX	78340	TX
77833	TX	77978	TX	78072	TX	78341	TX
77834	TX	77979	TX	78075	TX	78342	TX
77835	TX	77982	TX	78076	TX	78343	TX
77836	TX	77983	TX	78102	TX	78349	TX
77837	TX	77984	TX	78104	TX	78350	TX
77838	TX	77986	TX	78107	TX	78352	TX
77839	TX	77987	TX	78108	TX	78353	TX
77850	TX	77989	TX	78111	TX	78355	TX
77852	TX	77990	TX	78113	TX	78357	TX
77853	TX	77991	TX	78114	TX	78358	TX
77855	TX	77993	TX	78115	TX	78359	TX
77856	TX	77994	TX	78116	TX	78360	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
78361	TX	78607	TX	78837	TX	78954	TX
78362	TX	78608	TX	78838	TX	78956	TX
78363	TX	78609	TX	78839	TX	78957	TX
78364	TX	78610	TX	78840	TX	78959	TX
78368	TX	78611	TX	78841	TX	78960	TX
78370	TX	78612	TX	78842	TX	78961	TX
78372	TX	78614	TX	78843	TX	78962	TX
78373	TX	78616	TX	78847	TX	78963	TX
78374	TX	78620	TX	78850	TX	79001	TX
78375	TX	78621	TX	78851	TX	79002	TX
78376	TX	78622	TX	78852	TX	79003	TX
78377	TX	78623	TX	78853	TX	79005	TX
78379	TX	78629	TX	78860	TX	79007	TX
78381	TX	78632	TX	78861	TX	79008	TX
78382	TX	78635	TX	78870	TX	79009	TX
78383	TX	78636	TX	78871	TX	79010	TX
78384	TX	78638	TX	78872	TX	79011	TX
78385	TX	78639	TX	78873	TX	79014	TX
78387	TX	78640	TX	78877	TX	79015	TX
78389	TX	78643	TX	78879	TX	79016	TX
78390	TX	78644	TX	78880	TX	79018	TX
78391	TX	78648	TX	78881	TX	79019	TX
78393	TX	78650	TX	78883	TX	79021	TX
78536	TX	78654	TX	78884	TX	79022	TX
78545	TX	78655	TX	78885	TX	79024	TX
78547	TX	78656	TX	78886	TX	79025	TX
78548	TX	78657	TX	78931	TX	79027	TX
78561	TX	78658	TX	78932	TX	79031	TX
78564	TX	78659	TX	78933	TX	79032	TX
78569	TX	78661	TX	78934	TX	79033	TX
78578	TX	78662	TX	78935	TX	79034	TX
78580	TX	78663	TX	78938	TX	79035	TX
78582	TX	78670	TX	78940	TX	79036	TX
78584	TX	78672	TX	78941	TX	79039	TX
78585	TX	78677	TX	78942	TX	79040	TX
78588	TX	78737	TX	78943	TX	79041	TX
78590	TX	78801	TX	78944	TX	79042	TX
78591	TX	78802	TX	78945	TX	79043	TX
78594	TX	78827	TX	78946	TX	79044	TX
78597	TX	78828	TX	78947	TX	79045	TX
78598	TX	78829	TX	78948	TX	79046	TX
78602	TX	78830	TX	78949	TX	79051	TX
78603	TX	78832	TX	78950	TX	79052	TX
78604	TX	78833	TX	78951	TX	79053	TX
78605	TX	78834	TX	78952	TX	79054	TX
78606	TX	78836	TX	78953	TX	79056	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79057	TX	79237	TX	79359	TX	79547	TX
79059	TX	79239	TX	79360	TX	79548	TX
79061	TX	79240	TX	79367	TX	79549	TX
79062	TX	79241	TX	79369	TX	79550	TX
79063	TX	79243	TX	79370	TX	79553	TX
79064	TX	79244	TX	79371	TX	79556	TX
79065	TX	79245	TX	79372	TX	79560	TX
79066	TX	79247	TX	79373	TX	79565	TX
79068	TX	79248	TX	79376	TX	79566	TX
79070	TX	79250	TX	79377	TX	79567	TX
79072	TX	79251	TX	79378	TX	79713	TX
79073	TX	79252	TX	79379	TX	79714	TX
79077	TX	79255	TX	79380	TX	79718	TX
79078	TX	79256	TX	79381	TX	79719	TX
79079	TX	79257	TX	79383	TX	79730	TX
79080	TX	79258	TX	79501	TX	79734	TX
79081	TX	79259	TX	79502	TX	79735	TX
79082	TX	79261	TX	79503	TX	79738	TX
79083	TX	79311	TX	79504	TX	79739	TX
79084	TX	79312	TX	79505	TX	79740	TX
79085	TX	79313	TX	79506	TX	79742	TX
79087	TX	79314	TX	79510	TX	79743	TX
79088	TX	79316	TX	79512	TX	79744	TX
79091	TX	79320	TX	79516	TX	79745	TX
79092	TX	79322	TX	79517	TX	79749	TX
79093	TX	79323	TX	79518	TX	79752	TX
79094	TX	79324	TX	79519	TX	79754	TX
79095	TX	79325	TX	79520	TX	79755	TX
79096	TX	79326	TX	79521	TX	79756	TX
79097	TX	79330	TX	79525	TX	79770	TX
79098	TX	79331	TX	79526	TX	79772	TX
79201	TX	79336	TX	79527	TX	79777	TX
79220	TX	79338	TX	79528	TX	79778	TX
79221	TX	79339	TX	79529	TX	79780	TX
79223	TX	79342	TX	79532	TX	79781	TX
79225	TX	79343	TX	79533	TX	79782	TX
79226	TX	79344	TX	79534	TX	79783	TX
79227	TX	79345	TX	79535	TX	79785	TX
79229	TX	79346	TX	79537	TX	79786	TX
79230	TX	79347	TX	79538	TX	79788	TX
79231	TX	79351	TX	79539	TX	79789	TX
79232	TX	79353	TX	79540	TX	79830	TX
79233	TX	79355	TX	79543	TX	79831	TX
79234	TX	79356	TX	79544	TX	79832	TX
79235	TX	79357	TX	79545	TX	79834	TX
79236	TX	79358	TX	79546	TX	79837	TX

ADDENDUM H- SPECIALTY CARE PSA ZIP CODES

Specialty Physician PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79839	TX	80642	CO	80820	CO	81063	CO
79842	TX	80643	CO	80821	CO	81064	CO
79843	TX	80648	CO	80822	CO	81066	CO
79845	TX	80649	CO	80823	CO	81067	CO
79846	TX	80650	CO	80824	CO	81071	CO
79847	TX	80651	CO	80825	CO	81073	CO
79848	TX	80652	CO	80826	CO	81074	CO
79850	TX	80653	CO	80827	CO	81076	CO
79851	TX	80654	CO	80828	CO	81077	CO
79852	TX	80701	CO	80830	CO	81081	CO
79854	TX	80705	CO	80834	CO	81082	CO
79855	TX	80720	CO	80835	CO	81084	CO
80101	CO	80721	CO	80836	CO	81087	CO
80107	CO	80723	CO	80860	CO	81089	CO
80117	CO	80727	CO	80861	CO	81090	CO
80420	CO	80729	CO	80862	CO	81091	CO
80421	CO	80731	CO	80863	CO	81092	CO
80430	CO	80732	CO	80866	CO	81120	CO
80432	CO	80733	CO	81020	CO	81121	CO
80434	CO	80734	CO	81021	CO	81123	CO
80436	CO	80735	CO	81024	CO	81124	CO
80438	CO	80737	CO	81027	CO	81125	CO
80440	CO	80740	CO	81029	CO	81126	CO
80442	CO	80742	CO	81030	CO	81127	CO
80444	CO	80743	CO	81033	CO	81128	CO
80446	CO	80744	CO	81034	CO	81129	CO
80447	CO	80746	CO	81036	CO	81130	CO
80448	CO	80749	CO	81038	CO	81132	CO
80449	CO	80750	CO	81039	CO	81133	CO
80451	CO	80754	CO	81040	CO	81134	CO
80452	CO	80755	CO	81041	CO	81135	CO
80456	CO	80757	CO	81042	CO	81138	CO
80459	CO	80758	CO	81043	CO	81140	CO
80468	CO	80759	CO	81044	CO	81141	CO
80473	CO	80801	CO	81045	CO	81144	CO
80475	CO	80802	CO	81046	CO	81147	CO
80476	CO	80804	CO	81047	CO	81148	CO
80478	CO	80805	CO	81049	CO	81151	CO
80480	CO	80807	CO	81050	CO	81152	CO
80482	CO	80810	CO	81052	CO	81153	CO
80546	CO	80812	CO	81054	CO	81154	CO
80550	CO	80813	CO	81055	CO	81157	CO
80551	CO	80814	CO	81057	CO	81212	CO
80610	CO	80815	CO	81058	CO	81215	CO
80611	CO	80816	CO	81059	CO	81221	CO
80612	CO	80818	CO	81062	CO	81222	CO

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
01084	MA	12407	NY	12836	NY	13675	NY
01098	MA	12413	NY	12842	NY	13690	NY
01840	MA	12414	NY	12851	NY	13695	NY
01842	MA	12418	NY	12853	NY	13826	NY
02535	MA	12422	NY	12855	NY	14041	NY
02539	MA	12423	NY	12857	NY	14062	NY
02552	MA	12424	NY	12858	NY	14138	NY
02554	MA	12427	NY	12860	NY	14213	NY
02557	MA	12431	NY	12861	NY	14301	NY
02564	MA	12435	NY	12862	NY	14302	NY
02568	MA	12436	NY	12864	NY	14303	NY
02573	MA	12439	NY	12870	NY	14619	NY
02575	MA	12442	NY	12872	NY	14707	NY
02584	MA	12444	NY	12874	NY	14708	NY
02713	MA	12450	NY	12883	NY	14709	NY
02826	RI	12451	NY	12886	NY	14710	NY
02839	RI	12452	NY	12928	NY	14711	NY
02858	RI	12454	NY	12932	NY	14712	NY
03238	NH	12460	NY	12936	NY	14714	NY
03279	NH	12463	NY	12952	NY	14715	NY
04490	ME	12468	NY	12956	NY	14716	NY
04737	ME	12470	NY	12960	NY	14717	NY
04929	ME	12473	NY	12961	NY	14718	NY
04965	ME	12482	NY	12964	NY	14721	NY
05077	VT	12485	NY	12974	NY	14722	NY
05447	VT	12492	NY	12978	NY	14723	NY
10030	NY	12496	NY	12993	NY	14726	NY
10039	NY	12502	NY	12996	NY	14727	NY
10455	NY	12503	NY	12998	NY	14728	NY
11216	NY	12541	NY	13026	NY	14732	NY
11247	NY	12723	NY	13144	NY	14733	NY
11451	NY	12733	NY	13301	NY	14735	NY
12015	NY	12736	NY	13312	NY	14739	NY
12042	NY	12741	NY	13315	NY	14740	NY
12051	NY	12745	NY	13342	NY	14741	NY
12058	NY	12750	NY	13345	NY	14743	NY
12083	NY	12752	NY	13368	NY	14744	NY
12087	NY	12759	NY	13415	NY	14745	NY
12108	NY	12765	NY	13426	NY	14747	NY
12124	NY	12766	NY	13436	NY	14750	NY
12139	NY	12788	NY	13482	NY	14751	NY
12147	NY	12789	NY	13489	NY	14752	NY
12164	NY	12792	NY	13607	NY	14754	NY
12176	NY	12808	NY	13639	NY	14756	NY
12192	NY	12812	NY	13666	NY	14757	NY
12405	NY	12817	NY	13670	NY	14760	NY

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
14774	NY	16622	PA	18352	PA	21628	MD
14777	NY	16623	PA	18355	PA	21629	MD
14781	NY	16633	PA	18370	PA	21631	MD
14782	NY	16634	PA	18372	PA	21632	MD
14784	NY	16645	PA	18415	PA	21634	MD
14785	NY	16672	PA	18425	PA	21636	MD
14786	NY	16674	PA	18435	PA	21638	MD
14788	NY	16679	PA	18439	PA	21639	MD
14802	NY	16685	PA	18449	PA	21640	MD
14803	NY	16694	PA	18451	PA	21641	MD
14804	NY	16829	PA	18454	PA	21643	MD
14806	NY	16864	PA	18455	PA	21644	MD
14813	NY	16930	PA	18457	PA	21648	MD
14822	NY	16939	PA	18462	PA	21649	MD
14847	NY	17005	PA	18614	PA	21655	MD
14860	NY	17017	PA	18616	PA	21656	MD
14880	NY	17023	PA	18619	PA	21657	MD
14884	NY	17030	PA	18632	PA	21658	MD
14895	NY	17048	PA	18813	PA	21659	MD
14897	NY	17061	PA	18824	PA	21660	MD
15411	PA	17066	PA	18826	PA	21664	MD
15413	PA	17075	PA	18828	PA	21666	MD
15420	PA	17080	PA	20059	DC	21668	MD
15444	PA	17097	PA	20610	MD	21669	MD
15463	PA	17220	PA	20615	MD	21670	MD
15475	PA	17223	PA	20629	MD	21672	MD
15629	PA	17239	PA	20639	MD	21675	MD
15641	PA	17243	PA	20657	MD	21677	MD
15686	PA	17249	PA	20676	MD	21681	MD
15690	PA	17253	PA	20678	MD	21682	MD
15721	PA	17255	PA	20685	MD	21683	MD
15832	PA	17264	PA	20688	MD	21684	MD
15834	PA	17271	PA	20689	MD	21685	MD
15861	PA	17723	PA	20714	MD	21687	MD
16022	PA	17727	PA	20732	MD	21835	MD
16030	PA	17739	PA	20736	MD	21869	MD
16048	PA	17742	PA	20754	MD	21901	MD
16050	PA	17763	PA	21607	MD	21902	MD
16233	PA	17774	PA	21609	MD	21903	MD
16321	PA	18322	PA	21613	MD	21904	MD
16332	PA	18331	PA	21617	MD	21911	MD
16334	PA	18332	PA	21619	MD	21912	MD
16361	PA	18334	PA	21622	MD	21913	MD
16364	PA	18344	PA	21623	MD	21914	MD
16436	PA	18346	PA	21626	MD	21915	MD
16621	PA	18350	PA	21627	MD	21916	MD

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
21917	MD	22938	VA	23399	VA	23938	VA
21918	MD	22949	VA	23401	VA	23939	VA
21919	MD	22954	VA	23404	VA	23941	VA
21920	MD	22958	VA	23407	VA	23944	VA
21921	MD	22963	VA	23409	VA	23947	VA
21922	MD	22964	VA	23410	VA	23952	VA
21930	MD	22965	VA	23412	VA	23958	VA
22427	VA	22967	VA	23414	VA	23959	VA
22428	VA	22968	VA	23415	VA	23962	VA
22442	VA	22969	VA	23416	VA	23963	VA
22443	VA	22971	VA	23417	VA	23964	VA
22446	VA	22973	VA	23418	VA	23967	VA
22448	VA	22974	VA	23420	VA	23968	VA
22451	VA	22976	VA	23421	VA	23974	VA
22460	VA	23002	VA	23422	VA	23976	VA
22469	VA	23011	VA	23423	VA	24053	VA
22472	VA	23014	VA	23426	VA	24072	VA
22481	VA	23022	VA	23427	VA	24076	VA
22485	VA	23039	VA	23440	VA	24079	VA
22488	VA	23055	VA	23441	VA	24082	VA
22501	VA	23063	VA	23442	VA	24091	VA
22514	VA	23065	VA	23480	VA	24105	VA
22520	VA	23083	VA	23483	VA	24120	VA
22524	VA	23084	VA	23488	VA	24127	VA
22526	VA	23089	VA	23821	VA	24131	VA
22529	VA	23105	VA	23839	VA	24133	VA
22534	VA	23124	VA	23841	VA	24171	VA
22535	VA	23140	VA	23843	VA	24177	VA
22538	VA	23141	VA	23845	VA	24185	VA
22544	VA	23153	VA	23846	VA	24217	VA
22546	VA	23160	VA	23856	VA	24218	VA
22547	VA	23301	VA	23857	VA	24220	VA
22548	VA	23302	VA	23868	VA	24221	VA
22552	VA	23303	VA	23873	VA	24224	VA
22558	VA	23306	VA	23876	VA	24225	VA
22572	VA	23308	VA	23881	VA	24226	VA
22577	VA	23336	VA	23883	VA	24228	VA
22580	VA	23337	VA	23887	VA	24237	VA
22581	VA	23341	VA	23889	VA	24239	VA
22650	VA	23345	VA	23893	VA	24243	VA
22835	VA	23356	VA	23899	VA	24244	VA
22849	VA	23357	VA	23915	VA	24245	VA
22851	VA	23358	VA	23920	VA	24248	VA
22920	VA	23359	VA	23923	VA	24250	VA
22922	VA	23389	VA	23934	VA	24251	VA
22935	VA	23395	VA	23937	VA	24256	VA

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
24258	VA	24624	VA	25141	WV	25978	WV
24260	VA	24627	VA	25142	WV	25979	WV
24263	VA	24628	VA	25149	WV	25984	WV
24265	VA	24631	VA	25150	WV	25985	WV
24266	VA	24634	VA	25164	WV	26134	WV
24269	VA	24639	VA	25174	WV	26136	WV
24271	VA	24640	VA	25209	WV	26137	WV
24272	VA	24646	VA	25211	WV	26138	WV
24277	VA	24647	VA	25231	WV	26141	WV
24280	VA	24649	VA	25234	WV	26143	WV
24281	VA	24656	VA	25235	WV	26146	WV
24282	VA	24657	VA	25239	WV	26147	WV
24290	VA	24658	VA	25241	WV	26148	WV
24292	VA	24715	WV	25243	WV	26149	WV
24314	VA	24724	WV	25244	WV	26151	WV
24315	VA	24918	WV	25245	WV	26152	WV
24318	VA	24935	WV	25248	WV	26160	WV
24326	VA	24941	WV	25251	WV	26161	WV
24330	VA	24945	WV	25252	WV	26164	WV
24348	VA	24950	WV	25259	WV	26170	WV
24363	VA	24951	WV	25261	WV	26173	WV
24366	VA	24962	WV	25262	WV	26175	WV
24378	VA	24963	WV	25266	WV	26178	WV
24380	VA	24974	WV	25267	WV	26202	WV
24412	VA	24976	WV	25268	WV	26205	WV
24413	VA	24981	WV	25270	WV	26208	WV
24433	VA	24983	WV	25271	WV	26261	WV
24442	VA	24984	WV	25275	WV	26280	WV
24445	VA	24985	WV	25276	WV	26320	WV
24458	VA	24993	WV	25279	WV	26325	WV
24460	VA	25005	WV	25281	WV	26327	WV
24464	VA	25007	WV	25285	WV	26334	WV
24465	VA	25019	WV	25286	WV	26335	WV
24468	VA	25028	WV	25431	WV	26337	WV
24484	VA	25030	WV	25437	WV	26342	WV
24487	VA	25043	WV	25444	WV	26346	WV
24517	VA	25046	WV	25570	WV	26347	WV
24522	VA	25062	WV	25699	WV	26351	WV
24553	VA	25063	WV	25839	WV	26354	WV
24563	VA	25088	WV	25844	WV	26362	WV
24593	VA	25093	WV	25951	WV	26384	WV
24603	VA	25111	WV	25958	WV	26415	WV
24607	VA	25113	WV	25965	WV	26421	WV
24614	VA	25114	WV	25966	WV	26424	WV
24618	VA	25125	WV	25969	WV	26430	WV
24620	VA	25133	WV	25977	WV	26434	WV

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
26435	WV	27586	NC	27950	NC	29080	SC
26440	WV	27589	NC	27956	NC	29106	SC
26443	WV	27594	NC	27957	NC	29129	SC
26601	WV	27801	NC	27958	NC	29130	SC
26611	WV	27802	NC	27962	NC	29132	SC
26615	WV	27805	NC	27964	NC	29135	SC
26617	WV	27808	NC	27965	NC	29138	SC
26619	WV	27809	NC	27966	NC	29142	SC
26621	WV	27819	NC	27969	NC	29163	SC
26623	WV	27820	NC	27970	NC	29166	SC
26624	WV	27831	NC	27973	NC	29176	SC
26627	WV	27832	NC	27979	NC	29180	SC
26629	WV	27842	NC	27983	NC	29436	SC
26631	WV	27845	NC	28007	NC	29448	SC
26636	WV	27847	NC	28091	NC	29468	SC
26638	WV	27849	NC	28102	NC	29469	SC
26639	WV	27852	NC	28119	NC	29487	SC
26641	WV	27853	NC	28133	NC	29512	SC
26676	WV	27854	NC	28135	NC	29516	SC
26681	WV	27862	NC	28170	NC	29518	SC
26684	WV	27864	NC	28361	NC	29525	SC
26704	WV	27866	NC	28376	NC	29554	SC
26711	WV	27867	NC	28421	NC	29556	SC
26714	WV	27868	NC	28425	NC	29564	SC
26722	WV	27869	NC	28435	NC	29570	SC
26755	WV	27872	NC	28443	NC	29580	SC
26757	WV	27876	NC	28454	NC	29590	SC
26761	WV	27877	NC	28457	NC	29594	SC
26763	WV	27886	NC	28478	NC	29596	SC
26802	WV	27897	NC	28636	NC	29688	SC
26804	WV	27916	NC	28678	NC	29821	SC
26807	WV	27917	NC	28681	NC	29824	SC
26808	WV	27923	NC	28733	NC	29832	SC
26814	WV	27924	NC	28771	NC	29835	SC
26815	WV	27925	NC	28902	NC	29838	SC
26817	WV	27926	NC	28904	NC	29840	SC
26823	WV	27927	NC	28909	NC	29844	SC
26824	WV	27928	NC	29010	SC	29845	SC
26852	WV	27929	NC	29015	SC	29847	SC
26865	WV	27935	NC	29030	SC	30055	GA
26866	WV	27937	NC	29046	SC	30102	GA
26884	WV	27938	NC	29048	SC	30104	GA
26886	WV	27939	NC	29052	SC	30107	GA
27551	NC	27941	NC	29056	SC	30114	GA
27563	NC	27946	NC	29059	SC	30115	GA
27570	NC	27947	NC	29065	SC	30125	GA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
30132	GA	30530	GA	30828	GA	31553	GA
30138	GA	30537	GA	30833	GA	31566	GA
30141	GA	30547	GA	31002	GA	31624	GA
30142	GA	30552	GA	31003	GA	31625	GA
30143	GA	30558	GA	31016	GA	31629	GA
30146	GA	30562	GA	31017	GA	31638	GA
30148	GA	30568	GA	31020	GA	31642	GA
30151	GA	30573	GA	31024	GA	31643	GA
30153	GA	30576	GA	31026	GA	31648	GA
30157	GA	30581	GA	31029	GA	31650	GA
30169	GA	30619	GA	31031	GA	31704	GA
30175	GA	30627	GA	31038	GA	31763	GA
30177	GA	30628	GA	31042	GA	31787	GA
30183	GA	30629	GA	31044	GA	31804	GA
30188	GA	30630	GA	31045	GA	31805	GA
30189	GA	30633	GA	31046	GA	31807	GA
30217	GA	30646	GA	31050	GA	31811	GA
30219	GA	30647	GA	31052	GA	31822	GA
30230	GA	30648	GA	31054	GA	31823	GA
30240	GA	30660	GA	31064	GA	31826	GA
30241	GA	30667	GA	31066	GA	31831	GA
30261	GA	30668	GA	31078	GA	31833	GA
30291	GA	30671	GA	31085	GA	32008	FL
30401	GA	30673	GA	31086	GA	32013	FL
30413	GA	30705	GA	31090	GA	32042	FL
30420	GA	30707	GA	31301	GA	32044	FL
30421	GA	30708	GA	31303	GA	32058	FL
30424	GA	30711	GA	31304	GA	32059	FL
30425	GA	30724	GA	31305	GA	32060	FL
30427	GA	30725	GA	31309	GA	32062	FL
30434	GA	30728	GA	31310	GA	32064	FL
30438	GA	30730	GA	31312	GA	32066	FL
30446	GA	30731	GA	31313	GA	32071	FL
30447	GA	30739	GA	31314	GA	32091	FL
30448	GA	30741	GA	31315	GA	32094	FL
30449	GA	30747	GA	31316	GA	32162	FL
30453	GA	30750	GA	31319	GA	32324	FL
30455	GA	30751	GA	31320	GA	32326	FL
30457	GA	30753	GA	31323	GA	32327	FL
30464	GA	30803	GA	31326	GA	32330	FL
30467	GA	30807	GA	31327	GA	32331	FL
30471	GA	30810	GA	31329	GA	32332	FL
30477	GA	30818	GA	31331	GA	32333	FL
30499	GA	30820	GA	31333	GA	32340	FL
30511	GA	30821	GA	31542	GA	32341	FL
30525	GA	30823	GA	31543	GA	32343	FL

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
32346	FL	35031	AL	35575	AL	36276	AL
32350	FL	35034	AL	35577	AL	36278	AL
32351	FL	35035	AL	35618	AL	36280	AL
32352	FL	35042	AL	35643	AL	36310	AL
32353	FL	35049	AL	35650	AL	36311	AL
32355	FL	35052	AL	35651	AL	36313	AL
32357	FL	35054	AL	35672	AL	36314	AL
32358	FL	35072	AL	35953	AL	36316	AL
32422	FL	35079	AL	35959	AL	36317	AL
32425	FL	35082	AL	35960	AL	36318	AL
32427	FL	35089	AL	35973	AL	36322	AL
32428	FL	35097	AL	35983	AL	36340	AL
32433	FL	35112	AL	35987	AL	36344	AL
32434	FL	35120	AL	36009	AL	36345	AL
32435	FL	35121	AL	36020	AL	36349	AL
32437	FL	35125	AL	36022	AL	36350	AL
32439	FL	35128	AL	36024	AL	36352	AL
32452	FL	35131	AL	36025	AL	36353	AL
32454	FL	35133	AL	36026	AL	36360	AL
32455	FL	35135	AL	36028	AL	36361	AL
32459	FL	35136	AL	36034	AL	36362	AL
32462	FL	35146	AL	36040	AL	36371	AL
32463	FL	35182	AL	36041	AL	36373	AL
32464	FL	35183	AL	36042	AL	36374	AL
32550	FL	35184	AL	36045	AL	36375	AL
32622	FL	35187	AL	36049	AL	36401	AL
32628	FL	35188	AL	36054	AL	36429	AL
32648	FL	35441	AL	36062	AL	36432	AL
32680	FL	35442	AL	36071	AL	36435	AL
32692	FL	35443	AL	36078	AL	36454	AL
33471	FL	35447	AL	36080	AL	36473	AL
33513	FL	35448	AL	36092	AL	36475	AL
33514	FL	35461	AL	36093	AL	36477	AL
33521	FL	35462	AL	36251	AL	36513	AL
33538	FL	35466	AL	36255	AL	36518	AL
33585	FL	35469	AL	36258	AL	36529	AL
33597	FL	35471	AL	36261	AL	36538	AL
33834	FL	35474	AL	36262	AL	36539	AL
33865	FL	35481	AL	36263	AL	36548	AL
33873	FL	35491	AL	36264	AL	36553	AL
33890	FL	35540	AL	36266	AL	36556	AL
33944	FL	35541	AL	36267	AL	36558	AL
34484	FL	35551	AL	36269	AL	36569	AL
34785	FL	35553	AL	36273	AL	36581	AL
35004	AL	35565	AL	36274	AL	36583	AL
35013	AL	35572	AL	36275	AL	36584	AL

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
36585	AL	37301	TN	38001	TN	38472	TN
36720	AL	37305	TN	38006	TN	38473	TN
36721	AL	37313	TN	38008	TN	38477	TN
36722	AL	37339	TN	38010	TN	38478	TN
36723	AL	37352	TN	38012	TN	38549	TN
36726	AL	37356	TN	38021	TN	38562	TN
36728	AL	37365	TN	38034	TN	38564	TN
36740	AL	37366	TN	38036	TN	38585	TN
36741	AL	37387	TN	38037	TN	38588	TN
36744	AL	37640	TN	38039	TN	38602	MS
36751	AL	37642	TN	38040	TN	38603	MS
36753	AL	37645	TN	38041	TN	38606	MS
36756	AL	37650	TN	38042	TN	38609	MS
36765	AL	37657	TN	38044	TN	38610	MS
36766	AL	37680	TN	38045	TN	38611	MS
36768	AL	37683	TN	38046	TN	38618	MS
36769	AL	37688	TN	38048	TN	38619	MS
36776	AL	37691	TN	38050	TN	38620	MS
36786	AL	37692	TN	38052	TN	38621	MS
36792	AL	37707	TN	38057	TN	38622	MS
36793	AL	37711	TN	38060	TN	38623	MS
36904	AL	37715	TN	38061	TN	38625	MS
36906	AL	37724	TN	38063	TN	38626	MS
36908	AL	37726	TN	38066	TN	38628	MS
36910	AL	37730	TN	38067	TN	38629	MS
36912	AL	37731	TN	38068	TN	38632	MS
36913	AL	37752	TN	38069	TN	38633	MS
36915	AL	37765	TN	38074	TN	38634	MS
36916	AL	37770	TN	38075	TN	38635	MS
36919	AL	37773	TN	38076	TN	38637	MS
36921	AL	37779	TN	38311	TN	38638	MS
36922	AL	37807	TN	38329	TN	38641	MS
37015	TN	37811	TN	38332	TN	38642	MS
37025	TN	37824	TN	38336	TN	38643	MS
37033	TN	37825	TN	38337	TN	38646	MS
37035	TN	37829	TN	38340	TN	38647	MS
37082	TN	37851	TN	38347	TN	38649	MS
37083	TN	37857	TN	38352	TN	38651	MS
37096	TN	37866	TN	38363	TN	38654	MS
37097	TN	37867	TN	38374	TN	38658	MS
37098	TN	37869	TN	38380	TN	38659	MS
37137	TN	37870	TN	38381	TN	38661	MS
37140	TN	37872	TN	38449	TN	38663	MS
37143	TN	37873	TN	38454	TN	38664	MS
37146	TN	37879	TN	38455	TN	38665	MS
37150	TN	37887	TN	38460	TN	38666	MS

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
38668	MS	38921	MS	39078	MS	39324	MS
38670	MS	38922	MS	39079	MS	39327	MS
38671	MS	38923	MS	39080	MS	39328	MS
38672	MS	38924	MS	39083	MS	39330	MS
38674	MS	38925	MS	39086	MS	39332	MS
38676	MS	38927	MS	39087	MS	39336	MS
38679	MS	38928	MS	39088	MS	39337	MS
38680	MS	38930	MS	39092	MS	39338	MS
38683	MS	38935	MS	39094	MS	39339	MS
38685	MS	38941	MS	39095	MS	39341	MS
38686	MS	38943	MS	39096	MS	39345	MS
38736	MS	38944	MS	39097	MS	39346	MS
38737	MS	38945	MS	39098	MS	39347	MS
38738	MS	38946	MS	39109	MS	39348	MS
38749	MS	38947	MS	39110	MS	39350	MS
38751	MS	38948	MS	39115	MS	39352	MS
38753	MS	38950	MS	39116	MS	39354	MS
38754	MS	38951	MS	39117	MS	39355	MS
38761	MS	38952	MS	39119	MS	39356	MS
38768	MS	38953	MS	39130	MS	39358	MS
38771	MS	38954	MS	39140	MS	39359	MS
38778	MS	38955	MS	39144	MS	39360	MS
38829	MS	38957	MS	39146	MS	39361	MS
38839	MS	38958	MS	39150	MS	39362	MS
38843	MS	38959	MS	39152	MS	39363	MS
38847	MS	38961	MS	39153	MS	39365	MS
38850	MS	38962	MS	39157	MS	39366	MS
38851	MS	38963	MS	39158	MS	39367	MS
38854	MS	38964	MS	39162	MS	39421	MS
38855	MS	38965	MS	39163	MS	39422	MS
38856	MS	38966	MS	39166	MS	39423	MS
38858	MS	38967	MS	39168	MS	39426	MS
38859	MS	39038	MS	39169	MS	39427	MS
38860	MS	39039	MS	39171	MS	39428	MS
38875	MS	39040	MS	39173	MS	39429	MS
38876	MS	39045	MS	39176	MS	39439	MS
38877	MS	39046	MS	39179	MS	39451	MS
38878	MS	39051	MS	39189	MS	39452	MS
38880	MS	39057	MS	39191	MS	39455	MS
38912	MS	39059	MS	39192	MS	39456	MS
38913	MS	39063	MS	39194	MS	39457	MS
38914	MS	39069	MS	39203	MS	39461	MS
38915	MS	39071	MS	39207	MS	39462	MS
38916	MS	39072	MS	39217	MS	39463	MS
38917	MS	39074	MS	39322	MS	39466	MS
38920	MS	39077	MS	39323	MS	39470	MS

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
39474	MS	39776	MS	40461	KY	41128	KY
39475	MS	39826	GA	40467	KY	41132	KY
39476	MS	39842	GA	40481	KY	41135	KY
39477	MS	39854	GA	40486	KY	41137	KY
39478	MS	39867	GA	40488	KY	41139	KY
39479	MS	39870	GA	40701	KY	41141	KY
39481	MS	39877	GA	40702	KY	41142	KY
39482	MS	40006	KY	40730	KY	41143	KY
39483	MS	40007	KY	40734	KY	41144	KY
39520	MS	40011	KY	40754	KY	41146	KY
39521	MS	40019	KY	40759	KY	41149	KY
39522	MS	40036	KY	40763	KY	41156	KY
39525	MS	40045	KY	40769	KY	41164	KY
39529	MS	40046	KY	40771	KY	41166	KY
39556	MS	40047	KY	40903	KY	41169	KY
39558	MS	40050	KY	40906	KY	41171	KY
39572	MS	40055	KY	40915	KY	41173	KY
39576	MS	40057	KY	40921	KY	41174	KY
39630	MS	40058	KY	40923	KY	41175	KY
39641	MS	40068	KY	40930	KY	41179	KY
39643	MS	40070	KY	40935	KY	41181	KY
39647	MS	40071	KY	40943	KY	41183	KY
39653	MS	40075	KY	40946	KY	41189	KY
39654	MS	40109	KY	40949	KY	41203	KY
39656	MS	40110	KY	40953	KY	41214	KY
39661	MS	40150	KY	40982	KY	41224	KY
39663	MS	40165	KY	40995	KY	41231	KY
39665	MS	40311	KY	40997	KY	41250	KY
39667	MS	40312	KY	40999	KY	41262	KY
39668	MS	40316	KY	41002	KY	41267	KY
39735	MS	40322	KY	41004	KY	41307	KY
39737	MS	40346	KY	41006	KY	41310	KY
39739	MS	40350	KY	41008	KY	41314	KY
39741	MS	40355	KY	41033	KY	41317	KY
39744	MS	40359	KY	41040	KY	41338	KY
39745	MS	40363	KY	41043	KY	41339	KY
39747	MS	40376	KY	41044	KY	41344	KY
39750	MS	40380	KY	41045	KY	41348	KY
39751	MS	40387	KY	41046	KY	41351	KY
39752	MS	40402	KY	41061	KY	41364	KY
39754	MS	40410	KY	41064	KY	41366	KY
39755	MS	40421	KY	41083	KY	41385	KY
39767	MS	40434	KY	41086	KY	41386	KY
39771	MS	40444	KY	41095	KY	41390	KY
39772	MS	40446	KY	41098	KY	41410	KY
39773	MS	40447	KY	41121	KY	41419	KY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
41422	KY	42323	KY	42765	KY	45618	OH
41426	KY	42324	KY	43030	OH	45619	OH
41433	KY	42325	KY	43076	OH	45622	OH
41464	KY	42326	KY	43721	OH	45634	OH
41465	KY	42327	KY	43728	OH	45638	OH
41632	KY	42328	KY	43730	OH	45645	OH
42021	KY	42330	KY	43731	OH	45650	OH
42022	KY	42332	KY	43738	OH	45651	OH
42023	KY	42333	KY	43739	OH	45654	OH
42024	KY	42337	KY	43748	OH	45659	OH
42031	KY	42338	KY	43756	OH	45660	OH
42032	KY	42339	KY	43758	OH	45669	OH
42035	KY	42343	KY	43760	OH	45672	OH
42056	KY	42344	KY	43761	OH	45675	OH
42070	KY	42345	KY	43764	OH	45678	OH
42087	KY	42347	KY	43766	OH	45679	OH
42120	KY	42348	KY	43782	OH	45680	OH
42124	KY	42349	KY	43783	OH	45684	OH
42129	KY	42350	KY	43787	OH	45688	OH
42134	KY	42351	KY	43789	OH	45693	OH
42135	KY	42352	KY	43915	OH	45695	OH
42150	KY	42354	KY	44076	OH	45696	OH
42153	KY	42361	KY	44085	OH	45697	OH
42154	KY	42364	KY	44615	OH	45698	OH
42163	KY	42367	KY	44620	OH	45734	OH
42164	KY	42368	KY	44631	OH	45813	OH
42166	KY	42369	KY	44644	OH	45821	OH
42203	KY	42370	KY	44651	OH	45849	OH
42204	KY	42371	KY	44675	OH	45851	OH
42207	KY	42372	KY	45070	OH	45855	OH
42210	KY	42374	KY	45105	OH	45861	OH
42211	KY	42516	KY	45144	OH	45873	OH
42214	KY	42528	KY	45157	OH	45879	OH
42215	KY	42539	KY	45160	OH	45880	OH
42216	KY	42541	KY	45311	OH	46349	IN
42220	KY	42565	KY	45320	OH	46366	IN
42234	KY	42566	KY	45321	OH	46374	IN
42257	KY	42713	KY	45330	OH	46379	IN
42259	KY	42716	KY	45338	OH	46381	IN
42275	KY	42722	KY	45347	OH	46404	IN
42280	KY	42729	KY	45378	OH	46531	IN
42285	KY	42746	KY	45381	OH	46532	IN
42286	KY	42748	KY	45382	OH	46534	IN
42320	KY	42749	KY	45417	OH	46565	IN
42321	KY	42757	KY	45428	OH	46571	IN
42322	KY	42764	KY	45616	OH	46701	IN

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
46710	IN	47368	IN	47970	IN	49657	MI
46732	IN	47380	IN	47971	IN	49665	MI
46746	IN	47382	IN	47975	IN	49667	MI
46755	IN	47390	IN	47982	IN	49677	MI
46760	IN	47394	IN	47984	IN	49679	MI
46761	IN	47427	IN	47986	IN	49688	MI
46763	IN	47431	IN	47987	IN	49709	MI
46767	IN	47433	IN	47988	IN	49743	MI
46771	IN	47456	IN	47991	IN	49746	MI
46784	IN	47460	IN	47993	IN	49756	MI
46786	IN	47501	IN	48617	MI	49759	MI
46789	IN	47519	IN	48619	MI	49765	MI
46794	IN	47529	IN	48621	MI	49776	MI
46795	IN	47558	IN	48622	MI	49777	MI
46796	IN	47562	IN	48625	MI	49779	MI
47010	IN	47564	IN	48632	MI	49853	MI
47011	IN	47567	IN	48633	MI	49868	MI
47012	IN	47568	IN	48636	MI	50002	IA
47016	IN	47585	IN	48647	MI	50040	IA
47020	IN	47590	IN	48705	MI	50104	IA
47024	IN	47598	IN	48721	MI	50136	IA
47030	IN	47830	IN	48728	MI	50173	IA
47036	IN	47832	IN	48737	MI	50249	IA
47038	IN	47836	IN	48738	MI	50255	IA
47043	IN	47856	IN	48740	MI	50268	IA
47116	IN	47859	IN	48742	MI	50423	IA
47118	IN	47860	IN	48745	MI	50426	IA
47123	IN	47862	IN	48762	MI	50430	IA
47137	IN	47868	IN	49304	MI	50432	IA
47140	IN	47872	IN	49420	MI	50438	IA
47145	IN	47874	IN	49421	MI	50439	IA
47174	IN	47917	IN	49436	MI	50447	IA
47175	IN	47918	IN	49446	MI	50449	IA
47223	IN	47921	IN	49449	MI	50451	IA
47227	IN	47922	IN	49452	MI	50454	IA
47245	IN	47932	IN	49455	MI	50455	IA
47265	IN	47942	IN	49459	MI	50460	IA
47270	IN	47944	IN	49623	MI	50461	IA
47273	IN	47948	IN	49631	MI	50472	IA
47282	IN	47949	IN	49632	MI	50476	IA
47340	IN	47951	IN	49639	MI	50480	IA
47348	IN	47952	IN	49642	MI	50481	IA
47354	IN	47958	IN	49644	MI	50483	IA
47355	IN	47963	IN	49651	MI	50484	IA
47358	IN	47964	IN	49655	MI	50511	IA
47359	IN	47969	IN	49656	MI	50517	IA

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
50521	IA	50680	IA	52342	IA	54420	WI
50522	IA	50682	IA	52345	IA	54421	WI
50530	IA	50833	IA	52346	IA	54422	WI
50535	IA	50836	IA	52348	IA	54425	WI
50538	IA	50837	IA	52349	IA	54436	WI
50539	IA	50840	IA	52351	IA	54437	WI
50543	IA	50846	IA	52354	IA	54446	WI
50544	IA	50848	IA	52355	IA	54456	WI
50551	IA	50849	IA	52537	IA	54460	WI
50552	IA	50851	IA	52550	IA	54485	WI
50556	IA	50858	IA	52552	IA	54493	WI
50559	IA	50862	IA	52560	IA	54498	WI
50560	IA	51004	IA	52562	IA	54511	WI
50567	IA	51039	IA	52563	IA	54520	WI
50579	IA	51044	IA	52568	IA	54527	WI
50583	IA	51053	IA	52576	IA	54541	WI
50586	IA	51433	IA	52584	IA	54542	WI
50590	IA	51449	IA	52585	IA	54566	WI
50598	IA	51450	IA	52591	IA	54613	WI
50602	IA	51451	IA	52640	IA	54634	WI
50604	IA	51453	IA	52646	IA	54721	WI
50605	IA	51458	IA	52653	IA	54725	WI
50607	IA	51466	IA	52737	IA	54726	WI
50608	IA	51575	IA	52738	IA	54733	WI
50611	IA	51646	IA	52752	IA	54736	WI
50612	IA	52206	IA	52754	IA	54737	WI
50619	IA	52208	IA	52777	IA	54740	WI
50625	IA	52209	IA	53541	WI	54746	WI
50629	IA	52210	IA	53587	WI	54756	WI
50632	IA	52215	IA	53910	WI	54759	WI
50635	IA	52217	IA	53920	WI	54761	WI
50636	IA	52224	IA	53927	WI	54762	WI
50641	IA	52225	IA	53930	WI	54763	WI
50642	IA	52229	IA	53934	WI	54769	WI
50644	IA	52231	IA	53936	WI	54771	WI
50648	IA	52248	IA	53939	WI	54772	WI
50649	IA	52249	IA	53947	WI	54821	WI
50650	IA	52257	IA	53949	WI	54828	WI
50652	IA	52313	IA	53952	WI	54830	WI
50660	IA	52315	IA	53953	WI	54840	WI
50664	IA	52318	IA	53964	WI	54843	WI
50665	IA	52326	IA	54103	WI	54845	WI
50670	IA	52329	IA	54120	WI	54862	WI
50671	IA	52332	IA	54121	WI	54867	WI
50673	IA	52335	IA	54149	WI	54872	WI
50675	IA	52339	IA	54405	WI	54893	WI

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54930	WI	56446	MN	56655	MN	57213	SD
54943	WI	56452	MN	56660	MN	57214	SD
54960	WI	56453	MN	56662	MN	57217	SD
54965	WI	56458	MN	56672	MN	57218	SD
54966	WI	56461	MN	56676	MN	57219	SD
54967	WI	56467	MN	56678	MN	57221	SD
54970	WI	56470	MN	56688	MN	57223	SD
54976	WI	56473	MN	56710	MN	57225	SD
54982	WI	56474	MN	56713	MN	57226	SD
54984	WI	56479	MN	56720	MN	57231	SD
55604	MN	56484	MN	56724	MN	57233	SD
55605	MN	56510	MN	56727	MN	57234	SD
55606	MN	56514	MN	56728	MN	57236	SD
55612	MN	56516	MN	56729	MN	57237	SD
55613	MN	56518	MN	56731	MN	57238	SD
55615	MN	56519	MN	56732	MN	57239	SD
55702	MN	56524	MN	56733	MN	57241	SD
55703	MN	56525	MN	56734	MN	57242	SD
55781	MN	56527	MN	56735	MN	57246	SD
55785	MN	56528	MN	56737	MN	57248	SD
56009	MN	56534	MN	56738	MN	57249	SD
56020	MN	56541	MN	56740	MN	57258	SD
56032	MN	56545	MN	56744	MN	57261	SD
56042	MN	56548	MN	56755	MN	57268	SD
56051	MN	56549	MN	56757	MN	57271	SD
56097	MN	56550	MN	56758	MN	57273	SD
56114	MN	56551	MN	56760	MN	57274	SD
56122	MN	56557	MN	56762	MN	57278	SD
56123	MN	56566	MN	57013	SD	57321	SD
56125	MN	56571	MN	57014	SD	57323	SD
56131	MN	56574	MN	57015	SD	57329	SD
56141	MN	56576	MN	57021	SD	57337	SD
56151	MN	56581	MN	57027	SD	57342	SD
56172	MN	56584	MN	57032	SD	57345	SD
56178	MN	56587	MN	57034	SD	57346	SD
56318	MN	56588	MN	57036	SD	57349	SD
56336	MN	56621	MN	57039	SD	57353	SD
56347	MN	56626	MN	57043	SD	57356	SD
56389	MN	56628	MN	57047	SD	57361	SD
56430	MN	56633	MN	57051	SD	57365	SD
56433	MN	56634	MN	57053	SD	57367	SD
56435	MN	56639	MN	57064	SD	57369	SD
56436	MN	56641	MN	57070	SD	57380	SD
56437	MN	56644	MN	57077	SD	57422	SD
56438	MN	56651	MN	57108	SD	57428	SD
56440	MN	56652	MN	57212	SD	57435	SD

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

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Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
57438	SD	57657	SD	58341	ND	58482	ND
57448	SD	57661	SD	58343	ND	58484	ND
57451	SD	57716	SD	58344	ND	58486	ND
57466	SD	57720	SD	58346	ND	58487	ND
57468	SD	57724	SD	58348	ND	58488	ND
57470	SD	57735	SD	58351	ND	58490	ND
57471	SD	57747	SD	58352	ND	58523	ND
57473	SD	57750	SD	58353	ND	58524	ND
57521	SD	57752	SD	58355	ND	58528	ND
57531	SD	57755	SD	58356	ND	58529	ND
57540	SD	57756	SD	58357	ND	58530	ND
57542	SD	57763	SD	58361	ND	58531	ND
57543	SD	57764	SD	58366	ND	58533	ND
57544	SD	57766	SD	58367	ND	58538	ND
57547	SD	57770	SD	58369	ND	58540	ND
57548	SD	57772	SD	58370	ND	58541	ND
57552	SD	57776	SD	58372	ND	58542	ND
57553	SD	57782	SD	58374	ND	58544	ND
57555	SD	57794	SD	58379	ND	58545	ND
57559	SD	58013	ND	58380	ND	58549	ND
57560	SD	58017	ND	58381	ND	58552	ND
57562	SD	58032	ND	58386	ND	58559	ND
57563	SD	58040	ND	58415	ND	58561	ND
57566	SD	58043	ND	58416	ND	58562	ND
57567	SD	58058	ND	58418	ND	58564	ND
57568	SD	58060	ND	58422	ND	58565	ND
57569	SD	58067	ND	58423	ND	58566	ND
57570	SD	58069	ND	58425	ND	58568	ND
57572	SD	58212	ND	58428	ND	58569	ND
57576	SD	58224	ND	58430	ND	58570	ND
57577	SD	58239	ND	58431	ND	58571	ND
57579	SD	58249	ND	58433	ND	58573	ND
57585	SD	58254	ND	58438	ND	58575	ND
57620	SD	58255	ND	58440	ND	58576	ND
57625	SD	58259	ND	58442	ND	58577	ND
57630	SD	58260	ND	58444	ND	58579	ND
57632	SD	58269	ND	58448	ND	58580	ND
57633	SD	58272	ND	58451	ND	58620	ND
57636	SD	58281	ND	58452	ND	58621	ND
57644	SD	58311	ND	58454	ND	58625	ND
57646	SD	58316	ND	58456	ND	58626	ND
57648	SD	58319	ND	58458	ND	58627	ND
57650	SD	58323	ND	58463	ND	58632	ND
57651	SD	58329	ND	58466	ND	58634	ND
57652	SD	58332	ND	58475	ND	58636	ND
57656	SD	58335	ND	58478	ND	58640	ND

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
58642	ND	58838	ND	59223	MT	59462	MT
58643	ND	58844	ND	59225	MT	59467	MT
58645	ND	58847	ND	59230	MT	59469	MT
58646	ND	58849	ND	59231	MT	59479	MT
58647	ND	58852	ND	59240	MT	59524	MT
58650	ND	58854	ND	59241	MT	59537	MT
58654	ND	59011	MT	59242	MT	59538	MT
58710	ND	59016	MT	59244	MT	59544	MT
58712	ND	59018	MT	59247	MT	59546	MT
58713	ND	59020	MT	59248	MT	59631	MT
58716	ND	59022	MT	59250	MT	59632	MT
58721	ND	59025	MT	59252	MT	59634	MT
58723	ND	59027	MT	59253	MT	59638	MT
58727	ND	59029	MT	59254	MT	59641	MT
58730	ND	59030	MT	59256	MT	59643	MT
58731	ND	59031	MT	59257	MT	59644	MT
58734	ND	59033	MT	59258	MT	59647	MT
58736	ND	59034	MT	59259	MT	59710	MT
58737	ND	59035	MT	59260	MT	59713	MT
58741	ND	59046	MT	59261	MT	59721	MT
58744	ND	59047	MT	59263	MT	59722	MT
58747	ND	59050	MT	59273	MT	59728	MT
58752	ND	59052	MT	59274	MT	59729	MT
58757	ND	59054	MT	59275	MT	59731	MT
58758	ND	59055	MT	59276	MT	59733	MT
58759	ND	59058	MT	59314	MT	59740	MT
58760	ND	59059	MT	59315	MT	59745	MT
58761	ND	59062	MT	59317	MT	59747	MT
58765	ND	59065	MT	59318	MT	59749	MT
58768	ND	59066	MT	59319	MT	59759	MT
58769	ND	59072	MT	59322	MT	59820	MT
58771	ND	59073	MT	59326	MT	59830	MT
58772	ND	59074	MT	59330	MT	59831	MT
58773	ND	59075	MT	59337	MT	59832	MT
58775	ND	59077	MT	59339	MT	59837	MT
58776	ND	59081	MT	59341	MT	59842	MT
58778	ND	59082	MT	59343	MT	59843	MT
58787	ND	59084	MT	59345	MT	59844	MT
58788	ND	59086	MT	59349	MT	59845	MT
58789	ND	59087	MT	59411	MT	59848	MT
58790	ND	59089	MT	59417	MT	59853	MT
58792	ND	59211	MT	59419	MT	59854	MT
58794	ND	59214	MT	59427	MT	59856	MT
58831	ND	59215	MT	59434	MT	59858	MT
58833	ND	59219	MT	59447	MT	59859	MT
58835	ND	59222	MT	59452	MT	59866	MT

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
59867	MT	62023	IL	62649	IL	62954	IL
59872	MT	62033	IL	62655	IL	62967	IL
59873	MT	62036	IL	62663	IL	62972	IL
59874	MT	62045	IL	62664	IL	62979	IL
60628	IL	62047	IL	62667	IL	62983	IL
61014	IL	62053	IL	62672	IL	62984	IL
61046	IL	62065	IL	62674	IL	62985	IL
61051	IL	62069	IL	62682	IL	62995	IL
61053	IL	62070	IL	62683	IL	62999	IL
61074	IL	62079	IL	62685	IL	63012	MO
61078	IL	62080	IL	62690	IL	63016	MO
61085	IL	62085	IL	62691	IL	63019	MO
61285	IL	62088	IL	62694	IL	63048	MO
61318	IL	62093	IL	62805	IL	63050	MO
61418	IL	62204	IL	62812	IL	63051	MO
61421	IL	62205	IL	62817	IL	63065	MO
61424	IL	62353	IL	62819	IL	63066	MO
61425	IL	62375	IL	62822	IL	63070	MO
61426	IL	62378	IL	62825	IL	63071	MO
61437	IL	62418	IL	62828	IL	63342	MO
61449	IL	62428	IL	62829	IL	63357	MO
61454	IL	62432	IL	62836	IL	63378	MO
61460	IL	62436	IL	62838	IL	63383	MO
61469	IL	62447	IL	62840	IL	63390	MO
61471	IL	62448	IL	62856	IL	63430	MO
61479	IL	62458	IL	62857	IL	63445	MO
61480	IL	62459	IL	62859	IL	63453	MO
61483	IL	62468	IL	62860	IL	63465	MO
61491	IL	62471	IL	62865	IL	63466	MO
61532	IL	62475	IL	62867	IL	63472	MO
61546	IL	62479	IL	62871	IL	63474	MO
61567	IL	62480	IL	62874	IL	63544	MO
61917	IL	62481	IL	62880	IL	63545	MO
61924	IL	62610	IL	62884	IL	63551	MO
61932	IL	62611	IL	62885	IL	63556	MO
61933	IL	62612	IL	62890	IL	63560	MO
61940	IL	62617	IL	62891	IL	63565	MO
61944	IL	62618	IL	62896	IL	63566	MO
61949	IL	62621	IL	62897	IL	63567	MO
61955	IL	62622	IL	62908	IL	63622	MO
62006	IL	62626	IL	62909	IL	63630	MO
62009	IL	62627	IL	62912	IL	63631	MO
62011	IL	62630	IL	62923	IL	63632	MO
62012	IL	62633	IL	62934	IL	63648	MO
62013	IL	62640	IL	62939	IL	63660	MO
62014	IL	62644	IL	62943	IL	63662	MO

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
63664	MO	63964	MO	64779	MO	65661	MO
63674	MO	63965	MO	64780	MO	65666	MO
63750	MO	63966	MO	65013	MO	65676	MO
63751	MO	63967	MO	65017	MO	65682	MO
63760	MO	64421	MO	65026	MO	65685	MO
63763	MO	64424	MO	65031	MO	65690	MO
63764	MO	64426	MO	65047	MO	65692	MO
63781	MO	64427	MO	65064	MO	65715	MO
63782	MO	64436	MO	65075	MO	65729	MO
63787	MO	64437	MO	65082	MO	65741	MO
63821	MO	64442	MO	65083	MO	65752	MO
63828	MO	64449	MO	65325	MO	65755	MO
63829	MO	64451	MO	65326	MO	65760	MO
63833	MO	64458	MO	65335	MO	65761	MO
63837	MO	64459	MO	65338	MO	65762	MO
63847	MO	64466	MO	65355	MO	65764	MO
63848	MO	64467	MO	65438	MO	65766	MO
63852	MO	64470	MO	65443	MO	65767	MO
63855	MO	64471	MO	65452	MO	65768	MO
63857	MO	64473	MO	65457	MO	65773	MO
63860	MO	64480	MO	65459	MO	65778	MO
63862	MO	64481	MO	65466	MO	65783	MO
63863	MO	64483	MO	65473	MO	65784	MO
63866	MO	64485	MO	65486	MO	65791	MO
63867	MO	64622	MO	65534	MO	66008	KS
63868	MO	64623	MO	65546	MO	66010	KS
63869	MO	64632	MO	65556	MO	66017	KS
63870	MO	64633	MO	65572	MO	66024	KS
63873	MO	64639	MO	65580	MO	66035	KS
63874	MO	64642	MO	65582	MO	66040	KS
63875	MO	64643	MO	65583	MO	66054	KS
63876	MO	64645	MO	65584	MO	66056	KS
63878	MO	64646	MO	65588	MO	66060	KS
63880	MO	64655	MO	65590	MO	66066	KS
63933	MO	64667	MO	65603	MO	66070	KS
63934	MO	64668	MO	65606	MO	66072	KS
63937	MO	64672	MO	65608	MO	66073	KS
63941	MO	64680	MO	65609	MO	66075	KS
63943	MO	64682	MO	65618	MO	66087	KS
63944	MO	64720	MO	65622	MO	66088	KS
63950	MO	64722	MO	65635	MO	66090	KS
63951	MO	64723	MO	65637	MO	66094	KS
63952	MO	64730	MO	65638	MO	66097	KS
63956	MO	64742	MO	65644	MO	66413	KS
63957	MO	64745	MO	65646	MO	66414	KS
63963	MO	64752	MO	65655	MO	66429	KS

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
66451	KS	67346	KS	67857	KS	68736	NE
66510	KS	67349	KS	67861	KS	68739	NE
66512	KS	67352	KS	67863	KS	68745	NE
66523	KS	67353	KS	67864	KS	68749	NE
66524	KS	67355	KS	67869	KS	68751	NE
66528	KS	67360	KS	67870	KS	68753	NE
66537	KS	67361	KS	67877	KS	68757	NE
66543	KS	67418	KS	67878	KS	68759	NE
66713	KS	67423	KS	67951	KS	68768	NE
66725	KS	67437	KS	67952	KS	68770	NE
66728	KS	67455	KS	68003	NE	68771	NE
66739	KS	67473	KS	68015	NE	68774	NE
66767	KS	67474	KS	68016	NE	68778	NE
66770	KS	67481	KS	68017	NE	68779	NE
66773	KS	67519	KS	68018	NE	68784	NE
66778	KS	67523	KS	68033	NE	68785	NE
66781	KS	67529	KS	68037	NE	68792	NE
66782	KS	67547	KS	68040	NE	68816	NE
66843	KS	67550	KS	68041	NE	68821	NE
66845	KS	67552	KS	68042	NE	68826	NE
66850	KS	67563	KS	68048	NE	68827	NE
66862	KS	67574	KS	68050	NE	68833	NE
66869	KS	67621	KS	68058	NE	68864	NE
66936	KS	67623	KS	68065	NE	68920	NE
66941	KS	67632	KS	68066	NE	68924	NE
66942	KS	67639	KS	68070	NE	68945	NE
66949	KS	67644	KS	68073	NE	68959	NE
66956	KS	67646	KS	68304	NE	68966	NE
66963	KS	67647	KS	68307	NE	68969	NE
66970	KS	67651	KS	68347	NE	68971	NE
67024	KS	67657	KS	68349	NE	68977	NE
67029	KS	67661	KS	68366	NE	68982	NE
67035	KS	67663	KS	68403	NE	69024	NE
67054	KS	67664	KS	68407	NE	69032	NE
67059	KS	67669	KS	68409	NE	69040	NE
67068	KS	67675	KS	68413	NE	69043	NE
67109	KS	67730	KS	68455	NE	69044	NE
67111	KS	67731	KS	68463	NE	69121	NE
67112	KS	67739	KS	68628	NE	69125	NE
67118	KS	67744	KS	68648	NE	69128	NE
67127	KS	67745	KS	68663	NE	69133	NE
67142	KS	67756	KS	68710	NE	69135	NE
67155	KS	67836	KS	68717	NE	69145	NE
67159	KS	67844	KS	68727	NE	69147	NE
67334	KS	67849	KS	68728	NE	69148	NE
67345	KS	67854	KS	68732	NE	69154	NE

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
69157	NE	70510	LA	71030	LA	71276	LA
69190	NE	70511	LA	71032	LA	71277	LA
69210	NE	70528	LA	71034	LA	71282	LA
69214	NE	70533	LA	71036	LA	71284	LA
69217	NE	70542	LA	71039	LA	71286	LA
69331	NE	70548	LA	71043	LA	71316	LA
69334	NE	70555	LA	71045	LA	71320	LA
69335	NE	70575	LA	71046	LA	71322	LA
69336	NE	70631	LA	71049	LA	71323	LA
69340	NE	70632	LA	71050	LA	71326	LA
69343	NE	70639	LA	71052	LA	71327	LA
69345	NE	70643	LA	71055	LA	71329	LA
69347	NE	70645	LA	71058	LA	71330	LA
69351	NE	70656	LA	71063	LA	71331	LA
69360	NE	70659	LA	71065	LA	71333	LA
69365	NE	70711	LA	71068	LA	71334	LA
70030	LA	70715	LA	71070	LA	71339	LA
70031	LA	70732	LA	71071	LA	71341	LA
70032	LA	70736	LA	71072	LA	71342	LA
70039	LA	70747	LA	71073	LA	71350	LA
70043	LA	70749	LA	71075	LA	71351	LA
70044	LA	70752	LA	71078	LA	71354	LA
70047	LA	70753	LA	71080	LA	71355	LA
70057	LA	70754	LA	71222	LA	71357	LA
70070	LA	70755	LA	71226	LA	71362	LA
70075	LA	70756	LA	71227	LA	71366	LA
70078	LA	70759	LA	71233	LA	71369	LA
70079	LA	70760	LA	71234	LA	71371	LA
70080	LA	70762	LA	71235	LA	71373	LA
70085	LA	70773	LA	71237	LA	71375	LA
70087	LA	70783	LA	71241	LA	71403	LA
70090	LA	70813	LA	71242	LA	71404	LA
70092	LA	71001	LA	71245	LA	71406	LA
70127	LA	71002	LA	71247	LA	71407	LA
70128	LA	71004	LA	71251	LA	71410	LA
70187	LA	71008	LA	71253	LA	71417	LA
70339	LA	71016	LA	71254	LA	71419	LA
70341	LA	71018	LA	71256	LA	71422	LA
70355	LA	71019	LA	71260	LA	71423	LA
70372	LA	71021	LA	71263	LA	71426	LA
70375	LA	71023	LA	71266	LA	71429	LA
70390	LA	71024	LA	71268	LA	71432	LA
70391	LA	71025	LA	71270	LA	71439	LA
70393	LA	71027	LA	71272	LA	71440	LA
70441	LA	71028	LA	71273	LA	71443	LA
70453	LA	71029	LA	71275	LA	71446	LA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
71449	LA	72001	AR	72640	AR	73460	OK
71454	LA	72013	AR	72641	AR	73461	OK
71459	LA	72016	AR	72645	AR	73531	OK
71460	LA	72017	AR	72648	AR	73562	OK
71461	LA	72025	AR	72650	AR	73568	OK
71462	LA	72028	AR	72655	AR	73572	OK
71465	LA	72031	AR	72666	AR	73628	OK
71467	LA	72040	AR	72669	AR	73638	OK
71473	LA	72041	AR	72670	AR	73642	OK
71474	LA	72057	AR	72675	AR	73650	OK
71475	LA	72064	AR	72683	AR	73660	OK
71479	LA	72066	AR	72685	AR	73666	OK
71480	LA	72070	AR	72686	AR	73716	OK
71483	LA	72083	AR	72721	AR	73719	OK
71486	LA	72084	AR	72738	AR	73722	OK
71496	LA	72088	AR	72740	AR	73726	OK
71643	AR	72125	AR	72742	AR	73728	OK
71644	AR	72126	AR	72749	AR	73739	OK
71652	AR	72128	AR	72752	AR	73741	OK
71659	AR	72129	AR	72760	AR	73749	OK
71660	AR	72141	AR	72773	AR	73758	OK
71665	AR	72150	AR	72776	AR	73759	OK
71667	AR	72152	AR	72827	AR	73761	OK
71678	AR	72153	AR	72828	AR	73766	OK
71722	AR	72170	AR	72841	AR	73771	OK
71744	AR	72322	AR	72856	AR	73834	OK
71745	AR	72324	AR	72924	AR	73848	OK
71766	AR	72326	AR	72926	AR	73851	OK
71826	AR	72335	AR	72944	AR	73855	OK
71827	AR	72336	AR	72950	AR	74026	OK
71828	AR	72340	AR	72958	AR	74027	OK
71835	AR	72346	AR	73027	OK	74042	OK
71844	AR	72347	AR	73028	OK	74048	OK
71845	AR	72348	AR	73044	OK	74072	OK
71857	AR	72359	AR	73050	OK	74079	OK
71858	AR	72372	AR	73056	OK	74083	OK
71860	AR	72373	AR	73058	OK	74110	OK
71864	AR	72387	AR	73063	OK	74130	OK
71935	AR	72392	AR	73073	OK	74359	OK
71957	AR	72394	AR	73432	OK	74368	OK
71960	AR	72396	AR	73439	OK	74440	OK
71961	AR	72624	AR	73440	OK	74462	OK
71965	AR	72628	AR	73446	OK	74472	OK
71969	AR	72629	AR	73447	OK	74525	OK
71970	AR	72636	AR	73450	OK	74530	OK
71973	AR	72639	AR	73455	OK	74531	OK

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
74533	OK	75169	TX	75657	TX	76009	TX
74534	OK	75412	TX	75658	TX	76028	TX
74535	OK	75413	TX	75667	TX	76031	TX
74538	OK	75415	TX	75668	TX	76033	TX
74540	OK	75417	TX	75669	TX	76044	TX
74549	OK	75418	TX	75680	TX	76050	TX
74552	OK	75426	TX	75681	TX	76058	TX
74555	OK	75432	TX	75682	TX	76059	TX
74556	OK	75436	TX	75683	TX	76061	TX
74558	OK	75438	TX	75684	TX	76084	TX
74567	OK	75439	TX	75685	TX	76093	TX
74569	OK	75440	TX	75687	TX	76097	TX
74570	OK	75441	TX	75689	TX	76351	TX
74572	OK	75443	TX	75691	TX	76366	TX
74577	OK	75446	TX	75754	TX	76370	TX
74636	OK	75447	TX	75755	TX	76379	TX
74643	OK	75448	TX	75790	TX	76389	TX
74748	OK	75449	TX	75797	TX	76424	TX
74824	OK	75450	TX	75831	TX	76429	TX
74827	OK	75452	TX	75833	TX	76430	TX
74829	OK	75469	TX	75834	TX	76435	TX
74832	OK	75472	TX	75845	TX	76437	TX
74833	OK	75475	TX	75846	TX	76445	TX
74834	OK	75476	TX	75850	TX	76448	TX
74836	OK	75479	TX	75852	TX	76454	TX
74839	OK	75488	TX	75855	TX	76464	TX
74848	OK	75490	TX	75856	TX	76466	TX
74850	OK	75492	TX	75862	TX	76470	TX
74855	OK	75550	TX	75865	TX	76471	TX
74856	OK	75554	TX	75926	TX	76518	TX
74859	OK	75564	TX	75929	TX	76519	TX
74860	OK	75568	TX	75930	TX	76520	TX
74864	OK	75571	TX	75931	TX	76522	TX
74869	OK	75631	TX	75934	TX	76523	TX
74875	OK	75633	TX	75936	TX	76525	TX
74880	OK	75636	TX	75938	TX	76526	TX
74881	OK	75637	TX	75939	TX	76528	TX
74883	OK	75638	TX	75942	TX	76538	TX
74941	OK	75639	TX	75947	TX	76556	TX
74943	OK	75640	TX	75948	TX	76558	TX
74944	OK	75643	TX	75959	TX	76561	TX
74957	OK	75644	TX	75960	TX	76566	TX
75103	TX	75645	TX	75968	TX	76567	TX
75117	TX	75652	TX	75972	TX	76570	TX
75127	TX	75653	TX	75979	TX	76577	TX
75140	TX	75654	TX	75990	TX	76597	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
76598	TX	76937	TX	77582	TX	77993	TX
76599	TX	76941	TX	77585	TX	78001	TX
76629	TX	76943	TX	77597	TX	78003	TX
76632	TX	76945	TX	77616	TX	78005	TX
76656	TX	76949	TX	77624	TX	78007	TX
76661	TX	76950	TX	77625	TX	78008	TX
76680	TX	76951	TX	77656	TX	78009	TX
76685	TX	76953	TX	77657	TX	78011	TX
76820	TX	77011	TX	77659	TX	78012	TX
76821	TX	77306	TX	77660	TX	78014	TX
76824	TX	77326	TX	77661	TX	78016	TX
76828	TX	77327	TX	77663	TX	78017	TX
76832	TX	77328	TX	77664	TX	78019	TX
76834	TX	77331	TX	77665	TX	78021	TX
76837	TX	77332	TX	77836	TX	78022	TX
76841	TX	77335	TX	77837	TX	78026	TX
76842	TX	77350	TX	77838	TX	78039	TX
76844	TX	77351	TX	77850	TX	78050	TX
76845	TX	77359	TX	77852	TX	78052	TX
76848	TX	77360	TX	77853	TX	78055	TX
76849	TX	77364	TX	77855	TX	78056	TX
76854	TX	77368	TX	77856	TX	78057	TX
76855	TX	77369	TX	77857	TX	78059	TX
76856	TX	77371	TX	77859	TX	78060	TX
76859	TX	77374	TX	77863	TX	78061	TX
76861	TX	77376	TX	77864	TX	78062	TX
76862	TX	77399	TX	77865	TX	78063	TX
76864	TX	77418	TX	77867	TX	78064	TX
76865	TX	77423	TX	77870	TX	78065	TX
76866	TX	77445	TX	77871	TX	78066	TX
76869	TX	77452	TX	77872	TX	78067	TX
76870	TX	77466	TX	77878	TX	78071	TX
76871	TX	77473	TX	77879	TX	78072	TX
76873	TX	77474	TX	77882	TX	78075	TX
76874	TX	77476	TX	77950	TX	78076	TX
76875	TX	77485	TX	77957	TX	78102	TX
76877	TX	77514	TX	77960	TX	78104	TX
76878	TX	77519	TX	77961	TX	78107	TX
76880	TX	77533	TX	77962	TX	78111	TX
76882	TX	77535	TX	77963	TX	78113	TX
76883	TX	77538	TX	77969	TX	78114	TX
76884	TX	77547	TX	77970	TX	78116	TX
76888	TX	77560	TX	77971	TX	78117	TX
76930	TX	77561	TX	77978	TX	78118	TX
76933	TX	77564	TX	77990	TX	78119	TX
76936	TX	77575	TX	77991	TX	78121	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
78125	TX	78502	TX	78636	TX	79031	TX
78142	TX	78503	TX	78644	TX	79034	TX
78143	TX	78504	TX	78648	TX	79035	TX
78144	TX	78505	TX	78650	TX	79039	TX
78145	TX	78516	TX	78655	TX	79040	TX
78146	TX	78536	TX	78656	TX	79042	TX
78147	TX	78537	TX	78659	TX	79043	TX
78151	TX	78538	TX	78661	TX	79044	TX
78160	TX	78539	TX	78662	TX	79045	TX
78161	TX	78540	TX	78663	TX	79046	TX
78162	TX	78541	TX	78721	TX	79052	TX
78203	TX	78543	TX	78725	TX	79053	TX
78214	TX	78545	TX	78742	TX	79056	TX
78221	TX	78547	TX	78799	TX	79059	TX
78224	TX	78548	TX	78832	TX	79062	TX
78335	TX	78549	TX	78837	TX	79063	TX
78336	TX	78557	TX	78840	TX	79064	TX
78338	TX	78558	TX	78841	TX	79068	TX
78340	TX	78560	TX	78842	TX	79077	TX
78341	TX	78562	TX	78843	TX	79080	TX
78349	TX	78563	TX	78847	TX	79081	TX
78350	TX	78564	TX	78850	TX	79082	TX
78352	TX	78565	TX	78851	TX	79084	TX
78353	TX	78570	TX	78861	TX	79085	TX
78355	TX	78572	TX	78871	TX	79088	TX
78357	TX	78573	TX	78883	TX	79092	TX
78358	TX	78574	TX	78885	TX	79094	TX
78359	TX	78576	TX	78886	TX	79095	TX
78360	TX	78577	TX	78931	TX	79097	TX
78361	TX	78579	TX	78933	TX	79098	TX
78362	TX	78582	TX	78942	TX	79220	TX
78368	TX	78584	TX	78944	TX	79226	TX
78370	TX	78585	TX	78947	TX	79227	TX
78374	TX	78588	TX	78948	TX	79229	TX
78376	TX	78589	TX	78950	TX	79230	TX
78377	TX	78591	TX	78953	TX	79233	TX
78381	TX	78595	TX	78957	TX	79234	TX
78382	TX	78596	TX	79001	TX	79237	TX
78384	TX	78599	TX	79005	TX	79239	TX
78385	TX	78602	TX	79009	TX	79243	TX
78387	TX	78606	TX	79010	TX	79244	TX
78389	TX	78612	TX	79018	TX	79245	TX
78390	TX	78616	TX	79019	TX	79251	TX
78391	TX	78621	TX	79024	TX	79255	TX
78393	TX	78622	TX	79025	TX	79256	TX
78501	TX	78635	TX	79027	TX	79257	TX

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
79261	TX	79718	TX	80440	CO	81126	CO
79312	TX	79719	TX	80442	CO	81127	CO
79314	TX	79731	TX	80444	CO	81128	CO
79322	TX	79734	TX	80446	CO	81130	CO
79323	TX	79738	TX	80447	CO	81133	CO
79325	TX	79739	TX	80448	CO	81134	CO
79326	TX	79742	TX	80449	CO	81138	CO
79331	TX	79745	TX	80451	CO	81147	CO
79339	TX	79752	TX	80452	CO	81152	CO
79342	TX	79754	TX	80456	CO	81153	CO
79343	TX	79755	TX	80459	CO	81157	CO
79346	TX	79756	TX	80461	CO	81235	CO
79351	TX	79770	TX	80468	CO	81251	CO
79355	TX	79772	TX	80473	CO	81252	CO
79357	TX	79777	TX	80475	CO	81253	CO
79359	TX	79778	TX	80476	CO	81320	CO
79360	TX	79780	TX	80478	CO	81324	CO
79369	TX	79785	TX	80480	CO	81332	CO
79370	TX	79786	TX	80482	CO	81433	CO
79371	TX	79788	TX	80720	CO	82201	WY
79373	TX	79789	TX	80721	CO	82210	WY
79377	TX	79837	TX	80728	CO	82213	WY
79379	TX	79839	TX	80731	CO	82214	WY
79381	TX	79843	TX	80734	CO	82215	WY
79383	TX	79845	TX	80740	CO	82222	WY
79501	TX	79846	TX	80743	CO	82224	WY
79502	TX	79847	TX	80746	CO	82225	WY
79503	TX	79848	TX	80757	CO	82227	WY
79512	TX	79851	TX	80801	CO	82229	WY
79518	TX	79854	TX	80802	CO	82242	WY
79519	TX	79855	TX	80810	CO	82301	WY
79520	TX	79928	TX	80812	CO	82321	WY
79525	TX	80101	CO	80820	CO	82322	WY
79528	TX	80102	CO	80825	CO	82323	WY
79532	TX	80103	CO	80827	CO	82324	WY
79533	TX	80117	CO	80830	CO	82325	WY
79534	TX	80136	CO	80835	CO	82327	WY
79538	TX	80420	CO	80862	CO	82329	WY
79540	TX	80421	CO	81029	CO	82331	WY
79543	TX	80422	CO	81064	CO	82332	WY
79546	TX	80427	CO	81073	CO	82334	WY
79553	TX	80430	CO	81084	CO	82335	WY
79560	TX	80432	CO	81087	CO	82336	WY
79565	TX	80434	CO	81090	CO	82410	WY
79566	TX	80436	CO	81121	CO	82411	WY
79567	TX	80438	CO	81123	CO	82412	WY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
82420	WY	83227	ID	83466	ID	84034	UT
82421	WY	83228	ID	83467	ID	84035	UT
82422	WY	83229	ID	83468	ID	84038	UT
82423	WY	83232	ID	83469	ID	84039	UT
82426	WY	83237	ID	83546	ID	84046	UT
82428	WY	83246	ID	83601	ID	84050	UT
82431	WY	83253	ID	83602	ID	84055	UT
82432	WY	83263	ID	83604	ID	84061	UT
82434	WY	83283	ID	83610	ID	84063	UT
82441	WY	83286	ID	83612	ID	84064	UT
82633	WY	83322	ID	83619	ID	84069	UT
82637	WY	83324	ID	83622	ID	84071	UT
82701	WY	83325	ID	83623	ID	84074	UT
82710	WY	83327	ID	83624	ID	84076	UT
82711	WY	83335	ID	83627	ID	84078	UT
82712	WY	83337	ID	83628	ID	84079	UT
82714	WY	83338	ID	83629	ID	84080	UT
82715	WY	83349	ID	83631	ID	84083	UT
82720	WY	83352	ID	83632	ID	84085	UT
82721	WY	83420	ID	83633	ID	84086	UT
82723	WY	83421	ID	83637	ID	84510	UT
82729	WY	83422	ID	83639	ID	84511	UT
82730	WY	83423	ID	83643	ID	84512	UT
82901	WY	83424	ID	83645	ID	84513	UT
82902	WY	83425	ID	83647	ID	84516	UT
82922	WY	83429	ID	83648	ID	84518	UT
82923	WY	83431	ID	83650	ID	84521	UT
82925	WY	83433	ID	83654	ID	84522	UT
82929	WY	83434	ID	83655	ID	84523	UT
82930	WY	83435	ID	83661	ID	84525	UT
82931	WY	83436	ID	83666	ID	84528	UT
82932	WY	83438	ID	83672	ID	84530	UT
82933	WY	83442	ID	83805	ID	84531	UT
82934	WY	83443	ID	83809	ID	84533	UT
82935	WY	83444	ID	83813	ID	84534	UT
82936	WY	83445	ID	83826	ID	84535	UT
82937	WY	83446	ID	83845	ID	84536	UT
82938	WY	83447	ID	83847	ID	84537	UT
82939	WY	83450	ID	83853	ID	84620	UT
82941	WY	83451	ID	84008	UT	84624	UT
82942	WY	83452	ID	84018	UT	84631	UT
82943	WY	83455	ID	84022	UT	84635	UT
82944	WY	83462	ID	84023	UT	84636	UT
82945	WY	83463	ID	84026	UT	84637	UT
83113	WY	83464	ID	84028	UT	84638	UT
83115	WY	83465	ID	84029	UT	84640	UT

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
84644	UT	85618	AZ	87024	NM	87328	NM
84649	UT	85621	AZ	87026	NM	87347	NM
84650	UT	85624	AZ	87027	NM	87357	NM
84652	UT	85628	AZ	87028	NM	87364	NM
84654	UT	85637	AZ	87029	NM	87365	NM
84656	UT	85640	AZ	87031	NM	87375	NM
84657	UT	85645	AZ	87032	NM	87401	NM
84701	UT	85646	AZ	87034	NM	87402	NM
84711	UT	85648	AZ	87035	NM	87410	NM
84715	UT	85662	AZ	87036	NM	87412	NM
84723	UT	85701	AZ	87037	NM	87413	NM
84724	UT	85702	AZ	87038	NM	87415	NM
84728	UT	86030	AZ	87040	NM	87416	NM
84730	UT	86034	AZ	87041	NM	87417	NM
84732	UT	86039	AZ	87042	NM	87418	NM
84734	UT	86042	AZ	87045	NM	87419	NM
84739	UT	86043	AZ	87046	NM	87420	NM
84740	UT	86044	AZ	87049	NM	87421	NM
84743	UT	86053	AZ	87051	NM	87455	NM
84744	UT	86054	AZ	87052	NM	87461	NM
84747	UT	86343	AZ	87060	NM	87499	NM
84749	UT	86435	AZ	87061	NM	87520	NM
84750	UT	86441	AZ	87062	NM	87530	NM
84754	UT	86445	AZ	87063	NM	87540	NM
84766	UT	86507	AZ	87068	NM	87543	NM
84773	UT	86510	AZ	87070	NM	87579	NM
84775	UT	86520	AZ	87072	NM	87711	NM
85322	AZ	86538	AZ	87083	NM	87712	NM
85325	AZ	86547	AZ	87301	NM	87713	NM
85328	AZ	86556	AZ	87302	NM	87715	NM
85333	AZ	87001	NM	87305	NM	87722	NM
85334	AZ	87002	NM	87310	NM	87723	NM
85337	AZ	87005	NM	87311	NM	87724	NM
85342	AZ	87006	NM	87312	NM	87730	NM
85343	AZ	87007	NM	87313	NM	87732	NM
85344	AZ	87009	NM	87315	NM	87733	NM
85346	AZ	87010	NM	87316	NM	87734	NM
85348	AZ	87011	NM	87317	NM	87735	NM
85354	AZ	87012	NM	87319	NM	87736	NM
85357	AZ	87014	NM	87320	NM	87743	NM
85359	AZ	87016	NM	87321	NM	87746	NM
85361	AZ	87018	NM	87322	NM	87750	NM
85371	AZ	87020	NM	87323	NM	87752	NM
85601	AZ	87021	NM	87325	NM	87753	NM
85611	AZ	87022	NM	87326	NM	87801	NM
85617	AZ	87023	NM	87327	NM	87820	NM

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
87821	NM	88321	NM	89319	NV	93528	CA
87823	NM	88347	NM	89403	NV	93531	CA
87824	NM	88353	NM	89408	NV	93553	CA
87825	NM	88401	NM	89409	NV	93596	CA
87827	NM	88410	NM	89415	NV	93602	CA
87828	NM	88411	NM	89418	NV	93603	CA
87829	NM	88414	NM	89419	NV	93604	CA
87830	NM	88415	NM	89420	NV	93605	CA
87831	NM	88417	NM	89422	NV	93609	CA
87832	NM	88418	NM	89427	NV	93614	CA
87901	NM	88419	NM	89429	NV	93621	CA
87930	NM	88422	NM	89430	NV	93627	CA
87931	NM	88424	NM	89440	NV	93634	CA
87933	NM	88426	NM	89444	NV	93641	CA
87935	NM	88427	NM	89447	NV	93642	CA
87939	NM	88430	NM	89820	NV	93643	CA
87941	NM	88433	NM	89821	NV	93645	CA
87942	NM	88434	NM	90002	CA	93651	CA
87943	NM	88435	NM	91905	CA	93652	CA
88009	NM	88436	NM	92066	CA	93664	CA
88020	NM	88437	NM	92249	CA	93667	CA
88039	NM	89003	NV	92250	CA	93668	CA
88042	NM	89010	NV	92317	CA	93669	CA
88045	NM	89013	NV	92325	CA	93675	CA
88056	NM	89020	NV	92352	CA	93925	CA
88072	NM	89022	NV	92521	CA	94951	CA
88119	NM	89023	NV	93203	CA	95303	CA
88121	NM	89024	NV	93206	CA	95315	CA
88134	NM	89027	NV	93208	CA	95412	CA
88136	NM	89041	NV	93218	CA	95429	CA
88201	NM	89045	NV	93237	CA	95462	CA
88202	NM	89047	NV	93239	CA	95480	CA
88203	NM	89048	NV	93241	CA	95511	CA
88210	NM	89049	NV	93256	CA	95546	CA
88211	NM	89060	NV	93257	CA	95552	CA
88220	NM	89061	NV	93258	CA	95556	CA
88221	NM	89135	NV	93262	CA	95560	CA
88230	NM	89148	NV	93265	CA	95562	CA
88232	NM	89301	NV	93266	CA	95585	CA
88250	NM	89310	NV	93270	CA	95636	CA
88253	NM	89311	NV	93271	CA	95735	CA
88254	NM	89314	NV	93501	CA	95910	CA
88255	NM	89315	NV	93502	CA	95912	CA
88256	NM	89316	NV	93504	CA	95932	CA
88263	NM	89317	NV	93505	CA	95936	CA
88268	NM	89318	NV	93516	CA	95944	CA

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
95950	CA	97621	OR	99033	WA	99584	AK
95955	CA	97639	OR	99039	WA	99585	AK
95970	CA	97750	OR	99104	WA	99589	AK
95979	CA	97812	OR	99107	WA	99590	AK
95987	CA	97817	OR	99110	WA	99591	AK
96006	CA	97820	OR	99118	WA	99602	AK
96013	CA	97825	OR	99119	WA	99604	AK
96016	CA	97830	OR	99121	WA	99606	AK
96027	CA	97844	OR	99131	WA	99607	AK
96028	CA	97845	OR	99136	WA	99609	AK
96039	CA	97848	OR	99137	WA	99612	AK
96040	CA	97856	OR	99138	WA	99613	AK
96062	CA	97861	OR	99139	WA	99614	AK
96085	CA	97864	OR	99140	WA	99620	AK
96086	CA	97865	OR	99150	WA	99621	AK
96087	CA	97869	OR	99152	WA	99622	AK
96096	CA	97873	OR	99153	WA	99625	AK
96757	HI	97874	OR	99156	WA	99626	AK
96910	GU	98283	WA	99158	WA	99627	AK
96911	GU	98303	WA	99160	WA	99630	AK
96912	GU	98305	WA	99166	WA	99632	AK
96913	GU	98323	WA	99176	WA	99633	AK
96914	GU	98336	WA	99180	WA	99634	AK
96915	GU	98349	WA	99181	WA	99637	AK
96916	GU	98351	WA	99347	WA	99638	AK
96917	GU	98394	WA	99546	AK	99640	AK
96918	GU	98524	WA	99547	AK	99641	AK
96919	GU	98528	WA	99548	AK	99647	AK
96921	GU	98533	WA	99549	AK	99648	AK
96922	GU	98535	WA	99551	AK	99649	AK
96923	GU	98546	WA	99552	AK	99650	AK
96925	GU	98548	WA	99553	AK	99651	AK
96926	GU	98555	WA	99554	AK	99653	AK
96927	GU	98560	WA	99557	AK	99655	AK
96928	GU	98584	WA	99558	AK	99656	AK
96929	GU	98588	WA	99559	AK	99657	AK
96930	GU	98592	WA	99561	AK	99658	AK
96931	GU	98610	WA	99563	AK	99660	AK
96932	GU	98639	WA	99564	AK	99661	AK
96940	PW	98648	WA	99565	AK	99662	AK
97039	OR	98651	WA	99571	AK	99665	AK
97050	OR	98846	WA	99575	AK	99666	AK
97531	OR	99005	WA	99578	AK	99668	AK
97534	OR	99006	WA	99579	AK	99670	AK
97543	OR	99012	WA	99581	AK	99675	AK
97544	OR	99018	WA	99583	AK	99676	AK

ADDENDUM I- 2005 PRIMARY CARE HPSA ZIP CODES

2005 Primary Care HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
99679	AK	99766	AK				
99680	AK	99767	AK				
99681	AK	99768	AK				
99685	AK	99770	AK				
99689	AK	99773	AK				
99690	AK	99774	AK				
99691	AK	99776	AK				
99692	AK	99777	AK				
99720	AK	99778	AK				
99721	AK	99779	AK				
99722	AK	99780	AK				
99723	AK	99781	AK				
99724	AK	99782	AK				
99726	AK	99786	AK				
99727	AK	99788	AK				
99729	AK	99789	AK				
99730	AK	99791	AK				
99732	AK	99820	AK				
99733	AK	99825	AK				
99734	AK	99826	AK				
99736	AK	99829	AK				
99737	AK	99832	AK				
99738	AK	99840	AK				
99740	AK	99841	AK				
99741	AK	99903	AK				
99743	AK	99919	AK				
99744	AK	99921	AK				
99745	AK	99922	AK				
99746	AK	99923	AK				
99747	AK	99925	AK				
99748	AK	99926	AK				
99749	AK	99927	AK				
99750	AK						
99751	AK						
99752	AK						
99754	AK						
99755	AK						
99756	AK						
99757	AK						
99758	AK						
99759	AK						
99760	AK						
99761	AK						
99763	AK						
99764	AK						
99765	AK						

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
00606	PR	02360	MA	02738	MA	04455	ME
00611	PR	02361	MA	02740	MA	04457	ME
00617	PR	02362	MA	02741	MA	04459	ME
00627	PR	02375	MA	02742	MA	04460	ME
00641	PR	02381	MA	02743	MA	04462	ME
00646	PR	02558	MA	02744	MA	04487	ME
00650	PR	02561	MA	02745	MA	04493	ME
00664	PR	02562	MA	02746	MA	04495	ME
00667	PR	02563	MA	02747	MA	04765	ME
00670	PR	02601	MA	02748	MA	04777	ME
00677	PR	02630	MA	02760	MA	04782	ME
00685	PR	02632	MA	02761	MA	04928	ME
00687	PR	02634	MA	02763	MA	04930	ME
00692	PR	02635	MA	02764	MA	04933	ME
00703	PR	02636	MA	02766	MA	04953	ME
00707	PR	02637	MA	02767	MA	05440	VT
00718	PR	02638	MA	02768	MA	05463	VT
00719	PR	02639	MA	02769	MA	05474	VT
00720	PR	02641	MA	02771	MA	05824	VT
00721	PR	02644	MA	02777	MA	05837	VT
00723	PR	02647	MA	02779	MA	05840	VT
00735	PR	02648	MA	02780	MA	05846	VT
00739	PR	02649	MA	02790	MA	05858	VT
00742	PR	02655	MA	02791	MA	05901	VT
00744	PR	02660	MA	03218	NH	05902	VT
00745	PR	02664	MA	03220	NH	05903	VT
00751	PR	02668	MA	03225	NH	05904	VT
00754	PR	02670	MA	03226	NH	05905	VT
00757	PR	02672	MA	03237	NH	05906	VT
00765	PR	02673	MA	03246	NH	05907	VT
00766	PR	02675	MA	03247	NH	06029	CT
00767	PR	02702	MA	03249	NH	06043	CT
00769	PR	02703	MA	03252	NH	06066	CT
00772	PR	02712	MA	03253	NH	06071	CT
00773	PR	02714	MA	03256	NH	06072	CT
00794	PR	02715	MA	03269	NH	06075	CT
00795	PR	02717	MA	03276	NH	06076	CT
00953	PR	02718	MA	03289	NH	06077	CT
00954	PR	02719	MA	03298	NH	06084	CT
02031	MA	02720	MA	03299	NH	06231	CT
02048	MA	02721	MA	03809	NH	06232	CT
02334	MA	02722	MA	03810	NH	06237	CT
02345	MA	02723	MA	03837	NH	06238	CT
02346	MA	02724	MA	04430	ME	06248	CT
02356	MA	02725	MA	04448	ME	06265	CT
02357	MA	02726	MA	04451	ME	06279	CT

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
08001	NJ	08753	NJ	12134	NY	12485	NY
08005	NJ	08754	NJ	12139	NY	12492	NY
08023	NJ	08755	NJ	12148	NY	12496	NY
08038	NJ	08756	NJ	12151	NY	12701	NY
08067	NJ	08757	NJ	12157	NY	12719	NY
08069	NJ	08758	NJ	12164	NY	12720	NY
08070	NJ	08759	NJ	12166	NY	12721	NY
08072	NJ	12010	NY	12167	NY	12722	NY
08087	NJ	12015	NY	12170	NY	12723	NY
08098	NJ	12016	NY	12176	NY	12724	NY
08202	NJ	12019	NY	12177	NY	12725	NY
08204	NJ	12020	NY	12188	NY	12726	NY
08210	NJ	12022	NY	12190	NY	12727	NY
08212	NJ	12024	NY	12192	NY	12732	NY
08214	NJ	12025	NY	12405	NY	12733	NY
08218	NJ	12027	NY	12406	NY	12734	NY
08219	NJ	12028	NY	12407	NY	12736	NY
08242	NJ	12032	NY	12413	NY	12737	NY
08243	NJ	12035	NY	12414	NY	12738	NY
08247	NJ	12040	NY	12418	NY	12740	NY
08251	NJ	12042	NY	12421	NY	12741	NY
08252	NJ	12051	NY	12422	NY	12742	NY
08260	NJ	12057	NY	12423	NY	12743	NY
08270	NJ	12058	NY	12424	NY	12745	NY
08318	NJ	12065	NY	12427	NY	12747	NY
08343	NJ	12066	NY	12430	NY	12748	NY
08347	NJ	12068	NY	12431	NY	12749	NY
08527	NJ	12069	NY	12434	NY	12750	NY
08533	NJ	12070	NY	12436	NY	12751	NY
08701	NJ	12072	NY	12438	NY	12752	NY
08721	NJ	12073	NY	12439	NY	12754	NY
08722	NJ	12074	NY	12442	NY	12758	NY
08723	NJ	12078	NY	12444	NY	12759	NY
08724	NJ	12083	NY	12450	NY	12760	NY
08731	NJ	12086	NY	12451	NY	12762	NY
08732	NJ	12087	NY	12452	NY	12763	NY
08733	NJ	12089	NY	12454	NY	12764	NY
08734	NJ	12090	NY	12455	NY	12765	NY
08735	NJ	12092	NY	12459	NY	12766	NY
08738	NJ	12095	NY	12460	NY	12767	NY
08739	NJ	12108	NY	12463	NY	12768	NY
08740	NJ	12117	NY	12468	NY	12769	NY
08741	NJ	12118	NY	12470	NY	12770	NY
08742	NJ	12122	NY	12473	NY	12775	NY
08751	NJ	12124	NY	12474	NY	12776	NY
08752	NJ	12133	NY	12482	NY	12777	NY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
12778	NY	12878	NY	13126	NY	13452	NY
12779	NY	12879	NY	13131	NY	13454	NY
12781	NY	12883	NY	13132	NY	13460	NY
12783	NY	12885	NY	13135	NY	13461	NY
12784	NY	12886	NY	13136	NY	13464	NY
12785	NY	12913	NY	13142	NY	13470	NY
12786	NY	12928	NY	13143	NY	13472	NY
12787	NY	12932	NY	13144	NY	13475	NY
12788	NY	12936	NY	13145	NY	13491	NY
12789	NY	12941	NY	13146	NY	13493	NY
12790	NY	12942	NY	13148	NY	13730	NY
12791	NY	12943	NY	13154	NY	13731	NY
12792	NY	12946	NY	13155	NY	13733	NY
12803	NY	12950	NY	13156	NY	13739	NY
12808	NY	12956	NY	13165	NY	13740	NY
12810	NY	12960	NY	13166	NY	13750	NY
12811	NY	12961	NY	13167	NY	13751	NY
12812	NY	12964	NY	13301	NY	13752	NY
12814	NY	12974	NY	13302	NY	13753	NY
12815	NY	12975	NY	13309	NY	13754	NY
12817	NY	12977	NY	13316	NY	13755	NY
12824	NY	12987	NY	13317	NY	13756	NY
12827	NY	12993	NY	13320	NY	13757	NY
12828	NY	12996	NY	13324	NY	13758	NY
12831	NY	12997	NY	13329	NY	13774	NY
12836	NY	12998	NY	13331	NY	13775	NY
12838	NY	13028	NY	13332	NY	13778	NY
12839	NY	13033	NY	13339	NY	13780	NY
12842	NY	13036	NY	13340	NY	13782	NY
12843	NY	13042	NY	13350	NY	13783	NY
12845	NY	13044	NY	13353	NY	13786	NY
12847	NY	13064	NY	13357	NY	13788	NY
12851	NY	13065	NY	13360	NY	13801	NY
12852	NY	13069	NY	13361	NY	13804	NY
12853	NY	13074	NY	13365	NY	13806	NY
12855	NY	13076	NY	13406	NY	13809	NY
12856	NY	13083	NY	13407	NY	13814	NY
12857	NY	13093	NY	13410	NY	13815	NY
12858	NY	13103	NY	13411	NY	13830	NY
12860	NY	13107	NY	13416	NY	13832	NY
12862	NY	13111	NY	13420	NY	13837	NY
12863	NY	13113	NY	13426	NY	13838	NY
12864	NY	13114	NY	13428	NY	13839	NY
12870	NY	13115	NY	13431	NY	13841	NY
12872	NY	13121	NY	13436	NY	13842	NY
12874	NY	13124	NY	13437	NY	13843	NY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
13844	NY	14113	NY	14480	NY	14706	NY
13846	NY	14120	NY	14482	NY	14707	NY
13847	NY	14125	NY	14485	NY	14708	NY
13856	NY	14126	NY	14486	NY	14709	NY
13860	NY	14129	NY	14487	NY	14710	NY
14003	NY	14130	NY	14488	NY	14711	NY
14005	NY	14131	NY	14489	NY	14712	NY
14008	NY	14132	NY	14502	NY	14714	NY
14009	NY	14133	NY	14505	NY	14715	NY
14011	NY	14135	NY	14507	NY	14716	NY
14012	NY	14136	NY	14513	NY	14717	NY
14013	NY	14138	NY	14516	NY	14718	NY
14020	NY	14143	NY	14519	NY	14719	NY
14021	NY	14144	NY	14520	NY	14720	NY
14024	NY	14145	NY	14521	NY	14721	NY
14028	NY	14166	NY	14522	NY	14722	NY
14029	NY	14167	NY	14525	NY	14723	NY
14036	NY	14168	NY	14527	NY	14724	NY
14037	NY	14171	NY	14530	NY	14726	NY
14039	NY	14172	NY	14533	NY	14727	NY
14040	NY	14173	NY	14536	NY	14728	NY
14041	NY	14174	NY	14538	NY	14729	NY
14042	NY	14301	NY	14539	NY	14730	NY
14048	NY	14302	NY	14541	NY	14731	NY
14054	NY	14303	NY	14542	NY	14732	NY
14056	NY	14304	NY	14544	NY	14733	NY
14058	NY	14305	NY	14549	NY	14735	NY
14060	NY	14413	NY	14550	NY	14736	NY
14062	NY	14414	NY	14551	NY	14737	NY
14063	NY	14415	NY	14555	NY	14738	NY
14065	NY	14416	NY	14557	NY	14739	NY
14066	NY	14418	NY	14558	NY	14740	NY
14067	NY	14422	NY	14560	NY	14741	NY
14070	NY	14423	NY	14563	NY	14742	NY
14081	NY	14427	NY	14568	NY	14743	NY
14082	NY	14429	NY	14569	NY	14744	NY
14083	NY	14433	NY	14571	NY	14745	NY
14092	NY	14435	NY	14588	NY	14747	NY
14094	NY	14441	NY	14589	NY	14748	NY
14095	NY	14449	NY	14590	NY	14750	NY
14098	NY	14452	NY	14591	NY	14751	NY
14101	NY	14466	NY	14592	NY	14752	NY
14105	NY	14470	NY	14701	NY	14753	NY
14107	NY	14476	NY	14702	NY	14754	NY
14108	NY	14477	NY	14703	NY	14755	NY
14109	NY	14478	NY	14704	NY	14756	NY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
14757	NY	14887	NY	15364	PA	15467	PA
14758	NY	14891	NY	15370	PA	15468	PA
14760	NY	14892	NY	15380	PA	15469	PA
14766	NY	14893	NY	15401	PA	15470	PA
14767	NY	14895	NY	15410	PA	15472	PA
14769	NY	14897	NY	15411	PA	15473	PA
14770	NY	15001	PA	15413	PA	15474	PA
14772	NY	15003	PA	15415	PA	15475	PA
14774	NY	15005	PA	15416	PA	15476	PA
14775	NY	15009	PA	15417	PA	15478	PA
14777	NY	15010	PA	15420	PA	15480	PA
14778	NY	15012	PA	15421	PA	15482	PA
14779	NY	15026	PA	15422	PA	15484	PA
14781	NY	15027	PA	15424	PA	15485	PA
14782	NY	15042	PA	15425	PA	15486	PA
14783	NY	15043	PA	15428	PA	15488	PA
14784	NY	15050	PA	15430	PA	15489	PA
14785	NY	15052	PA	15431	PA	15490	PA
14786	NY	15059	PA	15433	PA	15492	PA
14787	NY	15061	PA	15435	PA	15501	PA
14788	NY	15066	PA	15436	PA	15502	PA
14802	NY	15074	PA	15437	PA	15510	PA
14803	NY	15077	PA	15438	PA	15520	PA
14804	NY	15081	PA	15439	PA	15521	PA
14805	NY	15310	PA	15440	PA	15522	PA
14806	NY	15315	PA	15442	PA	15530	PA
14812	NY	15316	PA	15443	PA	15531	PA
14813	NY	15320	PA	15444	PA	15532	PA
14815	NY	15322	PA	15445	PA	15533	PA
14818	NY	15325	PA	15446	PA	15534	PA
14822	NY	15327	PA	15447	PA	15535	PA
14824	NY	15334	PA	15449	PA	15537	PA
14837	NY	15337	PA	15450	PA	15538	PA
14841	NY	15338	PA	15451	PA	15539	PA
14842	NY	15341	PA	15454	PA	15540	PA
14847	NY	15344	PA	15455	PA	15541	PA
14857	NY	15346	PA	15456	PA	15542	PA
14859	NY	15348	PA	15458	PA	15544	PA
14860	NY	15349	PA	15459	PA	15545	PA
14863	NY	15351	PA	15460	PA	15546	PA
14865	NY	15352	PA	15461	PA	15547	PA
14869	NY	15353	PA	15462	PA	15548	PA
14876	NY	15354	PA	15463	PA	15549	PA
14878	NY	15357	PA	15464	PA	15550	PA
14880	NY	15359	PA	15465	PA	15551	PA
14884	NY	15362	PA	15466	PA	15552	PA

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
15553	PA	15752	PA	15957	PA	16142	PA
15554	PA	15753	PA	15959	PA	16143	PA
15555	PA	15754	PA	15963	PA	16155	PA
15557	PA	15756	PA	16001	PA	16156	PA
15558	PA	15757	PA	16002	PA	16157	PA
15559	PA	15758	PA	16003	PA	16160	PA
15560	PA	15759	PA	16016	PA	16201	PA
15561	PA	15761	PA	16017	PA	16210	PA
15562	PA	15763	PA	16018	PA	16211	PA
15563	PA	15765	PA	16020	PA	16212	PA
15564	PA	15771	PA	16021	PA	16215	PA
15565	PA	15772	PA	16022	PA	16217	PA
15630	PA	15774	PA	16025	PA	16218	PA
15631	PA	15777	PA	16029	PA	16222	PA
15656	PA	15783	PA	16030	PA	16223	PA
15673	PA	15801	PA	16034	PA	16226	PA
15681	PA	15821	PA	16035	PA	16228	PA
15682	PA	15822	PA	16038	PA	16229	PA
15686	PA	15823	PA	16039	PA	16236	PA
15701	PA	15827	PA	16040	PA	16238	PA
15705	PA	15828	PA	16041	PA	16239	PA
15710	PA	15831	PA	16045	PA	16244	PA
15712	PA	15832	PA	16048	PA	16245	PA
15713	PA	15834	PA	16049	PA	16246	PA
15716	PA	15841	PA	16050	PA	16249	PA
15717	PA	15845	PA	16051	PA	16250	PA
15720	PA	15846	PA	16052	PA	16253	PA
15721	PA	15848	PA	16053	PA	16256	PA
15723	PA	15849	PA	16057	PA	16259	PA
15724	PA	15853	PA	16061	PA	16261	PA
15725	PA	15856	PA	16101	PA	16262	PA
15727	PA	15857	PA	16102	PA	16263	PA
15728	PA	15861	PA	16103	PA	16301	PA
15729	PA	15866	PA	16105	PA	16312	PA
15731	PA	15868	PA	16107	PA	16313	PA
15732	PA	15870	PA	16108	PA	16317	PA
15734	PA	15920	PA	16112	PA	16319	PA
15736	PA	15924	PA	16115	PA	16321	PA
15739	PA	15926	PA	16116	PA	16322	PA
15741	PA	15928	PA	16117	PA	16323	PA
15742	PA	15929	PA	16120	PA	16329	PA
15745	PA	15935	PA	16123	PA	16340	PA
15746	PA	15936	PA	16132	PA	16341	PA
15747	PA	15937	PA	16136	PA	16342	PA
15748	PA	15949	PA	16140	PA	16343	PA
15750	PA	15953	PA	16141	PA	16344	PA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
16345	PA	16681	PA	17097	PA	17931	PA
16346	PA	16692	PA	17098	PA	17932	PA
16347	PA	16694	PA	17211	PA	17933	PA
16350	PA	16695	PA	17730	PA	17934	PA
16351	PA	16698	PA	17731	PA	17935	PA
16352	PA	16728	PA	17737	PA	17936	PA
16353	PA	16734	PA	17740	PA	17938	PA
16362	PA	16821	PA	17742	PA	17941	PA
16364	PA	16825	PA	17749	PA	17942	PA
16365	PA	16830	PA	17752	PA	17943	PA
16366	PA	16833	PA	17756	PA	17944	PA
16367	PA	16834	PA	17758	PA	17945	PA
16368	PA	16836	PA	17762	PA	17946	PA
16369	PA	16837	PA	17768	PA	17948	PA
16370	PA	16838	PA	17769	PA	17949	PA
16371	PA	16839	PA	17772	PA	17951	PA
16372	PA	16840	PA	17774	PA	17952	PA
16373	PA	16843	PA	17777	PA	17953	PA
16374	PA	16845	PA	17801	PA	17954	PA
16402	PA	16847	PA	17823	PA	17957	PA
16405	PA	16849	PA	17824	PA	17959	PA
16416	PA	16850	PA	17825	PA	17960	PA
16420	PA	16855	PA	17830	PA	17961	PA
16436	PA	16858	PA	17832	PA	17963	PA
16614	PA	16860	PA	17834	PA	17964	PA
16616	PA	16861	PA	17836	PA	17965	PA
16620	PA	16863	PA	17840	PA	17966	PA
16627	PA	16871	PA	17847	PA	17967	PA
16633	PA	16873	PA	17850	PA	17968	PA
16645	PA	16876	PA	17851	PA	17970	PA
16650	PA	16878	PA	17857	PA	17972	PA
16651	PA	16879	PA	17860	PA	17974	PA
16655	PA	16881	PA	17865	PA	17976	PA
16656	PA	17014	PA	17866	PA	17978	PA
16659	PA	17017	PA	17867	PA	17979	PA
16661	PA	17021	PA	17868	PA	17980	PA
16663	PA	17035	PA	17872	PA	17981	PA
16664	PA	17048	PA	17877	PA	17982	PA
16666	PA	17049	PA	17881	PA	17983	PA
16667	PA	17056	PA	17901	PA	17985	PA
16670	PA	17058	PA	17921	PA	18010	PA
16671	PA	17059	PA	17922	PA	18012	PA
16672	PA	17076	PA	17923	PA	18013	PA
16678	PA	17082	PA	17925	PA	18030	PA
16679	PA	17086	PA	17929	PA	18050	PA
16680	PA	17094	PA	17930	PA	18071	PA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
18210	PA	18614	PA	21523	MD	21683	MD
18211	PA	18616	PA	21531	MD	21684	MD
18212	PA	18619	PA	21536	MD	21685	MD
18214	PA	18624	PA	21538	MD	21686	MD
18216	PA	18626	PA	21541	MD	21687	MD
18218	PA	18628	PA	21550	MD	21688	MD
18220	PA	18632	PA	21561	MD	21690	MD
18229	PA	18801	PA	21607	MD	21727	MD
18230	PA	18812	PA	21609	MD	21750	MD
18231	PA	18813	PA	21613	MD	21759	MD
18232	PA	18816	PA	21617	MD	21811	MD
18235	PA	18818	PA	21619	MD	21813	MD
18237	PA	18820	PA	21622	MD	21817	MD
18240	PA	18821	PA	21623	MD	21821	MD
18241	PA	18822	PA	21626	MD	21822	MD
18242	PA	18823	PA	21627	MD	21824	MD
18244	PA	18824	PA	21628	MD	21829	MD
18245	PA	18825	PA	21629	MD	21835	MD
18248	PA	18826	PA	21631	MD	21836	MD
18250	PA	18827	PA	21632	MD	21838	MD
18252	PA	18828	PA	21634	MD	21841	MD
18254	PA	18830	PA	21636	MD	21842	MD
18255	PA	18834	PA	21638	MD	21843	MD
18324	PA	18839	PA	21639	MD	21851	MD
18328	PA	18842	PA	21640	MD	21853	MD
18336	PA	18843	PA	21641	MD	21857	MD
18337	PA	18844	PA	21643	MD	21862	MD
18340	PA	18847	PA	21644	MD	21863	MD
18343	PA	19311	PA	21648	MD	21864	MD
18351	PA	19362	PA	21649	MD	21866	MD
18371	PA	19363	PA	21655	MD	21867	MD
18373	PA	19374	PA	21656	MD	21869	MD
18413	PA	19549	PA	21657	MD	21870	MD
18421	PA	20106	VA	21658	MD	21871	MD
18425	PA	20113	VA	21659	MD	21872	MD
18426	PA	20130	VA	21660	MD	21890	MD
18428	PA	20135	VA	21664	MD	21901	MD
18430	PA	20137	VA	21666	MD	21902	MD
18435	PA	20140	VA	21668	MD	21903	MD
18441	PA	20184	VA	21669	MD	21904	MD
18451	PA	20185	VA	21670	MD	21911	MD
18457	PA	20188	VA	21672	MD	21912	MD
18458	PA	20198	VA	21675	MD	21913	MD
18464	PA	20682	MD	21677	MD	21914	MD
18465	PA	21520	MD	21681	MD	21915	MD
18470	PA	21522	MD	21682	MD	21916	MD

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21917	MD	22548	VA	22727	VA	22960	VA
21918	MD	22552	VA	22730	VA	22963	VA
21919	MD	22553	VA	22731	VA	22964	VA
21920	MD	22558	VA	22732	VA	22965	VA
21921	MD	22565	VA	22735	VA	22967	VA
21922	MD	22567	VA	22738	VA	22968	VA
21930	MD	22570	VA	22743	VA	22969	VA
22002	VA	22572	VA	22748	VA	22971	VA
22134	VA	22577	VA	22810	VA	22972	VA
22407	VA	22579	VA	22811	VA	22973	VA
22408	VA	22580	VA	22812	VA	22974	VA
22427	VA	22581	VA	22815	VA	22976	VA
22428	VA	22602	VA	22820	VA	22980	VA
22432	VA	22603	VA	22821	VA	22989	VA
22433	VA	22610	VA	22824	VA	23001	VA
22435	VA	22611	VA	22827	VA	23002	VA
22442	VA	22620	VA	22830	VA	23003	VA
22443	VA	22622	VA	22831	VA	23004	VA
22446	VA	22624	VA	22832	VA	23009	VA
22448	VA	22625	VA	22833	VA	23011	VA
22451	VA	22626	VA	22834	VA	23014	VA
22456	VA	22630	VA	22835	VA	23017	VA
22460	VA	22637	VA	22840	VA	23018	VA
22469	VA	22641	VA	22841	VA	23021	VA
22472	VA	22642	VA	22842	VA	23022	VA
22473	VA	22644	VA	22844	VA	23023	VA
22481	VA	22645	VA	22845	VA	23024	VA
22485	VA	22646	VA	22846	VA	23025	VA
22488	VA	22649	VA	22847	VA	23027	VA
22501	VA	22650	VA	22848	VA	23030	VA
22508	VA	22652	VA	22849	VA	23031	VA
22511	VA	22654	VA	22850	VA	23032	VA
22514	VA	22655	VA	22851	VA	23035	VA
22520	VA	22656	VA	22853	VA	23038	VA
22524	VA	22657	VA	22920	VA	23039	VA
22526	VA	22660	VA	22922	VA	23040	VA
22529	VA	22663	VA	22923	VA	23043	VA
22530	VA	22664	VA	22935	VA	23045	VA
22534	VA	22709	VA	22938	VA	23050	VA
22535	VA	22711	VA	22942	VA	23055	VA
22538	VA	22715	VA	22948	VA	23056	VA
22539	VA	22719	VA	22949	VA	23061	VA
22542	VA	22721	VA	22953	VA	23062	VA
22544	VA	22722	VA	22954	VA	23063	VA
22546	VA	22723	VA	22957	VA	23064	VA
22547	VA	22725	VA	22958	VA	23065	VA

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23066	VA	23160	VA	23417	VA	23878	VA
23067	VA	23161	VA	23418	VA	23881	VA
23068	VA	23163	VA	23420	VA	23882	VA
23070	VA	23169	VA	23421	VA	23883	VA
23071	VA	23170	VA	23422	VA	23884	VA
23072	VA	23175	VA	23423	VA	23885	VA
23076	VA	23176	VA	23424	VA	23887	VA
23079	VA	23177	VA	23426	VA	23888	VA
23083	VA	23178	VA	23427	VA	23889	VA
23084	VA	23180	VA	23430	VA	23890	VA
23085	VA	23181	VA	23431	VA	23891	VA
23086	VA	23183	VA	23440	VA	23893	VA
23089	VA	23184	VA	23441	VA	23894	VA
23091	VA	23190	VA	23442	VA	23897	VA
23092	VA	23191	VA	23480	VA	23898	VA
23093	VA	23238	VA	23483	VA	23899	VA
23101	VA	23301	VA	23487	VA	23915	VA
23102	VA	23302	VA	23488	VA	23917	VA
23103	VA	23303	VA	23662	VA	23919	VA
23105	VA	23304	VA	23801	VA	23920	VA
23106	VA	23306	VA	23821	VA	23921	VA
23107	VA	23308	VA	23822	VA	23923	VA
23108	VA	23314	VA	23827	VA	23924	VA
23109	VA	23315	VA	23828	VA	23927	VA
23110	VA	23336	VA	23829	VA	23934	VA
23117	VA	23337	VA	23830	VA	23936	VA
23119	VA	23341	VA	23833	VA	23937	VA
23123	VA	23345	VA	23837	VA	23938	VA
23124	VA	23356	VA	23839	VA	23939	VA
23125	VA	23357	VA	23840	VA	23941	VA
23126	VA	23358	VA	23841	VA	23944	VA
23128	VA	23359	VA	23842	VA	23947	VA
23129	VA	23389	VA	23843	VA	23950	VA
23130	VA	23395	VA	23844	VA	23952	VA
23131	VA	23396	VA	23845	VA	23958	VA
23138	VA	23397	VA	23846	VA	23959	VA
23139	VA	23399	VA	23850	VA	23962	VA
23140	VA	23401	VA	23856	VA	23963	VA
23141	VA	23404	VA	23857	VA	23964	VA
23147	VA	23407	VA	23866	VA	23967	VA
23148	VA	23409	VA	23868	VA	23968	VA
23149	VA	23410	VA	23872	VA	23970	VA
23153	VA	23412	VA	23873	VA	23974	VA
23154	VA	23414	VA	23874	VA	23976	VA
23155	VA	23415	VA	23875	VA	24053	VA
23156	VA	23416	VA	23876	VA	24054	VA

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24055	VA	24203	VA	24314	VA	24473	VA
24064	VA	24209	VA	24315	VA	24483	VA
24065	VA	24215	VA	24317	VA	24484	VA
24066	VA	24216	VA	24318	VA	24487	VA
24067	VA	24217	VA	24319	VA	24517	VA
24069	VA	24218	VA	24322	VA	24520	VA
24072	VA	24219	VA	24323	VA	24521	VA
24076	VA	24220	VA	24325	VA	24522	VA
24077	VA	24221	VA	24326	VA	24527	VA
24078	VA	24224	VA	24328	VA	24528	VA
24079	VA	24225	VA	24330	VA	24529	VA
24082	VA	24226	VA	24343	VA	24530	VA
24083	VA	24228	VA	24348	VA	24531	VA
24085	VA	24230	VA	24350	VA	24533	VA
24088	VA	24237	VA	24351	VA	24534	VA
24089	VA	24239	VA	24352	VA	24535	VA
24090	VA	24243	VA	24354	VA	24536	VA
24091	VA	24244	VA	24360	VA	24538	VA
24092	VA	24245	VA	24363	VA	24539	VA
24095	VA	24246	VA	24366	VA	24549	VA
24101	VA	24248	VA	24368	VA	24550	VA
24102	VA	24250	VA	24370	VA	24551	VA
24105	VA	24251	VA	24373	VA	24553	VA
24120	VA	24256	VA	24374	VA	24554	VA
24122	VA	24258	VA	24375	VA	24555	VA
24127	VA	24260	VA	24378	VA	24556	VA
24130	VA	24263	VA	24379	VA	24557	VA
24131	VA	24265	VA	24380	VA	24558	VA
24133	VA	24266	VA	24381	VA	24562	VA
24137	VA	24269	VA	24382	VA	24563	VA
24139	VA	24271	VA	24401	VA	24565	VA
24146	VA	24272	VA	24402	VA	24566	VA
24148	VA	24277	VA	24407	VA	24569	VA
24151	VA	24279	VA	24412	VA	24571	VA
24161	VA	24280	VA	24415	VA	24572	VA
24165	VA	24281	VA	24416	VA	24574	VA
24168	VA	24282	VA	24426	VA	24576	VA
24171	VA	24283	VA	24435	VA	24577	VA
24175	VA	24285	VA	24438	VA	24578	VA
24176	VA	24289	VA	24439	VA	24579	VA
24177	VA	24290	VA	24441	VA	24580	VA
24178	VA	24292	VA	24445	VA	24581	VA
24184	VA	24293	VA	24460	VA	24585	VA
24185	VA	24311	VA	24464	VA	24586	VA
24201	VA	24312	VA	24471	VA	24588	VA
24202	VA	24313	VA	24472	VA	24589	VA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
24592	VA	24831	WV	24892	WV	25133	WV
24593	VA	24832	WV	24894	WV	25141	WV
24594	VA	24834	WV	24895	WV	25142	WV
24595	VA	24836	WV	24896	WV	25148	WV
24597	VA	24839	WV	24897	WV	25149	WV
24598	VA	24841	WV	24898	WV	25150	WV
24599	VA	24842	WV	24899	WV	25154	WV
24603	VA	24843	WV	24918	WV	25164	WV
24607	VA	24844	WV	24919	WV	25165	WV
24614	VA	24845	WV	24935	WV	25169	WV
24618	VA	24846	WV	24941	WV	25180	WV
24620	VA	24847	WV	24942	WV	25181	WV
24624	VA	24848	WV	24945	WV	25193	WV
24627	VA	24849	WV	24951	WV	25203	WV
24628	VA	24850	WV	24962	WV	25204	WV
24631	VA	24851	WV	24963	WV	25205	WV
24634	VA	24852	WV	24974	WV	25206	WV
24639	VA	24853	WV	24976	WV	25208	WV
24646	VA	24854	WV	24981	WV	25209	WV
24647	VA	24855	WV	24983	WV	25211	WV
24649	VA	24856	WV	24984	WV	25231	WV
24656	VA	24857	WV	24985	WV	25239	WV
24657	VA	24859	WV	24993	WV	25241	WV
24658	VA	24860	WV	25005	WV	25243	WV
24716	WV	24861	WV	25009	WV	25244	WV
24719	WV	24862	WV	25010	WV	25245	WV
24726	WV	24866	WV	25018	WV	25248	WV
24801	WV	24867	WV	25019	WV	25251	WV
24808	WV	24868	WV	25021	WV	25252	WV
24811	WV	24869	WV	25024	WV	25256	WV
24813	WV	24870	WV	25028	WV	25258	WV
24815	WV	24871	WV	25030	WV	25259	WV
24816	WV	24872	WV	25043	WV	25262	WV
24817	WV	24873	WV	25049	WV	25266	WV
24818	WV	24874	WV	25051	WV	25267	WV
24820	WV	24877	WV	25053	WV	25270	WV
24821	WV	24878	WV	25063	WV	25271	WV
24822	WV	24879	WV	25081	WV	25275	WV
24823	WV	24880	WV	25088	WV	25276	WV
24824	WV	24881	WV	25093	WV	25279	WV
24825	WV	24882	WV	25108	WV	25281	WV
24826	WV	24883	WV	25111	WV	25283	WV
24827	WV	24884	WV	25113	WV	25285	WV
24828	WV	24887	WV	25114	WV	25286	WV
24829	WV	24888	WV	25125	WV	25411	WV
24830	WV	24889	WV	25130	WV	25419	WV

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
25422	WV	25678	WV	26058	WV	26354	WV
25431	WV	25682	WV	26070	WV	26362	WV
25434	WV	25685	WV	26075	WV	26372	WV
25437	WV	25686	WV	26134	WV	26374	WV
25444	WV	25687	WV	26135	WV	26376	WV
25501	WV	25688	WV	26138	WV	26378	WV
25506	WV	25690	WV	26141	WV	26384	WV
25507	WV	25691	WV	26143	WV	26405	WV
25511	WV	25692	WV	26146	WV	26407	WV
25512	WV	25694	WV	26148	WV	26410	WV
25514	WV	25696	WV	26149	WV	26411	WV
25517	WV	25697	WV	26160	WV	26412	WV
25519	WV	25699	WV	26161	WV	26415	WV
25521	WV	25704	WV	26164	WV	26416	WV
25523	WV	25770	WV	26170	WV	26421	WV
25524	WV	25771	WV	26173	WV	26424	WV
25529	WV	25810	WV	26175	WV	26425	WV
25530	WV	25811	WV	26178	WV	26430	WV
25534	WV	25826	WV	26203	WV	26434	WV
25535	WV	25845	WV	26206	WV	26435	WV
25540	WV	25848	WV	26208	WV	26436	WV
25544	WV	25870	WV	26217	WV	26440	WV
25555	WV	25875	WV	26222	WV	26443	WV
25557	WV	25876	WV	26238	WV	26444	WV
25562	WV	25882	WV	26250	WV	26447	WV
25564	WV	25913	WV	26266	WV	26452	WV
25565	WV	25916	WV	26275	WV	26456	WV
25567	WV	25928	WV	26288	WV	26519	WV
25570	WV	25943	WV	26298	WV	26520	WV
25571	WV	25951	WV	26320	WV	26524	WV
25573	WV	25965	WV	26321	WV	26525	WV
25608	WV	25966	WV	26325	WV	26535	WV
25621	WV	25969	WV	26327	WV	26537	WV
25623	WV	25977	WV	26328	WV	26542	WV
25650	WV	25978	WV	26334	WV	26547	WV
25651	WV	25979	WV	26335	WV	26601	WV
25661	WV	25985	WV	26337	WV	26611	WV
25665	WV	25988	WV	26338	WV	26612	WV
25666	WV	26030	WV	26339	WV	26615	WV
25667	WV	26032	WV	26342	WV	26617	WV
25669	WV	26034	WV	26343	WV	26618	WV
25670	WV	26035	WV	26346	WV	26619	WV
25671	WV	26037	WV	26347	WV	26621	WV
25672	WV	26050	WV	26349	WV	26623	WV
25674	WV	26055	WV	26350	WV	26624	WV
25676	WV	26056	WV	26351	WV	26627	WV

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
26629	WV	27016	NC	27305	NC	27570	NC
26631	WV	27018	NC	27306	NC	27573	NC
26634	WV	27019	NC	27311	NC	27574	NC
26636	WV	27020	NC	27312	NC	27583	NC
26638	WV	27021	NC	27314	NC	27584	NC
26639	WV	27022	NC	27315	NC	27586	NC
26641	WV	27025	NC	27316	NC	27589	NC
26704	WV	27027	NC	27320	NC	27594	NC
26705	WV	27028	NC	27321	NC	27596	NC
26711	WV	27042	NC	27322	NC	27801	NC
26714	WV	27043	NC	27323	NC	27802	NC
26716	WV	27046	NC	27325	NC	27805	NC
26719	WV	27048	NC	27326	NC	27807	NC
26722	WV	27052	NC	27340	NC	27809	NC
26753	WV	27055	NC	27343	NC	27813	NC
26755	WV	27201	NC	27344	NC	27816	NC
26757	WV	27202	NC	27349	NC	27819	NC
26761	WV	27207	NC	27350	NC	27820	NC
26763	WV	27208	NC	27351	NC	27822	NC
26764	WV	27209	NC	27355	NC	27823	NC
26767	WV	27212	NC	27356	NC	27824	NC
26801	WV	27213	NC	27359	NC	27825	NC
26802	WV	27215	NC	27370	NC	27826	NC
26804	WV	27216	NC	27371	NC	27831	NC
26807	WV	27217	NC	27374	NC	27832	NC
26808	WV	27220	NC	27375	NC	27838	NC
26810	WV	27228	NC	27376	NC	27839	NC
26812	WV	27229	NC	27379	NC	27840	NC
26814	WV	27242	NC	27501	NC	27841	NC
26815	WV	27244	NC	27506	NC	27842	NC
26817	WV	27247	NC	27508	NC	27843	NC
26818	WV	27252	NC	27521	NC	27844	NC
26823	WV	27253	NC	27525	NC	27845	NC
26824	WV	27256	NC	27536	NC	27846	NC
26836	WV	27258	NC	27537	NC	27847	NC
26838	WV	27259	NC	27541	NC	27849	NC
26845	WV	27281	NC	27543	NC	27850	NC
26851	WV	27288	NC	27544	NC	27851	NC
26852	WV	27289	NC	27546	NC	27852	NC
26865	WV	27291	NC	27549	NC	27853	NC
26866	WV	27292	NC	27551	NC	27854	NC
26884	WV	27293	NC	27552	NC	27857	NC
26886	WV	27294	NC	27553	NC	27861	NC
27006	NC	27295	NC	27556	NC	27862	NC
27011	NC	27299	NC	27559	NC	27864	NC
27014	NC	27302	NC	27563	NC	27866	NC

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
27867	NC	27944	NC	28080	NC	28350	NC
27869	NC	27946	NC	28088	NC	28357	NC
27870	NC	27947	NC	28091	NC	28358	NC
27871	NC	27948	NC	28097	NC	28359	NC
27872	NC	27949	NC	28102	NC	28360	NC
27873	NC	27950	NC	28104	NC	28361	NC
27874	NC	27953	NC	28108	NC	28362	NC
27875	NC	27954	NC	28109	NC	28363	NC
27876	NC	27956	NC	28119	NC	28364	NC
27877	NC	27957	NC	28127	NC	28366	NC
27880	NC	27958	NC	28128	NC	28367	NC
27881	NC	27959	NC	28129	NC	28368	NC
27882	NC	27960	NC	28133	NC	28369	NC
27883	NC	27962	NC	28135	NC	28370	NC
27885	NC	27964	NC	28137	NC	28371	NC
27886	NC	27965	NC	28139	NC	28372	NC
27887	NC	27966	NC	28160	NC	28373	NC
27888	NC	27967	NC	28163	NC	28374	NC
27890	NC	27968	NC	28167	NC	28375	NC
27892	NC	27969	NC	28168	NC	28376	NC
27893	NC	27970	NC	28170	NC	28377	NC
27894	NC	27972	NC	28173	NC	28378	NC
27895	NC	27973	NC	28261	NC	28379	NC
27896	NC	27974	NC	28315	NC	28380	NC
27897	NC	27976	NC	28318	NC	28382	NC
27915	NC	27978	NC	28319	NC	28383	NC
27916	NC	27979	NC	28320	NC	28384	NC
27917	NC	27981	NC	28323	NC	28385	NC
27919	NC	27982	NC	28325	NC	28386	NC
27920	NC	27983	NC	28326	NC	28387	NC
27921	NC	27985	NC	28327	NC	28388	NC
27923	NC	28001	NC	28328	NC	28392	NC
27924	NC	28002	NC	28329	NC	28393	NC
27925	NC	28007	NC	28330	NC	28394	NC
27926	NC	28009	NC	28332	NC	28398	NC
27927	NC	28018	NC	28334	NC	28399	NC
27928	NC	28019	NC	28335	NC	28420	NC
27929	NC	28021	NC	28337	NC	28421	NC
27930	NC	28023	NC	28338	NC	28422	NC
27935	NC	28024	NC	28339	NC	28423	NC
27936	NC	28037	NC	28340	NC	28424	NC
27937	NC	28040	NC	28341	NC	28425	NC
27938	NC	28043	NC	28344	NC	28430	NC
27939	NC	28074	NC	28345	NC	28431	NC
27941	NC	28076	NC	28347	NC	28432	NC
27943	NC	28079	NC	28349	NC	28433	NC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
28434	NC	28516	NC	28651	NC	28782	NC
28435	NC	28518	NC	28654	NC	28902	NC
28436	NC	28520	NC	28656	NC	28904	NC
28438	NC	28521	NC	28659	NC	28909	NC
28439	NC	28524	NC	28665	NC	29001	SC
28441	NC	28525	NC	28666	NC	29006	SC
28442	NC	28528	NC	28667	NC	29010	SC
28443	NC	28529	NC	28669	NC	29014	SC
28444	NC	28531	NC	28670	NC	29015	SC
28446	NC	28537	NC	28672	NC	29018	SC
28447	NC	28538	NC	28674	NC	29030	SC
28448	NC	28551	NC	28678	NC	29038	SC
28450	NC	28552	NC	28681	NC	29039	SC
28451	NC	28553	NC	28683	NC	29041	SC
28452	NC	28554	NC	28684	NC	29046	SC
28453	NC	28556	NC	28685	NC	29047	SC
28454	NC	28557	NC	28693	NC	29048	SC
28455	NC	28570	NC	28694	NC	29051	SC
28456	NC	28571	NC	28697	NC	29055	SC
28457	NC	28572	NC	28705	NC	29056	SC
28458	NC	28575	NC	28708	NC	29058	SC
28459	NC	28577	NC	28712	NC	29059	SC
28461	NC	28579	NC	28718	NC	29065	SC
28462	NC	28580	NC	28720	NC	29067	SC
28463	NC	28581	NC	28722	NC	29080	SC
28464	NC	28582	NC	28733	NC	29101	SC
28465	NC	28583	NC	28737	NC	29102	SC
28466	NC	28587	NC	28743	NC	29105	SC
28467	NC	28589	NC	28746	NC	29106	SC
28468	NC	28594	NC	28747	NC	29107	SC
28469	NC	28606	NC	28749	NC	29111	SC
28470	NC	28612	NC	28750	NC	29112	SC
28471	NC	28615	NC	28752	NC	29113	SC
28472	NC	28617	NC	28753	NC	29115	SC
28478	NC	28624	NC	28754	NC	29116	SC
28479	NC	28626	NC	28756	NC	29117	SC
28501	NC	28629	NC	28761	NC	29118	SC
28502	NC	28630	NC	28762	NC	29129	SC
28503	NC	28631	NC	28765	NC	29130	SC
28504	NC	28635	NC	28766	NC	29132	SC
28508	NC	28636	NC	28768	NC	29133	SC
28509	NC	28637	NC	28771	NC	29135	SC
28510	NC	28640	NC	28772	NC	29137	SC
28511	NC	28642	NC	28773	NC	29138	SC
28512	NC	28643	NC	28774	NC	29142	SC
28515	NC	28649	NC	28777	NC	29143	SC

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
29146	SC	29565	SC	29809	SC	29944	SC
29148	SC	29567	SC	29812	SC	29945	SC
29162	SC	29570	SC	29813	SC	30011	GA
29163	SC	29573	SC	29816	SC	30016	GA
29164	SC	29580	SC	29817	SC	30041	GA
29166	SC	29584	SC	29821	SC	30052	GA
29176	SC	29590	SC	29822	SC	30104	GA
29180	SC	29594	SC	29824	SC	30110	GA
29325	SC	29596	SC	29826	SC	30113	GA
29332	SC	29643	SC	29828	SC	30125	GA
29340	SC	29645	SC	29829	SC	30132	GA
29341	SC	29658	SC	29831	SC	30137	GA
29342	SC	29664	SC	29832	SC	30138	GA
29351	SC	29665	SC	29834	SC	30140	GA
29360	SC	29672	SC	29835	SC	30141	GA
29370	SC	29675	SC	29838	SC	30143	GA
29384	SC	29676	SC	29839	SC	30148	GA
29430	SC	29678	SC	29840	SC	30153	GA
29431	SC	29679	SC	29841	SC	30157	GA
29432	SC	29686	SC	29842	SC	30175	GA
29434	SC	29691	SC	29844	SC	30176	GA
29436	SC	29693	SC	29845	SC	30177	GA
29437	SC	29696	SC	29847	SC	30179	GA
29447	SC	29702	SC	29850	SC	30180	GA
29448	SC	29706	SC	29851	SC	30182	GA
29453	SC	29709	SC	29853	SC	30204	GA
29461	SC	29712	SC	29856	SC	30206	GA
29468	SC	29714	SC	29860	SC	30216	GA
29469	SC	29717	SC	29861	SC	30217	GA
29471	SC	29718	SC	29899	SC	30218	GA
29476	SC	29720	SC	29911	SC	30219	GA
29477	SC	29721	SC	29912	SC	30222	GA
29479	SC	29722	SC	29913	SC	30233	GA
29512	SC	29724	SC	29916	SC	30234	GA
29516	SC	29727	SC	29918	SC	30251	GA
29518	SC	29728	SC	29921	SC	30256	GA
29520	SC	29729	SC	29922	SC	30257	GA
29525	SC	29741	SC	29923	SC	30258	GA
29536	SC	29742	SC	29924	SC	30284	GA
29542	SC	29743	SC	29927	SC	30292	GA
29543	SC	29744	SC	29932	SC	30293	GA
29547	SC	29801	SC	29933	SC	30295	GA
29554	SC	29802	SC	29934	SC	30401	GA
29556	SC	29803	SC	29936	SC	30410	GA
29563	SC	29804	SC	29939	SC	30411	GA
29564	SC	29805	SC	29943	SC	30412	GA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
30420	GA	30549	GA	30667	GA	31031	GA
30421	GA	30552	GA	30668	GA	31032	GA
30424	GA	30555	GA	30671	GA	31033	GA
30425	GA	30557	GA	30673	GA	31035	GA
30427	GA	30558	GA	30680	GA	31037	GA
30428	GA	30559	GA	30705	GA	31039	GA
30438	GA	30560	GA	30707	GA	31042	GA
30445	GA	30562	GA	30708	GA	31044	GA
30446	GA	30563	GA	30711	GA	31045	GA
30447	GA	30565	GA	30724	GA	31046	GA
30448	GA	30567	GA	30725	GA	31049	GA
30449	GA	30568	GA	30728	GA	31050	GA
30453	GA	30571	GA	30730	GA	31051	GA
30455	GA	30572	GA	30731	GA	31052	GA
30457	GA	30573	GA	30738	GA	31054	GA
30464	GA	30575	GA	30739	GA	31055	GA
30467	GA	30576	GA	30741	GA	31058	GA
30470	GA	30577	GA	30747	GA	31060	GA
30471	GA	30580	GA	30750	GA	31066	GA
30473	GA	30581	GA	30751	GA	31067	GA
30499	GA	30582	GA	30752	GA	31070	GA
30510	GA	30596	GA	30753	GA	31071	GA
30511	GA	30598	GA	30757	GA	31072	GA
30512	GA	30599	GA	30806	GA	31076	GA
30513	GA	30619	GA	30807	GA	31078	GA
30514	GA	30620	GA	30808	GA	31079	GA
30517	GA	30623	GA	30810	GA	31081	GA
30522	GA	30624	GA	30817	GA	31082	GA
30523	GA	30625	GA	30819	GA	31083	GA
30525	GA	30627	GA	30820	GA	31084	GA
30528	GA	30628	GA	30821	GA	31086	GA
30529	GA	30629	GA	30828	GA	31087	GA
30530	GA	30630	GA	31001	GA	31089	GA
30531	GA	30631	GA	31002	GA	31090	GA
30534	GA	30633	GA	31003	GA	31091	GA
30535	GA	30634	GA	31004	GA	31092	GA
30537	GA	30635	GA	31006	GA	31094	GA
30538	GA	30645	GA	31007	GA	31096	GA
30539	GA	30646	GA	31008	GA	31303	GA
30540	GA	30647	GA	31016	GA	31304	GA
30541	GA	30648	GA	31017	GA	31305	GA
30544	GA	30650	GA	31018	GA	31307	GA
30545	GA	30660	GA	31020	GA	31312	GA
30546	GA	30663	GA	31024	GA	31316	GA
30547	GA	30664	GA	31026	GA	31318	GA
30548	GA	30666	GA	31029	GA	31319	GA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
31326	GA	31762	GA	32011	FL	32131	FL
31327	GA	31763	GA	32013	FL	32132	FL
31329	GA	31766	GA	32024	FL	32133	FL
31331	GA	31767	GA	32025	FL	32134	FL
31516	GA	31769	GA	32038	FL	32135	FL
31518	GA	31770	GA	32041	FL	32136	FL
31537	GA	31772	GA	32052	FL	32137	FL
31542	GA	31774	GA	32053	FL	32138	FL
31543	GA	31777	GA	32055	FL	32139	FL
31544	GA	31781	GA	32056	FL	32140	FL
31549	GA	31783	GA	32059	FL	32141	FL
31551	GA	31785	GA	32060	FL	32142	FL
31553	GA	31787	GA	32061	FL	32147	FL
31556	GA	31789	GA	32062	FL	32148	FL
31557	GA	31790	GA	32064	FL	32149	FL
31562	GA	31791	GA	32066	FL	32151	FL
31566	GA	31796	GA	32071	FL	32157	FL
31622	GA	31797	GA	32082	FL	32158	FL
31624	GA	31798	GA	32092	FL	32159	FL
31625	GA	31801	GA	32094	FL	32162	FL
31629	GA	31803	GA	32095	FL	32164	FL
31638	GA	31804	GA	32096	FL	32168	FL
31639	GA	31805	GA	32097	FL	32169	FL
31642	GA	31806	GA	32102	FL	32170	FL
31643	GA	31807	GA	32105	FL	32173	FL
31645	GA	31810	GA	32110	FL	32174	FL
31646	GA	31811	GA	32111	FL	32175	FL
31648	GA	31812	GA	32112	FL	32176	FL
31650	GA	31814	GA	32113	FL	32177	FL
31713	GA	31815	GA	32114	FL	32178	FL
31714	GA	31816	GA	32115	FL	32179	FL
31720	GA	31821	GA	32116	FL	32180	FL
31723	GA	31822	GA	32117	FL	32181	FL
31726	GA	31823	GA	32118	FL	32182	FL
31728	GA	31824	GA	32119	FL	32183	FL
31729	GA	31825	GA	32120	FL	32185	FL
31732	GA	31826	GA	32121	FL	32187	FL
31741	GA	31827	GA	32122	FL	32189	FL
31742	GA	31830	GA	32123	FL	32190	FL
31745	GA	31831	GA	32124	FL	32192	FL
31746	GA	31832	GA	32125	FL	32193	FL
31749	GA	31836	GA	32126	FL	32195	FL
31754	GA	32004	FL	32127	FL	32198	FL
31759	GA	32007	FL	32128	FL	32259	FL
31760	GA	32008	FL	32129	FL	32260	FL
31761	GA	32009	FL	32130	FL	32320	FL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
32321	FL	32447	FL	32722	FL	32923	FL
32322	FL	32448	FL	32723	FL	32924	FL
32323	FL	32449	FL	32724	FL	32925	FL
32328	FL	32452	FL	32725	FL	32926	FL
32329	FL	32454	FL	32726	FL	32927	FL
32331	FL	32455	FL	32727	FL	32931	FL
32333	FL	32456	FL	32728	FL	32932	FL
32334	FL	32457	FL	32735	FL	32934	FL
32335	FL	32459	FL	32736	FL	32935	FL
32336	FL	32460	FL	32738	FL	32936	FL
32337	FL	32461	FL	32739	FL	32937	FL
32340	FL	32462	FL	32744	FL	32940	FL
32341	FL	32463	FL	32753	FL	32941	FL
32343	FL	32464	FL	32754	FL	32948	FL
32344	FL	32465	FL	32756	FL	32949	FL
32345	FL	32538	FL	32757	FL	32950	FL
32347	FL	32550	FL	32759	FL	32951	FL
32348	FL	32565	FL	32763	FL	32952	FL
32350	FL	32570	FL	32764	FL	32953	FL
32356	FL	32572	FL	32767	FL	32954	FL
32357	FL	32617	FL	32774	FL	32955	FL
32359	FL	32619	FL	32775	FL	32956	FL
32360	FL	32621	FL	32776	FL	32957	FL
32361	FL	32625	FL	32778	FL	32958	FL
32420	FL	32626	FL	32780	FL	32959	FL
32421	FL	32628	FL	32781	FL	32960	FL
32422	FL	32634	FL	32782	FL	32961	FL
32423	FL	32639	FL	32783	FL	32962	FL
32424	FL	32644	FL	32784	FL	32963	FL
32425	FL	32648	FL	32796	FL	32964	FL
32426	FL	32663	FL	32899	FL	32965	FL
32427	FL	32664	FL	32901	FL	32966	FL
32428	FL	32666	FL	32902	FL	32967	FL
32430	FL	32668	FL	32903	FL	32968	FL
32431	FL	32680	FL	32904	FL	32969	FL
32432	FL	32681	FL	32905	FL	32970	FL
32433	FL	32683	FL	32906	FL	32971	FL
32434	FL	32686	FL	32907	FL	32976	FL
32435	FL	32692	FL	32908	FL	32978	FL
32437	FL	32693	FL	32909	FL	33471	FL
32439	FL	32696	FL	32910	FL	33513	FL
32440	FL	32702	FL	32911	FL	33514	FL
32442	FL	32706	FL	32912	FL	33521	FL
32443	FL	32713	FL	32919	FL	33523	FL
32445	FL	32720	FL	32920	FL	33524	FL
32446	FL	32721	FL	32922	FL	33525	FL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
33526	FL	33849	FL	33912	FL	34102	FL
33537	FL	33850	FL	33913	FL	34103	FL
33538	FL	33851	FL	33914	FL	34104	FL
33539	FL	33852	FL	33915	FL	34105	FL
33540	FL	33853	FL	33916	FL	34106	FL
33541	FL	33854	FL	33917	FL	34107	FL
33542	FL	33855	FL	33918	FL	34108	FL
33543	FL	33856	FL	33919	FL	34109	FL
33544	FL	33857	FL	33920	FL	34110	FL
33574	FL	33858	FL	33921	FL	34112	FL
33576	FL	33859	FL	33922	FL	34113	FL
33585	FL	33860	FL	33924	FL	34114	FL
33593	FL	33862	FL	33927	FL	34116	FL
33597	FL	33863	FL	33928	FL	34117	FL
33801	FL	33865	FL	33931	FL	34119	FL
33802	FL	33867	FL	33932	FL	34120	FL
33803	FL	33868	FL	33936	FL	34133	FL
33804	FL	33870	FL	33938	FL	34134	FL
33805	FL	33871	FL	33944	FL	34135	FL
33806	FL	33872	FL	33945	FL	34136	FL
33807	FL	33873	FL	33946	FL	34137	FL
33809	FL	33875	FL	33947	FL	34138	FL
33810	FL	33876	FL	33948	FL	34139	FL
33811	FL	33877	FL	33949	FL	34140	FL
33813	FL	33880	FL	33950	FL	34142	FL
33815	FL	33881	FL	33951	FL	34143	FL
33820	FL	33882	FL	33952	FL	34145	FL
33823	FL	33883	FL	33953	FL	34146	FL
33825	FL	33884	FL	33954	FL	34201	FL
33826	FL	33885	FL	33955	FL	34202	FL
33827	FL	33888	FL	33956	FL	34203	FL
33830	FL	33890	FL	33957	FL	34204	FL
33831	FL	33896	FL	33960	FL	34205	FL
33834	FL	33897	FL	33965	FL	34206	FL
33835	FL	33898	FL	33970	FL	34207	FL
33836	FL	33901	FL	33971	FL	34208	FL
33837	FL	33902	FL	33972	FL	34209	FL
33838	FL	33903	FL	33980	FL	34210	FL
33839	FL	33904	FL	33981	FL	34211	FL
33840	FL	33905	FL	33982	FL	34212	FL
33841	FL	33906	FL	33983	FL	34215	FL
33843	FL	33907	FL	33990	FL	34216	FL
33844	FL	33908	FL	33991	FL	34217	FL
33845	FL	33909	FL	33993	FL	34218	FL
33846	FL	33910	FL	33994	FL	34219	FL
33847	FL	33911	FL	34101	FL	34220	FL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
34221	FL	34293	FL	34492	FL	34762	FL
34222	FL	34295	FL	34498	FL	34785	FL
34223	FL	34420	FL	34601	FL	34788	FL
34224	FL	34421	FL	34602	FL	34789	FL
34228	FL	34423	FL	34603	FL	34797	FL
34229	FL	34428	FL	34604	FL	34945	FL
34230	FL	34429	FL	34605	FL	34946	FL
34231	FL	34430	FL	34606	FL	34947	FL
34232	FL	34431	FL	34607	FL	34948	FL
34233	FL	34432	FL	34608	FL	34949	FL
34234	FL	34433	FL	34609	FL	34950	FL
34235	FL	34434	FL	34610	FL	34951	FL
34236	FL	34436	FL	34611	FL	34952	FL
34237	FL	34442	FL	34613	FL	34953	FL
34238	FL	34445	FL	34614	FL	34954	FL
34239	FL	34446	FL	34636	FL	34956	FL
34240	FL	34447	FL	34639	FL	34972	FL
34241	FL	34448	FL	34652	FL	34973	FL
34242	FL	34449	FL	34653	FL	34974	FL
34243	FL	34450	FL	34654	FL	34979	FL
34250	FL	34451	FL	34655	FL	34981	FL
34251	FL	34452	FL	34656	FL	34982	FL
34260	FL	34453	FL	34661	FL	34983	FL
34264	FL	34460	FL	34667	FL	34984	FL
34265	FL	34461	FL	34668	FL	34985	FL
34266	FL	34464	FL	34669	FL	34986	FL
34267	FL	34465	FL	34673	FL	34987	FL
34268	FL	34470	FL	34674	FL	34988	FL
34269	FL	34471	FL	34679	FL	35004	AL
34270	FL	34472	FL	34680	FL	35010	AL
34272	FL	34473	FL	34690	FL	35011	AL
34274	FL	34474	FL	34691	FL	35014	AL
34275	FL	34475	FL	34705	FL	35016	AL
34276	FL	34476	FL	34711	FL	35032	AL
34277	FL	34477	FL	34712	FL	35034	AL
34278	FL	34478	FL	34713	FL	35035	AL
34280	FL	34479	FL	34729	FL	35038	AL
34281	FL	34480	FL	34731	FL	35042	AL
34282	FL	34481	FL	34736	FL	35044	AL
34284	FL	34482	FL	34737	FL	35045	AL
34285	FL	34483	FL	34748	FL	35046	AL
34286	FL	34484	FL	34749	FL	35051	AL
34287	FL	34487	FL	34753	FL	35052	AL
34288	FL	34488	FL	34755	FL	35054	AL
34289	FL	34489	FL	34756	FL	35063	AL
34292	FL	34491	FL	34759	FL	35072	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
35074	AL	35481	AL	35610	AL	35962	AL
35079	AL	35491	AL	35615	AL	35963	AL
35082	AL	35501	AL	35616	AL	35964	AL
35085	AL	35502	AL	35618	AL	35966	AL
35089	AL	35503	AL	35643	AL	35967	AL
35096	AL	35504	AL	35646	AL	35968	AL
35097	AL	35540	AL	35649	AL	35971	AL
35112	AL	35541	AL	35650	AL	35973	AL
35120	AL	35542	AL	35651	AL	35974	AL
35125	AL	35543	AL	35652	AL	35975	AL
35128	AL	35544	AL	35653	AL	35976	AL
35130	AL	35545	AL	35654	AL	35978	AL
35131	AL	35546	AL	35660	AL	35979	AL
35133	AL	35548	AL	35661	AL	35980	AL
35135	AL	35549	AL	35662	AL	35981	AL
35136	AL	35550	AL	35672	AL	35983	AL
35143	AL	35551	AL	35674	AL	35984	AL
35146	AL	35552	AL	35739	AL	35986	AL
35148	AL	35553	AL	35740	AL	35987	AL
35149	AL	35554	AL	35742	AL	35988	AL
35150	AL	35555	AL	35744	AL	35989	AL
35151	AL	35559	AL	35745	AL	36003	AL
35160	AL	35560	AL	35746	AL	36005	AL
35161	AL	35563	AL	35747	AL	36006	AL
35171	AL	35564	AL	35751	AL	36008	AL
35175	AL	35565	AL	35752	AL	36009	AL
35182	AL	35570	AL	35755	AL	36010	AL
35183	AL	35571	AL	35756	AL	36015	AL
35184	AL	35572	AL	35764	AL	36016	AL
35188	AL	35573	AL	35765	AL	36017	AL
35441	AL	35574	AL	35766	AL	36020	AL
35442	AL	35575	AL	35768	AL	36022	AL
35443	AL	35576	AL	35769	AL	36023	AL
35447	AL	35577	AL	35771	AL	36024	AL
35448	AL	35578	AL	35772	AL	36025	AL
35459	AL	35579	AL	35774	AL	36026	AL
35460	AL	35580	AL	35776	AL	36027	AL
35461	AL	35581	AL	35950	AL	36028	AL
35462	AL	35582	AL	35951	AL	36029	AL
35464	AL	35584	AL	35953	AL	36030	AL
35466	AL	35585	AL	35956	AL	36031	AL
35469	AL	35586	AL	35957	AL	36032	AL
35470	AL	35587	AL	35958	AL	36033	AL
35471	AL	35592	AL	35959	AL	36034	AL
35474	AL	35593	AL	35960	AL	36035	AL
35477	AL	35594	AL	35961	AL	36037	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36038	AL	36274	AL	36462	AL	36752	AL
36039	AL	36275	AL	36467	AL	36753	AL
36040	AL	36276	AL	36470	AL	36754	AL
36041	AL	36278	AL	36471	AL	36756	AL
36042	AL	36280	AL	36473	AL	36763	AL
36045	AL	36310	AL	36474	AL	36764	AL
36047	AL	36311	AL	36475	AL	36765	AL
36048	AL	36313	AL	36476	AL	36766	AL
36049	AL	36314	AL	36477	AL	36768	AL
36051	AL	36316	AL	36480	AL	36769	AL
36053	AL	36317	AL	36481	AL	36776	AL
36054	AL	36318	AL	36483	AL	36778	AL
36061	AL	36322	AL	36509	AL	36779	AL
36062	AL	36340	AL	36513	AL	36782	AL
36066	AL	36344	AL	36518	AL	36783	AL
36067	AL	36345	AL	36522	AL	36785	AL
36068	AL	36349	AL	36529	AL	36786	AL
36071	AL	36350	AL	36538	AL	36790	AL
36072	AL	36352	AL	36539	AL	36792	AL
36075	AL	36353	AL	36548	AL	36793	AL
36078	AL	36360	AL	36553	AL	36850	AL
36079	AL	36361	AL	36556	AL	36851	AL
36080	AL	36362	AL	36558	AL	36853	AL
36081	AL	36371	AL	36569	AL	36856	AL
36082	AL	36373	AL	36581	AL	36858	AL
36083	AL	36374	AL	36583	AL	36859	AL
36087	AL	36375	AL	36584	AL	36860	AL
36088	AL	36401	AL	36585	AL	36861	AL
36089	AL	36420	AL	36720	AL	36866	AL
36091	AL	36425	AL	36721	AL	36867	AL
36092	AL	36429	AL	36722	AL	36868	AL
36093	AL	36431	AL	36723	AL	36869	AL
36251	AL	36432	AL	36726	AL	36871	AL
36255	AL	36435	AL	36728	AL	36872	AL
36256	AL	36439	AL	36732	AL	36875	AL
36258	AL	36442	AL	36736	AL	36901	AL
36261	AL	36444	AL	36738	AL	36904	AL
36262	AL	36445	AL	36740	AL	36906	AL
36263	AL	36449	AL	36741	AL	36907	AL
36264	AL	36454	AL	36742	AL	36908	AL
36266	AL	36455	AL	36744	AL	36910	AL
36267	AL	36456	AL	36745	AL	36912	AL
36268	AL	36457	AL	36748	AL	36913	AL
36269	AL	36458	AL	36749	AL	36915	AL
36270	AL	36460	AL	36750	AL	36916	AL
36273	AL	36461	AL	36751	AL	36919	AL

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
36921	AL	37162	TN	37369	TN	37753	TN
36922	AL	37175	TN	37370	TN	37754	TN
36925	AL	37178	TN	37371	TN	37755	TN
37015	TN	37180	TN	37380	TN	37756	TN
37016	TN	37183	TN	37381	TN	37757	TN
37020	TN	37184	TN	37385	TN	37760	TN
37023	TN	37185	TN	37387	TN	37762	TN
37025	TN	37187	TN	37391	TN	37763	TN
37026	TN	37188	TN	37395	TN	37765	TN
37028	TN	37190	TN	37397	TN	37766	TN
37029	TN	37301	TN	37640	TN	37770	TN
37032	TN	37303	TN	37642	TN	37771	TN
37033	TN	37305	TN	37643	TN	37772	TN
37035	TN	37307	TN	37644	TN	37773	TN
37049	TN	37309	TN	37645	TN	37774	TN
37050	TN	37313	TN	37650	TN	37779	TN
37058	TN	37314	TN	37657	TN	37807	TN
37061	TN	37316	TN	37658	TN	37819	TN
37071	TN	37317	TN	37680	TN	37820	TN
37073	TN	37321	TN	37682	TN	37821	TN
37078	TN	37322	TN	37683	TN	37822	TN
37079	TN	37325	TN	37687	TN	37824	TN
37082	TN	37326	TN	37688	TN	37825	TN
37083	TN	37327	TN	37691	TN	37826	TN
37087	TN	37328	TN	37692	TN	37829	TN
37088	TN	37329	TN	37694	TN	37840	TN
37090	TN	37331	TN	37707	TN	37841	TN
37096	TN	37332	TN	37708	TN	37843	TN
37097	TN	37333	TN	37709	TN	37845	TN
37098	TN	37334	TN	37713	TN	37846	TN
37101	TN	37335	TN	37714	TN	37847	TN
37121	TN	37336	TN	37715	TN	37848	TN
37122	TN	37337	TN	37719	TN	37851	TN
37134	TN	37338	TN	37722	TN	37852	TN
37136	TN	37339	TN	37724	TN	37854	TN
37137	TN	37348	TN	37725	TN	37861	TN
37140	TN	37352	TN	37726	TN	37866	TN
37143	TN	37354	TN	37727	TN	37867	TN
37144	TN	37356	TN	37729	TN	37869	TN
37146	TN	37359	TN	37730	TN	37870	TN
37147	TN	37360	TN	37731	TN	37871	TN
37149	TN	37361	TN	37732	TN	37872	TN
37150	TN	37362	TN	37733	TN	37873	TN
37152	TN	37365	TN	37742	TN	37874	TN
37160	TN	37366	TN	37748	TN	37879	TN
37161	TN	37367	TN	37752	TN	37880	TN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
37881	TN	38221	TN	38340	TN	38471	TN
37885	TN	38222	TN	38341	TN	38472	TN
37887	TN	38223	TN	38342	TN	38473	TN
37888	TN	38224	TN	38344	TN	38475	TN
37890	TN	38225	TN	38345	TN	38476	TN
37892	TN	38226	TN	38347	TN	38477	TN
38001	TN	38229	TN	38348	TN	38478	TN
38004	TN	38230	TN	38351	TN	38481	TN
38006	TN	38231	TN	38352	TN	38483	TN
38008	TN	38232	TN	38357	TN	38485	TN
38011	TN	38235	TN	38359	TN	38486	TN
38012	TN	38236	TN	38361	TN	38488	TN
38021	TN	38237	TN	38363	TN	38504	TN
38023	TN	38238	TN	38365	TN	38541	TN
38034	TN	38240	TN	38367	TN	38542	TN
38037	TN	38241	TN	38368	TN	38543	TN
38039	TN	38242	TN	38370	TN	38549	TN
38040	TN	38251	TN	38371	TN	38551	TN
38041	TN	38253	TN	38372	TN	38553	TN
38042	TN	38254	TN	38374	TN	38554	TN
38043	TN	38255	TN	38375	TN	38556	TN
38044	TN	38256	TN	38376	TN	38559	TN
38046	TN	38257	TN	38377	TN	38562	TN
38048	TN	38258	TN	38379	TN	38564	TN
38050	TN	38260	TN	38380	TN	38565	TN
38052	TN	38261	TN	38381	TN	38568	TN
38053	TN	38271	TN	38387	TN	38570	TN
38054	TN	38281	TN	38388	TN	38573	TN
38055	TN	38310	TN	38390	TN	38575	TN
38057	TN	38311	TN	38393	TN	38577	TN
38058	TN	38315	TN	38425	TN	38579	TN
38060	TN	38317	TN	38449	TN	38580	TN
38061	TN	38318	TN	38450	TN	38583	TN
38063	TN	38320	TN	38452	TN	38585	TN
38066	TN	38321	TN	38453	TN	38587	TN
38067	TN	38324	TN	38454	TN	38588	TN
38069	TN	38326	TN	38455	TN	38589	TN
38071	TN	38327	TN	38456	TN	38602	MS
38074	TN	38328	TN	38457	TN	38603	MS
38075	TN	38329	TN	38459	TN	38606	MS
38077	TN	38332	TN	38460	TN	38609	MS
38079	TN	38333	TN	38462	TN	38610	MS
38080	TN	38334	TN	38463	TN	38611	MS
38083	TN	38336	TN	38464	TN	38618	MS
38201	TN	38337	TN	38468	TN	38619	MS
38220	TN	38339	TN	38469	TN	38620	MS

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
38621	MS	38820	MS	38926	MS	39090	MS
38622	MS	38827	MS	38927	MS	39092	MS
38623	MS	38828	MS	38928	MS	39094	MS
38625	MS	38829	MS	38929	MS	39095	MS
38626	MS	38833	MS	38940	MS	39096	MS
38627	MS	38834	MS	38943	MS	39097	MS
38628	MS	38835	MS	38947	MS	39098	MS
38629	MS	38838	MS	38948	MS	39107	MS
38632	MS	38839	MS	38950	MS	39108	MS
38633	MS	38841	MS	38951	MS	39109	MS
38634	MS	38843	MS	38953	MS	39111	MS
38635	MS	38846	MS	38954	MS	39112	MS
38637	MS	38847	MS	38955	MS	39113	MS
38638	MS	38850	MS	38957	MS	39114	MS
38641	MS	38851	MS	38958	MS	39115	MS
38642	MS	38852	MS	38960	MS	39116	MS
38643	MS	38854	MS	38961	MS	39117	MS
38646	MS	38855	MS	38962	MS	39119	MS
38647	MS	38856	MS	38963	MS	39140	MS
38649	MS	38858	MS	38964	MS	39144	MS
38650	MS	38859	MS	38965	MS	39146	MS
38651	MS	38860	MS	38966	MS	39149	MS
38652	MS	38863	MS	39038	MS	39150	MS
38654	MS	38864	MS	39039	MS	39152	MS
38658	MS	38865	MS	39040	MS	39153	MS
38659	MS	38869	MS	39044	MS	39159	MS
38661	MS	38871	MS	39051	MS	39160	MS
38663	MS	38873	MS	39054	MS	39162	MS
38664	MS	38875	MS	39057	MS	39166	MS
38665	MS	38876	MS	39059	MS	39168	MS
38666	MS	38877	MS	39061	MS	39169	MS
38668	MS	38878	MS	39062	MS	39171	MS
38670	MS	38880	MS	39063	MS	39173	MS
38671	MS	38901	MS	39067	MS	39176	MS
38672	MS	38902	MS	39069	MS	39177	MS
38674	MS	38912	MS	39074	MS	39179	MS
38676	MS	38913	MS	39077	MS	39189	MS
38679	MS	38914	MS	39078	MS	39191	MS
38680	MS	38915	MS	39079	MS	39192	MS
38683	MS	38916	MS	39080	MS	39194	MS
38685	MS	38917	MS	39081	MS	39322	MS
38686	MS	38920	MS	39082	MS	39323	MS
38721	MS	38921	MS	39083	MS	39324	MS
38745	MS	38922	MS	39086	MS	39327	MS
38754	MS	38923	MS	39087	MS	39328	MS
38765	MS	38924	MS	39088	MS	39330	MS

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
39332	MS	39481	MS	39776	MS	40057	KY
39336	MS	39482	MS	39813	GA	40058	KY
39337	MS	39483	MS	39823	GA	40060	KY
39338	MS	39520	MS	39826	GA	40061	KY
39339	MS	39521	MS	39827	GA	40062	KY
39341	MS	39522	MS	39828	GA	40063	KY
39345	MS	39525	MS	39829	GA	40065	KY
39346	MS	39529	MS	39832	GA	40066	KY
39347	MS	39556	MS	39841	GA	40067	KY
39348	MS	39558	MS	39842	GA	40068	KY
39352	MS	39561	MS	39845	GA	40069	KY
39354	MS	39572	MS	39846	GA	40070	KY
39355	MS	39573	MS	39854	GA	40071	KY
39356	MS	39576	MS	39859	GA	40075	KY
39358	MS	39577	MS	39861	GA	40076	KY
39359	MS	39630	MS	39862	GA	40078	KY
39360	MS	39631	MS	39866	GA	40104	KY
39361	MS	39633	MS	39867	GA	40107	KY
39362	MS	39638	MS	39870	GA	40108	KY
39363	MS	39641	MS	39877	GA	40109	KY
39366	MS	39643	MS	39897	GA	40110	KY
39367	MS	39645	MS	40003	KY	40111	KY
39421	MS	39647	MS	40004	KY	40115	KY
39422	MS	39653	MS	40006	KY	40117	KY
39423	MS	39654	MS	40007	KY	40119	KY
39426	MS	39656	MS	40008	KY	40129	KY
39427	MS	39661	MS	40009	KY	40140	KY
39428	MS	39663	MS	40011	KY	40142	KY
39429	MS	39664	MS	40012	KY	40143	KY
39439	MS	39665	MS	40013	KY	40144	KY
39451	MS	39668	MS	40019	KY	40145	KY
39452	MS	39669	MS	40020	KY	40146	KY
39455	MS	39735	MS	40022	KY	40150	KY
39456	MS	39737	MS	40033	KY	40152	KY
39457	MS	39739	MS	40036	KY	40153	KY
39460	MS	39741	MS	40037	KY	40155	KY
39461	MS	39744	MS	40040	KY	40157	KY
39462	MS	39745	MS	40045	KY	40161	KY
39463	MS	39750	MS	40046	KY	40164	KY
39466	MS	39751	MS	40047	KY	40165	KY
39470	MS	39752	MS	40048	KY	40170	KY
39474	MS	39754	MS	40049	KY	40171	KY
39475	MS	39755	MS	40050	KY	40176	KY
39476	MS	39771	MS	40051	KY	40178	KY
39478	MS	39772	MS	40052	KY	40311	KY
39479	MS	39773	MS	40055	KY	40312	KY

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
40316	KY	40602	KY	40921	KY	41127	KY
40322	KY	40603	KY	40923	KY	41128	KY
40328	KY	40604	KY	40927	KY	41132	KY
40334	KY	40618	KY	40930	KY	41135	KY
40336	KY	40619	KY	40931	KY	41137	KY
40342	KY	40620	KY	40932	KY	41139	KY
40346	KY	40621	KY	40935	KY	41141	KY
40350	KY	40622	KY	40941	KY	41142	KY
40355	KY	40734	KY	40943	KY	41143	KY
40358	KY	40771	KY	40944	KY	41144	KY
40359	KY	40801	KY	40946	KY	41146	KY
40360	KY	40803	KY	40949	KY	41149	KY
40363	KY	40806	KY	40951	KY	41156	KY
40366	KY	40807	KY	40953	KY	41159	KY
40371	KY	40808	KY	40962	KY	41160	KY
40374	KY	40810	KY	40964	KY	41164	KY
40376	KY	40815	KY	40972	KY	41166	KY
40380	KY	40816	KY	40979	KY	41169	KY
40387	KY	40818	KY	40982	KY	41170	KY
40402	KY	40819	KY	40983	KY	41171	KY
40409	KY	40820	KY	40995	KY	41173	KY
40410	KY	40823	KY	40997	KY	41174	KY
40419	KY	40824	KY	40999	KY	41175	KY
40421	KY	40827	KY	41002	KY	41179	KY
40434	KY	40828	KY	41004	KY	41180	KY
40437	KY	40829	KY	41008	KY	41181	KY
40442	KY	40830	KY	41037	KY	41183	KY
40444	KY	40831	KY	41039	KY	41189	KY
40445	KY	40840	KY	41040	KY	41201	KY
40446	KY	40843	KY	41041	KY	41203	KY
40447	KY	40844	KY	41043	KY	41214	KY
40448	KY	40847	KY	41044	KY	41224	KY
40456	KY	40849	KY	41045	KY	41230	KY
40460	KY	40854	KY	41046	KY	41231	KY
40461	KY	40855	KY	41049	KY	41232	KY
40467	KY	40858	KY	41061	KY	41250	KY
40472	KY	40863	KY	41064	KY	41262	KY
40473	KY	40865	KY	41065	KY	41264	KY
40481	KY	40868	KY	41081	KY	41267	KY
40484	KY	40870	KY	41083	KY	41301	KY
40486	KY	40873	KY	41086	KY	41307	KY
40488	KY	40874	KY	41093	KY	41310	KY
40489	KY	40903	KY	41095	KY	41311	KY
40492	KY	40906	KY	41098	KY	41313	KY
40495	KY	40914	KY	41121	KY	41314	KY
40601	KY	40915	KY	41124	KY	41317	KY

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
41332	KY	41540	KY	41839	KY	42088	KY
41333	KY	41542	KY	41843	KY	42120	KY
41338	KY	41543	KY	41844	KY	42124	KY
41339	KY	41544	KY	41847	KY	42129	KY
41342	KY	41546	KY	41859	KY	42133	KY
41344	KY	41547	KY	41861	KY	42140	KY
41347	KY	41548	KY	41862	KY	42150	KY
41348	KY	41549	KY	42021	KY	42151	KY
41351	KY	41553	KY	42022	KY	42153	KY
41360	KY	41554	KY	42023	KY	42154	KY
41362	KY	41555	KY	42024	KY	42157	KY
41364	KY	41557	KY	42025	KY	42163	KY
41365	KY	41558	KY	42027	KY	42164	KY
41366	KY	41559	KY	42028	KY	42166	KY
41368	KY	41560	KY	42029	KY	42167	KY
41377	KY	41561	KY	42031	KY	42201	KY
41385	KY	41562	KY	42032	KY	42202	KY
41386	KY	41563	KY	42033	KY	42203	KY
41390	KY	41564	KY	42035	KY	42204	KY
41397	KY	41566	KY	42037	KY	42206	KY
41410	KY	41567	KY	42038	KY	42207	KY
41419	KY	41568	KY	42039	KY	42209	KY
41422	KY	41569	KY	42040	KY	42210	KY
41426	KY	41571	KY	42044	KY	42211	KY
41433	KY	41572	KY	42045	KY	42214	KY
41444	KY	41632	KY	42047	KY	42215	KY
41464	KY	41714	KY	42048	KY	42216	KY
41465	KY	41725	KY	42051	KY	42219	KY
41501	KY	41730	KY	42055	KY	42220	KY
41502	KY	41740	KY	42056	KY	42234	KY
41503	KY	41743	KY	42058	KY	42251	KY
41512	KY	41749	KY	42060	KY	42252	KY
41513	KY	41759	KY	42061	KY	42256	KY
41514	KY	41762	KY	42063	KY	42257	KY
41519	KY	41764	KY	42064	KY	42259	KY
41520	KY	41766	KY	42066	KY	42261	KY
41522	KY	41772	KY	42069	KY	42265	KY
41524	KY	41775	KY	42070	KY	42267	KY
41526	KY	41776	KY	42078	KY	42273	KY
41527	KY	41777	KY	42079	KY	42275	KY
41528	KY	41817	KY	42081	KY	42276	KY
41531	KY	41822	KY	42082	KY	42280	KY
41534	KY	41828	KY	42083	KY	42283	KY
41535	KY	41831	KY	42084	KY	42285	KY
41538	KY	41834	KY	42085	KY	42286	KY
41539	KY	41836	KY	42087	KY	42287	KY

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
42288	KY	42459	KY	43044	OH	43359	OH
42320	KY	42460	KY	43047	OH	43408	OH
42321	KY	42461	KY	43060	OH	43412	OH
42322	KY	42462	KY	43070	OH	43416	OH
42323	KY	42463	KY	43072	OH	43430	OH
42324	KY	42516	KY	43076	OH	43432	OH
42325	KY	42528	KY	43078	OH	43433	OH
42326	KY	42539	KY	43083	OH	43436	OH
42327	KY	42541	KY	43084	OH	43439	OH
42328	KY	42565	KY	43103	OH	43440	OH
42330	KY	42566	KY	43116	OH	43445	OH
42332	KY	42602	KY	43117	OH	43446	OH
42333	KY	42603	KY	43145	OH	43449	OH
42337	KY	42629	KY	43146	OH	43452	OH
42338	KY	42631	KY	43151	OH	43456	OH
42339	KY	42634	KY	43153	OH	43458	OH
42343	KY	42635	KY	43164	OH	43468	OH
42344	KY	42638	KY	43301	OH	43510	OH
42345	KY	42642	KY	43302	OH	43515	OH
42347	KY	42647	KY	43306	OH	43516	OH
42348	KY	42649	KY	43307	OH	43523	OH
42349	KY	42653	KY	43314	OH	43524	OH
42350	KY	42711	KY	43315	OH	43527	OH
42351	KY	42712	KY	43316	OH	43532	OH
42352	KY	42713	KY	43317	OH	43533	OH
42354	KY	42716	KY	43320	OH	43534	OH
42361	KY	42717	KY	43321	OH	43535	OH
42364	KY	42721	KY	43322	OH	43540	OH
42365	KY	42722	KY	43323	OH	43545	OH
42367	KY	42726	KY	43325	OH	43548	OH
42368	KY	42729	KY	43326	OH	43550	OH
42369	KY	42731	KY	43330	OH	43555	OH
42370	KY	42743	KY	43332	OH	43558	OH
42371	KY	42746	KY	43334	OH	43716	OH
42372	KY	42748	KY	43335	OH	43718	OH
42374	KY	42749	KY	43337	OH	43719	OH
42403	KY	42754	KY	43338	OH	43728	OH
42404	KY	42755	KY	43340	OH	43730	OH
42409	KY	42757	KY	43341	OH	43731	OH
42411	KY	42759	KY	43342	OH	43739	OH
42437	KY	42762	KY	43345	OH	43747	OH
42444	KY	42764	KY	43346	OH	43748	OH
42445	KY	42765	KY	43349	OH	43752	OH
42450	KY	42782	KY	43350	OH	43754	OH
42455	KY	42786	KY	43351	OH	43756	OH
42456	KY	43009	OH	43356	OH	43757	OH

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
43758	OH	43942	OH	44288	OH	44841	OH
43759	OH	43943	OH	44408	OH	44844	OH
43760	OH	43944	OH	44431	OH	44845	OH
43761	OH	43946	OH	44490	OH	44849	OH
43764	OH	43947	OH	44493	OH	44853	OH
43766	OH	43948	OH	44607	OH	44861	OH
43782	OH	43950	OH	44609	OH	44867	OH
43783	OH	43951	OH	44612	OH	44882	OH
43786	OH	43952	OH	44615	OH	44883	OH
43787	OH	43953	OH	44619	OH	45070	OH
43789	OH	43961	OH	44620	OH	45102	OH
43793	OH	43963	OH	44621	OH	45103	OH
43804	OH	43964	OH	44622	OH	45105	OH
43832	OH	43966	OH	44624	OH	45106	OH
43837	OH	43967	OH	44625	OH	45112	OH
43840	OH	43970	OH	44629	OH	45118	OH
43901	OH	43971	OH	44631	OH	45119	OH
43902	OH	43972	OH	44639	OH	45120	OH
43903	OH	43973	OH	44644	OH	45122	OH
43905	OH	43974	OH	44651	OH	45130	OH
43906	OH	43976	OH	44653	OH	45140	OH
43907	OH	43977	OH	44656	OH	45144	OH
43908	OH	43981	OH	44663	OH	45145	OH
43909	OH	43984	OH	44671	OH	45147	OH
43910	OH	43985	OH	44672	OH	45150	OH
43912	OH	43986	OH	44675	OH	45153	OH
43913	OH	43988	OH	44678	OH	45154	OH
43914	OH	44003	OH	44679	OH	45156	OH
43915	OH	44004	OH	44680	OH	45157	OH
43916	OH	44005	OH	44681	OH	45158	OH
43917	OH	44010	OH	44682	OH	45160	OH
43925	OH	44030	OH	44683	OH	45168	OH
43926	OH	44032	OH	44693	OH	45171	OH
43927	OH	44041	OH	44695	OH	45176	OH
43928	OH	44047	OH	44697	OH	45245	OH
43930	OH	44048	OH	44699	OH	45311	OH
43931	OH	44068	OH	44802	OH	45320	OH
43932	OH	44076	OH	44803	OH	45321	OH
43933	OH	44082	OH	44807	OH	45330	OH
43934	OH	44084	OH	44809	OH	45337	OH
43935	OH	44085	OH	44815	OH	45338	OH
43937	OH	44088	OH	44818	OH	45339	OH
43938	OH	44093	OH	44827	OH	45347	OH
43939	OH	44099	OH	44828	OH	45361	OH
43940	OH	44231	OH	44830	OH	45371	OH
43941	OH	44234	OH	44836	OH	45378	OH

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
45381	OH	45784	OH	45899	OH	46301	IN
45382	OH	45806	OH	46035	IN	46302	IN
45383	OH	45810	OH	46039	IN	46304	IN
45389	OH	45812	OH	46041	IN	46341	IN
45616	OH	45813	OH	46045	IN	46349	IN
45618	OH	45815	OH	46047	IN	46366	IN
45619	OH	45819	OH	46049	IN	46368	IN
45622	OH	45821	OH	46050	IN	46372	IN
45634	OH	45827	OH	46057	IN	46374	IN
45638	OH	45830	OH	46058	IN	46379	IN
45645	OH	45831	OH	46065	IN	46381	IN
45650	OH	45832	OH	46067	IN	46385	IN
45651	OH	45835	OH	46068	IN	46393	IN
45654	OH	45836	OH	46072	IN	46502	IN
45659	OH	45837	OH	46076	IN	46508	IN
45660	OH	45838	OH	46104	IN	46510	IN
45669	OH	45843	OH	46105	IN	46524	IN
45672	OH	45844	OH	46106	IN	46531	IN
45675	OH	45848	OH	46110	IN	46532	IN
45678	OH	45849	OH	46115	IN	46534	IN
45679	OH	45851	OH	46120	IN	46538	IN
45680	OH	45853	OH	46121	IN	46539	IN
45684	OH	45855	OH	46126	IN	46542	IN
45688	OH	45856	OH	46127	IN	46555	IN
45693	OH	45859	OH	46128	IN	46562	IN
45695	OH	45861	OH	46130	IN	46566	IN
45696	OH	45863	OH	46133	IN	46567	IN
45697	OH	45864	OH	46135	IN	46574	IN
45698	OH	45870	OH	46142	IN	46580	IN
45712	OH	45871	OH	46143	IN	46581	IN
45713	OH	45873	OH	46144	IN	46582	IN
45714	OH	45874	OH	46146	IN	46590	IN
45720	OH	45875	OH	46148	IN	46701	IN
45724	OH	45876	OH	46150	IN	46702	IN
45729	OH	45877	OH	46155	IN	46703	IN
45741	OH	45879	OH	46156	IN	46710	IN
45742	OH	45880	OH	46161	IN	46711	IN
45743	OH	45884	OH	46162	IN	46713	IN
45760	OH	45886	OH	46164	IN	46720	IN
45769	OH	45888	OH	46170	IN	46723	IN
45770	OH	45891	OH	46171	IN	46725	IN
45771	OH	45893	OH	46172	IN	46732	IN
45772	OH	45894	OH	46173	IN	46733	IN
45775	OH	45895	OH	46175	IN	46737	IN
45779	OH	45896	OH	46181	IN	46740	IN
45783	OH	45898	OH	46184	IN	46742	IN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
46747	IN	46994	IN	47136	IN	47361	IN
46750	IN	46998	IN	47137	IN	47362	IN
46755	IN	47001	IN	47138	IN	47366	IN
46760	IN	47003	IN	47139	IN	47368	IN
46763	IN	47006	IN	47140	IN	47369	IN
46764	IN	47010	IN	47142	IN	47371	IN
46767	IN	47011	IN	47145	IN	47373	IN
46769	IN	47012	IN	47160	IN	47380	IN
46772	IN	47016	IN	47161	IN	47381	IN
46776	IN	47017	IN	47164	IN	47382	IN
46779	IN	47018	IN	47165	IN	47384	IN
46780	IN	47019	IN	47166	IN	47385	IN
46782	IN	47020	IN	47167	IN	47386	IN
46783	IN	47021	IN	47170	IN	47387	IN
46784	IN	47022	IN	47174	IN	47388	IN
46785	IN	47023	IN	47175	IN	47390	IN
46787	IN	47024	IN	47177	IN	47394	IN
46792	IN	47025	IN	47223	IN	47424	IN
46794	IN	47030	IN	47225	IN	47427	IN
46796	IN	47031	IN	47227	IN	47431	IN
46910	IN	47032	IN	47240	IN	47432	IN
46912	IN	47033	IN	47245	IN	47433	IN
46913	IN	47034	IN	47261	IN	47435	IN
46915	IN	47035	IN	47263	IN	47438	IN
46916	IN	47036	IN	47265	IN	47439	IN
46917	IN	47037	IN	47270	IN	47441	IN
46920	IN	47038	IN	47272	IN	47443	IN
46922	IN	47039	IN	47273	IN	47445	IN
46923	IN	47040	IN	47282	IN	47448	IN
46929	IN	47041	IN	47283	IN	47449	IN
46931	IN	47042	IN	47322	IN	47452	IN
46932	IN	47043	IN	47325	IN	47453	IN
46935	IN	47060	IN	47326	IN	47454	IN
46939	IN	47102	IN	47331	IN	47455	IN
46942	IN	47107	IN	47336	IN	47456	IN
46945	IN	47108	IN	47337	IN	47457	IN
46947	IN	47110	IN	47340	IN	47459	IN
46950	IN	47114	IN	47344	IN	47460	IN
46961	IN	47115	IN	47351	IN	47465	IN
46967	IN	47116	IN	47352	IN	47469	IN
46968	IN	47117	IN	47353	IN	47471	IN
46975	IN	47118	IN	47354	IN	47501	IN
46977	IN	47120	IN	47355	IN	47514	IN
46978	IN	47123	IN	47356	IN	47515	IN
46982	IN	47125	IN	47358	IN	47519	IN
46988	IN	47135	IN	47360	IN	47520	IN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
47522	IN	47840	IN	47964	IN	48621	MI
47523	IN	47842	IN	47966	IN	48622	MI
47525	IN	47846	IN	47969	IN	48624	MI
47529	IN	47847	IN	47970	IN	48625	MI
47531	IN	47848	IN	47971	IN	48627	MI
47536	IN	47849	IN	47974	IN	48629	MI
47537	IN	47850	IN	47975	IN	48630	MI
47550	IN	47852	IN	47980	IN	48632	MI
47551	IN	47854	IN	47982	IN	48633	MI
47552	IN	47855	IN	47984	IN	48636	MI
47553	IN	47856	IN	47986	IN	48647	MI
47556	IN	47859	IN	47987	IN	48651	MI
47558	IN	47860	IN	47988	IN	48652	MI
47562	IN	47861	IN	47991	IN	48653	MI
47564	IN	47862	IN	47993	IN	48656	MI
47567	IN	47864	IN	47995	IN	48658	MI
47568	IN	47865	IN	47997	IN	48659	MI
47574	IN	47868	IN	48032	MI	48701	MI
47576	IN	47872	IN	48039	MI	48703	MI
47577	IN	47874	IN	48097	MI	48705	MI
47579	IN	47875	IN	48110	MI	48720	MI
47581	IN	47879	IN	48117	MI	48721	MI
47584	IN	47881	IN	48131	MI	48723	MI
47585	IN	47882	IN	48133	MI	48725	MI
47586	IN	47884	IN	48140	MI	48726	MI
47588	IN	47917	IN	48144	MI	48728	MI
47590	IN	47918	IN	48157	MI	48729	MI
47598	IN	47921	IN	48159	MI	48730	MI
47601	IN	47922	IN	48160	MI	48731	MI
47611	IN	47923	IN	48166	MI	48733	MI
47612	IN	47925	IN	48177	MI	48735	MI
47615	IN	47926	IN	48179	MI	48736	MI
47616	IN	47928	IN	48182	MI	48737	MI
47617	IN	47929	IN	48413	MI	48738	MI
47620	IN	47932	IN	48432	MI	48739	MI
47631	IN	47942	IN	48435	MI	48740	MI
47633	IN	47944	IN	48441	MI	48741	MI
47634	IN	47948	IN	48445	MI	48742	MI
47635	IN	47949	IN	48467	MI	48743	MI
47638	IN	47950	IN	48468	MI	48744	MI
47830	IN	47951	IN	48470	MI	48745	MI
47831	IN	47952	IN	48475	MI	48746	MI
47832	IN	47958	IN	48610	MI	48748	MI
47833	IN	47959	IN	48612	MI	48749	MI
47836	IN	47960	IN	48617	MI	48750	MI
47838	IN	47963	IN	48619	MI	48754	MI

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
48755	MI	49249	MI	49436	MI	49682	MI
48757	MI	49250	MI	49446	MI	49683	MI
48758	MI	49252	MI	49449	MI	49688	MI
48759	MI	49253	MI	49452	MI	49709	MI
48762	MI	49256	MI	49455	MI	49729	MI
48763	MI	49257	MI	49459	MI	49743	MI
48764	MI	49258	MI	49611	MI	49746	MI
48765	MI	49262	MI	49612	MI	49756	MI
48766	MI	49265	MI	49615	MI	49759	MI
48767	MI	49266	MI	49616	MI	49765	MI
48768	MI	49267	MI	49617	MI	49776	MI
48769	MI	49268	MI	49621	MI	49777	MI
48770	MI	49270	MI	49622	MI	49779	MI
48831	MI	49271	MI	49623	MI	49805	MI
49026	MI	49274	MI	49627	MI	49812	MI
49031	MI	49275	MI	49628	MI	49813	MI
49043	MI	49276	MI	49629	MI	49821	MI
49047	MI	49278	MI	49630	MI	49845	MI
49055	MI	49279	MI	49631	MI	49847	MI
49057	MI	49280	MI	49632	MI	49848	MI
49061	MI	49281	MI	49633	MI	49858	MI
49062	MI	49282	MI	49635	MI	49863	MI
49065	MI	49286	MI	49636	MI	49873	MI
49067	MI	49287	MI	49639	MI	49874	MI
49071	MI	49288	MI	49640	MI	49886	MI
49076	MI	49289	MI	49642	MI	49887	MI
49095	MI	49304	MI	49644	MI	49893	MI
49104	MI	49305	MI	49646	MI	49896	MI
49107	MI	49307	MI	49648	MI	49901	MI
49112	MI	49311	MI	49650	MI	49902	MI
49117	MI	49314	MI	49651	MI	49903	MI
49130	MI	49320	MI	49653	MI	49910	MI
49220	MI	49323	MI	49654	MI	49911	MI
49221	MI	49328	MI	49655	MI	49912	MI
49227	MI	49332	MI	49656	MI	49915	MI
49228	MI	49335	MI	49657	MI	49918	MI
49229	MI	49336	MI	49659	MI	49920	MI
49232	MI	49338	MI	49664	MI	49925	MI
49233	MI	49340	MI	49665	MI	49927	MI
49235	MI	49342	MI	49667	MI	49929	MI
49236	MI	49344	MI	49670	MI	49935	MI
49238	MI	49346	MI	49674	MI	49938	MI
49239	MI	49348	MI	49676	MI	49947	MI
49242	MI	49419	MI	49677	MI	49948	MI
49247	MI	49420	MI	49679	MI	49950	MI
49248	MI	49421	MI	49680	MI	49953	MI

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
49959	MI	50110	IA	50263	IA	50473	IA
49960	MI	50115	IA	50264	IA	50475	IA
49964	MI	50117	IA	50268	IA	50476	IA
49967	MI	50122	IA	50269	IA	50478	IA
49968	MI	50123	IA	50273	IA	50480	IA
49969	MI	50126	IA	50274	IA	50481	IA
49971	MI	50127	IA	50276	IA	50483	IA
50002	IA	50128	IA	50277	IA	50484	IA
50003	IA	50129	IA	50420	IA	50511	IA
50006	IA	50133	IA	50421	IA	50514	IA
50008	IA	50135	IA	50423	IA	50517	IA
50020	IA	50136	IA	50424	IA	50522	IA
50022	IA	50137	IA	50426	IA	50525	IA
50025	IA	50140	IA	50427	IA	50526	IA
50026	IA	50144	IA	50430	IA	50531	IA
50028	IA	50147	IA	50431	IA	50533	IA
50029	IA	50150	IA	50432	IA	50535	IA
50033	IA	50153	IA	50434	IA	50538	IA
50038	IA	50155	IA	50435	IA	50539	IA
50039	IA	50164	IA	50436	IA	50540	IA
50041	IA	50165	IA	50438	IA	50542	IA
50042	IA	50167	IA	50439	IA	50546	IA
50043	IA	50168	IA	50440	IA	50551	IA
50048	IA	50170	IA	50441	IA	50552	IA
50050	IA	50173	IA	50444	IA	50554	IA
50052	IA	50206	IA	50446	IA	50556	IA
50054	IA	50208	IA	50447	IA	50559	IA
50059	IA	50216	IA	50448	IA	50560	IA
50060	IA	50217	IA	50449	IA	50561	IA
50063	IA	50218	IA	50450	IA	50563	IA
50064	IA	50222	IA	50451	IA	50567	IA
50065	IA	50227	IA	50452	IA	50571	IA
50067	IA	50228	IA	50453	IA	50573	IA
50069	IA	50230	IA	50454	IA	50574	IA
50070	IA	50232	IA	50455	IA	50575	IA
50071	IA	50233	IA	50456	IA	50578	IA
50072	IA	50235	IA	50458	IA	50579	IA
50074	IA	50240	IA	50459	IA	50581	IA
50076	IA	50250	IA	50460	IA	50583	IA
50101	IA	50251	IA	50461	IA	50586	IA
50102	IA	50255	IA	50465	IA	50590	IA
50103	IA	50257	IA	50466	IA	50593	IA
50104	IA	50258	IA	50468	IA	50598	IA
50107	IA	50259	IA	50470	IA	50599	IA
50108	IA	50261	IA	50471	IA	50601	IA
50109	IA	50262	IA	50472	IA	50602	IA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
50603	IA	50666	IA	51024	IA	51448	IA
50604	IA	50668	IA	51028	IA	51449	IA
50605	IA	50669	IA	51029	IA	51450	IA
50606	IA	50670	IA	51031	IA	51453	IA
50607	IA	50671	IA	51035	IA	51454	IA
50608	IA	50672	IA	51037	IA	51458	IA
50609	IA	50673	IA	51038	IA	51460	IA
50611	IA	50674	IA	51045	IA	51461	IA
50612	IA	50675	IA	51046	IA	51462	IA
50616	IA	50676	IA	51048	IA	51465	IA
50619	IA	50677	IA	51049	IA	51466	IA
50620	IA	50680	IA	51050	IA	51467	IA
50621	IA	50681	IA	51053	IA	51520	IA
50622	IA	50682	IA	51058	IA	51525	IA
50624	IA	50833	IA	51061	IA	51527	IA
50625	IA	50835	IA	51062	IA	51528	IA
50627	IA	50836	IA	51201	IA	51529	IA
50628	IA	50837	IA	51230	IA	51530	IA
50629	IA	50839	IA	51231	IA	51531	IA
50630	IA	50840	IA	51235	IA	51533	IA
50631	IA	50841	IA	51237	IA	51534	IA
50632	IA	50843	IA	51240	IA	51535	IA
50633	IA	50845	IA	51241	IA	51536	IA
50635	IA	50846	IA	51242	IA	51537	IA
50636	IA	50848	IA	51243	IA	51540	IA
50638	IA	50849	IA	51245	IA	51541	IA
50641	IA	50851	IA	51246	IA	51543	IA
50642	IA	50853	IA	51248	IA	51544	IA
50644	IA	50854	IA	51331	IA	51545	IA
50645	IA	50857	IA	51334	IA	51546	IA
50647	IA	50858	IA	51344	IA	51549	IA
50648	IA	50859	IA	51346	IA	51550	IA
50649	IA	50860	IA	51347	IA	51551	IA
50650	IA	50862	IA	51351	IA	51552	IA
50652	IA	50863	IA	51355	IA	51554	IA
50653	IA	51001	IA	51360	IA	51555	IA
50654	IA	51004	IA	51363	IA	51556	IA
50655	IA	51005	IA	51364	IA	51557	IA
50657	IA	51008	IA	51365	IA	51560	IA
50658	IA	51009	IA	51432	IA	51561	IA
50659	IA	51012	IA	51433	IA	51562	IA
50660	IA	51014	IA	51439	IA	51563	IA
50661	IA	51016	IA	51441	IA	51564	IA
50662	IA	51017	IA	51442	IA	51565	IA
50664	IA	51018	IA	51446	IA	51570	IA
50665	IA	51019	IA	51447	IA	51571	IA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
51574	IA	52075	IA	52226	IA	52361	IA
51578	IA	52076	IA	52229	IA	52362	IA
51579	IA	52077	IA	52231	IA	52531	IA
51593	IA	52078	IA	52236	IA	52535	IA
51639	IA	52079	IA	52237	IA	52537	IA
51640	IA	52134	IA	52248	IA	52538	IA
51645	IA	52135	IA	52249	IA	52542	IA
51646	IA	52136	IA	52251	IA	52544	IA
51648	IA	52140	IA	52252	IA	52549	IA
51649	IA	52141	IA	52254	IA	52550	IA
51650	IA	52142	IA	52255	IA	52551	IA
51652	IA	52146	IA	52257	IA	52552	IA
51653	IA	52147	IA	52301	IA	52555	IA
51654	IA	52151	IA	52305	IA	52560	IA
52030	IA	52154	IA	52306	IA	52562	IA
52031	IA	52155	IA	52307	IA	52563	IA
52032	IA	52156	IA	52308	IA	52565	IA
52033	IA	52157	IA	52309	IA	52568	IA
52035	IA	52158	IA	52310	IA	52569	IA
52036	IA	52159	IA	52312	IA	52570	IA
52037	IA	52160	IA	52313	IA	52571	IA
52038	IA	52162	IA	52315	IA	52572	IA
52040	IA	52163	IA	52316	IA	52573	IA
52041	IA	52164	IA	52318	IA	52574	IA
52042	IA	52166	IA	52320	IA	52576	IA
52043	IA	52169	IA	52321	IA	52581	IA
52044	IA	52170	IA	52323	IA	52583	IA
52047	IA	52171	IA	52325	IA	52584	IA
52048	IA	52172	IA	52326	IA	52585	IA
52049	IA	52175	IA	52329	IA	52588	IA
52050	IA	52203	IA	52330	IA	52590	IA
52052	IA	52204	IA	52332	IA	52591	IA
52053	IA	52205	IA	52334	IA	52593	IA
52054	IA	52206	IA	52335	IA	52594	IA
52055	IA	52207	IA	52337	IA	52601	IA
52056	IA	52208	IA	52339	IA	52620	IA
52057	IA	52209	IA	52342	IA	52623	IA
52060	IA	52210	IA	52345	IA	52626	IA
52064	IA	52212	IA	52346	IA	52630	IA
52065	IA	52215	IA	52347	IA	52637	IA
52066	IA	52216	IA	52348	IA	52638	IA
52069	IA	52217	IA	52349	IA	52640	IA
52070	IA	52220	IA	52351	IA	52641	IA
52071	IA	52223	IA	52354	IA	52642	IA
52072	IA	52224	IA	52355	IA	52644	IA
52074	IA	52225	IA	52358	IA	52645	IA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
52646	IA	53088	WI	53952	WI	54182	WI
52647	IA	53504	WI	53953	WI	54201	WI
52649	IA	53510	WI	53962	WI	54202	WI
52650	IA	53516	WI	53964	WI	54204	WI
52651	IA	53518	WI	53968	WI	54205	WI
52652	IA	53525	WI	54021	WI	54209	WI
52653	IA	53530	WI	54101	WI	54210	WI
52654	IA	53536	WI	54102	WI	54211	WI
52655	IA	53541	WI	54103	WI	54212	WI
52659	IA	53554	WI	54104	WI	54213	WI
52660	IA	53569	WI	54107	WI	54216	WI
52701	IA	53573	WI	54110	WI	54217	WI
52720	IA	53586	WI	54111	WI	54226	WI
52721	IA	53587	WI	54112	WI	54234	WI
52727	IA	53599	WI	54114	WI	54235	WI
52729	IA	53801	WI	54119	WI	54246	WI
52730	IA	53802	WI	54120	WI	54411	WI
52731	IA	53803	WI	54121	WI	54414	WI
52732	IA	53804	WI	54123	WI	54416	WI
52733	IA	53805	WI	54124	WI	54426	WI
52736	IA	53806	WI	54125	WI	54448	WI
52737	IA	53807	WI	54127	WI	54450	WI
52738	IA	53808	WI	54128	WI	54459	WI
52739	IA	53809	WI	54129	WI	54479	WI
52742	IA	53810	WI	54137	WI	54484	WI
52747	IA	53811	WI	54138	WI	54486	WI
52749	IA	53812	WI	54139	WI	54488	WI
52750	IA	53813	WI	54141	WI	54499	WI
52751	IA	53816	WI	54143	WI	54511	WI
52752	IA	53817	WI	54149	WI	54512	WI
52754	IA	53818	WI	54151	WI	54513	WI
52757	IA	53820	WI	54152	WI	54515	WI
52759	IA	53824	WI	54153	WI	54519	WI
52760	IA	53825	WI	54154	WI	54520	WI
52761	IA	53827	WI	54156	WI	54521	WI
52766	IA	53910	WI	54157	WI	54524	WI
52769	IA	53920	WI	54159	WI	54525	WI
52771	IA	53927	WI	54160	WI	54534	WI
52772	IA	53929	WI	54161	WI	54536	WI
52774	IA	53930	WI	54165	WI	54537	WI
52776	IA	53934	WI	54166	WI	54538	WI
52777	IA	53936	WI	54169	WI	54540	WI
52778	IA	53944	WI	54171	WI	54541	WI
53014	WI	53948	WI	54174	WI	54542	WI
53061	WI	53949	WI	54175	WI	54545	WI
53062	WI	53950	WI	54177	WI	54547	WI

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
54550	WI	54832	WI	55373	MN	56044	MN
54552	WI	54839	WI	55376	MN	56045	MN
54554	WI	54840	WI	55380	MN	56047	MN
54555	WI	54844	WI	55382	MN	56050	MN
54556	WI	54845	WI	55389	MN	56051	MN
54557	WI	54847	WI	55390	MN	56056	MN
54558	WI	54856	WI	55396	MN	56057	MN
54559	WI	54865	WI	55748	MN	56058	MN
54560	WI	54872	WI	55760	MN	56060	MN
54561	WI	54891	WI	55785	MN	56062	MN
54565	WI	54893	WI	55787	MN	56068	MN
54566	WI	54922	WI	55921	MN	56069	MN
54610	WI	54928	WI	55922	MN	56076	MN
54612	WI	54930	WI	55923	MN	56081	MN
54613	WI	54943	WI	55931	MN	56083	MN
54616	WI	54948	WI	55935	MN	56089	MN
54618	WI	54960	WI	55939	MN	56096	MN
54622	WI	54965	WI	55943	MN	56097	MN
54625	WI	54966	WI	55949	MN	56098	MN
54627	WI	54967	WI	55954	MN	56111	MN
54629	WI	54970	WI	55961	MN	56113	MN
54630	WI	54976	WI	55962	MN	56114	MN
54637	WI	54978	WI	55965	MN	56120	MN
54641	WI	54982	WI	55971	MN	56122	MN
54646	WI	54984	WI	55974	MN	56123	MN
54661	WI	55040	MN	55975	MN	56125	MN
54721	WI	55301	MN	55990	MN	56131	MN
54722	WI	55307	MN	56007	MN	56136	MN
54736	WI	55310	MN	56009	MN	56137	MN
54738	WI	55314	MN	56013	MN	56141	MN
54741	WI	55320	MN	56014	MN	56142	MN
54743	WI	55324	MN	56016	MN	56143	MN
54747	WI	55325	MN	56017	MN	56149	MN
54755	WI	55328	MN	56020	MN	56150	MN
54756	WI	55329	MN	56022	MN	56151	MN
54758	WI	55332	MN	56023	MN	56152	MN
54759	WI	55333	MN	56025	MN	56160	MN
54760	WI	55334	MN	56027	MN	56161	MN
54769	WI	55335	MN	56028	MN	56166	MN
54770	WI	55338	MN	56029	MN	56172	MN
54773	WI	55341	MN	56032	MN	56178	MN
54814	WI	55342	MN	56033	MN	56180	MN
54816	WI	55355	MN	56035	MN	56208	MN
54821	WI	55358	MN	56036	MN	56212	MN
54827	WI	55363	MN	56042	MN	56214	MN
54830	WI	55366	MN	56043	MN	56215	MN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56218	MN	56336	MN	56533	MN	56629	MN
56220	MN	56339	MN	56534	MN	56633	MN
56222	MN	56347	MN	56535	MN	56634	MN
56223	MN	56350	MN	56536	MN	56641	MN
56224	MN	56357	MN	56537	MN	56644	MN
56226	MN	56361	MN	56538	MN	56646	MN
56228	MN	56367	MN	56540	MN	56649	MN
56230	MN	56379	MN	56541	MN	56651	MN
56231	MN	56389	MN	56542	MN	56652	MN
56232	MN	56430	MN	56543	MN	56653	MN
56237	MN	56431	MN	56545	MN	56654	MN
56241	MN	56434	MN	56546	MN	56655	MN
56243	MN	56435	MN	56547	MN	56658	MN
56245	MN	56437	MN	56548	MN	56660	MN
56248	MN	56438	MN	56549	MN	56661	MN
56249	MN	56440	MN	56550	MN	56662	MN
56252	MN	56446	MN	56551	MN	56668	MN
56255	MN	56452	MN	56552	MN	56669	MN
56256	MN	56453	MN	56553	MN	56672	MN
56257	MN	56464	MN	56556	MN	56676	MN
56260	MN	56469	MN	56557	MN	56679	MN
56262	MN	56473	MN	56560	MN	56684	MN
56263	MN	56474	MN	56561	MN	56710	MN
56265	MN	56477	MN	56565	MN	56712	MN
56266	MN	56478	MN	56566	MN	56713	MN
56270	MN	56479	MN	56567	MN	56715	MN
56271	MN	56481	MN	56568	MN	56716	MN
56274	MN	56482	MN	56571	MN	56720	MN
56277	MN	56484	MN	56572	MN	56721	MN
56280	MN	56510	MN	56573	MN	56722	MN
56283	MN	56513	MN	56574	MN	56723	MN
56284	MN	56514	MN	56576	MN	56724	MN
56285	MN	56515	MN	56579	MN	56727	MN
56287	MN	56516	MN	56580	MN	56728	MN
56292	MN	56517	MN	56581	MN	56729	MN
56293	MN	56518	MN	56584	MN	56731	MN
56294	MN	56519	MN	56585	MN	56732	MN
56295	MN	56520	MN	56586	MN	56733	MN
56297	MN	56522	MN	56587	MN	56734	MN
56304	MN	56523	MN	56588	MN	56735	MN
56309	MN	56524	MN	56590	MN	56736	MN
56311	MN	56525	MN	56592	MN	56737	MN
56318	MN	56527	MN	56594	MN	56738	MN
56324	MN	56528	MN	56621	MN	56742	MN
56329	MN	56529	MN	56626	MN	56744	MN
56333	MN	56531	MN	56627	MN	56748	MN

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
56750	MN	57212	SD	57321	SD	57462	SD
56755	MN	57213	SD	57323	SD	57465	SD
56757	MN	57214	SD	57328	SD	57466	SD
56758	MN	57216	SD	57330	SD	57468	SD
56760	MN	57217	SD	57331	SD	57469	SD
56762	MN	57218	SD	57332	SD	57470	SD
57001	SD	57219	SD	57337	SD	57471	SD
57004	SD	57221	SD	57339	SD	57472	SD
57010	SD	57223	SD	57340	SD	57473	SD
57012	SD	57225	SD	57341	SD	57476	SD
57014	SD	57226	SD	57344	SD	57477	SD
57015	SD	57231	SD	57345	SD	57520	SD
57016	SD	57232	SD	57346	SD	57521	SD
57017	SD	57233	SD	57349	SD	57531	SD
57021	SD	57234	SD	57353	SD	57532	SD
57024	SD	57236	SD	57354	SD	57537	SD
57025	SD	57237	SD	57359	SD	57540	SD
57028	SD	57238	SD	57364	SD	57542	SD
57029	SD	57239	SD	57365	SD	57543	SD
57036	SD	57241	SD	57366	SD	57544	SD
57037	SD	57242	SD	57368	SD	57547	SD
57038	SD	57244	SD	57374	SD	57548	SD
57042	SD	57246	SD	57375	SD	57551	SD
57043	SD	57247	SD	57376	SD	57557	SD
57044	SD	57248	SD	57383	SD	57559	SD
57045	SD	57249	SD	57385	SD	57560	SD
57047	SD	57251	SD	57420	SD	57562	SD
57048	SD	57252	SD	57421	SD	57564	SD
57049	SD	57253	SD	57422	SD	57568	SD
57050	SD	57258	SD	57424	SD	57569	SD
57051	SD	57259	SD	57428	SD	57574	SD
57052	SD	57261	SD	57429	SD	57576	SD
57053	SD	57264	SD	57430	SD	57577	SD
57054	SD	57265	SD	57434	SD	57579	SD
57057	SD	57268	SD	57435	SD	57585	SD
57058	SD	57269	SD	57436	SD	57601	SD
57059	SD	57270	SD	57437	SD	57620	SD
57062	SD	57271	SD	57438	SD	57621	SD
57063	SD	57273	SD	57440	SD	57622	SD
57065	SD	57274	SD	57448	SD	57623	SD
57066	SD	57278	SD	57451	SD	57629	SD
57069	SD	57311	SD	57452	SD	57631	SD
57070	SD	57313	SD	57454	SD	57632	SD
57073	SD	57314	SD	57456	SD	57634	SD
57075	SD	57315	SD	57457	SD	57638	SD
57076	SD	57319	SD	57461	SD	57639	SD

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
57640	SD	58007	ND	58236	ND	58428	ND
57641	SD	58008	ND	58238	ND	58430	ND
57642	SD	58011	ND	58241	ND	58431	ND
57644	SD	58012	ND	58254	ND	58433	ND
57645	SD	58013	ND	58259	ND	58436	ND
57646	SD	58015	ND	58262	ND	58438	ND
57648	SD	58017	ND	58265	ND	58439	ND
57649	SD	58018	ND	58271	ND	58440	ND
57650	SD	58027	ND	58272	ND	58441	ND
57651	SD	58029	ND	58276	ND	58442	ND
57653	SD	58030	ND	58277	ND	58444	ND
57657	SD	58032	ND	58282	ND	58448	ND
57658	SD	58033	ND	58317	ND	58451	ND
57659	SD	58036	ND	58318	ND	58452	ND
57660	SD	58038	ND	58319	ND	58454	ND
57714	SD	58039	ND	58324	ND	58456	ND
57716	SD	58040	ND	58331	ND	58458	ND
57717	SD	58041	ND	58332	ND	58460	ND
57720	SD	58043	ND	58335	ND	58463	ND
57724	SD	58046	ND	58337	ND	58466	ND
57725	SD	58048	ND	58339	ND	58474	ND
57729	SD	58053	ND	58341	ND	58475	ND
57742	SD	58054	ND	58343	ND	58477	ND
57750	SD	58056	ND	58344	ND	58478	ND
57752	SD	58057	ND	58346	ND	58482	ND
57755	SD	58058	ND	58348	ND	58484	ND
57756	SD	58060	ND	58351	ND	58486	ND
57760	SD	58061	ND	58356	ND	58487	ND
57761	SD	58064	ND	58357	ND	58488	ND
57762	SD	58067	ND	58361	ND	58489	ND
57764	SD	58068	ND	58363	ND	58490	ND
57767	SD	58069	ND	58365	ND	58494	ND
57770	SD	58071	ND	58370	ND	58495	ND
57772	SD	58074	ND	58374	ND	58520	ND
57775	SD	58075	ND	58379	ND	58521	ND
57776	SD	58076	ND	58380	ND	58524	ND
57780	SD	58077	ND	58381	ND	58530	ND
57788	SD	58079	ND	58384	ND	58531	ND
57790	SD	58081	ND	58386	ND	58535	ND
57791	SD	58212	ND	58413	ND	58540	ND
57794	SD	58216	ND	58415	ND	58542	ND
58001	ND	58220	ND	58416	ND	58544	ND
58002	ND	58222	ND	58418	ND	58549	ND
58004	ND	58224	ND	58422	ND	58552	ND
58005	ND	58225	ND	58423	ND	58559	ND
58006	ND	58230	ND	58425	ND	58561	ND

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
58563	ND	58747	ND	59062	MT	59318	MT
58565	ND	58748	ND	59063	MT	59319	SD
58566	ND	58750	ND	59067	MT	59322	MT
58573	ND	58752	ND	59069	MT	59323	MT
58575	ND	58757	ND	59072	MT	59324	MT
58576	ND	58758	ND	59073	MT	59327	MT
58577	ND	58759	ND	59074	MT	59332	MT
58579	ND	58760	ND	59076	MT	59333	MT
58581	ND	58761	ND	59077	MT	59337	MT
58620	ND	58762	ND	59083	MT	59343	MT
58621	ND	58765	ND	59084	MT	59345	MT
58623	ND	58768	ND	59087	MT	59347	MT
58625	ND	58772	ND	59211	MT	59348	MT
58626	ND	58773	ND	59214	MT	59353	MT
58627	ND	58775	ND	59215	MT	59419	MT
58631	ND	58778	ND	59219	MT	59420	MT
58632	ND	58782	ND	59222	MT	59422	MT
58634	ND	58783	ND	59223	MT	59433	MT
58636	ND	58787	ND	59225	MT	59436	MT
58638	ND	58788	ND	59230	MT	59440	MT
58640	ND	58789	ND	59231	MT	59442	MT
58642	ND	58790	ND	59240	MT	59446	MT
58643	ND	58792	ND	59241	MT	59447	MT
58644	ND	58793	ND	59242	MT	59450	MT
58645	ND	58831	ND	59244	MT	59452	MT
58646	ND	58833	ND	59247	MT	59460	MT
58647	ND	58835	ND	59248	MT	59462	MT
58650	ND	58838	ND	59250	MT	59467	MT
58651	ND	58844	ND	59252	MT	59468	MT
58653	ND	58847	ND	59253	MT	59469	MT
58654	ND	58854	ND	59254	MT	59479	MT
58710	ND	59001	MT	59256	MT	59520	MT
58711	ND	59003	MT	59257	MT	59523	MT
58712	ND	59004	MT	59258	MT	59524	MT
58713	ND	59010	MT	59260	MT	59526	MT
58716	ND	59012	MT	59261	MT	59527	MT
58721	ND	59019	MT	59263	MT	59529	MT
58723	ND	59028	MT	59273	MT	59535	MT
58727	ND	59038	MT	59274	MT	59537	MT
58730	ND	59039	MT	59275	MT	59538	MT
58731	ND	59043	MT	59276	MT	59542	MT
58736	ND	59046	MT	59311	MT	59544	MT
58737	ND	59054	MT	59312	MT	59546	MT
58740	ND	59058	MT	59314	MT	59547	MT
58741	ND	59059	MT	59316	MT	59641	MT
58744	ND	59061	MT	59317	MT	59643	MT

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
59644	MT	60930	IL	61085	IL	61335	IL
59647	MT	60931	IL	61087	IL	61336	IL
59711	MT	60932	IL	61230	IL	61337	IL
59756	MT	60938	IL	61231	IL	61338	IL
59820	MT	60939	IL	61233	IL	61340	IL
59827	MT	60942	IL	61234	IL	61341	IL
59828	MT	60945	IL	61235	IL	61342	IL
59829	MT	60948	IL	61238	IL	61344	IL
59830	MT	60951	IL	61241	IL	61345	IL
59831	MT	60953	IL	61243	IL	61346	IL
59832	MT	60954	IL	61250	IL	61348	IL
59833	MT	60955	IL	61251	IL	61349	IL
59835	MT	60956	IL	61252	IL	61350	IL
59837	MT	60960	IL	61254	IL	61354	IL
59840	MT	60963	IL	61258	IL	61356	IL
59841	MT	60966	IL	61260	IL	61358	IL
59842	MT	60967	IL	61261	IL	61359	IL
59844	MT	60968	IL	61262	IL	61360	IL
59845	MT	60970	IL	61263	IL	61361	IL
59848	MT	60973	IL	61270	IL	61362	IL
59853	MT	60974	IL	61272	IL	61363	IL
59856	MT	61001	IL	61273	IL	61364	IL
59858	MT	61011	IL	61274	IL	61368	IL
59859	MT	61012	IL	61276	IL	61369	IL
59866	MT	61014	IL	61277	IL	61370	IL
59867	MT	61015	IL	61281	IL	61371	IL
59870	MT	61020	IL	61283	IL	61372	IL
59871	MT	61025	IL	61285	IL	61373	IL
59872	MT	61028	IL	61301	IL	61374	IL
59873	MT	61036	IL	61312	IL	61375	IL
59874	MT	61037	IL	61314	IL	61376	IL
59875	MT	61041	IL	61315	IL	61377	IL
60470	IL	61043	IL	61316	IL	61379	IL
60518	IL	61046	IL	61317	IL	61412	IL
60531	IL	61049	IL	61320	IL	61413	IL
60549	IL	61051	IL	61321	IL	61415	IL
60551	IL	61052	IL	61322	IL	61418	IL
60557	IL	61053	IL	61323	IL	61419	IL
60911	IL	61059	IL	61325	IL	61421	IL
60912	IL	61065	IL	61326	IL	61424	IL
60918	IL	61071	IL	61327	IL	61425	IL
60922	IL	61074	IL	61328	IL	61426	IL
60924	IL	61075	IL	61329	IL	61427	IL
60926	IL	61078	IL	61330	IL	61431	IL
60927	IL	61081	IL	61332	IL	61432	IL
60928	IL	61084	IL	61334	IL	61433	IL

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
61434	IL	61553	IL	61842	IL	62010	IL
61437	IL	61554	IL	61844	IL	62011	IL
61441	IL	61555	IL	61846	IL	62012	IL
61442	IL	61558	IL	61848	IL	62013	IL
61443	IL	61560	IL	61850	IL	62014	IL
61449	IL	61561	IL	61854	IL	62015	IL
61450	IL	61563	IL	61855	IL	62016	IL
61452	IL	61564	IL	61856	IL	62017	IL
61454	IL	61565	IL	61857	IL	62018	IL
61459	IL	61567	IL	61858	IL	62019	IL
61460	IL	61568	IL	61865	IL	62021	IL
61465	IL	61570	IL	61866	IL	62022	IL
61466	IL	61571	IL	61870	IL	62023	IL
61468	IL	61610	IL	61876	IL	62024	IL
61469	IL	61611	IL	61882	IL	62025	IL
61471	IL	61721	IL	61883	IL	62026	IL
61476	IL	61727	IL	61884	IL	62027	IL
61477	IL	61729	IL	61910	IL	62028	IL
61479	IL	61733	IL	61911	IL	62030	IL
61480	IL	61734	IL	61913	IL	62031	IL
61482	IL	61735	IL	61914	IL	62032	IL
61483	IL	61738	IL	61917	IL	62033	IL
61484	IL	61742	IL	61919	IL	62034	IL
61486	IL	61747	IL	61924	IL	62035	IL
61490	IL	61749	IL	61925	IL	62036	IL
61491	IL	61750	IL	61928	IL	62037	IL
61501	IL	61755	IL	61929	IL	62040	IL
61516	IL	61759	IL	61930	IL	62044	IL
61519	IL	61760	IL	61932	IL	62045	IL
61520	IL	61771	IL	61933	IL	62046	IL
61524	IL	61777	IL	61936	IL	62047	IL
61530	IL	61778	IL	61937	IL	62048	IL
61531	IL	61810	IL	61940	IL	62049	IL
61532	IL	61811	IL	61941	IL	62050	IL
61534	IL	61812	IL	61942	IL	62051	IL
61535	IL	61813	IL	61944	IL	62052	IL
61537	IL	61814	IL	61949	IL	62053	IL
61540	IL	61817	IL	61951	IL	62054	IL
61541	IL	61818	IL	61953	IL	62056	IL
61542	IL	61830	IL	61955	IL	62058	IL
61543	IL	61831	IL	61956	IL	62060	IL
61544	IL	61832	IL	61957	IL	62061	IL
61545	IL	61833	IL	62001	IL	62062	IL
61546	IL	61834	IL	62002	IL	62063	IL
61548	IL	61839	IL	62006	IL	62065	IL
61550	IL	61841	IL	62009	IL	62067	IL

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62069	IL	62313	IL	62433	IL	62556	IL
62070	IL	62314	IL	62434	IL	62557	IL
62074	IL	62316	IL	62435	IL	62560	IL
62075	IL	62318	IL	62436	IL	62565	IL
62076	IL	62319	IL	62438	IL	62567	IL
62077	IL	62321	IL	62439	IL	62568	IL
62078	IL	62323	IL	62441	IL	62570	IL
62079	IL	62329	IL	62442	IL	62571	IL
62080	IL	62330	IL	62444	IL	62572	IL
62081	IL	62334	IL	62446	IL	62610	IL
62082	IL	62336	IL	62447	IL	62611	IL
62083	IL	62340	IL	62448	IL	62612	IL
62084	IL	62341	IL	62449	IL	62613	IL
62085	IL	62343	IL	62451	IL	62617	IL
62086	IL	62344	IL	62454	IL	62618	IL
62087	IL	62345	IL	62458	IL	62621	IL
62088	IL	62352	IL	62459	IL	62622	IL
62089	IL	62353	IL	62460	IL	62624	IL
62090	IL	62354	IL	62462	IL	62626	IL
62091	IL	62355	IL	62463	IL	62627	IL
62092	IL	62356	IL	62464	IL	62630	IL
62093	IL	62357	IL	62465	IL	62633	IL
62094	IL	62358	IL	62466	IL	62639	IL
62095	IL	62361	IL	62468	IL	62640	IL
62097	IL	62362	IL	62471	IL	62642	IL
62098	IL	62363	IL	62474	IL	62644	IL
62215	IL	62366	IL	62475	IL	62649	IL
62218	IL	62367	IL	62476	IL	62655	IL
62234	IL	62370	IL	62477	IL	62659	IL
62238	IL	62373	IL	62478	IL	62662	IL
62245	IL	62375	IL	62479	IL	62663	IL
62246	IL	62378	IL	62480	IL	62664	IL
62247	IL	62379	IL	62481	IL	62667	IL
62249	IL	62380	IL	62510	IL	62672	IL
62262	IL	62410	IL	62511	IL	62673	IL
62265	IL	62413	IL	62517	IL	62674	IL
62266	IL	62415	IL	62531	IL	62675	IL
62273	IL	62417	IL	62533	IL	62681	IL
62274	IL	62418	IL	62534	IL	62682	IL
62275	IL	62420	IL	62538	IL	62683	IL
62281	IL	62422	IL	62540	IL	62685	IL
62284	IL	62423	IL	62546	IL	62686	IL
62294	IL	62427	IL	62547	IL	62688	IL
62310	IL	62428	IL	62550	IL	62690	IL
62311	IL	62431	IL	62553	IL	62691	IL
62312	IL	62432	IL	62555	IL	62694	IL

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
62801	IL	62862	IL	62953	IL	63052	MO
62805	IL	62863	IL	62954	IL	63053	MO
62806	IL	62865	IL	62956	IL	63056	MO
62807	IL	62867	IL	62957	IL	63057	MO
62809	IL	62869	IL	62960	IL	63060	MO
62811	IL	62870	IL	62962	IL	63061	MO
62812	IL	62871	IL	62963	IL	63065	MO
62815	IL	62874	IL	62964	IL	63066	MO
62817	IL	62875	IL	62965	IL	63069	MO
62818	IL	62878	IL	62967	IL	63070	MO
62819	IL	62879	IL	62969	IL	63071	MO
62820	IL	62880	IL	62970	IL	63072	MO
62821	IL	62881	IL	62972	IL	63079	MO
62822	IL	62882	IL	62973	IL	63330	MO
62823	IL	62884	IL	62976	IL	63333	MO
62824	IL	62885	IL	62977	IL	63334	MO
62825	IL	62886	IL	62979	IL	63336	MO
62827	IL	62887	IL	62983	IL	63339	MO
62828	IL	62888	IL	62984	IL	63342	MO
62829	IL	62890	IL	62985	IL	63343	MO
62832	IL	62891	IL	62987	IL	63344	MO
62833	IL	62892	IL	62988	IL	63347	MO
62834	IL	62893	IL	62990	IL	63349	MO
62835	IL	62895	IL	62991	IL	63350	MO
62836	IL	62896	IL	62992	IL	63351	MO
62837	IL	62897	IL	62993	IL	63353	MO
62838	IL	62899	IL	62995	IL	63357	MO
62839	IL	62908	IL	62996	IL	63359	MO
62840	IL	62909	IL	62997	IL	63361	MO
62842	IL	62910	IL	62999	IL	63362	MO
62843	IL	62912	IL	63010	MO	63363	MO
62844	IL	62913	IL	63012	MO	63369	MO
62847	IL	62914	IL	63015	MO	63370	MO
62849	IL	62917	IL	63016	MO	63377	MO
62850	IL	62923	IL	63019	MO	63378	MO
62851	IL	62928	IL	63020	MO	63379	MO
62852	IL	62930	IL	63023	MO	63381	MO
62853	IL	62934	IL	63028	MO	63383	MO
62854	IL	62935	IL	63030	MO	63384	MO
62855	IL	62938	IL	63037	MO	63387	MO
62856	IL	62939	IL	63041	MO	63389	MO
62857	IL	62941	IL	63047	MO	63390	MO
62858	IL	62943	IL	63048	MO	63430	MO
62859	IL	62944	IL	63049	MO	63431	MO
62860	IL	62946	IL	63050	MO	63432	MO
62861	IL	62947	IL	63051	MO	63433	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
63434	MO	63552	MO	63823	MO	63951	MO
63435	MO	63555	MO	63825	MO	63952	MO
63436	MO	63556	MO	63826	MO	63953	MO
63437	MO	63558	MO	63827	MO	63955	MO
63438	MO	63560	MO	63828	MO	63956	MO
63439	MO	63563	MO	63830	MO	63957	MO
63440	MO	63565	MO	63833	MO	63960	MO
63441	MO	63566	MO	63834	MO	63963	MO
63442	MO	63567	MO	63838	MO	63964	MO
63443	MO	63622	MO	63839	MO	63965	MO
63445	MO	63625	MO	63840	MO	63966	MO
63446	MO	63627	MO	63841	MO	63967	MO
63447	MO	63629	MO	63845	MO	64001	MO
63448	MO	63630	MO	63846	MO	64011	MO
63450	MO	63631	MO	63848	MO	64012	MO
63451	MO	63632	MO	63849	MO	64017	MO
63452	MO	63633	MO	63850	MO	64020	MO
63453	MO	63638	MO	63851	MO	64021	MO
63456	MO	63645	MO	63853	MO	64022	MO
63457	MO	63648	MO	63860	MO	64037	MO
63458	MO	63654	MO	63862	MO	64062	MO
63459	MO	63655	MO	63866	MO	64067	MO
63460	MO	63660	MO	63867	MO	64071	MO
63462	MO	63661	MO	63868	MO	64074	MO
63464	MO	63662	MO	63869	MO	64076	MO
63465	MO	63664	MO	63870	MO	64077	MO
63466	MO	63665	MO	63871	MO	64078	MO
63467	MO	63666	MO	63873	MO	64079	MO
63468	MO	63670	MO	63874	MO	64080	MO
63469	MO	63673	MO	63877	MO	64083	MO
63472	MO	63674	MO	63878	MO	64084	MO
63473	MO	63730	MO	63879	MO	64090	MO
63474	MO	63735	MO	63881	MO	64096	MO
63530	MO	63738	MO	63882	MO	64097	MO
63531	MO	63750	MO	63931	MO	64098	MO
63532	MO	63751	MO	63934	MO	64402	MO
63534	MO	63753	MO	63935	MO	64420	MO
63537	MO	63760	MO	63936	MO	64421	MO
63538	MO	63763	MO	63937	MO	64422	MO
63539	MO	63764	MO	63939	MO	64424	MO
63543	MO	63772	MO	63941	MO	64426	MO
63544	MO	63781	MO	63942	MO	64427	MO
63545	MO	63782	MO	63943	MO	64430	MO
63547	MO	63787	MO	63944	MO	64436	MO
63549	MO	63820	MO	63947	MO	64437	MO
63551	MO	63822	MO	63950	MO	64438	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
64441	MO	64642	MO	64747	MO	65025	MO
64442	MO	64643	MO	64750	MO	65026	MO
64447	MO	64644	MO	64751	MO	65031	MO
64449	MO	64645	MO	64752	MO	65034	MO
64451	MO	64646	MO	64756	MO	65035	MO
64453	MO	64647	MO	64765	MO	65037	MO
64454	MO	64648	MO	64767	MO	65038	MO
64456	MO	64649	MO	64771	MO	65042	MO
64458	MO	64650	MO	64772	MO	65046	MO
64459	MO	64652	MO	64777	MO	65047	MO
64463	MO	64654	MO	64778	MO	65048	MO
64465	MO	64655	MO	64779	MO	65050	MO
64466	MO	64656	MO	64780	MO	65051	MO
64467	MO	64657	MO	64783	MO	65054	MO
64469	MO	64660	MO	64784	MO	65055	MO
64470	MO	64661	MO	64790	MO	65058	MO
64471	MO	64664	MO	64831	MO	65064	MO
64473	MO	64667	MO	64833	MO	65069	MO
64474	MO	64668	MO	64836	MO	65072	MO
64480	MO	64670	MO	64840	MO	65075	MO
64481	MO	64671	MO	64842	MO	65078	MO
64483	MO	64672	MO	64843	MO	65081	MO
64485	MO	64673	MO	64844	MO	65082	MO
64486	MO	64676	MO	64847	MO	65083	MO
64489	MO	64679	MO	64848	MO	65084	MO
64490	MO	64680	MO	64853	MO	65085	MO
64492	MO	64681	MO	64854	MO	65230	MO
64493	MO	64682	MO	64856	MO	65236	MO
64494	MO	64683	MO	64858	MO	65240	MO
64497	MO	64686	MO	64859	MO	65246	MO
64499	MO	64687	MO	64861	MO	65247	MO
64601	MO	64688	MO	64862	MO	65248	MO
64620	MO	64689	MO	64863	MO	65250	MO
64622	MO	64720	MO	64864	MO	65254	MO
64623	MO	64722	MO	64865	MO	65258	MO
64624	MO	64723	MO	64866	MO	65261	MO
64625	MO	64725	MO	64868	MO	65263	MO
64632	MO	64728	MO	64873	MO	65274	MO
64633	MO	64730	MO	64874	MO	65275	MO
64635	MO	64734	MO	65001	MO	65281	MO
64636	MO	64741	MO	65011	MO	65282	MO
64637	MO	64742	MO	65013	MO	65283	MO
64638	MO	64743	MO	65016	MO	65286	MO
64639	MO	64744	MO	65017	MO	65301	MO
64640	MO	64745	MO	65018	MO	65302	MO
64641	MO	64746	MO	65024	MO	65325	MO

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
65326	MO	65564	MO	65661	MO	65746	MO
65327	MO	65565	MO	65662	MO	65747	MO
65329	MO	65567	MO	65664	MO	65752	MO
65332	MO	65570	MO	65666	MO	65753	MO
65333	MO	65571	MO	65667	MO	65754	MO
65334	MO	65580	MO	65668	MO	65755	MO
65335	MO	65582	MO	65669	MO	65756	MO
65337	MO	65586	MO	65675	MO	65760	MO
65338	MO	65588	MO	65676	MO	65761	MO
65345	MO	65589	MO	65681	MO	65762	MO
65350	MO	65590	MO	65682	MO	65764	MO
65354	MO	65603	MO	65685	MO	65766	MO
65355	MO	65605	MO	65686	MO	65767	MO
65433	MO	65606	MO	65688	MO	65768	MO
65438	MO	65608	MO	65689	MO	65769	MO
65440	MO	65609	MO	65690	MO	65772	MO
65441	MO	65610	MO	65692	MO	65773	MO
65443	MO	65611	MO	65701	MO	65774	MO
65444	MO	65618	MO	65702	MO	65775	MO
65446	MO	65620	MO	65704	MO	65776	MO
65449	MO	65622	MO	65705	MO	65777	MO
65453	MO	65623	MO	65706	MO	65778	MO
65456	MO	65624	MO	65707	MO	65779	MO
65463	MO	65625	MO	65708	MO	65783	MO
65464	MO	65626	MO	65711	MO	65784	MO
65466	MO	65629	MO	65712	MO	65785	MO
65468	MO	65630	MO	65713	MO	65788	MO
65470	MO	65631	MO	65714	MO	65789	MO
65479	MO	65632	MO	65715	MO	65790	MO
65483	MO	65633	MO	65717	MO	65791	MO
65484	MO	65634	MO	65720	MO	65793	MO
65486	MO	65635	MO	65721	MO	66002	KS
65501	MO	65636	MO	65722	MO	66007	KS
65532	MO	65637	MO	65723	MO	66008	KS
65535	MO	65638	MO	65724	MO	66010	KS
65536	MO	65641	MO	65725	MO	66013	KS
65540	MO	65644	MO	65728	MO	66014	KS
65541	MO	65646	MO	65729	MO	66015	KS
65542	MO	65647	MO	65730	MO	66016	KS
65543	MO	65652	MO	65732	MO	66017	KS
65546	MO	65654	MO	65734	MO	66023	KS
65548	MO	65655	MO	65735	MO	66024	KS
65552	MO	65656	MO	65737	MO	66026	KS
65555	MO	65657	MO	65741	MO	66032	KS
65557	MO	65658	MO	65742	MO	66033	KS
65560	MO	65660	MO	65745	MO	66035	KS

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
66036	KS	66418	KS	66748	KS	66933	KS
66039	KS	66419	KS	66749	KS	66936	KS
66040	KS	66423	KS	66751	KS	66937	KS
66041	KS	66427	KS	66755	KS	66938	KS
66042	KS	66428	KS	66757	KS	66941	KS
66052	KS	66429	KS	66758	KS	66942	KS
66053	KS	66431	KS	66759	KS	66943	KS
66054	KS	66436	KS	66761	KS	66944	KS
66056	KS	66438	KS	66767	KS	66945	KS
66058	KS	66440	KS	66770	KS	66946	KS
66060	KS	66451	KS	66772	KS	66948	KS
66064	KS	66501	KS	66773	KS	66949	KS
66066	KS	66507	KS	66777	KS	66951	KS
66067	KS	66508	KS	66778	KS	66952	KS
66070	KS	66509	KS	66781	KS	66953	KS
66071	KS	66510	KS	66782	KS	66955	KS
66072	KS	66512	KS	66783	KS	66956	KS
66073	KS	66516	KS	66834	KS	66958	KS
66075	KS	66518	KS	66838	KS	66962	KS
66076	KS	66522	KS	66839	KS	66963	KS
66077	KS	66523	KS	66840	KS	66967	KS
66078	KS	66524	KS	66843	KS	66968	KS
66079	KS	66526	KS	66845	KS	66970	KS
66080	KS	66528	KS	66846	KS	67002	KS
66086	KS	66534	KS	66849	KS	67003	KS
66087	KS	66537	KS	66850	KS	67004	KS
66088	KS	66538	KS	66851	KS	67009	KS
66090	KS	66540	KS	66852	KS	67010	KS
66091	KS	66541	KS	66853	KS	67013	KS
66092	KS	66543	KS	66855	KS	67017	KS
66093	KS	66544	KS	66856	KS	67018	KS
66094	KS	66548	KS	66857	KS	67022	KS
66095	KS	66550	KS	66858	KS	67024	KS
66097	KS	66552	KS	66859	KS	67029	KS
66401	KS	66555	KS	66860	KS	67031	KS
66403	KS	66710	KS	66861	KS	67035	KS
66404	KS	66713	KS	66862	KS	67036	KS
66406	KS	66714	KS	66863	KS	67039	KS
66408	KS	66717	KS	66866	KS	67045	KS
66411	KS	66725	KS	66869	KS	67047	KS
66412	KS	66727	KS	66870	KS	67049	KS
66413	KS	66728	KS	66871	KS	67051	KS
66414	KS	66732	KS	66872	KS	67053	KS
66415	KS	66736	KS	66873	KS	67054	KS
66416	KS	66739	KS	66901	KS	67058	KS
66417	KS	66742	KS	66932	KS	67059	KS

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
67063	KS	67449	KS	67623	KS	67839	KS
67068	KS	67450	KS	67625	KS	67841	KS
67073	KS	67451	KS	67626	KS	67844	KS
67103	KS	67454	KS	67628	KS	67849	KS
67105	KS	67455	KS	67629	KS	67850	KS
67106	KS	67457	KS	67632	KS	67853	KS
67109	KS	67459	KS	67634	KS	67854	KS
67111	KS	67466	KS	67635	KS	67857	KS
67112	KS	67473	KS	67638	KS	67861	KS
67118	KS	67474	KS	67640	KS	67863	KS
67119	KS	67475	KS	67642	KS	67864	KS
67120	KS	67480	KS	67643	KS	67867	KS
67122	KS	67481	KS	67645	KS	67869	KS
67123	KS	67482	KS	67648	KS	67878	KS
67127	KS	67483	KS	67649	KS	67951	KS
67133	KS	67490	KS	67650	KS	67952	KS
67137	KS	67492	KS	67651	KS	68001	NE
67140	KS	67511	KS	67653	KS	68003	NE
67142	KS	67512	KS	67654	KS	68014	NE
67144	KS	67513	KS	67657	KS	68015	NE
67150	KS	67519	KS	67658	KS	68016	NE
67152	KS	67520	KS	67659	KS	68017	NE
67154	KS	67524	KS	67663	KS	68018	NE
67155	KS	67525	KS	67665	KS	68019	NE
67159	KS	67526	KS	67669	KS	68020	NE
67334	KS	67530	KS	67673	KS	68023	NE
67345	KS	67544	KS	67675	KS	68025	NE
67346	KS	67545	KS	67730	KS	68026	NE
67349	KS	67547	KS	67731	KS	68030	NE
67352	KS	67548	KS	67733	KS	68031	NE
67353	KS	67552	KS	67735	KS	68033	NE
67355	KS	67553	KS	67739	KS	68034	NE
67360	KS	67554	KS	67741	KS	68036	NE
67361	KS	67556	KS	67744	KS	68037	NE
67410	KS	67557	KS	67745	KS	68038	NE
67417	KS	67559	KS	67747	KS	68039	NE
67418	KS	67563	KS	67748	KS	68040	NE
67423	KS	67564	KS	67749	KS	68041	NE
67427	KS	67565	KS	67756	KS	68042	NE
67431	KS	67567	KS	67758	KS	68044	NE
67437	KS	67573	KS	67761	KS	68045	NE
67438	KS	67575	KS	67762	KS	68047	NE
67439	KS	67576	KS	67764	KS	68048	NE
67441	KS	67578	KS	67835	KS	68050	NE
67444	KS	67579	KS	67836	KS	68055	NE
67445	KS	67622	KS	67837	KS	68057	NE

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
68058	NE	68350	NE	68444	NE	68726	NE
68061	NE	68351	NE	68445	NE	68727	NE
68062	NE	68352	NE	68447	NE	68728	NE
68063	NE	68354	NE	68450	NE	68729	NE
68065	NE	68355	NE	68452	NE	68730	NE
68066	NE	68357	NE	68453	NE	68731	NE
68067	NE	68359	NE	68455	NE	68732	NE
68070	NE	68360	NE	68456	NE	68733	NE
68071	NE	68361	NE	68457	NE	68736	NE
68072	NE	68362	NE	68458	NE	68739	NE
68073	NE	68364	NE	68463	NE	68740	NE
68301	NE	68365	NE	68464	NE	68741	NE
68303	NE	68366	NE	68465	NE	68743	NE
68304	NE	68370	NE	68466	NE	68745	NE
68305	NE	68374	NE	68621	NE	68749	NE
68307	NE	68375	NE	68622	NE	68751	NE
68309	NE	68376	NE	68623	NE	68753	NE
68310	NE	68377	NE	68624	NE	68756	NE
68313	NE	68378	NE	68626	NE	68757	NE
68314	NE	68380	NE	68628	NE	68759	NE
68315	NE	68381	NE	68632	NE	68760	NE
68318	NE	68403	NE	68633	NE	68761	NE
68320	NE	68405	NE	68635	NE	68764	NE
68321	NE	68406	NE	68636	NE	68768	NE
68322	NE	68407	NE	68637	NE	68770	NE
68323	NE	68409	NE	68638	NE	68771	NE
68325	NE	68413	NE	68640	NE	68772	NE
68326	NE	68414	NE	68648	NE	68773	NE
68327	NE	68415	NE	68649	NE	68774	NE
68328	NE	68416	NE	68651	NE	68776	NE
68329	NE	68420	NE	68654	NE	68778	NE
68330	NE	68421	NE	68658	NE	68779	NE
68331	NE	68422	NE	68662	NE	68783	NE
68332	NE	68423	NE	68663	NE	68784	NE
68333	NE	68424	NE	68664	NE	68785	NE
68335	NE	68429	NE	68665	NE	68786	NE
68337	NE	68431	NE	68666	NE	68787	NE
68338	NE	68433	NE	68667	NE	68789	NE
68340	NE	68434	NE	68669	NE	68790	NE
68341	NE	68436	NE	68710	NE	68792	NE
68342	NE	68437	NE	68714	NE	68815	NE
68343	NE	68439	NE	68717	NE	68816	NE
68345	NE	68440	NE	68718	NE	68817	NE
68347	NE	68441	NE	68720	NE	68820	NE
68348	NE	68442	NE	68723	NE	68821	NE
68349	NE	68443	NE	68724	NE	68823	NE

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68826	NE	68957	NE	69140	NE	70044	LA
68827	NE	68960	NE	69142	NE	70046	LA
68831	NE	68961	NE	69145	NE	70047	LA
68833	NE	68964	NE	69147	NE	70050	LA
68834	NE	68966	NE	69148	NE	70051	LA
68835	NE	68967	NE	69150	NE	70057	LA
68837	NE	68969	NE	69154	NE	70066	LA
68838	NE	68970	NE	69157	NE	70070	LA
68842	NE	68971	NE	69161	NE	70075	LA
68844	NE	68972	NE	69163	NE	70076	LA
68850	NE	68974	NE	69166	NE	70078	LA
68852	NE	68975	NE	69167	NE	70079	LA
68853	NE	68977	NE	69168	NE	70080	LA
68859	NE	68978	NE	69171	NE	70081	LA
68862	NE	68979	NE	69190	NE	70082	LA
68863	NE	68980	NE	69201	NE	70083	LA
68864	NE	68981	NE	69210	NE	70084	LA
68871	NE	69001	NE	69211	NE	70085	LA
68872	NE	69020	NE	69212	NE	70087	LA
68873	NE	69022	NE	69214	NE	70091	LA
68875	NE	69024	NE	69216	NE	70092	LA
68878	NE	69025	NE	69217	NE	70339	LA
68879	NE	69026	NE	69218	NE	70340	LA
68882	NE	69028	NE	69219	NE	70341	LA
68920	NE	69029	NE	69220	NE	70342	LA
68922	NE	69031	NE	69221	NE	70343	LA
68926	NE	69032	NE	69301	NE	70344	LA
68928	NE	69034	NE	69331	NE	70352	LA
68929	NE	69036	NE	69333	NE	70353	LA
68930	NE	69038	NE	69334	NE	70356	LA
68932	NE	69039	NE	69336	NE	70359	LA
68933	NE	69040	NE	69345	NE	70360	LA
68934	NE	69042	NE	69346	NE	70361	LA
68935	NE	69043	NE	69348	NE	70363	LA
68936	NE	69044	NE	69350	NE	70364	LA
68938	NE	69046	NE	69366	NE	70372	LA
68939	NE	69121	NE	70030	LA	70377	LA
68941	NE	69122	NE	70031	LA	70380	LA
68942	NE	69125	NE	70032	LA	70381	LA
68943	NE	69128	NE	70037	LA	70390	LA
68944	NE	69129	NE	70038	LA	70391	LA
68946	NE	69130	NE	70039	LA	70392	LA
68947	NE	69133	NE	70040	LA	70393	LA
68948	NE	69134	NE	70041	LA	70395	LA
68952	NE	69135	NE	70042	LA	70397	LA
68954	NE	69138	NE	70043	LA	70426	LA

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70427	LA	70640	LA	70767	LA	71071	LA
70429	LA	70643	LA	70772	LA	71072	LA
70438	LA	70644	LA	70773	LA	71073	LA
70449	LA	70645	LA	70776	LA	71075	LA
70450	LA	70648	LA	70777	LA	71078	LA
70462	LA	70650	LA	70780	LA	71079	LA
70467	LA	70651	LA	70781	LA	71080	LA
70510	LA	70654	LA	70783	LA	71082	LA
70511	LA	70655	LA	70785	LA	71218	LA
70512	LA	70656	LA	70786	LA	71219	LA
70514	LA	70658	LA	70788	LA	71220	LA
70516	LA	70659	LA	70789	LA	71221	LA
70517	LA	70706	LA	71001	LA	71222	LA
70519	LA	70710	LA	71002	LA	71223	LA
70521	LA	70711	LA	71003	LA	71226	LA
70522	LA	70715	LA	71008	LA	71229	LA
70523	LA	70716	LA	71016	LA	71230	LA
70525	LA	70717	LA	71018	LA	71232	LA
70526	LA	70719	LA	71019	LA	71233	LA
70527	LA	70720	LA	71021	LA	71234	LA
70528	LA	70721	LA	71023	LA	71237	LA
70531	LA	70722	LA	71024	LA	71241	LA
70532	LA	70726	LA	71025	LA	71242	LA
70533	LA	70727	LA	71027	LA	71243	LA
70534	LA	70729	LA	71028	LA	71247	LA
70537	LA	70730	LA	71030	LA	71249	LA
70538	LA	70732	LA	71031	LA	71250	LA
70540	LA	70733	LA	71032	LA	71251	LA
70542	LA	70736	LA	71034	LA	71253	LA
70543	LA	70740	LA	71036	LA	71254	LA
70546	LA	70744	LA	71038	LA	71256	LA
70548	LA	70747	LA	71039	LA	71259	LA
70549	LA	70748	LA	71040	LA	71260	LA
70555	LA	70749	LA	71045	LA	71261	LA
70556	LA	70752	LA	71046	LA	71263	LA
70559	LA	70753	LA	71048	LA	71264	LA
70575	LA	70754	LA	71049	LA	71266	LA
70578	LA	70755	LA	71050	LA	71268	LA
70581	LA	70756	LA	71052	LA	71269	LA
70582	LA	70757	LA	71055	LA	71276	LA
70584	LA	70759	LA	71058	LA	71277	LA
70591	LA	70760	LA	71063	LA	71279	LA
70631	LA	70761	LA	71065	LA	71282	LA
70632	LA	70762	LA	71066	LA	71284	LA
70638	LA	70764	LA	71068	LA	71286	LA
70639	LA	70765	LA	71070	LA	71295	LA

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
71316	LA	71426	LA	71659	AR	71841	AR
71320	LA	71428	LA	71660	AR	71842	AR
71322	LA	71429	LA	71661	AR	71844	AR
71323	LA	71432	LA	71662	AR	71845	AR
71324	LA	71434	LA	71663	AR	71846	AR
71326	LA	71435	LA	71665	AR	71851	AR
71327	LA	71439	LA	71666	AR	71852	AR
71329	LA	71441	LA	71667	AR	71853	AR
71330	LA	71443	LA	71670	AR	71854	AR
71331	LA	71446	LA	71671	AR	71857	AR
71333	LA	71449	LA	71674	AR	71858	AR
71334	LA	71450	LA	71676	AR	71859	AR
71336	LA	71452	LA	71678	AR	71860	AR
71339	LA	71454	LA	71701	AR	71861	AR
71340	LA	71456	LA	71711	AR	71864	AR
71341	LA	71457	LA	71720	AR	71865	AR
71342	LA	71458	LA	71721	AR	71866	AR
71343	LA	71459	LA	71722	AR	71901	AR
71350	LA	71460	LA	71726	AR	71902	AR
71351	LA	71461	LA	71728	AR	71903	AR
71354	LA	71462	LA	71740	AR	71909	AR
71355	LA	71463	LA	71743	AR	71910	AR
71357	LA	71465	LA	71744	AR	71913	AR
71362	LA	71467	LA	71745	AR	71914	AR
71363	LA	71468	LA	71751	AR	71920	AR
71366	LA	71469	LA	71752	AR	71921	AR
71368	LA	71474	LA	71753	AR	71922	AR
71369	LA	71475	LA	71754	AR	71923	AR
71371	LA	71479	LA	71764	AR	71929	AR
71373	LA	71480	LA	71766	AR	71932	AR
71375	LA	71486	LA	71770	AR	71933	AR
71377	LA	71496	LA	71772	AR	71935	AR
71378	LA	71497	LA	71820	AR	71937	AR
71401	LA	71630	AR	71822	AR	71940	AR
71403	LA	71631	AR	71823	AR	71941	AR
71406	LA	71635	AR	71826	AR	71942	AR
71407	LA	71639	AR	71827	AR	71943	AR
71411	LA	71642	AR	71828	AR	71944	AR
71414	LA	71643	AR	71832	AR	71945	AR
71415	LA	71644	AR	71833	AR	71949	AR
71416	LA	71646	AR	71834	AR	71950	AR
71417	LA	71647	AR	71835	AR	71951	AR
71418	LA	71651	AR	71836	AR	71952	AR
71419	LA	71652	AR	71837	AR	71953	AR
71423	LA	71654	AR	71839	AR	71956	AR
71425	LA	71658	AR	71840	AR	71957	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
71958	AR	72046	AR	72133	AR	72352	AR
71959	AR	72048	AR	72134	AR	72354	AR
71960	AR	72051	AR	72136	AR	72358	AR
71961	AR	72052	AR	72137	AR	72359	AR
71962	AR	72055	AR	72139	AR	72360	AR
71964	AR	72057	AR	72140	AR	72365	AR
71965	AR	72059	AR	72141	AR	72368	AR
71966	AR	72060	AR	72143	AR	72370	AR
71968	AR	72063	AR	72145	AR	72372	AR
71969	AR	72064	AR	72149	AR	72373	AR
71970	AR	72065	AR	72150	AR	72377	AR
71971	AR	72066	AR	72153	AR	72379	AR
71972	AR	72067	AR	72156	AR	72385	AR
71973	AR	72068	AR	72157	AR	72386	AR
71998	AR	72069	AR	72160	AR	72387	AR
72001	AR	72070	AR	72166	AR	72391	AR
72002	AR	72071	AR	72168	AR	72392	AR
72003	AR	72072	AR	72170	AR	72394	AR
72006	AR	72073	AR	72176	AR	72395	AR
72007	AR	72074	AR	72178	AR	72396	AR
72010	AR	72080	AR	72179	AR	72410	AR
72011	AR	72081	AR	72189	AR	72412	AR
72012	AR	72082	AR	72310	AR	72413	AR
72013	AR	72083	AR	72311	AR	72415	AR
72016	AR	72084	AR	72313	AR	72422	AR
72017	AR	72085	AR	72315	AR	72424	AR
72020	AR	72086	AR	72316	AR	72425	AR
72021	AR	72087	AR	72319	AR	72426	AR
72022	AR	72088	AR	72320	AR	72428	AR
72023	AR	72101	AR	72321	AR	72429	AR
72024	AR	72102	AR	72322	AR	72430	AR
72025	AR	72103	AR	72324	AR	72432	AR
72026	AR	72104	AR	72326	AR	72433	AR
72027	AR	72105	AR	72329	AR	72434	AR
72028	AR	72107	AR	72330	AR	72435	AR
72029	AR	72108	AR	72331	AR	72436	AR
72030	AR	72110	AR	72335	AR	72438	AR
72031	AR	72121	AR	72336	AR	72439	AR
72036	AR	72123	AR	72338	AR	72440	AR
72037	AR	72125	AR	72340	AR	72441	AR
72038	AR	72126	AR	72341	AR	72442	AR
72040	AR	72127	AR	72346	AR	72443	AR
72041	AR	72128	AR	72347	AR	72444	AR
72042	AR	72129	AR	72348	AR	72445	AR
72044	AR	72130	AR	72350	AR	72449	AR
72045	AR	72131	AR	72351	AR	72450	AR

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
72451	AR	72561	AR	72680	AR	72951	AR
72453	AR	72565	AR	72683	AR	72958	AR
72454	AR	72566	AR	72685	AR	73001	OK
72455	AR	72567	AR	72686	AR	73005	OK
72456	AR	72569	AR	72687	AR	73006	OK
72457	AR	72572	AR	72718	AR	73009	OK
72458	AR	72573	AR	72721	AR	73010	OK
72459	AR	72577	AR	72738	AR	73012	OK
72460	AR	72581	AR	72740	AR	73015	OK
72461	AR	72584	AR	72742	AR	73016	OK
72462	AR	72585	AR	72745	AR	73017	OK
72464	AR	72587	AR	72752	AR	73021	OK
72465	AR	72610	AR	72760	AR	73022	OK
72466	AR	72617	AR	72773	AR	73024	OK
72469	AR	72619	AR	72776	AR	73027	OK
72470	AR	72623	AR	72820	AR	73028	OK
72472	AR	72624	AR	72821	AR	73029	OK
72474	AR	72626	AR	72824	AR	73031	OK
72475	AR	72628	AR	72826	AR	73033	OK
72476	AR	72629	AR	72827	AR	73036	OK
72478	AR	72634	AR	72828	AR	73038	OK
72479	AR	72635	AR	72829	AR	73040	OK
72482	AR	72636	AR	72833	AR	73041	OK
72512	AR	72639	AR	72834	AR	73042	OK
72513	AR	72640	AR	72835	AR	73043	OK
72517	AR	72641	AR	72838	AR	73044	OK
72519	AR	72642	AR	72841	AR	73047	OK
72521	AR	72645	AR	72842	AR	73048	OK
72523	AR	72648	AR	72851	AR	73050	OK
72525	AR	72650	AR	72853	AR	73052	OK
72528	AR	72651	AR	72855	AR	73053	OK
72529	AR	72653	AR	72856	AR	73055	OK
72530	AR	72654	AR	72857	AR	73056	OK
72532	AR	72655	AR	72860	AR	73057	OK
72533	AR	72657	AR	72863	AR	73058	OK
72536	AR	72658	AR	72865	AR	73061	OK
72537	AR	72659	AR	72924	AR	73062	OK
72540	AR	72661	AR	72926	AR	73063	OK
72542	AR	72663	AR	72927	AR	73065	OK
72543	AR	72666	AR	72928	AR	73073	OK
72544	AR	72668	AR	72930	AR	73074	OK
72545	AR	72669	AR	72933	AR	73075	OK
72546	AR	72670	AR	72943	AR	73077	OK
72555	AR	72672	AR	72944	AR	73078	OK
72556	AR	72675	AR	72949	AR	73080	OK
72560	AR	72677	AR	72950	AR	73090	OK

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
73093	OK	73569	OK	73750	OK	74039	OK
73094	OK	73570	OK	73755	OK	74041	OK
73095	OK	73572	OK	73756	OK	74042	OK
73098	OK	73573	OK	73757	OK	74044	OK
73425	OK	73575	OK	73758	OK	74047	OK
73430	OK	73622	OK	73759	OK	74048	OK
73432	OK	73624	OK	73760	OK	74051	OK
73433	OK	73626	OK	73761	OK	74052	OK
73434	OK	73628	OK	73762	OK	74053	OK
73439	OK	73632	OK	73763	OK	74054	OK
73440	OK	73638	OK	73764	OK	74056	OK
73441	OK	73641	OK	73766	OK	74060	OK
73442	OK	73642	OK	73768	OK	74061	OK
73446	OK	73646	OK	73770	OK	74066	OK
73447	OK	73647	OK	73771	OK	74067	OK
73448	OK	73650	OK	73772	OK	74068	OK
73449	OK	73651	OK	73835	OK	74071	OK
73450	OK	73654	OK	73838	OK	74072	OK
73453	OK	73655	OK	73842	OK	74079	OK
73455	OK	73658	OK	73844	OK	74080	OK
73456	OK	73659	OK	73847	OK	74082	OK
73459	OK	73660	OK	73859	OK	74083	OK
73460	OK	73661	OK	73860	OK	74084	OK
73461	OK	73663	OK	73931	OK	74131	OK
73476	OK	73664	OK	73932	OK	74301	OK
73491	OK	73666	OK	73933	OK	74330	OK
73520	OK	73667	OK	73937	OK	74331	OK
73529	OK	73716	OK	73938	OK	74332	OK
73530	OK	73717	OK	73946	OK	74333	OK
73531	OK	73718	OK	73947	OK	74335	OK
73533	OK	73719	OK	73950	OK	74337	OK
73534	OK	73722	OK	74001	OK	74338	OK
73536	OK	73724	OK	74002	OK	74339	OK
73542	OK	73726	OK	74003	OK	74340	OK
73546	OK	73728	OK	74004	OK	74342	OK
73548	OK	73729	OK	74005	OK	74343	OK
73551	OK	73731	OK	74006	OK	74344	OK
73553	OK	73734	OK	74009	OK	74345	OK
73555	OK	73737	OK	74014	OK	74346	OK
73559	OK	73739	OK	74015	OK	74347	OK
73561	OK	73741	OK	74022	OK	74349	OK
73562	OK	73742	OK	74026	OK	74350	OK
73564	OK	73744	OK	74027	OK	74352	OK
73565	OK	73746	OK	74029	OK	74354	OK
73566	OK	73747	OK	74035	OK	74355	OK
73568	OK	73749	OK	74036	OK	74358	OK

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
74359	OK	74538	OK	74721	OK	74845	OK
74360	OK	74540	OK	74722	OK	74848	OK
74361	OK	74542	OK	74723	OK	74849	OK
74362	OK	74543	OK	74724	OK	74850	OK
74363	OK	74546	OK	74726	OK	74855	OK
74364	OK	74547	OK	74727	OK	74856	OK
74365	OK	74549	OK	74728	OK	74859	OK
74366	OK	74552	OK	74729	OK	74860	OK
74367	OK	74553	OK	74730	OK	74864	OK
74368	OK	74554	OK	74731	OK	74867	OK
74369	OK	74555	OK	74733	OK	74868	OK
74370	OK	74556	OK	74734	OK	74869	OK
74425	OK	74557	OK	74735	OK	74872	OK
74426	OK	74558	OK	74736	OK	74875	OK
74429	OK	74560	OK	74737	OK	74878	OK
74430	OK	74561	OK	74738	OK	74880	OK
74432	OK	74562	OK	74740	OK	74881	OK
74435	OK	74565	OK	74741	OK	74883	OK
74438	OK	74567	OK	74743	OK	74884	OK
74440	OK	74569	OK	74745	OK	74901	OK
74442	OK	74570	OK	74747	OK	74902	OK
74446	OK	74572	OK	74748	OK	74930	OK
74454	OK	74574	OK	74750	OK	74931	OK
74457	OK	74576	OK	74752	OK	74932	OK
74458	OK	74577	OK	74753	OK	74935	OK
74459	OK	74601	OK	74754	OK	74936	OK
74461	OK	74602	OK	74755	OK	74937	OK
74462	OK	74603	OK	74756	OK	74939	OK
74466	OK	74604	OK	74759	OK	74940	OK
74467	OK	74630	OK	74760	OK	74941	OK
74472	OK	74631	OK	74761	OK	74942	OK
74477	OK	74632	OK	74764	OK	74943	OK
74501	OK	74633	OK	74766	OK	74944	OK
74502	OK	74636	OK	74818	OK	74945	OK
74521	OK	74637	OK	74824	OK	74946	OK
74522	OK	74641	OK	74826	OK	74947	OK
74523	OK	74643	OK	74827	OK	74948	OK
74525	OK	74644	OK	74829	OK	74949	OK
74528	OK	74646	OK	74830	OK	74951	OK
74529	OK	74647	OK	74831	OK	74953	OK
74530	OK	74651	OK	74832	OK	74954	OK
74531	OK	74652	OK	74833	OK	74955	OK
74533	OK	74653	OK	74834	OK	74956	OK
74534	OK	74701	OK	74836	OK	74957	OK
74535	OK	74702	OK	74837	OK	74959	OK
74536	OK	74720	OK	74839	OK	74960	OK

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
74962	OK	75437	TX	75566	TX	75773	TX
74963	OK	75438	TX	75567	TX	75778	TX
74964	OK	75439	TX	75568	TX	75780	TX
74965	OK	75440	TX	75570	TX	75782	TX
74966	OK	75441	TX	75571	TX	75783	TX
75020	TX	75443	TX	75572	TX	75784	TX
75021	TX	75444	TX	75574	TX	75785	TX
75058	TX	75446	TX	75630	TX	75790	TX
75076	TX	75447	TX	75631	TX	75797	TX
75090	TX	75448	TX	75633	TX	75831	TX
75091	TX	75449	TX	75636	TX	75833	TX
75092	TX	75450	TX	75637	TX	75834	TX
75103	TX	75451	TX	75638	TX	75835	TX
75114	TX	75452	TX	75639	TX	75844	TX
75117	TX	75459	TX	75640	TX	75845	TX
75118	TX	75469	TX	75642	TX	75846	TX
75124	TX	75471	TX	75643	TX	75847	TX
75125	TX	75472	TX	75644	TX	75849	TX
75126	TX	75474	TX	75645	TX	75850	TX
75127	TX	75475	TX	75650	TX	75851	TX
75140	TX	75476	TX	75651	TX	75855	TX
75142	TX	75478	TX	75656	TX	75856	TX
75143	TX	75479	TX	75657	TX	75858	TX
75147	TX	75481	TX	75659	TX	75862	TX
75152	TX	75482	TX	75661	TX	75865	TX
75154	TX	75483	TX	75668	TX	75925	TX
75156	TX	75488	TX	75669	TX	75926	TX
75157	TX	75489	TX	75670	TX	75928	TX
75158	TX	75490	TX	75671	TX	75929	TX
75161	TX	75491	TX	75672	TX	75930	TX
75163	TX	75492	TX	75683	TX	75931	TX
75167	TX	75494	TX	75685	TX	75932	TX
75169	TX	75495	TX	75686	TX	75933	TX
75410	TX	75497	TX	75688	TX	75934	TX
75412	TX	75550	TX	75692	TX	75935	TX
75413	TX	75551	TX	75694	TX	75936	TX
75414	TX	75554	TX	75754	TX	75938	TX
75415	TX	75555	TX	75755	TX	75939	TX
75417	TX	75556	TX	75756	TX	75942	TX
75418	TX	75559	TX	75758	TX	75947	TX
75420	TX	75560	TX	75759	TX	75948	TX
75426	TX	75561	TX	75764	TX	75954	TX
75431	TX	75562	TX	75765	TX	75959	TX
75432	TX	75563	TX	75766	TX	75960	TX
75433	TX	75564	TX	75770	TX	75966	TX
75436	TX	75565	TX	75772	TX	75968	TX

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
75972	TX	76245	TX	76458	TX	76642	TX
75973	TX	76246	TX	76459	TX	76644	TX
75974	TX	76250	TX	76462	TX	76645	TX
75975	TX	76251	TX	76463	TX	76648	TX
75976	TX	76252	TX	76464	TX	76649	TX
75977	TX	76253	TX	76466	TX	76650	TX
75979	TX	76255	TX	76467	TX	76652	TX
75990	TX	76258	TX	76468	TX	76653	TX
76008	TX	76261	TX	76469	TX	76656	TX
76009	TX	76263	TX	76470	TX	76660	TX
76023	TX	76264	TX	76471	TX	76661	TX
76028	TX	76265	TX	76472	TX	76665	TX
76035	TX	76267	TX	76474	TX	76666	TX
76044	TX	76268	TX	76475	TX	76667	TX
76048	TX	76270	TX	76476	TX	76671	TX
76049	TX	76271	TX	76483	TX	76673	TX
76050	TX	76272	TX	76484	TX	76675	TX
76055	TX	76273	TX	76485	TX	76676	TX
76058	TX	76351	TX	76486	TX	76677	TX
76059	TX	76352	TX	76487	TX	76678	TX
76061	TX	76357	TX	76490	TX	76680	TX
76064	TX	76365	TX	76491	TX	76685	TX
76065	TX	76366	TX	76518	TX	76686	TX
76066	TX	76370	TX	76519	TX	76687	TX
76067	TX	76377	TX	76520	TX	76689	TX
76068	TX	76379	TX	76522	TX	76690	TX
76071	TX	76380	TX	76523	TX	76692	TX
76073	TX	76388	TX	76539	TX	76820	TX
76078	TX	76389	TX	76550	TX	76821	TX
76082	TX	76426	TX	76555	TX	76824	TX
76084	TX	76427	TX	76556	TX	76828	TX
76085	TX	76430	TX	76567	TX	76831	TX
76087	TX	76431	TX	76570	TX	76832	TX
76088	TX	76435	TX	76577	TX	76834	TX
76097	TX	76437	TX	76596	TX	76841	TX
76098	TX	76439	TX	76621	TX	76842	TX
76225	TX	76442	TX	76622	TX	76844	TX
76227	TX	76443	TX	76627	TX	76845	TX
76228	TX	76444	TX	76628	TX	76848	TX
76230	TX	76445	TX	76629	TX	76853	TX
76233	TX	76448	TX	76631	TX	76856	TX
76234	TX	76449	TX	76632	TX	76859	TX
76238	TX	76452	TX	76634	TX	76861	TX
76239	TX	76453	TX	76635	TX	76864	TX
76240	TX	76454	TX	76636	TX	76865	TX
76241	TX	76455	TX	76637	TX	76869	TX

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
76870	TX	77473	TX	77850	TX	78026	TX
76871	TX	77474	TX	77852	TX	78039	TX
76873	TX	77484	TX	77853	TX	78050	TX
76875	TX	77485	TX	77855	TX	78052	TX
76877	TX	77514	TX	77856	TX	78053	TX
76878	TX	77519	TX	77857	TX	78055	TX
76880	TX	77533	TX	77859	TX	78056	TX
76882	TX	77535	TX	77861	TX	78059	TX
76883	TX	77538	TX	77863	TX	78060	TX
76884	TX	77560	TX	77865	TX	78062	TX
76885	TX	77561	TX	77867	TX	78063	TX
76888	TX	77564	TX	77868	TX	78064	TX
76930	TX	77575	TX	77869	TX	78065	TX
76933	TX	77580	TX	77870	TX	78066	TX
76936	TX	77582	TX	77871	TX	78067	TX
76941	TX	77585	TX	77873	TX	78070	TX
76943	TX	77597	TX	77875	TX	78071	TX
76945	TX	77611	TX	77876	TX	78072	TX
76949	TX	77614	TX	77878	TX	78075	TX
76951	TX	77616	TX	77879	TX	78076	TX
76953	TX	77624	TX	77880	TX	78107	TX
77326	TX	77625	TX	77882	TX	78108	TX
77327	TX	77626	TX	77950	TX	78111	TX
77328	TX	77630	TX	77957	TX	78113	TX
77331	TX	77631	TX	77960	TX	78114	TX
77332	TX	77632	TX	77961	TX	78116	TX
77335	TX	77639	TX	77962	TX	78117	TX
77350	TX	77656	TX	77963	TX	78118	TX
77351	TX	77657	TX	77969	TX	78119	TX
77359	TX	77659	TX	77970	TX	78121	TX
77360	TX	77660	TX	77971	TX	78122	TX
77363	TX	77661	TX	77990	TX	78124	TX
77364	TX	77662	TX	77991	TX	78133	TX
77368	TX	77663	TX	77993	TX	78140	TX
77369	TX	77664	TX	78001	TX	78143	TX
77371	TX	77665	TX	78003	TX	78144	TX
77374	TX	77670	TX	78007	TX	78147	TX
77376	TX	77830	TX	78008	TX	78151	TX
77399	TX	77831	TX	78009	TX	78154	TX
77418	TX	77833	TX	78011	TX	78159	TX
77423	TX	77834	TX	78012	TX	78160	TX
77426	TX	77835	TX	78014	TX	78161	TX
77445	TX	77836	TX	78016	TX	78163	TX
77446	TX	77837	TX	78019	TX	78266	TX
77452	TX	77838	TX	78021	TX	78335	TX
77466	TX	77839	TX	78022	TX	78336	TX

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Primary Care PSA Zip Code List

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
78338	TX	78609	TX	78931	TX	79054	TX
78340	TX	78610	TX	78932	TX	79056	TX
78341	TX	78612	TX	78933	TX	79057	TX
78343	TX	78614	TX	78938	TX	79059	TX
78349	TX	78616	TX	78940	TX	79061	TX
78350	TX	78620	TX	78941	TX	79062	TX
78353	TX	78621	TX	78942	TX	79064	TX
78355	TX	78623	TX	78944	TX	79065	TX
78357	TX	78629	TX	78945	TX	79066	TX
78360	TX	78632	TX	78946	TX	79068	TX
78361	TX	78635	TX	78947	TX	79078	TX
78362	TX	78636	TX	78948	TX	79079	TX
78363	TX	78639	TX	78949	TX	79080	TX
78364	TX	78640	TX	78950	TX	79081	TX
78368	TX	78643	TX	78952	TX	79082	TX
78373	TX	78650	TX	78953	TX	79083	TX
78376	TX	78658	TX	78954	TX	79084	TX
78377	TX	78659	TX	78956	TX	79088	TX
78379	TX	78662	TX	78957	TX	79092	TX
78384	TX	78663	TX	78959	TX	79094	TX
78385	TX	78672	TX	78960	TX	79096	TX
78387	TX	78677	TX	78961	TX	79097	TX
78393	TX	78737	TX	78963	TX	79098	TX
78536	TX	78827	TX	79001	TX	79109	TX
78545	TX	78828	TX	79002	TX	79110	TX
78547	TX	78829	TX	79003	TX	79114	TX
78548	TX	78830	TX	79005	TX	79118	TX
78561	TX	78832	TX	79007	TX	79119	TX
78564	TX	78833	TX	79008	TX	79121	TX
78569	TX	78834	TX	79009	TX	79185	TX
78578	TX	78836	TX	79010	TX	79220	TX
78580	TX	78839	TX	79011	TX	79223	TX
78582	TX	78850	TX	79018	TX	79226	TX
78584	TX	78851	TX	79019	TX	79227	TX
78585	TX	78852	TX	79024	TX	79229	TX
78588	TX	78853	TX	79031	TX	79232	TX
78590	TX	78860	TX	79034	TX	79233	TX
78591	TX	78861	TX	79035	TX	79234	TX
78594	TX	78872	TX	79036	TX	79236	TX
78597	TX	78873	TX	79039	TX	79237	TX
78598	TX	78877	TX	79040	TX	79239	TX
78602	TX	78879	TX	79042	TX	79240	TX
78603	TX	78880	TX	79044	TX	79243	TX
78604	TX	78883	TX	79046	TX	79244	TX
78606	TX	78885	TX	79052	TX	79245	TX
78607	TX	78886	TX	79053	TX	79248	TX

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
79255	TX	79521	TX	79778	TX	80834	CO
79256	TX	79525	TX	79780	TX	80835	CO
79257	TX	79526	TX	79781	TX	80836	CO
79261	TX	79527	TX	79782	TX	80861	CO
79312	TX	79528	TX	79783	TX	81020	CO
79313	TX	79532	TX	79785	TX	81024	CO
79314	TX	79533	TX	79786	TX	81027	CO
79323	TX	79534	TX	79788	TX	81029	CO
79325	TX	79535	TX	79837	TX	81033	CO
79326	TX	79537	TX	79839	TX	81034	CO
79331	TX	79538	TX	79843	TX	81038	CO
79336	TX	79539	TX	79845	TX	81041	CO
79338	TX	79540	TX	79846	TX	81042	CO
79339	TX	79543	TX	79847	TX	81043	CO
79342	TX	79544	TX	79848	TX	81044	CO
79346	TX	79545	TX	79850	TX	81046	CO
79351	TX	79546	TX	79851	TX	81047	CO
79353	TX	79547	TX	79854	TX	81049	CO
79355	TX	79548	TX	79855	TX	81052	CO
79358	TX	79549	TX	80101	CO	81054	CO
79359	TX	79550	TX	80107	CO	81057	CO
79360	TX	79553	TX	80117	CO	81059	CO
79367	TX	79556	TX	80420	CO	81062	CO
79369	TX	79560	TX	80421	CO	81063	CO
79370	TX	79565	TX	80430	CO	81064	CO
79371	TX	79566	TX	80432	CO	81073	CO
79372	TX	79567	TX	80434	CO	81074	CO
79373	TX	79713	TX	80440	CO	81076	CO
79376	TX	79718	TX	80448	CO	81081	CO
79377	TX	79719	TX	80449	CO	81082	CO
79379	TX	79730	TX	80456	CO	81084	CO
79380	TX	79735	TX	80473	CO	81087	CO
79381	TX	79738	TX	80475	CO	81090	CO
79383	TX	79739	TX	80480	CO	81091	CO
79501	TX	79740	TX	80720	CO	81092	CO
79502	TX	79742	TX	80740	CO	81120	CO
79503	TX	79743	TX	80743	CO	81123	CO
79504	TX	79744	TX	80757	CO	81124	CO
79506	TX	79749	TX	80801	CO	81125	CO
79510	TX	79752	TX	80805	CO	81126	CO
79512	TX	79754	TX	80807	CO	81129	CO
79516	TX	79755	TX	80812	CO	81131	CO
79517	TX	79756	TX	80815	CO	81132	CO
79518	TX	79770	TX	80820	CO	81133	CO
79519	TX	79772	TX	80827	CO	81134	CO
79520	TX	79777	TX	80830	CO	81135	CO

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ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
81138	CO	82053	WY	82844	WY	83420	ID
81140	CO	82054	WY	82845	WY	83421	ID
81141	CO	82060	WY	83203	ID	83423	ID
81143	CO	82082	WY	83210	ID	83425	ID
81144	CO	82222	WY	83211	ID	83429	ID
81148	CO	82225	WY	83212	ID	83431	ID
81149	CO	82227	WY	83215	ID	83433	ID
81151	CO	82242	WY	83217	ID	83434	ID
81152	CO	82301	WY	83218	ID	83435	ID
81153	CO	82321	WY	83221	ID	83436	ID
81154	CO	82323	WY	83226	ID	83438	ID
81155	CO	82324	WY	83227	ID	83442	ID
81201	CO	82325	WY	83228	ID	83443	ID
81211	CO	82327	WY	83229	ID	83444	ID
81212	CO	82329	WY	83232	ID	83445	ID
81215	CO	82331	WY	83235	ID	83446	ID
81220	CO	82332	WY	83236	ID	83447	ID
81221	CO	82334	WY	83237	ID	83450	ID
81222	CO	82335	WY	83241	ID	83451	ID
81223	CO	82410	WY	83251	ID	83462	ID
81226	CO	82411	WY	83253	ID	83463	ID
81227	CO	82412	WY	83256	ID	83464	ID
81228	CO	82420	WY	83262	ID	83465	ID
81232	CO	82421	WY	83263	ID	83466	ID
81233	CO	82422	WY	83271	ID	83467	ID
81236	CO	82426	WY	83274	ID	83468	ID
81240	CO	82428	WY	83276	ID	83469	ID
81242	CO	82431	WY	83277	ID	83523	ID
81244	CO	82432	WY	83278	ID	83536	ID
81246	CO	82434	WY	83283	ID	83543	ID
81248	CO	82441	WY	83285	ID	83548	ID
81252	CO	82638	WY	83286	ID	83555	ID
81253	CO	82701	WY	83314	ID	83602	ID
81290	CO	82715	WY	83322	ID	83604	ID
81320	CO	82723	WY	83324	ID	83610	ID
81324	CO	82730	WY	83327	ID	83612	ID
81332	CO	82801	WY	83330	ID	83617	ID
81401	CO	82831	WY	83332	ID	83620	ID
81402	CO	82832	WY	83336	ID	83622	ID
81411	CO	82833	WY	83337	ID	83624	ID
81422	CO	82835	WY	83343	ID	83628	ID
81424	CO	82836	WY	83347	ID	83629	ID
81425	CO	82837	WY	83349	ID	83631	ID
81429	CO	82838	WY	83350	ID	83632	ID
81431	CO	82839	WY	83352	ID	83636	ID
82050	WY	82842	WY	83355	ID	83637	ID

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
83639	ID	84724	UT	85245	AZ	85609	AZ
83643	ID	84725	UT	85278	AZ	85610	AZ
83645	ID	84729	UT	85320	AZ	85613	AZ
83650	ID	84730	UT	85321	AZ	85614	AZ
83654	ID	84732	UT	85322	AZ	85615	AZ
83657	ID	84733	UT	85324	AZ	85616	AZ
83666	ID	84734	UT	85325	AZ	85617	AZ
83670	ID	84737	UT	85326	AZ	85620	AZ
83672	ID	84738	UT	85328	AZ	85622	AZ
84008	UT	84739	UT	85332	AZ	85625	AZ
84018	UT	84740	UT	85333	AZ	85626	AZ
84023	UT	84741	UT	85334	AZ	85627	AZ
84026	UT	84743	UT	85337	AZ	85629	AZ
84028	UT	84744	UT	85341	AZ	85630	AZ
84030	UT	84745	UT	85342	AZ	85632	AZ
84035	UT	84746	UT	85343	AZ	85633	AZ
84038	UT	84747	UT	85344	AZ	85634	AZ
84039	UT	84749	UT	85346	AZ	85635	AZ
84046	UT	84750	UT	85347	AZ	85636	AZ
84050	UT	84754	UT	85348	AZ	85638	AZ
84063	UT	84755	UT	85354	AZ	85639	AZ
84064	UT	84757	UT	85357	AZ	85643	AZ
84076	UT	84758	UT	85358	AZ	85644	AZ
84078	UT	84762	UT	85359	AZ	85650	AZ
84079	UT	84763	UT	85360	AZ	85655	AZ
84085	UT	84765	UT	85361	AZ	85670	AZ
84086	UT	84766	UT	85362	AZ	85671	AZ
84513	UT	84767	UT	85371	AZ	85736	AZ
84516	UT	84770	UT	85387	AZ	86021	AZ
84518	UT	84771	UT	85390	AZ	86301	AZ
84521	UT	84773	UT	85530	AZ	86302	AZ
84522	UT	84774	UT	85531	AZ	86303	AZ
84523	UT	84775	UT	85535	AZ	86304	AZ
84525	UT	84779	UT	85536	AZ	86305	AZ
84528	UT	84780	UT	85543	AZ	86312	AZ
84537	UT	84781	UT	85546	AZ	86313	AZ
84620	UT	84782	UT	85548	AZ	86314	AZ
84652	UT	84783	UT	85551	AZ	86320	AZ
84654	UT	84784	UT	85552	AZ	86321	AZ
84657	UT	84790	UT	85601	AZ	86322	AZ
84701	UT	84791	UT	85602	AZ	86323	AZ
84710	UT	85070	AZ	85603	AZ	86324	AZ
84711	UT	85217	AZ	85605	AZ	86325	AZ
84715	UT	85218	AZ	85606	AZ	86326	AZ
84722	UT	85219	AZ	85607	AZ	86327	AZ
84723	UT	85220	AZ	85608	AZ	86329	AZ

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
86330	AZ	87009	NM	87735	NM	88121	NM
86331	AZ	87011	NM	87736	NM	88122	NM
86332	AZ	87013	NM	87743	NM	88123	NM
86333	AZ	87016	NM	87746	NM	88124	NM
86334	AZ	87018	NM	87750	NM	88125	NM
86335	AZ	87023	NM	87752	NM	88126	NM
86336	AZ	87024	NM	87753	NM	88130	NM
86337	AZ	87025	NM	87801	NM	88132	NM
86338	AZ	87027	NM	87820	NM	88133	NM
86340	AZ	87028	NM	87821	NM	88134	NM
86341	AZ	87031	NM	87823	NM	88135	NM
86342	AZ	87032	NM	87824	NM	88136	NM
86343	AZ	87034	NM	87825	NM	88201	NM
86351	AZ	87035	NM	87827	NM	88202	NM
86401	AZ	87036	NM	87828	NM	88203	NM
86402	AZ	87041	NM	87829	NM	88230	NM
86403	AZ	87042	NM	87830	NM	88232	NM
86404	AZ	87043	NM	87831	NM	88253	NM
86405	AZ	87044	NM	87832	NM	88301	NM
86406	AZ	87046	NM	87901	NM	88312	NM
86411	AZ	87048	NM	87930	NM	88316	NM
86412	AZ	87052	NM	87931	NM	88318	NM
86413	AZ	87053	NM	87933	NM	88321	NM
86426	AZ	87057	NM	87935	NM	88323	NM
86427	AZ	87060	NM	87939	NM	88324	NM
86429	AZ	87061	NM	87942	NM	88336	NM
86430	AZ	87062	NM	87943	NM	88338	NM
86431	AZ	87063	NM	88009	NM	88341	NM
86432	AZ	87068	NM	88020	NM	88343	NM
86433	AZ	87070	NM	88029	NM	88345	NM
86434	AZ	87072	NM	88030	NM	88346	NM
86436	AZ	87083	NM	88031	NM	88348	NM
86437	AZ	87124	NM	88039	NM	88351	NM
86438	AZ	87144	NM	88042	NM	88353	NM
86439	AZ	87174	NM	88045	NM	88355	NM
86440	AZ	87711	NM	88056	NM	88401	NM
86441	AZ	87712	NM	88101	NM	88410	NM
86442	AZ	87713	NM	88102	NM	88411	NM
86443	AZ	87715	NM	88103	NM	88414	NM
86444	AZ	87722	NM	88112	NM	88415	NM
86445	AZ	87723	NM	88113	NM	88417	NM
86446	AZ	87724	NM	88115	NM	88418	NM
87001	NM	87730	NM	88116	NM	88419	NM
87002	NM	87732	NM	88118	NM	88422	NM
87004	NM	87733	NM	88119	NM	88424	NM
87006	NM	87734	NM	88120	NM	88426	NM

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
88427	NM	89447	NV	92314	CA	93275	CA
88429	NM	89448	NV	92315	CA	93280	CA
88430	NM	89449	NV	92323	CA	93282	CA
88431	NM	89460	NV	92332	CA	93283	CA
88433	NM	89705	NV	92333	CA	93285	CA
88434	NM	90704	CA	92338	CA	93286	CA
88435	NM	92004	CA	92347	CA	93287	CA
88436	NM	92220	CA	92363	CA	93501	CA
88437	NM	92222	CA	92364	CA	93502	CA
89001	NV	92223	CA	92365	CA	93504	CA
89003	NV	92225	CA	92366	CA	93505	CA
89007	NV	92226	CA	92386	CA	93516	CA
89008	NV	92227	CA	92563	CA	93518	CA
89010	NV	92230	CA	92589	CA	93523	CA
89013	NV	92231	CA	92590	CA	93527	CA
89017	NV	92232	CA	92591	CA	93555	CA
89020	NV	92233	CA	92592	CA	93556	CA
89022	NV	92241	CA	92593	CA	93558	CA
89023	NV	92242	CA	93015	CA	93581	CA
89024	NV	92243	CA	93016	CA	93596	CA
89027	NV	92244	CA	93040	CA	93601	CA
89028	NV	92249	CA	93205	CA	93604	CA
89029	NV	92250	CA	93207	CA	93610	CA
89039	NV	92251	CA	93208	CA	93614	CA
89041	NV	92252	CA	93215	CA	93615	CA
89042	NV	92257	CA	93216	CA	93618	CA
89043	NV	92259	CA	93218	CA	93620	CA
89045	NV	92266	CA	93221	CA	93623	CA
89046	NV	92267	CA	93226	CA	93635	CA
89047	NV	92268	CA	93238	CA	93637	CA
89048	NV	92273	CA	93240	CA	93638	CA
89049	NV	92275	CA	93247	CA	93639	CA
89060	NV	92276	CA	93249	CA	93643	CA
89061	NV	92277	CA	93250	CA	93644	CA
89403	NV	92278	CA	93252	CA	93645	CA
89408	NV	92280	CA	93255	CA	93647	CA
89409	NV	92281	CA	93256	CA	93653	CA
89410	NV	92282	CA	93257	CA	93661	CA
89411	NV	92283	CA	93258	CA	93665	CA
89413	NV	92284	CA	93260	CA	93666	CA
89423	NV	92286	CA	93265	CA	93669	CA
89428	NV	92304	CA	93267	CA	93673	CA
89429	NV	92309	CA	93268	CA	94512	CA
89430	NV	92310	CA	93270	CA	94571	CA
89440	NV	92311	CA	93272	CA	95221	CA
89444	NV	92312	CA	93274	CA	95222	CA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
95223	CA	95464	CA	96063	CA	97366	OR
95224	CA	95485	CA	96074	CA	97367	OR
95225	CA	95493	CA	96075	CA	97368	OR
95226	CA	95527	CA	96078	CA	97369	OR
95228	CA	95552	CA	96080	CA	97372	OR
95229	CA	95563	CA	96090	CA	97376	OR
95232	CA	95595	CA	96091	CA	97380	OR
95233	CA	95620	CA	96092	CA	97388	OR
95245	CA	95646	CA	96093	CA	97390	OR
95246	CA	95903	CA	96101	CA	97391	OR
95247	CA	95910	CA	96104	CA	97394	OR
95248	CA	95913	CA	96108	CA	97406	OR
95249	CA	95919	CA	96110	CA	97407	OR
95250	CA	95920	CA	96112	CA	97410	OR
95251	CA	95922	CA	96115	CA	97411	OR
95252	CA	95925	CA	96116	CA	97414	OR
95254	CA	95935	CA	96118	CA	97415	OR
95255	CA	95936	CA	96120	CA	97416	OR
95257	CA	95939	CA	96124	CA	97417	OR
95301	CA	95943	CA	96125	CA	97420	OR
95306	CA	95944	CA	96126	CA	97423	OR
95311	CA	95948	CA	96799	AS	97424	OR
95312	CA	95951	CA	96862	HI	97427	OR
95318	CA	95954	CA	96970	MH	97428	OR
95322	CA	95963	CA	97016	OR	97429	OR
95324	CA	95967	CA	97018	OR	97432	OR
95325	CA	95969	CA	97029	OR	97434	OR
95334	CA	95972	CA	97033	OR	97435	OR
95338	CA	95978	CA	97039	OR	97436	OR
95342	CA	95981	CA	97048	OR	97439	OR
95345	CA	95988	CA	97050	OR	97441	OR
95369	CA	96006	CA	97051	OR	97442	OR
95374	CA	96010	CA	97053	OR	97443	OR
95388	CA	96015	CA	97054	OR	97444	OR
95389	CA	96021	CA	97056	OR	97447	OR
95422	CA	96024	CA	97064	OR	97449	OR
95423	CA	96029	CA	97065	OR	97450	OR
95424	CA	96035	CA	97111	OR	97457	OR
95426	CA	96041	CA	97115	OR	97458	OR
95435	CA	96046	CA	97127	OR	97459	OR
95443	CA	96048	CA	97148	OR	97462	OR
95451	CA	96052	CA	97341	OR	97463	OR
95453	CA	96054	CA	97343	OR	97464	OR
95457	CA	96055	CA	97357	OR	97465	OR
95458	CA	96059	CA	97364	OR	97466	OR
95461	CA	96061	CA	97365	OR	97467	OR

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
97469	OR	97828	OR	98527	WA	98593	WA
97470	OR	97830	OR	98528	WA	98595	WA
97472	OR	97831	OR	98531	WA	98596	WA
97473	OR	97836	OR	98532	WA	98610	WA
97476	OR	97839	OR	98533	WA	98612	WA
97479	OR	97842	OR	98535	WA	98614	WA
97481	OR	97843	OR	98536	WA	98621	WA
97484	OR	97844	OR	98537	WA	98624	WA
97486	OR	97845	OR	98538	WA	98631	WA
97491	OR	97846	OR	98539	WA	98637	WA
97492	OR	97848	OR	98541	WA	98638	WA
97493	OR	97856	OR	98542	WA	98639	WA
97494	OR	97857	OR	98544	WA	98640	WA
97495	OR	97861	OR	98546	WA	98641	WA
97496	OR	97864	OR	98547	WA	98643	WA
97497	OR	97865	OR	98548	WA	98644	WA
97498	OR	97869	OR	98550	WA	98647	WA
97499	OR	97872	OR	98552	WA	98648	WA
97523	OR	97873	OR	98554	WA	98651	WA
97526	OR	97874	OR	98555	WA	98802	WA
97527	OR	97885	OR	98557	WA	98813	WA
97528	OR	98222	WA	98559	WA	98830	WA
97531	OR	98236	WA	98560	WA	98843	WA
97532	OR	98241	WA	98561	WA	98845	WA
97533	OR	98243	WA	98562	WA	98850	WA
97534	OR	98245	WA	98563	WA	98858	WA
97538	OR	98249	WA	98564	WA	99004	WA
97543	OR	98250	WA	98565	WA	99008	WA
97544	OR	98260	WA	98566	WA	99011	WA
97711	OR	98261	WA	98568	WA	99012	WA
97730	OR	98279	WA	98569	WA	99015	WA
97734	OR	98280	WA	98570	WA	99018	WA
97741	OR	98282	WA	98571	WA	99022	WA
97750	OR	98286	WA	98572	WA	99029	WA
97751	OR	98297	WA	98575	WA	99030	WA
97752	OR	98330	WA	98577	WA	99031	WA
97753	OR	98336	WA	98582	WA	99032	WA
97754	OR	98355	WA	98583	WA	99039	WA
97760	OR	98356	WA	98584	WA	99103	WA
97761	OR	98361	WA	98585	WA	99107	WA
97812	OR	98377	WA	98586	WA	99117	WA
97817	OR	98398	WA	98587	WA	99118	WA
97818	OR	98520	WA	98588	WA	99119	WA
97820	OR	98522	WA	98590	WA	99121	WA
97823	OR	98524	WA	98591	WA	99122	WA
97825	OR	98526	WA	98592	WA	99134	WA

ADDENDUM J- PRIMARY CARE PSA ZIP CODES

Primary Care PSA Zip Code List

Effective for claims with dates of service 01/01/05 through 12/31/07.

ZIP Code	State	ZIP Code	State	ZIP Code	State	ZIP Code	State
99138	WA	99633	AK	99777	AK		
99139	WA	99638	AK	99781	AK		
99140	WA	99640	AK	99788	AK		
99144	WA	99647	AK	99820	AK		
99146	WA	99648	AK	99825	AK		
99147	WA	99649	AK	99826	AK		
99150	WA	99650	AK	99829	AK		
99152	WA	99653	AK	99832	AK		
99153	WA	99657	AK	99840	AK		
99154	WA	99658	AK	99841	AK		
99156	WA	99660	AK				
99159	WA	99661	AK				
99160	WA	99662	AK				
99166	WA	99665	AK				
99180	WA	99666	AK				
99185	WA	99670	AK				
99347	WA	99675	AK				
99401	WA	99685	AK				
99402	WA	99689	AK				
99403	WA	99691	AK				
99546	AK	99692	AK				
99547	AK	99704	AK				
99548	AK	99720	AK				
99549	AK	99722	AK				
99553	AK	99724	AK				
99554	AK	99726	AK				
99558	AK	99729	AK				
99563	AK	99730	AK				
99564	AK	99733	AK				
99565	AK	99740	AK				
99571	AK	99741	AK				
99579	AK	99743	AK				
99581	AK	99744	AK				
99583	AK	99745	AK				
99585	AK	99746	AK				
99590	AK	99748	AK				
99591	AK	99754	AK				
99602	AK	99755	AK				
99604	AK	99756	AK				
99606	AK	99757	AK				
99612	AK	99758	AK				
99613	AK	99760	AK				
99620	AK	99765	AK				
99625	AK	99767	AK				
99627	AK	99768	AK				
99632	AK	99774	AK				

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
00801	VI	04441	ME	07543	NJ	12173	NY
00802	VI	04442	ME	12015	NY	12174	NY
00803	VI	04443	ME	12017	NY	12175	NY
00804	VI	04451	ME	12025	NY	12176	NY
00805	VI	04455	ME	12029	NY	12184	NY
00820	VI	04462	ME	12031	NY	12187	NY
00821	VI	04464	ME	12032	NY	12192	NY
00822	VI	04478	ME	12035	NY	12194	NY
00823	VI	04479	ME	12036	NY	12195	NY
00824	VI	04481	ME	12037	NY	12197	NY
00830	VI	04485	ME	12042	NY	12405	NY
00831	VI	04490	ME	12043	NY	12406	NY
00840	VI	04497	ME	12050	NY	12407	NY
00841	VI	04628	ME	12051	NY	12413	NY
00850	VI	04637	ME	12058	NY	12414	NY
00851	VI	04648	ME	12060	NY	12418	NY
00936	PR	04654	ME	12062	NY	12421	NY
00956	PR	04657	ME	12064	NY	12422	NY
00957	PR	04666	ME	12071	NY	12423	NY
00958	PR	04668	ME	12073	NY	12424	NY
00959	PR	04671	ME	12075	NY	12427	NY
00960	PR	04686	ME	12076	NY	12430	NY
00961	PR	04691	ME	12078	NY	12431	NY
00965	PR	04732	ME	12083	NY	12434	NY
00966	PR	04733	ME	12087	NY	12436	NY
00969	PR	04737	ME	12092	NY	12438	NY
00970	PR	04747	ME	12093	NY	12439	NY
00971	PR	04759	ME	12095	NY	12442	NY
02801	RI	04764	ME	12106	NY	12444	NY
02826	RI	04765	ME	12115	NY	12450	NY
02835	RI	04768	ME	12116	NY	12451	NY
02837	RI	04772	ME	12117	NY	12452	NY
02838	RI	04775	ME	12122	NY	12454	NY
02840	RI	04776	ME	12124	NY	12455	NY
02841	RI	04777	ME	12125	NY	12459	NY
02842	RI	04780	ME	12130	NY	12460	NY
02858	RI	04781	ME	12131	NY	12463	NY
02871	RI	04787	ME	12134	NY	12468	NY
02878	RI	04920	ME	12136	NY	12470	NY
04226	ME	04923	ME	12149	NY	12473	NY
04257	ME	04950	ME	12155	NY	12474	NY
04276	ME	04958	ME	12157	NY	12482	NY
04278	ME	04979	ME	12160	NY	12485	NY
04406	ME	07108	NJ	12165	NY	12492	NY
04414	ME	07505	NJ	12167	NY	12496	NY
04415	ME	07513	NJ	12172	NY	12502	NY

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
12503	NY	12957	NY	13364	NY	13667	NY
12513	NY	12960	NY	13367	NY	13668	NY
12516	NY	12961	NY	13368	NY	13669	NY
12517	NY	12964	NY	13404	NY	13670	NY
12521	NY	12965	NY	13411	NY	13672	NY
12523	NY	12966	NY	13415	NY	13676	NY
12526	NY	12967	NY	13433	NY	13677	NY
12529	NY	12969	NY	13439	NY	13678	NY
12530	NY	12970	NY	13450	NY	13680	NY
12534	NY	12973	NY	13457	NY	13681	NY
12541	NY	12974	NY	13459	NY	13683	NY
12544	NY	12976	NY	13460	NY	13684	NY
12565	NY	12977	NY	13464	NY	13687	NY
12851	NY	12980	NY	13468	NY	13690	NY
12852	NY	12983	NY	13470	NY	13694	NY
12855	NY	12986	NY	13473	NY	13695	NY
12857	NY	12987	NY	13482	NY	13696	NY
12858	NY	12989	NY	13485	NY	13697	NY
12870	NY	12993	NY	13488	NY	13699	NY
12872	NY	12995	NY	13489	NY	13730	NY
12879	NY	12996	NY	13613	NY	13731	NY
12883	NY	12997	NY	13614	NY	13733	NY
12913	NY	12998	NY	13617	NY	13739	NY
12914	NY	13065	NY	13620	NY	13740	NY
12915	NY	13124	NY	13621	NY	13747	NY
12916	NY	13136	NY	13623	NY	13750	NY
12917	NY	13143	NY	13625	NY	13751	NY
12920	NY	13146	NY	13626	NY	13752	NY
12922	NY	13148	NY	13630	NY	13753	NY
12926	NY	13154	NY	13633	NY	13755	NY
12927	NY	13155	NY	13635	NY	13756	NY
12928	NY	13165	NY	13639	NY	13757	NY
12930	NY	13305	NY	13642	NY	13758	NY
12932	NY	13312	NY	13645	NY	13775	NY
12936	NY	13315	NY	13646	NY	13776	NY
12937	NY	13325	NY	13647	NY	13778	NY
12939	NY	13326	NY	13648	NY	13780	NY
12941	NY	13327	NY	13649	NY	13782	NY
12942	NY	13332	NY	13652	NY	13783	NY
12943	NY	13333	NY	13654	NY	13786	NY
12945	NY	13335	NY	13655	NY	13788	NY
12946	NY	13337	NY	13658	NY	13796	NY
12949	NY	13342	NY	13660	NY	13801	NY
12950	NY	13343	NY	13662	NY	13804	NY
12953	NY	13345	NY	13664	NY	13806	NY
12956	NY	13348	NY	13666	NY	13807	NY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
13808	NY	14423	NY	14703	NY	14755	NY
13809	NY	14433	NY	14704	NY	14756	NY
13810	NY	14435	NY	14706	NY	14757	NY
13814	NY	14437	NY	14707	NY	14758	NY
13815	NY	14449	NY	14708	NY	14760	NY
13820	NY	14454	NY	14709	NY	14766	NY
13825	NY	14462	NY	14710	NY	14767	NY
13830	NY	14466	NY	14711	NY	14769	NY
13832	NY	14480	NY	14712	NY	14770	NY
13834	NY	14481	NY	14714	NY	14772	NY
13838	NY	14485	NY	14715	NY	14774	NY
13839	NY	14486	NY	14716	NY	14775	NY
13841	NY	14487	NY	14717	NY	14777	NY
13842	NY	14488	NY	14718	NY	14778	NY
13843	NY	14489	NY	14719	NY	14779	NY
13844	NY	14502	NY	14720	NY	14781	NY
13846	NY	14505	NY	14721	NY	14782	NY
13847	NY	14510	NY	14722	NY	14783	NY
13849	NY	14513	NY	14723	NY	14784	NY
13856	NY	14516	NY	14724	NY	14785	NY
13859	NY	14517	NY	14726	NY	14786	NY
13860	NY	14519	NY	14727	NY	14787	NY
13861	NY	14520	NY	14728	NY	14788	NY
14029	NY	14521	NY	14729	NY	14801	NY
14041	NY	14522	NY	14730	NY	14802	NY
14042	NY	14529	NY	14731	NY	14803	NY
14048	NY	14533	NY	14732	NY	14804	NY
14060	NY	14538	NY	14733	NY	14805	NY
14061	NY	14539	NY	14735	NY	14806	NY
14062	NY	14541	NY	14736	NY	14807	NY
14063	NY	14542	NY	14737	NY	14808	NY
14065	NY	14545	NY	14738	NY	14809	NY
14070	NY	14551	NY	14739	NY	14810	NY
14081	NY	14555	NY	14740	NY	14812	NY
14101	NY	14556	NY	14741	NY	14813	NY
14129	NY	14558	NY	14742	NY	14815	NY
14133	NY	14560	NY	14743	NY	14818	NY
14135	NY	14563	NY	14744	NY	14819	NY
14136	NY	14568	NY	14745	NY	14820	NY
14138	NY	14572	NY	14747	NY	14821	NY
14166	NY	14588	NY	14748	NY	14822	NY
14168	NY	14589	NY	14750	NY	14823	NY
14171	NY	14590	NY	14751	NY	14824	NY
14173	NY	14592	NY	14752	NY	14826	NY
14413	NY	14701	NY	14753	NY	14827	NY
14414	NY	14702	NY	14754	NY	14830	NY

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
14831	NY	15351	PA	15461	PA	15752	PA
14836	NY	15352	PA	15462	PA	15754	PA
14839	NY	15353	PA	15463	PA	15758	PA
14840	NY	15354	PA	15464	PA	15759	PA
14841	NY	15357	PA	15465	PA	15763	PA
14843	NY	15359	PA	15466	PA	15764	PA
14846	NY	15362	PA	15467	PA	15765	PA
14847	NY	15364	PA	15468	PA	15770	PA
14855	NY	15370	PA	15469	PA	15771	PA
14856	NY	15380	PA	15470	PA	15772	PA
14858	NY	15401	PA	15472	PA	15776	PA
14860	NY	15410	PA	15473	PA	15777	PA
14865	NY	15413	PA	15474	PA	15780	PA
14869	NY	15415	PA	15475	PA	15784	PA
14870	NY	15416	PA	15476	PA	15828	PA
14873	NY	15417	PA	15478	PA	15920	PA
14874	NY	15420	PA	15480	PA	15929	PA
14876	NY	15421	PA	15482	PA	16049	PA
14877	NY	15422	PA	15484	PA	16201	PA
14878	NY	15425	PA	15486	PA	16210	PA
14879	NY	15428	PA	15488	PA	16212	PA
14880	NY	15429	PA	15489	PA	16215	PA
14884	NY	15430	PA	15490	PA	16217	PA
14885	NY	15431	PA	15492	PA	16218	PA
14891	NY	15433	PA	15631	PA	16222	PA
14895	NY	15435	PA	15656	PA	16226	PA
14897	NY	15436	PA	15682	PA	16228	PA
14898	NY	15437	PA	15686	PA	16229	PA
15012	PA	15438	PA	15701	PA	16236	PA
15072	PA	15439	PA	15705	PA	16238	PA
15087	PA	15440	PA	15711	PA	16239	PA
15310	PA	15442	PA	15713	PA	16244	PA
15315	PA	15443	PA	15716	PA	16249	PA
15316	PA	15444	PA	15720	PA	16250	PA
15320	PA	15445	PA	15723	PA	16259	PA
15322	PA	15446	PA	15727	PA	16261	PA
15325	PA	15447	PA	15728	PA	16262	PA
15327	PA	15449	PA	15729	PA	16263	PA
15334	PA	15450	PA	15730	PA	16301	PA
15337	PA	15451	PA	15731	PA	16312	PA
15338	PA	15454	PA	15734	PA	16313	PA
15341	PA	15455	PA	15739	PA	16317	PA
15344	PA	15456	PA	15744	PA	16319	PA
15346	PA	15458	PA	15745	PA	16321	PA
15348	PA	15459	PA	15746	PA	16322	PA
15349	PA	15460	PA	15748	PA	16323	PA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
16329	PA	16923	PA	17261	PA	17948	PA
16340	PA	16925	PA	17262	PA	17949	PA
16341	PA	16926	PA	17263	PA	17951	PA
16342	PA	16927	PA	17265	PA	17952	PA
16343	PA	16928	PA	17268	PA	17953	PA
16344	PA	16929	PA	17270	PA	17954	PA
16345	PA	16930	PA	17271	PA	17957	PA
16346	PA	16932	PA	17272	PA	17959	PA
16347	PA	16933	PA	17721	PA	17960	PA
16350	PA	16935	PA	17724	PA	17961	PA
16351	PA	16936	PA	17726	PA	17963	PA
16352	PA	16937	PA	17729	PA	17964	PA
16353	PA	16938	PA	17735	PA	17965	PA
16362	PA	16939	PA	17738	PA	17966	PA
16364	PA	16940	PA	17745	PA	17967	PA
16365	PA	16941	PA	17747	PA	17968	PA
16366	PA	16942	PA	17748	PA	17970	PA
16367	PA	16943	PA	17750	PA	17972	PA
16368	PA	16945	PA	17751	PA	17974	PA
16369	PA	16946	PA	17760	PA	17976	PA
16370	PA	16947	PA	17764	PA	17978	PA
16371	PA	16948	PA	17765	PA	17979	PA
16372	PA	16950	PA	17767	PA	17980	PA
16373	PA	17201	PA	17773	PA	17981	PA
16374	PA	17210	PA	17778	PA	17982	PA
16402	PA	17214	PA	17779	PA	17983	PA
16405	PA	17217	PA	17901	PA	17985	PA
16416	PA	17219	PA	17921	PA	18012	PA
16420	PA	17220	PA	17922	PA	18030	PA
16436	PA	17221	PA	17923	PA	18058	PA
16720	PA	17222	PA	17925	PA	18071	PA
16746	PA	17224	PA	17929	PA	18210	PA
16748	PA	17225	PA	17930	PA	18211	PA
16822	PA	17231	PA	17931	PA	18212	PA
16848	PA	17232	PA	17932	PA	18214	PA
16901	PA	17235	PA	17933	PA	18216	PA
16910	PA	17236	PA	17934	PA	18218	PA
16911	PA	17237	PA	17935	PA	18220	PA
16912	PA	17244	PA	17936	PA	18229	PA
16914	PA	17246	PA	17938	PA	18230	PA
16915	PA	17247	PA	17941	PA	18231	PA
16917	PA	17250	PA	17942	PA	18232	PA
16918	PA	17251	PA	17943	PA	18235	PA
16920	PA	17252	PA	17944	PA	18237	PA
16921	PA	17254	PA	17945	PA	18240	PA
16922	PA	17256	PA	17946	PA	18241	PA

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
18242	PA	18413	PA	18629	PA	21536	MD
18244	PA	18415	PA	18630	PA	21538	MD
18245	PA	18417	PA	18636	PA	21541	MD
18248	PA	18419	PA	18657	PA	21550	MD
18250	PA	18420	PA	18801	PA	21561	MD
18252	PA	18421	PA	18810	PA	21610	MD
18254	PA	18424	PA	18812	PA	21620	MD
18255	PA	18425	PA	18813	PA	21635	MD
18301	PA	18426	PA	18814	PA	21645	MD
18320	PA	18427	PA	18815	PA	21650	MD
18321	PA	18428	PA	18816	PA	21651	MD
18322	PA	18430	PA	18817	PA	21661	MD
18323	PA	18431	PA	18818	PA	21667	MD
18324	PA	18435	PA	18820	PA	21678	MD
18325	PA	18436	PA	18821	PA	21690	MD
18326	PA	18437	PA	18822	PA	22650	VA
18327	PA	18438	PA	18823	PA	22835	VA
18328	PA	18439	PA	18824	PA	22849	VA
18330	PA	18441	PA	18825	PA	22851	VA
18331	PA	18443	PA	18826	PA	22920	VA
18332	PA	18445	PA	18827	PA	22922	VA
18333	PA	18446	PA	18828	PA	22938	VA
18334	PA	18449	PA	18829	PA	22949	VA
18335	PA	18451	PA	18830	PA	22954	VA
18336	PA	18453	PA	18831	PA	22958	VA
18337	PA	18454	PA	18832	PA	22964	VA
18340	PA	18455	PA	18833	PA	22967	VA
18341	PA	18456	PA	18834	PA	22969	VA
18342	PA	18457	PA	18837	PA	22971	VA
18344	PA	18458	PA	18840	PA	22976	VA
18346	PA	18459	PA	18842	PA	24464	VA
18347	PA	18460	PA	18843	PA	24553	VA
18348	PA	18461	PA	18844	PA	28420	NC
18349	PA	18462	PA	18845	PA	28422	NC
18350	PA	18463	PA	18846	PA	28451	NC
18352	PA	18464	PA	18847	PA	28452	NC
18353	PA	18465	PA	18848	PA	28459	NC
18354	PA	18466	PA	18850	PA	28461	NC
18355	PA	18469	PA	18851	PA	28462	NC
18356	PA	18470	PA	18853	PA	28465	NC
18357	PA	18472	PA	18854	PA	28467	NC
18360	PA	18473	PA	19549	PA	28468	NC
18370	PA	18610	PA	21520	MD	28469	NC
18371	PA	18615	PA	21522	MD	28470	NC
18372	PA	18623	PA	21523	MD	28479	NC
18405	PA	18624	PA	21531	MD	28611	NC

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
28630	NC	32425	FL	33070	FL	44492	OH
28633	NC	32426	FL	43301	OH	44493	OH
28638	NC	32427	FL	43302	OH	44607	OH
28645	NC	32428	FL	43306	OH	44619	OH
28661	NC	32431	FL	43314	OH	44625	OH
28667	NC	32432	FL	43322	OH	44634	OH
29015	SC	32433	FL	43325	OH	44820	OH
29065	SC	32434	FL	43332	OH	44827	OH
29106	SC	32435	FL	43335	OH	44833	OH
29130	SC	32437	FL	43337	OH	44854	OH
29132	SC	32439	FL	43341	OH	44856	OH
29176	SC	32440	FL	43342	OH	44881	OH
29180	SC	32442	FL	43356	OH	44887	OH
32004	FL	32443	FL	43920	OH	45101	OH
32007	FL	32445	FL	43945	OH	45105	OH
32033	FL	32446	FL	43962	OH	45110	OH
32080	FL	32447	FL	43968	OH	45115	OH
32082	FL	32448	FL	44003	OH	45118	OH
32084	FL	32452	FL	44004	OH	45119	OH
32085	FL	32454	FL	44005	OH	45121	OH
32086	FL	32455	FL	44010	OH	45123	OH
32092	FL	32459	FL	44030	OH	45130	OH
32095	FL	32460	FL	44032	OH	45131	OH
32112	FL	32462	FL	44041	OH	45132	OH
32131	FL	32463	FL	44047	OH	45133	OH
32138	FL	32464	FL	44048	OH	45135	OH
32139	FL	32550	FL	44068	OH	45142	OH
32140	FL	32619	FL	44076	OH	45144	OH
32145	FL	32628	FL	44082	OH	45154	OH
32147	FL	32648	FL	44084	OH	45155	OH
32148	FL	32666	FL	44085	OH	45167	OH
32149	FL	32680	FL	44088	OH	45168	OH
32157	FL	32692	FL	44093	OH	45171	OH
32160	FL	32693	FL	44099	OH	45172	OH
32177	FL	33001	FL	44408	OH	45616	OH
32178	FL	33036	FL	44413	OH	45618	OH
32181	FL	33037	FL	44415	OH	45629	OH
32185	FL	33040	FL	44423	OH	45630	OH
32187	FL	33041	FL	44427	OH	45636	OH
32189	FL	33042	FL	44431	OH	45648	OH
32193	FL	33043	FL	44432	OH	45650	OH
32259	FL	33044	FL	44441	OH	45652	OH
32260	FL	33045	FL	44445	OH	45653	OH
32420	FL	33050	FL	44455	OH	45657	OH
32422	FL	33051	FL	44460	OH	45660	OH
32423	FL	33052	FL	44490	OH	45662	OH

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
45663	OH	47039	IN	48060	MI	48754	MI
45671	OH	47040	IN	48061	MI	48755	MI
45677	OH	47041	IN	48063	MI	48757	MI
45679	OH	47042	IN	48064	MI	48758	MI
45682	OH	47043	IN	48074	MI	48759	MI
45684	OH	47060	IN	48079	MI	48767	MI
45687	OH	47424	IN	48097	MI	48768	MI
45693	OH	47438	IN	48401	MI	48769	MI
45694	OH	47439	IN	48410	MI	48809	MI
45697	OH	47441	IN	48413	MI	48811	MI
45699	OH	47443	IN	48416	MI	48812	MI
46928	IN	47445	IN	48419	MI	48815	MI
46930	IN	47449	IN	48422	MI	48818	MI
46933	IN	47453	IN	48426	MI	48829	MI
46938	IN	47457	IN	48427	MI	48834	MI
46952	IN	47459	IN	48432	MI	48838	MI
46953	IN	47465	IN	48434	MI	48845	MI
46957	IN	47471	IN	48435	MI	48846	MI
46986	IN	47838	IN	48441	MI	48849	MI
46987	IN	47845	IN	48445	MI	48850	MI
46989	IN	47848	IN	48450	MI	48851	MI
46991	IN	47849	IN	48453	MI	48852	MI
47001	IN	47850	IN	48454	MI	48860	MI
47006	IN	47852	IN	48456	MI	48865	MI
47010	IN	47855	IN	48465	MI	48870	MI
47011	IN	47861	IN	48466	MI	48873	MI
47012	IN	47864	IN	48467	MI	48875	MI
47016	IN	47865	IN	48468	MI	48881	MI
47017	IN	47879	IN	48469	MI	48884	MI
47018	IN	47882	IN	48470	MI	48885	MI
47019	IN	48001	MI	48471	MI	48886	MI
47020	IN	48002	MI	48472	MI	48887	MI
47021	IN	48004	MI	48475	MI	48888	MI
47022	IN	48006	MI	48701	MI	48891	MI
47023	IN	48014	MI	48720	MI	49028	MI
47024	IN	48022	MI	48723	MI	49030	MI
47025	IN	48023	MI	48725	MI	49031	MI
47030	IN	48027	MI	48726	MI	49032	MI
47031	IN	48028	MI	48729	MI	49036	MI
47032	IN	48032	MI	48731	MI	49040	MI
47033	IN	48039	MI	48733	MI	49042	MI
47034	IN	48040	MI	48735	MI	49047	MI
47035	IN	48041	MI	48736	MI	49061	MI
47036	IN	48049	MI	48741	MI	49066	MI
47037	IN	48054	MI	48744	MI	49067	MI
47038	IN	48059	MI	48746	MI	49072	MI

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
49075	MI	49289	MI	49812	MI	53137	WI
49082	MI	49309	MI	49816	MI	53156	WI
49089	MI	49312	MI	49817	MI	53178	WI
49091	MI	49322	MI	49818	MI	53206	WI
49093	MI	49327	MI	49821	MI	53503	WI
49094	MI	49329	MI	49822	MI	53504	WI
49095	MI	49337	MI	49825	MI	53506	WI
49099	MI	49339	MI	49826	MI	53507	WI
49112	MI	49347	MI	49829	MI	53510	WI
49130	MI	49349	MI	49835	MI	53516	WI
49220	MI	49401	MI	49836	MI	53518	WI
49221	MI	49403	MI	49837	MI	53526	WI
49227	MI	49404	MI	49839	MI	53530	WI
49228	MI	49409	MI	49840	MI	53533	WI
49229	MI	49412	MI	49845	MI	53535	WI
49232	MI	49413	MI	49847	MI	53538	WI
49233	MI	49417	MI	49848	MI	53540	WI
49235	MI	49422	MI	49854	MI	53541	WI
49236	MI	49423	MI	49858	MI	53543	WI
49238	MI	49424	MI	49862	MI	53544	WI
49239	MI	49426	MI	49863	MI	53549	WI
49242	MI	49427	MI	49864	MI	53551	WI
49247	MI	49428	MI	49872	MI	53553	WI
49248	MI	49429	MI	49873	MI	53554	WI
49249	MI	49430	MI	49874	MI	53555	WI
49250	MI	49434	MI	49878	MI	53556	WI
49252	MI	49435	MI	49880	MI	53561	WI
49253	MI	49448	MI	49883	MI	53565	WI
49255	MI	49456	MI	49884	MI	53569	WI
49256	MI	49460	MI	49886	MI	53573	WI
49257	MI	49464	MI	49887	MI	53577	WI
49258	MI	49711	MI	49891	MI	53578	WI
49262	MI	49712	MI	49893	MI	53580	WI
49265	MI	49713	MI	49894	MI	53581	WI
49266	MI	49720	MI	49895	MI	53582	WI
49268	MI	49727	MI	49896	MI	53583	WI
49271	MI	49730	MI	49911	MI	53584	WI
49274	MI	49734	MI	49938	MI	53586	WI
49275	MI	49735	MI	49947	MI	53587	WI
49276	MI	49751	MI	49959	MI	53588	WI
49279	MI	49782	MI	49968	MI	53594	WI
49281	MI	49795	MI	49969	MI	53595	WI
49282	MI	49796	MI	53036	WI	53599	WI
49286	MI	49797	MI	53038	WI	53801	WI
49287	MI	49806	MI	53047	WI	53802	WI
49288	MI	49807	MI	53094	WI	53803	WI

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ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
53804	WI	53953	WI	54120	WI	54424	WI
53805	WI	53954	WI	54121	WI	54425	WI
53806	WI	53955	WI	54124	WI	54428	WI
53807	WI	53958	WI	54125	WI	54429	WI
53808	WI	53959	WI	54127	WI	54430	WI
53809	WI	53960	WI	54128	WI	54432	WI
53810	WI	53961	WI	54135	WI	54433	WI
53811	WI	53962	WI	54137	WI	54434	WI
53812	WI	53964	WI	54138	WI	54435	WI
53813	WI	53965	WI	54139	WI	54436	WI
53816	WI	53968	WI	54141	WI	54437	WI
53817	WI	53969	WI	54143	WI	54439	WI
53818	WI	54001	WI	54149	WI	54442	WI
53820	WI	54002	WI	54150	WI	54446	WI
53821	WI	54003	WI	54151	WI	54447	WI
53824	WI	54004	WI	54153	WI	54450	WI
53825	WI	54005	WI	54154	WI	54451	WI
53826	WI	54006	WI	54156	WI	54452	WI
53827	WI	54007	WI	54157	WI	54456	WI
53901	WI	54009	WI	54159	WI	54459	WI
53910	WI	54010	WI	54161	WI	54460	WI
53911	WI	54011	WI	54166	WI	54462	WI
53913	WI	54013	WI	54171	WI	54464	WI
53920	WI	54014	WI	54174	WI	54465	WI
53923	WI	54015	WI	54175	WI	54470	WI
53924	WI	54016	WI	54177	WI	54480	WI
53925	WI	54017	WI	54182	WI	54485	WI
53927	WI	54020	WI	54202	WI	54486	WI
53928	WI	54021	WI	54204	WI	54487	WI
53929	WI	54022	WI	54209	WI	54490	WI
53930	WI	54023	WI	54210	WI	54491	WI
53932	WI	54024	WI	54211	WI	54493	WI
53934	WI	54025	WI	54212	WI	54498	WI
53935	WI	54026	WI	54213	WI	54499	WI
53936	WI	54027	WI	54226	WI	54511	WI
53937	WI	54028	WI	54234	WI	54512	WI
53940	WI	54082	WI	54235	WI	54513	WI
53941	WI	54101	WI	54246	WI	54514	WI
53942	WI	54102	WI	54405	WI	54515	WI
53943	WI	54103	WI	54409	WI	54517	WI
53944	WI	54104	WI	54414	WI	54519	WI
53948	WI	54107	WI	54416	WI	54520	WI
53949	WI	54111	WI	54418	WI	54521	WI
53950	WI	54112	WI	54420	WI	54524	WI
53951	WI	54114	WI	54421	WI	54525	WI
53952	WI	54119	WI	54422	WI	54526	WI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54527	WI	54632	WI	54747	WI	54840	WI
54530	WI	54634	WI	54749	WI	54841	WI
54532	WI	54635	WI	54750	WI	54843	WI
54534	WI	54637	WI	54751	WI	54844	WI
54536	WI	54638	WI	54754	WI	54845	WI
54537	WI	54639	WI	54755	WI	54846	WI
54538	WI	54640	WI	54756	WI	54847	WI
54540	WI	54641	WI	54758	WI	54848	WI
54541	WI	54642	WI	54759	WI	54850	WI
54542	WI	54643	WI	54760	WI	54853	WI
54545	WI	54645	WI	54761	WI	54855	WI
54546	WI	54646	WI	54762	WI	54856	WI
54547	WI	54648	WI	54763	WI	54857	WI
54550	WI	54649	WI	54764	WI	54858	WI
54552	WI	54651	WI	54765	WI	54859	WI
54554	WI	54652	WI	54766	WI	54861	WI
54555	WI	54654	WI	54767	WI	54862	WI
54556	WI	54655	WI	54769	WI	54865	WI
54557	WI	54656	WI	54770	WI	54867	WI
54558	WI	54657	WI	54771	WI	54868	WI
54559	WI	54658	WI	54772	WI	54870	WI
54560	WI	54659	WI	54773	WI	54871	WI
54561	WI	54660	WI	54801	WI	54872	WI
54563	WI	54661	WI	54805	WI	54875	WI
54565	WI	54662	WI	54806	WI	54876	WI
54566	WI	54664	WI	54810	WI	54888	WI
54610	WI	54665	WI	54812	WI	54889	WI
54611	WI	54666	WI	54813	WI	54890	WI
54612	WI	54667	WI	54814	WI	54891	WI
54613	WI	54670	WI	54816	WI	54893	WI
54615	WI	54721	WI	54817	WI	54895	WI
54616	WI	54723	WI	54818	WI	54896	WI
54618	WI	54725	WI	54819	WI	54926	WI
54619	WI	54728	WI	54821	WI	54928	WI
54620	WI	54730	WI	54822	WI	54929	WI
54621	WI	54731	WI	54824	WI	54930	WI
54622	WI	54733	WI	54826	WI	54933	WI
54623	WI	54734	WI	54827	WI	54940	WI
54624	WI	54735	WI	54828	WI	54943	WI
54625	WI	54736	WI	54829	WI	54945	WI
54626	WI	54737	WI	54830	WI	54946	WI
54627	WI	54738	WI	54832	WI	54948	WI
54628	WI	54739	WI	54834	WI	54949	WI
54629	WI	54740	WI	54835	WI	54950	WI
54630	WI	54743	WI	54837	WI	54960	WI
54631	WI	54746	WI	54839	WI	54961	WI

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
54962	WI	57446	SD	58043	ND	58265	ND
54965	WI	57448	SD	58045	ND	58270	ND
54966	WI	57449	SD	58046	ND	58271	ND
54967	WI	57450	SD	58053	ND	58272	ND
54969	WI	57451	SD	58054	ND	58273	ND
54970	WI	57452	SD	58056	ND	58274	ND
54975	WI	57454	SD	58057	ND	58276	ND
54976	WI	57455	SD	58058	ND	58277	ND
54977	WI	57456	SD	58060	ND	58282	ND
54978	WI	57457	SD	58061	ND	58313	ND
54981	WI	57460	SD	58065	ND	58318	ND
54982	WI	57461	SD	58067	ND	58344	ND
54983	WI	57465	SD	58068	ND	58359	ND
54984	WI	57466	SD	58069	ND	58361	ND
54990	WI	57468	SD	58074	ND	58368	ND
57219	SD	57469	SD	58075	ND	58380	ND
57232	SD	57470	SD	58076	ND	58384	ND
57239	SD	57471	SD	58077	ND	58385	ND
57247	SD	57472	SD	58081	ND	58428	ND
57261	SD	57473	SD	58210	ND	58430	ND
57270	SD	57474	SD	58212	ND	58444	ND
57273	SD	57475	SD	58216	ND	58463	ND
57274	SD	57476	SD	58218	ND	58475	ND
57401	SD	57477	SD	58219	ND	58478	ND
57402	SD	57479	SD	58220	ND	58482	ND
57420	SD	57481	SD	58222	ND	58487	ND
57421	SD	57601	SD	58223	ND	58488	ND
57422	SD	57631	SD	58224	ND	58523	ND
57424	SD	57632	SD	58225	ND	58524	ND
57426	SD	57646	SD	58227	ND	58528	ND
57427	SD	57648	SD	58229	ND	58529	ND
57428	SD	58001	ND	58230	ND	58530	ND
57429	SD	58008	ND	58231	ND	58531	ND
57430	SD	58009	ND	58233	ND	58533	ND
57432	SD	58013	ND	58236	ND	58538	ND
57433	SD	58015	ND	58237	ND	58540	ND
57434	SD	58016	ND	58238	ND	58541	ND
57435	SD	58017	ND	58240	ND	58542	ND
57436	SD	58018	ND	58241	ND	58544	ND
57437	SD	58027	ND	58243	ND	58545	ND
57438	SD	58030	ND	58250	ND	58549	ND
57439	SD	58032	ND	58254	ND	58552	ND
57440	SD	58033	ND	58257	ND	58559	ND
57441	SD	58035	ND	58259	ND	58562	ND
57442	SD	58040	ND	58261	ND	58564	ND
57445	SD	58041	ND	58262	ND	58565	ND

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
58568	ND	58833	ND	59073	MT	59827	MT
58569	ND	58835	ND	59074	MT	59828	MT
58570	ND	58838	ND	59075	MT	59829	MT
58571	ND	58844	ND	59081	MT	59830	MT
58573	ND	58847	ND	59082	MT	59831	MT
58575	ND	58854	ND	59086	MT	59832	MT
58576	ND	59001	MT	59089	MT	59833	MT
58577	ND	59007	MT	59631	MT	59835	MT
58579	ND	59008	MT	59632	MT	59837	MT
58580	ND	59011	MT	59634	MT	59840	MT
58634	ND	59013	MT	59638	MT	59841	MT
58711	ND	59014	MT	59641	MT	59842	MT
58716	ND	59016	MT	59642	MT	59843	MT
58721	ND	59018	MT	59643	MT	59844	MT
58723	ND	59019	MT	59644	MT	59845	MT
58727	ND	59020	MT	59645	MT	59848	MT
58730	ND	59022	MT	59647	MT	59853	MT
58737	ND	59025	MT	59710	MT	59854	MT
58740	ND	59026	MT	59713	MT	59855	MT
58747	ND	59027	MT	59720	MT	59856	MT
58748	ND	59028	MT	59721	MT	59858	MT
58750	ND	59029	MT	59722	MT	59859	MT
58752	ND	59030	MT	59724	MT	59860	MT
58757	ND	59031	MT	59725	MT	59863	MT
58758	ND	59033	MT	59728	MT	59864	MT
58759	ND	59034	MT	59729	MT	59865	MT
58760	ND	59035	MT	59731	MT	59866	MT
58761	ND	59041	MT	59732	MT	59867	MT
58762	ND	59046	MT	59733	MT	59870	MT
58763	ND	59047	MT	59735	MT	59871	MT
58765	ND	59050	MT	59736	MT	59872	MT
58769	ND	59052	MT	59739	MT	59873	MT
58770	ND	59053	MT	59740	MT	59874	MT
58771	ND	59054	MT	59745	MT	59875	MT
58772	ND	59055	MT	59746	MT	59910	MT
58773	ND	59059	MT	59747	MT	59914	MT
58775	ND	59061	MT	59749	MT	59915	MT
58776	ND	59063	MT	59751	MT	59917	MT
58778	ND	59065	MT	59754	MT	59918	MT
58782	ND	59066	MT	59755	MT	59923	MT
58783	ND	59067	MT	59759	MT	59929	MT
58784	ND	59068	MT	59761	MT	59930	MT
58787	ND	59069	MT	59762	MT	59931	MT
58793	ND	59070	MT	59820	MT	59933	MT
58794	ND	59071	MT	59821	MT	59934	MT
58831	ND	59072	MT	59824	MT	59935	MT

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
60111	IL	66840	KS	67438	KS	75114	TX
60112	IL	66842	KS	67443	KS	75118	TX
60115	IL	66851	KS	67456	KS	75126	TX
60129	IL	66858	KS	67460	KS	75142	TX
60135	IL	66859	KS	67464	KS	75143	TX
60145	IL	66861	KS	67475	KS	75147	TX
60146	IL	66866	KS	67476	KS	75157	TX
60150	IL	67002	KS	67483	KS	75158	TX
60178	IL	67004	KS	67491	KS	75160	TX
60520	IL	67005	KS	67546	KS	75161	TX
60548	IL	67008	KS	70340	LA	76055	TX
60550	IL	67010	KS	70342	LA	76363	TX
60552	IL	67012	KS	70380	LA	76364	TX
60556	IL	67013	KS	70381	LA	76371	TX
60619	IL	67017	KS	70392	LA	76373	TX
66042	KS	67019	KS	70510	LA	76380	TX
66067	KS	67022	KS	70511	LA	76384	TX
66076	KS	67023	KS	70514	LA	76385	TX
66078	KS	67031	KS	70522	LA	76436	TX
66079	KS	67038	KS	70528	LA	76457	TX
66080	KS	67039	KS	70533	LA	76531	TX
66092	KS	67042	KS	70538	LA	76565	TX
66095	KS	67051	KS	70540	LA	76621	TX
66711	KS	67053	KS	70542	LA	76622	TX
66712	KS	67063	KS	70548	LA	76627	TX
66713	KS	67072	KS	70555	LA	76628	TX
66724	KS	67073	KS	70575	LA	76631	TX
66725	KS	67074	KS	70634	LA	76636	TX
66728	KS	67102	KS	70637	LA	76645	TX
66734	KS	67103	KS	70638	LA	76648	TX
66735	KS	67105	KS	70640	LA	76650	TX
66739	KS	67106	KS	70644	LA	76660	TX
66741	KS	67107	KS	70648	LA	76666	TX
66743	KS	67119	KS	70651	LA	76673	TX
66746	KS	67120	KS	70652	LA	76676	TX
66753	KS	67123	KS	70653	LA	76692	TX
66756	KS	67131	KS	70654	LA	76821	TX
66760	KS	67132	KS	70655	LA	76837	TX
66762	KS	67133	KS	70657	LA	76841	TX
66763	KS	67140	KS	70658	LA	76848	TX
66770	KS	67144	KS	70660	LA	76855	TX
66773	KS	67146	KS	70662	LA	76859	TX
66778	KS	67152	KS	71357	LA	76861	TX
66780	KS	67154	KS	71366	LA	76862	TX
66781	KS	67156	KS	71375	LA	76865	TX
66782	KS	67428	KS	71463	LA	76866	TX

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
76875	TX	79373	TX	82301	WY	82944	WY
76930	TX	79381	TX	82310	WY	82945	WY
76932	TX	79383	TX	82321	WY	83001	WY
76933	TX	79505	TX	82322	WY	83002	WY
76937	TX	79511	TX	82323	WY	83011	WY
76941	TX	79516	TX	82324	WY	83012	WY
76945	TX	79517	TX	82325	WY	83013	WY
76949	TX	79526	TX	82327	WY	83014	WY
76953	TX	79527	TX	82329	WY	83025	WY
77422	TX	79529	TX	82331	WY	83101	WY
77430	TX	79549	TX	82332	WY	83110	WY
77431	TX	79550	TX	82334	WY	83111	WY
77463	TX	79566	TX	82335	WY	83112	WY
77480	TX	79567	TX	82336	WY	83113	WY
77486	TX	79720	TX	82501	WY	83114	WY
77511	TX	79721	TX	82510	WY	83115	WY
77512	TX	79733	TX	82512	WY	83116	WY
77515	TX	79748	TX	82513	WY	83118	WY
77516	TX	79902	TX	82514	WY	83119	WY
77531	TX	79903	TX	82515	WY	83120	WY
77534	TX	79904	TX	82516	WY	83121	WY
77541	TX	79906	TX	82520	WY	83122	WY
77542	TX	79908	TX	82523	WY	83123	WY
77566	TX	79911	TX	82524	WY	83124	WY
77577	TX	79912	TX	82638	WY	83126	WY
77578	TX	79913	TX	82642	WY	83127	WY
77581	TX	79914	TX	82649	WY	83128	WY
77583	TX	79918	TX	82901	WY	83414	WY
77584	TX	79920	TX	82902	WY	84003	UT
77588	TX	79923	TX	82922	WY	84004	UT
78801	TX	79924	TX	82923	WY	84013	UT
78802	TX	79925	TX	82925	WY	84017	UT
78838	TX	79928	TX	82929	WY	84022	UT
78870	TX	79930	TX	82930	WY	84024	UT
78881	TX	79931	TX	82931	WY	84029	UT
78884	TX	79935	TX	82932	WY	84032	UT
79201	TX	79936	TX	82933	WY	84033	UT
79223	TX	79937	TX	82934	WY	84034	UT
79225	TX	79961	TX	82935	WY	84036	UT
79227	TX	79966	TX	82936	WY	84042	UT
79236	TX	79968	TX	82937	WY	84043	UT
79247	TX	79973	TX	82938	WY	84049	UT
79248	TX	79974	TX	82939	WY	84055	UT
79252	TX	79976	TX	82941	WY	84057	UT
79259	TX	79977	TX	82942	WY	84058	UT
79351	TX	79996	TX	82943	WY	84059	UT

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
84060	UT	87022	NM	87528	NM	88033	NM
84061	UT	87023	NM	87529	NM	88044	NM
84062	UT	87024	NM	87530	NM	88046	NM
84068	UT	87025	NM	87531	NM	88047	NM
84069	UT	87026	NM	87532	NM	88048	NM
84071	UT	87027	NM	87533	NM	88052	NM
84074	UT	87029	NM	87537	NM	88054	NM
84080	UT	87031	NM	87539	NM	88058	NM
84082	UT	87032	NM	87543	NM	88063	NM
84083	UT	87034	NM	87548	NM	88072	NM
84097	UT	87035	NM	87549	NM	88081	NM
84098	UT	87036	NM	87551	NM	88321	NM
84510	UT	87038	NM	87553	NM	88510	TX
84511	UT	87040	NM	87554	NM	88511	TX
84512	UT	87041	NM	87556	NM	88512	TX
84530	UT	87042	NM	87557	NM	88513	TX
84531	UT	87044	NM	87558	NM	88514	TX
84533	UT	87049	NM	87564	NM	88515	TX
84534	UT	87051	NM	87566	NM	88516	TX
84535	UT	87060	NM	87571	NM	88517	TX
84536	UT	87061	NM	87575	NM	88518	TX
84601	UT	87063	NM	87576	NM	88519	TX
84602	UT	87064	NM	87577	NM	88520	TX
84603	UT	87068	NM	87578	NM	88521	TX
84604	UT	87070	NM	87579	NM	88523	TX
84605	UT	87072	NM	87580	NM	88524	TX
84606	UT	87083	NM	87581	NM	88525	TX
84626	UT	87315	NM	87582	NM	88526	TX
84633	UT	87357	NM	87936	NM	88527	TX
84651	UT	87510	NM	87937	NM	88528	TX
84653	UT	87511	NM	87940	NM	88529	TX
84655	UT	87512	NM	87941	NM	88530	TX
84660	UT	87513	NM	88001	NM	88531	TX
84663	UT	87514	NM	88002	NM	88532	TX
84664	UT	87515	NM	88003	NM	88533	TX
87002	NM	87516	NM	88004	NM	88534	TX
87005	NM	87517	NM	88005	NM	88535	TX
87006	NM	87518	NM	88006	NM	88536	TX
87007	NM	87519	NM	88007	NM	88538	TX
87009	NM	87520	NM	88008	NM	88539	TX
87012	NM	87521	NM	88011	NM	88540	TX
87014	NM	87522	NM	88012	NM	88541	TX
87016	NM	87523	NM	88021	NM	88542	TX
87017	NM	87524	NM	88024	NM	88543	TX
87020	NM	87525	NM	88027	NM	88544	TX
87021	NM	87527	NM	88032	NM	88545	TX

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
88546	TX	89013	NV	89446	NV	92258	CA
88547	TX	89017	NV	89447	NV	92259	CA
88548	TX	89020	NV	89496	NV	92260	CA
88549	TX	89022	NV	89801	NV	92261	CA
88550	TX	89023	NV	89802	NV	92262	CA
88553	TX	89041	NV	89803	NV	92263	CA
88554	TX	89042	NV	89815	NV	92264	CA
88555	TX	89043	NV	89820	NV	92266	CA
88556	TX	89045	NV	89821	NV	92270	CA
88557	TX	89047	NV	89822	NV	92273	CA
88558	TX	89048	NV	89823	NV	92276	CA
88559	TX	89049	NV	89824	NV	92281	CA
88560	TX	89060	NV	89825	NV	92283	CA
88561	TX	89061	NV	89826	NV	92292	CA
88562	TX	89135	NV	89828	NV	92305	CA
88563	TX	89148	NV	89830	NV	92385	CA
88565	TX	89301	NV	89831	NV	93202	CA
88566	TX	89310	NV	89832	NV	93203	CA
88567	TX	89311	NV	89833	NV	93204	CA
88568	TX	89314	NV	89834	NV	93205	CA
88569	TX	89315	NV	89835	NV	93206	CA
88570	TX	89316	NV	89883	NV	93207	CA
88571	TX	89317	NV	92201	CA	93208	CA
88572	TX	89318	NV	92202	CA	93212	CA
88573	TX	89319	NV	92203	CA	93215	CA
88574	TX	89403	NV	92210	CA	93216	CA
88575	TX	89404	NV	92211	CA	93218	CA
88576	TX	89406	NV	92222	CA	93220	CA
88577	TX	89407	NV	92227	CA	93221	CA
88578	TX	89408	NV	92230	CA	93223	CA
88579	TX	89409	NV	92231	CA	93226	CA
88580	TX	89414	NV	92232	CA	93230	CA
88581	TX	89415	NV	92233	CA	93232	CA
88582	TX	89418	NV	92234	CA	93235	CA
88583	TX	89419	NV	92235	CA	93237	CA
88584	TX	89420	NV	92236	CA	93238	CA
88585	TX	89421	NV	92240	CA	93239	CA
88586	TX	89422	NV	92241	CA	93240	CA
88587	TX	89425	NV	92243	CA	93241	CA
88588	TX	89426	NV	92244	CA	93244	CA
88589	TX	89427	NV	92249	CA	93245	CA
88590	TX	89429	NV	92250	CA	93246	CA
89001	NV	89430	NV	92251	CA	93247	CA
89003	NV	89438	NV	92253	CA	93250	CA
89008	NV	89444	NV	92255	CA	93255	CA
89010	NV	89445	NV	92257	CA	93256	CA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
93257	CA	93516	CA	95334	CA	95988	CA
93258	CA	93517	CA	95340	CA	96009	CA
93260	CA	93518	CA	95341	CA	96010	CA
93262	CA	93519	CA	95344	CA	96014	CA
93263	CA	93528	CA	95348	CA	96021	CA
93265	CA	93529	CA	95351	CA	96023	CA
93266	CA	93531	CA	95353	CA	96024	CA
93267	CA	93541	CA	95354	CA	96025	CA
93270	CA	93546	CA	95355	CA	96027	CA
93271	CA	93554	CA	95357	CA	96029	CA
93272	CA	93561	CA	95365	CA	96031	CA
93276	CA	93581	CA	95368	CA	96032	CA
93280	CA	93596	CA	95369	CA	96034	CA
93282	CA	93601	CA	95374	CA	96035	CA
93283	CA	93604	CA	95376	CA	96037	CA
93285	CA	93608	CA	95378	CA	96038	CA
93286	CA	93610	CA	95382	CA	96039	CA
93287	CA	93614	CA	95385	CA	96041	CA
93292	CA	93615	CA	95386	CA	96044	CA
93301	CA	93620	CA	95388	CA	96046	CA
93302	CA	93627	CA	95422	CA	96048	CA
93303	CA	93635	CA	95423	CA	96050	CA
93304	CA	93637	CA	95424	CA	96052	CA
93305	CA	93638	CA	95426	CA	96055	CA
93306	CA	93639	CA	95435	CA	96056	CA
93307	CA	93643	CA	95443	CA	96057	CA
93308	CA	93644	CA	95451	CA	96058	CA
93309	CA	93645	CA	95453	CA	96059	CA
93311	CA	93653	CA	95457	CA	96061	CA
93312	CA	93661	CA	95458	CA	96063	CA
93313	CA	93665	CA	95461	CA	96064	CA
93314	CA	93668	CA	95464	CA	96067	CA
93380	CA	93669	CA	95485	CA	96068	CA
93383	CA	93670	CA	95493	CA	96074	CA
93384	CA	95301	CA	95527	CA	96075	CA
93385	CA	95303	CA	95552	CA	96078	CA
93386	CA	95307	CA	95560	CA	96080	CA
93387	CA	95312	CA	95563	CA	96085	CA
93388	CA	95315	CA	95568	CA	96086	CA
93389	CA	95317	CA	95595	CA	96090	CA
93390	CA	95319	CA	95913	CA	96091	CA
93501	CA	95322	CA	95920	CA	96092	CA
93502	CA	95324	CA	95939	CA	96093	CA
93504	CA	95326	CA	95943	CA	96094	CA
93505	CA	95328	CA	95951	CA	96097	CA
93512	CA	95333	CA	95963	CA	96107	CA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
96109	CA	97366	OR	97525	OR	98552	WA
96113	CA	97367	OR	97526	OR	98554	WA
96114	CA	97368	OR	97527	OR	98557	WA
96117	CA	97369	OR	97528	OR	98559	WA
96119	CA	97372	OR	97530	OR	98561	WA
96121	CA	97376	OR	97531	OR	98562	WA
96123	CA	97380	OR	97532	OR	98563	WA
96127	CA	97388	OR	97533	OR	98566	WA
96128	CA	97390	OR	97534	OR	98568	WA
96130	CA	97391	OR	97535	OR	98569	WA
96132	CA	97394	OR	97536	OR	98571	WA
96133	CA	97410	OR	97537	OR	98575	WA
96134	CA	97416	OR	97538	OR	98577	WA
96136	CA	97417	OR	97539	OR	98583	WA
96747	HI	97429	OR	97540	OR	98586	WA
96757	HI	97432	OR	97541	OR	98587	WA
96760	HI	97435	OR	97543	OR	98590	WA
96771	HI	97436	OR	97544	OR	98595	WA
96858	HI	97441	OR	98068	WA	98602	WA
96940	PW	97442	OR	98305	WA	98605	WA
97102	OR	97443	OR	98320	WA	98612	WA
97103	OR	97447	OR	98324	WA	98613	WA
97107	OR	97457	OR	98325	WA	98614	WA
97108	OR	97462	OR	98326	WA	98617	WA
97110	OR	97467	OR	98331	WA	98619	WA
97112	OR	97469	OR	98339	WA	98620	WA
97118	OR	97470	OR	98343	WA	98621	WA
97121	OR	97473	OR	98350	WA	98623	WA
97122	OR	97479	OR	98357	WA	98624	WA
97130	OR	97481	OR	98358	WA	98628	WA
97131	OR	97484	OR	98362	WA	98631	WA
97134	OR	97486	OR	98363	WA	98635	WA
97135	OR	97494	OR	98365	WA	98637	WA
97136	OR	97495	OR	98368	WA	98638	WA
97138	OR	97496	OR	98376	WA	98640	WA
97141	OR	97497	OR	98381	WA	98641	WA
97143	OR	97498	OR	98382	WA	98643	WA
97145	OR	97499	OR	98520	WA	98644	WA
97146	OR	97501	OR	98526	WA	98647	WA
97147	OR	97502	OR	98527	WA	98650	WA
97149	OR	97503	OR	98535	WA	98670	WA
97341	OR	97504	OR	98536	WA	98672	WA
97343	OR	97520	OR	98537	WA	98673	WA
97357	OR	97522	OR	98541	WA	98812	WA
97364	OR	97523	OR	98547	WA	98814	WA
97365	OR	97524	OR	98550	WA	98819	WA

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
98823	WA	99117	WA	99371	WA	99622	AK
98824	WA	99118	WA	99546	AK	99625	AK
98827	WA	99119	WA	99547	AK	99626	AK
98829	WA	99121	WA	99548	AK	99627	AK
98832	WA	99122	WA	99549	AK	99628	AK
98833	WA	99123	WA	99551	AK	99629	AK
98834	WA	99124	WA	99552	AK	99630	AK
98837	WA	99126	WA	99553	AK	99632	AK
98840	WA	99129	WA	99554	AK	99633	AK
98841	WA	99131	WA	99555	AK	99634	AK
98844	WA	99133	WA	99557	AK	99636	AK
98846	WA	99134	WA	99558	AK	99637	AK
98848	WA	99135	WA	99559	AK	99638	AK
98849	WA	99137	WA	99561	AK	99640	AK
98851	WA	99138	WA	99563	AK	99641	AK
98853	WA	99139	WA	99564	AK	99645	AK
98855	WA	99140	WA	99565	AK	99647	AK
98856	WA	99141	WA	99566	AK	99648	AK
98857	WA	99144	WA	99569	AK	99649	AK
98859	WA	99146	WA	99571	AK	99650	AK
98860	WA	99147	WA	99573	AK	99651	AK
98862	WA	99148	WA	99574	AK	99652	AK
98922	WA	99150	WA	99575	AK	99653	AK
98925	WA	99151	WA	99576	AK	99654	AK
98926	WA	99152	WA	99578	AK	99655	AK
98934	WA	99153	WA	99579	AK	99656	AK
98940	WA	99154	WA	99580	AK	99657	AK
98941	WA	99155	WA	99581	AK	99658	AK
98943	WA	99156	WA	99583	AK	99660	AK
98946	WA	99157	WA	99584	AK	99661	AK
98950	WA	99159	WA	99585	AK	99662	AK
99008	WA	99160	WA	99586	AK	99665	AK
99013	WA	99166	WA	99588	AK	99666	AK
99029	WA	99167	WA	99589	AK	99667	AK
99032	WA	99169	WA	99590	AK	99668	AK
99034	WA	99173	WA	99591	AK	99670	AK
99040	WA	99180	WA	99602	AK	99674	AK
99101	WA	99181	WA	99604	AK	99675	AK
99103	WA	99185	WA	99606	AK	99676	AK
99105	WA	99321	WA	99607	AK	99677	AK
99107	WA	99322	WA	99609	AK	99678	AK
99109	WA	99341	WA	99612	AK	99679	AK
99110	WA	99344	WA	99613	AK	99680	AK
99114	WA	99349	WA	99614	AK	99681	AK
99115	WA	99356	WA	99620	AK	99683	AK
99116	WA	99357	WA	99621	AK	99685	AK

ADDENDUM K- MENTAL HEALTH HPSA ZIP CODES

2005 Mental Health HPSA Zip Code List

Effective for claims with 2005 dates of service.

ZIP	STATE	ZIP	STATE	ZIP	STATE	ZIP	STATE
99686	AK	99748	AK	99919	AK		
99687	AK	99749	AK	99921	AK		
99688	AK	99750	AK	99922	AK		
99689	AK	99751	AK	99923	AK		
99690	AK	99752	AK	99925	AK		
99691	AK	99754	AK	99926	AK		
99692	AK	99755	AK	99927	AK		
99693	AK	99756	AK	99928	AK		
99694	AK	99757	AK	99929	AK		
99701	AK	99758	AK				
99702	AK	99759	AK				
99703	AK	99760	AK				
99704	AK	99761	AK				
99705	AK	99763	AK				
99706	AK	99764	AK				
99707	AK	99765	AK				
99708	AK	99766	AK				
99709	AK	99767	AK				
99710	AK	99768	AK				
99711	AK	99770	AK				
99712	AK	99773	AK				
99714	AK	99774	AK				
99716	AK	99775	AK				
99720	AK	99776	AK				
99721	AK	99777	AK				
99722	AK	99779	AK				
99723	AK	99780	AK				
99724	AK	99781	AK				
99725	AK	99782	AK				
99726	AK	99786	AK				
99727	AK	99788	AK				
99729	AK	99789	AK				
99730	AK	99791	AK				
99732	AK	99820	AK				
99733	AK	99825	AK				
99734	AK	99826	AK				
99736	AK	99827	AK				
99737	AK	99829	AK				
99738	AK	99830	AK				
99740	AK	99832	AK				
99741	AK	99833	AK				
99743	AK	99840	AK				
99744	AK	99841	AK				
99745	AK	99901	AK				
99746	AK	99903	AK				
99747	AK	99918	AK				

ADDENUM L

LIST OF CPT[1]/HCPCS CODES USED TO DESCRIBE CERTAIN DESIGNATED HEALTH SERVICE CATEGORIES[2] UNDER SECTION 1877 OF THE SOCIAL SECURITY ACT—Effective January 1, 2005

CLINICAL LABORATORY SERVICES

INCLUDE CPT codes for all clinical laboratory services in the 80000 series, except EXCLUDE CPT codes for the following blood component collection services:

86890	Autologous blood process
86891	Autologous blood, op salvage
86927	Plasma, fresh frozen
86930	Frozen blood prep
86931	Frozen blood thaw
86932	Frozen blood freeze/thaw
86945	Blood product/irradiation
86950	Leukacyte transfusion
86965	Pooling blood platelets
86985	Split blood or products

INCLUDE the following CPT and HCPCS level 2 codes for other clinical laboratory services:

0010T	TB test, gamma interferon
0023T	Phenotype drug test, hiv 1
0026T	Measure remnant lipoproteins
0030T	Antiprothrombin antibody

1CPT codes and descriptions only are copyright 2004 American Medical Association. All rights are reserved and applicable FARS/DFARS clauses apply.

[2] This list does not include codes for the following designated health service categories: durable medical equipment and supplies; parenteral and enteral nutrients, equipment and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services. For the full definition of designated health services, refer to 42 CFR 411.351. For more information, refer to http://cms.hhs.gov/medlearn/refphys.asp.

0041T	Detect ur infect agnt w/cpas
0043T	Co expired gas analysis
0058T	Cryopreservation, ovary tiss
0059T	Cryopreservation, oocyte
0064T	Spectroscop eval expired gas
0085T	Breath test heart reject
0087T	Sperm eval hyaluronan
36415	Routine venipuncture
G0027	Semen analysis
G0103	Psa, total screening
G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0306	CBC/diffwbc w/o platelet
G0307	CBC without platelet
G0328	Fecal blood scrn immunoassay
P2028	Cephalin floculation test
P2029	Congo red blood test
P2033	Blood thymol turbidity
P2038	Blood mucoprotein
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys
P9612	Catheterize for urine spec
P9615	Urine specimen collect mult
Q0111	Wet mounts/ w preparations
Q0112	Potassium hydroxide preps
Q0113	Pinworm examinations
Q0114	Fern test
Q0115	Post-coital mucous exam

PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY

INCLUDE the following CPT codes for the physical therapy/occupational therapy/speech-language pathology services in the 97000 series:

97001	Pt evaluation

97002	Pt re-evaluation
97003	Ot evaluation
97004	Ot re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97020	Microwave therapy
97022	Whirlpool therapy
97024	Diathermy treatment
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97039	Physical therapy treatment
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97139	Physical medicine procedure
97140	Manual therapy
97150	Group therapeutic procedures
97504	Orthotic training
97520	Prosthetic training
97530	Therapeutic activities
97532	Cognitive skills development
97533	Sensory integration
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20cm or <
97598	Active wound care > 20cm
97602	Wound(s) care nonselective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97703	Prosthetic checkout
97750	Physical performance test
97755	Assistive technology assess
97799	Physical medicine procedure

INCLUDE CPT codes for physical therapy/occupational therapy/speech-language pathology services not in the 97000 series:

64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
92507	Speech/hearing therapy
92508	Speech/hearing therapy
92526	Oral function therapy
92597	Oral speech device eval
92607	Ex for speech device rx, 1hr
92608	Ex for speech device rx addl
92609	Use of speech device service
92610	Evaluate swallowing function
92611	Motion fluoroscopy/swallow
92612	Endoscopy swallow tst (fees)
92614	Laryngoscopic sensory test
92616	Fees w/laryngeal sense test
93797	Cardiac rehab
93798	Cardiac rehab/monitor
94667	Chest wall manipulation
94668	Chest wall manipulation
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual
95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
96000	Motion analysis, video/3d
96001	Motion test w/ft press meas
96002	Dynamic surface emg
96003	Dynamic fine wire emg
96105	Assessment of aphasia
96110	Developmental test, lim
96111	Developmental test, extend
96115	Neurobehavior status exam
0029T	Magnetic tx for incontinence

INCLUDE HCPCS level 2 codes for the following physical therapy/occupational therapy/speech-language pathology services:

G0279	Excorp shock tx, elbow epi

G0280	Excorp shock tx other than
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

RADIOLOGY AND CERTAIN OTHER IMAGING SERVICES

INCLUDE the following codes in the CPT 70000 series:

70100	X-ray exam of jaw
70110	X-ray exam of jaw
70120	X-ray exam of mastoids
70130	X-ray exam of mastoids
70134	X-ray exam of middle ear
70140	X-ray exam of facial bones
70150	X-ray exam of facial bones
70160	X-ray exam of nasal bones
70190	X-ray exam of eye sockets
70200	X-ray exam of eye sockets
70210	X-ray exam of sinuses
70220	X-ray exam of sinuses
70240	X-ray exam, pituitary saddle
70250	X-ray exam of skull
70260	X-ray exam of skull
70300	X-ray exam of teeth
70310	X-ray exam of teeth
70320	Full mouth x-ray of teeth
70328	X-ray exam of jaw joint
70330	X-ray exam of jaw joints
70336	Magnetic image, jaw joint
70350	X-ray head for orthodontia
70355	Panoramic x-ray of jaws
70360	X-ray exam of neck
70370	Throat x-ray & fluoroscopy
70371	Speech evaluation, complex
70380	X-ray exam of salivary gland
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 sft tsue nck w/o & w/dye
70496	Ct angiography, head
70498	Ct angiography, neck
70540	Mri orbit/face/neck w/o dye
70542	Mri orbit/face/neck w/dye
70543	Mri orbt/fac/nck w/o & w/dye
70544	Mr angiography head w/o dye
70545	Mr angiography head w/dye
70546	Mr angiograph head w/o&w/dye
70547	Mr angiography neck w/o dye
70548	Mr angiography neck w/dye
70549	Mr angiograph neck w/o&w/dye
70551	Mri brain w/o dye
70552	Mri brain w/dye
70553	Mri brain w/o & w/dye
71010	Chest x-ray
71015	Chest x-ray
71020	Chest x-ray
71021	Chest x-ray
71022	Chest x-ray
71023	Chest x-ray and fluoroscopy
71030	Chest x-ray
71034	Chest x-ray and fluoroscopy
71035	Chest x-ray
71100	X-ray exam of ribs
71101	X-ray exam of ribs/chest
71110	X-ray exam of ribs
71111	X-ray exam of ribs/chest
71120	X-ray exam of breastbone
71130	X-ray exam of breastbone
71250	Ct thorax w/o dye
71260	Ct thorax w/dye
71270	Ct thorax w/o & w/dye
71275	Ct angiography, chest
71550	Mri chest w/o dye
71551	Mri chest w/dye
71552	Mri chest w/o & w/dye
71555	Mri angio chest w or w/o dye
72010	X-ray exam of spine
72020	X-ray exam of spine
72040	X-ray exam of neck spine
72050	X-ray exam of neck spine

72052	X-ray exam of neck spine
72069	X-ray exam of trunk spine
72070	X-ray exam of thoracic spine
72072	X-ray exam of thoracic spine
72074	X-ray exam of thoracic spine
72080	X-ray exam of trunk spine
72090	X-ray exam of trunk spine
72100	X-ray exam of lower spine
72110	X-ray exam of lower spine
72114	X-ray exam of lower spine
72120	X-ray exam of lower spine
72125	Ct neck spine w/o dye
72126	Ct neck spine w/dye
72127	Ct neck spine w/o & w/dye
72128	Ct chest spine w/o dye
72129	Ct chest spine w/dye
72130	Ct chest spine w/o & w/dye
72131	Ct lumbar spine w/o dye
72132	Ct lumbar spine w/dye
72133	Ct lumbar spine w/o & w/dye
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
72170	X-ray exam of pelvis
72190	X-ray exam of pelvis
72191	Ct angiograph pelv w/o&w/dye
72192	Ct pelvis w/o dye
72193	Ct pelvis w/dye
72194	Ct pelvis w/o & w/dye
72195	Mri pelvis w/o dye
72196	Mri pelvis w/dye
72197	Mri pelvis w/o & w/dye
72198	Mr angio pelvis w/o & w/dye
72200	X-ray exam sacroiliac joints
72202	X-ray exam sacroiliac joints
72220	X-ray exam of tailbone
73000	X-ray exam of collar bone
73010	X-ray exam of shoulder blade
73020	X-ray exam of shoulder

73030	X-ray exam of shoulder
73050	X-ray exam of shoulders
73060	X-ray exam of humerus
73070	X-ray exam of elbow
73080	X-ray exam of elbow
73090	X-ray exam of forearm
73092	X-ray exam of arm, infant
73100	X-ray exam of wrist
73110	X-ray exam of wrist
73120	X-ray exam of hand
73130	X-ray exam of hand
73140	X-ray exam of finger(s)
73200	Ct upper extremity w/o dye
73201	Ct upper extremity w/dye
73202	Ct uppr extremity w/o&w/dye
73206	Ct angio upr extrm w/o&w/dye
73218	Mri upper extremity w/o dye
73219	Mri upper extremity w/dye
73220	Mri uppr extremity w/o&w/dye
73221	Mri joint upr extrem w/o dye
73222	Mri joint upr extrem w/dye
73223	Mri joint upr extr w/o&w/dye
73500	X-ray exam of hip
73510	X-ray exam of hip
73520	X-ray exam of hips
73540	X-ray exam of pelvis & hips
73550	X-ray exam of thigh
73560	X-ray exam of knee, 1 or 2
73562	X-ray exam of knee, 3
73564	X-ray exam, knee, 4 or more
73565	X-ray exam of knees
73590	X-ray exam of lower leg
73592	X-ray exam of leg, infant
73600	X-ray exam of ankle
73610	X-ray exam of ankle
73620	X-ray exam of foot
73630	X-ray exam of foot
73650	X-ray exam of heel
73660	X-ray exam of toe(s)
73700	Ct lower extremity w/o dye
73701	Ct lower extremity w/dye
73702	Ct lwr extremity w/o&w/dye
73706	Ct angio lwr extr w/o&w/dye
73718	Mri lower extremity w/o dye
73719	Mri lower extremity w/dye

73720	Mri lwr extremity w/o&w/dye
73721	Mri jnt of lwr extre w/o dye
73722	Mri joint of lwr extr w/dye
73723	Mri joint lwr extr w/o&w/dye
73725	Mr ang lwr ext w or w/o dye
74000	X-ray exam of abdomen
74010	X-ray exam of abdomen
74020	X-ray exam of abdomen
74022	X-ray exam series, abdomen
74150	Ct abdomen w/o dye
74160	Ct abdomen w/dye
74170	Ct abdomen w/o &w/dye
74175	Ct angio abdom w/o & w/dye
74181	Mri abdomen w/o dye
74182	Mri abdomen w/dye
74183	Mri abdomen w/o & w/dye
74185	Mri angio, abdom w orw/o dye
74210	Contrst x-ray exam of throat
74220	Contrast x-ray, esophagus
74230	Cine/vid x-ray, throat/esoph
74240	X-ray exam, upper gi tract
74241	X-ray exam, upper gi tract
74245	X-ray exam, upper gi tract
74246	Contrst x-ray uppr gi tract
74247	Contrst x-ray uppr gi tract
74249	Contrst x-ray uppr gi tract
74250	X-ray exam of small bowel
74290	Contrast x-ray, gallbladder
74291	Contrast x-rays, gallbladder
74710	X-ray measurement of pelvis
75552	Heart mri for morph w/o dye
75553	Heart mri for morph w/dye
75554	Cardiac MRI/function
75555	Cardiac MRI/limited study
75635	Ct angio abdominal arteries
76000	Fluoroscope examination
76006	X-ray stress view
76010	X-ray, nose to rectum
76020	X-rays for bone age
76040	X-rays, bone evaluation
76061	X-rays, bone survey
76062	X-rays, bone survey
76065	X-rays, bone evaluation
76066	Joint survey, single view
76070	Ct bone density, axial

76071	Ct bone density, peripheral
76075	Dxa bone density, axial
76076	Dxa bone density/peripheral
76077	Dxa bone density/v-fracture
76078	Radiographic absorptiometry
76082	Computer mammogram add-on
76083	Computer mammogram add-on
76090	Mammogram, one breast
76091	Mammogram, both breasts
76092	Mammogram, screening
76093	Magnetic image, breast
76094	Magnetic image, both breasts
76100	X-ray exam of body section
76101	Complex body section x-ray
76102	Complex body section x-rays
76120	Cine/video x-rays
76125	Cine/video x-rays add-on
76150	X-ray exam, dry process
76370	Ct scan for therapy guide
76375	3d/holograph reconstr add-on
76380	CAT scan follow-up study
76400	Magnetic image, bone marrow
76499	Radiographic procedure
76506	Echo exam of head
76510	Ophth us, b & quant a
76511	Ophth us, quant a only
76512	Ophth us, b w/non-quant a
76513	Echo exam of eye, water bath
76514	Echo exam of eye, thickness
76516	Echo exam of eye
76519	Echo exam of eye
76536	Us exam of head and neck
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
76800	Us exam, spinal canal
76801	Ob us < 14 wks, single fetus
76802	Ob us < 14 wks, add'l fetus
76805	Ob us >/= 14 wks, sngl fetus
76810	Ob us >/= 14 wks, addl fetus
76811	Ob us, detailed, sngl fetus

76812	Ob us, detailed, addl fetus
76815	Ob us, limited, fetus(s)
76816	Ob us, follow-up, per fetus
76818	Fetal biophys profile w/nst
76819	Fetal biophys profil w/o nst
76820	Umbilical artery echo
76821	Middle cerebral artery echo
76825	Echo exam of fetal heart
76826	Echo exam of fetal heart
76827	Echo exam of fetal heart
76828	Echo exam of fetal heart
76856	Us exam, pelvic, complete
76857	Us exam, pelvic, limited
76870	Us exam, scrotum
76880	Us exam, extremity
76885	Us exam infant hips, dynamic
76886	Us exam infant hips, static
76970	Ultrasound exam follow-up
76977	Us bone density measure
76999	Echo examination procedure

INCLUDE the following CPT codes for echocardiography and vascular ultrasound:

93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93320	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93321	Doppler echo exam, heart [if used in conjunction with 93303-93308]
93325	Doppler color flow add-on [if used in conjunction with 93303-93308]
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Intracranial study
93890	Tcd, vasoreactivity study
93892	Tcd, emboli detect w/o inj
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study

93926	Lower extremity study
93930	Upper extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing

INCLUDE the following CPT and HCPCS level 2 codes:

51798	Us urine capacity measure
78350	Bone mineral, single photon
91110	Gi tract capsule endoscopy
0028T	Dexa body composition study
0042T	Ct perfusion w/contrast, cbf
0067T	Ct colonography;dx
G0130	Single energy x-ray study
G0202	Screeningmammographydigital
G0204	Diagnosticmammographydigital
G0206	Diagnosticmammographydigital
G0288	Recon, CTA for surg plan
Q0092	Set up port xray equipment
R0070	Transport portable x-ray
R0075	Transport port x-ray multipl

RADIATION THERAPY SERVICES AND SUPPLIES

INCLUDE the following codes in the CPT 70000 series:

77261	Radiation therapy planning
77262	Radiation therapy planning
77263	Radiation therapy planning
77280	Set radiation therapy field
77285	Set radiation therapy field
77290	Set radiation therapy field
77295	Set radiation therapy field
77299	Radiation therapy planning
77300	Radiation therapy dose plan
77301	Radiotherapy dose plan, imrt
77305	Teletx isodose plan simple

77310	Teletx isodose plan intermed
77315	Teletx isodose plan complex
77321	Special teletx port plan
77326	Brachytx isodose calc simp
77327	Brachytx isodose calc interm
77328	Brachytx isodose plan compl
77331	Special radiation dosimetry
77332	Radiation treatment aid(s)
77333	Radiation treatment aid(s)
77334	Radiation treatment aid(s)
77336	Radiation physics consult
77370	Radiation physics consult
77399	External radiation dosimetry
77401	Radiation treatment delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77417	Radiology port film(s)
77418	Radiation tx delivery, imrt
77427	Radiation tx management, x5
77431	Radiation therapy management
77432	Stereotactic radiation trmt
77470	Special radiation treatment
77499	Radiation therapy management
77520	Proton trmt, simple w/o comp
77522	Proton trmt, simple w/comp
77523	Proton trmt, intermediate
77525	Proton treatment, complex
77600	Hyperthermia treatment
77605	Hyperthermia treatment
77610	Hyperthermia treatment
77615	Hyperthermia treatment
77620	Hyperthermia treatment
77750	Infuse radioactive materials
77761	Apply intrcav radiat simple
77762	Apply intrcav radiat interm

77763	Apply intrcav radiat compl
77776	Apply interstit radiat simpl
77777	Apply interstit radiat inter
77778	Apply interstit radiat compl
77781	High intensity brachytherapy
77782	High intensity brachytherapy
77783	High intensity brachytherapy
77784	High intensity brachytherapy
77789	Apply surface radiation
77790	Radiation handling
77799	Radium/radioisotope therapy

INCLUDE the following CPT and HCPCS level 2 codes classified elsewhere:

19296	Place po breast cath for rad
19297	Place breast cath for rad
19298	Place breast rad tube/caths
31643	Diag bronchoscope/catheter
55859	Percut/needle insert, pros
57155	Insert uteri tandems/ovoids
58346	Insert heyman uteri capsule
61770	Incise skull for treatment
61793	Focus radiation beam
92974	Cath place, cardio brachytx
0073T	Delivery, comp imrt
0082T	Stereotactic rad delivery
0083T	Stereotactic rad tx mngmt
G0173	Stereo radiosurgery,complete
G0242	Multisource photon ster plan
G0243	Multisour photon stero treat
G0251	Linear acc based stero radio
G0338	Linear accelerator stero pln
G0339	Robot lin-radsurg com, first
G0340	Robt lin-radsurg fractx 2-5

EPO AND OTHER DIALYSIS-RELATED DRUGS

The physician self-referral prohibition does not apply to the following codes for EPO and other dialysis-related drugs furnished in or by an ESRD facility if the conditions in §411.355(g) are satisfied:

J0630	Calcitonin salmon injection
J0636	Inj calcitriol per 0.1 mcg

J0895	Deferoxamine mesylate inj
J1270	Injection, doxercalciferol
J1750	Iron dextran
J1756	Iron sucrose injection
J1955	Inj levocarnitine per 1 gm
J2501	Paricalcitol
J2916	Na ferric gluconate complex
J2993	Reteplase injection
J2995	Inj streptokinase /250000 IU
J2997	Alteplase recombinant
J3364	Urokinase 5000 IU injection
P9041	Albumin (human),5%, 50ml
P9045	Albumin (human), 5%, 250ml
P9046	Albumin (human), 25%, 20ml
P9047	Albumin (human), 25%, 50ml
Q4054	Darbepoetin alfa, esrd use
Q4055	Epoetin alfa, esrd use

PREVENTIVE SCREENING TESTS, IMMUNIZATIONS AND VACCINES

The physician self-referral prohibition does not apply to the following tests if they are performed for screening purposes and satisfy the conditions in §411.355(h):

76083	Computer mammogram add-on
76092	Mammogram, screening
80061	Lipid panel [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82465	Assay, bld/serum cholesterol [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
82947	Assay, glucose, blood quant [only when billed with ICD-9-CM code V77.1]
82950	Glucose test [only when billed with ICD-9-CM code V77.1]
82951	Glucose tolerance test (GTT) [only when billed with ICD-9-CM code V77.1]
83718	Assay of lipoprotein [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
84478	Assay of triglycerides [only when billed with one of the following ICD-9-CM codes: V81.0, V81.1, or V.81.2]
G0103	Psa, total screening

G0107	CA screen; fecal blood test
G0123	Screen cerv/vag thin layer
G0124	Screen c/v thin layer by MD
G0141	Scr c/v cyto,autosys and md
G0143	Scr c/v cyto,thinlayer,rescr
G0144	Scr c/v cyto,thinlayer,rescr
G0145	Scr c/v cyto,thinlayer,rescr
G0147	Scr c/v cyto, automated sys
G0148	Scr c/v cyto, autosys, rescr
G0202	Screening mammographydigital
G0328	Fecal blood scrn immunoassay
P3000	Screen pap by tech w md supv
P3001	Screening pap smear by phys

The physician self-referral prohibition does not apply to the following immunization and vaccine codes if they satisfy the conditions in §411.355(h):

90655	Flu vaccine no preserv 6-35m
90656	Flu vaccine no preserv 3 & >
90657	Flu vaccine, 3 yrs, im
90658	Flu vaccine, 3 yrs & >, im
90732	Pneumococcal vaccine
90740	Hepb vacc, ill pat 3 dose im
90743	Hep b vacc, adol, 2 dose im
90744	Hepb vacc ped/adol 3 dose im
90746	Hep b vaccine, adult, im
90747	Hepb vacc, ill pat 4 dose im

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