DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 410, 411, 414, 415, and 485

[CMS–1413–P]

RIN 0938–AP40

Medicare Program; Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2010

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

ACTION: Proposed rule.

SUMMARY: This proposed rule would address proposed changes to Medicare Part B payment policy. We are proposing these changes to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services. This proposed rule discusses: Refinements to resource-based work, practice expense and malpractice relative value units (RVUs); geographic practice cost indices (GPCIs); telehealth services; several coding issues; physician fee schedule update for CY 2010; payment for covered part B outpatient drugs and biologicals; the competitive acquisition program (CAP); payment for renal dialysis services; the chiropractic services demonstration; comprehensive outpatient rehabilitation facilities; physician self-referral; the ambulance fee schedule; the clinical laboratory fee schedule; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and certain provisions of the Medicare Improvements for Patients and Providers Act of 2008. (*See* the Table of contents for a listing of the specific issues.)

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. on Monday, August 31, 2009.

ADDRESSES: In commenting, please refer to file code CMS–1413–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically*. You may submit electronic comments on this regulation to *http://www.regulations.gov*. Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail*. You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–P, P.O. Box 8013, Baltimore, MD 21244–8013.

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

3. *By express or overnight mail*. You may send written comments to the following address only: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–1413–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier*. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

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

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

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

FOR FURTHER INFORMATION CONTACT:

Rick Ensor, (410) 786–5617, for issues related to practice expense methodology.

Craig Dobyski, (410) 786–4584, for issues related to geographic practice cost indices.

Esther Markowitz, (410) 786–4595, for issues related to telehealth services.

Ken Marsalek, (410) 786–4502, for issues related to the physician practice information survey and the multiple procedure payment reduction.

Cathleen Scally, (410) 786–5714, for issues related to the initial preventive physical examination or consultation services.

Regina Walker-Wren, (410) 786–9160, for issues related to the phasing out of the outpatient mental health treatment limitation.

Diane Stern, (410) 786–1133, for issues related to the physician quality reporting initiative and incentives for e-prescribing.

Lisa Grabert, (410) 786–6827, for issues related to the Physician Resource Use Feedback Program.

Colleen Bruce, (410) 786–5529, for issues related to value-based purchasing.

Sandra Bastinelli, (410) 786–3630, for issues related to the implementation of accreditation standards.

Jim Menas, (410) 786–4507, for issues related to teaching anesthesia services.

Sarah McClain, (410) 786–2994, for issues related to the coverage of cardiac rehabilitation services.

Dorothy Shannon, (410) 786–3396, for issues related to payment for cardiac rehabilitation services.

Roya Lofti, (410) 786–4072, for issues related to the coverage of pulmonary rehabilitation.

Jamie Hermansen, (410) 786–2064, for issues related to kidney disease patient education programs.

Terri Harris, (410) 786–6830 for issues related to payment for kidney disease patient education.

Henry Richter, (410) 786–4562, or Lisa Hubbard, (410) 786–5472, for issues related to renal dialysis provisions and payments for end-stage renal disease facilities.

Cheryl Gilbreath, (410) 786–5919, for issues related to payment for covered outpatient drugs and biologicals.

Edmund Kasaitis, (410) 786–0477, or Bonny Dahm, (410) 786–4006, for issues related to the Competitive Acquisition Program (CAP) for Part B drugs.

Pauline Lapin, (410) 786–6883, for issues related to the chiropractic services demonstration budget neutrality issue.

Monique Howard, (410) 786–3869, for issues related to CORF conditions of coverage.

Roechel Kujawa, (410) 786–9111, for issues related to ambulance services.

Anne Tayloe Hauswald, (410) 786–4546, for clinical laboratory issues.

Troy Barsky, (410) 786–8873, or Roy Albert, (410) 786–1872, for issues related to physician self-referral.

Michelle Peterman, (410) 786–2591, or Iffat Fatima, (410) 786–6709 for issues related to the grandfathering

provisions of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) Competitive Acquisition Program.

Ralph Goldberg, (410) 786–4870, or Heidi Edmunds, (410) 786–1781, for issues related to the damages process caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program.

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

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: *http://www.regulations.gov*. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

Table of Contents

To assist readers in referencing sections contained in this preamble, we are providing a 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* (CFR). Information on the regulation's impact appears throughout the preamble, and therefore, is not exclusively in section V. of this proposed rule.

Addendum F—Proposed CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas
Addendum G—Propsoed CY 2010 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

Acronyms

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

AACVPR American Association of Cardiovascular and Pulmonary Rehabilitation
ACC American College of Cardiology
ACGME Accreditation Council on Graduate Medical Education
ACR American College of Radiology
AFROC Association of Freestanding Radiation Oncology Centers
AHA American Heart Association
AHRQ [HHS'] Agency for Healthcare Research and Quality
AIDS Acquired immune deficiency syndrome
AMA American Medical Association
AMP Average manufacturer price
AOA American Osteopathic Association
APA American Psychological Association
APTA American Physical Therapy Association
ASC Ambulatory surgical center
ASP Average sales price
ASRT American Society of Radiologic Technologists
ASTRO American Society for Therapeutic Radiology and Oncology
ATA American Telemedicine Association
AWP Average wholesale price
BBA Balanced Budget Act of 1997 (Pub. L. 105–33)
BBRA [Medicare, Medicaid and State Child Health Insurance Program] Balanced Budget Refinement Act of 1999 (Pub. L. 106–113)
BIPA Medicare, Medicaid, and SCHIP Benefits Improvement Protection Act of 2000 (Pub. L. 106–554)
BLS Bureau of Labor Statistics
BN Budget neutrality
CABG Coronary artery bypass graft
CAD Coronary artery disease
CAH Critical access hospital
CAHEA Committee on Allied Health Education and Accreditation
CAP Competitive acquisition program
CBSA Core-Based Statistical Area
CCHIT Certification Commission for Healthcare Information Technology
CEAMA Council on Education of the American Medical Association
CF Conversion factor
CfC Conditions for Coverage
CFR Code of Federal Regulations
CKD Chronic kidney disease
CLFS Clinical laboratory fee schedule
CMA California Medical Association
CMHC Community mental health center
CMP Civil money penalty
CMS Centers for Medicare & Medicaid Services
CNS Clinical nurse specialist
CoP Condition of participation
COPD Chronic obstructive pulmonary disease
CORF Comprehensive Outpatient Rehabilitation Facility
COS Cost of service
CPEP Clinical Practice Expert Panel
CPI Consumer Price Index
CPI–U Consumer price index for urban customers
CPT [Physicians'] Current Procedural Terminology (4th Edition, 2002, copyrighted by the American Medical Association)
CR Cardiac rehabilitation
CRNA Certified registered nurse anesthetist
CRP Canalith repositioning
CRT Certified respiratory therapist
CSW Clinical social worker
CY Calendar year
DHS Designated health services
DME Durable medical equipment
DMEPOS Durable medical equipment, prosthetics, orthotics, and supplies
DOQ Doctor's Office Quality
DRA Deficit Reduction Act of 2005 (Pub. L. 109–171)
DSMT Diabetes self-management training
E/M Evaluation and management
EDI Electronic data interchange
EEG Electroencephalogram
EHR Electronic health record
EKG Electrocardiogram
EMG Electromyogram
EMTALA Emergency Medical Treatment and Active Labor Act
EOG Electro-oculogram
EPO Erythropoietin
ESRD End-stage renal disease
FAX Facsimile
FDA Food and Drug Administration (HHS)
FEV Forced expiratory volume
FFS Fee-for-service
FR **Federal Register**
FVC Forced expiratory vital capacity (liters)
GAF Geographic adjustment factor
GAO General Accountability Office
GEM Generating Medicare [Physician Quality Performance Measurement Results]
GFR Glomerular filtration rate
GPO Group purchasing organization
GPCI Geographic practice cost index
HAC Hospital-acquired conditions
HBAI Health and behavior assessment and intervention
HCPAC Health Care Professional Advisory Committee
HCPCS Healthcare Common Procedure Coding System
HCRIS Healthcare Cost Report Information System
HDRT High dose radiation therapy
HH PPS Home Health Prospective Payment System
HHA Home health agency
HHRG Home health resource group
HHS [Department of] Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
HIT Health information technology
HITECH Health Information Technology for Economic and Clinical Health Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act)
HITSP Healthcare Information Technology Standards Panel
HIV Human immunodeficiency virus
HOPD Hospital outpatient department
HPSA Health Professional Shortage Area
HRSA Health Resources Services Administration (HHS)
ICD International Classification of Diseases
IACS Individuals Access to CMS Systems
ICF Intermediate care facilities
ICR Intensive cardiac rehabilitation
ICR Information collection requirement
IDTF Independent diagnostic testing facility
IFC Interim final rule with comment period
IMRT Intensity-Modulated Radiation Therapy
IPPE Initial preventive physical examination
IPPS Inpatient prospective payment system
IRS Internal Revenue Service
ISO Insurance services office
IVD Ischemic Vascular Disease
IVIG Intravenous immune globulin
IWPUT Intra-service work per unit of time
JRCERT Joint Review Committee on Education in Radiologic Technology
JUA Joint underwriting association
KDE Kidney disease education
MA Medicare Advantage
MA–PD Medicare Advantage-Prescription Drug Plans
MCMP Medicare Care Management Performance
MedCAC Medicare Evidence Development and Coverage Advisory Committee (formerly the Medicare Coverage Advisory Committee (MCAC))
MedPAC Medicare Payment Advisory Commission
MEI Medicare Economic Index
MIEA–TRHCA Medicare Improvements and Extension Act of 2006 (that is, Division B of the Tax Relief and Health Care Act of 2006 (TRHCA) (Pub. L. 109–432)
MIPPA Medicare Improvements for Patients and Providers Act of 2008 (Pub. L. 110–275)
MMA Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Pub. L. 108–173)
MMSEA Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173)
MNT Medical nutrition therapy
MP Malpractice
MPPR Multiple procedure payment reduction
MQSA Mammography Quality Standards Act of 1992 (Pub. L. 102–539)
MRA Magnetic resonance angiography
MRI Magnetic resonance imaging
MS-DRG Medicare Severity-Diagnosis related group
MSA Metropolitan statistical area
NCD National Coverage Determination
NCH National Claims History
NCPDP National Council for Prescription Drug Programs
NCQDIS National Coalition of Quality Diagnostic Imaging Services
NDC National drug code
NF Nursing facility
NISTA National Institute of Standards and Technology Act
NP Nurse practitioner
NPDB National Practitioner Data Bank
NPI National Provider Identifier

NPP Nonphysician practitioner
NPPES National Plan and Provider Enumeration System
NQF National Quality Forum
NRC Nuclear Regulatory Commission
NTTAA National Technology Transfer and Advancement Act of 1995 (Pub. L. 104–113)
NUBC National Uniform Billing Committee
OACT [CMS'] Office of the Actuary
OBRA Omnibus Budget Reconciliation Act
ODF Open door forum
OIG Office of Inspector General
OMB Office of Management and Budget
ONC [HHS'] Office of the National Coordinator
OPPS Outpatient prospective payment system
OSA Obstructive Sleep Apnea
OSCAR Online Survey and Certification and Reporting
P4P Pay for performance
PA Physician assistant
PBM Pharmacy benefit manager
PC Professional component
PCF Patient compensation fund
PCI Percutaneous coronary intervention
PDE Prescription drug event
PDP Prescription drug plan
PE Practice expense
PE/HR Practice expense per hour
PEAC Practice Expense Advisory Committee
PECOS Provider Enrollment, Chain, and Ownership System
PERC Practice Expense Review Committee
PFS Physician Fee Schedule
PGP [Medicare] Physician Group Practice
PHP Partial hospitalization program
PIM [Medicare] Program Integrity Manual
PLI Professional liability insurance
POA Present on admission
POC Plan of care
PPI Producer price index
PPIS Physician Practice Information Survey
PPS Prospective payment system
PPTA Plasma Protein Therapeutics Association
PQRI Physician Quality Reporting Initiative
PRA Paperwork Reduction Act
PSA Physician scarcity areas
PSG Polysomnography
PT Physical therapy
PTCA Percutaneous transluminal coronary angioplasty
RA Radiology assistant
Recovery Act American Recovery and Reinvestment Act (Pub. L. 111–5)
ResDAC Research Data Assistance Center
RFA Regulatory Flexibility Act
RIA Regulatory impact analysis
RN Registered nurse
RNAC Reasonable net acquisition cost
RPA Radiology practitioner assistant
RRT Registered respiratory therapist
RUC [AMA's Specialty Society] Relative (Value) Update Committee
RVU Relative value unit
SBA Small Business Administration
SGR Sustainable growth rate
SLP Speech-language pathology
SMS [AMA's] Socioeconomic Monitoring System
SNF Skilled nursing facility
SOR System of record
SRS Stereotactic radiosurgery
TC Technical Component
TIN Tax identification number
TRHCA Tax Relief and Health Care Act of 2006 (Pub. L. 109–432)
TTO Transtracheal oxygen
UPMC University of Pittsburgh Medical Center
USDE United States Department of Education
VBP Value-based purchasing
WAMP Widely available market price

I. Background

Since January 1, 1992, Medicare has paid for physicians' services under section 1848 of the Social Security Act (the Act), ''Payment for Physicians' Services.'' The Act requires that payments under the physician fee schedule (PFS) be based on national uniform relative value units (RVUs) based on the relative resources used in furnishing a service. Section 1848(c) of the Act requires that national RVUs be established for physician work, practice expense (PE), and malpractice expense. Before the establishment of the resource-based relative value system, Medicare payment for physicians' services was based on reasonable charges.

A. Development of the Relative Value System

1. Work RVUs

The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act (OBRA) of 1989 (Pub. L. 101–239), and OBRA 1990, (Pub. L. 101–508). The final rule, published on November 25, 1991 (56 FR 59502), set forth the fee schedule for payment for physicians' services beginning January 1, 1992. Initially, only the physician work RVUs were resource-based, and the PE and malpractice RVUs were based on average allowable charges.

The physician 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 physician work RVUs for most codes in a cooperative agreement with the Department of Health and Human Services (DHHS). In constructing the code-specific vignettes for the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the Federal government, and obtained input from numerous physician specialty groups.

Section 1848(b)(2)(B) of the Act specifies that the RVUs for anesthesia services are based on RVUs from a uniform relative value guide, with appropriate adjustment of the conversion factor (CF), in a manner to assure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. We established a separate CF for anesthesia services, and we continue to utilize time units as a factor in determining payment for these services. As a result, there is a separate payment methodology for anesthesia services.

We establish physician work RVUs for new and revised codes based on our review of recommendations received from the American Medical Association's (AMA) Specialty Society Relative Value Update Committee (RUC).

2. Practice Expense Relative Value Units (PE RVUs)

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 Act and required us to develop resource-based PE RVUs for each physician's service beginning in 1998. We were to consider general categories of expenses (such as office rent and wages of personnel, but excluding malpractice expenses) comprising PEs.

Section 4505(a) of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33), amended section 1848(c)(2)(C)(ii) of the Act to delay implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a 4-year transition period from charge-based PE RVUs to resource-based RVUs.

We established the resource-based PE RVUs for each physicians' service in a final rule, published November 2, 1998 (63 FR 58814), effective for services furnished in 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, resource-based PE RVUs did not become fully effective until 2002.

This resource-based system was based on two significant sources of actual PE data: The Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. The CPEP data were collected from panels of physicians, practice administrators, and nonphysicians (for example, registered nurses (RNs)) nominated by physician specialty societies and other groups. The CPEP panels identified the direct inputs required for each physician's service in both the office setting and out-of-office setting. We have since refined and revised these inputs based on recommendations from the RUC. The AMA's SMS data provided aggregate

specialty-specific information on hours worked and PEs.

Separate PE RVUs are established for procedures that can be performed in both a nonfacility setting, such as a physician's office, and a facility setting, such as a hospital outpatient department. The difference between the facility and nonfacility RVUs reflects the fact that a facility typically receives separate payment from Medicare for its costs of providing the service, apart from payment under the PFS. The nonfacility RVUs reflect all of the direct and indirect PEs of providing a particular service.

Section 212 of the Balanced Budget Refinement Act of 1999 (BBRA) (Pub. L. 106–113) directed the Secretary of Health and Human Services (the Secretary) 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 to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the Calendar Year (CY) 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating PE RVUs beginning in CY 2007 and provided for a 4-year transition for the new PE RVUs under this new methodology.

3. Resource-Based Malpractice (MP) RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act requiring us to implement resource-based malpractice (MP) RVUs for services furnished on or after 2000. The resource-based MP RVUs were implemented in the PFS final rule published November 2, 1999 (64 FR 59380). The MP RVUs were based on malpractice insurance premium data collected from commercial and physician-owned insurers from all the States, the District of Columbia, and Puerto Rico.

4. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review all RVUs no less often than every 5 years. The first 5-Year Review of the physician work RVUs was published on November 22, 1996 (61 FR 59489) and was effective in 1997. The second 5-Year Review was published in the CY 2002 PFS final rule with comment period (66 FR 55246) and was effective in 2002. The third 5-Year Review of physician work RVUs was published in the CY 2007 PFS final rule with comment period (71 FR 69624) and was effective on January 1, 2007. (**Note:** Additional codes relating to the third 5-Year Review of physician work RVUs were addressed in the CY 2008 PFS final rule with comment period (72 FR 66360).)

In 1999, the AMA's RUC established the Practice Expense Advisory Committee (PEAC) for the purpose of refining the direct PE inputs. Through March 2004, the PEAC provided recommendations to CMS for over 7,600 codes (all but a few hundred of the codes currently listed in the AMA's Current Procedural Terminology (CPT) codes). As part of the CY 2007 PFS final rule with comment period (71 FR 69624), we implemented a new methodology for determining resource-based PE RVUs and are transitioning this over a 4-year period. (**Note:** In section II.A.2. of this proposed rule, we are proposing to use new survey data under the PE methodology.)

In the CY 2005 PFS final rule with comment period (69 FR 66236), we implemented the first 5-Year Review of the MP RVUs (69 FR 66263). (**Note**: In section II.C. of this proposed rule, we are proposing to update the malpractice RVUs with the use of new data.)

5. Adjustments to RVUs are Budget Neutral

Section 1848(c)(2)(B)(ii)(II) of the Act provides that adjustments in RVUs for a year may not cause total PFS payments to differ by more than $20 million from what they would have been if the adjustments were not made. In accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if adjustments to RVUs cause expenditures to change by more than $20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than $20 million.

As explained in the CY 2009 PFS final rule with comment period (73 FR 69730), as required by section 133(b) of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275), the separate budget neutrality (BN) adjustor resulting from the third 5-Year Review of physician work RVUs is being applied to the CF beginning with CY 2009 rather than the work RVUs.

B. Components of the Fee Schedule Payment Amounts

To calculate the payment for every physicians' service, the components of the fee schedule (physician work, PE, and MP RVUs) are adjusted by a geographic practice cost index (GPCI). The GPCIs reflect the relative costs of physician work, PE, and malpractice expense in an area compared to the national average costs for each component.

RVUs are converted to dollar amounts through the application of a CF, which is calculated by CMS' Office of the Actuary (OACT).

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

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU malpractice} \times \text{GPCI malpractice})] \times \text{CF}$$

C. Most Recent Changes to the Fee Schedule

The CY 2009 PFS final rule with comment period (73 FR 69726) implemented changes to the PFS and other Medicare Part B payment policies finalized the CY 2008 interim RVUs and implemented interim RVUs for new and revised codes for CY 2009 to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services.

The CY 2009 PFS final rule with comment period also addressed other policies, as well as certain provisions of the MIPPA.

As required by the statute, and based on section 131 of the MIPPA, the CY 2009 PFS final rule with comment period also announced that the PFS update is 1.1 percent for CY 2009, the initial estimate for the sustainable growth rate for CY 2009 is 7.4 percent, and the conversion factor (CF) for CY 2009 is $36.0666.

II. Provisions of the Proposed Regulation

A. Resource-Based Practice Expense (PE) Relative Value Units (RVUs)

Practice expense (PE) is the portion of the resources used in furnishing the service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages but excluding malpractice expenses, as specified in section 1848(c)(1)(B) of the Act.

Section 121 of the Social Security Amendments of 1994 (Pub. L. 103–432), enacted on October 31, 1994, required CMS to develop a methodology for a resource-based system for determining

PE RVUs for each physician's service. Until that time, PE RVUs were based on historical allowed charges. This legislation stated that the revised PE methodology must consider the staff, equipment, and supplies used in the provision of various medical and surgical services in various settings beginning in 1998. The Secretary has interpreted this to mean that Medicare payments for each service would be based on the relative PE resources typically involved with furnishing the service.

The initial implementation of resource-based PE RVUs was delayed from January 1, 1998, until January 1, 1999, by section 4505(a) of the BBA. In addition, section 4505(b) of the BBA required that the new payment methodology be phased in over 4 years, effective for services furnished in CY 1999, and fully effective in CY 2002. The first step toward implementation of the statute was to adjust the PE values for certain services for CY 1998. Section 4505(d) of the BBA required that, in developing the resource-based PE RVUs, the Secretary must—

- Use, to the maximum extent possible, generally-accepted cost accounting principles that recognize all staff, equipment, supplies, and expenses, not solely those that can be linked to specific procedures and actual data on equipment utilization.
- Develop a refinement method to be used during the transition.
- Consider, in the course of notice and comment rulemaking, impact projections that compare new proposed payment amounts to data on actual physician PE.

In CY 1999, we began the 4-year transition to resource-based PE RVUs utilizing a ''top-down'' methodology whereby we allocated aggregate specialty-specific practice costs to individual procedures. The specialty-specific PEs were derived from the American Medical Association's (AMA's) Socioeconomic Monitoring Survey (SMS). In addition, under section 212 of the BBRA, we established a process extending through March 2005 to supplement the SMS data with data submitted by a specialty. The aggregate PEs for a given specialty were then allocated to the services furnished by that specialty on the basis of the direct input data (that is, the staff time, equipment, and supplies) and work RVUs assigned to each CPT code.

For CY 2007, we implemented a new methodology for calculating PE RVUs. Under this new methodology, we use the same data sources for calculating PE, but instead of using the ''top-down'' approach to calculate the direct PE RVUs, under which the aggregate direct and indirect costs for each specialty are allocated to each individual service, we now utilize a ''bottom-up'' approach to calculate the direct costs. Under the ''bottom up'' approach, we determine the direct PE by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide each service. The costs of the resources are calculated using the refined direct PE inputs assigned to each CPT code in our PE database, which are based on our review of recommendations received from the AMA's Relative Value Update Committee (RUC). For a more detailed explanation of the PE methodology, *see* the Five-Year Review of Work Relative Value Units Under the PFS and Proposed Changes to the Practice Expense Methodology proposed notice (71 FR 37242) and the CY 2007 PFS final rule with comment period (71 FR 69629).

Note: In section II.A.1 of this proposed rule, we discuss the current methodology used for calculating PE. In section II.A.2. of this proposed rule, which contains PE proposals for CY 2010, we are proposing to use data from the AMA Physician Practice Information Survey (PPIS) in place of the AMA's SMS survey data and supplemental survey data that is currently used in the PE methodology.

1. Current Methodology

a. Data Sources for Calculating Practice Expense

The AMA's SMS survey data and supplemental survey data from the specialties of cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, gastroenterology, radiology, independent diagnostic testing facilities (IDTFs), radiation oncology, and urology are used to develop the PE per hour (PE/HR) for each specialty. For those specialties for which we do not have PE/HR, the appropriate PE/HR is obtained from a crosswalk to a similar specialty.

The AMA developed the SMS survey in 1981 and discontinued it in 1999. Beginning in 2002, we incorporated the 1999 SMS survey data into our calculation of the PE RVUs, using a 5-year average of SMS survey data. (*See* the CY 2002 PFS final rule with comment period (66 FR 55246).) The SMS PE survey data are adjusted to a common year, 2005. The SMS data provide the following six categories of PE costs:

- Clinical payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician clinical personnel.
- Administrative payroll expenses, which are payroll expenses (including fringe benefits) for nonphysician personnel involved in administrative, secretarial, or clerical activities.
- Office expenses, which include expenses for rent, mortgage interest, depreciation on medical buildings, utilities, and telephones.
- Medical material and supply expenses, which include expenses for drugs, x-ray films, and disposable medical products.
- Medical equipment expenses, which include depreciation, leases, and rent of medical equipment used in the diagnosis or treatment of patients.
- All other expenses, which include expenses for legal services, accounting, office management, professional association memberships, and any professional expenses not previously mentioned in this section.

In accordance with section 212 of the BBRA, we established a process to supplement the SMS data for a specialty with data collected by entities and organizations other than the AMA (that is, those entities and organizations representing the specialty itself). (See the Criteria for Submitting Supplemental Practice Expense Survey Data interim final rule with comment period (65 FR 25664).) Originally, the deadline to submit supplementary survey data was through August 1, 2001. In the CY 2002 PFS final rule (66 FR 55246), the deadline was extended through August 1, 2003. To ensure maximum opportunity for specialties to submit supplementary survey data, we extended the deadline to submit surveys until March 1, 2005 in the Revisions to Payment Policies Under the Physician Fee Schedule for CY 2004 final rule with comment period (68 FR 63196) (hereinafter referred to as CY 2004 PFS final rule with comment period).

The direct cost data for individual services were originally developed by the Clinical Practice Expert Panels (CPEP). The CPEP data include the supplies, equipment, and staff times specific to each procedure. The CPEPs consisted of panels of physicians, practice administrators, and nonphysicians (for example, RNs) who were nominated by physician specialty societies and other groups. There were 15 CPEPs consisting of 180 members from more than 61 specialties and subspecialties. Approximately 50 percent of the panelists were physicians.

The CPEPs identified specific inputs involved in each physician's service provided in an office or facility setting.

The inputs identified were the quantity and type of nonphysician labor, medical supplies, and medical equipment. The CPEP data has been regularly updated by various RUC committees on PE.

b. Allocation of PE to Services

The aggregate level specialty-specific PEs are derived from the AMA's SMS survey and supplementary survey data. To establish PE RVUs for specific services, it is necessary to establish the direct and indirect PE associated with each service.

(i) *Direct costs.* The direct costs are determined by adding the costs of the resources (that is, the clinical staff, equipment, and supplies) typically required to provide the service. The costs of these resources are calculated from the refined direct PE inputs in our PE database. These direct inputs are then scaled to the current aggregate pool of direct PE RVUs. The aggregate pool of direct PE RVUs can be derived using the following formula: (PE RVUs × physician CF) × (average direct percentage from SMS /(Supplemental PE/HR data)).

(ii) *Indirect costs.* The SMS and supplementary survey data are the source for the specialty-specific aggregate indirect costs used in our PE calculations. We then allocate the indirect costs to the code level on the basis of the direct costs specifically associated with a code and the greater of either the clinical labor costs or the physician work RVUs. For calculation of the 2010 PE RVUs, we use the 2008 procedure-specific utilization data crosswalked to 2010 services. To arrive at the indirect PE costs—

- We apply a specialty-specific indirect percentage factor to the direct expenses to recognize the varying proportion that indirect costs represent of total costs by specialty. For a given service, the specific indirect percentage factor to apply to the direct costs for the purpose of the indirect allocation is calculated as the weighted average of the ratio of the indirect to direct costs (based on the survey data) for the specialties that furnish the service. For example, if a service is furnished by a single specialty with indirect PEs that were 75 percent of total PEs, the indirect percentage factor to apply to the direct costs for the purposes of the indirect allocation would be (0.75/0.25) = 3.0. The indirect percentage factor is then applied to the service level adjusted indirect PE allocators.
- We use the specialty-specific PE/HR from the SMS survey data, as well as the supplemental surveys for cardiothoracic surgery, vascular surgery, physical and occupational therapy, independent laboratories, allergy/immunology, cardiology, dermatology, radiology, gastroenterology, IDTFs, radiation oncology, and urology. (**Note:** For radiation oncology, the data represent the combined survey data from the American Society for Therapeutic Radiology and Oncology (ASTRO) and the Association of Freestanding Radiation Oncology Centers (AFROC)). As discussed in the CY 2008 PFS final rule with comment period (72 FR 66233), the PE/HR survey data for radiology is weighted by practice size. We incorporate this PE/HR into the calculation of indirect costs using an index which reflects the relationship between each specialty's indirect scaling factor and the overall indirect scaling factor for the entire PFS. For example, if a specialty had an indirect practice cost index of 2.00, this specialty would have an indirect scaling factor that was twice the overall average indirect scaling factor. If a specialty had an indirect practice cost index of 0.50, this specialty would have an indirect scaling factor that was half the overall average indirect scaling factor.
- When the clinical labor portion of the direct PE RVU is greater than the physician work RVU for a particular service, the indirect costs are allocated based upon the direct costs and the clinical labor costs. For example, if a service has no physician work and 1.10 direct PE RVUs, and the clinical labor portion of the direct PE RVUs is 0.65 RVUs, we would use the 1.10 direct PE RVUs and the 0.65 clinical labor portions of the direct PE RVUs to allocate the indirect PE for that service.

c. Facility and Nonfacility Costs

Procedures that can be furnished in a physician's office, as well as in a hospital or facility setting have two PE RVUs: Facility and nonfacility. The nonfacility setting includes physicians' offices, patients' homes, freestanding imaging centers, and independent pathology labs. Facility settings include hospitals, ambulatory surgical centers (ASCs), and skilled nursing facilities (SNFs). The methodology for calculating PE RVUs is the same for both facility and nonfacility RVUs, but is applied independently to yield two separate PE RVUs. Because the PEs for services provided in a facility setting are generally included in the payment to the facility (rather than the payment to the physician under the PFS), the PE RVUs are generally lower for services provided in the facility setting.

d. Services With Technical Components (TCs) and Professional Components (PCs)

Diagnostic services are generally comprised of two components: A professional component (PC) and a technical component (TC), both of which may be performed independently or by different providers. When services have TCs, PCs, and global components that can be billed separately, the payment for the global component equals the sum of the payment for the TC and PC. This is a result of using a weighted average of the ratio of indirect to direct costs across all the specialties that furnish the global components, TCs, and PCs; that is, we apply the same weighted average indirect percentage factor to allocate indirect expenses to the global components, PCs, and TCs for a service. (The direct PE RVUs for the TC and PC sum to the global under the bottom-up methodology.)

e. Transition Period

As discussed in the CY 2007 PFS final rule with comment period (71 FR 69674), the change to the PE methodology was implemented over a 4-year period. In CY 2010, the transition period is concluded and PE RVUs will be calculated based entirely on the current methodology.

f. PE RVU Methodology

The following is a description of the PE RVU methodology.

(i) Setup File

First, we create a setup file for the PE methodology. The setup file contains the direct cost inputs, the utilization for each procedure code at the specialty and facility/nonfacility place of service level, and the specialty-specific survey PE per physician hour data.

(ii) Calculate the Direct Cost PE RVUs

Sum the Costs of Each Direct Input

Step 1: Sum the direct costs of the inputs for each service. The direct costs consist of the costs of the direct inputs for clinical labor, medical supplies, and medical equipment. The clinical labor cost is the sum of the cost of all the staff types associated with the service; it is the product of the time for each staff type and the wage rate for that staff type. The medical supplies cost is the sum of the supplies associated with the service; it is the product of the quantity of each supply and the cost of the supply. The medical equipment cost is the sum of the cost of the equipment associated with the service; it is the product of the number of minutes each piece of equipment is used in the

service and the equipment cost per minute. The equipment cost per minute is calculated as described at the end of this section.

Apply a BN Adjustment to the Direct Inputs

Step 2: Calculate the current aggregate pool of direct PE costs. To do this, multiply the current aggregate pool of total direct and indirect PE costs (that is, the current aggregate PE RVUs multiplied by the CF) by the average direct PE percentage from the SMS and supplementary specialty survey data.

Step 3: Calculate the aggregate pool of direct costs. To do this, for all PFS services, sum the product of the direct costs for each service from Step 1 and the utilization data for that service.

Step 4: Using the results of Step 2 and Step 3 calculate a direct PE BN adjustment so that the aggregate direct cost pool does not exceed the current aggregate direct cost pool and apply it to the direct costs from Step 1 for each service.

Step 5: Convert the results of Step 4 to an RVU scale for each service. To do this, divide the results of Step 4 by the Medicare PFS CF.

(iii) Create the indirect PE RVUs.

Create indirect allocators.

Step 6: Based on the SMS and supplementary specialty survey data, calculate direct and indirect PE percentages for each physician specialty.

Step 7: Calculate direct and indirect PE percentages at the service level by taking a weighted average of the results of Step 6 for the specialties that furnish the service. Note that for services with TCs and PCs, we are calculating the direct and indirect percentages across the global components, PCs, and TCs. That is, the direct and indirect percentages for a given service (for example, echocardiogram) do not vary by the PC, TC and global component.

Step 8: Calculate the service level allocators for the indirect PEs based on the percentages calculated in Step 7. The indirect PEs are allocated based on the three components: The direct PE RVU, the clinical PE RVU, and the work RVU.

For most services the indirect allocator is: *indirect percentage * (direct PE RVU/direct percentage) + work RVU.*

There are two situations where this formula is modified:

- If the service is a global service (that is, a service with global, professional, and technical components), then the indirect allocator is: *Indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU + work RVU.*
- If the clinical labor PE RVU exceeds the work RVU (and the service is not a global service), then the indirect allocator is: *Indirect percentage * (direct PE RVU/direct percentage) + clinical PE RVU.*

Note: For global services, the indirect allocator is based on both the work RVU and the clinical labor PE RVU. We do this to recognize that, for the professional service, indirect PEs will be allocated using the work RVUs, and for the TC service, indirect PEs will be allocated using the direct PE RVU and the clinical labor PE RVU. This also allows the global component RVUs to equal the sum of the PC and TC RVUs.

For presentation purposes in the examples in the Table 1, the formulas were divided into two parts for each service. The first part does not vary by service and is *the indirect percentage * (direct PE RVU/direct percentage).* The second part is either the work RVU, clinical PE RVU, or both depending on whether the service is a global service and whether the clinical PE RVU exceeds the work RVU (as described earlier in this step.)

Apply a BN Adjustment to the Indirect Allocators

Step 9: Calculate the current aggregate pool of indirect PE RVUs by multiplying the current aggregate pool of PE RVUs by the average indirect PE percentage from the physician specialty survey data. This is similar to the Step 2 calculation for the direct PE RVUs.

Step 10: Calculate an aggregate pool of indirect PE RVUs for all PFS services by adding the product of the indirect PE allocators for a service from Step 8 and the utilization data for that service. This is similar to the Step 3 calculation for the direct PE RVUs.

Step 11: Using the results of Step 9 and Step 10, calculate an indirect PE adjustment so that the aggregate indirect allocation does not exceed the available aggregate indirect PE RVUs and apply it to indirect allocators calculated in Step 8. This is similar to the Step 4 calculation for the direct PE RVUs.

Calculate the Indirect Practice Cost Index

Step 12: Using the results of Step 11, calculate aggregate pools of specialty-specific adjusted indirect PE allocators for all PFS services for a specialty by adding the product of the adjusted indirect PE allocator for each service and the utilization data for that service.

Step 13: Using the specialty-specific indirect PE/HR data, calculate specialty-specific aggregate pools of indirect PE for all PFS services for that specialty by adding the product of the indirect PE/HR for the specialty, the physician time for the service, and the specialty's utilization for the service.

Step 14: Using the results of Step 12 and Step 13, calculate the specialty-specific indirect PE scaling factors as under the current methodology.

Step 15: Using the results of Step 14, calculate an indirect practice cost index at the specialty level by dividing each specialty-specific indirect scaling factor by the average indirect scaling factor for the entire PFS.

Step 16: Calculate the indirect practice cost index at the service level to ensure the capture of all indirect costs. Calculate a weighted average of the practice cost index values for the specialties that furnish the service.

Note: For services with TCs and PCs, we calculate the indirect practice cost index across the global components, PCs, and TCs. Under this method, the indirect practice cost index for a given service (for example, echocardiogram) does not vary by the PC, TC and global component.

Step 17: Apply the service level indirect practice cost index calculated in Step 16 to the service level adjusted indirect allocators calculated in Step 11 to get the indirect PE RVU.

(iv) Calculate the Final PE RVUs

Step 18: Add the direct PE RVUs from Step 6 to the indirect PE RVUs from Step 17.

Step 19: Calculate and apply the final PE BN adjustment by comparing the results of Step 18 to the current pool of PE RVUs. This final BN adjustment is required primarily because certain specialties are excluded from the PE RVU calculation for ratesetting purposes, but all specialties are included for purposes of calculating the final BN adjustment. (*See* ''Specialties excluded from ratesetting calculation'' below in this section.)

(v) Setup File Information

- *Specialties excluded from ratesetting calculation:* For the purposes of calculating the PE RVUs, we exclude certain specialties such as midlevel practitioners paid at a percentage of the PFS, audiology, and low volume specialties from the calculation. These specialties *are* included for the purposes of calculating the BN adjustment.
- *Crosswalk certain low volume physician specialties:* Crosswalk the utilization of certain specialties with relatively low PFS utilization to the associated specialties.
- *Physical therapy utilization:* Crosswalk the utilization associated with all physical therapy services to the specialty of physical therapy.
- *Identify professional and technical services not identified under the usual*

TC and 26 modifiers: Flag the services that are PC and TC services, but do not use TC and 26 modifiers (for example, electrocardiograms). This flag associates the PC and TC with the associated global code for use in creating the indirect PE RVU. For example, the professional service code 93010 is associated with the global code 93000.

- *Payment modifiers:* Payment modifiers are accounted for in the creation of the file. For example, services billed with the assistant at surgery modifier are paid 16 percent of the PFS amount for that service; therefore, the utilization file is modified to only account for 16 percent of any service that contains the assistant at surgery modifier.
- *Work RVUs:* The setup file contains the work RVUs from this proposed rule.

(vi) Equipment cost per minute

The equipment cost per minute is calculated as:

*(1/(minutes per year * usage)) * price * ((interest rate/(1 − (1/((1 + interest rate) ** life of equipment)))) + maintenance)*

Where:

minutes per year = maximum minutes per year if usage were continuous (that is, usage = 1); 150,000 minutes.

usage = equipment utilization assumption; 0.9 for certain equipment (*see* section II.A.2. of this proposed rule) and 0.5. for others.

price = price of the particular piece of equipment.

interest rate = 0.11.

life of equipment = useful life of the particular piece of equipment.

maintenance = factor for maintenance; 0.05.

Note: To illustrate the PE calculation, in Table 1 we have used the conversion factor (CF) of $36.0666 which is the CF effective January 1, 2009 as published in CY 2009 PFS final rule with comment period.

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TABLE 1: Calculation of PE RVUs under Methodology for Selected Codes

		Step	Source	Formula	99213 Office visit, est Nonfacility	33533 CABG, arterial, single Facility	71020 Chest x-ray Nonfacility	71020TC Chest x-ray Nonfacility	7102026 Chest x-ray Nonfacility	93000 ECG, complete Nonfacility	93005 ECG, tracing Nonfacility	93010 ECG, report Nonfacility
(1)	Labor cost (Lab)	Step 1	AMA		$13.32	$77.52	$5.74	$5.74	$----	$6.12	$6.12	$----
(2)	Supply cost (Sup)	Step 1	AMA		$2.98	$7.34	$3.39	$3.39	$----	$1.19	$1.19	$----
(3)	Equipment cost (Eqp)	Step 1	AMA		$0.19	$0.65	$8.17	$8.17	$----	$0.12	$0.12	$----
(4)	Direct cost (Dir)	Step 1		=(1)+(2)+(3)	$16.50	$85.51	$17.31	$17.31	$----	$7.43	$7.43	$----
(5)	Direct adjustment (Dir Adj)	Steps 2-4	See footnote*		0.508	0.508	0.508	0.508	0.508	0.508	0.508	0.508
(6)	Adjusted labor	Steps 2-4	=Lab*Dir Adj	=(1)*(5)	$6.76	$39.35	$2.91	$2.91	$----	$3.11	$3.11	$----
(7)	Adjusted supplies	Steps 2-4	=Sup*Dir Adj	=(2)*(5)	$1.51	$3.73	$1.72	$1.72	$----	$0.61	$0.61	$----
(8)	Adjusted equipment	Steps 2-4	=Eqp*Dir Adj	=(3)*(5)	$0.10	$0.33	$4.15	$4.15	$----	$0.06	$0.06	$----
(9)	Adjusted direct	Steps 2-4		=(6)+(7)+(8)	$8.38	$43.41	$8.79	$8.79	$----	$3.77	$3.77	$----
(10)	Conversion Factor (CF)	Step 5	MFS		36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666	36.0666
(11)	Adj. labor cost converted	Step 5	=(Lab*Dir Adj)/CF	=(6)/(10)	0.19	1.09	0.08	0.08		0.09	0.09	
(12)	Adj. supply cost converted	Step 5	=(Sup*Dir Adj)/CF	=(7)/(10)	0.04	0.10	0.05	0.05		0.02	0.02	
(13)	Adj. equip cost converted	Step 5	=(Eqp*Dir Adj)/CF	=(8)/(10)	0.00	0.01	0.12	0.12		0.00	0.00	
(14)	Adj. direct cost converted	Step 5		=(11)+(12)+(13)	0.23	1.20	0.24	0.24		0.10	0.10	
(15)	Wrk RVU	Setup File	MFS		0.97	33.64	0.22		0.22	0.17		0.17
(16)	Dir pct	Steps 6, 7	Surveys		25.6%	18.0%	28.5%	28.5%	28.5%	28.8%	28.8%	28.8%
(17)	Ind pct	Steps 6, 7	Surveys		74.4%	82.0%	71.5%	71.5%	71.5%	71.2%	71.2%	71.2%
(18)	Ind. Alloc. formula (1st part)	Step 8	See Step 8		((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)	((14)/(16))*(17)
(19)	Ind. Alloc. (1st part)	Step 8		See (18)	0.68	5.48	0.61	0.61		0.26	0.26	
(20)	Ind. Alloc. formulas (2nd part)	Step 8	See Step 8		(15)	(15)	(15)+(11)	(11)	(15)	(15)+(11)	(11)	(15)
(21)	Ind. Alloc. (2nd part)	Step 8		See (20)	0.97	33.64	0.30	0.08	0.22	0.26	0.11	0.17
(22)	Indirect Allocator (1st+2nd)	Step 8		=(19)+(21)	1.65	39.12	0.91	0.69	0.22	0.51	0.37	0.17
(23)	Indirect Adjustment (Ind Adj)	Steps 9-11	See footnote**		0.367	0.367	0.367	0.367	0.367	0.367	0.367	0.367
(24)	Adjusted Indirect Allocator	Steps 9-11	=Ind Alloc * Ind Adj		0.60	14.35	0.33	0.25	0.08	0.19	0.14	0.06
(25)	Ind .Practice Cost Index (PCI)	Steps 12-16	See Steps 12-16		1.094	0.901	0.846	0.846	0.846	0.929	0.929	0.929
(26)	Adjusted Indirect	Step 17	= Adj. Ind Alloc*PCI	=(24)*(25)	0.66	12.92	0.28	0.22	0.07	0.18	0.13	0.06
(27)	PE RVU	Steps 18-19	=(Adj Dir+Adj Ind) *budn	=((14)+(26)) *budn	0.89	14.07	0.52	0.46	0.07	0.28	0.23	0.06

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Note: Proposed PE RVU in Table 1, row 27, may not match Addendum B due to rounding.

* The direct adj = [current PE RVUs * CF * avg dir pct] / [sum direct inputs] = [Step 2] / [Step 3]

** The indirect adj = [current PE RVUs * avg ind pct] / [sum of ind allocators] = [Step 9] / [Step 10]

2. PE Proposals for CY 2010

a. SMS and Supplemental Survey Background

Currently, we use PE/HR obtained from the SMS surveys from 1995–1999. For several specialties that collected additional PE/HR data through a more recent supplemental survey, we accepted and incorporated these data in developing current PE/HR values.

While the SMS survey was not specifically designed for the purpose of establishing PE RVUs, we found these data to be the best available at the time. The SMS was a multi-specialty survey effort conducted using a consistent survey instrument and method across specialties. The survey sample was randomly drawn from the AMA Physician Masterfile to ensure national representativeness. The AMA discontinued the SMS survey in 1999.

As required by the BBRA, we also established a process by which specialty groups could submit supplemental PE data. In the May 3, 2000 interim final rule entitled, Medicare Program; Criteria for Submitting Supplemental Practice Expense Survey Data, (65 FR 25664), we established criteria for acceptance of supplemental data. The criteria were modified in the CY 2001 and CY 2003 PFS final rules with comment period (65 FR 65380 and 67 FR 79971, respectively). We currently use supplemental survey data for the following specialties: Cardiology; dermatology; gastroenterology; radiology; cardiothoracic surgery; vascular surgery; physical and occupational therapy; independent laboratories; allergy/immunology; independent diagnostic testing facilities (IDTFs); radiation oncology; medical oncology; and urology.

Because the SMS data and the supplemental survey data are from different time periods, we have historically inflated them by the MEI to help put them on as comparable a time basis as we can when calculating the PE RVUs. This MEI proxy has been necessary in the past due to the lack of contemporaneous, consistently collected, and comprehensive multispecialty survey data.

b. Physician Practice Information Survey (PPIS)

The AMA has conducted a new survey, the PPIS, which was expanded (relative to the SMS) to include nonphysician practitioners (NPPs) paid under the PFS. The PPIS, administered in CY 2007 and CY 2008, was designed to update the specialty-specific PE/HR data used to develop PE RVUs.

The AMA and our contractor, The Lewin Group (Lewin), analyzed the PPIS data and calculated the PE/HR for physician and nonphysician specialties, respectively. The AMA's summary worksheets and Lewin's final report are available on the CMS Web site at *http://www.cms.gov/PhysicianFeeSched/*. (*See* AMA PPIS Worksheets 1–3 and Lewin Group Final Report PPIS.) Table 2 shows the current indirect PE/HR based on SMS and supplemental surveys, the PPIS indirect PE/HR, and the indirect cost percentages of total costs.

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES

[Current and PPIS]

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
All Physicians.	$59.04	$86.36	67	74	
Allergy and Immunology	153.29	162.68	62	67	
Anesthesiology	19.76	29.37	56	82	
Audiology	59.04	72.17	67	85	All Physicians.
Cardiology	131.02	88.04	56	65	
Cardiothoracic Surgery	61.75	67.83	68	83	
Chiropractor	49.60	65.33	69	86	Internal Medicine.
Clinical Laboratory (Billing Independently) *	66.46	71.01	37	37	
Clinical Psychology	29.07	20.07	90	93	Psychiatry.
Clinical Social Work	29.07	17.80	90	97	Psychiatry.
Colon & Rectal Surgery	53.93	90.85	77	80	
Dermatology	158.49	184.62	70	70	
Emergency Medicine	36.85	38.36	88	94	
Endocrinology	49.60	84.39	69	73	
Family Medicine	52.79	90.15	62	76	
Gastroenterology	101.30	96.78	70	75	
General Practice	52.79	78.59	62	69	
General Surgery	53.93	82.74	77	82	
Geriatrics	49.60	54.14	69	74	
Hand Surgery	98.56	148.78	72	77	
Independent Diagnostic Testing Facilities *	466.16	501.45	50	50	
Internal Medicine	49.60	84.03	69	76	
Interventional Pain Medicine	59.04	156.79	67	70	
Interventional Radiology	118.48	82.55	58	81	
Medical Oncology	141.84	129.94	59	56	
Nephrology	49.60	66.00	69	80	
Neurology	66.05	110.39	74	87	
Neurosurgery	89.64	115.76	86	87	
Nuclear Medicine	118.48	39.80	58	77	
Obstetrics/Gynecology	69.74	99.32	67	67	
Ophthalmology	103.28	170.08	65	70	
Optometry	59.04	88.02	67	77	All Physicians.
Oral Surgery (Dentist only)	96.01	173.19	71	65	Otolaryngology.

TABLE 2—INDIRECT PE/HR AND INDIRECT PERCENTAGES—Continued

[Current and PPIS]

Specialty	Current indirect PE/HR	PPIS indirect PE/HR	Current indirect %	PPIS indirect %	Current crosswalk
Orthopaedic Surgery	98.56	131.40	72	81	
Osteopathic Manipulative Therapy	59.04	53.93	67	93	
Otolaryngology	96.01	141.53	71	75	
Pain Medicine	59.04	122.41	67	70	
Pathology	59.80	74.98	70	74	
Pediatrics	51.52	76.27	62	69	
Physical Medicine and Rehabilitation	84.92	110.13	71	84	
Physical Therapy	35.17	57.26	65	84	
Plastic Surgery	99.32	134.82	67	74	
Podiatry	59.04	74.76	67	82	All Physicians.
Psychiatry	29.07	30.09	90	94	
Pulmonary Disease	44.63	55.26	76	74	
Radiation Oncology (Hospital Based & Freestanding)	114.00	126.66	50	56	
Radiology	118.48	95.60	58	71	
Registered Dieticians	59.04	18.45	67	84	All Physicians.
Rheumatology	84.92	98.08	71	67	
Urology	119.57	97.02	69	73	
Vascular Surgery	60.10	83.98	63	73	

* Did not participate in PPIS. Data based on Supplemental Survey.

The PPIS is a multispecialty, nationally representative, PE survey of both physician and NPPs using a consistent survey instrument and methods highly consistent with those used for the SMS and the supplemental surveys. The PPIS has gathered information from 3,656 respondents across 51 physician specialty and health care professional groups. We believe the PPIS is the most comprehensive source of PE survey information available to date.

As noted, the BBRA required us to establish criteria for accepting supplemental survey data. Since the supplemental surveys were specific to individual specialties and not part of a comprehensive multispecialty survey, we had required certain precision levels be met in order to ensure that the supplemental data was sufficiently valid, and to be accepted for use in the development of the PE RVUs. Because the PPIS is a contemporaneous, consistently collected, and comprehensive multispecialty survey, we do not believe similar precision requirements are necessary and are not proposing to establish them for the use of the PPIS data.

For physician specialties, the survey responses were adjusted for non-response bias. Non-response bias is the bias that results when the characteristics of survey respondents differ in meaningful ways, such as in the mix of practice sizes, from the general population. The non-response adjustment was developed based on a comparison of practice size and other characteristic information between the PPIS survey respondents and data from the AMA Masterfile (for physician specialties) or information from specialty societies (for non-physician specialties). For six specialties (that is, chiropractors, clinical social workers, nuclear medicine, osteopathic manipulative therapy, physical therapy, and registered dietians) such an adjustment was not possible due to a lack of available characteristic data. The AMA and Lewin have indicated that the non-response weighting has only a small impact on PE/HR values.

Under our current policy, various specialties without SMS or supplemental survey data have been crosswalked to other similar specialties to obtain a proxy PE/HR. For specialties that were part of the PPIS for which we currently use a crosswalked PE/HR, we are proposing instead to use the PPIS-based PE/HR. We are proposing to continue current crosswalks for specialties that did not participate in PPIS.

Supplemental survey data on independent labs, from the College of American Pathologists, was implemented for payments in CY 2005. Supplemental survey data from the National Coalition of Quality Diagnostic Imaging Services (NCQDIS), representing IDTFs, was blended with supplementary survey data from the American College of Radiology (ACR) and implemented for payments in CY 2007. Neither IDTFs nor Independent Labs participated in PPIS. Therefore, we are proposing to continue using the current PE/HR that was developed using their supplemental survey data.

We are not proposing to use the PPIS data for reproductive endocrinology, sleep medicine, and spine surgery since these specialties are not separately recognized by Medicare and we do not know how to blend this data with the Medicare recognized specialty data. We seek comment on this issue.

We are not proposing changes to the manner in which the PE/HR data are used in the current PE RVU methodology. We are merely proposing to update the PE/HR data itself based on the new survey. We propose to utilize the PE/HR developed using PPIS data for all Medicare recognized specialties that participated in the PPIS for payments effective January 1, 2010. The impact of using the new PPIS-based PE/HR is discussed in the Regulatory Impact Analysis in section V. of this proposed rule.

c. Equipment Utilization Rate

As part of the PE methodology associated with the allocation of equipment costs for calculating PE RVUs, we have adopted an equipment usage assumption of 50 percent. Most recently, we included a discussion in the CY 2008 PFS proposed rule on this equipment usage assumption (72 FR 38132). We noted that if the assumed equipment usage percentage is set too high, the result would be an insufficient allowance at the service level for the practice costs associated with equipment. If the assumed equipment usage percentage is set too low, the result would be an excessive allowance for the practice costs of equipment at the service level. We acknowledged that

the current 50 percent usage assumption does not capture the actual usage rates for all equipment, but stated that we did not believe that we had strong empirical evidence to justify any alternative approaches.

The commenters' recommendations about making adjustments to the 50 percent utilization rate assumption varied. Certain commenters recommended we do nothing until stronger empirical evidence is available, while other commenters recommended a decrease in the utilization assumption, and some commenters recommended an increase in the utilization assumption. The particular changes recommended in the utilization assumption were, in most cases, directly related to a specific code.

In the CY 2008 PFS final rule with comment period (72 FR 66232), we agreed with commenters that the equipment utilization rate should continue to be examined for accuracy. We reiterated our commitment to continue to work with interested parties on this issue. We indicated that we would continue to monitor the appropriateness of the equipment utilization assumption, and evaluate whether changes should be proposed in light of the data available.

Since the publication of the CY 2008 PFS final rule with comment period, MedPAC addressed this issue again in its March 2009 Report to Congress (*see http://www.medpac.gov/documents/Mar09_EntireReport.pdf*). In part of its discussion, MedPAC stated:

''In 2006, the Commission sponsored a survey by NORC of imaging providers in six markets, which found that MRI and CT machines are used much more than the 25 hours per week that CMS assumes (Table 2B–6). According to data from this survey, MRI scanners are used 52 hours per week, on average (median of 46 hours), and CT machines are operated 42 hours per week, on average (median of 40 hours) (NORC 2006).[32] Although the survey results are not nationally representative, they are representative of imaging providers in the six markets included in the survey. We also analyzed data from a 2007 survey of CT providers by IMV, a market research firm (IMV Medical Information Division 2008). IMV data are widely used in the industry and have also appeared in published studies (Baker *et al.* 2008, Baker and Atlas 2004). Using IMV's data on 803 nonhospital CT providers (imaging centers, clinics, and physician offices), we calculated that the average provider uses its CT scanner 50 hours per week, which is twice the number CMS assumes.[33] The IMV survey also found that nonhospital providers increased the average number of procedures per CT machine by 31 percent from 2003 to 2007, which indicates that providers either used their machines more hours per day or performed more scans per hour (IMV Medical Information Division 2008).'' (p. 108)

We believe the studies cited by MedPAC strongly suggest that our current usage rate assumption is significantly understated, especially with respect to the types of high cost equipment that were the subject of the studies. Our current 50 percent utilization rate translates into about 25 hours per week out of a 50 hour work week. The median value of 46 hours for MRIs from the first study cited by MedPAC is equivalent to a utilization rate of 92 percent on a 50-hour week. For CT scanners, averaging the value from the first study of 40 hours per week and the value from the second study of 50 hours per week yields 45 hours and is equivalent to a 90 percent utilization rate on a 50 hour work week. We believe the studies cited by MedPAC suggest what we have long suspected, that physicians and suppliers would not typically make huge capital investments in equipment that would only be utilized 50 percent of the time. All of the equipment cited in the MedPAC studies is priced over $1 million. Therefore, we are proposing to change the equipment usage assumption from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. We will continue to explore data sources regarding the utilization rates of equipment priced at less than $1 million dollars, but are not proposing a change in the usage rate for this less expensive equipment at this time.

As MedPAC indicated in its report, we do not believe this proposal would create access issues in rural areas. MedPAC noted,

''According to our analysis of data from the American Hospital Association's 2006 AHA annual survey of hospitals, 95% of rural hospitals provide CT services in their community (AHA 2007). Therefore, if rural areas do not have physician offices or freestanding centers with MRI and CT machines, most of these communities have access to such services through a hospital.'' (p. 110)

However, we welcome any additional analyses regarding access issues, and, as in our CY 2008 and CY 2009 rulemaking, we welcome additional empirical data relating to equipment utilization rates. Our understanding is that the PPIS survey did not produce information that can inform the utilization rate discussion, but we invite comments on this or other data sources.

d. Miscellaneous PE Issues

As we have discussed in the past rulemaking (*see* the CY 2008 PFS final rule with comment period (72 FR 66236) and the CY 2007 PFS final rule with comment period (71 FR 69647)), we continue to have concerns about the issue of PE RVUs for services which are utilized 24 hours a day/7 days a week, such as certain monitoring systems. For example, the PE equipment methodology was not developed with this type of 24/7 equipment in mind. We are continuing to analyze the issue of PEs for services which are utilized 24 hours a day/7 days a week to identify any modifications to our methodology that would address the specific ''constant use'' issues associated with these services. Services that are currently contractor priced in CY 2009 would remain contractor priced in CY 2010. Any proposed changes will be communicated through future rulemaking.

We also received comments regarding the PE direct cost inputs (for example, supply costs and the useful life of the renewable sources) related to several high dose radiation therapy (HDRT) and placement CPT codes. Based on our review of these codes and comments received, we are requesting that the AMA RUC consider these CPT codes for additional review.

e. AMA RUC Recommendations for Direct PE Inputs

The AMA RUC provided recommendations for PE inputs for the codes listed in Table 3.

TABLE 3—CODES WITH AMA RUC PE RECOMMENDATIONS

CPT[1] code	Description
37183 ...	Remove hepatic shunt (tips).
47382 ...	Percut ablate liver rf.
50200 ...	Biopsy of kidney.
55873 ...	Cryoablate prostate.
93025 ...	Microvolt t-wave assess.

[1] CPT codes and descriptions are Copyright 2009 American Medical Association.

We are in agreement with the AMA RUC recommendations for the direct PE inputs for the codes listed in Table 3 and propose to adopt these for CY 2010.

B. Geographic Practice Cost Indices (GPCIs): Locality Discussion

1. Update—Expiration of 1.0 Work GPCI Floor

Section 1848(e)(1)(A) of the Act requires us to develop separate Geographic Practice Cost Indices (GPCIs) to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (that is, work, PE and malpractice). While requiring that the PE 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, adjust the GPCIs at least every 3 years. This section also specifies that if more than 1 year has elapsed since the last GPCI revision, we must phase in the adjustment over 2 years, applying only one-half of any adjustment in each year. As discussed in the CY 2009 PFS final rule with comment period (73 FR 69740), the CY 2009 adjustment to the GPCIs reflected the fully implemented fifth comprehensive GPCI update. We also noted that section 134 of the MIPPA extended the 1.000 work GPCI floor from July 1, 2008, through December 31, 2009. (**Note:** The 1.000 work GPCI floor was enacted and implemented for CY 2006, and, prior to enactment of the MIPPA, was set to expire on June 30, 2008.) Additionally, section 1848(e)(1)(G) of the Act, as amended by section 134(b) of the MIPPA, set a permanent 1.5 work GPCI floor in Alaska for services furnished beginning January 1, 2009. Therefore, as required by the MIPPA, beginning on January 1, 2010, the 1.000 work GPCI floor will be removed. However, the 1.500 work GPCI floor for Alaska will remain in place. *See* Addenda D and E of this proposed rule for the GPCIs and summarized geographic adjustment factors (GAFs), respectively.

2. Payment Localities

a. Background

As stated above in this section, section 1848(e)(1)(A) of the Act requires us to develop separate GPCIs to measure resource cost differences among localities compared to the national average for each of the three fee schedule components (this is, work, PE, and malpractice). Payments under the PFS are based on the relative resources involved in furnishing physicians' services, and are adjusted for differences in relative resource costs among payment localities using the GPCIs. As a result, PFS payments vary between localities.

The current PFS locality structure was developed and implemented in 1997. There are currently 89 localities including 37 higher-cost areas; 16 Rest of State areas (comprising the remaining counties not located in a higher-cost area within a State); 34 Statewide areas; and Puerto Rico and the Virgin Islands which are designated as ''territory-wide'' localities. The development of the current locality structure is described in detail in the CY 1997 PFS proposed rule (61 FR 34615) and the subsequent final rule (61 FR 59494).

As we have frequently noted, any changes to the locality configuration must be made in a budget neutral manner. Therefore, any change in localities can lead to significant redistributions in payments. For many years, we have not considered making changes to localities without the support of a State medical association in order to demonstrate consensus for the change among the professionals whose payments would be affected (with some increasing and some decreasing). However, we have recognized that, over time, changes in demographics or local economic conditions may lead us to conduct a more comprehensive examination of existing payment localities.

Payment Locality Approaches Discussed in the CY 2008 PFS Proposed Rule

For the past several years, we have been involved in discussions with California physicians and their representatives about recent shifts in relative demographics and economic conditions among a number of counties within the current California payment locality structure. In the CY 2008 PFS proposed rule and final rule with comment period, we described three potential options for changing the payment localities in California (72 FR 38139 and 72 FR 66245, respectively).

After reviewing the comments on these options, we decided not to proceed with implementing any of them at that time. We explained that there was no consensus among the California medical community as to which, if any, of the options would be most acceptable. We also received suggestions from the Medicare Payment Advisory Commission (MedPAC) for developing changes in payment localities for the entire country and other States expressed interest in having their payment localities reconfigured as well. In addition, other commenters wanted us to consider a national reconfiguration of localities rather than just making changes one State at a time. Because of the divergent views expressed in comments, we explained in the CY 2008 PFS final rule with comment period that we intended to conduct a thorough analysis of potential approaches to reconfiguring localities and would address this issue again in future rulemaking.

Interim Study of Alternative Payment Localities Under the PFS

As a follow-up to the CY 2008 PFS final rule with comment period, we contracted with Acumen, LLC (Acumen), to conduct a preliminary study of several options for revising the payment localities on a nationwide basis. The contractor's interim report was posted on the CMS Web site on August 21, 2008, and we requested comments from the public. The report entitled, ''Review of Alternative GPCI Payment Locality Structures,'' is still accessible from the CMS PFS Web page under the heading ''Interim Study of Alternative Payment Localities under the PFS.'' The report may also be accessed directly from the following link: *http://www.cms.hhs.gov/PhysicianFeeSched/10_Interim_Study.asp#TopOfPage*. We accepted comments on the interim report through November 3, 2008. The alternative locality configurations discussed in the report are described briefly below in this section.

Option 1: CMS Core Based Statistical Area (CBSA) Payment Locality Configuration

This option uses the Office of Management and Budget (OMB's) Metropolitan Statistical Area (MSA) designations for the payment locality configuration. MSAs would be considered as urban CBSAs. Micropolitan Areas (as defined by OMB) and rural areas would be considered as non-urban (rest of State) CBSAs. This approach would be consistent with the inpatient hospital prospective payment system (IPPS) pre-reclassification CBSA assignments and with the geographic payment adjustments used in other Medicare payment systems. This option would increase the number of localities from 89 to 439.

Option 2: Separate High Cost Counties From Existing Localities (Separate Counties)

Under this approach, higher cost counties are removed from their existing locality structure and they would each be placed into their own locality. This option would increase the number of localities from 89 to 214 using a 5 percent GAF differential to separate high cost counties.

Option 3: Separate MSAs From Statewide Localities (Separate MSAs)

This option begins with Statewide localities and creates separate localities for higher cost MSAs (rather than removing higher cost counties from their existing locality as described in option 2). This option would increase the number of localities from 89 to 130 using a 5 percent GAF differential to separate high cost MSAs.

Option 4: Group Counties Within a State Into Locality Tiers Based on Costs (Statewide Tiers)

This option creates tiers of counties (within each State) that may or may not be contiguous but share similar practice costs. This option would increase the number of localities from 89 to 140 using a 5 percent GAF differential to group similar counties into Statewide tiers.

Additionally, as discussed in the interim locality study report, our contractor, Acumen, applied a ''smoothing'' adjustment to the current PFS locality structure, as well as to each of the alternative locality configurations (except option 4: Statewide Tiers). The ''smoothing'' adjustment was applied to mitigate large payment differences (or payment ''cliffs'') between adjacent counties. Since large payment differences between adjacent counties could influence a physician's decision on a practice location (and possibly impact access to care), the ''smoothing'' adjustment was applied to ensure that GAF differences between adjacent counties do not exceed 10 percent. (For more information on the ''smoothing'' adjustment *see* the interim locality study report on the PFS Web page via the link provided above.)

b. Summary of Public Comments on Interim Locality Study Report

In the CY 2009 PFS proposed rule (73 FR 38514), we encouraged interested parties to submit comments on the options presented both in the proposed rule and in the interim report posted on our Web site. We also requested comments and suggestions on other potential alternative locality configurations (in addition to the options described in the report). Additionally, we requested comments on the administrative and operational issues associated with the various options under consideration. We also emphasized that we would not be proposing any changes to the current PFS locality structure for CY 2009 and that we would provide extensive opportunities for public comment before proposing any change. The following is a summary of the comments received on the alternative locality options discussed in the CY 2009 PFS proposed rule and interim locality study report.

(1) Introduction and General Support for Change

We received approximately 200 comments on the CY 2009 PFS proposed rule and locality study report from various specialty groups, medical societies, State medical associations, individual practitioners, and beneficiaries. Commenters generally commended us for acknowledging the need to reconfigure PFS payment localities and expressed support for our study of alternative locality configurations. Many commenters urged us to expedite changes to the current locality structure in order to accurately reflect the geographic cost differences of operating a medical practice. For example, the Connecticut State Medical Society commented that the current locality configuration contributes to medical access issues and problems with recruitment and retention of practitioners (with an emphasis on access to primary care).

Another commenter stated that Ohio's Statewide locality configuration needs to be changed because a Statewide locality designation does not account for the (presumably higher) cost of operating a medical practice in northern Ohio. The commenter also objected to the agency's approach to requests for changes to the current locality structure (which includes an assessment of support for the changes by the medical community, including the relevant State medical associations). The commenter believes the State medical association does not represent all of the physicians in Ohio.

Another commenter stated that a change in the PFS locality structure is long overdue. The commenter stated that San Diego County is the most underpaid area in the nation and that grouping that county with the Rest of California locality is erroneous. Moreover, several commenters stated that a timely reassessment is needed and urged us to update the locality structure every 3 years. Two commenters believe that previous studies completed on the PFS locality structure by MedPAC, GAO, Urban Institute, as well as the current study by Acumen, support immediate reform to the current PFS locality structure.

We received many comments from hospitals and physicians located in Frederick County Maryland (which is currently grouped with the Rest of Maryland locality). The commenters support each of the alternative locality configurations we presented because each option results in PFS payment increases for services furnished in Frederick County. The commenters stated that Frederick County is considered a 'bedroom community' for the DC/Northern Virginia area, has experienced the highest growth rate in the State, and noted that the cost of living has increased significantly. Additionally, the commenters noted that the last economic census aligns costs in Frederick County with those in Montgomery County (whose doctors receive higher payment amounts) and that Frederick County competes with physician practices in Montgomery County for professional staff. Moreover, the commenters believe that because of inadequate PFS payment amounts, access to care is becoming a problem and emergency room visits are on the rise.

(2) Cautious Approach

Some commenters requested that we take a cautious approach to reconfiguring the locality structure. For instance, the Texas Medical Association stated that because of the redistributive impact that results from any locality reconfiguration, CMS should avoid making large scale changes at one time. Additionally, another commenter stated that ''stakeholders'' should be given a long advance notification period (at least 2 full calendar years) prior to the effective date of any changes to the PFS locality configuration. The commenter also stated that the current locality structure should remain in place (for each locality) unless the need for revision is strongly substantiated because of a change in practice cost patterns. A specialty society expressed support for postponing any adjustments for at least 1 year to allow for more discussion between CMS and ''stakeholders''.

(3) Guiding Principles

We received several comments from California that suggested a set of goals for reforming the PFS payment locality structure. The goals suggested by the commenters are as follows:

- Improve payment accuracy (as compared to the current locality structure);
- Move towards MSA-based localities;
- Mitigate payment reductions to rural California areas (and therefore minimize corresponding negative impact on access to care in California); and
- Promote administrative simplification by aligning physician and hospital payment localities.

The California Medical Association (CMA) urged us to apply a consistent methodology across all payment localities and requested that any revision to the localities include a ''formula driven'' mechanism that can be applied repeatedly to future revisions. A California county medical society stated that more specific objectives for reforming PFS payment localities should be developed. For example, the commenter suggested that

payment reductions for practitioners should not exceed 1.5 percent in any given year, GAF differentials between adjacent localities should not exceed 10 percent, and that contiguous localities with less than a 1 percent difference in their GAF's should be combined into a single locality.

(4) Comments on the Studied Alternative Locality Options

We received many comments on the options for reconfiguring PFS payment localities presented in the interim locality study report. One commenter stated that option 1 (the CMS CBSA locality configuration) is the best option because it provides the greatest payment accuracy. The same commenter also stated that using CBSAs as the PFS locality definition would be similar to other Medicare payment systems (for example, the IPPS). Therefore, the commenter believed that geographic payment adjustments for physicians and hospitals would be consistent for a given geographic area. The CMA and a California county medical society stated that although option 1 would provide the greatest payment accuracy, it would also lead to significant payment reductions for many counties. Those same commenters expressed concern with the negative impact of transitioning directly to the CMS CBSA locality configuration. If adopted, the commenters suggested that the CMS CBSA locality configuration be implemented in stages over several years. The Texas Medical Association echoed this concern and urged us not to adopt option 1 unless we employ a hold harmless floor along with ''material'' increases in the conversion factor.

The Texas Medical Association also stated that option 2 (Separate High Cost Counties from Existing Localities) results in less significant payment reductions to rural practitioners, as compared to the reductions seen under option 1 (CMS CBSA) and option 4 (Statewide Tiers). However, the commenter did not support option 2 because it would create different localities within major urban areas and, therefore, provide incentives for ''border-crossing,'' (in other words, incentives for physicians to move their medical practice to an adjacent urbanized county to obtain a higher payment amount). Additionally, the Texas Medical Association stated that option 2 increases administrative complexity due to the additional number of localities and the need to reallocate source data into smaller (county level) areas. The CMA also stated that option 2 results in less significant payment reductions (as compared to the other options). However, the CMA stated that option 2 continues to produce inaccurate payments because it applies MSA-based data to county-based localities.

Many commenters from the State of California expressed support for option 3 (Separate High Cost MSAs from Statewide Localities) because the commenters believed it would improve payment accuracy (over the current locality configuration) and at the same time mitigate the payment reductions to rural areas that would occur under option 1 (CMS CBSA) and option 4 (Statewide Tiers). The CMA explained that selecting an MSA-based locality approach would provide consistency with the hospital payment system and enable physicians to better compete with hospitals for the local work force. For example, the commenters stated that hospitals located in the Santa Cruz MSA are some of the highest paid in the nation. However, under the PFS locality structure, Santa Cruz County is grouped with the Rest of California locality, which is the lowest paid PFS locality in the State.

The Texas Medical Association suggested that we adopt option 3 because it minimizes payment reductions to lower cost rural areas. For example, since option 3 results in the fewest payment localities (as compared to the other alternative locality configurations), it reduces the redistribution effects of separating higher cost areas from rural ''rest of State'' areas. The commenter also stated that option 3 (Separate MSAs) matches payment with the underlying data better than option 2 (Separate Counties) and option 4 (Statewide Tiers). Some commenters expressed their belief that MSAs are better basic locality units than counties because the cost data is more reliably derived directly from MSAs (instead of counties). Several commenters who supported the adoption of an MSA-based PFS locality structure suggested that option 3 could be used as a transition to the CMS CBSA locality configuration (option 1).

With regard to option 4 (Statewide Tiers), the Texas Medical Association stated that the Statewide Tiers locality configuration creates payment areas that are poorly aligned with the underlying data and results in unacceptable payment decreases to small urban and rural areas. The Florida Medical Association explained that many localities have experienced a shift in population and economic development since the last PFS locality reconfiguration. The commenter stated that counties with similar costs should be grouped together in the same locality regardless of geographic location and that the Statewide cost tier locality structure (option 4) would accomplish this objective. The CMA stated that under option 4, counties are not geographically contiguous and noted that the counties grouped together in a locality may not be related to one another economically. The commenter suggested that noncontiguous counties may experience more frequent economic changes than contiguous counties. The commenter expressed concern that option 4 would need to be updated more frequently and therefore payments to physicians will fluctuate more often. A California county medical society stated that option 4 creates payment errors for counties in seven California localities that currently have accurate payments. The Connecticut State Medical Society stated that New Haven County would experience an increase under option 4.

(5) Smoothing Adjustment

Many commenters from the State of California did not support the concept of ''smoothing'' because it would require payment reductions for higher cost counties to offset the increases given to lower cost counties (in order to achieve budget neutrality). Additionally, the same commenters stated that physicians in ''smoothed'' counties benefit financially from the smoothing adjustment solely because they are located adjacent to high cost areas. They also stated that a ''smoothing'' adjustment would be complex to administer, and difficult to understand. The CMA, a California county medical society, and another commenter from California stated that a ''smoothing'' adjustment would require a change in the statute and that current Medicare statute requires GPCIs to reflect the relative costs differences among localities for work, PE, and malpractice expense. Another commenter recommended that we study the extent to which a ''smoothing'' adjustment can be used as a temporary measure; in order to phase-in significant changes in payment levels resulting from a PFS locality reconfiguration.

(6) Other Alternative Options

A few commenters submitted suggestions on other potential alternative PFS locality configurations in addition to those discussed in the interim report. For example, one medical clinic suggested a ''market-based'' approach instead of the current ''cost-based'' methodology. Under this approach, PFS payment would be geographically adjusted based on the ratio of Medicare participating

physicians to Medicare beneficiaries. The commenter suggested that payment amounts should be increased in geographic areas with a low physician to Medicare beneficiary ratio (for example, 1 physician for every 3,000 beneficiaries) and decreased in areas with a higher ratio (for example, 1 physician for every 200 beneficiaries). The commenter stated that ''this process could be used to bring physician to patient ratios in the United States to equilibrium.''

The CMA and a California county medical society suggested variations of option 2 (Separate Counties) with the intention of reducing the number of localities that would result under this option. The commenters suggested adopting a ''basic locality unit'' (for example, MSA) instead of a county when removing areas from an existing locality. For example, if 5 counties are removed from a ''Rest of State'' locality, and included within the same MSA, the 5 counties would be grouped into a single new locality rather than 5 separate new localities. The commenter also suggested that if removed counties are contiguous and have similar costs (even if not part of same MSA); they should be consolidated into one new locality instead of separate localities. The commenters stated that either of these variations would reduce the number of new localities created under option 2.

Additionally, the CMA and a California county medical society suggested a variation of option 4 (Statewide Tiers). The commenters stated that fixed cost tiers be established for each State using .05 GAF increments which would lock in the upper and lower GAF values for each cost tier. Under this approach, the fixed cost tiers would not change based on updates to the GPCIs; however, a county could be moved to a lower (or higher) cost tier without the need to define new tiers for the entire state.

(7) Redistribution of Payment

Many commenters acknowledged that a significant redistribution of payments would occur under each alternative locality configuration option and requested that we minimize the payment discrepancy between urban and rural areas to ensure continued access to services. Additionally several commenters stated that any changes to the locality configuration should not be unfair to rural practitioners. One specialty college noted that any new locality configuration must be budget neutral, resulting in a shift of resources from one geographic area to another. The commenter expressed concern that the requirement for budget neutrality may help physicians who practice in certain geographic areas, but will be costly to others. As such, the commenters stated that each alternative PFS locality option could create problems for medical access in areas where payments are reduced. As a method to minimize payment reduction, a few commenters requested that we continue the application of the 1.0 work GPCI floor.

The AMA stated that any proposal to reconfigure PFS payment localities should not necessitate budget-neutral payment redistributions. The commenter expressed the concern raised by other commenters that some localities would receive payment increases under some options while other localities would experience significant payment reductions to offset these increases. The commenters requested that if new locality definitions are proposed, new funding should be provided to increase payments in localities that are found to be underpaid. The commenters also stated that budget neutral redistributions would only exacerbate an already flawed and under-funded Medicare PFS. The AMA suggested that States with a Statewide locality should be given the option of remaining a Statewide locality and that CMS should continue its policy of allowing any State the option of converting to a Statewide locality at the request of the State Medical Association.

The Iowa Medical Society stated that Medicare PFS payment levels in Iowa are among the lowest in the country and that the four alternative locality configurations all appear to further reduce payments to State physicians. As such, they requested that Iowa remain a Statewide locality under any nationwide locality change.

Because of the redistribution effect of any locality reconfiguration, some commenters did not find any of the potential alternative locality configurations preferable to the current payment locality structure. For example, one physician academy stated that all four of the alternative locality scenarios result in disproportionately lower GAFs for non-MSA counties. Therefore, the commenter encouraged us to maintain the current locality structure until we identify an alternative that decreases the number of payment localities and supports practitioners in rural and underserved areas. The commenter also expressed support for a locality reconfiguration that minimizes the number of payment localities; does not exceed the current number of 89 localities and eliminates geographic payment adjustments (except those designed to encourage physicians to practice in underserved areas). Furthermore, the Florida Medical Association urged us to work with Congress to remove the application of budget neutrality when making changes to the PFS payment locality structure. The commenter suggested that we use the current GCPI values as a ''floor'' to ensure that future updates to the localities will not result in payment reductions.

(8) Methodology

The CMA and a California county medical society commended the contractor, Acumen, for the accuracy of its calculations, modeling of the options, and observations. However, they recommended a change in the iterative methodology used to develop option 2 and option 3. The commenters stated that the threshold for removing high cost counties from existing localities (option 2) and removing high cost MSAs from Statewide localities (option 3) should be equal to or greater than 5 percent (not just greater than 5 percent) with no rounding up for GAF differences below 5 percent. Additionally, with regard to option 2, the commenters recommended that counties with identical GAFs to the county being considered for a new locality should not be included in the calculation of the ''Rest of Locality'' GAF (which is used for comparison to the higher cost county).

Additionally, the commenters objected to the methodology used for the ''smoothing'' adjustment. The commenters believe that a new locality created by smoothing should not have a significantly lower GAF than it would if the county was a single locality. For example, the commenters noted that San Diego County (which is currently included in the Rest of California locality) has a county-level GAF of 1.056. However, when the smoothing adjustment is applied to the current locality configuration, the GAF for San Diego is 1.018.

One research institute questioned why high cost counties were separated from existing localities (option 2) and high cost MSAs were separated from Statewide localities (option 3); instead of separating low cost counties and low cost MSAs. The commenter stated that the CMS CBSA methodology is not designed to be sensitive enough to detect significant geographic differences in physician compensation and PE. The commenter questioned whether compensation and PE costs are correlated directly with population density.

Clarification on Methodology Used To Develop Alternative Locality Configurations Discussed in the Interim Report

With regard to the iterative methodology used for option 2 and option 3, the contractor, Acumen, analyzed these alternative locality configurations based on its understanding of the MedPAC ideas. A threshold of greater than 5 percent was used to separate high cost counties from existing localities (option 2) and to separate high cost MSAs from Statewide localities (option 3). Additionally, the contractor compared just one county (or MSA) at a time against the weighted average GAF of all the lower-ranked counties in the Medicare locality. Counties with the same GAF were not treated as a group. In ranking counties by GAF, the contractor used physician work RVUs to break ''ties.'' In other words, when two counties in a Medicare locality had the same GAF, the county with the higher physician work RVU was ranked as if it had the higher GAF. Keeping counties with identical GAFs together would be another possible strategy for developing alternative PFS payment localities. The high cost counties and MSAs were removed in the iterative process to reflect ongoing concerns regarding individual high cost counties (usually in ''rest of state'' areas) where the GAF is significantly higher than the norm for the locality. Removing low cost counties would isolate very low cost areas leading to further reductions in PFS payment levels for physicians and practitioners in these counties.

With regard to the sensitivity of the CBSA methodology and whether compensation and PE cost are correlated directly to population density; the CBSA methodology has three types of areas: MSAs, Metropolitan Divisions within MSAs, and non-MSA areas. None of these definitions involve population density per se, although MSAs must include core areas with populations of 50,000 or greater. Given that the CBSA methodology has more regions than the other alternative locality configurations, it could potentially draw on more detailed levels of data than the other options, and therefore, result in a more precise reflection of geographic cost differences.

(9) Suggested Additional Topics for Review

One commenter stated that the interim locality study report should have addressed how a change in payment locality structure might impact a physician's choice regarding practice location and Medicare beneficiary access to physician services.

The CMA and a California county medical society stated that the interim locality study should have included a discussion of payment accuracy under the current locality structure and under each potential locality configuration. The commenters stated that a discussion of the potential negative impact under a particular option without a discussion of the accuracy of payment for each option is misleading. Additionally, they suggested adding a discussion of potential methods to mitigate payment reductions.

(10) Administrative and Operational Issues

We received few comments on administrative and operational issues related to making changes to the PFS payment locality structure. Some commenters stated that a locality revision would impose a minimal amount of additional administrative burden. However, the commenters did not specify whose administrative burden they were assessing. One commenter stated that implementing the CMS CBSA locality configuration (option 1) would be a significant administrative burden. Additionally, one health care plan explained that many Medicare Advantage Plans are based on Medicare fees in specific localities. As such, any fee schedule locality revision would be a large scale and costly administrative undertaking for managed care plans as well as for ''traditional'' Medicare.

(11) Underlying Data

We also received comments on the data used to develop GPCI values. Although we appreciate these comments, the focus of the interim locality study was not intended to be a review of the underlying data sources used to develop GPCI values. As discussed earlier, the interim locality study was a review of potential approaches for redefining the Medicare PFS payment localities.

Response to Comments

We would like to thank the public for the many thoughtful comments on the interim locality study report entitled, ''Review of Alternative GPCI Payment Locality Structures''. As noted by the commenters and reflected in the report, significant payment redistribution would occur if a nationwide change in the PFS locality configuration were undertaken. All four of the potential alternative payment locality configurations reviewed in the report would increase the number of localities and separate higher cost, typically urban areas from lower cost, typically rural ''Rest of State'' areas. In general, payments to urban areas would increase while rural areas would see a decrease in payment under each of the options studied because they would no longer be grouped with higher cost ''urbanized'' areas. We intend to review the suggestions made by the commenters and consider the impact of each of the potential alternative locality configurations. We will also explore whether alternative underlying data sources are available nationwide. A final report will be posted to the CMS Web site after further review of the studied alternative locality approaches.

We are not proposing changes in the PFS locality structure at this time. As explained in the CY 2009 PFS final rule with comment period, in the event we decide to make a specific proposal for changing the locality configuration, we would provide extensive opportunities for public input (for example, town hall meetings or open door forums, as well as opportunities for public comments afforded by the rulemaking process).

C. Malpractice Relative Value Units (RVUs)

1. Background

Section 1848(c) of the Act requires that each service paid under the PFS be comprised of three components: work, PE, and malpractice. From 1992 to 1999, malpractice RVUs were charge-based, using weighted specialty-specific malpractice expense percentages and 1991 average allowed charges. Malpractice RVUs for new codes after 1991 were extrapolated from similar existing codes or as a percentage of the corresponding work RVU. Section 4505(f) of the BBA required us to implement resource-based malpractice RVUs for services furnished beginning in 2000. Initial implementation of resource-based malpractice RVUs occurred in 2000. The statute also requires that we review, and if necessary adjust, RVUs no less often than every 5 years. The first review and update of resource based malpractice RVUs was addressed in the CY 2005 PFS final rule (69 FR 66263). Minor modifications to the methodology were addressed in the CY 2006 PFS final rule (70 FR 70153). In this current rule, we are proposing to implement the second review and update of malpractice RVUs.

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

The proposed malpractice RVUs were developed by Acumen, LLC (Acumen) under contract to us.

The methodology used in calculating the proposed second review and update of resource-based malpractice RVUs largely parallels the process used in the CY 2005 update. The calculation requires information on malpractice premiums, linked to the physician work conducted by different specialties that furnish Medicare services. Because malpractice costs vary by State and specialty, the malpractice premium information must be weighted geographically and across specialties. Accordingly, the proposed malpractice expense RVUs are based upon three data sources:

- Actual CY 2006 and CY 2007 malpractice premium data.
- CY 2008 Medicare payment data on allowed services and charges.
- CY 2008 Geographic adjustment data for malpractice premiums.

Similar to the previous update of the resource-based malpractice expense RVUs, we are proposing to revise the 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 through State Departments of Insurance. We propose to use actual CY 2006 and CY 2007 malpractice premium data because they are the most current data available (CY 2008 malpractice premium data were not consistently available during the data collection process). Accounting for market shares, three fourths of all included rate filings were implemented in CY 2006 and CY 2007. The remaining rate filings were implemented in CY 2003 through CY 2005 but still effective in CY 2006 and CY 2007. Carriers submit rate filings to their State Departments of Insurance listing the premiums and other features of their coverage. The rate filings include an effective date, which is the date the premiums go into effect. Some States require premium changes to be approved before their effective date; others just require the rate filings to be submitted. We try to capture at least 2 companies and at least 50 percent of the market share, starting with the largest carriers in a State.

The primary determinants of malpractice liability costs continue to be physician specialty, level of surgical involvement, and the physician's malpractice history. We collected malpractice premium data from 49 States and the District of Columbia for all physician specialties represented by major insurance providers. Rate filings were not available through Departments of Insurance in Mississippi or Puerto Rico. Premiums were for $1 million/$3 million, mature, claims-made policies (policies covering claims made, rather than services furnished during the policy term). A $1 million/$3 million liability limit policy means that the most that would be paid on any claim is $1 million and that the most that the policy would pay for several claims over the timeframe of the policy is $3 million. We collected data 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 surcharges for 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) in States where PCF participation is mandatory. We sought to collect premium data representing at least 50 percent of physician malpractice premiums paid in each State as identified by State Departments of Insurance and by the National Association of Insurance Commissioners (NAIC).

Rather than select the top 20 physician specialties as when the malpractice RVU were originally established and updated, we included premium information for all physician and surgeon specialties and risk classifications available in the collected rate filings. Most insurance companies provided crosswalks from insurance services office (ISO) codes to named specialties; we matched these crosswalks to CMS specialty codes. We also preserved information obtained regarding surgery classes, which are categorizations that affect premium rates. For example, many insurance companies grouped general practice physicians into nonsurgical, minor-surgical and major-surgical classes, each with different malpractice premiums. Some companies provided additional surgical subclasses; for example, distinguishing general practice physicians that conducted obstetric procedures, which further impacted malpractice rates. We standardized this information to CMS specialty codes.

We could not identify malpractice premium rates through typical malpractice rate filings for some physician specialties, nonphysician practitioners (NPPs), and other entities (for example, independent diagnostic testing facilities (IDTFs)) paid under the PFS. In the absence of available premium data for these specialties and entities, we took a number of steps.

We collected data from one of the largest association program insurance brokers and administrators in the United States providing malpractice insurance to medical physicists. We incorporated the data into the calculation of the proposed update to the malpractice RVUs for TC services. (*See* section II.C.3 of this proposed rule for a discussion of this issue.)

We also crosswalked 13 specialties for which there was not significant collected data available (those in less than 35 States' malpractice premium rate filings) to similar specialties and risk classes. The unassigned specialties and the specialty to which we are proposing to assign them are shown in Table 4. The remaining four specialties were dropped, meaning they were not included in the weighted averages for calculating the malpractice RVUs.

Note: While we were able to collect data on many more specialties on this survey than under the previous one, these four specialties were also dropped under the previous version of the survey because of a lack of available data. This left 44 specialties, representing 90 percent of Medicare services, for which we used the malpractice premium data to develop risk factors.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
09	Interventional Pain Management	72	Pain Management.
19	Oral Surgery	03	Allergy Immunology*.
35	Chiropractic	03	Allergy Immunology*.
62	Psychologist	03	Allergy Immunology*.
65	Physical Therapist	03	Allergy Immunology*.

TABLE 4—CROSSWALK OF SPECIALTIES TO SIMILAR PHYSICIAN SPECIALTIES—Continued

Spec. code	Specialty name	Crosswalk specialty code	Crosswalk specialty
67	Occupational Therapist	03	Allergy Immunology*.
68	Clinical Psychologist	03	Allergy Immunology*.
79	Addiction Medicine	03	Allergy Immunology*.
85	Maxillofacial Surgery	03	Allergy Immunology*.
86	Neuropsychiatry	26	Psychiatry.
91	Surgical Oncology	02	General Surgery.
94	Interventional Radiology	30	Diagnostic Radiology.
98	Gynecological/Oncology	90	Medical Oncology.
99	Unknown Physician Specialty	01	General Practice.

*Lowest Physician Specialty.

The methodology presented in this proposed rule conceptually follows the specialty-weighted approach used in the CY 2000 and CY 2005 PFS final rules with comment period (63 FR 59383 and 69 FR 66263, respectively) and incorporates the minor modifications discussed in the CY 2006 final rule with comment period (70 FR 70153). We revised the current specialty-weighted approach to accommodate additional data gathered during the malpractice premium data collection. The specialty-weighted approach bases the malpractice RVUs upon a weighted average of the risk factors of all specialties furnishing a given service. This approach ensures that all specialties furnishing a given service are accounted for in the calculation of the final malpractice RVUs. Our proposed methodology is as follows:

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

(2) *Determine which risk class(es) to use within each specialty.* Many specialties had premium rates that differed for major surgery, minor surgery, and no surgery. These surgery classes are designed to reflect differences in risk of professional liability and the cost of malpractice claims if they occur. The same concept applies to procedures; some procedures carry greater liability risks. Accordingly, we identified major, minor, nonsurgical, and obstetric procedures among all Medicare procedures by established indicators (Global Surgery Flags). Table 5 shows the surgery class definitions used in the proposed methodology.

TABLE 5—SURGERY CLASSES BY PROCEDURE CODE

Surgery class	CPT code range	Global surgery flag
Major Surgery (Maj)	10000–69999	90 Day.
Minor Surgery (Min)	10000–69999	All Other.
Obstetrics (OB)	59000–59899	N/A.
No Surgery (NS)	All other CPT Codes	N/A.

To account for the presence of surgery classes in the malpractice premium data and the task of mapping these premiums to procedures, we sought to calculate distinct risk factors for major, minor, and nonsurgical procedures, as well as a comparable approach for obstetric premiums and procedures. However, the availability of data by surgery class varied across specialties. In light of the complexity of the surgery class data, we evaluated both the frequency with which rate class data were reported and a preliminary set of normed national average premiums, calculated for all classes reported in the data. Because no single approach accurately addressed the risk weights and value differences of various specialty/procedure combinations, we developed five strategies for handling the surgical classes and defining specialties. These strategies are summarized in Table 6.

(a) *Substantial Data for Each Class:* For 13 out of 44 specialties, we determined that there was sufficient data for each surgical class, as well as sufficient differences in rates between classes, to use the surgical class data as the basis for risk factors by surgical class.

(b) *Major Surgery Dominates:* These 8 surgical specialties typically had rate filings that specified major surgery as the predominate rate reported. Filings that distinguished minor surgery or nonsurgical were relatively rare. For most of these surgical specialties, we did not have ''unspecified'' rate filings. When we had ''unspecified'' rate filings, the unspecified category was sometimes above and sometimes below the major surgery rate. For these cases, we assigned the premium for major surgery to all procedures conducted by this specialty. (In practice, the major surgery procedures dominate the services actually furnished.)

(c) *Little or No Data for Major Surgery:* For five other specialties, specific premiums for major surgery were uncommon, but most States had rate filings that represented minor surgery or nonsurgical coverage. These five specialties had unspecified rates that were less common than the minor surgery-nonsurgery distinction and the nonsurgery rates. Therefore, for these five specialties we assigned the minor surgery rate filings for both major surgery and minor surgery procedures, and the nonsurgery filings for nonsurgical procedures.

(d) *Unspecified Dominates:* Many malpractice rate filings did not specify surgery classes for some specialties; we refer to these instances as unspecified malpractice rates. In only two cases, we choose the unspecified premium as the premium information to use for the specialty. For both of these specialties, fewer than 20 States had rate filings that distinguished by surgical classes, while more than 40 had general rate filings for the specialty.

(e) *Blend All Available:* For the last 16 specialties, there was wide variation across the State filings in terms of whether or not surgical classes were reported and which categories were reported. Because there was no clear strategy for these remaining specialties, we blended the rate information we collected into one general premium rate and applied that rate for all three premiums (major, minor and nonsurgical). For these specialties, we developed a weighted average ''blended'' premium at the national level, according to the percentage of physician work RVUs correlated with the surgery classes within each specialty.

TABLE 6—SUMMARY OF APPROACHES TO DEFINING PREMIUMS BY SURGICAL CLASS

Situation	Specialty codes
1. Substantial Data for Each Class (13)	01 (non-OB), 04, 06, 07. 08 (non-OB), 10, 13, 18. 16 (non-OB), 38, 39, 46, 93.
2. Major Surgery Dominates (8)	02, 14, 20, 24, 28, 33, 77, 78.
3. Little or No Data for Major Surgery (5)	11, 22, 37, 44, 82.
4. Unspecified Dominates (2)	05, 72.
5. Blend All Available (16)	03, 25, 26, 29, 30, 34, 36, 40, 48, 66, 71, 81, 83, 84, 90, 92.

For rarely-billed Medicare procedures, we did not apply the 5 percent threshold for inclusion of services or specialties as utilized in previous MP RVU updates. Rather, we are proposing to use the risk factor of the dominant specialty by services for each procedure for which the number of allowed services is less than 100. This approach reflects the risk factors of the specialty that most frequently furnishes these low volume procedures.

(3) *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 furnished 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, allergy/immunology. Table 7 shows the risk factors by specialty and surgery class.

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
1	General Practice	1.50	2.26	3.56
2	General Surgery	5.87	5.87	5.87
3	Allergy Immunology	1.00	1.00	1.00
4	Otolaryngology	1.44	2.37	3.55
5	Anesthesiology	2.22	2.22	2.22
6	Cardiology	1.87	2.65	6.09
7	Dermatology	1.14	2.06	3.96
8	Family Practice	1.57	2.23	3.79
10	Gastroenterology	2.03	2.48	4.09
11	Internal Medicine	1.72	2.52	2.52
13	Neurology	2.20	2.90	10.28
14	Neurosurgery	9.94	9.94	9.94
16	Obstetrics Gynecology	1.67	2.37	4.64
18	Ophthalmology	1.07	1.68	1.90
19	Oral Surgery	1.00	1.00	1.00
20	Orthopedic Surgery	5.46	5.46	5.46
22	Pathology	1.74	2.26	2.26
24	Plastic and Reconstructive Surgery	5.51	5.51	5.51
25	Physical Medicine and Rehabilitation	1.14	1.14	1.14
26	Psychiatry	1.22	1.22	1.22
28	Colorectal Surgery	3.99	3.99	3.99
29	Pulmonary Disease	2.08	2.08	2.08
30	Diagnostic Radiology	2.62	2.62	2.62
33	Thoracic Surgery	6.51	6.51	6.51
34	Urology	2.64	2.64	2.64
35	Chiropractic	1.00	1.00	1.00
36	Nuclear Medicine	1.55	1.55	1.55
37	Pediatric Medicine	1.49	2.41	2.41
38	Geriatric Medicine	1.43	2.23	4.22
39	Nephrology	1.61	2.27	4.17
40	Hand Surgery	3.49	3.49	3.49
44	Infectious Disease	2.09	2.52	2.52
46	Endocrinology	1.51	2.23	4.46

TABLE 7—RISK FACTORS BY SPECIALTY AND SURGERY CLASS—Continued

Medicare code	Medicare name	Non-surgical RF	Minor-surgical RF	Major-surgical RF
48	Podiatry	1.98	1.98	1.98
62	Psychologist	1.00	1.00	1.00
65	Physical Therapist	1.00	1.00	1.00
66	Rheumatology	1.56	1.56	1.56
67	Occupational Therapist	1.00	1.00	1.00
68	Clinical Psychologist	1.00	1.00	1.00
71	Registered Dietitian/Nutrition Professional	1.54	1.54	1.54
72	Pain Management	2.21	2.21	2.21
77	Vascular Surgery	6.50	6.50	6.50
78	Cardiac Surgery	6.89	6.89	6.89
79	Addiction Medicine	1.00	1.00	1.00
81	Critical Care (Intensivists)	2.15	2.15	2.15
82	Hematology	1.59	2.03	2.03
83	Hematology/Oncology	1.72	1.72	1.72
84	Preventive Medicine	1.16	1.16	1.16
85	Maxillofacial Surgery	1.00	1.00	1.00
86	Neuropsychiatry	1.22	1.22	1.22
90	Medical Oncology	1.76	1.76	1.76
91	Surgical Oncology	5.87	5.87	5.87
92	Radiation Oncology	2.30	2.30	2.30
93	Emergency Medicine	2.29	3.77	4.87
94	Interventional Radiology	2.62	2.62	2.62
98	Gynecological/Oncology	1.76	1.76	1.76
99	Unknown Physician Specialty	1.50	2.26	3.56

One complication in the calculation of specialty risk factors is technical component (TC) data. Many procedures are comprised of professional components (PC) and TCs. These components are referred to as global procedures when billed together. The TC represents the cost of equipment, supplies, and technician/staff salaries involved in furnishing a procedure, such as the taking of an x-ray by a technician. The PC represents the portion of a service that is furnished by a physician such as the interpretation of an x-ray by the physician. The distinction is important because PCs and TCs have different associated risk factors and face different malpractice insurance costs. The previous update of the malpractice RVUs did not update the TCs due to the lack of available malpractice premium data for entities providing TC services. In the past, we were unable to obtain data concerning malpractice costs associated with the TC, so we based the malpractice RVUs for TC services and the TC portion of global services on historical allowed charges.

We have had ongoing discussions with the AMA RUC and various specialty societies about this issue. In the CY 2008 PFS proposed rule (72 FR 38143), we noted that the Professional Liability Insurance (PLI) workgroup, a subset of the AMA RUC brought to our attention the fact that there are approximately 600 services that have TC malpractice RVUs that are greater than the PC malpractice RVUs. The PLI workgroup requested that we make changes to these malpractice RVUs and suggested that it is illogical for the malpractice RVUs for the TC of a service to be higher than the malpractice RVUs for the PC.

We responded that we would like to develop a resource-based methodology for the technical portion of these malpractice RVUs; but that we did not have data to support such a change. We asked for information about whether, and if so, how technicians employed by facilities purchase PLI or how their professional liability is covered. We also asked for comments on what types of PLI are carried by entities that furnish these technical services.

In the CY 2009 PFS proposed rule (73 FR 38515), we stated that the issue of assigning malpractice RVUs for the TC of certain services continues to be a source of concern for several physician associations and for CMS. We noted that we did not receive a response to our CY 2008 request for additional data on this issue and that this issue is one of importance to CMS. We also stated that the lack of available PLI data affects our ability to make a resource-based evaluation of the TC malpractice RVUs for these codes. We indicated that as part of our work to update the malpractice RVUs in CY 2010, we would instruct our contractor to research available data sources for the malpractice costs associated with the TC portion of these codes and that we would also ask the contractor to look at what is included in general liability insurance versus PLI for physicians and other professional staff. We also stated that if data sources were available, we would instruct the contractor to gather the data so we will be ready to implement revised malpractice RVUs for the TC of these codes in conjunction with the update of malpractice RVUs for the PCs in CY 2010.

In the CY 2009 PFS final rule (73 FR 69741), we again responded to comments on this issue. We noted that one commenter provided us with the name of a company that provides liability insurance to imaging facilities. We stated that we planned to share the information with our contractor and that if premium data could be identified; it would be incorporated into the malpractice RVU update. Our contractor, Acumen LLC, contacted the company suggested by the commenter and obtained medical physicist malpractice premium data from one of the largest association program insurance brokers and administrators in the United States providing this type of malpractice insurance. The premium data indicate that medical physicists have very low malpractice premiums relative to physicians.

Medical physicists are involved in complex services such as Intensity-Modulated Radiation Therapy (IMRT). IMRT is an advanced mode of radiotherapy that utilizes computer-controlled x-ray accelerators to deliver radiation doses to a malignant tumor. Based on the complexity of these services, we believe that medical

physicists would pay one of the highest malpractice premium rates of the entities furnishing TC services and that using their data as a proxy (in the absence of actual premium data) to develop malpractice RVUs for TC services would be more realistic than our current approach for these entities. Moreover, we believe it is unlikely that actual malpractice premium rates for these entities would exceed those for medical physicists. Therefore, based on this new data collection, we are proposing to use the medical physicists' premium data as a proxy for the malpractice premiums paid by entities providing TC services. We believe that the use of this data will better reflect the level of malpractice premiums paid by entities providing TC services than the current charge-based malpractice RVUs or crosswalks to the malpractice premium data of physician specialties.

As we have done in the past, we continue to encourage public commenters to submit or identify alternative data that we might use for the purpose of establishing malpractice RVUs.

(4) *Calculate malpractice RVUs for each code.* Resource-based malpractice RVUs were calculated for each procedure. The first step was to identify the percentage of services furnished by each specialty for each respective procedure code. This percentage was then multiplied by each respective specialty's risk factor as calculated in Step 3. The products for all specialties for the procedure were then added together, yielding a specialty-weighted malpractice RVU reflecting the weighted malpractice costs across all specialties for that procedure. This sum was then multiplied by the procedure's work RVUs to account for differences in risk-of-service.

Certain codes have no physician work RVUs. The overwhelming majority of these codes are the TCs of diagnostic tests, such as x-rays and cardiac catheterization, which have a distinctly separate TC (the taking of an x-ray by a technician) and PC (the interpretation of the x-ray by a physician). Examples of other codes with no work RVUs are audiology tests and injections. These services are usually furnished by NPPs, in this example, audiologists and nurses, respectively. In many cases, the NPP 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 NPP or entity, not the professional liability of the physician.

Our proposed methodology, however, would result in zero malpractice RVUs for codes with no physician work, since we propose the use of physician work RVUs to adjust for risk-of-service. We believe that zero malpractice RVUs for reasons other than rounding would be inappropriate because NPPs and entities such as IDTFs also have malpractice liability.

Note that the earlier discussion above in ''(3) Calculate a risk factor for each specialty'' addressed the proposed use of the medical physicist premium data to develop a TC risk factor. This TC risk factor is used in (3), as noted above, along with the global risk factor to calculate a PC risk factor. Once the global and PC risk factors are calculated, they are used here in step (4) to calculate the global and PC malpractice RVUs. Once we have calculated the global and PC malpractice RVUs, we propose to address the lack of work RVUs for TC services by setting the TC malpractice RVUs equal to the difference between the global malpractice RVUs and PC malpractice RVUs.

(5) *Rescale for budget neutrality.* The statute requires that changes to fee schedule RVUs be budget neutral. The current resource-based malpractice RVUs and the proposed resource-based malpractice RVUs were constructed using entirely different malpractice premium data. Thus, the last step is to adjust for budget neutrality by rescaling the proposed malpractice RVUs so that the total proposed resource-based malpractice RVUs equal the total current resource-based malpractice RVUs.

We are requesting comments on our proposed methodology for updating the malpractice RVUs. We are especially interested in comments on our proposed process for revising the malpractice RVUs of the TC of codes with no physician work. Additionally, we intend to post the Acumen report, ''Interim Report on Malpractice RVUs for the CY 2010 Medicare Physician Fee Schedule Proposed Rule'' on the CMS Web site in conjunction with publication of this proposed.

D. Medicare Telehealth Services

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

Section 1834(m)(4)(F) of the Act defines telehealth services as professional consultations, office visits, and office psychiatry services, and any additional service specified by the Secretary. 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 December 31, 2002 **Federal Register** (67 FR 79988), we established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public an ongoing opportunity to submit requests for adding services. We assign any request to make additions to the list of Medicare telehealth services to one of the following categories:

- *Category #1:* Services that are similar to professional consultations, office visits, and office psychiatry services. In reviewing these requests, we look for similarities between the requested and existing telehealth services for 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. Requesters 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.

Since establishing the process, we have added the following to the list of Medicare telehealth services: Psychiatric diagnostic interview examination; ESRD services with two to three visits per month and four or more visits per month (although we require at least one visit a month to be furnished in-person ''hands on,'' by a physician, clinical nurse specialist (CNS), nurse practitioner (NP), or physician assistant (PA) to examine the vascular access site); individual medical nutrition therapy; neurobehavioral status exam; and follow-up inpatient telehealth consultations.

Requests to add services to the list of Medicare telehealth services must be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. For example, requests submitted before the end of CY 2008 are considered for the CY 2010 proposed rule. Each request for adding a service to the list of Medicare telehealth

services must include any supporting documentation you wish us to consider as we review the request. Because we use the annual PFS rulemaking process as a vehicle for making changes to the list of Medicare telehealth services, requesters should be advised that any information submitted is subject to disclosure for this purpose. For more information on submitting a request for an addition to the list of Medicare telehealth services, including where to mail these requests, visit our Web site at *http://www.cms.hhs.gov/telehealth/*.

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

We received requests in CY 2008 to add the following services as Medicare telehealth services effective for CY 2010: (1) Health and behavior assessment and intervention (HBAI) procedures; and (2) nursing facility services. In addition, we received a number of requests to add services that we considered previously and did not approve as Medicare telehealth services in previous PFS rules. These requested services include critical care services; initial and subsequent hospital care; group medical nutrition therapy; diabetes self-management training; speech and language pathology services; and physical and occupational therapy services. The following is a discussion of these requests.

a. Health and Behavior Assessment and Intervention (HBAI)

The American Psychological Association (APA) submitted a request to add HBAI services (as described by HCPCS codes 96150 through 96154) to the list of approved telehealth services. The APA asks us to evaluate and approve HBAI services as Category #1 service because they are comparable to the psychotherapy services currently approved for telehealth.

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To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and the existing telehealth services in the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter.

Clinical psychologists furnish HBAI services to beneficiaries to help them manage or improve their behavior in response to physical problems. Elements of HBAI services typically include interviewing, observing, and counseling beneficiaries to help them modify their behavior. These elements are also common to the office psychiatry services currently approved for telehealth. We believe the interaction between a practitioner and a beneficiary receiving individual HBAI services (as described by HCPCS codes 96150 through 96152) is similar to the assessment and counseling elements of the individual office psychiatry services currently approved for telehealth. Therefore, we are proposing to revise § 410.78 and § 414.65 to include individual HBAI services as Medicare telehealth services.

With regard to group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154), we note that no group services are currently approved as Medicare telehealth services. Group counseling services have a different interactive dynamic between the physician or practitioner and his or her patients as compared to individual services. No other group counseling or other group services are approved as telehealth services. Since the interactive dynamic for group HBAI services is not similar to that for individual HBAI services or any other approved telehealth services, we do not believe that group HBAI or family-with-patient HBAI services are properly considered as Category #1 requests. To be considered as a Category #1 request, a service must be similar to the current list of Medicare telehealth services. (See 70 FR 45787 and 70157, and 73 FR 38516 and 69743).

Since the interactive dynamic between practitioner and patient for group HBAI and family-with-patient HBAI is not similar to that for office psychiatry services or any other service currently approved for telehealth, we believe that group HBAI and family-with-patient HBAI must be evaluated as Category #2 services. Because we consider group HBAI and family-with-patient HBAI to be Category #2 services, we need to evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requester did not submit evidence suggesting that the use of a telecommunications system to deliver these services would produce similar diagnostic findings or therapeutic interventions as compared to the face-to-face delivery of these services. As such, we do not propose to add group HBAI (as described by HCPCS code 96153) or family-with-patient HBAI (as described by HCPCS code 96154) to the list of approved telehealth services.

b. Nursing Facility Services

In 2005, we received a request to add the following nursing facility services to the list of approved telehealth services: Initial nursing facility care (as described by HCPCS codes 99304 through 99306); subsequent nursing facility care (HCPCS codes 99307 through 99310); nursing facility discharge services (HCPCS codes 99315 and 99316); and other nursing facility services (HCPCS code 99318). In the CY 2007 PFS final rule with comment period, we did not add these nursing facility care services to the list of approved telehealth services because these procedure codes did not describe services that were appropriate to add to the list of available telehealth originating sites in CY 2007. At that time, skilled nursing facilities (SNFs) were not defined in the statute as originating sites (71 FR 69657).

However, section 149 of the MIPPA added SNFs as telehealth originating sites effective for services furnished on or after January 1, 2009. In light of this provision, the American Telemedicine Association (ATA) urged us to add nursing facility care codes to the list of telehealth services for CY 2009, as requested in 2005.

In the CY 2009 PFS final rule with comment period, we noted that section 149 of the MIPPA did not add any services to the list of Medicare telehealth services. In the CY 2009 PFS final rule with comment period, we also responded to the ATA's comment suggesting that we add nursing facility care codes to the list of telehealth services for CY 2009, as requested in 2005. In our response, we noted that when we received the 2005 request to consider the addition of nursing facility care services for telehealth for CY 2007, we did not include a full review of these codes in either the CY 2007 PFS proposed rule or final rule with comment period since we believed it was not relevant to add the nursing facility services codes when the SNFs in which these services would be furnished were not eligible originating sites. In the CY 2009 PFS final rule with comment period, we responded that we believe it would be more appropriate to consider the addition of nursing facility care services for telehealth through our existing process, including full notice and comment procedures. We committed to revisiting the 2005 request to add the nursing facility codes in the CY 2010 PFS proposed rule, and we noted that we would accept additional information in support of the 2005 request if we received the information prior to December 31, 2008 (73 FR 69747).

Subsequent to publication of the CY 2009 PFS final rule with comment period, the ATA submitted an amended request to add subsequent nursing facility care; nursing facility discharge

services; and other nursing facility services to the list of approved telehealth services. The Center for Telehealth and e-Health Law submitted a request to add the same nursing facility services and indicated its support of ATA's request. We also received a request from the Marshfield Clinic to add the same services requested by the ATA, plus the initial nursing facility care services. The requesters drew analogies to the evaluation and management (E/M) services currently approved for telehealth, and they provided evidence in support of their belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

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The procedure codes included in these requests are used to report E/M services furnished onsite to patients in nursing facilities. In the context of these codes, ''nursing facility'' describes SNFs, NFs, intermediate care facilities, and psychiatric residential treatment centers.

Medicare telehealth services can only be furnished to beneficiaries located at an originating site authorized by law. A SNF (as defined in section 1819(a) of the Act) is the only type of nursing facility that can also be considered an originating site for telehealth services. Therefore, our review of these services focuses on the potential impact of adding these services when furnished via telehealth to a Medicare beneficiary located in a SNF.

Federally-Mandated Visits in Skilled Nursing Facilities

In describing our assessment, we first describe the service requirements of a Medicare SNF stay. In response to concerns about inadequate care provided to residents of nursing homes, the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) (Pub. L. 100–203) included extensive revisions to the requirements for Medicare and Medicaid certified nursing homes. These provisions were designed to significantly improve the quality of life and the quality of care provided to residents of nursing homes, and were a high priority for the Department of Health and Human Services.

Specific requirements for assuring the quality of care that SNFs must meet to participate in Medicare are specified in section 1819 of the Act. In addition, section 1819(d)(4)(B) of the Act provides that ''[a] skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.'' The provisions of 42 CFR Part 483 codify the requirements set forth in the statute that long term care facilities are obligated to meet in order to participate in the Medicare and/or Medicaid program.

Section 1819(b)(6)(A) of the Act requires that the medical care of every SNF resident must be provided under the supervision of a physician. The requirements contained in § 483.40 include a prescribed visit schedule and specify that the physician must perform the initial visit personally. Section 483.40(c) requires that the resident of a SNF must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. As we indicated in the preamble to the February 2, 1989 final rule (54 FR 5341), and again in response to comments in the September 26, 1991 final rule (56 FR 48826), the wording of the regulation states that the resident ''must be seen'' by the physician and requires an actual, face-to-face contact. Except for certain stated exceptions, all required physician visits must be made personally by the physician. Section 483.40(e)(2) requires that when personal performance of a particular task by a physician is specified in the regulations, performance of that task cannot be delegated to anyone else. Section 483.40(c)(4) requires that the physician must perform the initial visit personally, and § 483.40(c)(5), allows the physician the option of alternating with a qualified NPP (that is, physician assistant, nurse practitioner, or clinical nurse specialist) in making the subsequent required visits. These regulations ensure that at least a minimal degree of personal contact between physician or qualified NPP and resident is maintained, both at the point of admission to the facility and periodically during the course of the resident's stay (54 FR 5342).

In the CY 2009 PFS final rule with comment period (73 FR 69747), we noted that in considering nursing facility care for telehealth, we would need to carefully evaluate the use of telehealth for the personal visits that are currently required under § 483.40. The OBRA '87 and other long-term care legislation enacted since then require a SNF to care for its residents ''in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident'' as specified in section 1819(b)(1)(A) of the Act. We believe that a minimum number of periodic, comprehensive, hands-on examinations of a resident by a physician or a qualified NPP are necessary to ensure that the resident receives quality care. We believe that the complexity of care required by many residents of SNFs warrants at least a minimal degree of direct personal contact between physicians or qualified NPPs and SNF residents. Therefore, we believe that these Federally-mandated visits should be conducted in-person, and not as telehealth services, in order to provide direct personal contact between the resident and the physician or qualified NPP.

In the MMA, the Congress recognized the importance of furnishing the Federally-mandated visits in person, rather than via telehealth. Section 418 of the MMA required the Secretary to submit a Report to Congress evaluating the use of telehealth in SNFs. If the Secretary determined that it was advisable to permit a SNF to be an originating site for telehealth services, the MMA provided the Secretary with the authority to expand telehealth originating sites to include SNFs. SNFs were permitted to be added as originating sites only if the Secretary could establish a mechanism to ensure that telehealth does not serve as a substitute for in-person visits furnished by a physician, or for in-person visits furnished by a physician assistant, nurse practitioner, or clinical nurse specialist.

On November 9, 2007, the Secretary provided to Congress the report specified under section 418 of the MMA, entitled, ''Permitting Skilled Nursing Facilities to be Originating Telehealth Sites.'' Overall, the Report noted that evidence concerning the net impact of allowing SNFs to be originating telehealth sites was not conclusive and further analysis was needed. With respect to Federally-mandated visits in SNFs, the Report stated that the Secretary could use its authority to add services to and delete services from the list of Medicare telehealth services as a mechanism to ensure that Federally-mandated visits are not furnished as a Medicare telehealth service by not adding these visits to the lists of Medicare telehealth services.

In consideration of the history of the OBRA '87, 42 CFR part 483, and Congressional concern expressed in section 418 of the MMA, we do not propose to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We are proposing to revise § 410.78 to restrict physicians and practitioners from using telehealth to furnish the physician visits required under § 483.40(c).

In the following sections, we will separately review the use of telehealth for each of the subcategories of nursing facility services included in these requests. In these discussions, we will also indicate which of these subcategories are used to describe E/M services that fulfill Federal requirements for personal visits under § 483.40.

Initial Nursing Facility Care

The initial nursing facility care procedure codes (as described by HCPCS codes 99304 through 99306) are used to report the initial E/M visit in a SNF or NF that fulfills Federally-mandated requirements under § 483.40(c). For survey and certification requirements, this initial visit must occur no later than 30 days after admission. In a SNF, a physician must furnish the initial visit.

One of the requesters noted that once the patient is transferred to the SNF, it might be days until a physician can see a resident in-person. The requester believes a higher quality of care would be provided if the initial nursing facility service can be done in an expeditious manner—via telehealth—rather than delayed until the physician is on site.

As noted above, we are not proposing to add any procedure codes that are used exclusively to describe E/M services that fulfill Federal requirements for personal visits under § 483.40. We believe that these Federally-mandated visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Further, we believe it is particularly important that the Federally-mandated initial visit should be conducted in-person because this will ensure that the physician can comprehensively assess the resident's condition upon admission to the SNF through a thorough hands-on examination. We believe that even if the initial visit is delayed for a few days, it is necessary for the resident of a SNF to have a face-to-face visit with the physician who is developing a plan of care. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the initial visit in a face-to-face encounter, and not via telehealth, is necessary to assure quality care. As such, we are not proposing to add the initial nursing facility care services (as described by HCPCS codes 99304 through 99306) to the list of approved telehealth services.

Subsequent Nursing Facility Care

The subsequent nursing facility care procedure codes (as described by HCPCS codes 99307 through 99310) are used to report either a Federally-mandated periodic visit under § 483.40(c), or any E/M visit, prior to and after the initial physician visit, that is reasonable and medically necessary to meet the medical needs of the individual resident.

The long-term care regulations at § 483.40 require periodic physician visits for residents of SNFs (and NFs) at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. After the initial visit, Federally-mandated periodic visits in SNFs may, at the option of the physician, alternate between personal visits by the physician and visits by a qualified NPP (who is under the supervision of a physician, and meets the other requirements specified at § 483.40(e)). As noted above, we are not proposing to allow the use of telehealth to furnish these Federally-mandated personal visits. We believe that these Federally-mandated periodic visits should be conducted in-person because this will ensure at least a minimal degree of direct personal contact between physicians or qualified NPPs and residents. Under section 1819(b)(2) of the Act, a SNF must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. We believe that furnishing the periodic personal visits in face-to-face encounters, and not via telehealth, is necessary to assure quality care.

We considered the possibility of approving subsequent nursing facility care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits. In past years, we did not add hospital E/M visits to the list of Medicare approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (*See* 69 FR 47511, 69 FR 66276, 72 FR 38144, 72 FR 66250, 73 FR 38517, and 73 FR 69745.) Many residents of SNFs require medically complex care, and we have similar concerns about allowing physicians or NPPs to furnish E/M visits via telehealth to residents of SNFs.

Because the complexity of care required by many residents of SNFs may be significantly greater than the complexity of care generally associated with patients receiving the office visits approved for telehealth, we do not consider E/M visits furnished to residents of SNFs similar to the office visits on the current list of Medicare telehealth services. Therefore, we believe the use of subsequent nursing facility care for medically necessary E/M visits that are in addition to Federally mandated periodic personal visits must be evaluated as a Category #2 service.

Because we consider subsequent nursing facility care to be a Category #2 request, we evaluate whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. The requesters submitted supporting documentation intended to suggest that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

One study assessed the impact of videoconferencing (as opposed to communication by telephone without video) on nighttime, on-call medical decision-making in the nursing home. The comparison of videoconferencing with telephonic communication of information by nurses does not provide a comparative analysis demonstrating that E/M visits furnished via telehealth to residents of SNFs is equivalent to the face-to-face delivery of such services. As such, this study was not relevant to this review.

Another study assessed the value of a monitoring system in reducing falls and injuries in non-acute late-evening and nighttime situations in a nursing home setting. The monitoring system described in this study was comprised of sensors to alert caregivers via a silent pager when a high-risk resident exits his or her bed, bedroom, or bathroom. This allows caregivers to aid the resident and potentially reduce falls. The technologies utilized in this study do not correspond with our definitions of telehealth as specified in § 410.78. In addition, this type of resident monitoring is performed typically by nursing staff and is not an E/M visit. As such, this study was not relevant to this review.

A third study presented the savings achieved through avoiding transport to emergency departments and physicians' offices by furnishing visits via telehealth to residents in nursing facilities. The study did not provide any comparative analysis of the services furnished via telehealth with those furnished in person.

A fourth study evaluated the impact of telemedicine as a decision aid for residents of long-term care SNFs with chronic wounds. The patients selected for this study were alert and

intellectually interactive. The study concluded that furnishing a telehealth consultation prior to a face-to-face consultation increased the level of patient comfort with care-related decisions made during the face-to-face consultation. The control group did not receive an equivalent intermediate consultation face-to-face that could be compared to the services furnished to the test group. We acknowledge the study's findings that the intermediate telehealth consultation was a useful decision aid, but we do not consider this a comparative analysis between delivery of the same type of care via telehealth versus face-to-face.

We received a pilot study evaluating the usefulness of E/M services furnished via telehealth for making routine medical decisions in the nursing home. The nursing home residents were evaluated over videoconferencing and then evaluated immediately afterward by the same clinician in person. On a scale of 1 to 5 (1 being the least ill), the clinicians assessed the illness level of these residents at 3 or below, with the illness level for over 65 percent of the encounters assessed at ''1.'' Videoconferencing without a face-to-face examination was sufficient for making medical decisions in most cases studied in this pilot, although face-to-face examinations were preferred. Clinicians generated orders in 30 percent of these paired encounters, with a predominance of orders generated after, rather than before, the face-to-face examination. The study also noted that even when nursing home residents were alert, they had limited participation in the telemedicine interactions and were not as involved in making informed medical decisions with their clinicians, compared to face-to-face encounters. The study suggests that remote examination by video might serve as a substitute for some routine visits, if interspersed with face-to-face examinations. The study concluded that videoconferencing is feasible for making routine medical decisions in the nursing home.

We appreciate the comparative analysis provided by this study. However, we note that this study focused on the usefulness of telehealth for routine decision-making in the nursing home, and the reported illness levels of the residents in these sample encounters was relatively low to moderate. We do not consider these findings persuasive that telehealth can, more generally, be an adequate substitute for the face-to-face delivery of E/M visits to residents of SNFs who might require more medically complex care.

We considered the possibility of approving the use of telehealth to furnish E/M visits to residents of SNFs who do not require medically complex care or approving subsequent nursing facility care for telehealth only for medically necessary E/M visits with straightforward or low complexity medical decision-making (as described by HCPCS codes 99307 and 99308). Although this last pilot study concluded that videoconferencing is feasible for making routine medical decisions in the nursing home, we are concerned with the study's finding that residents with low to moderate levels of reported illness had limited participation in the telemedicine interactions and less involvement in making informed medical decisions with their clinicians, compared to face-to-face encounters. Under section 1819(c)(1)(A) of the Act, a SNF must protect and promote the rights of each resident, including the right to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care or treatment. Under § 483.10(b)(3), a resident has the right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to his or her medical condition. If the use of telehealth does not elicit from residents with low to moderate reported illness adequate participation in making informed medical decisions with their clinicians when compared to face-to-face encounters, we believe that telehealth is not an adequate substitute for the face-to-face delivery of E/M visits to any residents of SNFs.

After reviewing these studies, we do not have sufficient comparative analysis or other compelling evidence to demonstrate that furnishing E/M visits via telehealth to residents of SNFs is an adequate substitute for the face-to-face encounter between the practitioner and the resident, especially in cases where the resident requires medically complex care. Therefore, we are not proposing to add subsequent nursing facility care services (as described by HCPCS codes 99307 through 99310) to the list of approved telehealth services.

Nursing Facility Discharge Day Management

The nursing facility discharge day management codes (as described by HCPCS codes 99315 and 99316) are used to report an E/M visit that prepares a resident for discharge from a nursing facility. We note that there is no Medicare Part B requirement to furnish and bill an E/M visit in preparation for a resident's discharge from a SNF. However, if a physician or qualified NPP bills a Nursing Facility Discharge Services code, we believe that a face-to-face encounter will better insure that the resident is prepared for discharge, as we do not have evidence that nursing facility discharge services via telehealth is adequately equivalent to face-to-face provision. As such, we are not proposing to add the nursing facility discharge day management services (as described by HCPCS codes 99315 and 99316) to the list of approved telehealth services.

Other Nursing Facility Service

In 2006, CPT added a procedure code for Other Nursing Facility Service (CPT code 99318) to describe an annual nursing facility assessment. An annual assessment is not one of the required visits under the long-term care regulations at § 483.40. For Medicare purposes, this code can be used in lieu of a Subsequent Nursing Facility Care code to report a Federally-mandated periodic personal visit furnished under § 483.40(c). An annual assessment visit billed using CPT code 99318 does not represent a distinct benefit service for Medicare Part B physician services, and it cannot be billed in addition to the required number of Federally-mandated periodic personal visits. Under Medicare Part B, we cover this procedure code if the visit fully meets the CPT code 99318 requirements for an annual nursing facility assessment and if such an annual assessment falls on the 60-day mandated visit cycle. We are not proposing to add the other nursing facility care services (as described by HCPCS code 99318) to the list of approved telehealth services because this code is payable by Medicare only if the visit is substituted for a Federally-mandated visit under § 483.40(c). As explained above, we believe all of the Federally-mandated periodic visits must be conducted in person.

Follow-up Inpatient Consultations

Prior to 2006, follow-up inpatient consultations (as described by CPT codes 99261 through 99263) were approved telehealth services. In 2006, the CPT Editorial Panel of the American Medical Association (AMA) deleted the codes for follow-up inpatient consultations. In the hospital setting, the AMA advised practitioners to bill for services that would previously have been billed as follow-up inpatient consultations using the procedure codes for subsequent hospital care (as described by CPT codes 99231 through 99233). In the nursing facility setting,

the AMA advised practitioners to bill for these services using the procedure codes for subsequent nursing facility care (as described by CPT codes 99307 through 99310).

In the CY 2008 PFS proposed rule (72 FR 38144) and subsequent final rule with comment period (72 FR 66250), we discussed a request from the ATA to add subsequent hospital care to the list of approved telehealth services. Because there was no method for practitioners to bill for follow-up consultations delivered via telehealth to hospital inpatients, the ATA requested that we add the subsequent hospital care codes to the list of Medicare approved telehealth services. We expressed our concern that subsequent hospital care codes describe a broader range of services than follow-up consultations, including some services that may not be appropriate to be furnished via telehealth. We committed to continue evaluating the issues.

In the CY 2009 PFS proposed rule (73 FR 38517), we proposed to create a new series of HCPCS codes for follow-up inpatient telehealth consultations. In the CY 2009 PFS final rule with comment period (73 FR 69745), we finalized our proposal to create follow-up inpatient telehealth consultation codes (as described by HCPCS codes G0406 through G0408) and added these G-codes to the list of Medicare telehealth services. These HCPCS codes are limited to the range of services included in the scope of the previous CPT codes for follow-up inpatient consultations, and the descriptions limit the use of such services for telehealth. (*See* the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.3.1 for the current definition of follow-up inpatient telehealth consultations.)

We note that if the former codes for follow-up consultations (as described by CPT codes 99261 through 99263) still existed, these procedure codes would also be available to practitioners to submit claims to their Medicare contractors for payment of follow-up consultations provided via telehealth to patients located in SNFs. Although we did not receive a public request to add follow-up inpatient consultations for patients in SNFs to the list of approved Medicare telehealth services, we recognize a similar need to establish a method for practitioners to furnish and bill for follow-up consultations delivered via telehealth to patients in SNFs.

We considered the possibility of approving subsequent nursing facility care for telehealth with specific limitations, for example, approving subsequent nursing facility care for telehealth only when the codes are used for follow-up consultations. However, as discussed above, we do not believe it would be appropriate for E/M visits to be furnished via telehealth to treat residents of SNFs requiring medically complex care. We are concerned that it could be difficult to implement sufficient controls and monitoring to ensure that the use of the subsequent nursing facility care codes for telehealth is limited to the delivery of services that were formerly described as follow-up inpatient consultations.

We considered creating new G-codes to enable practitioners to bill for the services that were formerly described as follow-up inpatient telehealth consultations when furnished to residents of SNFs. We examined the feasibility of creating such codes to parallel the subsequent nursing facility care services, which are the codes currently used to bill these follow-up consultations in a face-to-face encounter. We found that the elements of the four levels of subsequent nursing facility care did not correspond to the three levels of the deleted CPT codes previously used for follow-up inpatient consultations. We believe that it would be administratively simpler to utilize the three existing codes for follow-up inpatient telehealth consultations rather than add additional G-codes. The use of the same ''follow-up inpatient telehealth consultation'' G-codes for services furnished in both hospital inpatient and SNF settings would also correspond to the use of the previous CPT codes for services furnished to hospital inpatients and residents of SNFs.

For CY 2010, we are proposing to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and SNFs. The HCPCS codes will clearly designate these services as follow-up consultations provided via telehealth, and not subsequent nursing facility care used for E/M visits. Utilization of these codes for patients in SNFs will facilitate payment for these services, as well as enable us to monitor whether the codes are used appropriately.

As described in the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270.2.1 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.3.1, follow-up inpatient telehealth consultations include monitoring progress, recommending management modifications, or advising on a new plan of care in response to changes in the patient's status or no changes on the consulted health issue. Counseling and coordination of care with other providers or agencies is included as well, consistent with the nature of the problem(s) and the patient's needs. The physician or practitioner who furnishes the inpatient follow-up consultation via telehealth cannot be the physician of record or the attending physician, and the follow-up inpatient consultation would be distinct from the follow-up care provided by a physician of record or the attending physician. If a physician consultant has initiated treatment at an initial consultation and participates thereafter in the patient's ongoing care management, such care would not be included in the definition of a follow-up inpatient consultation and is not appropriate for delivery via telehealth.

Consistent with our policy for follow-up telehealth consultations furnished to hospital inpatients, in order to bill and receive payment for these services, physicians and practitioners must submit the appropriate HCPCS procedure code for follow-up inpatient telehealth consultations along with the ''GT'' modifier (''via interactive audio and video telecommunications system''). By coding and billing the ''GT'' modifier with the follow-up inpatient telehealth consultation codes, the distant site physician or practitioner certifies that the beneficiary was present at an eligible originating site when the telehealth service was furnished. (*See* the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.6.1 for instructions for submission of interactive telehealth claims.)

In the case of Federal telemedicine demonstration programs conducted in Alaska or Hawaii, store and forward technologies may be used as a substitute for an interactive telecommunications system. Covered store and forward telehealth services are billed with the ''GQ'' modifier, ''via asynchronous telecommunications system.'' By using the ''GQ'' modifier, the distant site physician or practitioner certifies that the asynchronous medical file was collected and transmitted to him or her at the distant site from a Federal telemedicine demonstration project conducted in Alaska or Hawaii. (*See* the CMS Internet-Only Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.6.2 for instructions for submission of telehealth store and forward claims.)

c. Critical Care Services

In the CY 2009 PFS proposed rule (73 FR 38517), we reviewed a request submitted by the University of Pittsburgh Medical Center (UPMC) to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. UPMC drew analogies to the E/M consultation services currently approved for telehealth and described how it uses telehealth to give stroke patients timely access to consultative input from highly specialized physicians who are not available to furnish services face-to-face.

In the CY 2009 PFS final rule with comment period (73 FR 69744), we did not add critical care services to the list of approved telehealth services. This request was not considered as a category #1 request because, as we stated, we believe that remote critical care services are a different service than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). We stated that we had no evidence suggesting that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care, and we did not add critical care services to the list of Medicare approved telehealth services. We noted that this decision does not preclude physicians from providing telehealth consultations to critically ill patients.

Following publication of the CY 2009 PFS final rule with comment period, Philips Healthcare, the maker of a remote critical care system, submitted an expanded request to add critical care services to the list of Medicare approved telehealth services. The Philips Healthcare request stated that critical care services can be approved as a Category #1 service based on their similarity to the inpatient consultation services currently approved for telehealth. The requester noted that many of the components of critical care are similar to a high-level inpatient consultation service, which is currently approved for telehealth. Common components include obtaining a patient history, conducting an examination, and engaging in complex medical decision-making for patients who may be severely ill. Because we classified critical care as a Category #2 service last year, Philips also submitted evidence to support its belief that the use of telehealth could be a reasonable surrogate for the face-to-face delivery of this type of care.

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To determine whether to assign a request to Category #1, we look for similarities between the service that is being considered for addition and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter. In this case, we look for such similarities between critical care and inpatient consultations and other similar services on the current list of approved Medicare telehealth services. Critical care (as described by HCPCS codes 99291 and 99292) is the direct delivery by a physician of medical care for a critically ill or critically injured patient. It involves high complexity decision-making to assess, manipulate, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient's condition. Within the current standards of practice, we believe critical care services require the physical presence of the physician rendering the critical care services. We also note that a number of hands-on interventions (for example, gastric intubation and vascular access procedures), when furnished on the day a physician bills for critical care, are included in the critical care service and are not reported separately. Inpatient consultations generally do not include hands-on interventions. Because we believe that critical care services (as described by HCPCS codes 99291 and 99292) require the physical presence of a physician who is available to furnish any necessary hands-on interventions, we do not consider critical care services similar to any services on the current list of Medicare telehealth services. Therefore, we believe critical care must be evaluated as a Category #2 service.

In order to evaluate critical care services as a Category #2 service, we need to determine whether these are services for which telehealth can be an adequate substitute for a face-to-face encounter. In CPT 2009, the AMA defined remote critical care services tracking codes (codes 0188T through 0189T) with cross-references to critical care services (HCPCS codes 99291 through 99292). CPT directs that only one physician may report either critical care services or remote critical care services for the same period. The requester cites this as evidence that the AMA considers the two services equivalent, and that critical care should be approved as a Category #2 service. We do not consider the CPT coding guidance persuasive evidence that remote critical care is the telehealth delivery of critical care, as defined by HCPCS codes 99291 and 99292. We believe that if the AMA valued the two services equally, they would not have created separate tracking codes for remote critical care services.

As we noted in the CY 2009 PFS final rule with comment period, consistent with the AMA's creation of tracking codes, we believe that remote critical care services are different from the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Category III CPT codes track utilization of a service, facilitating data collection on, and assessment of, new services and procedures. We believe that the data collected for these tracking codes will help provide useful information on how to best categorize and value remote critical care services in the future.

The requester also submitted studies which conclude that remote critical care services furnished by intensivists improve mortality rates, decrease length of stay, reduce per patient costs, and improve compliance with best practices, thereby improving patient outcomes. These studies are similar to the ones we received and reviewed from the CY 2009 PFS proposed rule. We maintain that remote critical care services are not the telehealth delivery of critical care services (as described by HCPCS codes 99291 and 99292). Therefore, we do not find the new studies submitted with the CY 2010 request persuasive that telehealth can be an adequate substitute for the face-to-face delivery of critical care services (as described by HCPCS codes 99291 and 99292).

We continue to believe that remote critical care services are different services than the telehealth delivery of critical care (as described by HCPCS codes 99291 and 99292). As such, we are not proposing to add critical care services (as described by HCPCS codes 99291 and 99292) to the list of approved telehealth services. We reiterate that our decision not to add critical care services to the list of approved telehealth services does not preclude physicians from furnishing telehealth consultations to critically ill patients.

d. Other Requests

We received a number of requests to add services that we reviewed and did not approve in previous PFS Rules. The following are brief summaries and references to previous discussions regarding our decisions not to add these procedure codes to the list of Medicare approved telehealth services. As explained further below, we are not reconsidering these previous decisions.

Initial and Subsequent Hospital Care

We received a request to add initial hospital care (as described by HCPCS codes 99221 through 99223) and subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved telehealth services. In response to previous requests, we did not add initial or subsequent hospital care to the list of approved telehealth services because of our concern regarding the use of telehealth for the ongoing E/M of a high-acuity hospital inpatient. (*See* 69 FR 47510 and 66276, 72 FR 38144 and 66250, and 73 FR 38517 and 69745.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are not proposing to add initial hospital care (as described by HCPCS codes 99221 through 99223) or subsequent hospital care (as described by HCPCS codes 99231 through 99233) to the list of approved telehealth services.

Group Medical Nutrition Therapy Services

We received a request to add group medical nutrition therapy (MNT) services (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services. In response to a previous request, we did not add group MNT to the list of approved telehealth services because we believe that group services are not appropriately delivered through telehealth. (*See* 70 FR 45787 and 70157.) We did not receive any new information with this request that would alter our previous decision. Therefore, we are not proposing to add group MNT (as described by HCPCS codes G0271 and 97804) to the list of approved telehealth services.

Diabetes Self-Management Training (DSMT)

We received a request to add diabetes self-management training (DSMT) (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services. In response to previous requests, we did not add DSMT to the list of approved telehealth services because of the statutory requirement that DSMT include teaching beneficiaries to self-administer injectable drugs. Furthermore, DSMT is often performed in group settings and we believe that group services are not appropriately delivered through telehealth. (*See* 70 FR 45787 and 70157, and 73 FR 38516 and 69743.) We did not receive any new information with this request that would alter our previous decisions. Therefore, we are not proposing to add DSMT (as described by HCPCS codes G0108 and G0109) to the list of approved telehealth services.

Speech and Language Pathology Services

We received a request to add various speech and language pathology services to the list of approved telehealth services. Speech-language pathologists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we do not propose to add any speech and language pathology services to the list of Medicare telehealth services. (For further discussion, *see* 69 FR 47512 and 66276, and 71 FR 48995 and 69657.)

Physical and Occupational Therapy Services

We received a request to add various physical and occupational therapy services to the list of approved telehealth services. Physical and occupational therapists are not permitted under current law to furnish and receive payment for Medicare telehealth services. Therefore, we are not proposing to add any physical and occupational therapy services to the list of approved telehealth services. (For further discussion, *see* 71 FR 48995 and 69657.)

E. Coding Issues

1. Canalith Repositioning

In 2008, the CPT Editorial Panel created a new code for canalith repositioning (CRP). This procedure is a treatment for vertigo which involves therapeutic maneuvering of the patient's body and head in order to use the force of gravity to redeposit the calcium crystal debris in the semicircular canal system.

In the CY 2009 PFS final rule with comment period (73 FR 69896), new CPT code 95992, *Canalith repositioning procedure(s) (eg, Epley maneuver, Semont maneuver), per day*, was assigned the bundled status indicator (B). We explained that this procedure previously was billed as part of an evaluation and management (E/M) service or under a number of CPT codes, including CPT code 97112, *Therapeutic procedure, one or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities.* We also explained that because neurologists and therapists are the predominant providers of this service to Medicare patients (each at 22 percent), it was assigned as a ''sometimes therapy'' service under the therapy code abstract file.

We received comments on this issue from the American Physical Therapy Association (APTA), as well as other organizations expressing opposition to our decision to bundle the new code. Commenters stated that they believe that our decision to bundle CPT code 95992 is flawed since physical therapists are unable to bill E/M services. The commenter also stated that therapists would be precluded from using another code for billing for this service because CPT correct coding instructions require that the provider/supplier select the procedure that most accurately defines the service provided. Commenters also expressed concern that this could impact beneficiary access to this service.

Based upon the commenters' feedback, we realized that we had failed to address how therapists would bill for the service since they cannot bill E/M services. In order to address this situation so that access to this service would not be impacted, we included language in a change request (CR) (the quarterly update CR for April) and also released a MedLearn article informing PTs to continue using one of the more generally defined ''always therapy'' CPT codes (97112) as a temporary measure. *See http://www.cms.hhs.gov/transmittals/downloads/R1691CP.pdf* and *http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6397.pdf*.

In response to the concerns raised and upon additional review of this issue for CY 2010, we are proposing to change the status indicator from B (Bundled) to I (Invalid). We propose that physicians would continue to be paid for CRP as a part of an E/M service. Physical therapists would continue to use one of the more generally defined ''always therapy'' CPT codes (97112). We believe that this will enable beneficiaries to continue to receive this service while at the same time it will address our concerns about the potential for duplicate billing for this service to the extent that this service is paid as a part of an E/M service. As a result of this proposal, CPT code 95992 would be removed as a ''sometimes'' therapy code from the therapy code list.

2. Payment for an Initial Preventive Physical Examination (IPPE)

Beginning January 1, 2010, we propose to increase the payment for an initial preventive physical examination (IPPE) furnished face-to-face with the patient and billed with HCPCS code G0402, *Initial preventive physical examination; face-to-face visit, services*

limited to new beneficiary during the first 12 months of Medicare enrollment. The IPPE service includes a broad array of components and focuses on primary care, health promotion, and disease prevention.

Section 101(b) of the MIPPA changed the IPPE benefit by adding to the IPPE visit the measurement of an individual's body mass index and, upon an individual's consent, end-of-life planning. Section 101(b) of the MIPPA also removed the screening electrocardiogram (EKG) as a mandatory service of the IPPE.

In order to implement this MIPPA provision, in the CY 2009 PFS final rule with comment period (73 FR 69870), we created HCPCS code G0402 as a new HCPCS code and retained, on an interim basis, the work RVUs of 1.34 assigned to HCPCS code G0344, the code that was previously used to bill for the IPPE. While we did not believe the revisions to the IPPE required by MIPPA impacted the work RVUs associated with this service, we solicited public comments on this issue, as well as suggested valuations of this service to reflect resources involved in furnishing the service.

We received comments from several medical groups representing primary care physicians and geriatricians, as well as comments from the American Medical Association concerning this issue. The commenters stated that the IPPE service was undervalued prior to the addition of components by the MIPPA. Commenters also stated that the current level of work RVUs would discourage delivery of appropriate end-of-life planning with the beneficiary. One commenter suggested the work associated with HCPCS code G0402 for the IPPE, as described in statute, is captured in existing CPT code 99387, *Preventive Medicine Service, new patient, Initial comprehensive preventive medicine, 65 years and older.* (This code is not paid under the PFS.) The work RVUs for this CPT code are 2.06.

Based on a review of the comments and upon further evaluation of the component services of the IPPE, we believe the services, in the context of work and intensity, contained in HCPCS code G0402 are most equivalent to those services contained in CPT code 99204, *Evaluation and management new patient, office or other outpatient visit*, and propose increasing the work RVUs for HCPCS code G0402 to 2.30 effective for services furnished beginning on January 1, 2010.

3. Audiology Codes: Policy Clarification of Existing CPT Codes

In the CY 2009 PFS final rule with comment period (73 FR 69890), we noted that the RUC reviewed and recommended work RVUs for 6 audiology codes with which we agreed (that is, CPT codes 92620, 92621, 92625, 92626, 92627, and 92640). We also noted that in the Medicare program, audiology services are provided under the diagnostic test benefit and that some of the work descriptors for these services include ''counseling,'' ''potential for remediation,'' and ''establishment of interventional goals.'' We noted that we do not believe these aspects fit within the diagnostic test benefit, and therefore, we solicited comment on this issue.

Since audiology services fall under the diagnostic test benefit, aspects of services that are therapeutic or management activities are not payable to audiologists. This distinction is of particular importance since CPT codes 92620, 92621, 92626, 92627, and 92640 are ''timed'' codes, that is, these codes are billed based on the actual time spent furnishing the service. In response to our request, the society that represents speech language pathologists, audiologists, and speech and language scientists, provided the following comments.

Comment: With respect to the term ''counseling,'' the commenter stated that ''counseling'' as used in the intraservice work description for CPT code 92640, *Diagnostic analysis with programming of auditory brainstem implant, per hour*, is used in the context of informational rather than personal counseling. In this instance the counseling provides information and guidance to the patient on what to expect relative to the service (application of the electrical stimulation). This counseling is an integral part of the diagnostic procedure and not a means of providing therapy or active treatment.

Response: We appreciate the comments related to counseling by the specialty society, but are not persuaded that counseling is an integral part of a diagnostic test. Although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, counseling the patient about how to compensate for a hearing loss is part of a therapeutic service. As such, therapeutic and/or management of disease process counseling are not part of the diagnostic test benefit and time attributable to such activities is not payable to audiologists under the Medicare program.

Comment: With respect to the term ''potential for remediation,'' which is found as part of the intraservice work descriptor for CPT code 92625, *Assessment of tinnitus* (*includes pitch, loudness matching, and masking*), the commenter states that the procedure evaluates the frequency and intensity characteristics of the perceived tinnitus in addition to measuring how the tinnitus responds to a masking noise. The response to masking noise is diagnostic information that audiologists and physicians refer to as the ''potential for remediation.'' This assessment is thus a part of a complete diagnostic workup and is not a treatment or therapeutic service.

Response: The intraservice work for this service includes informing the patient of the outcome of the evaluation and the potential for remediation. As noted above, although we understand that test results are sometimes conveyed to the patient during or at the conclusion of a diagnostic test, discussing therapeutic options and/or providing therapy or management based on test results are not part of a diagnostic test. Discussing the potential for remediation does not appear to be part of a diagnostic test. While this service can involve a small amount of nondiagnostic work, CPT code 92625 is not a timed code and the bulk of the work described in the code appears to be diagnostic in nature.

Comment: With respect to the term ''establishment of interventional goals,'' this phrase is found in the intraservice work description of CPT code 92626, *Evaluation of auditory rehabilitation status; first hour.* The commenter states that this procedure focuses on diagnostic information relative to the patient's ability to use residual hearing with a hearing aid, a cochlear implant, or with no electronic device. The intervention goals may take a variety of forms, such as the following: Meeting audiological criteria for cochlear implantation; a recommendation to continue use of hearing aids (that is, not a cochlear implant candidate); and the need to coordinate with a speech-language pathologist for auditory training. This provides the physician with a complete diagnostic evaluation of the patient's residual hearing status. There is no element of therapy or treatment associated with this service.

Response: Diagnostic testing usually does not involve the establishment of interventional goals. The test report usually contains test findings and may suggest additional tests. While we appreciate the comments of the specialty society, we are not persuaded that establishing interventional goals is

part of a diagnostic test under Medicare. The establishment of interventional goals is clearly a function of therapeutic management. As such, establishment of goals is not part of the diagnostic test benefit and time attributable to such activity is not payable to an audiologist under the Medicare program.

We appreciate the comments we received on this issue. We want to emphasize that therapeutic and/or management activities associated with these audiology tests are not payable to audiologists because of the benefit category under which these tests are covered. We may also issue instructions to contractors to monitor these services to prevent inappropriate payments.

4. Consultation Services

a. Background

The current physician visit and consultation codes were developed by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel in November 1990. A consultation service is an evaluation and management (E/M) service furnished to evaluate and possibly treat a patient's problem(s). It can involve an opinion, advice, recommendation, suggestion, direction, or counsel from a physician or qualified NPP at the request of another physician or appropriate source. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10A for more information.) A consultation service must be documented and a written report given to the requesting professional. Currently, consultation services are predominantly billed by specialty physicians. Primary care physicians infrequently furnish these services.

The required documentation supports the accuracy and medical necessity of a consultation service that is requested and provided. Medicare pays for a consultation service when the request and report are documented as a consultation service, regardless of whether treatment is initiated during the consultation evaluation service. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10B.) A consultation request between professionals may be done orally by telephone, face-to-face, or by written prescription brought from one professional to another by the patient. The request must be documented in the medical record.

In the Physician Fee Schedule Final Rule issued June 5, 1991, (56 FR 25828) we stated that the agency's goal for the development of the new visit and consultation codes was that they meet two criteria: (1) They should be used reliably and consistently by all physicians and carriers; that is, the same service should be coded the same way by different physicians; and (2) they should be defined in a way that enables us to properly crosswalk the new codes to the relative values for the Harvard vignettes so valid RVUs for work are assigned to the new codes.

Based on requests from the physician community to clarify our consultation payment policy and to provide consultation examples, we convened an internal workgroup of medical officers within CMS (then called the Health Care Financing Administration, or HCFA) and revised the payment policy instructions in August 1999 in the Medicare Claims Processing Manual (at § 30.6.10 as cited above). We provided examples of consultation services and examples of clinical scenarios that did not satisfy Medicare criteria for consultation services. Without explicit instructions for every possible clinical scenario outlined in national policy instructions or in AMA coding definitions or coding instructions, the local policy interpretations by Medicare contractors were not universally equivalent or acceptable to the physician community and resulted in denials in different localities. Some Medicare contractors would consider a consultation service with treatment to be an initial visit rather than a consultation thus resulting in a denial for the billed consultation. We clarified in the 1999 revision that Medicare would pay for a consultation whether treatment was initiated at the consultation visit or not. The physician community has stated that terms such as referral, transfer and consultation, used interchangeably by physicians in clinical settings, confuse the actual meaning of a consultation service and that interpretation of these words varies greatly among members of that community as some label a transfer as a referral and others label a consultation as a referral. Although we clarified the terms referral and consultation in the 1999 revision, there was disagreement with our policy by physicians in the health care community and by AMA CPT staff. We provided our documentation guidance so physicians would be in compliance with our payment policy. The consultation definition in the AMA CPT simply stated that the consultant's opinion or other information must be communicated to the requesting physician.

Additional manual revisions in both January and September 2001 (at § 30.6.10 as cited above) clarified that NPPs can both request and furnish consultation services within their scope of practice and licensure requirements. We continued to explain our documentation requirements to the physician community through our Medicare contractors and in our discussions with the AMA CPT staff. Under our current policy and in the AMA CPT definition, a consultation service must have a request from another physician or other professional and be followed by a report to the requesting professional. The AMA CPT definition does not state the request must be written in the requesting physician's medical record. However, we require the request to be documented in the requesting physician's plan of care in the medical record as a condition for Medicare payment. The E/M documentation guidelines which apply to all E/M visits or consultations (*http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp*) clearly state that when referrals are made, consultations are requested, or advice is sought, the medical record should indicate to whom and where the referral or consultation is made or from whom the advice is requested. Our Medicare contractors are responsible for reviewing and paying consultation claims when submitted. When there is a question that triggers a review of a consultation service, our Medicare contractors will look at both the requesting physician's medical record (where the request should be noted) and the consultant's medical record where the consultation is reported and at the report generated for the requesting physician. Medicare contractors do not look for evidence of documentation on every claim, only when there is a concern raised during random sampling or during a specific audit performed by a contractor. The AMA CPT coding manual, which is not a payment manual, does not specify these requirements, and, therefore, as we understand it, many physicians do not agree with the CMS policy.

In March 2006, the Office of the Inspector General (OIG) published a report entitled, ''Consultations in Medicare: Coding and Reimbursement'' (OEI–09–02–00030). The purpose of the report was to assess whether Medicare's payments for consultation services were appropriate. While the OIG study was being conducted, we continued our ongoing discussions with the AMA CPT staff for potential changes to the consultation definition and guidance in CPT. The findings in the OIG report (based on claims paid by Medicare in 2001) indicated that Medicare allowed

approximately $1.1 billion more in 2001 than it should have for services that were billed as consultations. Approximately 75 percent of services paid as consultations did not meet all applicable program requirements (per the Medicare instructions) resulting in improper payments. The majority of these errors (47 percent of the claims reviewed) were billed as the wrong type or level of consultation. The second most frequent error was for services that did not meet the definition of a consultation (19 percent of the claims reviewed). The third category of improperly paid claims was a lack of appropriate documentation (9 percent of the claims reviewed). The OIG recommended that CMS, through our Medicare contractors, should educate physicians and other health care practitioners about Medicare criteria and proper billing for all types and levels of consultations with emphasis on the highest levels and follow-up inpatient consultation services.

We agreed with the OIG findings that additional education would help physicians understand the differences in the requirements for a consultation service from those for other E/M services. With each additional revision from 1999 until the OIG study began, we continually educated physicians through the guidance provided by our Medicare contractors. However, there remained discrepancies with unclear and ambiguous terms and instructions in the AMA CPT consultation coding definition, transfer of care and documentation, and the feedback from the physician community indicated they disagreed with Medicare guidance.

Prior to the official publication of the OIG report, we issued a Medlearn Matters article, effective January 2006, to educate the physician community about requirements and proper billing for all types and levels of consultation services as requested by the OIG in their report. The Medlearn Matters article reflected the manual changes we made in 2006 and the AMA CPT coding changes as noted below.

Our consultation policy revisions continued as a work-in-progress over several years as disagreements were raised by the physician community. We continued to work with AMA CPT coding staff in an attempt to have improved guidance for consultation services in the CPT coding definition. In looking at physician claims data (for example, the low usage of confirmatory consultation services) and in response to concerns from the physician community regarding how to correctly use the follow-up consultation codes, the AMA CPT Editorial Panel chose to delete some of the consultation codes for 2006. The Follow-Up Inpatient Consultation codes (CPT codes 99261 through 99263) and the Confirmatory Consultation codes (CPT codes 99271 through 99275) were deleted. During our ongoing discussions, the AMA CPT staff, maintained that physicians did not fully understand the use of these codes and historically submitted them inappropriately for payment as was reflected in the OIG study.

We issued a manual revision in the Medicare Claims Processing Manual (at § 30.6.10 as cited above) simultaneously with the publication of AMA CPT 2006 coding changes removing the follow-up consultation codes, and instructed physicians to use the existing subsequent hospital care code(s) and subsequent nursing facility care codes for visits following a consultation service. The confirmatory consultation codes (which were typically used for second opinions) were also removed and we instructed physicians to use the existing E/M codes for a second opinion service. We further clarified the documentation requirements by making it easier to document a request for a consultation service from another physician and to submit a consultation report to the requesting professional. Again, physicians stated that a consultant has no control over what a requesting or referring physician writes in a medical record, and that they should not be penalized for the behavior of others. However, our consultation policy instructions apply to all physicians, whether they request a consultation or furnish a consultation. As noted above, documentation by both the requesting physician and the physician who furnishes the consultation, is required under the E/M documentation guidelines. The E/M documentation guidelines have been in use since 1995. In our discussions with the AMA CPT staff and physician groups, and national physician open door conference calls, we have emphasized that the requesting physician medical record is not reviewed unless there is a specific audit or random sampling performed. The physician furnishing the consultation service should document in the medical record from whom a request is received.

We continue to hear from the AMA and from specific national physician specialty representatives that physicians are dissatisfied with Medicare documentation requirements and guidance that distinguish a consultation service from other E/M services such as transfer of care. CPT has not clarified transfer of care. Therefore, many physician groups disagree with our requirements for documentation of transfer of care. Interpretation differs from one physician to another as to whether transfer of care should be reported as an initial E/M service or as a consultation service.

Despite our efforts, the physician community disagrees with Medicare interpretation and guidance for documentation of transfer of care and consultation. The existing consultation coding definition in the AMA CPT definition remains ambiguous and confusing for certain clinical scenarios and without a clear definition of transfer of care. The CPT consultation codes are used by physicians and qualified NPPs to identify their services for Medicare payment. There is an absence of any guidance in the AMA CPT consultation coding definition that distinguishes a transfer of care service (when a new patient visit is billed) from a consultation service (when a consultation service is billed). Medicare does provide guidance although there is disagreement with our policy from AMA CPT staff and some members of the physician community. Because of the disparity between AMA coding guidance and Medicare policy some physicians state they have difficulty in choosing the appropriate code to bill. The payment for both inpatient consultation and office/outpatient consultation services is higher than for initial hospital care and new patient office/outpatient visits. However, the associated physician work is clinically similar. Many physicians contend that there is more work involved with a new patient visit than a consultation service because of the post work involvement with a new patient. The payment for a consultation service has been set higher than for initial visits because a written report must be made to the requesting professional. However, all medically necessary Medicare services require documentation in some form in a patient's medical record. Over the past several years, some physicians have asked CMS to recognize the provision of the consultation report via a different form of communication in lieu of a written letter report to the requesting physician so as to lessen any paperwork burden on physicians. We have eased the consultation reporting requirements by lessening the required level of formality and permitting the report to be made in any written form of communication, (including submission of a copy of the evaluation examination taken directly from the medical record and submitted without a letter format) as long as the identity of the physician who furnished the consultation is

evident. Although preparation and submission of the consultant's report is no longer the major defining aspect of consultation services, the higher payment has remained. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.10 F.)

Both AMA CPT coding rules and Medicare Part B payment policy have always required that there is only one admitting physician of record for a particular patient in the hospital or nursing facility setting. (AMA CPT 2009, Hospital Inpatient Services, Initial Hospital Care, p.12) This physician has been the only one permitted to bill the initial hospital care codes or initial nursing facility codes. All other physicians must bill either the subsequent hospital care codes, subsequent nursing facility care codes or consultation codes. (*See* the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.9.1 G.)

Beginning January 1, 2008, we ceased to recognize office/outpatient consultation CPT codes for payment of hospital outpatient visits (72 FR 66790 through 66795). Instead, we instructed hospitals to bill a new or established patient visit CPT code, as appropriate to the particular patient, for all hospital outpatient visits. Regardless of all of our efforts to educate physicians on Medicare guidance for documentation, transfer of care, and consultation policy, disagreement in the physician community prevails.

b. Proposal

Beginning January 1, 2010, we propose to budget neutrally eliminate the use of all consultation codes (inpatient and office/outpatient codes for various places of service except for telehealth consultation G-codes) by increasing the work RVUs for new and established office visits, increasing the work RVUs for initial hospital and initial nursing facility visits, and incorporating the increased use of these visits into our PE and malpractice RVU calculations.

We note that section 1834(m) of the Act includes ''professional consultations'' (including the initial inpatient consultation codes ''as subsequently modified by the Secretary'') in the definition of telehealth services. We recognize that consultations furnished via telehealth can facilitate the provision of certain services and/or medical expertise that might not otherwise be available to a patient located at an originating site. Therefore, for CY 2010, if we finalize our proposed policy to eliminate consultations from the PFS, then we propose to create HCPCS codes specific to the telehealth delivery of initial inpatient consultations. The purpose of these codes would be solely to preserve the ability for practitioners to provide and bill for initial inpatient consultations delivered via telehealth. These codes are intended for use by practitioners when furnishing services that meet Medicare requirements relating to coverage and payment for telehealth services. Practitioners would use these codes to submit claims to their Medicare contractors for payment of initial inpatient consultations provided via telehealth. The new HCPCS codes would be limited to the range of services included in the scope of the CPT codes for initial inpatient consultations, and the descriptions would be modified to limit the use of such services for telehealth. The HCPCS codes would clearly designate these as initial inpatient consultations provided via telehealth, and not initial hospital care or initial nursing facility care used for inpatient visits. Utilization of these codes would allow us to provide payment for these services, as well as enable us to monitor whether the codes are used appropriately.

If we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, then we also propose to crosswalk the RVUs for these services from the RVUs for initial hospital care (as described by CPT codes 99221 through 99223). We believe this is appropriate because a physician or practitioner furnishing a telehealth service is paid an amount equal to the amount that would have been paid if the service had been furnished without the use of a telecommunication system. Since physicians and practitioners furnishing initial inpatient consultations in a face-to-face encounter to hospital inpatients must continue to utilize initial hospital care codes (as described by CPT codes 99221 through 99223), we believe it is appropriate to set the RVUs for the proposed inpatient telehealth consultation G-codes at the same level as for the initial hospital care codes.

We considered creating separate G-codes to enable practitioners to bill initial inpatient telehealth consultations when furnished to residents of SNFs and crosswalking the RVUs to initial nursing facility care (as described by CPT codes 99304 through 99306). For the sake of administrative simplicity, if we create HCPCS G-codes specific to the telehealth delivery of initial inpatient consultations, they will be defined in § 410.78 and in our manuals as appropriate for use to deliver care to beneficiaries in hospitals or skilled nursing facilities. If we adopt this proposal, then we will make corresponding changes to our regulations at § 410.78 and § 414.65. In addition, we will add the definition of these codes to the CMS Internet-Only Medicare Benefit Policy Manual, Pub. 100–02, Chapter 15, Section 270 and the Medicare Claims Processing Manual, Pub. 100–04, Chapter 12, Section 190.

Outside the context of telehealth services, physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient's admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported. The initial visit in a skilled nursing facility and nursing facility must be furnished by a physician except as otherwise permitted as specified in § 483.40(c)(4). In the nursing facility setting, an NPP who is enrolled in the Medicare program, and who is not employed by the facility, may perform the initial visit when the State law permits this. (*See* this exception in the Internet-Only Medicare Claims Processing Manual, Pub. 100–04, chapter 12, § 30.6.13A). An NPP, who is enrolled in the Medicare program is permitted to report the initial hospital care visit or new patient office visit, as appropriate, under current Medicare policy. Because of an existing CPT coding rule and current Medicare payment policy regarding the admitting physician, we will create a modifier to identify the admitting physician of record for hospital inpatient and nursing facility admissions. For operational purposes, this modifier will distinguish the admitting physician of record who oversees the patient's care from other physicians who may be furnishing specialty care. The admitting physician of record will be required to append the specific modifier to the initial hospital care or initial nursing facility care code which will identify him or her as the admitting physician of record who is overseeing the patient's care. Subsequent care visits by all physicians and qualified NPPs will be reported as subsequent hospital care codes and subsequent nursing facility care codes.

We believe the rationale for a differential payment for a consultation service is no longer supported because documentation requirements are now similar across all E/M services. To be consistent with OPPS policy, as noted above, we will pay only new and established office or other clinic visits under the PFS.

This proposed change would be implemented in a budget neutral

manner, meaning it would not increase or decrease PFS expenditures. We would make this change budget neutral for the work RVUs by increasing the work RVUs for new and established office visits by approximately 6 percent to reflect the elimination of the office consultation codes and the work RVUs for initial hospital and facility visits by approximately 2 percent to reflect the elimination of the facility consultation codes. We have crosswalked the utilization for the office consultation codes into the office visits and the utilization of the hospital and facility consultation codes into the initial hospital and facility visits. This change would be made budget neutral in the PE and malpractice RVU methodologies through the use of the new work RVUs and the crosswalked utilization. The PE and malpractice RVU methodologies are described elsewhere in this proposed rule.

We are soliciting comments on the proposal, described more fully above, to eliminate payment for all consultation services codes under the PFS and to allow all physicians to bill, in lieu of a consultation service code, an initial hospital care visit or initial nursing facility care visit for their first visit during a patient's admission to the hospital or nursing facility. Additionally, we are soliciting comments on the proposal to create HCPCS G-codes to identify the telehealth delivery of initial inpatient consultations.

F. Potentially Misvalued Services Under the Physician Fee Schedule

1. Valuing Services Under the Physician Fee Schedule

The American Medical Association's (AMA) Relative Value System Update Committee (RUC) provides recommendations to CMS for the valuation of new and revised codes, as well as codes identified as misvalued. On an ongoing basis, the AMA RUC's Practice Expense (PE) Subcommittee reviews direct PE (clinical staff, medical supplies, medical equipment) for individual services and examines the many broad and methodological issues relating to the development of PE relative value units (RVUs).

To address concerns expressed by stakeholders with regard to the process we use to price services paid under the PFS, the AMA RUC created the Five-Year Review Identification Workgroup. As we stated in the CY 2009 PFS proposed rule (73 FR 38582), the workgroup identified some potentially misvalued codes through several vehicles, namely, identifying codes with site of service anomalies, high intra-service work per unit time (IWPUT), and services with high volume growth. The IWPUT is derived from components of the ''building-block'' approach, as described in the CY 2007 PFS proposed rule (71 FR 37172), and is used as a measure of service intensity. There were 204 services identified as misvalued last year and we plan to continue working with the AMA RUC to identify additional codes that are potentially misvalued. In the CY 2009 PFS proposed rule (73 FR 38586), we also listed approaches for the AMA RUC to utilize, namely, the review of the fastest growing procedure codes, review of Harvard-valued codes, and review of PE RVUs.

We plan to address the AMA RUC's recommendations from the February and April 2009 meetings for codes with site of service anomalies in the CY 2010 PFS final rule with comment period in a manner consistent with the way we address other AMA RUC recommendations. Specifically, we complete our own review of the AMA RUC recommendations; and then in the PFS final rule with comment period, we describe the AMA RUC's recommendations, indicate whether or not we accept them, and provide a rationale for our decision. The values for these services will be published as interim values for the next calendar year.

We believe that there are additional steps we can take to help address the issue of potentially misvalued services. In the CY 2009 PFS proposed rule, we identified approaches to address this issue including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.

2. High Cost Supplies

In the CY 2009 PFS proposed rule (73 FR 38582), we proposed a process to update the prices associated with high cost supplies over $150 every 2 years. We explained that we would need the cooperation of the medical community in obtaining typical prices in the marketplace. We also outlined examples of acceptable documentation. Although we received many thoughtful comments on the proposed process for updating high-cost supplies, as stated in the CY 2009 PFS final rule with comment period (73 FR 69882), we are continuing to examine alternatives on the best way to obtain accurate pricing information and will propose a revised process in future rulemaking.

3. Review of Services Often Billed Together and the Possibility of Expanding the Multiple Procedure Payment Reduction (MPPR) to Additional Nonsurgical Procedures

In the CY 2009 PFS final rule with comment period (73 FR 69882), we stated that we plan to perform a data analysis of nonsurgical CPT codes that are often billed together. This would identify whether there are inequities in PFS payments that are a result of variations between services in the comprehensiveness of the codes used to report the services, or in the payment policies applied to each (for example, global surgery and MPPRs). The rationale for the MPPR is that certain clinical labor activities, supplies, and equipment are not performed or furnished twice when multiple procedures are performed. We stated that we would consider developing a proposal either to bundle additional services or expand application of the MPPR to additional procedures.

Several specialty groups noted that the AMA RUC has already taken action to identify frequently occurring code pairs. The commenters support the AMA RUC's recommendation that CMS analyze data to identify nonsurgical CPT codes that are billed together 90 to 95 percent of the time. Additionally, the Medicare Payment Advisory Committee (MedPAC) requested that we consider duplicative physician work, as well as PE, in any expansion of the MPPR.

We plan to analyze codes furnished together more than 75 percent of the time, excluding E/M codes. We will analyze both physician work and PE inputs. If duplications are found, we will consider whether an MPPR or bundling of services is most appropriate. Any proposed changes will be made through rulemaking and be subject to public comment at a later date.

4. AMA RUC Review of Potentially Misvalued Codes

a. Site of Service Anomalies

The AMA RUC created the Five-Year Review Identification Workgroup to respond to concerns expressed by the MedPAC, the Congress, and other stakeholders regarding accurate pricing under the PFS. The workgroup identified potentially misvalued codes through several vehicles. For example, the workgroup focused on codes for which there have been shifts in the site of service (site of service anomalies), codes with a high intra-service work per unit of time (IWPUT), and codes that were high volume. There were 204 potentially misvalued services

identified in 2008 (*see* the CY 2009 PFS final rule with comment period (73 FR 69883)). These codes were reviewed by the AMA RUC and recommendations were submitted to CMS in 2008.

In the CY 2009 PFS final rule with comment period (73 FR 69883), we noted that although we would accept the AMA RUC valuation for these site of service anomaly codes for 2009, we recognized that many of them included deletion or modification of certain inputs such as hospital days, office visits, service times, and discharge day management services in the global period. We also indicated that we had concerns about the methodology used by the AMA RUC to review these services which may have resulted in removal of hospital days and deletion or reallocation of office visits without extraction of the associated RVUs from the valuation of the code. However, we stated that we believed the AMA RUC-recommended valuations were still a better representation of the resources used to furnish these services than the current ones. We also stated that we would continue to examine these codes and would consider whether it would be appropriate to propose additional changes in future rulemaking.

After further review of these codes, we believe it would be appropriate to propose further changes to several of the codes where the valuation has been adjusted to reflect changes in the site of service. Specifically, we are proposing changes to codes for which the AMA RUC review process deleted or reallocated pre-service and post service times, hospital days, office visits, and discharge day management services without the extraction of the associated RVUs.

We believe the AMA RUC-recommended values do not reflect the extraction of the RVUs associated with deleted or reallocated pre-service and post-service times, hospital days, office visits, and discharge day management services. Therefore, we have recalculated the work RVUs based upon the AMA RUC-recommended inputs (that is, changes in pre-service and post-service times and associated E/M services). The proposed work RVUs for each CPT code shown in Table 8 were recalculated using the pre-AMA RUC review work RVUs as a starting point, and adjusting them for the addition or extraction of pre-service and post-service times, inpatient hospital days, discharge day management services and outpatient visits as recommended by the AMA RUC. We used the following methodology:

1. For each CPT code noted in Table 8, we separated out each component (that is, pre-service time, intra-service time, post-service time, inpatient hospital day, discharge day management services, and outpatient visits) that comprised the entire work RVUs for the service.

2. We calculated the incremental difference between the pre-service and post-service time from before and after the AMA RUC review, and multiplied that difference by an IWPUT intensity factor of 0.0224, which is a constant in the IWPUT equation. For example, if the pre-service time prior to the AMA RUC review was 75 minutes and, following its review, the AMA RUC recommended an increase in pre-service time to 85 minutes, we multiplied the difference (10 minutes) by 0.0224 to determine the RVUs associated with the increase in pre-service time, and then added that number of RVUs to the pre-AMA RUC evaluation work RVU.

3. We then added or removed the work RVUs associated with the extraction or reallocation of each inpatient hospital day, outpatient visit or discharge day management service as appropriate. For example, assume that prior to the AMA RUC review a code was assigned:

- 1 inpatient hospital day (currently billed using CPT code 99231 and assigned 0.76 work RVUs);
- 1 discharge day management service (currently billed using CPT code 99238 and assigned 1.28 work RVUs); and
- 2 outpatient visits (currently billed using 99212 and assigned 0.45 work RVUs).

After the AMA RUC review, the inpatient hospital day and discharge day management service were removed. To account for the removal of these services, we would have subtracted 0.76 work RVUs (represents the removal of the work RVUs for 1 inpatient hospital day) and 1.28 work RVUs (represents the removal of the work RVUs for 1 discharge day management service) from the pre-AMA RUC review work RVUs in order to develop the CMS proposed work RVUs.

The methodology discussed above was used for each code noted in Table 8 and reflects the extraction of the RVUs associated with deleted or reallocated hospital days, office visits, discharge day management services, and pre-service and post-service times based upon the AMA RUC recommendations.

TABLE 8: CY 2010 CMS PROPOSED WORK RVUS

CPT code [1]	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC recommended work RVU	2010 CMS proposed work RVU
21025	Excision of bone, lower jaw	11.07	9.87	7.23
23415	Release of shoulder ligament	10.09	9.07	10.64
25116	Remove wrist/forearm lesion	7.38	7.38	4.83
42440	Excise submaxillary gland	7.05	7.05	6.88
52341	Cysto w/ureter stricture tx	6.11	5.35	5.20
52342	Cysto w/up stricture tx	6.61	5.85	5.63
52343	Cysto w/renal stricture tx	7.31	6.55	6.55
52344	Cysto/uretero, stricture tx	7.81	7.05	6.83
52345	Cysto/uretero w/up stricture	8.31	7.55	8.51
52346	Cystouretero w/renal strict	9.34	8.58	9.02
52400	Cystouretero w/congen repr	10.06	8.66	8.25
52500	Revision of bladder neck	9.39	7.99	8.49
52640	Relieve bladder contracture	6.89	4.73	4.28
53445	Insert uro/ves nck sphincter	15.21	15.21	17.02
54410	Remove/replace penis prosth	16.48	15.00	16.01
54530	Removal of testis	9.31	8.35	8.65
57287	Revise/remove sling repair	11.49	10.97	10.36
62263	Epidural lysis mult sessions	6.41	6.41	6.04
62350	Implant spinal canal cath	8.04	6.00	1.29

TABLE 8: CY 2010 CMS PROPOSED WORK RVUS—Continued

CPT code [1]	Descriptor	Pre-AMA RUC eval. work RVU	2009 AMA RUC recommended work RVU	2010 CMS proposed work RVU
63650	Implant neuroelectrodes	7.57	7.15	4.18
63685	Insrt/redo spine n generator	7.87	6.00	4.27
64708	Revise arm/leg nerve	6.22	6.22	7.36
64831	Repair of digit nerve	10.23	9.00	9.74
65285	Repair of eye wound	14.43	14.43	14.43

[1] All CPT codes copyright 2008 American Medical Association.

Using the methodology described above, the adjustments to work RVUs for CPT codes 62355, 62360, 62361, 62362, and 62365 would result in negative valuation: 62355 = −1.96; 62360 = −2.31; 62361 = −2.42; 62362 = −2.46; and 62365 = −1.88. For these codes, we are requesting that the AMA RUC re-review the entire family of associated codes and in the interim will maintain the AMA RUC recommended values until a methodology is developed to address codes that result in negative valuation when the methodology described above is utilized.

In addition to the proposed revisions to the AMA RUC-recommended RVUs described above, we encourage the AMA RUC to utilize the building block methodology as described in the CY 2007 PFS proposed rule (71 FR 37172) in the future when revaluing codes with site of service anomalies. We recognize that the AMA RUC looks at families of codes and may assign RVUs based on a particular code ranking within the family. However, the relative value scale requires each service to be valued based on the resources used in furnishing the service.

We are also seeking public comment on alternative methodologies that could be utilized to establish work RVUs for codes that would have a negative valuation under the methodology we used for the proposed revisions to the AMA RUC-recommended values described above.

b. ''23-Hour'' Stay

For services that are performed in the outpatient setting and require a hospital stay of less than 24 hours, we consider this an outpatient service and recognize the additional time associated with the patient evaluation and assessment in the post-service period. We are requesting that the AMA RUC include the additional minutes in their recommendations to CMS. We do not believe the current minutes assigned in the post-service period accurately reflects the total time required for evaluation and assessment of the patient. We believe the use of E/M codes for services rendered in the post-service period for procedures requiring less than a 24-hour hospital stay would result in overpayment for pre-service and intraservice work that would not be provided. Therefore, we will not allow an additional E/M service to be billed for care furnished during the post procedure period when care is furnished for an outpatient service requiring less than a 24-hour hospital stay.

5. Establishing Appropriate Relative Values for Physician Fee Schedule Services

In MedPAC's March 2006 Report to Congress, MedPAC made a number of recommendations to improve the review of the relative values for PFS services. Since that time, we have taken significant action to improve the accuracy of the RVUs. As MedPAC noted in its recent March 2009 Report to Congress, ''CMS and the AMA RUC have taken several steps to improve the review process'' in the intervening years since those initial recommendations. Many of our efforts to improve the accuracy of RVUs have also resulted in substantial increases in the payments for primary care services, which was one of the motivations for MedPAC's recommendations.

- We completed the most recent Five-Year Review of work RVUs, resulting in an increase in over 25 percent to the work RVUs for primary care services.
- We significantly revised the methodology for determining PE RVUs, resulting in more than a 5 percent increase for primary care services.
- We improved our processes for identifying potentially misvalued services by engaging in an ongoing review that includes screens for rapidly growing services and services with substantial shifts in site of service. We also identified approaches to address the issue of potentially misvalued services including reviewing services often billed together and the possibility of expanding the multiple procedure payment reduction (MPPR) to additional nonsurgical procedures and the update of high cost supplies.
- As discussed elsewhere in this proposed rule, we are proposing a number of improvements to the calculation and establishment of the work, PE, and malpractice RVUs that would result in overall payment increases to primary care specialties of between 6 percent and 8 percent in CY 2010. These changes include a 6 percent increase in the work RVUs for office visits as a result of our proposal regarding consultation services; our proposed use of more accurate specialty-specific survey data on physician practice costs; our proposal to revise the utilization rate assumption for certain equipment; and our proposed use of updated and expanded malpractice premium data in the calculation of the malpractice RVUs.

MedPAC has in the past also recommended the establishment of a group panel of experts separate from the AMA RUC to review RVUs. This original March 2006 recommendation was summarized in its March 2008 Report to Congress:

> ''We also recommended that CMS establish a group of experts, separate from the AMA RUC, to help the agency conduct these and other activities. This recommendation was intended not to supplant the AMA RUC but to augment it. To that end, the panel should include members who do not directly benefit from changes to Medicare's payment rates, such as experts in medical economics and technology diffusion and physicians who are employed by managed care organizations and academic medical centers.''

The idea of a group of experts separate from the AMA RUC, to help the agency improve the review of relative values raises a number of issues. We seek broad public input on the following questions and other aspects of such an approach:

- How could input from a group of experts best be incorporated into existing processes of rulemaking and agency receipt of AMA RUC recommendations?
- What specifically would be the roles of a group of experts (for example,

identify potentially misvalued services, provide recommendations on valuation of specified services, review AMA RUC recommendations selected by the Secretary, *etc.*)?

• What should be the composition of a group of experts? How could such a group provide expertise on services that clinician group members do not furnish?

• How would such a group relate to the AMA RUC and existing Secretarial advisory panels such as the Practicing Physician Advisory Committee?

Also of interest are comments on the resources required to establish and maintain such a group. As MedPAC noted in its March 2006 Report with respect to the group of experts ''we recognize that these recommendations will increase demands on CMS and urge the Congress to provide the agency with the financial resources and administrative flexibility needed to undertake them.''

We welcome comments on these topics, as well as others of interest to the stakeholder community. We will consider these comments as we consider the establishment of a group of experts to assist us in our ongoing reviews of the PFS RVUs.

G. Issues Related to the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

This section addresses certain provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub. L. 110–275). We are proposing to revise our policies and regulations as described below in order to conform them to the statutory amendments.

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

Prior to the enactment of the MIPPA, section 1833(c) of the Act provided that for expenses incurred in any calendar year in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital, only 62½ percent of such expenses are considered to be incurred under Medicare Part B when determining the amount of payment and application of the Part B deductible in any calendar year. This provision is known as the outpatient mental health treatment limitation (the limitation), and has resulted in Medicare paying only 50 percent of the approved amount for outpatient mental health treatment, rather than the 80 percent that is paid for most other outpatient services.

Section 102 of the MIPPA amends the statute to phase out the limitation on recognition of expenses incurred for outpatient mental health treatment, which will result in an increase in the Medicare Part B payment for outpatient mental health services to 80 percent by CY 2014. When this section is fully implemented in 2014, Medicare will pay for outpatient mental health services at the same level as other Part B services. For CY 2010, section 102 of the MIPPA provides that Medicare will recognize 68¾ percent of expenses incurred for outpatient mental health treatment, which translates to a payment of 55 percent of the Medicare-approved amount. Section 102 of the MIPPA specifies that the phase out of the limitation will be implemented as shown in Table 9 (provided that the patient has satisfied his or her deductible).

TABLE 9—IMPLEMENTATION OF SECTION 102 OF THE MIPPA

Calendar year	Recognized incurred expenses (in percent)	Patient pays (in percent)	Medicare pays (in percent)
CY 2009 and prior calendar years	62.50	50	50
CY 2010 and CY 2011	68.75	45	55
CY 2012	75.00	40	60
CY 2013	81.25	35	65
CY 2014	100.00	20	80

At present, § 410.155(c) of the regulations includes examples to illustrate application of the current limitation. We are proposing to remove these examples from our regulations and, instead, to provide examples in this proposed rule, in our manual, and under provider education materials as needed. The following examples illustrate the application of the limitation in various circumstances as it is gradually reduced under section 102 of the MIPPA. We note that although we have used the CY 2009 Part B deductible of $135 for purposes of the examples below, the actual deductible amount for CY 2010 and future years will be subject to change.

Example #1: In 2010, a clinical psychologist submits a claim for $200 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $180. Since clinical psychologists must accept assignment, the patient is not liable for the $20 in excess charges. The patient previously satisfied the $135 annual Part B deductible. The limitation reduces the amount of incurred expenses to 68¾ percent of the approved amount. Medicare pays 80 percent of the remaining incurred expenses. The Medicare payment and patient liability are computed as shown in Table 10.

TABLE 10—EXAMPLE #1—CY 2010

1. Actual charges	$200.00
2. Medicare-approved amount	180.00
3. Medicare incurred expenses (0.6875 × line 2)*	123.75
4. Unmet deductible	0.00
5. Remainder after subtracting deductible (line 3 minus line 4)	123.75
6. Medicare payment (0.80 × line 5)	99.00
7. Patient liability (line 2 minus line 6)	81.00

*The recognized incurred expenses for 2010 are 68¾ percent.

Example #2: In 2012, a clinical social worker submits a claim for $135 for outpatient treatment of a patient's mental disorder. The Medicare-approved amount is $120. Since clinical social workers must accept assignment, the patient is not liable for the $15 in excess charges. The limitation reduces the amount of incurred expenses to 75 percent of the approved amount. The patient previously satisfied $70 of the $135 annual Part B deductible, leaving $65 unmet (*see* Table 11).

TABLE 11—EXAMPLE #2—CY 2012

1. Actual charges	$135.00
2. Medicare-approved amount	120.00
3. Medicare incurred expenses (0.75 × line 2)*	90.00
4. Unmet deductible	65.00
5. Remainder after subtracting deductible (line 3 minus line 4)	25.00
6. Medicare payment (0.80 × line 5)	20.00
7. Patient liability (line 2 minus line 6)	100.00

*The recognized incurred expenses for CY 2012 are 75 percent.

Example #3: In CY 2013, a physician who does not accept assignment submits a claim for $780 for services in connection with the treatment of a mental disorder that did not require inpatient hospitalization. The Medicare-approved amount is $750. Because the physician does not accept assignment, the patient is liable for the $30 in excess charges. The patient has not satisfied any of the $135 Part B annual deductible (*see* Table 12).

TABLE 12—EXAMPLE #3—CY 2013

1. Actual charges	$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (0.8125 × line 2)*	609.38
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	474.38
6. Medicare payment (0.80 × line 5)	379.50
7. Patient liability (line 1 minus line 6)	400.50

*The recognized incurred expenses for CY 2013 are 81¼ percent.

Example #4: A patient's Part B expenses during CY 2014 are for a physician's services in connection with the treatment of a mental disorder that initially required inpatient hospitalization, with subsequent physician services furnished on an outpatient basis. The patient has not satisfied any of the $135 Part B deductible. The physician accepts assignment and submits a claim for $780. The Medicare-approved amount is $750. Since the limitation will be completely phased out as of January 1, 2014, the entire $750 Medicare-approved amount is recognized as the total incurred expenses because such expenses are no longer reduced. Also, there is no longer any distinction between mental health services the patient receives as an inpatient or outpatient (*see* Table 13).

TABLE 13—EXAMPLE #4—CY 2014

1. Actual charges	$780.00
2. Medicare-approved amount	750.00
3. Medicare incurred expenses (1.00 × line 2)*	750.00
4. Unmet deductible	135.00
5. Remainder after subtracting deductible (line 3 minus line 4)	615.00
6. Medicare payment (0.80 × line 5)	492.00
7. Beneficiary liability (line 2 minus line 6)	258.00

*The recognized incurred expenses for CY 2014 are 100 percent.

Section 102 of the MIPPA did not make any other changes to the outpatient mental health treatment limitation. Therefore, other aspects of the limitation will remain unchanged during the transition period between CYs 2010 and 2014. The limitation will continue to be applied as it has been in accordance with our regulation at § 410.155(b) which specifies that the limitation applies to outpatient treatment of a mental, psychoneurotic, or personality disorder, identified under the International Classification of Diseases (ICD) diagnosis code range 290–319. We use the place of service code, and the procedure code to identify services to which the limitation applies.

Additionally, we are proposing to make technical corrections to § 410.155(b)(2) in order to update and clarify the services to which the limitation does not apply. Our proposed technical changes are as follows:

- Under § 410.155(b)(2)(ii), revise the regulation to specify the HCPCS code, M0064 (or any successor code), that represents the statutory exception to the limitation for brief office visits for the sole purpose of monitoring or changing drug prescriptions used in mental health treatment.
- At § 410.155(b)(2)(iv), we are proposing to revise the regulation to add neuropsychological tests and diagnostic psychological tests to the examples of diagnostic services that are not subject to the limitation when performed to establish a diagnosis.
- Under § 410.155(b)(2)(v), we are proposing to revise the regulation to specify the CPT code 90862 (or any successor code) that represents pharmacologic management services to which the limitation does not apply when furnished to treat a patient who is diagnosed with Alzheimer's disease or a related disorder.

Finally, we are proposing to add a new paragraph (c) to § 410.155 that provides a basic formula for computing the limitation during the phase-out period from CY 2010 through CY 2013, as well as after the limitation is fully removed from CY 2014 onward.

2. Section 131: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

a. Program Background and Statutory Authority

The Physician Quality Reporting Initiative (PQRI) is a voluntary reporting program that provides an incentive payment to eligible professionals who satisfactorily report data on quality measures for covered professional services during a specified reporting period. Under section 1848(k)(3)(B) of the Act, the term ''eligible professional'' means any of the following: (1) A physician; (2) A practitioner described in section 1842(b)(18)(C); (3) A physical or occupational therapist or a qualified speech-language pathologist; (4) A qualified audiologist. The PQRI was first implemented in 2007 as a result of section 101 of Division B of the Tax Relief and Health Care Act of 2006—the Medicare Improvements and Extension Act of 2006 (Pub. L. 109–432) (MIEA–TRHCA), which was enacted on December 20, 2006. The PQRI was extended and further enhanced as a result of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Pub. L. 110–173) (MMSEA), which was enacted on December 29, 2007, and the MIPPA, which was enacted on July 15, 2008. Changes to the PQRI as a result of these laws, as well as information about the PQRI in 2007, 2008, and 2009 are discussed in detail in the CY 2008 PFS proposed rule (72 FR 38196 through 38204), CY 2008 PFS final rule with comment period (72 FR 66336 through 66353), CY 2009 PFS proposed rule (73 FR 38558 through 38575), and CY 2009 PFS final rule with comment period (73 FR 69817 through 69847). In addition, detailed information about the PQRI is available on the CMS Web site at *http://www.cms.hhs.gov/PQRI*.

b. Incentive Payments for the 2010 PQRI

For 2010, section 1848(m)(1)(B) of the Act authorizes the Secretary to provide an incentive payment equal to 2.0 percent of the estimated total allowed charges (based on claims submitted not later than 2 months after the end of the reporting period) for all covered professional services furnished during the reporting period for 2010. Although PQRI incentive payments are only authorized through 2010 under section 1848(m)(1)(A) of the Act, section 1848(k)(2)(C) of the Act provides for the use of consensus-based quality measures for the PQRI for 2010 and subsequent years.

The PQRI incentive payment amount is calculated using estimated allowed charges for all covered professional services furnished under the PFS, not just those charges associated with the reported quality measures. ''Allowed charges'' refers to total charges, including the beneficiary deductible and coinsurance, and is not limited to the 80 percent paid by Medicare or the portion covered by Medicare where Medicare is secondary payer. Amounts billed above the PFS amounts for assigned and non-assigned claims will not be included in the calculation of the incentive payment amount. In addition, since, by definition under section 1848(k)(3)(A)) of the Act, ''covered professional services'' are limited to services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional, other Part B services and items that may be billed by eligible professionals but are not paid under or based upon the Medicare Part B PFS are not included in the calculation of the incentive payment amount.

Under section 1848(m)(6)(C) of the Act, the ''reporting period'' for the 2008 through 2011 PQRI is defined to be the entire year, but the Secretary is authorized to revise the reporting period for years after 2009 if the Secretary determines such ''revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden.''

We are also required by section 1848(m)(5)(F) of the Act to establish alternative criteria for satisfactorily reporting and alternative reporting periods for registry-based reporting and for reporting measures groups. Therefore, eligible professionals who meet the proposed alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups for the proposed 2010 alternative reporting periods for registry-based reporting and for reporting measures groups would also be eligible to earn an incentive payment equal to 2.0 percent of the estimated total Medicare Part B PFS allowed charges for all covered professional services furnished by the eligible professional during the proposed alternative reporting periods for 2010 PQRI registry-based reporting or for reporting measures groups.

The proposed PQRI reporting options for an individual eligible professional seeking to qualify for a 2010 PQRI incentive payment (that is, the proposed PQRI reporting mechanisms, proposed reporting periods, and proposed criteria for satisfactory reporting, including the proposed alternative reporting periods and alternative criteria for satisfactorily reporting for registry-based reporting and for reporting measures groups) are addressed in sections II.G.2.c. through II.G.2.f. of this proposed rule. The proposed 2010 PQRI quality measures and proposed 2010 PQRI measures groups are discussed in section II.G.2.i. of this proposed rule.

Prior to 2010, the PQRI was an incentive program in which determination of whether an eligible professional satisfactorily reported quality data was made at the individual professional level, based on the National Provider Identifier (NPI). Although the incentive payments were made to the practice(s) represented by the Tax Identification Number (TIN) to which payments are made for the individual professional's services, there were no incentive payments made to the group practice based on a determination that the group practice, as a whole, satisfactorily reported PQRI quality measures data. To the extent individuals (based on the individuals' NPIs) satisfactorily reported data on PQRI quality measures that were associated with more than one practice or TIN, the determination of whether an eligible professional satisfactorily reported PQRI quality measures data was made for each unique TIN/NPI combination. Therefore, the incentive payment amount was calculated for each unique TIN/NPI combination and payment was made to the holder of the applicable TIN.

However, section 1848(m)(3)(C)(i) of the Act requires that by January 1, 2010, the Secretary establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures for the PQRI for covered professional services for a reporting period, if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary. Therefore, beginning with the 2010 PQRI, group practices who satisfactorily submit data on quality measures also would be eligible to earn an incentive payment equal to 2.0 percent of the

estimated total allowed charges for all covered professional services furnished by the group practice during the applicable reporting period. As required by section 1848(m)(3)(C)(iii) of the Act, payments to a group practice by reason of the process described above shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures. Therefore, an individual eligible professional who is participating in the group practice reporting option as a member of a group practice would not be able to separately earn a PQRI incentive payment as an individual eligible professional.

The process proposed to be used to determine whether a group practice satisfactorily submits data on quality measures for the 2010 PQRI is described in section II.G.2.g. of this proposed rule. The proposed measures on which a group practice would need to report in order to be treated as satisfactorily submitting data on quality measures for the 2010 PQRI are discussed in section II.G.2.j. of this proposed rule.

c. Proposed 2010 Reporting Periods for Individual Eligible Professionals

As we indicated above, section 1848(m)(6)(C) of the Act defines ''reporting period'' for 2010 to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. To be consistent with section 1848(m)(6)(C) of the Act and with prior years, we propose the 2010 PQRI reporting period for the reporting of individual PQRI quality measures through claims or a qualified electronic health record (EHR) (*see* section II.G.2.d. of this proposed rule for discussion of proposed 2010 PQRI reporting mechanisms) will be the entire year (that is, January 1, 2010 through December 31, 2010).

We also considered exercising our authority to revise the reporting period for claims-based reporting of individual measures by proposing to add an alternative reporting period beginning July 1, 2010 for claims-based reporting of individual measures. Doing so would make the reporting periods for claims-based reporting of individual measures consistent with the alternative reporting periods for reporting measures groups and for registry-based reporting that have been in place since the 2008 PQRI. This would allow an eligible professional to earn a PQRI incentive payment equal to 2.0 percent of his or her estimated allowed charges for covered professional services furnished for the last half of 2010 if he or she satisfactorily reports data on individual PQRI quality measures through claims during the last half of 2010. We received input from a few stakeholders in support of a partial year reporting period for claims-based reporting of individual measures to give more eligible professionals the opportunity to begin reporting later in the year. Other stakeholders recommended that we offer the same reporting periods for all reporting mechanisms. We agree that having the same reporting periods for all reporting mechanisms may be less complex. We also agree that the addition of a 6-month reporting period may facilitate participation in PQRI for certain eligible professionals. However, we do not believe that making a 6-month reporting period available would serve to enhance the validity of results on measures reported or to maximize scientific validity as required under section 1848(m)(6)(C)(ii) of the Act. In addition, given our desire to transition from the use of the claims-based reporting mechanism as the primary reporting mechanism for clinical quality measures for PQRI after 2010 to rely more heavily on registry-based reporting (*see* section II.G.2.d. of this proposed rule for further discussion), we do not believe it appropriate to add a new 6-month reporting period for claims-based reporting of individual measures. Given the fact that we seek to lessen reliance on the claims-based reporting mechanism for the PQRI after 2010, we believe the cost of adding a 6-month reporting period for claims-based reporting of individual measures outweighs any added flexibility that eligible professionals may receive in the short-term.

Nevertheless, we invite comments on the decision to not propose a 6-month reporting period for claims-based reporting of individual PQRI quality measures.

In addition, section 1848(m)(5)(F) of the Act requires, for 2008 and subsequent years, the Secretary to establish alternative reporting periods for reporting groups of measures and for registry-based reporting. To satisfy the requirements of section 1848(m)(5)(F) of the Act and to maintain program stability, we propose to retain the 2 alternative reporting periods from the 2008 and 2009 PQRI for reporting measures groups and for registry-based reporting: (1) The entire year; and (2) a 6-month reporting period beginning July 1. Therefore, for 2010, the proposed alternative reporting periods for reporting measures groups and for registry-based reporting are: (1) January 1, 2010 through December 31, 2010; and (2) July 1, 2010 through December 31, 2010. We note that the 6-month reporting period, beginning July 1, 2010, is proposed to be available for reporting on measures groups and for reporting using the registry-based reporting mechanism only. For an eligible professional who satisfactorily reports measures groups or through the registry-based reporting mechanism for the 6-month reporting period, the eligible professional would qualify to earn a PQRI incentive payment equal to 2.0 percent of his or her total estimated allowed charges for covered professional services furnished between July 1, 2010 and December 31, 2010 only. The incentive payment would not be calculated based on the eligible professional's charges for covered professional services for the entire year.

d. Proposed 2010 PQRI Reporting Mechanisms for Individual Eligible Professionals

When the PQRI was first implemented in 2007, there was only 1 reporting mechanism available to submit data on PQRI quality measures. For the 2007 PQRI, the only way that eligible professionals could submit data on PQRI quality measures was by reporting the appropriate quality data codes on their Medicare Part B claims (claims-based reporting). For the 2008 PQRI, we added a second reporting mechanism as required by section 1848(k)(4) of the Act, so that eligible professionals could submit data on PQRI quality measures to a qualified PQRI registry and request the registry to submit PQRI quality measures results and numerator and denominator data on the 2008 PQRI quality measures or measures groups on their behalf (registry-based reporting). For the 2009 PQRI, we retained the 2 reporting mechanisms used in the 2008 PQRI (that is, claims-based reporting and registry-based reporting) for reporting individual PQRI quality measures and for reporting measures groups.

To promote the adoption of EHRs, we also conducted limited testing of a third reporting mechanism for the 2008 PQRI, which was the submission of clinical quality data extracted from an EHR, or the EHR-based reporting mechanism. No incentive payment was available to those eligible professionals who participated in testing the EHR-based reporting mechanism. In the CY 2009 PFS proposed rule (73 FR 38564 through 38565), we described our plans to test the submission of clinical quality

data extracted from qualified EHR products for five 2008 PQRI measures and proposed to accept PQRI data from EHRs and to pay PQRI incentive payments based on that submission for a limited subset of the proposed 2009 PQRI quality measures. However, as described in the CY 2009 PFS final rule with comment period (73 FR 69830), we did not finalize our proposal to allow eligible professionals to submit clinical quality data extracted from EHRs for purposes of receiving a PQRI incentive payment for 2009. Since the 2008 EHR testing process was not complete at the time of publication of the CY 2009 PFS final rule, we instead opted to continue to test the submission of clinical quality data extracted from EHRs in 2009 and provide no incentive payment to those eligible professionals participating in testing the EHR-based reporting mechanism in 2009.

For the 2010 PQRI, we are proposing to retain the claims-based reporting mechanism and the registry-based reporting mechanism. In addition, we are again proposing for the 2010 PQRI to accept PQRI quality measures data extracted from a qualified EHR product for a limited subset of the proposed 2010 PQRI quality measures, as identified in Table 20, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination based on that testing process that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. We will make the determination as to whether accepting data from EHRs on quality measures is practical and feasible for the 2010 PQRI prior to publication of the CY 2010 PFS final rule with comment period. We will indicate in the CY 2010 PFS final rule with comment period whether we intend to finalize this proposal. If we finalize this proposal, then, unlike in prior years, an eligible professional would be able to earn a PQRI incentive payment through the EHR-based reporting mechanism in 2010.

We seek to offer more reporting mechanisms because we recognize that 1 mode of quality reporting does not suit all practices and our experience with the registry-based reporting mechanism thus far has been favorable. While the availability of multiple reporting mechanisms should increase opportunities for eligible professionals to satisfactorily report quality data for the PQRI, we also recognize that there are a number of limitations associated with claims-based reporting. On one hand, claims submission is available to nearly all eligible professionals. On the other hand, submission of quality data on claims has certain drawbacks since the claims processing system was developed for billing purposes and not for the submission of quality data. As we noted in the CY 2009 PFS final rule with comment period (73 FR 69833), for example, measures with complex specifications, such as those that require multiple diagnosis codes are not as conducive to claims-based reporting and may be associated with a greater number of invalidly reported quality data codes. Similarly, when multiple measures share the same codes it may be difficult to determine which measure(s) the eligible professional intended to report through claims.

We believe that EHR-based reporting is a viable option for overcoming the limitations associated with claims-based reporting of quality measures. Therefore, we propose to add an EHR-based reporting mechanism for the 2010 PQRI in order to promote the adoption and use of EHRs and to provide both eligible professionals and CMS experience on EHR-based quality reporting.

Furthermore, on February 17, 2009, the President signed into law the American Recovery and Reinvestment Act (the Recovery Act) (Pub. L. 111–5). Section 4101(a) of the Health Information Technology for Economic and Clinical Health (HITECH) Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act), which amends section 1848 of the Act to add new subsection (o), authorizes incentive payments under Medicare for certain eligible professionals who are ''meaningful EHR users'' beginning in 2011. However, the provisions in this proposed rule do not implement any HITECH Act statutory provisions. While our efforts to encourage the adoption and use of EHRs through testing EHR-based data submission in the 2008 and 2009 PQRI and our proposal to add an EHR-based reporting mechanism for the purpose of receiving a PQRI incentive payment for the 2010 PQRI could potentially provide invaluable experience and serve as a foundation for establishing the capacity for eligible professionals to send, and for CMS to receive, data on quality measures via EHRs, the provisions of the HITECH Act will be implemented in future notice and comment rulemaking.

In summary, we propose that for 2010, an eligible professional may choose to report data on PQRI quality measures through claims, to a qualified registry (for the qualification requirements for registries, see section II.G.2.i.(4) of this proposed rule), or through a qualified EHR product (for the qualification requirements for EHR vendors and their products, see section II.G.2.i.(5) of this proposed rule). Depending on which PQRI individual quality measures or measures groups an eligible professional selects, however, one or more of the proposed reporting mechanisms may not be available for reporting a particular 2010 PQRI individual quality measure or measures group. The proposed 2010 reporting mechanisms through which each proposed 2010 PQRI individual quality measure and measures group could be reported is identified in Tables 14 through 15. We invite comments on the proposed reporting mechanisms for the 2010 PQRI, including our proposal to add an EHR-based reporting mechanism to the 2010 PQRI, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible.

While we propose to retain the claims-based reporting mechanism for 2010, we note that we are considering significantly limiting the claims-based mechanism of reporting clinical quality measures for the PQRI after 2010. This would be contingent upon there being an adequate number and variety of registries available and/or EHR reporting options. Potentially, we would retain claims-based reporting in years after 2010 principally for the reporting of structural measures, such as Measure #124 Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR), and circumstances where claims-based reporting is the only available mechanism for certain categories of eligible professionals to report on PQRI quality measures.

Reducing our reliance on the claims-based reporting mechanism after 2010 will allow us and eligible professionals to devote available resources to maximizing the potential of registries and EHRs for quality measurement reporting. Both mechanisms hold the promise of more sophisticated and timely reporting on clinical quality measures. Clinical data registries allow the collection of more detailed data, including outcomes, without the necessity of a single submission contemporaneously with claims billing, which overcomes some of the limitations of the claims-based reporting mechanism. Registries can also provide feedback and quality improvement information based on reported data. Finally, clinical data registries can also receive data from EHRs, and therefore, serve as an alternative means to reporting clinical quality data extracted

from an EHR. As we continue to qualify additional registries, we believe that there will be a sufficient number of qualified PQRI registries by 2011 to make it possible to reduce or even discontinue the claims-based reporting mechanism for most measures after 2010. We invite comments on our intent to lessen our reliance on the claims-based reporting mechanism for the PQRI beyond 2010.

Regardless of the reporting mechanism chosen by an eligible professional, there is no requirement for the eligible professional to sign up or register to participate in the PQRI. However, there may be some requirements for participation through a specific reporting mechanism that are unique to that particular reporting mechanism. In addition to the criteria for satisfactory reporting of individual measures and measures groups described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, eligible professionals must ensure that they meet all requirements for their chosen reporting mechanism.

(1) Requirements for Individual Eligible Professionals Who Choose the Claims-Based Reporting Mechanism

For eligible professionals who choose to participate in the PQRI by submitting data on individual quality measures or measures groups through the claims-based reporting mechanism, the only requirement associated with claims-based reporting that we are proposing apart from the proposed criteria for satisfactory reporting of individual measures and measures described below in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule, is the submission of the appropriate PQRI quality data codes on the professionals' Medicare Part B claims. An eligible professional would be permitted to submit the quality data codes for the eligible professional's selected individual PQRI quality measures or measures group at any time during the 2010 reporting period. Please note, however, that as required by section 1848(m)(1)(A) of the Act, all claims for services furnished between January 1, 2010 and December 31, 2010 must be processed by no later than February 28, 2011 to be included in the 2010 PQRI analysis.

(2) Requirements for Individual Eligible Professionals Who Choose the Registry-Based Reporting Mechanism

In order to report quality measures results and numerator and denominator data on the 2010 PQRI individual quality measures or measures group through a qualified clinical registry, we propose that eligible professionals would need to enter into and maintain an appropriate legal arrangement with a qualified 2010 PQRI registry. Such arrangements would provide for the registry's receipt of patient-specific data from the eligible professional and the registry's disclosure of quality measures results and numerator and denominator data on PQRI quality measures or measures groups on behalf of the eligible professional to CMS. Thus, the registry would act as a Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191) (HIPAA) Business Associate and agent of the eligible professional. Such agents are referred to as ''data submission vendors.'' The ''data submission vendors'' would have the requisite legal authority to provide clinical quality measures results and numerator and denominator data on individual quality measures or measures groups on behalf of the eligible professional for the PQRI. The registry, acting as a data submission vendor, would submit registry-derived measures information to the CMS designated database for the PQRI, using a CMS-specified record layout. The record layout will be provided to the registry by CMS.

To maintain compliance with applicable statutes and regulations, our program and its data system must maintain compliance with the HIPAA requirements for requesting, processing, storing, and transmitting data. Eligible professionals that conduct HIPAA covered transactions also must maintain compliance with the HIPAA requirements.

Eligible professionals choosing to participate in PQRI by submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures groups through the registry-based reporting mechanism for 2010 would need to select a qualified PQRI registry and submit information on PQRI individual quality measures or measures groups to the selected registry in the form and manner and by the deadline specified by the registry.

The process and requirements that we propose to use to determine whether a registry is qualified to submit quality measures results and numerator and denominator data on PQRI quality measures or measures groups on an eligible professional's behalf in 2010 are described in section II.G.2.d. of this proposed rule. We will post on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov* a list of qualified registries for the 2010 PQRI, including the registry name, contact information, and the 2010 measure(s) and/or measures group(s) for which the registry is qualified and intends to report. We propose to post the names of 2010 PQRI qualified registries in 2 phases. In either event, even though a registry is listed as ''qualified,'' we cannot guarantee or assume responsibility for the registry's successful submission of PQRI quality measures results and numerator and denominate data on PQRI quality measures or measures groups on behalf of eligible professionals.

In the first phase, we anticipate that by December 31, 2009, we will be able to, at minimum, post a list of those registries qualified for the 2010 PQRI based on: (1) Being a qualified registry for the 2008 and 2009 PQRI that successfully submitted 2008 PQRI quality measures results and numerator and denominator data on the quality measures; (2) having received a letter indicating their continued interest in being a PQRI registry for 2010; and (3) the registry's compliance with the 2010 PQRI registry requirements. By posting this first list of qualified registries for the 2010 PQRI, we seek to make available the names of registries that can be qualified at the start of the 2010 reporting period. We do this to accommodate requests we have received from eligible professionals who wish to avoid claims-based reporting pending knowing whether a particular registry is qualified for the 2010 PQRI.

In the second phase, we anticipate to complete posting of the list of qualified 2010 registries as soon as we have completed vetting the registries interested in participating in the 2010 PQRI and identified the qualified registries for the 2010 PQRI, which we anticipate will be completed by no later than Summer 2010. An eligible professional's ability to report PQRI quality measures results and numerator and denominator data on PQRI quality measures or measures groups using the registry-based reporting mechanism should not be impacted by the complete list of qualified registries for the 2010 PQRI being made available after the start of the reporting period. First, registries will not begin submitting eligible professionals' PQRI quality measures results and numerator and denominator data on the quality measures or measures groups to CMS until 2011. Second, if an eligible professional decides that he or she is no longer interested in submitting quality measures results and numerator and denominator data on PQRI individual quality measures or measures group through the registry-based reporting mechanism after the complete list of qualified registries becomes available, this does not preclude the eligible

professional from attempting to meet the criteria for satisfactory reporting through another 2010 PQRI reporting mechanism.

In addition to meeting the above proposed requirements specific to registry-based reporting, eligible professionals who choose to participate in PQRI through the registry-based reporting mechanism would need to meet the relevant criteria proposed for satisfactory reporting of individual measures or measures groups that all eligible professionals must meet in order to qualify to earn a 2010 PQRI incentive payment. The criteria for satisfactory reporting of individual measures and measures groups are described in sections II.G.2.e. and II.G.2.f., respectively, of this proposed rule.

(3) Requirements for Individual Eligible Professionals Who Choose the EHR-Based Reporting Mechanism

For eligible professionals who choose to participate in the 2010 PQRI by submitting data on individual quality measures through the EHR-based reporting mechanism, the only proposed requirements associated with EHR-based reporting other than meeting the criteria for satisfactory reporting of individual measures described in section II.G.2.e. of this proposed rule are to: (1) Select a qualified EHR product and (2) submit clinical quality data extracted from the EHR to a CMS clinical data warehouse. Provided that our 2009 EHR data submission testing process is successful, we propose to begin accepting submission of clinical quality data extracted from ''qualified'' EHRs on January 1, 2010, or as soon thereafter as is technically feasible. We propose that eligible professionals will have until March 31, 2011 to complete data submission through qualified EHRs for services furnished during the 2010 PQRI reporting period. The process that was used to determine whether an EHR vendor and its EHR product(s) are qualified to submit clinical quality data extracted from EHRs for the 2010 PQRI is described in section II.G.2.d.5. of this proposed rule.

The specifications for the electronic transmission of the proposed 2010 PQRI measures identified in Table 20 (section II.G.2.i.(4) of this proposed rule) as being under consideration for EHR-based reporting in 2010 will be posted on a public Web site when available. We will announce the availability and exact location of these specifications through familiar CMS communications channels, including the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. The posting of specifications for the electronic transmission of any particular measure prior to publication of the final rule does not signify that the measure will necessarily be selected for the 2010 PQRI measure set, nor that EHR-based reporting will be accepted for that measure even if it may otherwise be included in the 2010 PQRI. However, by posting the specifications for electronic transmission of these measures, we seek to allow sufficient time for EHR vendors to adapt their products to support EHR-based capture and submission of data for these measures prior to the start of any 2010 PQRI reporting periods.

We do not propose any option to report measures groups through EHR-based reporting on services furnished during 2010. Because EHR-based reporting to CMS of data on quality measures would be new to PQRI for 2010, we propose to make available only the criteria applicable to reporting of individual PQRI measures.

We cannot assume responsibility for the successful submission of data from eligible professionals' EHRs. Any eligible professional who chooses to submit PQRI data extracted from an EHR should contact the EHR product's vendor to determine if the product is qualified and has been updated to facilitate PQRI quality measures data submission. Such professionals also should begin attempting submission promptly after we announce that the clinical data warehouse is ready to accept 2010 PQRI quality measures data through the EHR mechanism in order to assure the professional has a reasonable period of time to work with his or her EHR and/or its vendor to correct any problems that may complicate or preclude successful quality measures data submission through that EHR. As we indicated above, data submission for the 2010 PQRI would need to be completed by March 31, 2011.

(4) Qualification Requirements for Registries

In order to be ''qualified'' to submit quality measures results and numerator and denominator data on PQRI quality measures and measures groups on behalf of eligible professionals pursuing incentive payment for the 2008 and 2009 PQRI, we required registries to complete a self-nomination process and to meet certain technical and other requirements. For the 2009 PQRI, registries that were ''qualified'' for 2008 did not need to be ''re-qualified'' for 2009 unless they were unsuccessful at submitting 2008 PQRI data (that is, failed to submit 2008 PQRI data per the 2008 PQRI registry requirements). Registries that were ''qualified'' for 2008 and wished to continue to participate in 2009 were only required to communicate their desire to continue participation for 2009 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2009 and their compliance with the 2009 PQRI registry requirements by March 31, 2009.

For the 2010 PQRI, we are again proposing to require a self-nomination process for registries wishing to submit 2010 PQRI quality measures or measures groups on behalf of eligible professionals for services furnished during the applicable reporting periods in 2010. Similar to the 2008 and 2009 PQRI registry self-nomination process, the proposed registry self-nomination process for the 2010 PQRI would be based on a registry meeting specific technical and other requirements.

In order to be consistent with the registry requirements from prior program years, we propose that the 2010 registry requirements be substantially the same as for 2008 and 2009. Specifically, to be considered a qualified registry for purposes of submitting individual quality measures and measures groups on behalf of eligible professionals who choose to report using this reporting mechanism under the 2010 PQRI, we propose that a registry would need to:

- Be in existence as of January 1, 2009.
- Be able to collect all needed data elements and calculate results for at least 3 measures in the 2010 PQRI program (according to the posted 2010 PQRI Measure Specifications).
- Be able to calculate and submit measure-level reporting rates by TIN/NPI;
- Be able to calculate and submit, by TIN/NPI, a performance rate (that is, the percentage of a defined population who receive a particular process of care or achieve a particular outcome) for each measure on which the TIN/NPI reports;
- Be able to separate out and report on Medicare Part B FFS patients;
- Provide the name of the registry;
- Provide the reporting period start date the registry will cover;
- Provide the reporting period end date the registry will cover;
- Provide the measure numbers for the PQRI quality measures on which the registry is reporting;
- Provide the measure title for the PQRI quality measures on which the registry is reporting;
- Report the number of eligible instances (reporting denominator);
- Report the number of instances of quality service performed (numerator);

- Report the number of performance exclusions;
- Report the number of reported instances, performance not met (eligible professional receives credit for reporting, not for performance);
- Be able to transmit this data in a CMS-approved XML format. We expect that this CMS-specified record layout will be substantially the same as for the 2008 and 2009 PQRI. This layout will be provided to registries in 2010;
- Comply with a CMS-specified secure method for data submission, such as submitting its data in an XML file through an Individuals Access to CMS Systems (IACS) user account;
- Submit an acceptable ''validation strategy'' to CMS by March 31, 2010. A validation strategy ascertains whether eligible professionals have submitted accurately and on at least the minimum number (80 percent) of their eligible patients, visits, procedures, or episodes for a given measure. Acceptable validation strategies often include such provisions as the registry being able to conduct random sampling of their participants' data, but may also be based on other credible means of verifying the accuracy of data content and completeness of reporting or adherence to a required sampling method;
- Enter into and maintain with its participating professionals an appropriate Business Associate agreement that provides for the registry's receipt of patient-specific data from the eligible professionals, as well as the registry's disclosure of quality measure results and numerator and denominator data on behalf of eligible professionals who wish to participate in the PQRI program;
- Obtain and keep on file signed documentation that each holder of an NPI whose data are submitted to the registry has authorized the registry to submit quality measures results and numerator and denominator data to CMS for the purpose of PQRI participation. This documentation must be obtained at the time the eligible professional signs up with the registry to submit PQRI quality measures data to the registry and must meet any applicable laws, regulations, and contractual business associate agreements;
- Provide CMS access (if requested) to review the Medicare beneficiary data on which 2010 PQRI registry-based submissions are founded;
- Provide the reporting option (reporting period and reporting criteria) that the eligible professional has satisfied or chosen; and
- Provide CMS a signed, written attestation statement via mail or e-mail which states that the quality measure results and numerator and denominator data provided to CMS are accurate and complete.

With respect to the submission of 2010 measure results and numerator and denominator data on measures groups, we propose to retain the following registry requirements from the 2009 PQRI:

- Indicate the reporting period chosen for each eligible professional who chooses to submit data on measures groups;
- Base reported information on measures groups only on patients to whom services were furnished during the 12-month reporting period of January through December 2010 or the 6-month reporting period of July 2010 through December 2010;
- Agree that the registry's data may be inspected by CMS under our oversight authority if non-Medicare patients are included in the patient sample;
- Be able to report data on all of the measures in a given measures group and on either 30 patients from January 1 through December 31, 2010 (note this patient sample must include some Medicare Part B FFS beneficiaries) or on 80 percent of applicable Medicare Part B FFS patients for each eligible professional (with a minimum of 15 patients during the January 1, 2010 through December 31, 2010 reporting period or a minimum of 8 patients during the July 1, 2010 through December 31, 2010 reporting period) (*see* criteria for satisfactory reporting of measures groups described in section II.G.2.f. of this proposed rule for further information); and
- Be able to report the number of Medicare FFS patients and the number of Medicare Advantage patients that are included in the patient sample for a given measures group.

In addition to the above requirements, we propose the following new requirements for registries for the 2010 PQRI:

- Registries must have at least 25 participants;
- Registries must provide at least 1 feedback report per year to participating eligible professionals;
- Registries must not be owned and managed by an individual locally-owned single-specialty group (in other words, single-specialty practices with only 1 practice location or solo practitioner practices would be prohibited from self-nominating to become a qualified PQRI registry);
- Registries must participate in ongoing 2010 PQRI mandatory support conference calls hosted by CMS (approximately 1 call per month);
- Registries must provide a flow and XML of a measure's calculation process for each measure type that the registry intends to calculate; and
- Registries must use PQRI measure specifications to calculate reporting or performance unless otherwise stated.

These proposed new requirements are intended to improve the registry-based reporting mechanism by taking advantage of some of the registries' existing quality improvement functions, maximizing the registry's ability to successfully submit eligible professionals' quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups to CMS, and discouraging small physician offices or an individual eligible professional from self-nominating to become a qualified registry. We are concerned that an individual eligible professional or a small practice does not have the resources or capabilities to successfully submit quality measures results and numerator and denominator data on PQRI individual measures or measures groups through the registry data submission process.

We propose to post the final 2010 PQRI registry requirements, including the exact date by which registries that wish to qualify for 2010 must submit a self-nomination letter and instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that new registries that wish to self-nominate for 2010 will be required to do so by January 31, 2010.

Similar to the 2009 PQRI, we propose that registries that were ''qualified'' for 2009 and wish to continue to participate in 2010 would not need to be ''re-qualified'' for 2010 unless they are unsuccessful at submitting 2009 PQRI data (that is, fail to submit 2009 PQRI data per the 2009 PQRI registry requirements). We further propose that registries that were ''qualified'' for 2009, were successful in submitting 2009 PQRI data, and wish to continue to participate in 2010 would need to indicate their desire to continue participation for 2010 by submitting a letter to CMS indicating their continued interest in being a PQRI registry for 2010 and their compliance with the 2010 PQRI registry requirements by no later than October 31, 2009. Instructions regarding the procedures for submitting this letter will be provided to qualified 2009 PQRI registries on the 2009 PQRI registry support conference calls.

If a qualified 2009 PQRI registry fails to submit 2009 PQRI data per the 2009 PQRI registry requirements, we propose

the registry would be considered unsuccessful at submitting 2009 PQRI data and would need to go through the full self-nomination process again to participate in the 2010 PQRI. By March 31, 2010, registries that are unsuccessful submitting quality measures results and numerator and denominator data for 2009 would need to be able to meet the 2010 PQRI registry requirements and go through the full vetting process again.

Finally, as discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above registry requirements would apply not only for the purpose of a registry qualifying to report 2010 PQRI quality measure results and numerator and denominator data on PQRI individual quality measures or measures groups, but also for the purpose of a registry qualifying to submit the proposed electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

(5) Qualification Requirements for EHR Vendors and Their Products

In the CY 2009 PFS final rule with comment period (73 FR 69830), we announced our intent to qualify EHR vendors and their specific products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse so that we may potentially begin to accept data via EHRs for purposes of satisfactorily reporting data on quality measures in future PQRI reporting. We stated that we anticipate posting on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, by December 31, 2008, a list of requirements that EHR vendors must be able to meet in order to self-nominate to have their product ''qualified'' to potentially be able to submit quality measures data for the 2010 PQRI to CMS. We also stated that qualifying EHR vendors ahead of actual data submission will facilitate the live data submission process.

On December 31, 2008, the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program,'' was posted on the Reporting page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, which described the EHR vendor requirements and the EHR vendor self-nomination process.

The vendor's EHR system must be updated according to the Draft 2009 EHR specifications posted on the QualityNet Web site at *http://www.qualitynet.org* in order for an EHR vendor and its product to qualify to submit test information on 2009 PQRI measures, and for possible EHR data submission for future PQRI reporting years. In addition, the 2009 PQRI EHR test-vendors must meet the following requirements:

- Be able to collect and transmit all required data elements according to the 2009 EHR Specifications.
- Be able to separate out and report on Medicare Part B FFS patients only.
- Be able to include TIN/NPI information submitted with an eligible professional's quality data.
- Be able to transmit this data in the CMS-approved format.
- Comply with a secure method for data submission.
- Enter into and maintain with its participating professionals an appropriate legal arrangement that provides for the EHR vendor to receive patient-specific data from the eligible professional, as well as the EHR vendor's disclosure of protected health information on behalf of eligible professionals who wish to participate in the 2009 PQRI EHR test program.
- Obtain and keep on file signed documentation that each NPI whose data is submitted to the EHR vendor has authorized the EHR vendor to submit patient data to CMS for the purpose of PQRI testing. This documentation must meet the standards of applicable law, regulations, and contractual or business associate agreements.

As described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program,'' which is posted on the Reporting page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, EHR vendors who wish to qualify to participate in the 2009 PQRI EHR test program were required to submit a self-nomination letter requesting inclusion in the 2009 EHR testing process by February 13, 2009. All nominees would then go through a vetting process. Those nominees passing this vetting process would be asked to submit test data (that is, mock-up data) or to submit live test data from some of their clients (users) with their permission. Vendors who successfully submit their test data would also need to be able to adapt their system to any changes in the measure specifications that may arise due to Healthcare Information Technology Standards Panel (HITSP) or Certification Commission for Healthcare Information Technology (CCHIT) adoption of quality measure data reporting criteria.

It is expected that the process for qualifying self-nominated EHR vendors may conclude in 2009. At the conclusion of this process, we propose that those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product (that is, the name of the vendor software product and the version that is qualified), which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2010 PQRI, if and when, EHR submission is included in the 2010 PQRI as a PQRI reporting mechanism.

As discussed further under section II.G.5.c.(1) of this proposed rule, we propose that the above EHR vendor requirements would apply not only for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to submit data extracted from the EHR for the 2010 PQRI, but also for the purpose of a vendor's EHR product being qualified for the purpose of the product's users being able to electronically submit data extracted from the EHR for the electronic prescribing measure for the 2010 E-Prescribing Incentive Program.

During 2010, we expect to use the self-nomination process described in the ''Requirements for Electronic Health Record (EHR) Vendors to Participate in the 2009 PQRI EHR Testing Program'' posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI/20_Reporting.asp#TopOfPage*, to qualify additional EHR vendors and their EHR products to submit quality data extracted from their EHR products to the CMS clinical quality data warehouse for program years after 2010. We anticipate that the requirements will be similar to those used to qualify EHR products for the 2009 PQRI EHR testing, but they may be modified based on the results of our 2009 EHR testing. At the conclusion of this process, sometime in late 2010, those EHR products that meet all of the EHR vendor requirements will be listed on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* as a ''qualified'' EHR product, which indicates that the product's users may submit quality data to CMS (either directly from their system or through the vendor—which is yet to be determined) for the 2011 PQRI or subsequent years, if and when, EHR submission is included as a PQRI reporting mechanism for years after 2010.

e. Proposed Criteria for Satisfactory Reporting of Individual Quality Measures for Individual Eligible Professionals

Under section 1848(m)(3)(A) of the Act, the criteria for satisfactorily

submitting data on individual quality measures through claims-based reporting require the reporting of at least 3 applicable measures in at least 80 percent of the cases in which the measure is reportable. If fewer than 3 measures are applicable to the services of the professional, the professional may meet the criteria by reporting on all applicable measures (that is, 1 to 2 measures) for at least 80 percent of the cases where the measures are reportable. It is assumed that if an eligible professional submits quality data codes for a particular measure, the measure applies to the eligible professional.

In prior program years, when we were required, under section 1848(m)(5)(F) of the Act, to establish alternative criteria for satisfactorily reporting using the registry-based reporting mechanism, we decided that the criteria for registry-based reporting of individual measures should be consistent with the criteria for claims-based reporting of individual measures. Thus, we adopted the same criteria for satisfactory reporting of individual measures through registry-based reporting as the criteria for satisfactory reporting of individual measures through claims-based reporting except that an eligible professional could choose to report through the registry-based reporting mechanism only if there are at least 3 PQRI quality measures applicable to the services of the professional. For the 2008 or 2009 PQRI, eligible professionals could not satisfactorily report PQRI measures through the registry-based reporting mechanism by reporting on fewer than 3 measures.

For years after 2009, section 1848(m)(3)(D) of the Act authorizes the Secretary, in consultation with stakeholders and experts, to revise the criteria for satisfactorily reporting data on quality measures. Based on this authority and the input we have received from stakeholders via the invitation to submit suggestions for the 2010 PQRI reporting options posted on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* in April 2009, we propose 3 criteria for satisfactory reporting of individual PQRI quality measures for 2010. In an effort to continue to be consistent with the criteria of satisfactory reporting used in prior PQRI program years, we propose to retain the following 2 criteria with respect to satisfactorily reporting data on individual quality measures in circumstances where 3 or more individual quality measures apply to the services furnished by an eligible professional:

- Report on at least 3 2010 PQRI measures (unless fewer than 3 2010 PQRI measures apply to the services furnished by the eligible professional); and
- Report each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

These criteria would apply to all proposed 2010 PQRI reporting mechanisms available for reporting individual PQRI quality measures (that is, claims-based reporting, registry-based reporting, and EHR-based reporting).

If an eligible professional has fewer than 3 PQRI measures that apply to the professional's services, then the professional would be able to meet the criteria for satisfactorily reporting data on individual quality measures by meeting the following 2 proposed criteria:

- Reporting on all measures that apply to the services furnished by the professional (that is 1 to 2 measures); and
- Reporting each measure for at least 80 percent of the eligible professional's Medicare Part B FFS patients for whom services were furnished during the reporting period to which the measure applies.

We propose that, as in previous years, these criteria for satisfactorily reporting data on fewer than 3 individual quality measures would be available for the claims-based reporting mechanism only. An eligible professional who has fewer than 3 PQRI measures that apply to the professional's services would not be able to meet the criteria for satisfactory reporting by reporting on all applicable measures (that is, 1 or 2 measures) through the registry-based reporting mechanism.

While we have received input from several stakeholders requesting that we permit an eligible professional to report fewer than 3 measures through the registry-based reporting mechanism if fewer than 3 measures apply to him or her, doing so would be inefficient. First, in addition to needing to analyze the data submitted to us by the registry, we would have to analyze the claims data to ensure that no additional measures are applicable to the eligible professional, much like what we do under the Measure Applicability Validation process for claims-based reporting. Second, we would also have to analyze the claims data to ensure that the eligible professional had not attempted to report additional measures through claims. For these reasons, we are not proposing to permit eligible professionals who choose the registry-based or EHR-based reporting mechanism to report on individual quality measures to report on fewer than 3 measures if only 1 or 2 measures apply to the services they furnish.

Based on the previously stated assumption that a measure applies to the eligible professional if an eligible professional submits quality data codes for a particular measure, we propose that an eligible professional who reports on fewer than 3 measures through the claims-based reporting mechanism in 2010 may be subject to the Measure Applicability Validation process, which allows us to determine whether an eligible professional should have reported quality data codes for additional measures. This process was applied in the 2007 and 2008 PQRI. When an eligible professional reports on fewer than 3 measures, we propose to review whether there are other closely related measures (such as those that share a common diagnosis or those that are representative of services typically provided by a particular type of professional). If an eligible professional who reports on fewer than 3 measures in 2010 reports on a measure that is part of an identified cluster of closely related measures and did not report on any other measure that is part of that identified cluster of closely related measures, then the professional would not qualify to receive a 2010 PQRI incentive payment. Additional information on the Measure Applicability Validation process can be found on the Analysis and Payment page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

In addition to the above criteria related to the number of measures on which an eligible professional would be required to report and the frequency of reporting, we propose a third criterion for satisfactory reporting of individual measures. Based on our authority to revise the criteria for satisfactory reporting under section 1848(m)(3)(D) of the Act, we propose that an eligible professional also be required to report data on at least one individual measure on a minimum number of Medicare Part B FFS patients seen during the reporting period, as detailed below. Establishing a minimum patient sample size requirement would enhance the scientific validity of eligible professionals' performance results and encourage eligible professionals to select to report only measures that are representative of the types of services they typically provide in their practice. If, for example, an eligible professional selects 3 patient-level measures (that is, measures in which the required

reporting frequency is a minimum of once per reporting period per individual eligible professional) where only one of his or her Medicare Part B FFS patients are eligible for the measures and there is no minimum patient sample size requirement, then the eligible professional currently could qualify to earn a PQRI incentive payment by reporting PQRI quality measures data only 3 times during the entire reporting period. We believe that information on such a small sample of cases would be insufficient to do any meaningful analysis of the eligible professional's performance on the reported measure. We also believe that a minimum patient sample size requirement would prevent an eligible professional from purposely selecting measures that apply to only a few of their patients.

Regardless of the reporting mechanism chosen by the eligible professional, we propose that the minimum patient sample size for reporting individual quality measures be 15 Medicare Part B FFS patients for the 12-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. This proposed number is based on our experience with the 2007 PQRI and the limited information we have available regarding the 2008 PQRI reporting experience. For the 2007 PQRI measures, where the only reporting period was a 6-month reporting period beginning July 1, 2007, the median number of instances in which an eligible professional could have reported a 2007 PQRI measure was, on average, 9 eligible instances per measure. If we assume that the number of eligible instances for the first half of 2007 were similar to the number of eligible instances in the second half of 2007, then we can assume that the median number of eligible instances was an average of 18 instances per measure for the entire year. Preliminary information from the 2008 PQRI, based on data through September 2008, indicate that the median number of instances in which an eligible professional could have reported a 2008 PQRI measure was, on average, 18 eligible instances per measure. Since eligible professionals are not required to report a measure for all eligible cases, we based the proposed minimum patient sample size threshold on 80 percent of 18 eligible instances, which is 14.4.

Similarly, for the 6-month reporting period (available for registry-based reporting only), we propose that the minimum patient sample size for reporting on individual quality measures be 8 Medicare Part B FFS patients seen during the 6-month reporting period. An eligible professional would need to meet this minimum patient sample size requirement for at least one measure on which the eligible professional chooses to report. We welcome comments on the proposal to add a minimum patient sample size criterion to the criteria for satisfactory reporting of data on individual quality measures. In addition, we invite comments on the specific thresholds proposed for the 12-month reporting period (available for claims-based, registry-based, and EHR-based reporting) and for the 6-month reporting period (available for registry-based reporting only) for reporting individual quality measures.

The proposed 2010 criteria for satisfactory reporting of data on individual PQRI quality measures are summarized in Table 14 and are arranged by reporting mechanism and reporting period.

TABLE 14—PROPOSED 2010 CRITERIA FOR SATISFACTORY REPORTING OF DATA ON INDIVIDUAL PQRI QUALITY MEASURES, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 3 PQRI measures, or 1–2 measures if less than 3 measures apply to the eligible professional; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	July 1, 2010–December 31, 2010.
EHR-based reporting	• Report at least 3 PQRI measures; • Report each measure for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measure applies; and • Report at least 1 PQRI measure on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measure applies.	January 1, 2010–December 31, 2010.

As illustrated in Table 14, there are a total of 4 proposed reporting options, or ways in which an eligible professional may meet the criteria for satisfactory reporting on individual quality measures for the 2010 PQRI. Each reporting option consists of the criteria for satisfactorily reporting such data and results on individual quality measures relevant to a given reporting mechanism and reporting period. While eligible professionals may potentially qualify as satisfactorily reporting individual quality measures under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

f. Proposed Criteria for Satisfactory Reporting Measures Groups for Individual Eligible Professionals

As described above, section 1848(m)(5)(F) of the Act requires that, for 2008 and subsequent years, the Secretary establish alternative reporting periods and alternative criteria for satisfactorily reporting groups of measures. In establishing these alternatives in prior years, we have labeled these groups of measures ''measures groups.'' We have previously defined ''measures groups'' as a subset of four or more PQRI measures that have a particular clinical condition or focus in common. The denominator definition and coding of the measures group identifies the condition or focus that is shared across the measures within a particular measures group.

In the 2008 and 2009 PQRI, measures groups were reportable through claims-based or registry-based reporting. For the 2008 and 2009 PQRI, there were 2 basic sets of criteria for satisfactory reporting measures groups through claims-based or registry-based reporting: (1) The reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the reporting period; or (2) the reporting of at least 1 measures group for a specified number of consecutive patients to whom the measures group applies during the reporting period. For registry-based reporting in the 2008 and 2009 PQRI, we allowed eligible professionals to include some non-Medicare Part B FFS patients in the consecutive patient sample under the second set of criteria. For registry-based reporting quality measures results and numerator and denominator data on measures groups in 2009, we also added to the first set of criteria a requirement to report the measures group on a minimum number of patients commensurate with the reporting period duration.

For the 2010 PQRI, we again propose 2 basic sets of criteria for satisfactory reporting on measures group. Both sets of criteria would apply to the claims-based and registry-based reporting mechanism. As discussed in section II.G.2.d.(3) of this proposed rule, we are not proposing to make the EHR-based reporting mechanism available for reporting on measures groups in 2010.

The first set of proposed criteria, which we propose to make available for either the 12-month or 6-month reporting period in 2010, would be consistent with the 2009 criteria for satisfactory reporting of measures groups through registry-based reporting, which require the reporting of at least 1 measures group for at least 80 percent of patients to whom the measures group applies during the applicable reporting period (with reporting required on a minimum number of Medicare Part B FFS patients commensurate with the reporting period duration). In the 2009 PQRI, there was a requirement under these criteria to report each measures group on at least 30 Medicare Part B FFS patients for the 12-month reporting period and at least 15 Medicare Part B FFS patients for the 6-month reporting period for registry-based reporting of measures groups. For the 2010 PQRI, we propose to revise the requirement by making these criteria applicable to both registry-based and claims-based reporting and to change the number of Medicare Part B FFS patients on which an eligible professional would be required to report a measures group. We propose to require an eligible professional who chooses to report on measures groups based on reporting on 80 percent of applicable patients to report on a minimum of 15 Medicare Part B FFS patients for the 12-month reporting period and a minimum of 8 Medicare Part B FFS patients for the 6-month reporting period, regardless of whether the eligible professional chooses to report the measures group through claims-based reporting or registry-based reporting. We propose to revise the required minimum sample size to make the proposed 2010 criteria for satisfactory reporting of measures groups consistent with the proposed 2010 criteria for satisfactory reporting of individual measures. We invite comments on our proposal to make the criteria for satisfactory reporting of measures groups more consistent with those proposed for reporting individual measures. We especially would be interested in comments with respect to our proposal to revise the minimum sample size requirement related to satisfactory reporting on measures group through the registry-based reporting mechanism so that the criteria for satisfactory reporting of measures groups, regardless of reporting mechanism, would be identical to those proposed for reporting individual measures.

The second set of proposed criteria, which we propose to make available for the 12-month reporting period only, would be based on reporting on a measures group on a specified minimum number of patients. The second set of criteria would require reporting on at least 1 measures group for at least 30 patients seen between January 1, 2010 and December 31, 2010 to whom the measures group applies. Unlike the 2009 PQRI, which required that eligible professionals report on consecutive patients (that is, patients seen in order, by date of service), the 30 patients on which an eligible professional would need to report a measures group for 2010 would not need to be consecutive patients. The eligible professional would be able to report on any 30 patients seen during the reporting period to which the measures group applies. We propose to remove the requirement to report on patients seen consecutively by date of service because our preliminary analysis of the 2008 PQRI claims-based reporting experience through September 2008 suggests that this requirement is difficult for professionals to apply accurately to meet the criteria for satisfactory reporting of measures groups. In addition, the questions we receive from eligible professionals indicate that many eligible professionals are not clear on how to determine which patients are ''consecutive'' and should be included in the patient sample. We believe that any adverse effect on the reliability or validity of the quality information received as a result of the removal of the requirement to report on patients seen consecutively and allowing eligible professionals to report on any 30 patients would be minimal. When eligible professionals report measures groups, they are required to report on multiple measures for a given clinical condition or focus, which makes it harder for them to selectively choose patients in an attempt to improve their performance results. We invite comments on our proposal to allow eligible professionals to report on measures groups on any 30 patients rather than a consecutive patient sample.

As in previous years, we propose that for 2010, the patients, for claims-based

reporting, would be limited to Medicare Part B FFS patients. We receive claims on Medicare patients only. For registry-based reporting, however, we propose that the patients could include some, but not be exclusively, non-Medicare Part B FFS patients.

The proposed 2010 criteria for satisfactory reporting on measures groups are summarized in Table 15, which is arranged by reporting mechanism and reporting period.

TABLE 15—PROPOSED 2010 CRITERIA FOR SATISFACTORY REPORTING ON MEASURES GROUPS, BY REPORTING MECHANISM AND REPORTING PERIOD

Reporting mechanism	Reporting criteria	Reporting period
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Claims-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010. January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 30 patients. Patients may include, but may not be exclusively, non-Medicare Part B FFS patients.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80% of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 15 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	January 1, 2010–December 31, 2010.
Registry-based reporting	• Report at least 1 PQRI measures group; • Report each measures group for at least 80 % of the eligible professional's Medicare Part B FFS patients seen during the reporting period to whom the measures group applies; and • Report each measures group on at least 8 Medicare Part B FFS patients seen during the reporting period to which the measures group applies.	July 1, 2010–December 31, 2010.

As illustrated in Table 15, there are a total of 6 proposed reporting options, or ways in which an eligible professional may meet the proposed criteria for satisfactory reporting of measures groups for the 2010 PQRI. Each reporting option consists of the criteria for satisfactory reporting relevant to a given reporting mechanism and reporting period. As stated previously, while eligible professionals may potentially qualify as satisfactorily reporting on measures groups under more than one of the proposed reporting criteria, proposed reporting mechanisms, and/or for more than one proposed reporting period, only one incentive payment would be made to an eligible professional based on the longest reporting period for which the eligible professional satisfactorily reports.

g. Proposed Reporting Option for Satisfactory Reporting on Quality Measures by Group Practices

As stated previously, section 1848(m)(3)(C)(i) of the Act requires the Secretary to establish and have in place a process by January 1, 2010 under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under PQRI if, in lieu of reporting measures under PQRI, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Section 1848(m)(3)(C)(ii) of the Act requires that this process provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Medicare Physician Group Practice (PGP) demonstration project under section 1866A of the Act.

In addition, payments to a group practice under section 1848(m) of the Act by reason of the process proposed herein shall be in lieu of the PQRI incentive payments that would otherwise be made to eligible professionals in the group practice for satisfactorily submitting data on quality measures (that is, prohibits double payments). Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice (that is, for each TIN/NPI combination) satisfactorily reported on PQRI quality measures, we will begin making incentive payments to group practices based on the determination that the group practice, as a whole (that is, for the TIN), satisfactorily reports on

PQRI quality measures for 2010. In addition, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that satisfactorily reports under the proposed group practice reporting option would not be eligible to earn a separate PQRI incentive payment for 2010 on the basis of his or her satisfactorily reporting PQRI quality measures data at the individual level.

(1) Definition of ''Group Practice''

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice satisfactorily submits PQRI quality measures data, we propose that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, as identified by NPIs) who have reassigned their billing rights to the TIN.

Generally, our intent is to build on an existing quality reporting program that group practices may already be familiar with by modeling the PQRI group practice reporting option after the PGP demonstration. Since the PGP demonstration is a demonstration program for large group practices, one of the requirements for group practices participating in the PGP demonstration is for each practice to have 200 or more members. To be consistent with the PGP demonstration, we also propose to limit initial implementation of the PQRI group practice reporting option for 2010 to similar large group practices. As we gain more experience with the group practice reporting option, we may consider lowering the group size threshold in the future. We invite comments on the proposed definition of ''group practice'' and our proposal to limit initial implementation of the PQRI group practice reporting option in 2010 to practices with 200 or more individual eligible professionals.

In order to participate in the 2010 PQRI through the group practice reporting option, we propose to require group practices to complete a self-nomination process and to meet certain technical and other requirements. Group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. We propose that each group practice would be required to meet the following requirements:

- Have an active Individuals Access to CMS Systems (IACS) user account;
- Provide CMS or a CMS designee with the group practice's TIN and the NPI numbers and names of all eligible professionals who will be participating as part of the group practice (that is, all individual NPI numbers associated with the group practice's TIN). This information must be provided in an electronic format specified by CMS, such as in an Excel spreadsheet; and
- Agree to have the group practice's PQRI quality measurement performance rates for each measure publicly reported by posting of the results on a CMS Web site.

We propose to post the final participation requirements for group practices, including the exact date by which group practices that wish to participate in the 2010 PQRI through the group practice reporting option must submit a self-nomination letter and other instructions for submitting the self-nomination letter, on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by November 15, 2009. We anticipate that group practices that wish to self-nominate for 2010 will be required to do so by the end of the first quarter of 2010, but not later than the end of the second quarter of 2010. Upon receipt of the self-nomination letters we will assess whether the participation requirements proposed above have been met by each self-nominated group practice.

(2) Process for Physician Group Practices To Participate as Group Practices and Criteria for Satisfactory Reporting Data on Quality Measures by Group Practices

For physician groups selected to participate in the PQRI group practice reporting option for 2010, we propose the reporting period would be the 12-month reporting period beginning January 1, 2010. We propose that group practices would be required to submit information on these measures using a data collection tool based on the data collection tool used in CMS' Medicare Care Management Performance (MCMP) demonstration and the quality measurement and reporting methods used in CMS' PGP demonstration. We propose that physician groups selected to participate in the 2010 PQRI through the group practice reporting option would be required to report on a common set of 26 NQF-endorsed quality measures that are based on measures currently used in the MCMP and/or PGP demonstration and that target high-cost chronic conditions and preventive care. These quality measures are identified in Table 34. Additional information on the MCMP and PGP demonstrations is posted on the Medicare Demonstrations section of the CMS Web site at *http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage*. Although our proposed process for physician groups to participate in PQRI as a group practice incorporates some characteristics and methods from the PGP demonstration and the MCMP demonstration, the PQRI group practice reporting option will be a separate program with its own specifications and methodology from the PGP and MCMP demonstration programs.

The proposed quality measures identified in Table 34 are based on a subset of the Doctor's Office Quality (DOQ) quality measures set developed and specified under the direction of CMS and which are used in the PGP and/or MCMP demonstration programs. Contributors to the development of the DOQ measure set included the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the American College of Cardiology (ACC), the American Heart Association (AHA), the National Diabetes Quality Improvement Alliance, the National Committee for Quality Assurance (NCQA), and the Veterans Health Administration (VA) and, in most instances, overlap with proposed 2010 PQRI measures. These quality measures are grouped into four disease modules: diabetes; heart failure; coronary artery disease; and preventive care services.

As part of the data submission process, we propose that, beginning in 2011, each group practice would be required to report quality measures with respect to services furnished during the 2010 reporting period (that is, January 1, 2010 through December 31, 2010) on an assigned sample of Medicare beneficiaries. We propose to analyze the January 1, 2010 through October 29, 2010 (that is, the last business day of October 2010) National Claims History (NCH) file to assign Medicare beneficiaries to each physician group practice using the same patient assignment methodology used in the PGP demonstration. Assigned beneficiaries are limited to those Medicare FFS beneficiaries with Medicare Parts A and B for whom Medicare is the primary payer. Assigned beneficiaries do not include Medicare Advantage enrollees. Essentially, a beneficiary would be assigned to the physician group that provides the plurality of a beneficiary's office or other outpatient E/M allowed charges (based on Medicare Part B claims submitted for the beneficiary for dates of services between January 1, 2010 and October 29, 2010). Beneficiaries with

only 1 visit to the group practice between January 1, 2010 and October 29, 2010 would be eliminated from the group practice's assigned patient sample. Once the beneficiary assignment has been made for each physician group, each physician group would be required to report the quality measures on a random sample of the assigned beneficiaries per disease module or preventive care measure. For each disease module or preventive care measure, the physician group would be required to report information on the assigned patients in the order in which they appear in the group's sample (that is, consecutively). In the fourth quarter of 2010, we would pull a random sample of assigned beneficiaries for each disease module or preventive care measure and provide the sample to the physician group consistent with the methods used in the PGP demonstration. Identical to the sampling method used in the PGP demonstration, the random sample must consist of at least 411 assigned beneficiaries. If the pool of eligible assigned beneficiaries is less than 411, then the group practice must report on 100 percent of the assigned beneficiaries to participate in the group practice reporting option.

We propose a unique reporting mechanism for the group practice reporting option that would not be available to individual eligible professionals participating in the 2010 PQRI. We propose that each physician group selected to participate in the group practice reporting option would have access to a database (that is, a data collection tool) that would include the assigned beneficiary sample and the quality measures. This data collection tool was originally developed for use in the PGP demonstration, updated for use in the MCMP demonstration, and would be updated as needed for use in the PQRI. The assigned beneficiaries' demographic and utilization information would be prepopulated based on claims data. We anticipate being able to provide the selected physician groups with access to this prepopulated database by the fourth quarter of 2010. The physician group would be required to populate the remaining data fields necessary for capturing quality measure information on each of the assigned beneficiaries. Numerators for each of the quality measures would include all beneficiaries in the denominator population who also satisfy the quality performance criteria for that measure. Denominators for each quality measure would include a sample of the assigned beneficiaries who meet the eligibility criteria for that quality measure module or preventive care measure.

We invite comments on our proposal to adopt the PGP demonstration's quality measurement and reporting methods for the PQRI group practice reporting option. We specifically request comments on the proposed patient assignment methodology and our proposal to use a data collection tool based on the one used in the MCMP demonstration as the reporting mechanism for physician groups selected to participate in the PQRI group practice reporting option.

We propose 2 criteria for satisfactory reporting of quality measures by a physician group. First, the physician group would be required to report completely on all of the proposed modules and measures listed in Table 34. Second, the physician group would be required to report on the first 411 consecutively assigned Medicare beneficiaries per disease module or preventive care measure. This is identical to the reporting criteria used in the PGP demonstration. By building on an existing demonstration program that large group practices may already have experience with, we hope to minimize burden on both group practices and CMS. The sample that we pull for and provide to each physician group would include more than the 411 assigned beneficiaries (the sample would include an over sample of approximately 50 percent). More beneficiaries are provided in the sample than the group practice is required to report on in order to account for beneficiaries included in the sample who cannot be confirmed with the diagnosis for a particular disease module or whose medical information may not be able to be located within the physician group's systems.

h. Statutory Requirements and Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

(1) Statutory Requirements for Measures Proposed for Inclusion in the 2010 PQRI

As a result of section 131(b) of the MIPPA, the statutory requirements with respect to the use of quality measures for the 2010 PQRI are different from the statutory requirements for previous program years. For the 2007 PQRI, section 1848(k)(2)(A)(i) of the Act required the Secretary to generally select the quality measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program. For the 2008 and 2009 PQRI, section 1848(k)(2)(B) of the Act required that the quality measures be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. For purposes of reporting data on quality measures for covered professional services furnished during 2010 and subsequent years for the PQRI, subject to the exception noted below, section 1848(k)(2)(C)(i) of the Act, as added by MIPPA, requires that the quality measures shall be such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under subsection 1890(a) of the Act, as added by section 183 of the MIPPA. On January 14, 2009, the U.S. Department of Health and Human Services awarded the contract required under section 1890(a) of the Act to the National Quality Forum (NQF).

In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the NQF, however, section 1848(k)(2)(C)(ii) of the Act authorizes the Secretary to specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary, such as the AQA alliance. In light of these statutory requirements, we believe that, except in certain specified circumstances, each proposed 2010 PQRI quality measure would need to be endorsed by the NQF by July 1, 2009. In those circumstances in which a feasible and practical measure has not been endorsed by the NQF, we believe that all other proposed 2010 PQRI quality measures would need to have at least been adopted by the AQA or another organization with comparable consensus-organization characteristics. However, in January 2009, the AQA announced that it will no longer be adopting measures and we are not aware of any other organizations with consensus-organization characteristics (*see* 73 FR 38565 through 38566 for discussion of the considerations applied in determining whether an entity is a consensus organization). Therefore, our policy with respect to identifying exceptions under section 1848(k)(2)(C)(ii) of the Act would be to give due consideration to measures that have been endorsed by the NQF. As a result, in reviewing measures for possible inclusion in the 2010 PQRI quality measure set, we propose that any new quality measures proposed for the 2010 PQRI must be NQF-endorsed

by July 1, 2009, while any proposed 2010 PQRI quality measures selected from the 2009 PQRI quality measure set would need to have been adopted by the AQA as of January 31, 2009, if the measure still is not endorsed by the NQF by July 1, 2009.

In addition, section 1848(k)(2)(D) of the Act requires that for each 2010 PQRI quality measure, ''the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish.'' Measure developers generally include a public comment phase in their measure development process. As part of the measure development process, measure developers typically solicit public comments on measures that they are testing in order to determine whether additional refinement of the measure(s) is needed prior to submission for consensus endorsement. For example, information on the measure development process employed by us when CMS or a CMS contractor is the measure developer is available in the ''Measures Management System Blueprint'' found on the CMS Web site at *http://www.cms.hhs.gov/apps/QMIS/mmsBlueprint.asp*.

Eligible professionals also have the opportunity to provide input on a measure as the measure is being vetted through the NQF consensus endorsement process (and previously, the AQA consensus adoption process). In particular, the NQF employs a public comment period for measures vetted through its consensus endorsement process (and previously, for the AQA, its consensus adoption process).

Finally, eligible professionals have an opportunity to provide input on the measures proposed for inclusion in the 2010 PQRI through this proposed rule, which provides a 60-day comment period. Accordingly, with regard to the 2010 PQRI, we believe we have satisfied this requirement in multiple ways.

(2) Other Considerations for Measures Proposed for Inclusion in the 2010 PQRI

Consistent with the statutory requirements described in section II.G.2.h.(1) of this proposed rule, we propose to apply the following considerations with respect to the selection of 2009 PQRI quality measures proposed for inclusion in the 2010 PQRI quality measure set:

- Where some 2009 PQRI quality measures have been endorsed by the NQF and others have not, those 2009 PQRI quality measures that have been specifically considered by NQF for possible endorsement, but NQF has declined to endorse it, are not proposed for inclusion in the 2010 PQRI quality measure set (that is, we propose to retire the measure for 2010).
- In circumstances where no NQF-endorsed measure is available, we propose to exercise the exception under section 1848(k)(2)(C)(ii) of the Act. Under these circumstances, a 2009 PQRI quality measure that previously (that is, prior to January 31, 2009) has been adopted by the AQA would meet the requirements under the Act and we propose that it would be appropriate for eligible professionals to use the measure to submit quality measures data and/or quality measures results and numerator and denominator data on quality measures, as appropriate.
- Although we do not propose to include any 2009 PQRI measures that have not been endorsed by the NQF or adopted by the AQA in the final 2010 PQRI quality measure set, we acknowledge that section 1848(k)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF) as long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been endorsed by the NQF and/or, prior to January 31, 2009, adopted by the AQA.
- The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards.
- 2009 PQRI measures that were part of the 2007 and/or 2008 PQRI in which the 2007 and 2008 PQRI analytics indicate a lack of significant reporting and usage were not considered for inclusion in the 2010 PQRI.

In addition to reviewing the 2009 PQRI measures and previously retired measures, for purposes of developing the proposed 2010 PQRI measures, we have reviewed and considered measure suggestions including comments received in response to the CY 2009 PFS proposed rule and final rule with comment period. Additionally, suggestions and input received through other venues, such as an invitation for measures suggestions posted on the PQRI section of the CMS Web site in February 2009 were also reviewed and considered for purposes of our development of the list of proposed 2010 PQRI quality measures.

With respect to the selection of new measures (that is, measures that have never been selected as part of a PQRI quality measure set for 2009 or any prior year), we propose to apply the following considerations, which include many of the same considerations applied to the selection of 2009 PQRI quality measures for proposed inclusion in the 2010 PQRI quality measure set described above:

- High Impact on Healthcare.
- Measures that are high impact and support CMS and HHS priorities for improved quality and efficiency of care for Medicare beneficiaries. These current and long term priority topics include: Prevention; chronic conditions; high cost and high volume conditions; elimination of health disparities; healthcare-associated infections and other conditions; improved care coordination; improved efficiency; improved patient and family experience of care; improved end-of-life/palliative care; effective management of acute and chronic episodes of care; reduced unwarranted geographic variation in quality and efficiency; and adoption and use of interoperable HIT.
- Measures that are included in, or facilitate alignment with, other Medicare, Medicaid, and CHIP programs in furtherance of overarching healthcare goals.
- NQF Endorsement.

+ Measures must be NQF-endorsed by July 1, 2009 in order to be considered for inclusion in the 2010 PQRI quality measure set.

+ Although we do not propose to include any new measures that are not endorsed by the NQF by July 1, 2009 in the final 2010 PQRI quality measure set, we acknowledge that section (k)(2)(C)(ii) of the Act provides an exception to the requirement that the Secretary select measures that have been endorsed by the entity with a contract under section 1890(a) of the Act (that is, the NQF). As

long as an area or medical topic for which a feasible and practical NQF-endorsed measure is not available has been identified and due consideration has been given to measures that have been adopted by the AQA or other consensus organization identified by Secretary.

+ The statutory requirements under section 1848(k)(2)(C) of the Act, subject to the exception noted above, require only that the measures be selected from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a) (that is, the NQF) and are silent with respect to how the measures that are submitted to the NQF for endorsement were developed. The basic steps for developing measures applicable to physicians and other eligible professionals prior to submission of the measures for endorsement may be carried out by a variety of different organizations. We do not believe there needs to be any special restrictions on the type or make up of the organizations carrying out this basic development of physician measures, such as restricting the initial development to physician-controlled organizations. Any such restriction would unduly limit the basic development of quality measures and the scope and utility of measures that may be considered for endorsement as voluntary consensus standards. The requirements under section 1848(k)(2)(C) of the Act pertain only to the selection of measures and not to the development of measures.

• Address Gaps in PQRI Measure Set.

+ Measures that increase the scope of applicability of the PQRI measures to services furnished to Medicare beneficiaries and expand opportunities for eligible professionals to participate in PQRI. We seek to achieve broad ability to assess the quality of care furnished to Medicare beneficiaries, and ultimately to compare performance among professionals. We seek to increase the circumstances where eligible professionals have at least 3 measures applicable to their practice and measures that help expand the number of measures groups with at least four measures in a group.

• Measures of various aspects of clinical quality including outcome measures, where appropriate and feasible, process measures, structural measures, efficiency measures, and measures of patient experience of care.

Other considerations that we propose to apply to the selection of measures for 2010, regardless of whether the measure is a 2009 PQRI measure or not, are:

• Measures that are functional, which is to say measures that can be technically implemented within the capacity of the CMS infrastructure for data collection, analysis, and calculation of reporting and performance rates. This leads to preference for measures that reflect readiness for implementation, such as those that are currently in the 2009 PQRI program or have been through testing. The purpose of measure testing is to reveal the measure's strengths and weaknesses so that the limitations can be addressed and the measure refined and strengthened prior to implementation. For new measures, preference is given to those that can be most efficiently implemented for data collection and submission. Therefore, any measures that have been found to be technically impractical to report because they are analytically challenging due to any number of factors, including those that are claims-based, have not been included in the 2010 PQRI. For example, in some cases, we have proposed to replace existing 2009 PQRI measures with updated and improved measures that are less technically challenging to report.

• For some measures that are useful, but where data submission is not feasible through all otherwise available PQRI reporting mechanisms, a measure may be included for reporting solely through specific reporting mechanism(s) in which its submission is feasible. For example, we are proposing to limit reporting of some measures that previously were available for claims-based reporting and registry-based reporting to registry-based reporting only because they were technically challenging to report and/or analyze through the claims-based reporting mechanism. For further discussion of the proposed reporting mechanisms, *see* section II.G.2.d. of this proposed rule.

We also reviewed 33 measures that have been retired from the PQRI in previous years using the considerations for selecting proposed measures for the 2010 PQRI discussed above. None were found to be eligible for inclusion in the 2010 PQRI quality measure set because they did not meet the criteria described above.

We welcome comments on the implication of including or excluding any given measure or measures proposed herein in the final 2010 PQRI quality measure set and on our approach in selecting measures. We recognize that some commenters may also wish to recommend additional measures for inclusion in the 2010 PQRI measures that we have not herein proposed. While we welcome all constructive comments and suggestions, and may consider such recommended measures for inclusion in future measure sets for PQRI and/or other programs to which such measures may be relevant, we will not be able to consider such additional measures for inclusion in the 2010 measure set.

As discussed above, section 1848(k)(2)(D) of the Act requires that the public have the opportunity to provide input during the selection of measures. We also are required by other applicable statutes to provide opportunity for public comment on provisions of policy or regulation that are established via notice and comment rulemaking. Measures that were not included in this proposed rule for inclusion in the 2010 PQRI that are recommended to CMS via comments on this proposed rule have not been placed before the public with opportunity for the public to comment on the selection of those measures within the rulemaking process. Even when measures have been published in the **Federal Register**, but in other contexts and not specifically proposed as PQRI measures, such publication does not provide true opportunity for public comment on those measures' potential inclusion in PQRI. Thus, such additional measures recommended for selection for the 2010 PQRI via comments on this proposed rule cannot be included in the 2010 measure set. However, as discussed above, we will consider comments and recommendations for measures, which may not be applicable to the final set of 2010 PQRI measures, for purposes of identifying measures for possible use in future years' PQRI or other initiatives to which those measures may be pertinent.

In addition, as in prior years, we note that we do not use notice and comment rulemaking as a means to update or modify measure specifications. Quality measures that have completed the consensus process have a designated party (usually, the measure developer/owner) who has accepted responsibility for maintaining the measure. In general, it is the role of the measure owner, developer, or maintainer to make changes to a measure. Therefore, comments requesting changes to a specific proposed PQRI measure's title, definition, and detailed specifications or coding should be directed to the measure developer identified in Tables 16 through 34. Contact information for the 2009 PQRI measure developers is listed in the ''2009 PQRI Quality Measures List,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

i. Proposed 2010 PQRI Quality Measures for Individual Eligible Professionals

As stated previously, individual eligible professionals have the choice of reporting PQRI quality measures data on either individual quality measures or on measures groups.

Consistent with the statutory requirements for measures included in the 2010 PQRI and other considerations for identifying proposed 2010 quality measures discussed in section II.G.2.h.(1) and II.G.2.h.(2), respectively, of this proposed rule, the individual quality measures identified for use in the 2010 PQRI will be selected from those we propose in this rule and will be finalized as of the date the CY 2010 PFS final rule with comment period goes on display at the Office of the Federal Register. No changes (that is, additions or deletions of measures) will be made after publication of the CY 2010 PFS final rule with comment period. However, as was the case for 2008 and 2009, we may make modifications or refinements, such as revisions to measures titles and code additions, corrections, or revisions to the detailed specifications for the 2010 measures until the beginning of the reporting period. Such specification modifications may be made through the last day preceding the beginning of the reporting period. The 2010 measures specifications for individual quality measures will be available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* when they are sufficiently developed or finalized. We are targeting finalization and publication of the detailed specifications for all 2010 PQRI measures on the PQRI section of the CMS Web site by November 15, 2009 and will, in no event, publish these specifications later than December 31, 2009. The detailed specifications will include instructions for reporting and identify the circumstances in which each measure is applicable.

For 2010, we are proposing that final PQRI quality measures will be selected from 153 of the 2009 PQRI measures and 149 measure suggestions received in response to the February 2009 invitation to submit suggestions for measures and measures groups for possible inclusion in the 2010 PQRI (that is, the ''Call for 2010 Measure Suggestions''). We propose to include a total of 168 measures (this includes both individual measures and measures that are part of a proposed 2010 measures group) on which individual eligible professionals can report for the 2010 PQRI. The individual PQRI quality measures proposed for the 2010 PQRI are listed in Tables 17 through 20 and fall into four broad categories as set forth below in this section. The four categories are the following:

(1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-Based Reporting;

(2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-based Reporting Only;

(3) New Individual Quality Measures Proposed for 2010; and

(4) Proposed 2010 Measures Available for EHR-based Reporting.

In addition, we propose 13 measures groups for 2010. The measures proposed for inclusion in each of the proposed 2010 measures groups are listed in Tables 21 through 33.

(1) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Claims-based Reporting and Registry-based Reporting

After careful consideration of 2009 PQRI measures, we propose to retire 7 measures because they did not meet one or more of the considerations for selection of proposed 2010 measures discussed in section II.G.2.h. of this proposed rule. The measures, including their Measure Number and Measure Title, and the specific reason(s) we are using as the basis for our proposal to retire the measures are identified in Table 16.

TABLE 16—2009 PQRI QUALITY MEASURES NOT PROPOSED FOR INCLUSION IN THE 2010 PQRI

Measure no.	Measure title	Reason for retirement
11	Stroke and Stroke Rehabilitation: Carotid Imagining Reporting	Analytically challenging / Replaced with another measure.
34	Stroke and Stroke Rehabilitation: Tissue Plasminogen Activator.	Analytically challenging / Replaced with another measure.
94	Otitis Media with Effusion (OME): Diagnostic Evaluation	Lack of significant reporting.
95	Otitis Media with Effusion (OME): Hearing Test	Lack of significant reporting.
143	Oncology: Medical and Radiation—Pain Intensity Quantified	Analytically challenging.
144	Oncology: Medical and Radiation—Plan of Care for Pain	Analytically challenging.
152	Coronary Artery Disease (CAD): Lipid Profile in Patients with CAD.	Declined for NQF Endorsement.

We propose to include in the 2010 PQRI quality measure set 116 of the 2009 PQRI measures, which would be available for either claims-based reporting or registry-based reporting as individual quality measures. We note that one of these proposed measures, Measure #46 Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility, is reportable through the registry-based reporting mechanism only in the 2009 PQRI. However, for the 2010 PQRI, we propose to make this measure available for either claims-based reporting or registry-based reporting. For the 2009 PQRI, registries have reported difficulty capturing the required information since the measure requires the inpatient discharge to be correlated to the outpatient visit. Therefore, for the 2010 PQRI we propose to make this measure available for both claims-based and registry-based reporting.

These 116 proposed measures do not include any measures that are proposed to be included as part of the 2010 Back Pain measures group. Similar to the 2009 PQRI, we propose that any 2010 PQRI measure that is included in the Back Pain measures group would not be reportable as individual measures through claims-based reporting or registry-based reporting.

The 116 individual 2009 PQRI measures proposed for inclusion in the 2010 PQRI quality measure set as individual quality measures for either claims-based reporting or registry-based reporting are listed by their Measure Number and Title in Table 17, along with the name of the measure's developer/owner, their NQF endorsement status as of May 1, 2009, and their AQA adoption status as of January 31, 2009. The PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again to identify a different

measure, even if the original measure to which the number was assigned is subsequently retired from the PQRI measure set. A description of the proposed measures listed in Table 17 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI.*

The 2009 measures that are proposed to be available for registry-based reporting only for the 2010 PQRI are discussed and identified in section II.G.2.i.(2) of this proposed rule.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Perscribed for Patients with CAD.	Yes	Yes	AMA–PCPI.
9	Major Depressive Disorder (MDD): Antidepressant Medication During Acute Phase for Patients with MDD.	Yes	Yes	NCQA.
10	Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports.	Yes	Yes	AMA–PCPI/NCQA.
12	Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation.	Yes	Yes	AMA–PCPI/NCQA.
14	Age-Related macular Degeneration (AMD): Dilated Macular Examination.	Yes	Yes	AMA–PCPI/NCQA.
18	Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy.	Yes	Yes	AMA–PCPI/NCQA.
19	Diabetic Retinopathy: Communication with the Physician Managing On-going Diabetes Care.	Yes	Yes	AMA–PCPI/NCQA.
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA–PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA–PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	Yes	Yes	AMA–PCPI/NCQA.
24	Osteoporosis: Communication with the Physician Managing On-going Care Post Fracture.	Yes	Yes	AMA–PCPI/NCQA.
28	Aspirin at Arrival for Acute Myocardial Infarction (AMI).	Yes	Yes	AMA–PCPI/NCQA.
30	Perioperative Care: Timing of Prophylactic Antibiotics—Administering Physician.	Yes	Yes	AMA–PCPI/NCQA.
31	Stroke and Stroke Rehabilitation: Deep Vein Thrombosis Prophylaxis (DVT) for Ischemic Stroke or Intracranial Hemorrhage.	Yes	Yes	AMA–PCPI/NCQA.
32	Stroke and Stroke Rehabilitation: Discharged on Antiplatelet Therapy.	Yes	Yes	AMA–PCPI/NCQA.
35	Stroke and Stroke Rehabilitation: Screening for Dysphagia.	Yes	Yes	AMA–PCPI/NCQA.
36	Stroke and Stroke Rehabilitation: Consideration for Rehabilitation Services.	Yes	Yes	AMA–PCPI/NCQA.
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
40	Osteoporosis: Management Following Fracture.	Yes	Yes	AMA–PCPI/NCQA.
41	Osteoporosis: Pharmacologic Therapy	Yes	Yes	AMA–PCPI/NCQA.
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Yes	Yes	Society of Thoracic Surgeons (STS).

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
45	Perioperative Care: Discontinuation of Prophylactic Antiobitics (Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
46	Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility.	Yes	Yes	AMA–PCPI/NCQA.
47	Advance Care Plan	Yes	Yes	AMA–PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 6 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
49	Urinary Incontinence: Characterization of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
50	Urinary Incontinence: Plan of Care for Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
51	Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation.	Yes	No	AMA–PCPI.
52	Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy.	Yes	No	AMA–PCPI.
53	Asthma: Pharmacologic Therapy	Yes	Yes	AMA–PCPI.
54	12-Lead Electrocardiogram (ECG) Performed for Non-Traumatic Chest Pain.	Yes	Yes	AMA–PCPI/NCQA.
55	12-Lead Electrocardiogram (ECG) Performed for Syncope.	Yes	Yes	AMA–PCPI/NCQA.
56	Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA–PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	Yes	Yes	AMA–PCPI/NCQA.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA–PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA–PCPI/NCQA.
64	Asthma: Asthma Assessment	Yes	Yes	AMA–PCPI.
65	Treatment for Children with Upper Respiratory Infection (URI): Avoidance of Inappropriate Use.	Yes	Yes	NCQA.
66	Appropriate Testing for Children with Pharyngitis.	Yes	Yes	NCQA.
67	Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow.	Yes	Yes	AMA–PCPI/American Society of Hematology (ASH).
68	Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy.	Yes	Yes	AMA–PCPI/ASH.
69	Multiple Myeloma: Treatment with Bisphosphonates.	Yes	Yes	AMA–PCPI/ASH.
70	Chronic Lymphocytic Leukemia (CLL): Baseline Flow Cytometry.	Yes	Yes	AMA–PCPI/ASH.
71	Breast Cancer: Hormonal Therapy for Stage IC–IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer.	Yes	Yes	AMA–PCPI/American Society of Clinical Oncology (ASCO)/National Comprehensive Cancer Network (NCCN).
72	Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients.	Yes	Yes	AMA–PCPI/ASCO/NCCN.
76	Prevention of Catheter-Related Bloodstream Infections (CRBSI): Central Venous Catheter (CVC) Insertion Protocol.	Yes	Yes	AMA–PCPI.
79	End Stage Renal Disease (ESRD): Influenza Immunization with Patients in ESRD.	Yes	Yes	AMA–PCPI.
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA–PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA–PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	Yes	Yes	AMA–PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	Yes	Yes	AMA–PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA–PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA–PCPI.
91	Acute Otitis Externa (ACE): Topical Therapy	No	Yes	AMA–PCPI.
92	Acute Otitis Externa (ACE): Pain Assessment.	No	Yes	AMA–PCPI.
93	Acute Otitis Externa (ACE): Systemic Antimicrobial Therapy—Avoidance of Inappropriate Use.	No	Yes	AMA–PCPI.
99	Breast Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grade.	Yes	Yes	AMA–PCPI/College of American Pathologists (CAP).
100	Colorectal Cancer Resection Pathology Reporting: pT Category (Primary Tumor) and pN Category (Regional Lymph Nodes) with Histologic Grace.	Yes	Yes	AMA–PCPI/CAP.
102	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients.	Yes	Yes	AMA–PCPI.
104	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Prostate Cancer Patients.	Yes	Yes	AMA–PCPI.
105	Prostate Cancer: Three-Dimensional (3D) Radiotherapy.	Yes	Yes	AMA–PCPI.
106	Major Depressive Disorder (MDD): Diagnostic Evaluation.	Yes	No	AMA–PCPI.
107	Major Depressive Disorder (MDD): Suicide Risk Assessment.	Yes	No	AMA–PCPI.
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
109	Osteoarthritis: Function and Pain Assessment.	Yes	No	AMA–PCPI.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥50 Years Old.	Yes	No	AMA–PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
116	Antibiotic Treatment for Adults with Acute Bronchitis: Avoidance of Inappropriate Use.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorous, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA–PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA–PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA–PCPI.
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/Quality Insights of Pennsylvania (QIP).

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
126	Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Evaluation.	Yes	Yes	American Podiatric Medical Association (APMA).
127	Diabetes Mellitus: Diabetic Foot and Ankle Care, Ulcer Prevention—Evaluation of Footwear.	Yes	Yes	APMA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
130	Documentation and Verification of Current Medications in the Medical Record.	Yes	Yes	CMS/QIP.
131	Pain Assessment Prior to Initiation of Patient Therapy and Follow-Up.	Yes	Yes	CMS/QIP.
134	Screening for Clinical Depression and Follow-Up Plan.	Yes	Yes	CMS/QIP.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	Yes	Yes	AMA–PCPI.
140	Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement.	No	Yes	AMA–PCPI/NCQA.
142	Osteoarthritis (OA): Assessment for Use of Anti-Inflammatory or Analgesic Over-the-Counter (OTC) Medications.	Yes	Yes	AMA–PCPI.
145	Radiology: Exposure Time Reported for Procedures Using Fluoroscopy.	Yes	Yes	AMA–PCPI/NCQA.
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening.	Yes	Yes	AMA–PCPI/NCQA.
147	Nuclear Medicine: Correlation with Existing Imaging Studies for All Patients Undergoing Bone Scintigraphy.	Yes	Yes	AMA–PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	Yes	Yes	AMA–PCPI.
154	Falls: Risk Assessment	No	Yes	AMA–PCPI/NCQA.
155	Falls: Plan of Care	No	Yes	AMA–PCPI/NCQA.
156	Oncology: Radiation Dose Limits to Normal Tissues.	Yes	Yes	AMA–PCPI.
157	Thoracic Surgery: Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection.	Yes	Yes	STS.
158	Endarterectomy: Use of Patch During Conventional Endarterectomy.	Yes	No	Society of Vascular Surgeons (SVS).
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
172	Hemodialysis Vascular Access Decision-Making by Surgeon to Maximize Placement of Autogenous Arterial Venous (AV) Fistula.	Yes	No	SVS.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening.	No	Yes	AMA–PCPI.
175	Pediatric End Stage Renal Disease (ESRD): Influenza Immunization.	No	Yes	AMA–PCPI.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA–PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA–PCPI/NCQA.
178	Rhuematoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA–PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA–PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA–PCPI/NCQA.
181	Elder Maltreatment Screen and Follow-Up Plan.	No	Yes	CMS/QIP.
182	Functional Outcome Assessment in Chiropractic Care.	No	Yes	CMS/QIP.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.
184	Hepatitis C: Hepatatis B Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.

TABLE 17—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR EITHER CLAIMS-BASED REPORTING OR REGISTRY-BASED REPORTING—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
185	Endoscopy & Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps—Avoidance of Inappropriate Use.	No	Yes	AMA–PCPI/NCQA.
186	Wound Care: Use of Compression System in Patients with Venous Ulcers.	No	Yes	AMA–PCPI/NCQA.

Please note that detailed measure specifications for 2009 individual PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. The 2010 PQRI quality measure specifications for any given individual quality measure may, therefore, be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(2) Proposed 2010 Individual Quality Measures Selected From the 2009 PQRI Quality Measures Set Available for Registry-Based Reporting Only

In the 2008 PQRI, all 2008 PQRI quality measures were reportable through either claims-based reporting or registry-based reporting. In the CY 2009 PFS final rule with comment period (73 FR 69833), we noted that some measures are not as conducive to claims-based reporting and indicated that 18 of the 2009 PQRI quality measures are not currently reportable through claims-based reporting due to their complexity. Instead, these 18 measures must be reported through a qualified PQRI registry for the 2009 PQRI. We referred to these measures as ''registry-only'' measures. As discussed further in section II.G.2.d. of this proposed rule, registry-based reporting overcomes some of the limitations of claims-based reporting.

For the 2010 PQRI, we again propose to include registry-only individual measures. For 2010, we propose to select 26 registry-only individual measures from the 2009 PQRI.

As we noted previously, 1 measure (measure #46) that was a registry-only measure for the 2009 PQRI is now proposed to be available for either claims-based reporting or registry-based reporting in the 2010 PQRI. Therefore, this measure is not included among these 26 proposed registry-only individual measures. These 26 proposed measures do include 9 measures that are available for either claims-based reporting or registry-based reporting in the 2009 PQRI and are now proposed to be included in the 2010 PQRI as registry-only measures. We are proposing to make more 2009 measures registry-only to relieve some analytical difficulties encountered during the 2009 PQRI.

Although we are designating certain measures as registry-only measures, we cannot guarantee that there will be a registry qualified to submit each registry-only measure for 2010. We rely on registries to self-nominate and identify the types of measures for which they would like to be qualified to submit quality measures results and numerator and denominator data on quality measures. If no registry self-nominates to submit measure results and numerator and denominator data on a particular type of measure for 2010, then an eligible professional would not be able to report that particular measure type. We invite comments on our proposal to increase the number of registry-only measures for the 2010 PQRI.

The Measure Number and Measure Title for these proposed registry-only measures are listed in Table 18 along with the name of each measure's developer, the measure's NQF endorsement status as of May 1, 2009, and the measure's AQA adoption status as of January 31, 2009. A description of the proposed measures listed in Table 18 can be found in the ''2009 PQRI Quality Measures List,'' which is available on the Measures and Codes page of the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. Measures that were available for either claims-based reporting or registry-based reporting in the 2009 PQRI but are proposed to be available for registry-based reporting only in the 2010 PQRI are identified by an asterisk (*) in Table 18.

TABLE 18—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA–PCPI.
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)*.	Yes	Yes	AMA–PCPI.

TABLE 18—PROPOSED 2010 MEASURES SELECTED FROM THE 2009 PQRI QUALITY MEASURE SET AVAILABLE FOR REGISTRY-BASED REPORTING ONLY—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
33	Stroke and Stroke Rehabilitation: Anticoagulant Therapy Prescribed for Atrial Fibrillation at Discharge.	Yes	Yes	AMA–PCPI/NCQA.
81	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis in ESRD Patients.	Yes	Yes	AMA–PCPI.
82	End Stage Renal Disease (ESRD): Plan of Care for Inadequate Peritoneal Dialysis.	Yes	Yes	AMA–PCPI.
83	Hepatitis C: Testing for Chronic Hepatitis C—Confirmation of Hepatitis C Viremia*.	Yes	Yes	AMA–PCPI.
118	Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LSVD)*.	Yes	No	AMA–PCPI.
136	Melanoma: Follow-Up Aspects of Care*	No	Yes	AMA–PCPI/NCQA.
137	Melanoma: Continuity of Care—Recall System*.	No	Yes	AMA–PCPI/NCQA.
138	Melanoma: Coordination of Care*	No	Yes	AMA–PCPI/NCQA.
139	Cataracts: Comprehensive Preoperative Assessment for Cataract Surgery with Intraocular Lens (IOL) Placement*.	No	Yes	AMA–PCPI/NCQA.
141	Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care*.	No	Yes	AMA–PCPI/NCQA.
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA–PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA–PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	Yes	Yes	STS.
174	Pediatric End Stage Renal Disease (ESRD): Plan of Care for Inadequate Hemodialysis.	No	Yes	AMA–PCPI.

* Individual 2009 PQRI measures that were available for both claims-based and registry-based reporting but proposed to be available for registry-based reporting only for the 2010 PQRI.

Please note that detailed measure specifications for 2009 PQRI quality measures may have been updated or modified during the NQF endorsement process or for other reasons prior to 2010. Therefore, the 2010 PQRI quality measure specifications for any given quality measure may be different from specifications for the same quality measure used for 2009. Specifications for all 2010 individual PQRI quality measures, whether or not included in the 2009 PQRI program, must be obtained from the specifications document for 2010 individual PQRI quality measures, which will be available on the PQRI section of the CMS Web site on or before December 31, 2009.

(3) New Individual Quality Measures Proposed for 2010

We propose to include in the 2010 PQRI quality measure set 22 measures that were not included in the 2009 PQRI quality measures provided that each

measure obtains NQF endorsement by July 1, 2009 and its detailed specifications are completed and ready for implementation in PQRI by August 15, 2009. Besides having NQF endorsement, the development of a measure is considered complete for the purposes of the 2010 PQRI if by August 15, 2009—(1) The final, detailed specifications for use in data collection for PQRI have been completed and are ready for implementation, and (2) all of the Category II Current Procedural Terminology (CPT II) codes required for the measure have been established and will be effective for CMS claims data submission on or before January 1, 2010. The titles of these proposed additional, or new, measures are listed in Table 19 along with the name of the measure developer and the proposed reporting mechanism (that is, whether the measure is proposed to be reportable using claims, registries, or both). For these 22 proposed measures, a PQRI Measure Number will be assigned to a measure if and when the measure is included in the final set of 2010 PQRI measures.

Due to the complexity of their measure specifications, we propose that 16 of these 22 measures would be available as registry-only measures for the 2010 PQRI. We do not believe that these 16 measures are conducive to the claims-based reporting mechanism. The remaining 6 measures would be available for reporting through either claims-based reporting or registry-based reporting.

TABLE 19—NEW INDIVIDUAL QUALITY MEASURES PROPOSED FOR 2010

Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer	Reporting mechanism(s)
Thrombolytic Therapy Administered	Yes	No	American Heart Association (AHA)/ American Stroke Association (ASA).	Registry.
Referral for Otologic Evaluation for Patients with Visible Congenital or Traumatic Deformity of the Ear.	Pending NQF review.	No	Audiology Quality Consortium (AQC)	Claims, Registry.
Referral for Otologic Evaluation for Patients with History of Active Drainage from the Ear within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Referral for Otologic Evaluation for Patients with a History of Sudden or Rapidly Progressive Hearing Loss within the Previous 90 days.	Pending NQF review.	No	AQC	Claims, Registry.
Cataracts: 20/40 or Better Visual Acuity within 90 days Following Cataract Surgery.	Pending NQF review.	Yes	American Academy of Ophthalmology (AAO)/AMA–PCPI/NCQA.	Registry.
Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures.	Pending NQF review.	Yes	AAO/AMA–PCPI/NCQA	Registry.
Perioperative Temperature Management.	Yes	Yes	AMA–PCPI	Claims, Registry.
Cancer Stage Documented	Yes	Yes	AMA–PCPI	Claims, Registry.
Stenosis Measurement in Carotid Imaging Studies.	Yes	Yes	American College of Radiology (ACR)/ AMA–PCPI/NCQA.	Claims, Registry.
Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Left Ventricular Function Assessment.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Patient Education	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	No	ACC/AHA/AMA–PCPI	Registry.
Blood Pressure Management: Control	Yes	No	NCQA	Registry.
Complete Lipid Profile	Yes	No	NCQA	Registry.
Cholesterol Count	Yes	No	NCQA	Registry.
Use of Aspirin or Another Anti-Thrombotic.	Yes	No	NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Chlamydia and Gonorrhea Screenings.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Screening for Injection Drug Use.	Yes	No	AMA–PCPI/NCQA	Registry.
HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA–PCPI/NCQA	Registry.

(4) Proposed 2010 Individual Quality Measures Available for EHR-Based Reporting

As discussed in section II.G.2.d.(3) of this proposed rule, we propose to accept PQRI data from EHRs for a limited subset of the proposed 2010 PQRI quality measures, contingent upon the successful completion of our 2009 EHR data submission testing process and a determination that accepting data from EHRs on quality measures for the 2010 PQRI is practical and feasible. The 10 proposed 2010 PQRI quality measures on which we propose to accept clinical quality data extracted from EHRs are identified in Table 20. We propose to make these measures available for electronic submission via an EHR because these measures target preventive care or common chronic conditions. In addition, 4 of these proposed measures overlap with measures used in the Medicare Quality Improvement Organization program's 9th Statement of Work. Finally, it is much less burdensome for an eligible professional to report Measure #124, which assesses adoption and use of EHRs, through an EHR than through claims.

TABLE 20—PROPOSED 2010 MEASURES AVAILABLE FOR EHR-BASED REPORTING

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI
7	Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI).	Yes	Yes	AMA–PCPI
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA
124	Health Information Technology (HIT): Adoption/Use of Electronic Health Records (EHR).	Yes	Yes	CMS/QIP

(5) Measures Proposed for Inclusion in 2010 Measures Groups

We propose to retain the 7 2009 PQRI measures groups for the 2010 PQRI: (1) Diabetes Mellitus; (2) CKD; (3) Preventive Care; (4) CABG; (5) Rheumatoid Arthritis; (6) Perioperative Care; and (7) Back Pain. These measures groups were selected for inclusion in the 2010 PQRI because they each contain at least 4 PQRI quality measures that share a common denominator definition.

Except for the CABG measures group, all 2009 measures groups are reportable either through claims-based reporting or registry-based reporting. The CABG measures group, for the 2009 PQRI, is reportable through the registry-based reporting mechanism only since some measures included in the 2009 CABG measures group are registry-only individual PQRI measures. For this reason, we propose the CABG measures group would be reportable through the registry-based reporting mechanism only for 2010 while the remaining 6 2009 PQRI measures groups would be reportable through either claims-based reporting or registry-based reporting for the 2010 PQRI.

Except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group are reportable either as individual measures or as part of a measures group. As stated in the CY 2009 PFS final rule with comment period (73 FR 69843 through 69844), as individual measures, the measures in the Back Pain measures group are too basic. However, taken together they are meaningful indicators of quality of care for back pain. For this reason, for the 2010 PQRI, we propose that except for the measures included in the Back Pain measures group, the measures included in a 2009 PQRI measures group that we propose to carry forward for the 2010 PQRI would be reportable either as individual measures or as part of a measures group.

The measures proposed for inclusion in the 2010 measures groups that are based on the measures groups from 2009 are identified in Tables 21 through 27. Some measures proposed for inclusion in some of these measures groups for 2010 were not included in the measures groups in 2009. The 2009 measures proposed for inclusion in a 2010 measures group that were not included in the measures group for 2009 are identified with an asterisk (*).

As with measures group reporting in the 2008 and 2009 PQRI, we propose that each eligible professional electing to report a group of measures for 2010 must report all measures in the group that are applicable to each patient or encounter to which the measures group applies at least up to the minimum number of patients required by applicable reporting criteria (described above in section II.G.2.f. of this proposed rule). The individual measures included in the final 2010 PQRI measures groups will be limited to

those measures which will be identified in the CY 2010 PFS final rule with comment period as final 2010 PQRI measures

TABLE 21—MEASURES PROPOSED FOR 2010 DIABETES MELLITUS MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control in Diabetes Mellitus.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein (LDL–C) Control in Diabetes Mellitus.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus.	Yes	No	NCQA.
117	Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient.	Yes	Yes	NCQA.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam*	Yes	No	NCQA.

*This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

TABLE 22—MEASURES PROPOSED FOR 2010 CKD MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
121	Chronic Kidney Disease (CKD): Laboratory Testing (Calcium, Phosphorus, Intact Parathyroid Hormone (iPTH) and Lipid Profile).	No	Yes	AMA–PCPI.
122	Chronic Kidney Disease (CKD): Blood Pressure Management.	No	Yes	AMA–PCPI.
123	Chronic Kidney Disease (CKD): Plan of Care—Elevated Hemoglobin for Patients Receiving Erythropoiesis-Stimulating Agents (ESA).	No	Yes	AMA–PCPI.
135	Chronic Kidney Disease (CKD): Influenza Immunization.	No	Yes	AMA–PCPI.
153	Chronic Kidney Disease (CKD): Referral for Arteriovenous (AV) Fistula.	No	Yes	AMA–PCPI.

TABLE 23—MEASURES PROPOSED FOR 2010 PREVENTIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
39	Screening or Therapy for Osteoporosis for Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older.	Yes	Yes	AMA–PCPI/NCQA.
110	Preventive Care and Screening: Influenza Immunization for Patients ≥ 50 Years Old.	Yes	No	AMA–PCPI.
111	Preventive Care and Screening: Pneumonia Vaccination for Patients 65 Years and Older.	Yes	Yes	NCQA.
112	Preventive Care and Screening: Screening Mammography.	Yes	Yes	NCQA.
113	Preventive Care and Screening: Colorectal Cancer Screening.	Yes	Yes	NCQA.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
128	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up.	Yes	Yes	CMS/QIP.
173	Preventive Care and Screening: Unhealthy Alcohol Use—Screening*.	No	Yes	AMA–PCPI.

*This 2009 PQRI measure was not part of this measures group for 2009, but is proposed for inclusion in this measures group for 2010.

TABLE 24—MEASURES PROPOSED FOR 2010 CABG MEASURES GROUP [+]

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
43	Coronary Artery Bypass Graft (CABG): Use of Internal Mammary Artery (IMA) in Patients with Isolated CABG Surgery.	Yes	Yes	Society of Thoracic Surgeons (STS).
44	Coronary Artery Bypass Graft (CABG): Preoperative Beta-Blocker in Patients with Isolated CABG Surgery.	Yes	Yes	STS.
164	Coronary Artery Bypass Graft (CABG): Prolonged Intubation (Ventilation).	Yes	Yes	STS.
165	Coronary Artery Bypass Graft (CABG): Deep Sternal Wound Infection Rate.	Yes	Yes	STS.
166	Coronary Artery Bypass Graft (CABG): Stroke/Cerebrovascular Accident (CVA).	Yes	Yes	STS.
167	Coronary Artery Bypass Graft (CABG): Postoperative Renal Insufficiency.	Yes	Yes	STS.
168	Coronary Artery Bypass Graft (CABG): Surgical Re-exploration.	Yes	Yes	STS.
169	Coronary Artery Bypass Graft (CABG): Antiplatelet Medications at Discharge.	Yes	Yes	STS.
170	Coronary Artery Bypass Graft (CABG): Beta-Blockers Administered at Discharge.	Yes	Yes	STS.
171	Coronary Artery Bypass Graft (CABG): Lipid Management and Counseling.	Yes	Yes	STS.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 25—MEASURES PROPOSED FOR 2010 RHEUMATOID ARTHRITIS MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
108	Rheumatoid Arthritis (RA): Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy.	Yes	No	NCQA.
176	Rheumatoid Arthritis (RA): Tuberculosis Screening.	No	Yes	AMA–PCPI/NCQA.
177	Rheumatoid Arthritis (RA): Periodic Assessment of Disease Activity.	No	Yes	AMA–PCPI/NCQA.
178	Rheumatoid Arthritis (RA): Functional Status Assessment.	No	Yes	AMA–PCPI/NCQA.
179	Rheumatoid Arthritis (RA): Assessment and Classification of Disease Prognosis.	No	Yes	AMA–PCPI/NCQA.
180	Rheumatoid Arthritis (RA): Glucocorticoid Management.	No	Yes	AMA–PCPI/NCQA.

TABLE 26—MEASURES PROPOSED FOR 2010 PERIOPERATIVE CARE MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
20	Perioperative Care: Timing of Antibiotic Prophylaxis—Ordering Physician.	Yes	Yes	AMA–PCPI/NCQA.
21	Perioperative Care: Selection of Prophylactic Antibiotic—First OR Second Generation Cephalosporin.	Yes	Yes	AMA–PCPI/NCQA.
22	Perioperative Care: Discontinuation of Prophylactic Antibiotics (Non-Cardiac Procedures).	Yes	Yes	AMA–PCPI/NCQA.
23	Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients).	Yes	Yes	AMA–PCPI/NCQA.

TABLE 27—MEASURES PROPOSED FOR 2010 BACK PAIN MEASURES GROUP

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
148	Back Pain: Initial Visit	Yes	Yes	NCQA.
149	Back Pain: Physical Exam	Yes	Yes	NCQA.
150	Back Pain: Advice for Normal Activities	Yes	Yes	NCQA.
151	Back Pain: Advice Against Bed Rest	Yes	Yes	NCQA.

In addition to the 7 measures groups that we propose to retain from the 2009 PQRI, we propose 6 new measures groups for the 2010 PQRI, for a total of 13 CY 2010 measures groups. The 6 new measures groups proposed for the 2010 PQRI are: (1) Coronary Artery Disease (CAD); (2) Heart Failure (HF); (3) Ischemic Vascular Disease (IVD); (4) Hepatitis C; (5) Human Immunodeficiency Virus (HIV)/Acquired Immune Deficiency Syndrome (AIDS); and (6) Community Acquired Pneumonia (CAP). Many of the 6 new measures groups proposed for 2010 contain proposed new registry-only measures, which would make them reportable through registry-based reporting only. Therefore, only 8 proposed 2010 measures groups would be reportable through either claims-based reporting or registry-based reporting: Diabetes Mellitus; CKD; Preventive Care; Perioperative Care; Rheumatoid Arthritis; Back Pain; Hepatitis C; and Community Acquired Pneumonia. We invite comments on our proposal to limit claims-based reporting of measures groups in 2010.

New measures groups are proposed for the 2010 PQRI in order to address gaps in quality reporting and are those that have a high impact on HHS and CMS priority topics for improved quality and efficiency for Medicare beneficiaries (such as prevention, chronic conditions, high cost/high volume conditions, improved care coordination, improved efficiency, improved patient and family experience of care, and effective management of acute and chronic episodes of care). Groups were identified in topical areas where: (1) 4 or more proposed 2010 measures are available; (2) the measures are NQF endorsed; and (3) they address a gap in quality reporting. The measures proposed for inclusion in these new 2010 measures groups are identified in Tables 28 through 33.

Some measures proposed for inclusion in these 6 measures group are current 2009 individual PQRI measures. The title of each such measure is preceded with its PQRI Measure Number in Tables 28 through 33. As stated previously, the PQRI Measure Number is a unique identifier assigned by CMS to all measures in the PQRI measure set. Once a PQRI Measure Number is assigned to a measure, it will not be used again, even if the measure is subsequently retired from the PQRI measure set. Measures that are not preceded by a number (in other words, those preceded by ''TBD'') in Tables 28 through 33 have never been part of a PQRI measure set until being proposed now. A number will be assigned to such measures if we include them in the final set of 2010 PQRI measures groups.

TABLE 28—MEASURES PROPOSED FOR 2010 CAD MEASURES GROUP +

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
6	Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD.	Yes	Yes	AMA–PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Coronary Artery Disease (CAD): Symptom and Activity Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA–PCPI.

+ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 29—MEASURES PROPOSED FOR 2010 HF MEASURES GROUP +

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
5	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD).	Yes	Yes	AMA–PCPI.
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.

TABLE 29—MEASURES PROPOSED FOR 2010 HF MEASURES GROUP [+]—Continued

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	Heart Failure (HF): Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure (HF): Patient Education	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA–PCPI.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 30—MEASURES PROPOSED FOR 2010 IVD MEASURES GROUP [+]

Measure number	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure Developer
114	Preventive Care and Screening: Inquiry Regarding Tobacco Use.	Yes	Yes	AMA–PCPI.
115	Preventive Care and Screening: Advising Smokers to Quit.	Yes	Yes	NCQA.
TBD	Blood Pressure Management: Control	Yes	No	NCQA.
TBD	Complete Lipid Profile	Yes	No	NCQA.
TBD	Cholesterol Control	Yes	No	NCQA.
TBD	Use of Aspirin or Another Anti-Thrombotic	Yes	No	NCQA.

[+] This measures group is proposed to be reportable through registry-based reporting only.

TABLE 31—MEASURES PROPOSED FOR 2010 HEPATITIS C MEASURES GROUP

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
84	Hepatitis C: Ribonucleic Acid (RNA) Testing Before Initiating Treatment.	Yes	Yes	AMA–PCPI.
85	Hepatitis C: HCV Genotype Testing Prior to Treatment.	Yes	Yes	AMA–PCPI.
86	Hepatitis C: Antiviral Treatment Prescribed	Yes	Yes	AMA–PCPI.
87	Hepatitis C: HCV Ribonucleic Acid (RNA) Testing at Week 12 of Treatment.	Yes	Yes	AMA–PCPI.
89	Hepatitis C: Counseling Regarding Risk of Alcohol Consumption.	Yes	Yes	AMA–PCPI.
90	Hepatitis C: Counseling Regarding Use of Contraception Prior to Antiviral Therapy.	Yes	Yes	AMA–PCPI.
183	Hepatitis C: Hepatitis A Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.
184	Hepatitis C: Hepatitis B Vaccination in Patients with HCV.	Yes	Yes	AMA–PCPI.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP [+]

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
159	HIV/AIDS: CD4+ Cell Count or CD4+ Percentage.	Yes	No	AMA–PCPI/NCQA.
160	HIV/AIDS: Pneumocystis Jiroveci Pneumonia (PCP) Prophylaxis.	Yes	No	AMA–PCPI/NCQA.
161	HIV/AIDS: Adolescent and Adult Patients with HIV/AIDS Who Are Prescribed Potent Antiretroviral Therapy.	Yes	No	AMA–PCPI/NCQA.
162	HIV/AIDS: HIV RNA Control After Six Months of Potent Antiretroviral Therapy.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Sexually Transmitted Diseases—Chlamydia and Gonorrhea Screenings.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Screening for High Risk Sexual Behaviors.	Yes	Yes	AMA–PCPI/NCQA.
TBD	HIV/AIDS: Screening for Injection Drug Use	Yes	Yes	AMA–PCPI/NCQA.

TABLE 32—MEASURES PROPOSED FOR 2010 HIV/AIDS MEASURES GROUP +—Continued

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
TBD	HIV/AIDS: Sexually Transmitted Diseases—Syphilis Screening.	Yes	No	AMA–PCPI/NCQA.

+ This measures group is proposed to be reportable through registry-based reporting only.

TABLE 33—MEASURES PROPOSED FOR 2010 COMMUNITY-ACQUIRED PNEUMONIA MEASURES GROUP

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
56	Community-Acquired Pneumonia (CAP): Vital Signs.	Yes	Yes	AMA–PCPI/NCQA.
57	Community-Acquired Pneumonia (CAP): Assessment of Oxygen Saturation.	Yes	Yes	AMA–PCPI/NCQA.
58	Community-Acquired Pneumonia (CAP): Assessment of Mental Status.	Yes	Yes	AMA–PCPI/NCQA.
59	Community-Acquired Pneumonia (CAP): Empiric Antibiotic.	Yes	Yes	AMA–PCPI/NCQA.

We note that the specifications for measures groups do not necessarily contain all the specification elements of each individual measure making up the measures group. This is based on the need for a common set of denominator specifications for all the measures making up a measures group in order to define the applicability of the measures group. Therefore, the specifications and instructions for measures groups will be provided separately from the specifications and instructions for the individual 2010 PQRI measures. We will post the detailed specifications and specific instructions for reporting measures groups on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI* by no later than December 31, 2008.

Additionally, the detailed measure specifications and instructions for submitting data on those proposed 2010 measures groups that were also included as 2009 PQRI measures groups may be updated or modified prior to 2010. Therefore, the 2010 PQRI measure specifications for any given measures group could be different from specifications and submission instructions for the same measures group used for 2009. These measure specification changes do not materially impact the intended meaning of the measures or the strength of the measures.

(6) Request for Public Comment on Measure Suggestions for Future PQRI Quality Measure Sets

As stated above, on February 1, 2009, we posted a ''Call for 2010 PQRI Measure Suggestions'' on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*. The ''Call for 2010 PQRI Measure Suggestions'' invited the public to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of existing measures groups) for consideration for possible inclusion in the proposed set of quality measure for use in the 2010 PQRI. To facilitate our evaluation of the suggested measures, we asked individuals or organizations submitting suggestions to provide us with the following information:

- Requestor contact information, such as name and title, organization/practice name, phone number and e-mail address;
- Measure title;
- Measure description;
- Measure owner/developer;
- NQF endorsement status, including the date of endorsement or anticipated endorsement (if not NQF-endorsed) and type of endorsement (for example, time-limited endorsement);
- AQA adoption status, including date of AQA adoption or anticipated AQA adoption;
- Preferred PQRI reporting option for the suggested measure(s) (that is, claims, registry, registry-only, measures group, measures group only, EHRs); and
- The measure specifications.

In lieu of posting a call for 2011 PQRI measure suggestions on the PQRI section of the CMS Web site in 2010, we invite commenters to submit suggestions for individual quality measures and measures groups (that is, suggestions for new measures groups and/or suggestions for the composition of proposed 2010 measures groups) for consideration for possible inclusion in the proposed set of quality measures for use in the 2011 PQRI. When submitting suggestions for future PQRI quality measure sets as part of the comment period for this proposed rule, commenters should submit all the information requested above for the ''Call for 2010 PQRI Measure Suggestions.''

Please note that suggesting individual measures or measures for a new or proposed measures group does not mean that the measure(s) will be included in the proposed or final sets of measures of any proposed or final rules that address the 2011 PQRI. We will determine what individual measures and measures group(s) to include in the proposed set of quality measures, and after a period of public comment, we will make the final determination with regard to the final set of quality measures for the 2011 PQRI.

j. Proposed 2010 PQRI Quality Measures for Physician Groups Selected to Participate in the Group Practice Reporting Option

As discussed in section II.G.2.g. of this proposed rule, we propose that physician groups selected to participate in the 2010 PQRI group practice reporting option would be required to report on 26 measures. These measures are NQF-endorsed measures currently collected as part of the PGP and/or MCMP demonstrations and are identified in Table 34. To the extent that a measure is an existing PQRI measure, the Measure Title is preceded by the measure's PQRI Measure Number. If there is no number in the Measure Number column of the table, then the

measure is not an existing PQRI measure and will be added to the 2010 PQRI for purposes of the group practice reporting option.

TABLE 34—MEASURES PROPOSED FOR PHYSICIAN GROUPS PARTICIPATING IN THE 2010 PQRI GROUP PRACTICE REPORTING OPTION

Measure No.	Measure title	NQF endorsement status as of 5/1/09	AQA adoption status as of 1/31/09	Measure developer
1	Diabetes Mellitus: Hemoglobin A1c Poor Control.	Yes	Yes	NCQA.
2	Diabetes Mellitus: Low Density Lipoprotein Control.	Yes	Yes	NCQA.
3	Diabetes Mellitus: High Blood Pressure Control.	Yes	No	NCQA.
5	Heart Failure: ACE Inhibitor or ARB Therapy for LVSD.	Yes	Yes	AMA–PCPI.
6	Coronary Artery Disease: Oral Anti-platelet Therapy.	Yes	Yes	AMA–PCPI.
7	Coronary Artery Disease:Beta-blocker Therapy for CAD Patients with Prior MI.	Yes	Yes	AMA–PCPI.
8	Heart Failure: Beta-blocker Therapy for LVSD.	Yes	Yes	AMA–PCPI.
110	Preventive Care: Influenza Vaccination for Patients > 50 years.	Yes	No	AMA–PCPI.
111	Preventive Care: Pneumonia Vaccination for Patients 65+ years.	Yes	Yes	NCQA.
112	Preventive Care: Screening Mammography	Yes	Yes	NCQA.
113	Preventive Care: Screening Colorectal Cancer.	Yes	Yes	NCQA/AMA–PCPI.
117	Diabetes Mellitus: Dilated Eye Exam	Yes	Yes	NCQA.
118	Coronary Artery Disease: ACE/ARB for Patients with CAD and Diabetes and/or LVSD.	Yes	No	AMA–PCPI.
119	Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy.	Yes	No	NCQA.
163	Diabetes Mellitus: Foot Exam	Yes	No	NCQA.
TBD	Diabetes Mellitus: Hemoglobin A1c Testing	Yes	No	NCQA.
TBD	Diabetes Mellitus: Lipid Profile	Yes	No	NCQA.
TBD	Heart Failure: Left Ventricular Function Testing.	Yes	Yes	CMS.
TBD	Heart Failure: Left Ventricular Function Assessment.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Weight Measurement	Yes	No	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Patient Education	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Coronary Artery Disease: Drug Therapy for Lowering LDL-Cholesterol.	Yes	Yes	ACC/AHA/AMA–PCPI.
TBD	Preventive Care: Blood Pressure Management.	Yes	No	ACC/AHA/AMA–PCPI.
TBD	Hypertension: Blood Pressure Control	Yes	No	CMS/NCQA.
TBD	Hypertension: Plan of Care	Yes	No	ACC/AHA/AMA–PCPI.

k. Public Reporting of PQRI Data

Section 1848(m)(5)(G) of the Act, as added by the MIPPA, requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submitted data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful electronic prescribers as defined and discussed further in section II.G.5. of this proposed rule. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule with comment period (73 FR 69846 through 69847) our intent, in 2010, to enhance the current Physician and Other Health Care Professionals directory at *http://www.medicare.gov* with the names of eligible professionals that satisfactorily submit quality data for the 2009 PQRI. In December 2008, we listed, by State, the names of eligible professionals who participated in the 2007 PQRI on the Physician and Other Health Care Professionals Directory.

As required by section 1848(m)(5)(G) of the Act, we intend to make public the names of eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI on the Physician and Other Health Care Professionals Directory. We anticipate that the names of individual eligible professionals and group practices that satisfactorily submit quality data for the 2010 PQRI will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of eligible professionals, on the Physician and Other Health Care Professionals Directory, we propose to post the names of eligible professionals who: (1) Submit data on the 2010 PQRI quality measures through one of the

reporting mechanisms available for the 2010 PQRI; (2) meet one of the proposed satisfactory reporting criteria of individual measures or measures groups for the 2010 PQRI described above in section II.G.2.e. and II.G.2.f., respectively of this proposed rule; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period.

Similarly, for purposes of publicly reporting the names of group practices, on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Submit data on the 2010 PQRI quality measures through the proposed group practice reporting option described in section II.G.2.g. of this proposed rule; (2) meet the proposed criteria for satisfactory reporting under the group practice reporting option; and (3) qualify to earn a PQRI incentive payment for covered professional services furnished during the applicable 2010 PQRI reporting period for group practices.

In addition to posting the information required by section 1848(m)(5)(G) of the Act, for those group practices that are selected to participate in PQRI under the group practice reporting option, we also propose to make the group practices' PQRI performance rates publicly available, for each of the measures. As we stated in the CY 2009 PFS proposed rule (73 FR 38574 through 38575), it is our goal to make the quality of care for services furnished to Medicare beneficiaries publicly available by making physician quality measure performance rates, either at the individual practitioner level or physician group level, publicly available. While we currently have Web pages at *http://www.medicare.gov* for the public reporting of performance results on standardized quality measures for hospitals (Hospital Compare), dialysis facilities (Dialysis Facility Compare), nursing homes (Nursing Home Compare), and home health facilities (Home Health Compare), we do not have a similar Compare Web site for information on the quality of care for services furnished by physicians and other professionals to Medicare beneficiaries.

Public reporting of group practices' PQRI performance results at the group practice level would allow us to move toward our goal of making information on physician performance publicly available. We believe that the way we have proposed to design the group practice reporting option (*see* section II.G.2.g. of this proposed rule) facilitates public reporting of the groups' performance results. Group practices participating in the group practice reporting option would have already agreed in advance to have their performance results publicly reported. All groups participating in the group practice reporting option would be reporting on identical measures, which facilitate comparison of the results across groups. In addition, as a result of the proposed reporting criteria, no performance results would be calculated based on small denominator sizes. Finally, because we intend to modify the data collection tool will provide each group practice with numerator, denominator, and performance rates for each measure at the time of tool submission, the group practice will have had an opportunity to review their performance results before they are made public.

In making performance rates for group practices publicly available, we will attribute the group practice's performance to the entire group. We will not post information with respect to the performance of individual physicians or other eligible professionals associated with the group. However, we may identify the individual eligible professionals who were associated with the group during the reporting period. We invite comments regarding our proposal to publicly report group practices' PQRI performance results.

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

a. Statutory Authority

As required under section 1848(n) of the Act, as added by section 131(c) of the MIPPA, we established and implemented by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. Section 1848(n) of the Act authorizes us, as we determine appropriate, to include information on the quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. Although we initially called this effort the Physician Resource Use Feedback Program, we are renaming this initiative the ''Physician Resource Use Measurement and Reporting Program'' (hereinafter referred to as ''Program'').

b. Background

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69866), the Program would consist of multiple phases. We included a summary of the activities of phase I of the Program in the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869). In addition to discussing phase I of the Program, we also highlighted the activities of several other initiatives, including Medicare Value-Based Purchasing (VBP) programs and demonstrations and related activities undertaken by the MedPAC and the Government Accountability Office (GAO). We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a detailed discussion of these activities.

In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869), we finalized, on an interim basis, the following parameters for phase I of the Program: (1) Use of both per capita and episode of care methodologies for resource use measurement; (2) cost of service category analysis (for example, imaging services or inpatient admissions); (3) use of 4 calendar years of claims data; (4) focus on high cost and/or high volume conditions; (5) reporting to physician specialties relevant to the selected focal conditions; (6) focus on physicians practicing in certain geographic areas, and (7) low, median, and high cost benchmarks. We intend to finalize these parameters in the CY 2010 PFS final rule with comment period.

c. Summary of Comments From the CY 2009 PFS Final Rule With Comment Period

Section 1848(n)(1)(B) of the Act requires that the Program measures resources based on the following: (1) An episode basis; (2) a per capita basis; or (3) both an episode and a per capita basis. We solicited public comments on the use of each of these measurement methodologies (73 FR 69868).

Comment: Commenters were in favor of using both the per capita and the per episode measurement methodologies.

Response: We agree with commenters that both the per capita and per episode methodologies are appropriate measures of cost for the Program. Each methodology offers distinct advantages. For a further discussion regarding the advantages, we refer readers to CMS' Medicare Resource Use Measurement Plan Web site at *http://www.cms.hhs.gov/QualityInitiativesGenInfo/downloads/ResourceUse_Roadmap_OEA_1–15_508.pdf*. We intend to finalize both

methodologies as options for use in future phases of the Program in the CY 2010 PFS final rule with comment period.

In phase I of the Program, we included cost of service (COS) category information from aggregated Medicare FFS claims data. We solicited public comment on which COS categories are most meaningful and actionable (73 FR 69868).

Comment: Commenters were overwhelmingly in favor of including E/M services and imaging services as meaningful and actionable COS categories. Further, commenters supported including laboratory services, outpatient services, procedures, and post-acute services as COS categories. No commenters raised specific categories that should be excluded.

Response: We appreciate the comments in support of the COS category analysis. We intend to finalize the option to include information on all of these COS categories in future phases of the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(3) of the Act requires that, to the extent practicable, the data for the reports shall be based on the most recent data available. In phase I of the Physician Resource Use Feedback Program, we used Medicare FFS claims data from CY 2004 through CY 2007. We solicited public comment on this approach (73 FR 69868).

Comment: The majority of commenters stated that 3 calendar years of data is sufficient for calculating resource use measures. Further, commenters emphasized, to the extent practicable, CMS should use the most recent three years of data available for the Program.

Response: We agree with commenters that 3 years of Medicare FFS claims data are sufficient for calculating resource use measures. We intend to finalize the use of the most recent 3 years of data available for the Program in the CY 2010 PFS final rule with comment period.

Under section 1848(n)(4)(B) of the Act, the Secretary may focus the Program as appropriate, including focusing on physicians who treat conditions that are high cost, high volume, or both. We finalized on an interim basis for phase I of the Program, the following conditions: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; and (8) urinary tract infection (73 FR 69868). We solicited public comments on the use of these high cost/high volume conditions (73 FR 69868).

Comment: Commenters strongly supported these conditions as appropriate for measuring the resources furnished to Medicare beneficiaries. In addition, several commenters suggested that we include diabetes among the priority conditions for the Program.

Response: We agree with commenters that diabetes is an important condition to capture in the Program. We intend to finalize the option to include: (1) Congestive heart failure; (2) chronic obstructive pulmonary disease; (3) prostate cancer; (4) cholecystitis; (5) coronary artery disease with acute myocardial infarction; (6) hip fracture; (7) community-acquired pneumonia; (8) urinary tract infection; and (9) diabetes, in the Program in the CY 2010 PFS final rule with comment period.

Under section 1848(n)(4)(A) of the Act, we are permitted to focus reporting on physician specialties that account for a certain percentage of spending for physicians' services. Based on the high cost and high volume conditions selected above, we included the following physician specialties in phase I of the Program: General internal medicine, family practice, gastroenterology, cardiology, general surgery, infectious disease, neurology, orthopedic surgery, physical medicine and rehabilitation, pulmonology, and urology (73 FR 69868). We solicited public comments on the inclusion of these physician specialties (73 FR 69868).

Comment: Commenters supported including all of the physician specialties listed above as appropriate for measurement and reporting based on the selected conditions.

Response: We agree with commenters that the physician specialties listed above should be included in the Program. We intend to finalize the option to include these physician specialties in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(D) of the Act permits us to focus the Program on physicians practicing in certain geographic areas. In the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) we referenced two geographic sites (Baltimore, MD and Boston, MA) for phase I of the Program, which we generally selected based on close proximity to the CMS central office and due to high per capita Medicare costs, respectively. Since the final rule was published, we have also mailed reports to physicians in the following sites:

- Greenville, SC;
- Indianapolis, IN;
- Northern New Jersey;
- Orange County, CA;
- Seattle, WA;
- Syracuse, NY;
- Boston, MA;
- Cleveland, OH;
- East Lansing, MI;
- Little Rock, AR;
- Miami, FL; and
- Phoenix, AZ.

Comment: Commenters were in favor of including a limited number of sites representing a wide range of geographic locations to facilitate a phased implementation. No commenters submitted specific areas that should be excluded.

Response: We appreciate the comments in support of including a limited number of sites. We intend to continue to include the geographic sites listed above, and identify a limited number of new locations, in the Program in the CY 2010 PFS final rule with comment period.

Section 1848(n)(4)(C) of the Act also permits us to focus the program on physicians who use a high amount of resources compared to other physicians. The resource use reports disseminated in phase I of the Program defined peer groups of physicians by focusing on one condition, one specialty, and one of the geographic locations mentioned above. Within each peer group, the resource use reports indicated whether the physician fell over the 90th percentile (high cost benchmark), below the 10th percentile (low cost benchmark), or over the 50th percentile (median cost benchmark). We solicited public comments on which cost benchmarks make the resource use reports meaningful, actionable, and fair (73 FR 69869).

Comment: Commenters supported the use of high, median, and low cost benchmarks because the benchmarks highlight useful cost categories within a given peer group.

Response: We agree with commenters that the high, median, and low cost benchmarks are appropriate. We intend to finalize these cost benchmarks as options to include in the Program in the CY 2010 PFS final rule with comment period.

Comment: A few commenters expressed support for including small geographic areas for benchmarking.

Response: Though we recognize that a small geographic benchmark may capture a more homogenous beneficiary population for comparison, smaller sample sizes may adversely affect the statistical precision of the comparison. A larger sample captured through broader geographic benchmarks makes

it less likely that physicians will be erroneously identified as high or low cost outliers.

In addition to commenting on specific statutory parameters, commenters also provided feedback on other general topics. Those comments and responses are included below.

Comment: A few commenters mentioned the use of proprietary commercial episode grouper software as a barrier to transparency within the Program. These commenters indicated that in order to understand and validate the resource use reports, physicians would need additional information about how the proprietary commercial software allocated costs to episodes.

Response: One of the primary goals of CMS' VBP initiatives is to implement performance-based incentive payment programs with transparent methodologies. We note that the Program is currently limited under section 1848(n)(1)(A) of the Act to confidential reporting. Use of physician resource use information for other purposes, such as payment or public reporting, would likely require a higher level of transparency than confidential reporting.

We note that we have previously discussed the use of proprietary products for payment purposes in previous rules published in the **Federal Register**. For example, we discussed the use of a proprietary product prior to implementation of the MS–DRGs in the FY 2007 IPPS final rule (72 FR 47171).

We recognize the efforts of episode grouper vendors toward improved transparency. For more information on episode groupers that is publicly available, we refer readers to the following Web sites: *http://www.ingenix.com/ThoughtLeadership/ETG/EtgRegistration/* and *http://www.thomsonreuters.com/business_units/healthcare/*.

We are soliciting public comment on the use of proprietary products to measure episodes of the care in the Program.

Comment: Some commenters expressed that the best method for dissemination of resource use reports is paper copies distributed via the mail. Others favored an electronic mechanism for dissemination. Some commenters expressed that resource use reports should be made available in both paper format and electronically.

Response: For phase I of the Program, we disseminated reports in paper form via mail. We agree with commenters that electronic dissemination would also be desirable. Pending resource availability, we will consider this suggestion in a future phase of the Program.

d. Phase I of the Program

As indicated above, the Program consists of multiple phases. Under this approach, each phase of the Program will inform future phases of the Program. We refer readers to the CY 2009 PFS final rule with comment period (73 FR 69866 through 69869) for a description of phase I Program activities. Using the parameters that were finalized on an interim basis, we have disseminated approximately 230 resource use reports to physicians in each of the 12 geographic regions listed above in this section. We refer readers to the following Web site to review a de-identified sample of the resource use reports disseminated to physicians: *http://rurinfo.mathematica-mpr.com/*. We are soliciting public comment on the design and elements of the sample resource use report used in phase I of the Program. We are particularly interested in receiving comment on the usefulness of the cost of service category drill-down analysis included on pages 10, 16, 20, 24, 28, 32, and 36 of the sample resource use report. These comments will inform future phases of the Program.

e. Phase II of the Program

For phase II, we are proposing to expand the Program in ways that will make the information more meaningful and actionable for physicians. We are proposing to add reporting to groups of physicians recognizing that physicians practice in various arrangements. Group level reporting provides a mechanism for addressing sample size issues that arise when individual physicians have too few Medicare beneficiaries with specific conditions to generate statistically significant reports. We are also proposing to add quality measurement information as context for interpreting comparative resource use. These proposals are addressed in greater detail below in this section.

Phase I of the Program focused on providing confidential feedback on resource use measures to individual physicians. Section 1848(n)(1)(A) of the Act states that the Secretary may also provide confidential feedback reports to groups of physicians. Many physicians practice in groups. Recognizing groups of physicians within the Program is consistent with other CMS VBP initiatives and demonstrations under the Medicare program.

We are proposing to provide reports to groups of physicians, in addition to providing reports to individual physicians, for the Program. In December 2008, CMS posted an Issues Paper on the Development of a Transition to a Medicare Physician Value-Based Purchasing Program for Physician and Other Professional Services.[1] The Issues paper describes cost of care measurement, the focus of Phase I of this Program, as one of the central tenets of Physician Value-Based Purchasing (*see* section II.G.4. of this proposed rule). Further, the Issues Paper referenced possible groups of physicians under consideration including: (1) Formally established single or multi-specialty group practices; (2) physicians practicing in defined geographic regions; and (3) physicians practicing within facilities or larger systems of care. We are soliciting public comments on the appropriateness of resource use measurement and reporting for these and other groups of physicians.

Phase I of the Program focused on providing confidential feedback on resource use measures. Section 1848(n)(1)(A) of the Act states that the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician. Providing physicians with feedback on both quality and cost of care better captures the value of the care provided. Including quality measures in the Program is consistent with the direction for other CMS VBP initiatives.

We are proposing the use of quality measures, in addition to resource use measures, for the Program. Possible sources of quality measures include the Physician Quality Reporting Initiative (PQRI) (*see* section II.G.2. of this proposed rule) and the Generating Medicare Physician Quality Performance Measurement Results (referred to as GEM) Project.[2] We refer readers to the Issues Paper, mentioned above,[3] for additional discussion on how CMS would use quality measures in this Program and for Physician Value-Based Purchasing (*see* section II.G.4. of this proposed rule). We are soliciting public comments on the use of PQRI, GEM, and other broader aggregate quality measures to be used to capture value for the groups proposed above in the Physician Resource Use Measurement and Reporting Program.

[1] *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.*

[2] *http://www.cms.hhs.gov/GEM/.*

[3] *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Pape.pdf.*

4. Section 131(d): Plan for Transition to Value-Based Purchasing Program for Physicians and Other Practitioners

a. Background

Value-based purchasing uses payment incentives and transparency to increase the value of care by rewarding providers for higher quality and more efficient services and for publicly reporting performance information. Section 131(d) of the MIPPA requires the Secretary to develop a plan to transition to a value-based purchasing (VBP) program for Medicare payment for covered professional services made under, or based on, the PFS. Section 131(d) of the MIPPA also states that by May 1, 2010, the Secretary shall submit a report to the Congress, containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate. The Secretary, through the Physician and Other Health Professional VBP (PVBP) Workgroup, submitted a progress letter to Congress on January 8, 2009 detailing the progress made on the VBP plan for physicians and other professionals.

Currently, Medicare health professional payments are based on quantity of services and procedures provided, without recognition of quality or efficiency. Under various authorities, we have pursued the implementation of building blocks to support the establishment of a VBP program for health professionals. These include initiatives in the following major topic areas: Quality and efficiency measurement and reporting, approaches for aligning incentives with providing higher quality care instead of higher volume of care, care coordination, prevention, and health information technology (HIT). The following is a list of examples of the initiatives specifically relevant to physicians and other health professionals:

- Pay for reporting of quality measurement data instituted under the Physician Quality Reporting Initiative (PQRI);
- Resource use reports comparing overall costs, as well as costs for treatment across episodes of care, as part of, as required by the Physician Resource Use Feedback Program (*See* section II.G.3. of this proposed rule); and
- Demonstration projects, including the Physician Group Practice demonstration of a shared savings model, gainsharing demonstrations, medical home and other care coordination and disease management demonstrations, and the Acute Care Episodes demonstration of a bundled payment model.

We are fully committed to implementing VBP incentives to drive quality improvement and greater efficiency for services furnished to Medicare beneficiaries.

b. Approach to Plan Development

We have created an internal cross-component team, the PVBP Workgroup, to lead development of the PVBP Plan. Four Subgroups were established to address the major sections of the Plan: Measures; incentives; data strategy and infrastructure; and public reporting. The PVBP Workgroup was tasked with reviewing the state-of-the-art in performance-based payment for physicians, including relevant Medicare programs and demonstrations and private sector initiatives; preparing an Issues Paper to present program objectives and design principles; engaging stakeholders and obtaining input on program design; and developing the PVBP Plan and Report to Congress. A similar approach was used in the development of the CMS Hospital VBP Plan.

To guide the planning process, the PVBP Workgroup adopted the following goal to improve Medicare beneficiary health outcomes and experience of care by using payment incentives and transparency to encourage higher quality, more efficient professional services. In pursuit of this goal, the Workgroup has defined the following objectives:

- Promote evidence-based medicine through measurement, payment incentives, and transparency.
- Reduce fragmentation and duplication through accountability across settings, alignment of measures and incentives across settings, better care coordination for smoother transitions, and attention to episodes of care.
- Encourage effective management of chronic disease by improving early detection and prevention, focusing on preventable hospital readmissions, and emphasizing the importance of advanced care planning and appropriate end-of-life care.
- Accelerate the adoption of effective, interoperable HIT, including clinical registries, e-prescribing, and electronic health records.
- Empower consumers to make value-based health care choices and encourage health professionals to improve the value of care by disseminating actionable performance information.

The goal and objectives were captured in an Issues Paper that was posted on the CMS Web site on November 24, 2008, in preparation for the December 9, 2008 Listening Session which was held at CMS headquarters. The Issues Paper included questions seeking public input on key design considerations. The Issues Paper is available on the CMS Web site at *http://www.cms.hhs.gov/PhysicianFeeSched/downloads/PhysicianVBP-Plan-Issues-Paper.pdf*. Nearly 500 stakeholders participated in the day-long Listening Session. We received both verbal and written comments that are informing the design of the PVBP Plan.

c. Stakeholder Input From the Listening Session

Both at the Listening Session, and in written comments received following the Session, we obtained input from a wide range of diverse stakeholders. A large portion of the comments were received from physician and other professional specialty societies. Commenters also included consumer advocates, health care consulting firms, and health IT vendors, and individual practicing physicians.

(1) Overarching Issues

Commenters generally affirmed the goal and objectives presented in the Issues Paper. Commenters encouraged the consideration of new payment approaches that cut across settings of care to align Medicare Part A and Part B payment incentives. Many commenters stated that the current Medicare payment system for health professionals is flawed in that it fails to align incentives for high-value care across providers and settings and that this cannot be fixed solely by a VBP program. Commenters agreed with the Issues Paper assumption that the Plan will need to contain more than one approach to accommodate different practice arrangements. Several commenters praised the attention given in the Issues Paper to addressing disparities and pointed out the necessity of adequate risk adjustment and proper use of measures, incentives, and program evaluation to protect vulnerable populations. Commenters also urged careful attention to the operational transition from the current payment system to VBP to minimize care delivery disruptions.

(2) Measurement

Commenters emphasized the importance of aligning measures across payment settings and applying measures consistently across payers. Many commenters stressed the need for valid, reliable, nationally-recognized measures, particularly in the areas of outcomes, care coordination, patient

experience, and the effective use of HIT. Adequate risk adjustment was raised as a paramount issue for outcomes and resource use measures. Regarding resource use measures, several commenters noted that quality and cost measures should be reported together and that CMS should get experience with confidential feedback reporting of resource use before using the information for incentives or public reporting (*See* section II.G.3. of this proposed rule). A few commenters suggested avoidable readmission rates as a good measure of both cost and quality of care. Commenters emphasized the importance of CMS working with health professionals on the selection of quality and cost measures.

Commenters generally agreed with the Issues Paper assumption that the Plan should address multiple levels of accountability, including individual health professionals, care teams, group practices, and accountable care entities. A few commenters mentioned that performance measurement at the regional level could help address regional variation. Consumer advocates made strong arguments for individual accountability, while noting that care delivery is ultimately a team effort. Others noted that measurement is more difficult at the individual level and that accountability at more aggregated levels could support promising payment models like bundled payment, gainsharing, and shared savings.

(3) Incentives

Commenters noted that incentive payments should be large enough to be meaningful, be made timely, and at least cover the cost of participating in the program. Commenters encouraged us to coordinate the incentives, as well as measures, with other payers. Many commenters stated that incentives should reward both improvement and attainment, and not be based on a ranking system that rewards only high attainers; instead, all who perform above a certain prospective benchmark should earn the incentive. Several commenters indicated that use of incentives could be an effective way to promote the use of effective HIT. Most commenters agreed that more than one incentive structure would be necessary to address different practice arrangements and to focus effort on specific objectives (for example, care coordination).

(4) Data Strategy and Infrastructure

Commenters emphasized that the administrative burden of data exchange, for both health professionals and CMS, should be minimized. Several commenters noted that clinical data registries and direct reporting from electronic health records were superior approaches to claims-based reporting for gathering clinical data. Commenters indicated that feedback on performance should be timely and detailed enough to be actionable. Commenters also asked for the opportunity to review and appeal the accuracy of their performance assessments prior to use of that information for payment incentives or public reporting.

(5) Public Reporting

Consumer advocates highlighted the importance of transparency while professional associations urged caution to assure that publicly reported information not be inaccurate or misleading for consumers. Several commenters noted that public reporting should address multiple levels of accountability, including individual health professionals, the care delivery team, group practices, and at the regional level. All agreed that publicly reported information should be user-friendly.

d. Next Steps in Plan Development

Building on input from the Listening Session on the Issues Paper topics, the PVBP Workgroup has begun to develop potential recommendations for inclusion in the Report to Congress. The first step is to design various approaches for performance-based payment that will address the planning goal and objectives for different practice arrangements. This design process will include identifying appropriate measures and incentive structures, considering the necessary data infrastructure, and addressing public reporting options. Consideration will be given to approaches that:

(1) Overlay the current PFS, such as differential fee schedule payments based on measured performance or for providing a medical home;

(2) Address multiple levels of accountability, including individual health professionals, as well as larger teams or organizations; and

(3) Promote more integrated care through shared savings models and bundled payment arrangements.

We are seeking further public comment on the development of the PVBP plan and Report to Congress. Comments already submitted by participating in person at the December 9, 2008 Listening Session or as written comments following the Session, do not need to be resubmitted. At this time, we are soliciting original comments that were not previously submitted. Particularly, we are interested in the comments further discussing the issues of the appropriate level of accountability (for example, group practice, individual, region), and appropriate data submission mechanisms. The PVBP Workgroup will use public comment to inform its development of the Plan and Report to Congress.

5. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

a. Program Background and Statutory Authority

As defined in § 423.159(a), e-prescribing is the transmission using electronic media, of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager (PBM), or health plan, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser.

As discussed in the CY 2009 PFS final rule with comment period (73 FR 69847), there are many potential advantages to e-prescribing. Yet, there has been limited adoption and use of electronic prescribing by physicians and other professionals who prescribe medications. It is estimated that only 12 percent of office-based prescribers currently use e-prescribing (Surescripts. ''National Progress Report on E-Prescribing.'' Welcome to the E-Prescribing Resource Center. 2008. Surescripts. 15 May 2009. *http://www.surescripts.com/downloads/NPR/national-progress-report.pdf*).

As described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69848), the MMA and the creation of the Medicare Prescription Drug Benefit Program (Part D) promoted the use of e-prescribing by requiring the adoption of uniform standards for the Medicare Part D electronic prescribing (''e-prescribing'') program. As required by section 1860D–4(e) of the Act, ''foundation standards'' were adopted on November 7, 2005 (70 FR 67568) and additional Part D e-prescribing standards were adopted on April 7, 2008, and were implemented April 1, 2009 (73 FR 18918). Section 1848(m) of the Act, as amended by section 132 of the MIPPA, further promotes the use of e-prescribing by authorizing incentive payments to eligible professionals or group practices who are ''successful electronic prescribers.'' This E-Prescribing Incentive Program is expected to encourage significant expansion of the use of e-prescribing by

authorizing a combination of financial incentives and payment adjustment and is separate from, and in addition to, any incentive payment that eligible professionals may earn through the PQRI program discussed in section II.G.2. of this proposed rule. Eligible professionals do not have to participate in PQRI to participate in the E-Prescribing Incentive Program (and vice versa).

For 2010, which is the second year of the E-Prescribing Incentive Program, the Secretary is authorized to provide successful e-prescribers, as defined in section 1848(m)(3)(B) of the Act and further discussed below in this section, an incentive payment equal to 2.0 percent of the total estimated (based on claims submitted not later than 2 months after the end of the reporting period) allowed charges for all covered professional services furnished during the 2010 reporting period. Covered professional services are defined under the statute to be services for which payment is made under, or is based on, the PFS and which are furnished by an eligible professional. The applicable electronic prescribing percent (2 percent) authorized for the 2010 E-Prescribing Incentive Program is the same as that authorized for the 2009 E-Prescribing Incentive Program.

Subject to section 1848(m)(2)(D) of the Act, as added by section 4101(f)(2)(B) of the HITECH Act (Title IV of Division B of the Recovery Act, together with Title XIII of Division A of the Recovery Act) (Pub. L. 111–5), which was enacted on February 17, 2009, the incentive payments for successful electronic prescribers for future years are authorized under section 1848(b)(2)(C) of the Act as follows:

- 1.0 percent for 2011.
- 1.0 percent for 2012.
- 0.5 percent for 2013.

Section 1848(m)(2)(D) of the Act, as added by section 4001(f)(2)(B) of the Recovery Act, specifies a limitation to the e-prescribing incentive in relation to whether the EHR incentive authorized by the Recovery Act is earned. Section 1848(m)(2)(D) of the Act specifically provides that the e-prescribing incentive does not apply to an eligible professional (or group practice), if, for the EHR reporting period, the eligible professional (or group practice) earns an incentive payment under the new Health Information Technology (HIT) incentive program authorized by the Recovery Act for eligible professionals who are meaningful EHR users. The new HIT incentive program for meaningful EHR users begins in 2011. Therefore, beginning in 2011, eligible professionals who earn an incentive under the new HIT incentive program for meaningful EHR users, with respect to a certified EHR technology that has e-prescribing capabilities, would not be eligible to earn a separate incentive payment for being a successful electronic prescriber under the E-prescribing Incentive Program.

In addition, under section 1848(a)(5)(A) of the Act, as added by section 132(b) of the MIPPA and amended by section 4001(f)(1) of the Recovery Act, a PFS payment adjustment applies beginning in 2012 to those who are not successful electronic prescribers. Specifically, for 2012, 2013, and 2014, if the eligible professional is not a successful electronic prescriber for the reporting period for the year, the fee schedule amount for covered professional services furnished by such professionals during the year shall be less than the fee schedule amount that would otherwise apply by:

- 1.0 percent for 2012.
- 1.5 percent for 2013.
- 2.0 percent for 2014.

We note that the criteria for determination of successful electronic prescriber proposed herein may not necessarily be the criteria that will be used to determine the applicability of the payment adjustment in the future. Policy considerations underlying the application of the incentive payment are not necessarily the same as those in applying a payment adjustment. In general, we believe that an incentive should be broadly available to encourage the widest possible adoption of e-prescribing, even for low volume prescribers. On the other hand, a payment adjustment should be applied primarily to assure that those who have a large volume of prescribing do so electronically, without penalizing those for whom the adoption and use of an e-prescribing system may be impractical given the low volume of prescribing. We will discuss the application of the payment adjustment in future notice and comment rulemaking, but prior to the beginning of the reporting period that will be used to determine the applicability of the payment adjustment.

Under section 1848(m)(6)(A) of the Act, the definition of ''eligible professional'' for purposes of eligibility for the E-Prescribing Incentive Program is identical to the definition of ''eligible professional'' for the PQRI under section 1848(k)(3)(B) of the Act. In other words, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(C) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. However, for purposes of the E-prescribing Incentive Program, eligibility is further restricted by scope of practice to those professionals who have prescribing authority. Detailed information about the types of professionals that are eligible to participate in the E-Prescribing Incentive Program is available on the ''Eligible Professionals'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

Similar to the PQRI, the E-Prescribing Incentive Program, in 2009, is an incentive program in which determination of whether an eligible professional is a successful electronic prescriber will be made at the individual professional level, based on the NPI. Inasmuch as some individuals (identified by NPIs) may be associated with more than one practice or TIN, the determination of whether an eligible professional is a successful electronic prescriber will be made to the holder of each unique TIN/NPI combination. Then, payment will be made to the applicable holder of the TIN. For 2010, the determination of whether an eligible professional is a successful electronic prescriber will continue to be made for each unique TIN/NPI combination. However, section 1848(m)(3)(C) of the Act requires the Secretary by January 1, 2010 to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under section 1848(a)(5) of the Act, for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary. Therefore, in addition to making incentive payments for 2010 to group practices based on separately analyzing whether the individual eligible professionals within the group practice are successful electronic prescribers, we will also begin making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful electronic prescriber.

b. The Proposed 2010 Reporting Period for the E-Prescribing Incentive Program

Section 1848(m)(6)(C)(i)(II) of the Act defines ''reporting period'' for the 2010

E-Prescribing Incentive Program to be the entire year. Section 1848(m)(6)(C)(ii) of the Act, as added by the MIPPA, however, authorizes the Secretary to revise the reporting period for years after 2009 if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. We propose the 2010 E-Prescribing Incentive Program reporting period will be the entire year (January 1, 2010–December 31, 2010). We believe that keeping the 2010 E-Prescribing Incentive Program reporting period consistent with the 2009 E-Prescribing Incentive Program reporting period will help to maintain program stability and be less confusing for eligible professionals.

Successful electronic prescribers would be eligible to receive an incentive payment equal to 2.0 percent of the total estimated allowed charges (based on claims submitted by no later than February 28, 2011) for all covered professional services furnished January 1, 2010 through December 31, 2010.

c. Proposed Criteria for Determination of Successful E-Prescriber for Eligible Professionals

Under section 1848(m)(3)(B) of the Act, in order to qualify for the incentive payment, an eligible professional must be a ''successful electronic prescriber,'' which the Secretary is authorized to identify using 1 of 2 possible criteria. One criterion, under section 1848(m)(3)(B)(ii) of the Act, is based on the eligible professional's reporting, in at least 50 percent of the reportable cases, on any e-prescribing quality measures that have been established under the physician reporting system under subsection 1848(k) (which, as noted previously, we have named ''PQRI'' for ease of reference) and are applicable to services furnished by the eligible professional during a reporting period. The second criterion, under section 1848(m)(3)(B)(iii) of the Act, is based on the electronic submission by the eligible professional of a sufficient number (as determined by the Secretary) of prescriptions under Part D during the reporting period. If the Secretary decides to use the latter standard, then, in accordance with section 1848(m)(3)(B)(iv) of the Act, the Secretary is authorized to use Part D drug claims data to assess whether a ''sufficient'' number of prescriptions has been submitted by eligible professionals. However, under section 1848(m)(3)(B)(i) of the Act, if the standard based on a sufficient number (as determined by the Secretary) of electronic Part D prescriptions is applied for a particular reporting period, then the standard based on the reporting on e-prescribing measures would no longer apply.

For 2009, as described in the CY 2009 PFS final rule with comment period (73 FR 69847 through 69852), we required eligible professionals to report on the e-prescribing measure that had been previously used in the 2008 PQRI. For 2010, we propose to continue to require eligible professionals to report on the electronic prescribing measure used in the 2009 E-Prescribing Incentive Program to determine whether an eligible professional is a successful e-prescriber, but we propose to use modified reporting criteria.

As we stated in the CY 2009 PFS final rule with comment period (73 FR 69848), we intend to consider the use of a certain number of Part D prescribing events as the basis for the incentive payment in future years. However, we do not believe that it is feasible to move to this substitute requirement in 2010. The accuracy and completeness of the Part D data with respect to whether a prescription was submitted electronically is unknown. Information on whether a prescription was submitted electronically by an individual eligible professional will not be collected on the Part D claims, or prescription drug event (PDE) data, until 2010. Also, prescription drug plan sponsors were not required to send PDE data with an individual prescriber's NPI until April 1, 2009. We currently have no information on the accuracy and completeness of the NPI data that is submitted with the PDE data. The NPI is needed in order for us to be able to link an eligible professional's PDE data to his or her Medicare Part B claims to calculate the incentive payment amount. During 2010, we expect to evaluate the adequacy of Part D data to determine the feasibility of its use for determining whether an eligible professional qualifies as a successful e-prescriber in future years.

(1) Reporting the Electronic Prescribing Measure

For 2009, we limited the reporting mechanism for the electronic prescribing measure to claims-based reporting. For 2010, we propose 3 reporting mechanisms for individual eligible professionals. First, we propose to retain the claims-based reporting mechanism that is used in the 2009 E-Prescribing Incentive Program. In addition, similar to the PQRI, for the E-prescribing Incentive Program, we propose to implement a registry-based reporting mechanism and, depending on whether we finalize the proposed EHR-based reporting mechanism for PQRI, we are also proposing that an EHR-based reporting mechanism be available for the electronic prescribing measure. In other words, eligible professionals would be able to choose whether to submit data on the electronic prescribing measure through claims, a qualified registry, or a qualified EHR product. As we stated in our discussion of the proposed PQRI reporting mechanisms for 2010 in section II.G.2.d. of this proposed rule, we recognize that one mode of quality reporting does not suit all practices. Similar to the PQRI, we believe that having multiple reporting mechanisms for the reporting of the electronic prescribing measure should increase opportunities for eligible professionals to successfully report the electronic prescribing measure. We invite comments on our proposal to provide alternatives to the claims-based reporting mechanism for reporting the electronic prescribing measure.

We propose that only registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit measure results and numerator and denominator data on the electronic prescribing measure on behalf of eligible professionals for the 2010 E-Prescribing Incentive Program. We note that not all registries qualified to submit quality measure results and numerator and denominator data on quality measures on behalf of eligible professionals for the 2010 PQRI would be qualified to submit quality measure results and numerator and denominator data on the e-prescribing measure. PQRI qualified registries will be qualified to submit specific types of measures. The electronic prescribing measure is reportable by an eligible professional any time he or she bills for one of the procedure codes for Part B services included in the measure's denominator. Some registries who self-nominate to become a qualified registry for PQRI may not choose to self-nominate to become a qualified registry for submitting measures that require reporting at each eligible visit. Registries will need to indicate their desire to qualify to submit measure results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI. The self-nomination process and

requirements for registries for the PQRI, which also would apply to the registries for the 2010 E-Prescribing Incentive Program, are discussed in section II.G.2.d.(4) of this proposed rule. We will post a list of qualified registries for the 2010 E-Prescribing Incentive Program on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified registries for the 2010 PQRI on the PQRI section of the CMS Web site.

Similarly, we propose that only EHR products ''qualified'' to potentially be able to submit clinical quality data extracted from the EHR to CMS for the 2010 PQRI would be considered ''qualified'' for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program. The self-nomination process and requirements for EHR vendors for the PQRI, which also would apply to the EHR vendors for the 2010 E-Prescribing Incentive Program are discussed in section II.G.2.d.(5) of this proposed rule. EHR vendors will need to indicate their desire to have one or more of their EHR products qualified for the purpose of an eligible professional potentially being able to submit data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program at the time that they submit their self-nomination letter for the 2010 PQRI. If we finalize the EHR-based reporting mechanism for the 2010 PQRI, we will post a list of qualified EHR vendors and their products (including the version that is qualified) for the 2010 E-Prescribing Incentive Program, on the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive* when we post the list of qualified EHR products for the 2010 PQRI on the PQRI section of the CMS Web site. We welcome comments on our proposal to limit the registries and EHR products qualified to submit the electronic prescribing measure for the 2010 E-Prescribing Incentive Program to those that are qualified registries and EHR products, respectively, for the 2010 PQRI.

(2) The Reporting Denominator for the Electronic Prescribing Measure

The electronic prescribing measure, similar to the PQRI measures, has 2 basic elements. These include: (1) A reporting denominator that defines the circumstances when the measure is reportable; and (2) a reporting numerator.

The denominator for the electronic prescribing measure consists of specific billing codes for professional services. The measure becomes reportable when any one of these procedure codes is billed by an eligible professional as Part B covered professional services. For 2009, the codes included in the measure's denominator were codes that are typically billed for services in the office or outpatient setting furnished by physicians or other eligible professionals. There are no diagnosis codes or age/gender requirements in order to be included in the measure's denominator (that is, reporting of the e–prescribing measure is not further limited to certain ages or a specific gender). However, as discussed further under section II.G.5.c.(5) of this proposed rule, eligible professionals are not required to report this measure in all cases in which the measure is reportable. Physicians and other eligible professionals who do not bill for one of the procedure codes for Part B covered professional services included in the measure's denominator will have no occasion to report the electronic prescribing measure.

Currently, the denominator codes for the electronic prescribing measure consist of the following CPT and G-codes: 90801; 90802; 90804; 90805; 90806; 90807; 90808; 90809; 92002; 92004; 92012; 92014; 96150; 96151; 96152; 99201; 99202; 99203; 99204; 99205; 99211; 99212; 99213; 99214; 99215; 99241; 99242; 99243; 99244; 99245; G0101; G0108; G0109.

As initially required under section 1848(k)(2)(A)(ii) of the Act, and further established through rulemaking and under section 1848(m)(2)(B) of the Act, however, we may modify the codes making up the denominator of the electronic prescribing measure. As such, we propose, in response to public comments received, to expand the scope of the denominator codes for 2010 to professional services outside the professional office and outpatient setting, such as professional services furnished in skilled nursing facilities or the home care setting. We propose to add the following CPT codes to the denominator of the electronic prescribing measure for 2010: 99304; 99305; 99306; 99307; 99308; 99309; 99310; 99315; 99316; 99341; 99342; 99343; 99344; 99345; 99347; 99348; 99349; 99350; and 90862. The proposed expansion of the electronic prescribing measure denominator is expected to provide more eligible professionals the opportunity to report the measure, and thus, provide more opportunities for eligible professionals to participate in the E-Prescribing Incentive Program. We invite comments on the proposed changes to codes identified for the electronic prescribing measure denominator.

By December 31, 2009, we will post the final specifications of the measure on the ''E-Prescribing Measure'' page of the E-Prescribing Incentive Program section of the CMS Web site at *http://www.cms.hhs.gov/ERXIncentive*.

(3) Qualified Electronic Prescribing System—Required Functionalities and Part D E-Prescribing Standards

To report the electronic prescribing measure in 2010, we propose that the eligible professional must report 1 of 3 ''G'' codes, as will be discussed below. However, in reporting any of the G-codes and thereby qualifying for the incentive payment for e-prescribing in 2010, the professional must have and regularly use a ''qualified'' electronic prescribing system as defined in the electronic prescribing measure specifications. If the professional does not have general access to an e-prescribing system in the practice setting, there is nothing to report. *Required Functionalities* for a *''Qualified'' Electronic Prescriber System*. What constitutes a ''qualified'' electronic prescribing system is based upon certain required functionalities that the system can perform. As currently specified in the measure, a ''qualified'' electronic prescribing system is one that can:

(a) Generate a complete active medication list incorporating electronic data received from applicable pharmacies and PBMs, if available.

(b) Allow eligible professionals to select medications, print prescriptions, electronically transmit prescriptions, and conduct alerts (written or acoustic signals to warn the prescriber of possible undesirable or unsafe situations including potentially inappropriate dose or route of administration of a drug, drug-drug interactions, allergy concerns, or warnings and cautions). This functionality must be enabled.

(c) Provide information related to lower cost, therapeutically appropriate alternatives (if any). The ability of an electronic prescribing system to receive tiered formulary information, if available, would suffice for this requirement for 2010 and until this function is more widely available in the marketplace.

(d) Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan (if available).

Part D E-Prescribing Standards. Section 1848(m)(3)(B)(v) of the Act, to the extent practicable, in determining whether an eligible professional is a successful e-prescriber, ''the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e)'' of the Act. The Part D standards for electronic prescribing systems establish which electronic standards Part D sponsors, providers, and dispensers must use when they electronically transmit prescriptions and certain prescription related information for Part D covered drugs that are prescribed for Part D eligible individuals. To be a qualified electronic prescribing system under the E-prescribing Incentive Program, electronic systems must convey the information listed above under (a) through (d) using the standards currently in effect for the Part D e-prescribing program. Additional Part D e-prescribing standards were implemented April 1, 2009. These latest Part D e-prescribing standards, and those that had previously been adopted, can be found on the CMS Web site at *http://www.cms.hhs.gov/eprescribing.*

To ensure that eligible professionals utilize electronic prescribing systems that meet these requirements, the electronic prescribing measure requires that those functionalities required for a ''qualified'' electronic prescribing system must utilize the adopted Part D e-prescribing standards. The Part D e-prescribing standards relevant to the four functionalities for a ''qualified'' system in the electronic prescribing measure, described above and listed as (a), (b), (c), and (d), are:

(a) *Generate medication list*—Use the National Council for Prescription Drug Programs (NCPDP) Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide, Version 8, Release 1, October 2005 (hereinafter ''NCPDP SCRIPT 8.1'') Medication History Standard;

(b) *Transmit prescriptions electronically*—Use the NCPDP SCRIPT 8.1 for the transactions listed at § 423.160(b)(2);

(c) *Provide information on lower cost alternatives*—Use the NCPDP Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0 (Version 1.0), October 2005 (hereinafter ''NCPDP Formulary and Benefits 1.0'');

(d) *Provide information on formulary or tiered formulary medications, patient eligibility, and authorization requirements received electronically from the patient's drug plan*—use:

(1) NCPDP Formulary and Benefits 1.0 for communicating formulary and benefits information between prescribers and plans.

(2) Accredited Standards Committee (ASC) X12N 270/271—Health Care Eligibility Benefit Inquiry and Response, Version 4010, May 2000, Washington Publishing Company, 004010X092 and Addenda to Health Care Eligibility Benefit Inquiry and Response, Version 4010A1, October 2002, Washington Publishing Company, 004010X092A1 for communicating eligibly information between the plan and prescribers.

(3) NCPDP Telecommunication Standard Specification, Version 5, Release 1 (Version 5.1), September 1999, and equivalent NCPDP Batch Standard Batch Implementation Guide, Version 1, Release 1 (Version 1.1), January 2000 for communicating eligibility information between the plan and dispensers.

There are, however, Part D e-prescribing standards that are in effect for functionalities that are not commonly utilized at this time. Such functionalities are not currently required for a ''qualified'' system under the electronic prescribing measure. One example is Rx Fill Notification, which is discussed in the Part D e-prescribing final rule (73 FR 18918, 18926). For purposes of the 2010 Electronic Prescribing Program and incentive payments, it is not required that the electronic prescribing system contain all functionalities for which there are available Part D e-prescribing standards. Rather, the only required functionalities are those stated in the measure and described above in the section entitled ''Required Functionalities for a 'Qualified' Electronic Prescribing System.'' For those required functionalities described above, we propose that a ''qualified'' system must use the adopted Part D e-prescribing standards for electronic messaging.

There are other aspects of the functionalities for a ''qualified'' system that are not dependent on electronic messaging and are part of the software of the electronic prescribing system, for which Part D standards for electronic prescribing do not pertain. For example, the requirements in qualification (b) listed above that require the system to allow professionals to select medications, print prescriptions, and conduct alerts are functions included in the particular software, for which Part D standards for electronic messaging do not apply.

We are aware that there are significant numbers of eligible professionals who are interested in earning the incentive payment, but currently do not have an electronic prescribing system. The electronic prescribing measure does not require the use of any particular system or transmission network; only that the system be a ''qualified'' system having the functionalities described above based on Part D e-prescribing standards.

(4) The Reporting Numerator for the Electronic Prescribing Measure

Currently, to report for an applicable case where 1 of the denominator codes is billed for Part B services, an eligible professional must report one of 3 G-codes specified in the electronic prescribing measure. Currently, the G-codes are the following:

- One G-code is used to report that all prescriptions in connection with the visit billed were electronically prescribed (G8443);
- Another G-code indicates that no prescriptions were generated during the visit (G8445); and
- A third G-code is used when some or all prescriptions were written or phoned in due to patient request, State or Federal law, the pharmacy's system being unable to receive the data electronically or because the prescription was for a narcotic or other controlled substance (G8446).

However, for 2010, we propose to modify the first G-code (G8443) to indicate that at least 1 prescription in connection with the visit billed was electronically prescribed. In addition, we propose to eliminate the 2 remaining G-codes from the measure's numerator: G8445; and G8446. We believe these modifications to the electronic prescribing measure will simplify reporting of the measure because the measure will only be reportable when an eligible professional has electronically prescribed. We invite comments on the proposed modifications to the electronic prescribing measure numerator.

The e-prescribing quality measure would not apply unless an eligible professional furnishes services indicated by one of the codes included in the measure's denominator. Therefore, for claims-based reporting, for example, it is not necessary for an eligible professional to report G-codes for the electronic prescribing measure on claims not containing one of the denominator codes. However, if reporting a G-code, the G-code data submission will only be considered valid if it appears on the same Part B claim containing one of the e-prescribing quality measure's denominator codes.

(5) Criteria for Successful Reporting of the Electronic Prescribing Measure

As discussed above, section 1848(m)(3)(B)(ii) of the Act specifies that an eligible professional shall be treated as a successful electronic prescriber for a reporting period based on the eligible professional's reporting of the electronic prescribing measure in at least 50 percent of applicable cases. However, section 1848(m)(3)(D) of the Act permits the Secretary in consultation with stakeholders and experts to revise the criteria for submitting data on electronic prescribing measures under section 1848(3)(B)(ii) of the Act for years after 2009. Therefore, we propose to revise the criteria for submitting data on the electronic prescribing measure. For 2010, rather than requiring that the electronic prescribing measure be reported for a certain proportion of reportable cases, we propose to make the determination of whether an eligible professional is a successful electronic prescriber based on a count of the number of times an eligible professional reports that at least one prescription created during the encounter was generated using a qualified e-prescribing system (that is, reports the modified G8443 code). We believe that modifying the criteria for submitting the electronic prescribing measure in this manner will bring us closer to our stated intention to transition to using a certain number of electronic Part D prescribing events as the basis for the incentive payment in future years. In proposing to revise the criteria for successful reporting of the electronic prescribing measure in this manner, we also assume that once an eligible professional has invested in an e-prescribing system, integrated the use of the e-prescribing system into the practice's work flows, and has used the system to some extent, he or she is likely to continue to use the e-prescribing system for most of the prescriptions he or she generates.

Preliminary data from the 2008 PQRI through September 2008 indicate that half of the eligible professionals who were eligible to report the electronic prescribing measure under the 2008 PQRI (measure #125) had 132 or more instances in which they were eligible to report the measure, with a maximum of 12,655 reporting instances. Therefore, in order to successfully report the measure under the 2009 criteria for successful e-prescribing (that is, reporting the measure for at least 50 percent of applicable cases), half of eligible professionals would have had to report measure #125 66 times or more (that is, 50 percent of 132 reporting instances), with a maximum of 6,328 times (that is, 50 percent of 12,655 reporting instances). For structural measures such as the electronic prescribing measure, once an eligible professional has demonstrated that he or she has integrated use of an e-prescribing system into his or her practice's work flow, requiring the eligible professional to continue to report the measure represents an administrative burden with little added benefit to the reliability and validity of the data being reported. In contrast, for clinical quality measures, the reliability and validity of the performance rates depends on the adequacy of the sample. Therefore, we propose that an eligible professional would be required to report that at least 1 prescription for a Medicare Part B FFS patient created during an encounter that is represented by 1 of the codes in the denominator of the electronic prescribing measure was generated using a qualified e-prescribing system for at least 25 times during the 2010 reporting period.

The proposed minimum reporting threshold of 25 is based on the notion that an eligible professional would need to e-prescribe, on average, for approximately 2 Medicare Part B FFS patient encounters per month during the reporting period in order to be considered a successful e-prescriber. The proposed reporting threshold of 25 also takes into consideration that prescriptions are not generated with every Medicare Part B FFS patient encounter and some prescriptions, such as narcotics, cannot be prescribed electronically.

We welcome comments on the proposed criteria for determination of successful electronic prescriber. We are particularly interested in comments related to the following:

- Our proposal to change the criteria for determining whether an eligible professional is a successful e-prescriber from requiring reporting of the electronic prescribing measure in 50 percent of applicable cases to a count of the number of times the eligible professional electronically prescribed; and
- The proposed threshold number of 25 times in which an eligible professional would be required to report that he or she electronically prescribed during the reporting period.

d. Determination of the 2010 Incentive Payment Amount for Individual Eligible Professionals Who Are Successful E-Prescribers

Section 1848(m)(2)(B) of the Act imposes a limitation on the E-prescribing incentive payment. The Secretary is authorized to choose 1 of 2 possible criteria for the limitation. The first criterion, under section 1848(m)(2)(B)(i) of the Act, is based upon whether the Medicare Part B allowed charges for covered professional services to which the electronic prescribing quality measure applies are less than 10 percent of the total Part B allowed charges for all covered professional services furnished by the eligible professional during the reporting period. The second criterion, under section 1848(m)(2)(B)(ii) of the Act, is based on whether the eligible professional submits (both electronically and nonelectronically) a sufficient number (as determined by the Secretary) of prescriptions under Part D (which can, again, be assessed using Part D drug claims data). If the Secretary decides to use the latter criterion, then, in accordance with section 1848(m)(2)(B) of the Act, the criterion based on the reporting on electronic prescribing measures would no longer apply. The statutory limitation also applies to the future application of the payment adjustment.

As discussed above, for 2010, we propose to make the determination of whether an eligible professional is a ''successful e-prescriber'' based on submission of the electronic prescribing measure. As a result, we propose to apply the criterion under section 1848(m)(2)(B)(i) for the limitation for the 2010 E-Prescribing Incentive Program. Therefore, in determining whether an eligible professional will receive an e-prescribing incentive payment for 2010, we would determine whether the 10 percent threshold is met based on the claims submitted by the eligible professional at the TIN/NPI level. This calculation is expected to take place in the first quarter of 2011 and would be performed by dividing the individual's total 2010 allowed charges for all such covered professional services submitted for the measure's HCPCS codes by the individual's total allowed charges for all covered professional services (as assessed at the TIN/NPI level). If the result is 10 percent or more, then the statutory limitation will not apply and a successful e-prescriber would earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the eligible professional would not earn an e-prescribing incentive payment—even if he or she electronically prescribes and reports G8443 at least 25 times for those eligible cases that occur during the 2010 reporting period. Although an individual eligible professional may

decide to conduct his or her own assessment of how likely this statutory limitation is expected to apply to him or her before deciding whether or not to report the electronic prescribing measure, an individual eligible professional may report the electronic prescribing measure without regard to the statutory limitation for the incentive payment.

e. Proposed Reporting Option for Satisfactory Reporting of the E-Prescribing Measure by Group Practices

As discussed previously, section 1848(m)(3)(C)(i) requires that by January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as meeting the requirements for submitting data on electronic prescribing quality measures for covered professional services for a reporting period (or, for purposes of the payment adjustment under subsection (a)(5), for a reporting period for a year) if, in lieu of reporting the electronic prescribing measure, the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time specified by the Secretary.

Section 1848(m)(3)(C)(ii) of the Act requires that the process established under section 1848(m)(3)(C)(i) of the Act provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A of the Act. In addition, section 1848(m)(3)(C)(iii) of the Act specifies that payments to a group practice by reason of the process established under section 1848(m)(3)(C)(ii) of the Act shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for being a successful e-prescriber. Therefore, while we will be making incentive payments to group practices based on the determination that the group practice, as a whole, is a successful e-prescriber for 2010, an individual eligible professional who is affiliated with a group practice participating in the group practice reporting option that successfully meets the proposed requirements for group practices would not be eligible to earn a separate e-prescribing incentive payment for 2010 on the basis of his or her successfully reporting the electronic prescribing measure at the individual level.

(1) Definition of ''Group Practice''

As stated above, section 1848(m)(3)(C)(i) of the Act authorizes the Secretary to define ''group practice.'' For purposes of determining whether a group practice is a successful e-prescriber, we propose that a ''group practice'' would consist of a physician group practice, as defined by a TIN, with at least 200 or more individual eligible professionals (or, NPIs) who have reassigned their billing rights to the TIN to be consistent with definition of ''group practice'' proposed for the PQRI group practice reporting option.

However, we propose to limit the group practices eligible to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option. At this time, we would like to limit the number of groups participating in the group practice reporting option until we get further experience with the group practice reporting option. Therefore, unlike individual eligible professionals who are not required to participate in the PQRI to be eligible to earn an e-prescribing incentive and vice versa, group practices would be required to participate in both PQRI and the E-Prescribing Incentive Program. As discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would be required to submit a self-nomination letter to CMS or a CMS designee requesting to participate in the 2010 PQRI group practice reporting option. Instructions for submitting the self-nomination letter will be posted on the PQRI section of the CMS Web site by November 15, 2009. In addition to meeting the eligibility requirements proposed in section II.G.2.g.(1) of this proposed rule, a group practice would also have to indicate how they intend to report the electronic prescribing measure (that is, which proposed reporting mechanism the group practice intends to use) for purposes of participating in the 2010 E-Prescribing Incentive Program group practice reporting option.

(2) Process for Group Practices to Participate as Group Practices and Criteria for Successful Reporting of the E-Prescribing Measure by Group Practices

For group practices selected to participate in the e-prescribing group practice reporting option for 2010, we propose the reporting period would be January 1, 2010 to December 31, 2010.

We propose that physician groups selected to participate in the 2010 E-Prescribing Incentive Program through the group practice reporting option would be able to choose to report the electronic prescribing measure through the claims-based, the registry-based, or, contingent upon us finalizing this reporting mechanism for the 2010 PQRI, the EHR-based reporting mechanism. As we proposed for individual eligible professionals, only registries and EHR products qualified to participate in the 2010 PQRI would be qualified for purposes of the 2010 e-prescribing group practice reporting option.

In order for a group practice to be considered a successful e-prescriber, we propose the group practice would have to report that at least 1 prescription during an encounter was generated using a qualified e-prescribing system in at least 2,500 instances during the reporting period.

In the absence of information about the composition of the group practices that may wish to participate in the E-Prescribing Incentive Program through the group practice reporting option rather than as individual eligible professionals, we assumed that the average group practice consists of 200 eligible professionals and that as many as half of the members of an average group practice do not furnish the services represented by the electronic prescribing measure's denominator codes, and thus, would not have an opportunity to report the electronic prescribing measure. Second, to be consistent with the proposed reporting criteria for individual eligible professionals, we also believe that each eligible professional in a group practice should be required to report that at least 1 prescription generated during an encounter that is represented by 1 of the electronic prescribing measure's denominator codes was generated electronically at least 25 times. Thus, for a group of 200 eligible professionals, we could extrapolate from our assumption that only half of the eligible professionals in an average practice of 200 eligible professionals would have the opportunity to report the electronic prescribing measure per group practice, the total number of reporting instances for the 100 remaining eligible professionals would be 2,500. We invite comments on the proposed criteria for determining whether a group practice is a successful e-prescriber. We also invite feedback on our underlying assumptions.

Section 1848(m)(2)(B) of the Act specifies that the limitation on the applicability of the e-prescribing incentive discussed in section II.G.5.d.

of this proposed rule applies to group practices as well as individual eligible professionals. Therefore, in determining whether a group practice will receive an e-prescribing incentive payment for 2010 by meeting the proposed reporting criteria described above, we would determine whether the 10 percent threshold is met based on the claims submitted by the group practice. This calculation is expected to take place in the first quarter of 2011 and would be determined by dividing the group practice's total 2010 allowed charges for all covered professional services submitted for the measure's HCPCS codes by the group practice's total Medicare Part B allowed charges for all covered professional services. If the result is 10 percent or more, then the statutory limitation will not apply and a group practice that is determined to be a successful e-prescriber would qualify to earn the e-prescribing incentive payment. If the result is less than 10 percent, then the statutory limitation will apply and the group practice would not qualify to earn the e-prescribing incentive payment.

f. Public Reporting of Names of Successful E-Prescribers

As discussed in section II.G.2.k. of this proposed rule, section 1848(m)(5)(G) of the Act requires the Secretary to post on the CMS Web site, in an easily understandable format, a list of the names of eligible professionals (or group practices) who satisfactorily submit data on quality measures for the PQRI and the names of the eligible professionals (or group practices) who are successful e-prescribers. In accordance with section 1848(m)(5)(G) of the Act, we indicated in the CY 2009 PFS final rule with comment period (73 FR 69851 through 69852) our intent, in 2010, to post the names of eligible professionals who are successful e-prescribers for the 2009 E-Prescribing Incentive Program at *http://www.medicare.gov*.

As required by section 1848(m)(5)(G) of the Act, we propose to make public the names of eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program on the Physician and Other Health Care Professionals Directory. The names of individual eligible professionals and group practices who are successful electronic prescribers for the 2010 E-Prescribing Incentive Program will be available in 2011 after the 2010 incentive payments are paid.

For purposes of publicly reporting the names of individual eligible professionals on the Physician and Other Health Care Professionals Directory, we propose to post the names of individual eligible professionals: (1) Whose 2010 PFS allowed charges make up at least 10 percent of the eligible professional's Medicare Part B charges for 2010; (2) who report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 25 times during the 2010 reporting period; and (3) who receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Since the PQRI and the E-Prescribing Incentive Program are two separate incentive programs and individual eligible professionals are not required to participate in both programs to earn an incentive under either program, it is possible for an eligible professional who participates in both incentive programs to be listed both as an individual eligible professional who satisfactorily submits data on quality measures for the PQRI and a successful electronic prescriber if he or she meets the criteria for both incentive programs.

For purposes of publicly reporting the names of group practices on the Physician and Other Health Care Professionals Directory, we propose to post the names of group practices who: (1) Report that at least 1 prescription generated during an encounter included in the electronic prescribing measure denominator was generated electronically (that is, who reported the G8443 code) at least 2500 times during the 2010 reporting period; and (2) receive an e-prescribing incentive payment for covered professional services furnished January 1, 2010 through December 31, 2010. Although group practices would be required to participate in both programs to earn an incentive under either program, the criteria for satisfactory reporting of PQRI measures for group practices are different from the criteria for successful reporting of the electronic prescribing measure by group practices. Therefore, it is possible for a group practice to be listed as a group practice that satisfactorily submits data on quality measures for the PQRI but not as a successful electronic prescriber or vice versa.

6. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services

Section 1834(e) of the Act, as added by section 135(a) of the MIPPA, requires that beginning January 1, 2012, Medicare payment may only be made for the technical component (TC) of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act to a supplier who is accredited by an accreditation organization designated by the Secretary.

a. Accreditation Requirement

This proposed rule would set forth the criteria for designating organizations to accredit suppliers furnishing the technical component (TC) of advanced diagnostic imaging services as specified in section 1834(c) of the Act. In addition, it would set forth the required procedures to ensure that the criteria used by an accreditation organization meet minimum standards for each imaging modality. These statutory requirements would be codified in § 414.68 of the payment rules for physicians and other practitioners.

The CMS-designated accreditation organization would apply standards that set qualifications for medical personnel who are not physicians but who furnish the TC. The standards would describe the qualifications and responsibilities of medical directors and supervising physicians including the following: Recognizing whether a particular medical director or supervising physician received training in advanced imaging services in a residency program; and has attained, through experience, the necessary expertise to be a medical director or supervising physician; has completed any continuing medical education courses related to advanced imaging services; or has met such other standards as the Secretary determines appropriate. In addition, the standards would require suppliers to: (1) Establish and maintain a quality control program to ensure the technical quality of diagnostic images produced by the supplier; (2) ensure the equipment used meets performance specifications; and (3) ensure safety of personnel. While the statute authorizes the Secretary to establish as criteria for accreditation any other standards or procedures the Secretary determines appropriate, we are not proposing to establish other standards or procedures at this time.

We expect to publish a notice to solicit applications from entities for the purposes of becoming a designated accreditation organization the same day that this proposed rule's subsequent final rule is issued, on or before November 1, 2009. Due to the tight timeframe, we expect to meet the January 1, 2010 statutory deadline in

order to designate organizations to accredit suppliers furnishing the TC of advanced diagnostic imaging services by waiving the 60-day delay in the imaging accreditation provisions of the final rule.

b. Accreditation for Suppliers

Section 1834(e) of the Act requires the Secretary to designate and approve accreditation organizations to accredit suppliers of the TC of advanced diagnostic imaging services. To promote consistency in accrediting providers and suppliers throughout the Medicare program, we are proposing to use existing procedures for the application, selection, and oversight of accreditation organizations detailed at 42 CFR part 488, subparts A and D and apply them to organizations accrediting suppliers of the TC of advanced diagnostic imaging services. We are proposing modifications to the existing part 488 requirements to meet the specialized needs of the advanced imaging industry. These modifications will require an independent accreditation organization applying for approval as a designated accreditation organization to include in their application:

• A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically:

+ Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

+ Qualifications and responsibilities of medical directors and supervising physicians, such as training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

+ Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished;

+ Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier.

• An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.

• Information to demonstrate the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

• The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation and any plans for reducing the burden and cost of accreditation to small and rural suppliers.

• Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

If, after review of an accreditation organization's submission of information, we determine that additional information is necessary to make a determination for approval or denial of the accreditation organization's application to be designated as an accreditation organization for suppliers of the TC of advanced diagnostic imaging services, the organization will be notified and afforded an opportunity to provide the additional information. We may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff. The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied, the notice will include the basis for denial and outline the reconsideration procedures. We will make every effort to issue a final decision no more than 30 calendar days from the time the completed reapplication is received by CMS. An accreditation organization may withdraw its application for designation under section 1834(e) of the Act at any time before the formal notice of approval is received. An accreditation organization that has been notified that its request for designation has been denied may request reconsideration in accordance with § 488.201 through § 488.211 in Subpart D. Any accreditation organization whose request for designation has been denied may resubmit its application if the organization (1) revises its accreditation program to address the rationale for denial of its previous request; (2) provides reasonable assurance that its accredited companies meet applicable Medicare requirements; and (3) resubmits the application in its entirety. If an accreditation organization has requested a reconsideration of our determination that its request for designation under section 1834(e) of the Act is denied, it may not submit a new application for the type of modality that is at issue in the reconsideration until the reconsideration is final.

A panel will evaluate all proposals from accreditation organizations seeking designation under section 1834(e) of the Act using existing CMS survey and certification processes as established in § 488.4.

c. Payment Rules for Suppliers of the TC of Advanced Diagnostic Imaging Services (§ 414.68)

We would specify in § 414.68 the statutory requirement of section 1834(e) of the Act that all suppliers of the TC of advanced diagnostic imaging services be accredited by a CMS-designated accreditation organization by January 1, 2012 for payments made under the fee schedule established under section 1848(b). In § 414.68(a), we are proposing to define the following:

• ''Accredited supplier'' as a supplier that has been accredited by a CMS-approved accreditation organization.

• ''Advanced Diagnostic Imaging Services'' as diagnostic magnetic resonance imaging, computed tomography, nuclear medicine, and positron emission tomography. We are not proposing at this time to include other diagnostic imaging services in this definition under section 1834(e)(1)(B)(ii) of the Act.

• ''CMS-approved accreditation organization'' as an independent accreditation organization designated by CMS to perform the accreditation function established in section 1834(e) of the Act.

d. Ongoing Responsibilities of CMS-Approved Accreditation Organizations

We are proposing to require a CMS-approved accreditation organization to perform the following activities on an ongoing basis. Provide to CMS in written form and on an ongoing basis all of the following:

• Copies of all accreditation surveys of specific suppliers along with any survey-related information that we may require (including corrective action plans and summaries of CMS requirements that were not met).

• Notice of all accreditation decisions.

• Notice of all complaints related to suppliers of the TC of advanced diagnostic imaging service.

• Information about any suppliers of the TC of advanced diagnostic imaging service for which the accrediting organization has denied the supplier's accreditation status.

• Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implemented the changes before or without CMS approval, we could withdraw approval of the accreditation organization.

• Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

• Provide CMS with written notice of any deficiencies and adverse actions

implemented by the CMS-approved accreditation organization against an accredited supplier of the TC of advanced diagnostic imaging within 2 days of identifying such deficiencies, if the deficiencies pose immediate jeopardy to a beneficiary or to the general public.

- Provide written notice of the withdrawal to all accredited suppliers within 10 days of CMS' notice to withdraw approval of the accreditation organization.
- Provide, on an annual basis, summary data specified by CMS that are related to the past year's accreditation activities and trends.

e. Continuing CMS Oversight of CMS-Approved Accreditation Organizations

We are proposing to add § 414.68 to establish specific criteria and procedures for continuing oversight and for withdrawing approval of an approved accreditation organization.

(1) Validation Audits

We are proposing to audit the accredited organizations in order to validate the survey accreditation process of approved accreditation organizations in the TC of advanced imaging. The audits would be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we will specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. We are proposing to require a supplier selected for a validation audit to authorize the validation audit to occur and authorize the CMS team or our contractor to monitor the correction of any deficiencies found through the validation audit. If a supplier selected for a validation audit failed to comply with the requirements at § 414.68, the supplier would no longer meet the Medicare requirements and, under this proposal, the supplier's accreditation for the TC of the advanced medical imaging would be revoked.

We are proposing that a CMS team or our contractor would conduct an audit of an accredited organization, examine the results of the accreditation organization's own survey procedure onsite, or observe the accreditation organization's survey, in order to validate the organization's accreditation process. At the conclusion of the review, we would identify any accreditation programs for which validation audit results indicated the following:

- A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that did not constitute immediate jeopardy to patient health and safety if not met;
- Any disparity between findings by the accreditation organization and findings by CMS or our contractor on standards that constituted immediate jeopardy to patient health and safety if not met; or
- There were widespread or systemic problems in the organization's accreditation process such that the accreditation no longer provided assurance that suppliers met or exceeded the Medicare requirements, irrespective of the rate of disparity.

(2) Notice of Intent To Withdraw Approval for Designating Authority

If a validation audit, onsite observation, or our concerns with the ethical conduct (that impacts the health and safety of the beneficiary) of an accreditation organization suggest that the accreditation organization is not meeting the requirements of proposed § 414.68, we would provide the organization written notice of its intent to withdraw approval of the accreditation organization's designating authority.

(3) Withdrawal of Approval for Designating Authority

We are proposing to withdraw approval of an accreditation organization at any time if we determine that:

- Accreditation by the organization no longer provides sufficient assurance that the suppliers of the TC of advanced imaging meet the requirements of section 1834(e) of the Act and the failure to meet those requirements could pose an immediate jeopardy to the health and safety of Medicare beneficiaries;
- Constitutes a significant hazard to the public health; or
- The accreditation organization failed to meet its obligations for application and reapplication procedures.

(4) Reconsideration

We are proposing to implement requirements under part 488 without substantive changes as the requirements have been utilized for the health care providers covered under part 488 since 1992. We are proposing that an accreditation organization dissatisfied with a determination that its accreditation requirements did not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization met the applicable standards would be entitled to a reconsideration. We are also proposing to reconsider any determination to deny, remove, or not renew the approval of the designating authority to accreditation organizations if the accreditation organization filed a written request for reconsideration through its authorized officials or through its legal representative.

We are proposing to require the accreditation organization to file the request within 30 calendar days of the receipt of CMS notice of an adverse determination or non-renewal. We propose to require the request for reconsideration to specify the findings or issues with which the accreditation organization disagreed and the reasons for the disagreement. A requestor could withdraw its request for reconsideration at any time before the issuance of a reconsideration determination. In response to a request for reconsideration, we would provide the accrediting organization the opportunity for an informal hearing that would be conducted by a hearing officer appointed by the CMS Administrator and provide the accrediting organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew its designating authority.

We would provide written notice of the time and place of the informal hearing at least 10 business days before the scheduled date. The informal reconsideration hearing would be open to CMS and the organization requesting the reconsideration, including authorized representatives, technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts), and legal counsel. The hearing would be conducted by the hearing officer who would receive testimony and documents related to the proposed action. Testimony and other evidence could be accepted by the hearing officer. However, it would be inadmissible under the usual rules of court procedures. The hearing officer would not have the authority to compel by subpoena the production of witnesses, papers, or other evidence. Within 45 calendar days of the close of the hearing, the hearing officer would

present the findings and recommendations to the accrediting organization that requested the reconsideration. The written report of the hearing officer would include separate numbered findings of fact and the legal conclusions of the hearing officer. The hearing officer's decision would be final.

We are interested in obtaining additional information on the role of radiology assistants (RA) and radiology practitioner assistants (RPA), including the level of physician supervision that would be appropriate when RAs and RPAs are involved in the performance of the TC of advanced medical imaging, whether the role varies by State, and related information. It would be particularly helpful for the commenter to identify specific clinical scenarios with associated CPT codes that would represent such services involving RAs and RPAs.

7. Section 139: Improvements for Medicare Anesthesia Teaching Programs

Section 139 of the MIPPA establishes a ''special payment rule for teaching anesthesiologists'' and provides a directive to the Secretary regarding payments for the services of ''teaching certified registered nurse anesthetists'' (teaching CRNAs). It also specifies the periods when the teaching anesthesiologist must be present during the procedure in order to receive payment for the case at 100 percent of the fee schedule amount (the regular fee schedule rate). These provisions are effective for services furnished on or after January 1, 2010.

a. Teaching Anesthesiologists: Special Payment Rule

The criteria for the payment of teaching anesthesiology services and the special rule for the teaching anesthesiologist are similar to the current criteria for payment of teaching surgeon services and the payment rule for the teaching surgeon involved in overlapping resident cases. Thus, there is a similarity in the payment rules for these physician specialties who work closely together.

(1) Payment for Anesthesia Services Furnished by a Physician

If the physician, usually an anesthesiologist, is involved in furnishing anesthesia services to a patient, the services can be furnished under one of three different scenarios. The anesthesiologist may—

- Personally perform the anesthesia services alone;
- Be involved in the case as a teaching anesthesiologist with an anesthesia resident; or
- Provide medical direction of the performance of anesthesia services for two, three or four concurrent cases involving a qualified individual (who may be a CRNA, an anesthesiologist assistant (AA), an anesthesia resident, or a student nurse anesthetist under certain circumstances).

Under the statute and CMS policy, if the anesthesiologist personally performs the anesthesia service alone or is involved in the case as a teaching anesthesiologist with an anesthesia resident, payment for the anesthesiologist's service is made at the regular fee schedule rate.

If the anesthesiologist furnishes medical direction for two, three or four concurrent anesthesia procedures, then payment for the anesthesiologist's service is made, in accordance with section 1848(a)(4)(B) of the Act, at 50 percent of the otherwise applicable fee schedule amount.

(2) Methodology for Payment of Anesthesia Services

Payment for anesthesia services furnished by a physician is made under the PFS, under section 1848(b)(2)(B) of the Act. The methodology for the calculation of the allowable amount is unique to anesthesia service only. Payment is made on the basis of anesthesia base units and time units, calculated from the actual anesthesia time of the case, instead of on the basis of work, PE, and malpractice RVUs. Payment for anesthesia services is also based on the anesthesia CF instead of the general PFS CF.

(3) Section 139(a) of the MIPPA

Section 139(a) of the MIPPA adds a new paragraph at section 1848(a)(6) of the Act to establish a ''special payment rule for teaching anesthesiologists''. This provision allows payment to be made at the regular fee schedule rate for the teaching anesthesiologist's involvement in the training of residents in either a single anesthesia case or in two concurrent anesthesia cases furnished on or after January 1, 2010. We will refer to anesthesia cases involving the training of residents as ''resident cases'' below in this section.

(4) Discussion

The Accreditation Council on Graduate Medical Education (ACGME) is a branch of the AMA, and it accredits allopathic residency programs. In order for a hospital to receive Medicare graduate medical education payments for its training programs, the residents must be in an ''approved medical residency program'' Under § 413.75(b), an approved medical residency program is one approved by one of the national organizations listed in § 415.152. One of the national organizations is the ACGME.

ACGME's policies and procedures require that each accredited residency program comply with the institutional requirements and the specialty program requirements. For approved anesthesia residency programs, ACGME requirements for faculty supervision and training of anesthesia residents specify that faculty members not direct anesthesia at more than two anesthetizing locations in the clinical setting. (*See* the ACGME Web site at *http://www.acgme.org*.)

Consistent with this requirement, the American Society of Anesthesiologists (ASA) has advised us that, when providing services in two concurrent cases, a teaching anesthesiologist might be engaged in two concurrent anesthesia resident cases, or in two mixed concurrent cases, one a resident case and the other a CRNA or AA case.

The statute applies the special payment rule for teaching anesthesiologists to the single resident case or two concurrent cases involving anesthesia residents as long as the teaching anesthesiologist meets the requirements in sections 1848(6)(A) and 1848(6)(B) of the Act. However, the statute does not directly address a single resident case that is concurrent to another case involving a CRNA, AA, or other qualified individual who can be medically directed. The issue is whether the medical direction payment rules apply to each of these cases or whether an alternative payment policy may apply.

One option in implementing this provision would be to strictly limit the special payment rule for teaching anesthesiologists to the single resident case (which is not concurrent to any other case) or the two concurrent resident cases (which are not concurrent to any other cases). For the mixed concurrent case, we could continue to apply our current medical direction payment policy to both the resident case and the other concurrent case. This would represent a continuation of our current medical direction payment policy, and would be predicated on the assumption that this is consistent with Congressional intent since the medical direction payment provisions at section 1848(a)(4) of the Act were left largely unchanged by section 139(a) of the MIPPA.

The other option would be to apply the special payment rule for teaching

anesthesiologists to the resident case when it is concurrent to a medically directed case, and to apply the medical direction payment policy to the medically directed case. While this represents a broader interpretation, it still limits the applicability of the special payment rule for teaching anesthesiologists to resident cases consistent with the terms of section 139 of the MIPPA.

The special payment rule under section 1848(a)(6) of the Act clearly applies for two concurrent anesthesia resident cases. The ACGME requirements also allow the supervision of two concurrent cases, but are not specific regarding whether the requirements relate only to two resident cases, or also to mixed concurrent cases. However, both the statute and ACGME requirements seem amenable to a policy that would allow the special teaching payment rule to apply in mixed concurrent cases, that is, the single resident case that is concurrent to another case not involving a resident. Additionally, we are concerned that if we continued to apply the medical direction payment policy to mixed concurrent cases, then financial differences in payment policy might cause teaching anesthesiologists to make changes in the scheduling of mixed resident and CRNA cases. This might limit the utilization of CRNAs in certain scenarios.

Accordingly, we are proposing to delete the current regulatory language at § 414.46(e) (which is no longer relevant) and add new language to specify that the special payment rule for teaching anesthesiologists applies to resident cases under the following scenarios:

- The teaching anesthesiologist is involved in one resident case (which is not concurrent to any other anesthesia case);
- The teaching anesthesiologist is involved in each of two concurrent resident cases (which are not concurrent to any other anesthesia case); or
- The teaching anesthesiologist is involved in one resident case that is concurrent to another case paid under medical direction payment rules.

Other than the application of the special payment rule for teaching anesthesiologists in the mixed concurrent case described above, we are not proposing any other revisions to our medical direction payment policies.

b. Teaching Anesthesiologists: Criteria for Payment

(1) Criteria for Payment of Teaching Anesthesiologists

Currently, the teaching anesthesiologist can be paid at the regular fee schedule rate for his or her involvement in a single resident case. As specified in § 415.178, the teaching anesthesiologist must be present with the anesthesia resident during all critical portions of the anesthesia procedure and be immediately available to furnish services during the entire procedure. Our manual instructions permit different physicians in the same anesthesia group to provide parts of the anesthesia service, and for the group to bill for the single anesthesia service. We refer to this practice as an ''anesthesia handoff.'' (*See* Medicare Claims Processing Manual 100–04, Chapter 12, Section 50 C.) Of course, the medical record must document those individual physicians who furnished the services.

This manual instruction is not limited in scope to nonteaching hospitals. Thus, it is possible that teaching anesthesiologists have interpreted it to permit handoffs during resident cases.

Our manual instructions state that for two overlapping surgeries, the teaching surgeon must be present during the critical or key portions of both operations (*See* Medicare Claims Processing Manual 100–04, Chapter 12, Section 100.1.2). It is our understanding that teaching surgeons do not hand off to another teaching surgeon during a key or critical portion of the surgical resident case.

(2) Section 139(a)(2) of the MIPPA

This section adds a new paragraph at section 1848(a)(6) of the Act which requires, in order for the special payment rule for teaching anesthesiologists to apply, that the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure. The new MIPPA provision regarding payment for services of a teaching anesthesiologist for two concurrent resident cases is similar to our current policy regarding payment for services of a teaching surgeon for two overlapping surgical resident cases.

(3) Discussion

The ASA has informed us that teaching anesthesiologists who work in the same anesthesia group sometimes provide different parts of the key or critical portions of a single anesthesia procedure. This type of a handoff situation might occur within an anesthesia group practice when there is an anesthesia procedure of long duration, but would not be limited to that circumstance.

From a quality standpoint, we do not believe multiple handoffs among teaching anesthesiologists during a case that involves the training of an anesthesia resident would be optimal. We do not have data on the extent to which anesthesia handoffs occur during resident or other cases, or whether quality of anesthesia care is affected. We note that section 1848(a)(6)(A) of the Act refers only to ''the'' teaching anesthesiologist, and requires that the teaching anesthesiologist be present during all critical or key portions of the service. However, section 1848(a)(6)(B) of the Act seems to contemplate some level of handoffs between teaching anesthesiologists, at least between those who have entered into an arrangement for such handoffs.

One option would be to permit different anesthesiologists in the same anesthesia group practice to be considered ''the teaching physician'' for purposes of being present at the key or critical portions of the anesthesia case. (These physicians must have reassigned their benefits to the group practice in order for the group to bill.) Although this option would be less disruptive to the current anesthesia practice arrangements (as reported by the ASA), it would establish rules for teaching anesthesiologists that are different from those for teaching surgeons.

Another option would be to require that, in order to meet the requirement of section 1848(a)(6)(A) of the Act, only one individual teaching anesthesiologist must be present during all of the key or critical portions of the procedure. However, another teaching anesthesiologist with whom ''the teaching anesthesiologist'' under subparagraph (A) has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure in order to meet the requirement under subparagraph (B). We believe this is the most logical reading of the statute and would be consistent with the way the teaching surgeon payment policy is applied for overlapping surgical cases.

In addition to explaining available options for implementing this provision, we are also soliciting specific comments on how the continuity of care and the quality of anesthesia care are preserved during handoffs. We are interested in whether there is an accepted maximum number of handoffs and whether there are any industry studies that have examined this issue. We would like to hear from anesthesia practices that do not use handoffs and what procedures they have implemented to achieve this

result. Finally, we would like to know what factors or variables are contributing to anesthesia handoffs and what short term adjustments can be made to affect these factors.

Although we are interested in receiving comments on these topics, we are proposing to more narrowly interpret the law and require that only one individual teaching anesthesiologist be present during all of the key or critical portions of the anesthesia procedure. We are also proposing that another teaching anesthesiologist with whom the teaching anesthesiologist has an arrangement could be immediately available to furnish services during a non-critical or non-key portion of the procedure.

c. Teaching CRNAs

(1) Payment for Anesthesia Services Furnished by a CRNA

Currently, a CRNA who provides anesthesia services while under the medical direction of an anesthesiologist is paid at 50 percent of the regular fee schedule rate as specified in section 1833(l)(4)(B)(iii) of the Act. A CRNA who provides anesthesia services without the medical direction of a physician is paid the regular fee schedule rate as specified in section 1833(l)(4)(A) of the Act.

(2) Payment for Anesthesia Services Furnished by a Teaching CRNA With a Student Nurse Anesthetist

The legislation that created the CRNA fee schedule payment system (that is, section 9320 of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509)) did not address payment for services furnished by teaching CRNAs involved in the training of student nurse anesthetists.

In the preamble to the CRNA fee schedule final rule published in the July 31, 1992 **Federal Register** (57 FR 33888), we stated that we would pay the teaching CRNA who is not medically directed by a physician at the regular fee schedule rate for his or her involvement in a single case with a student nurse anesthetist as long as he or she was present with the student throughout the anesthesia case. No payment would be made if the teaching CRNA divided his or her time between two concurrent cases involving student nurse anesthetists.

In August 2002, based on the recommendations of the American Association of Nurse Anesthetists (AANA), we modified our policy to allow the teaching CRNA not medically directed by a physician to be paid a portion of the regular fee schedule rate for each of two concurrent cases involving student nurse anesthetists. If the teaching CRNA is present with the student nurse anesthetist during the pre- and post-anesthesia care for each of the cases involving student nurse anesthetists, the teaching CRNA can bill the full base units (comprised of pre- and post-anesthesia services not included in the anesthesia time units) for each case and the actual amount of anesthesia time per case. The resulting payment for each of these anesthesia cases is greater than 50 percent, but less than 100 percent, of the regular fee schedule amount because the full base units plus the actual anesthesia time units spent by the teaching CRNA in each of the two cases yields a payment that is greater than 50 percent of the regular fee schedule amount.

(3) Comparison of Payment Policies for Teaching CRNAs and Teaching Anesthesiologists

For several years, the American Society of Anesthesiologists (ASA) requested that we revise our payment regulations to allow the teaching anesthesiologist to be paid the regular fee schedule amount for each of two concurrent resident cases. In the CY 2004 PFS final rule with comment period (68 FR 63224), we finalized a policy to permit the teaching anesthesiologist to be paid similarly to a teaching CRNA for each of two concurrent resident cases. This policy took effect for services furnished on or after January 1, 2004.

Thus, the payment policy is the same for a teaching CRNA for each of two concurrent student nurse anesthetist cases, and for a teaching anesthesiologist for each of two concurrent resident cases. The policy is that the anesthesia provider is paid the full base units plus time units, based on the actual anesthesia time, relating to each of two concurrent cases.

(4) Payment Policy for an Anesthesiologist, or an Anesthesiologist and CRNA Jointly, With a Student Nurse Anesthetist

Currently, there are circumstances where an anesthesiologist may be involved in the training of student nurse anesthetists in two concurrent anesthesia cases. These anesthesia cases are not paid under the teaching anesthesiologist payment policy, but are paid under the usual medical direction payment policy. Payment can be made for the physician's medical direction (that is, 50 percent of the regular fee schedule amount) for each of two concurrent cases.

If an anesthesiologist is medically directing two concurrent cases involving student nurse anesthetists and a CRNA is also jointly involved with the two student nurse anesthetist cases, then the physician service, in each case, can be paid under the medical direction rules at 50 percent of the regular fee schedule. Payment for the CRNA services would also be made at the medically directed rate (that is, 50 percent of the regular fee schedule) for CRNA services, but the time units used to compute the anesthesia fee would be based on the actual time the CRNA is involved in each case.

(5) Section 139(b) of the MIPPA

Section 139(b) of the MIPPA instructs the Secretary to make appropriate adjustments to Medicare teaching CRNA payment policy so that it—

- Is consistent with the adjustments made by the special payment rule for teaching anesthesiologists under section 139(a) of the MIPPA; and
- Maintains the existing payment differences between teaching anesthesiologists and teaching CRNAs.

We are proposing to implement the first directive (under section 139(b)(1) of the MIPPA) by establishing a new payment policy for teaching CRNAs that is similar to the special payment rule for teaching anesthesiologists, and to limit applicability of the rule to teaching CRNAs who are not medically directed. We are proposing to add a new regulation at § 414.61 to explain the conditions under which the special payment rule will apply and the method for calculating the amount of payment for anesthesia services furnished on or after January 1, 2010, by teaching CRNAs involved in the training of student nurse anesthetists. Under this proposal, we would pay the teaching CRNA at the regular fee schedule rate for each of two concurrent student nurse anesthetist cases. Our medical direction payment policy would continue to apply if both an anesthesiologist and a CRNA are involved in a student nurse anesthetist case that is concurrent to other anesthesia cases.

We believe the second directive in section 139(b)(2) of the MIPPA will be satisfied as a result of these proposals. Section 139(b)(1) of the MIPPA instructs CMS to make appropriate adjustments to implement a payment policy for teaching CRNAs that is consistent with the special payment rule for teaching anesthesiologists. Section 139(b)(2) of the MIPPA instructs CMS to maintain the existing payment differences between teaching anesthesiologists and teaching CRNAs. There currently are no substantive differences in payment

between teaching anesthesiologists and teaching CRNAs, and there would continue to be no such differences under our proposed policies.

(6) Payment for Teaching CRNAs Involved in Anesthesia Cases With Student Nurse Anesthetists

Under current policy, when a CRNA is involved in a single student nurse anesthetist case, the teaching CRNA must be present with the student throughout the case in order to be paid at the regular fee schedule rate. We are not proposing any change to this policy.

When the teaching CRNA is involved in two concurrent student nurse anesthetist cases, payment is based on the amount of anesthesia time the teaching CRNA spends with the student in each case. For example, if the teaching CRNA spends 40 percent of his or her time in concurrent case #1 and 60 percent of his or her time in concurrent case #2, and the total anesthesia time in both cases is 3 hours (or 180 minutes), then we would currently pay as follows:

- Case #1: (Base units + (0.4 × 180/15)) × Anesthesia CF
- Case #2: (Base units + (0.6 × 180/15)) × Anesthesia CF

The current payment policy has been predicated on paying the teaching CRNA for his or her actual time spent in the student nurse anesthetist case. We are now proposing to pay the teaching CRNA at the regular fee schedule rate for his or her involvement in two concurrent cases. If our goal is to minimize the effect of this change on teaching CRNAs' practice arrangements and time devoted to cases, then we would propose that the teaching CRNA continue to devote 100 percent of his or her time to the two concurrent cases. The teaching CRNA would decide how to allocate his or her time to optimize patient care in the two cases based on the complexity of the anesthesia case, the experience and skills of the student nurse anesthetist, the patient's health status, and other factors.

An alternative to this policy would be to apply the same criteria for teaching CRNAs as we use in § 415.178 with respect to teaching anesthesiologists. These criteria require the teaching anesthesiologist to be present during all critical or key portions of the anesthesia service. However, we believe these criteria are relevant and appropriate only for teaching anesthesiologists due to significant differences in experience, education and other qualifications between anesthesia residents and student nurse anesthetists. The anesthesia resident has completed medical school and is typically a licensed physician. In contrast, the student nurse anesthetist is an RN who usually has some clinical experience in ICU or critical care nursing prior to starting the CRNA training program. Thus, we believe the resident is more qualified through medical training and education than the student nurse anesthetist to provide elements of the anesthesia service without the immediate presence of the teaching anesthesiologist. Therefore, we propose to retain our current policy.

We note that the Congress did not amend the statutory provisions relating to medical direction at section 1848(a)(4) of the Act. We do not believe the directives at section 139(b) of the MIPPA extend to other arrangements in which anesthesiologists alone or both anesthesiologists and CRNAs jointly supervise student nurse anesthetists during concurrent anesthesia cases. Therefore, we are not proposing any changes to our current payment policies for anesthesia services furnished under other circumstances. We are proposing that when an anesthesia provider (physician or CRNA) furnishes anesthesia services in concurrent cases under other circumstances, the current policies regarding medical direction will continue to apply.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Cardiac Rehabilitation Services

Section 144(a) of the MIPPA amended Title XVIII of the Act, in pertinent part, to provide for coverage of cardiac rehabilitation (CR) and intensive cardiac rehabilitation (ICR) under Medicare Part B. The statute specifies certain conditions for these services, with coverage to begin on January 1, 2010. The addition of the new CR and ICR programs is designed to improve the health care of Medicare beneficiaries with cardiovascular disease. This proposed rule implements these MIPPA provisions in order to ensure services enhance the patient's clinical outcomes.

a. Background

Intensive cardiac rehabilitation (ICR) is a relatively new practice that is also commonly referred to as a ''lifestyle modification'' program. These programs typically involve the same elements as general CR programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of CR and also may be more rigorous.

b. Cardiac Rehabilitation Coverage Under Medicare

One mechanism we use to establish coverage for certain items and services is the national coverage determination (NCD) process. An NCD is a determination by the Secretary with respect to whether or not a particular item or service is covered nationally under Title XVIII.

Since 1982, Medicare has covered, under an NCD, cardiac rehabilitation for patients who experience stable angina, have had coronary artery bypass grafts, or have had an acute myocardial infarction within the past 12 months. The NCD is located in the Medicare NCD Manual (Pub. 100–03), section 20.10. Effective March 22, 2006, we modified the NCD language to cover comprehensive cardiac rehabilitation programs for patients who experience one of the following:

- A documented diagnosis of acute myocardial infarction within the preceding 12 months.
- A coronary bypass surgery.
- Stable angina pectoris.
- A heart valve repair/replacement.
- A percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.
- A heart or heart-lung transplant.

Comprehensive programs must include a medical evaluation, a program to modify cardiac risk factors, prescribed exercise, education, and counseling and may last for up to 36 sessions over 18 weeks or no more than 72 sessions over 36 weeks if determined appropriate by the local Medicare contractors. Facilities furnishing cardiac rehabilitation must have immediately available necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment and be staffed with personnel necessary to conduct the program safely and effectively who are trained in advanced life support techniques and exercise therapy for coronary disease. The program must also be under the direct supervision of a physician. Until section 144(a) of the MIPPA is effective, ICR programs are covered under this NCD and are subject to the same coverage requirements.

We are proposing to implement section 144(a) of the MIPPA and refine coverage for CR and ICR through this rulemaking process. When the rulemaking is completed, we will take the necessary steps to withdraw and/or modify the NCD.

c. Statutory Authority

Section 144(a) of the MIPPA amended the Medicare Part B program by adding new sections 1861(s)(2)(CC) and

1861(s)(2)(DD) of the Act to include items and services furnished under a ''cardiac rehabilitation program'' and an ''intensive cardiac rehabilitation program,'' respectively. A cardiac rehabilitation program is defined in new section 1861(eee)(1) of the Act and an intensive cardiac rehabilitation program is defined in new section 1861(eee)(4)(A) of the Act.

A cardiac rehabilitation program is a physician-supervised program that furnishes the following: Physician-prescribed exercise; cardiac risk factor modification, including education, counseling, and behavioral intervention; psychosocial assessment; outcomes assessment; and other items or services as determined by the Secretary under certain conditions. These items and services must be furnished in a physician's office, in a hospital on an outpatient basis, or in other settings as determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and emergencies at all times items and services are being furnished in a CR program except when provided in a hospital setting where such availability is presumed. The items and services furnished by a CR program are individualized and set forth in written treatment plans that describe the patient's individual diagnosis; the type, amount, frequency, and duration of items and services furnished under the plan; and the goals set for the individual under the plan. These written plans must be established, reviewed, and signed by a physician every 30 days.

We are proposing that ICR programs must provide the same items and services under the same conditions as CR programs but must demonstrate, as shown in peer-reviewed published research, that they have accomplished one or more of the following: Positively affected the progression of coronary heart disease, or reduced the need for coronary bypass surgery, or reduced the need for percutaneous coronary interventions (PCIs). The peer-reviewed published research must also show that the ICR program has resulted in a statistically significant reduction in 5 or more measures from their levels before ICR services to their levels after receipt of such services. These measures include low density lipoprotein; triglycerides; body mass index; systolic blood pressure; diastolic blood pressure; or the need for cholesterol, blood pressure, and diabetes medications.

Beneficiaries eligible for ICR must have experienced the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. Section 1861(eee)(4)(C) of the Act, as added by section 144(a)(1)(B) of the MIPPA, states that an ICR program may be provided in a series of 72, 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

The statute directs the Secretary to establish standards for the physician(s) supervising the ICR and/or CR programs to ensure that the physician has expertise in the management of individuals with cardiac pathophysiology and is licensed by the State in which the CR program (or ICR program) is offered. These standards ensure that the physician is responsible for the program and, in consultation with appropriate staff, is involved substantially in directing the progress of individuals in the program.

d. Proposals for Implementation

We are proposing to create new § 410.49, ''Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage.''

(1) Definitions

In this section, we are proposing several definitions for the terms used with respect to the programs and services required by section 144(a) of the MIPPA. These terms include the following:

- Cardiac rehabilitation program.
- Individualized treatment plan.
- Intensive cardiac rehabilitation.
- Physician.
- Physician-prescribed exercise
- Psychosocial assessment.
- Outcomes assessment.

(2) Covered Beneficiaries

In § 410.49, we are proposing to establish coverage for CR and ICR programs for beneficiaries who have experienced any of the following: An acute myocardial infarction within the preceding 12 months; a coronary bypass surgery; current stable angina pectoris; a heart valve repair or replacement; a PTCA or coronary stenting; or a heart or heart-lung transplant. We are proposing to maintain and refine coverage of general CR programs for beneficiaries with these six conditions as originally established in Pub. 100–03, section 20.10 as this coverage was determined to be reasonable and necessary under section 1862(a)(1)(A) of the Act due to a high level of supporting clinical evidence. We are also proposing through this rulemaking to use the NCD process in the future to identify additional medical indications for patients who could obtain CR under Medicare Part B. While CR programs include certain mandatory services, the written plans are highly individualized, and we propose to allow some flexibility in the type, amount, frequency, and duration of services provided in each session. However, as supported by medical literature and statements of the American Heart Association (AHA) and the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR),[4] aerobic exercise training using the muscles of ambulation is a mandatory component of any CR or ICR program. We recommend both low- and high-intensity exercise to produce optimal benefits, and suggest a combination of endurance, strengthening and stretching exercises. Patients in general CR programs must participate in a minimum of 2, 1-hour CR sessions a week, and a maximum of 2, 1-hour sessions a day. Patients in ICR programs may participate in up to 6, 1-hour sessions per day not to exceed 72, 1-hour sessions over an 18-week period. By a 1-hour session, we mean that each session must last a minimum of 60 minutes. Each day CR or ICR items and services are provided to a patient, aerobic exercises along with other exercises must be included (that is, a patient must exercise aerobically every day he or she attends a CR or ICR session). Exercise may include the use of treadmills, bicycles, light weights or other equipment, and should be intended to improve cardiovascular function, strength, endurance, and flexibility.

Section 144(a) of the MIPPA requires CR and ICR programs to furnish items and services including ''cardiac risk factor modification.'' This includes education, counseling, and behavioral intervention to the extent these services are closely related to the individual's care and treatment and tailored to patients' individual needs. We are proposing that patients must be provided with the information and tools to improve their overall cardiovascular health. Items and services furnished as part of the risk factor modification component should be highly

[4] Balady G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Journal of Cardiopulmonary Rehabilitation and Prevention* 2007;27:121–129.

individualized as multiple risk factors contribute to poor cardiovascular health. For example, these items and services may include smoking cessation counseling or referral, nutritional education and meal planning, stress management, prescription drug education and management information, disease history education in order to foster a better understanding of disease origins and disease symptomatology, and any other education, counseling and behavioral intervention deemed appropriate in each patient's individualized treatment plan.

The MIPPA provisions require a psychosocial assessment as part of the CR and ICR programs defined above. We are proposing that the initial assessment by program staff evaluate aspects of the individual's family and home situation that may affect their treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Prior to each 30-day review of the individualized treatment plan, the supervising physician or program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assist in ensuring that patients begin CR with a program tailored to their needs, a periodic re-evaluation is necessary to ensure that their psychosocial needs are in fact being met.

The MIPPA provisions also require that CR and ICR programs include outcomes assessment. Professional groups, such as the AHA and AACVPR, recognize a number of relevant patient outcomes that may be expected to accrue from the various components of cardiac rehabilitation.[5] We propose to define outcomes assessment as an evaluation of the patient's progress in the program using assessments from the commencement and conclusion of CR and ICR programs that are based upon patient centered outcomes. Patient centered outcomes must be measured at the beginning of the CR program, prior to each 30-day review of the individualized treatment plan, and at the end of the CR program. All assessments are considered part of the CR program and, as such, are conducted in the appropriate settings and not billed separately. These measures should include resting and exercising heart rate, resting and exercising systolic and diastolic blood pressure, weight, BMI, amount and dosage of medications required, self-reported quality of life, and behavioral measures (for example, smoking cessation, increased activity levels, change in exercise levels during CR). As CR programs must be highly individualized, alternate or additional measures may be appropriate. Patients' individualized treatment plans should be altered accordingly with changes and/or progress in each of the outcome measurements. Programs may also develop performance standards which measure the overall quality of the program, by assessing the group as a whole.

The MIPPA provisions require that CR services be provided under written individualized treatment plans. As CR programs are highly individualized, we propose that the physician define and set the parameters, including the individual's diagnosis, the types of services appropriate, and the treatment goals. The MIPPA provisions require the physician to establish the written individualized treatment plan and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the CR physician. If the plan is developed by the referring physician who is not the CR physician, the CR physician must also review and sign the plan prior to initiation of CR. Direct physician contact is not always required to meet the 30-day review standards, but might be necessary depending upon specific patient factors. Regardless, CR staff must provide both outcome and psychosocial assessments to the supervising physician prior to the 30-day deadline and the physician must evaluate the information provided by the CR staff. The CR staff may make recommendations for modifications to the program, but the physician will still modify the plan as needed, and review and sign the plan. The MIPPA provisions require written specificity relating to the type, amount, frequency, and duration of the items and services furnished under the individual's plan. As CR patients have had or may develop disabling cardiovascular disease, they require individual attention and assessments that address their individualized needs and meet realistic individualized goals through a specifically designed treatment plan. The individualized treatment plan should specify the combination of services necessary to address the patient's needs, as identified through the initial assessment and based upon changes in the patient's condition. It must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the individualized treatment plan should be consistent with current evidence-based professionally-accepted clinical practice standards such as those identified by the AHA and AACVPR.

The MIPPA provisions also authorize the Secretary to include other mandatory items and services within the scope of the CR program under certain conditions. We are not proposing to require any other items and services at the present time. If the Secretary determines that the addition of any other items and services is appropriate, additions will be made and implemented through future rulemaking.

Section 144(a) of the MIPPA provides for coverage of CR and ICR services in various settings which include a physician's office, a hospital on an outpatient basis or other settings determined appropriate by the Secretary. We are not proposing to cover CR or ICR in other settings at this time. If the Secretary determines that the addition of settings is appropriate, additions will be made through rulemaking. All settings should have all equipment and staff necessary, consistent with cardiac rehabilitation professional society recommendations, to provide statutorily-mandated items and services.

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. Professional groups such as the AHA and AACVPR recognize the need to provide appropriate patient supervision and, where appropriate, monitoring. We are proposing that such availability be met through existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because the physician must be present and immediately available where the services are being furnished. The physician must also be able to furnish

[5] Balady G, Williams M, Ades P, et al. Core Components of Cardiac Rehabilitation/Secondary Prevention Programs: 2007 Update. A Scientific Statement From the American Heart Association Exercise, Cardiac Rehabilitation, and Prevention Committee, the Council on Clinical Cardiology; the Councils on Cardiovascular Nursing, Epidemiology and Prevention, and Nutrition, Physical Activity, and Metabolism; and the American Association of Cardiovascular and Pulmonary Rehabilitation. *Journal of Cardiopulmonary Rehabilitation and Prevention* 2007;27:121–129.

assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For CR and ICR services provided in physicians' offices and other Part B settings paid under the PFS, the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with the § 410.26(b)(5). This does not mean that the physician must be in the room when the service or procedure is performed. For CR and ICR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services furnished in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is furnished. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of cardiac rehabilitation services at that time.

The MIPPA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption relating to direct physician supervision for hospital outpatient services means that direct physician supervision is the standard for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals, and we expect that hospitals are providing services in accordance with this standard.

New section 1861(eee)(4) of the Act requires ICR programs, to be qualified for Medicare coverage, to meet several standards. To become qualified, an ICR program must demonstrate through peer-reviewed, published research that it has accomplished one or more of the following: (1) Positively affected the progression of coronary heart disease; (2) reduced the need for coronary bypass surgery; or (3) reduced the need for percutaneous coronary interventions (PCIs). A qualified ICR program must also demonstrate through peer-reviewed published research that the ICR program accomplished a statistically significant reduction for patients in 5 or more specific measures from the individual's levels before ICR services to their levels after receipt of such services. These measures include: (1) Low density lipoproteins; (2) triglycerides; (3) body mass index; (4) systolic blood pressure; (5) diastolic blood pressure; and (6) the need for cholesterol, blood pressure, and diabetes medications. To ensure that ICR programs in fact meet these standards, we are proposing that programs intending to operate as ICR programs apply to CMS to receive designation as qualified ICR programs. Only designated programs would then be eligible for Medicare coverage and would be required to undergo regular re-evaluation to maintain such status. We are requesting public comments on establishing an annual re-evaluation process.

We are proposing that programs may apply to CMS to be designated qualified programs to provide ICR. To meet this designation, programs must submit to CMS detailed literature describing the program and the precise manner in which the program meets MIPPA provisions. Each program must also submit peer-reviewed, published research specific to the actual program applying for approval. The research must clearly demonstrate that the program under examination accomplishes at least the minimum outcomes as defined above. We are proposing, based on our general rulemaking authority that each ICR program must submit a detailed description of the items and services available to ICR patients and the capabilities of the facility in which the program takes place as well as the responsibilities of program staff. All materials shall be submitted to: Director, Coverage and Analysis Group, Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Mail Stop C1–09–06, Baltimore, Maryland 21244.

Following CMS review, ICR programs will either be notified of any missing information or inadequacies in their submissions (so they may resubmit in the future) or be notified of CMS designation as an ICR program. Designated programs will be identified in a list of ICR programs posted on the CMS Web site and in the **Federal Register**. We are proposing that all designated programs must demonstrate continued compliance with MIPPA standards every year in order to maintain qualified status.

We are proposing that for an ICR program to maintain its designation by CMS as a qualified ICR program, the program must submit specific outcomes assessment information. Programs shall submit information for all patients who initiated and completed the full ICR program during the initial year-long CMS designation. For each patient, programs must identify the following: (1) The medical condition qualifying the patient for eligibility to participate in ICR; (2) the patient's improvement in coronary heart disease, reduced need for coronary bypass surgery, and/or reduced need for PCIs; and (3) the levels of the 5 or more measures identified above at the beginning and end of the program. Programs must also submit average beginning and ending levels of at least those 5 measures for the program as a whole. If any changes are made to the ICR program during the initial year-long CMS designation, such changes must be documented and submitted with the outcomes assessment information. Programs will have 30 days to submit this information to CMS following the end of the initial approval period. In the month following receipt, we will review the submitted information and determine whether the program continues to meet the payment standards. We believe that re-evaluations of designated programs will assist CMS in ensuring that programs continue to demonstrate the outcome measures identified for initial designation. We are requesting public comments on annual program re-evaluations requirements, the required information for re-evaluation proposed above and if an administrative appeals process should be established for ICR programs that no longer meet outcomes standards. We are also asking for public comments on the time period for re-evaluations of ICR programs.

Section 144(a)(1)(B) of the MIPPA requires CR and ICR programs to be physician-supervised. In addition, section 144(a)(5) of the MIPPA requires the Secretary to establish standards to ensure that the physician, who has the appropriate expertise in the management of individuals with cardiac pathophysiology and is licensed to practice medicine in the State in which the CR or ICR program is offered, is responsible for the CR or ICR program. We propose to identify this physician who oversees or supervises the CR and ICR program in its entirety as the Medical Director. As required by

144(a)(5), we are proposing that the Medical Director must have training and proficiency in cardiovascular disease management and exercise training of heart disease patients. We also propose that the Medical Director, in consultation with other staff, must be involved substantially in directing the progress of individuals in the program. We are expressly seeking public comments on the precise level of expertise that is necessary for the Medical Director.

As discussed above, section 144(a)(2)(B) of MIPAA requires that a physician must be immediately available and accessible for medical consultations and medical emergencies at all times items and services are being furnished under the program. For purposes of this proposed rule we are identifying this physician as the supervising physician (that is, the physician that must be immediately available to furnish assistance and direction throughout the performance of CR and ICR services); we believe this physician also requires expertise in cardiac pathophysiology resulting from training or experience in cardiovascular disease management and exercise training of heart disease patients. This includes a physician billing Medicare Part B for providing services directly to a patient during a CR or ICR session. We are proposing standards for these physicians based on our general rulemaking authority which include expertise in the management of individuals with cardiac pathophysiology and licensure to practice medicine in the State in which the CR or ICR program is offered. We are expressly inviting public comments about the precise level of expertise that is necessary.

Please note that the program Medical Director may fulfill both roles of Medical Director and supervising physician (of individual CR and ICR services furnished to patients) provided that the requirements for direct physician supervision as required in §§ 410.26 and 410.27 are met when CR or ICR items and services are furnished, as discussed above.

We are requesting public comments regarding whether specific training and expertise standards are needed for the cardiac rehabilitation staff.

Section 1861(eee)(4)(C) of the Act provides for coverage of ICR programs that are provided in a series of 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks. Specific provisions for the number, duration, and time period for general CR programs are not identified in the MIPPA; however we propose to maintain, with slight refinements, coverage requirements previously established in Pub. L. 100–03, section 20.10 through this rulemaking process. For eligible beneficiaries, general CR is provided for up to 36 1-hour sessions, up to 2 sessions per day with no fewer than 2 sessions per week, over up to 18 weeks, with contractor discretion to expand these limitations to not exceed 72 sessions for 36 weeks. This is based on section 1862(a)(1)(A) of the Act and our general rulemaking authority. By 1-hour session, we mean that each session must last a minimum of 60 minutes.

e. Coding and Payment

(1) CR Payment

Currently, the following CPT codes are used for CR services described in section 144(a) of the MIPPA: CPT code 93797, *Physician services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)*; and CPT code 93798, *Physician services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)*. We are not proposing to revise these codes under the PFS because the CR program authorized by the existing NCD is essentially the same as that included in the MIPPA.

(2) ICR Payment

The statute requires that the hospital Outpatient Prospective Payment System (OPPS) payment amount for CR services be substituted for ICR under the PFS, specifically the payment for CPT codes 93797 and 93798 or any succeeding HCPCS codes for CR. We are proposing to create two new HCPCS codes for ICR services. These codes may only be billed by ICR programs that have been approved by CMS. The proposed codes are as follows:

- GXX28, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session*.
- GXX29, *Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session*.

These HCPCS codes will be recognized under the PFS and the OPPS. Under the OPPS the existing CR HCPCS codes, CPT codes 93797 and 93798, are assigned to APC 0095 (Cardiac Rehabilitation) for CY 2009. Because the payment under the PFS for the two proposed ICR G-codes is required to be the same as the payment for CR services under OPPS, we are proposing to pay the same amount as will be established through rulemaking for CY 2010. The proposed OPPS payment amount for CR services will be announced in the CY 2010 OPPS/ASC proposed rule. We are proposing that this amount will be adjusted for the appropriate locality by applying the GPCI under the PFS. The CY 2010 proposed APC assignments and payment rates for these two ICR G-codes will be published in the CY 2010 OPPS/ASC proposed rule. The proposed payment rate for the associated APC(s) will be included in Addendum A to the CY 2010 OPPS/ASC proposed rule.

We note that when a CR/ICR service is furnished in a hospital outpatient department, a physician cannot bill the Medicare contractor for CR/ICR unless the physician personally performs the CR/ICR service. To personally perform the CR/ICR service, the physician would provide direct care to a single patient for the entire session of CR/ICR that is being reported. In this case, the hospital would report the CR/ICR service and be paid the OPPS payment for the facility services associated with the CR/ICR session and the physician would report and be paid the PFS amount for the CR/ICR service. A physician cannot bill under the PFS for CR/ICR services furnished in a hospital for which the physician furnishes only supervision or for services furnished in part by others. If the physician furnishes no direct CR/ICR services for a given session or on a given day or provides direct CR/ICR services for less than the full session, then only the hospital would report the CR/ICR services and these services would be paid under the OPPS.

9. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions—Pulmonary Rehabilitation Services

Section 144 of the MIPPA amended Title XVIII of the Act to provide for coverage of pulmonary rehabilitation (PR) under Part B, under certain conditions, for services furnished on or after January 1, 2010. This proposed rule would implement the new Medicare pulmonary rehabilitation program and establish the requirements for providing such services to Medicare beneficiaries with a diagnosis of moderate to severe chronic obstructive pulmonary disease (COPD). COPD is not only one of the more common of the diseases in the category of chronic respiratory diseases, it is one of the more severely debilitating, characterized by chronic bronchitis and emphysema. Other diseases and conditions in this category include persistent asthma, bronchiectasis, primary pulmonary hypertension, obesity-related respiratory

disease, and ventilator dependency. This rule provides direction in implementing the MIPPA in order to ensure services are covered and enhance the patient's clinical outcomes.

a. Background

A PR program is typically a multidisciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy. The main goal of an individualized PR training program is to empower and facilitate the individuals' ability to exercise independently; exercise is the cornerstone of the PR program. Exercise is combined with other training and support mechanisms necessary to integrate prevention and encourage long-term adherence to the treatment plan. The appropriate PR program will train and motivate the patient to his or her maximum potential in self-care, and improve his or her overall quality of life.

b. Provisions of Section 144 of the MIPPA

In pertinent part, section 144 of the MIPPA amended section 1861(s)(2) of the Act to add a new subparagraph (CC) establishing coverage of items and services furnished under a ''pulmonary rehabilitation program.'' Pulmonary rehabilitation program is defined in new subsection (fff)(1) to mean a physician supervised program that furnishes several specific items and services. These include all of the following:

- Physician-prescribed exercise.
- Education or training (to the extent that the education and training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs).
- Psychosocial assessment.
- Outcomes assessment.
- Other items and services determined by the Secretary to be appropriate under certain conditions.

These components are to be provided in physicians' offices, hospital outpatient settings, and other settings determined appropriate by the Secretary. A physician must be immediately available and accessible for medical consultation and medical emergencies at all times when PR items and services are being furnished under the program. The individual's treatment is furnished under a written treatment plan that is developed by the physician for each beneficiary participating in a PR program. A physician must establish and review the plan and it must be signed by the physician every 30 days. This plan must include the individual's diagnosis, the scope of services to be provided in terms of type, amount, frequency and duration, and the goals set for the individual. To be covered and paid by Medicare, the PR program must provide all of the specified mandatory items and services. With respect to the Secretary's authority to require additional items and services, we are not proposing any additional services at the present time; however, we may propose additional items and services in the future.

c. Proposals

Under section 144 of the MIPPA, we are proposing to create a new § 410.47, ''Pulmonary Rehabilitation Program: Conditions for Coverage'' under Part B to add the PR program as a Medicare-covered service. The new section 1861(fff) of the Act outlines the mandatory components of a PR program. In accordance with this new section, any facility providing a PR program must meet all of the requirements outlined herein. The MIPPA provides for coverage of PR services in two specific settings (physician's office, hospital outpatient) and authorized the agency to consider the addition of other settings. We are not proposing any other settings at the present time.

The PR provisions defined by section 144 of the MIPPA are effective January 1, 2010.

(1) Definitions

We are proposing the following definitions for the programs and services required by MIPPA as related to PR provisions.

- *Individualized treatment plan:* A written plan which describes the individual's diagnosis; the type, amount, frequency and duration of the items and services to be furnished under the plan, including specifics related to the individual's particular needs for education and training; and the goals set for the individual under the plan.
- *Outcomes assessment:* A physician's evaluation of the patient's progress as it relates to his or her rehabilitation. The outcomes assessment is in writing and includes the following: (1) Pre- and post-assessments, based on patient-centered outcomes which are conducted by the physician at the beginning of the program and at the end of the program; and (2) objective clinical measures of exercise performance and self-reported measures of shortness of breath and behavior.
- *Physician:* A doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.
- *Physician-prescribed exercise:* Physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.
- *Psychosocial assessment:* A written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

This includes: (1) An assessment of those aspects of an individual's family and home situation that affect the individual's rehabilitation treatment; and (2) a psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

- *Pulmonary rehabilitation:* A short term physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(2) Coverage

We are proposing that Medicare Part B would cover PR for beneficiaries with moderate to severe COPD when ordered by the physician treating chronic respiratory diseases. A comprehensive PR program may be adapted for any person with chronic respiratory disease. The medical literature describes conditions associated with the possible need for PR including COPD, obesity-related respiratory disease, lung cancer, and neuromuscular diseases. However, the benefits of a PR program most strongly support its use for patients with moderate to severe COPD.

(a) Definition of Moderate to Severe COPD

Moderate to severe COPD is defined as GOLD classification II and III. The GOLD classification utilizes indices that measure airflow limitation and lung hyperinflation to determine severity of COPD. Specifically, the measurement of Forced Expiratory Volume (FEV) in the first second divided by the Forced Expiratory Vital Capacity (liters) (FEV1/FVC) gives a clinically useful index of airflow limitation. In other words, the volume of air exhaled that can be forced out in one second after taking a deep breath divided by the maximum volume of air exhaled as rapidly, forcefully and completely as possible from the point of maximum inhalation equals a numerical value used to grade COPD severity. Moderate and severe COPD are defined as:

- GOLD classification II (Moderate COPD)) is defined as FEV1/FVC<70 percent and FEV1 ≥30 percent to <80 percent predicted with or without chronic symptoms (Cough, sputum production, dyspnea).
- GOLD classification III (Severe COPD) is defined as FEV1/FVC < 70

percent and FEV1 < 30 percent predicted or FEV1 < 50 percent predicted plus respiratory failure or clinical signs of right heart failure.

Section 144 of the MIPPA does not specify the medical conditions for which coverage and payment are authorized for a PR program, other than a reference in the title to ''chronic obstructive pulmonary disease and other conditions''. Although the spectrum of possible conditions for which PR may be covered is broad, the medical guidelines most strongly supported the benefits of a PR program for individuals with moderate to severe COPD. The major national and international respiratory organizations (that is, ATS/ERS, the American College of Chest Physicians (AACP) jointly with the American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR), and Global Initiative for Chronic Obstructive Lung Disease) have recommended PR as the standard of care in the treatment of moderate to severe chronic obstructive pulmonary disease represented by GOLD classification II or III. Because there is not data to substantiate significantly improved outcomes for any other medical conditions, we are proposing to allow moderate to severe COPD as the only covered condition. We propose to consider expanding coverage to patients with other medical conditions, should evidence support these additional uses. We would propose in our regulations to use the national coverage determination process to consider expanding coverage of PR for other chronic respiratory.

(b) Use of the NCD Process

We are proposing to use the national coverage determination process as authorized by section 1871(1) of the Act, to consider expanding coverage to items and services furnished by PR programs. The NCD process is open and transparent and provides an opportunity for public comments. Moreover, the NCD process affords CMS the ability to conduct a timely assessment of recent clinical evidence through a flexible and transparent process. It allows us to make uniform nationwide coverage determinations for items and services in a more flexible manner than rulemaking. In most circumstances, the NCD process is required to be completed within 9 to 12 months of the time that we accept a formal request for an NCD on a particular service. The NCD process will maximize the clinical benefit of PR for beneficiaries, and permit more rapid changes in response to emerging clinical evidence.

(3) Physician-Prescribed Exercise

Since the determination of the optimal time spent on each of the specific components within a PR program is highly individualized under the written plan of care, we are proposing to give the program medical director considerable flexibility. However, aerobic exercise is widely considered the cornerstone of pulmonary rehabilitation, and practice guidelines in the medical literature suggest exercise training of the muscles of ambulation as an essential component of a PR program. Each session must include some physician-prescribed aerobic exercise. We recommend both low- and high-intensity exercise to produce clinical benefits. It is suggested that exercise sessions involving a combination of endurance and strength training (to increase muscle strength and muscle mass) be conducted at least twice per week to achieve physiological benefits. Exercise may include use of treadmills, bicycles or other equipment, and should provide increased pulmonary function, strength, endurance, and flexibility.

(4) Education or Training Under the PR Program

Section 144 requires that education or training must meet the statutory requirements that mandate that it must be closely and clearly related to the individual's care and treatment, as well as meeting the specific needs of the individual. As part of the written individualized treatment plan the physician should evaluate and include only that education and training which addresses the needs particular to the patient that will further their independence in activities of daily living. The training and education prescribed should assist patients in learning to adapt to their limitations and improve the quality of their lives. Patients with COPD often use respiratory therapy modalities and equipment to aid their breathing. Education and training should be provided as necessary to ensure proper use and compliance with the physician's prescription. Instruction should include proper use, care, and cleaning of home respiratory equipment. Examples of equipment for which instruction would be appropriate include nebulizers/compressors, transtracheal oxygen (TTO), peak flow meters, and oxygen-conserving devices. Current medical literature provides for education as an integral component of pulmonary rehabilitation. The supervising physician must ensure the education or training helps further the primary objective of understanding and self-management of the chronic respiratory disease, specifically focused on COPD, including educational information on prevention and treatment of exacerbations. Examples of training sessions include those on respiratory techniques for physical energy conservation, work simplification, and relaxation techniques. Skills training and education also encourage behavioral changes by the patient, which can lead to improved health and long-term adherence. For example, brief smoking cessation counseling, as appropriate and respiratory problem management, should be included. Other topics for education may include the proper use of medications and nutrition counseling.

(5) Psychosocial Assessment

Section 144 of the MIPPA requires a psychosocial assessment as part of the PR program; we propose that it should be a written assessment. The initial assessment by program staff will evaluate aspects of the individual's family and home situation that may affect his or her treatment, and consider at the outset if referrals to support groups, community and/or home care services are necessary. Individual psychological considerations will also be addressed. For example, smoking is well known to be a cause of COPD. Depression and anxiety are commonly reported concerns for this patient population. Psychosocial intervention could help facilitate behavioral changes, such as smoking cessation, as well as assist with managing symptoms such as dyspnea. The assessment should include a written evaluation of the patient's need, as appropriate, for depression management, stress reduction, relaxation techniques, and strategies for coping with lung disease. This proposed rule does not propose any changes to the existing NCD (210.4) for ''Smoking and Tobacco-Use Cessation Counseling.''

The psychosocial assessment should include thorough screening and evaluation of the individual's lifestyle and other behaviors. Prior to each 30-day review of the individualized treatment plan, the program staff will conduct an evaluation of the individual's response to, and rate of progress under, the treatment plan and make recommendations to the physician as necessary. While the individualized treatment plan discussed below will assure that patients begin PR with a program tailored to their needs, periodic re-evaluations are necessary to ensure that their psychosocial needs are in fact being met.

(6) Outcomes Assessment

Section 144 of the MIPPA also requires that the PR program include outcomes assessment. In this proposed rule, we define outcomes assessment as an objective clinical measure of the effectiveness of the PR program for the individual patient. Patient-centered outcomes should be measured at the beginning of the PR program, prior to each 30-day review of the individualized treatment plan, and no later than at the end of the PR program. All such assessments are considered part of the PR program and as such are conducted in the appropriate settings and may not be billed separately. These measures should include clinical measures such as a 6-minute walk, weight, exercise performance, self-reported dyspnea (exertional and with daily activities), behavioral measures (supplemental oxygen use, smoking status), and a quality-of-life assessment. Some of the common program outcome measures examined in PR are functional exercise capacity, survival, and ADLs.

(7) Individualized Treatment Plan

Section 144 of the MIPPA requires that the physician develop, sign, and review an individualized treatment plan. In recognizing that PR programs are inherently highly individualized, we are proposing that the physician shall define and set the parameters, including types, amount, frequency and duration of the services, and goals, for the individual's treatment plan that include each of the four component services within the maximum duration of the program. The MIPPA requires the physician to establish the written individualized treatment plan at the start of the program and conduct subsequent reviews every 30 days. This plan may initially be developed by the referring physician or the PR physician. If the plan is developed by the referring physician who is not the PR physician, the PR physician must also review and sign the plan prior to initiation of PR. We would expect the supervising physician to have initial direct contact with the individual prior to subsequent treatment by auxiliary personnel. We would also expect at least one direct contact with the beneficiary in each 30-day period. Regardless, PR staff must provide both outcome and psychosocial assessments to the responsible physician prior to the 30-day deadline. Even if the PR staff makes recommendations for modifications to the program the physician will still be responsible for modifying the plan as needed, and reviewing and signing the plan prior to implementation for the individual. The MIPPA also requires written specificity relating to the type, amount, frequency and duration of items, and services furnished to the individual. Patients with chronic respiratory disease require individual attention, and assessments which address individualized needs must be designed to meet realistic individual goals. Therefore, the individualized plan of care should specify the mix of services necessary to address the patient's needs, as identified through the initial assessment, and based upon changes in the patient's condition. Further, it must include measurable and expected outcomes and estimated timetables to achieve these outcomes. The outcomes specified in the patient plan of care should be consistent with current evidence-based professionally-accepted clinical practice standards.

(8) Settings

In the MIPPA, the Congress has identified 2 appropriate settings for pulmonary rehabilitation, and also authorized the agency to provide additional settings for the PR program. We considered whether these new requirements should extend to CORFs, which are governed by different statutory provisions in section 1861(cc) of the Act. Given the differences in the statutory language, we do not propose extending the PR program requirements to CORFs. Individuals requiring PR program services have a chronic respiratory disease and are in need of supervised aerobic exercise, not physical therapy. Conversely, in the CORF setting physical therapy is the cornerstone component and a mandatory service, while exercise is not. Thus, the PR program is for an inherently different patient population, and allows for the first time, payment for exercise for COPD patients. Therefore, we propose not to include the CORF as a setting for a PR program. The respiratory therapy services performed in a CORF are part of a CORF program of services and not part of a PR program. We would consider the inclusion of additional settings through future rulemaking.

Both physician offices and outpatient settings must meet the standards as defined in the rule for safety and emergency care. These include both the immediate availability of the physician during the PR program and certain equipment requirements. In order to ensure proper safeguards in the statutorily-prescribed settings, the setting must have the cardio-pulmonary, emergency diagnostic and therapeutic equipment accepted as medically necessary by the medical community for emergency treatment related to a chronic respiratory disease condition. Some examples of this equipment are oxygen, defibrillators, and cardio-pulmonary resuscitation equipment. The setting must have all equipment and staff necessary to provide all of the statutorily-mandated items and services. We would expect that any additional settings which may be added through future rulemaking would similarly need to meet all of the aforementioned requirements.

(9) Physician Supervision

Section 144 of the MIPPA includes requirements for immediate and ongoing physician availability and accessibility for both medical consultations and medical emergencies at all times items and services are being furnished under the program. We are proposing to define such availability in accordance with existing definitions for direct physician supervision in physician offices and hospital outpatient departments at § 410.26(a)(2) (defined through cross reference to § 410.32(b)(3)(ii)) and § 410.27(f), respectively. Direct supervision, as defined in the regulations, is consistent with the language of the MIPPA because a physician must be present and immediately available where the services are being furnished. A physician must also be able to furnish assistance and direction throughout the performance of the services, which would include medical consultations and medical emergencies.

For PR services furnished in physicians' offices and other Part B settings paid under the PFS, this means that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service or procedure in accordance with § 410.26(b)(5). It does not mean that the physician must be in the room when the service or procedure is performed. For PR services provided to hospital outpatients, direct physician supervision is the standard set forth in the April 7, 2000 OPPS final rule with comment period (68 FR 18524 through 18526) for supervision of hospital outpatient therapeutic services covered and paid by Medicare in hospitals and provider-based departments of hospitals. We currently define and specify the requirement for direct supervision for services provided in provider-based departments of hospitals at § 410.27(f). For this purpose, the physician must be on the premises of the location (meaning the provider-based department) and immediately available to furnish assistance and

direction throughout the performance of the procedure. This does not mean that the physician must be present in the room when the procedure is performed. If we were to propose future changes to the physician office or hospital outpatient policies for direct physician supervision, we would provide our assessment of the implications of those proposals for the supervision of pulmonary rehabilitation services at that time.

The MIPAA provisions state that in the case of items and services furnished under such a program in a hospital, physician availability shall be presumed. As we have stated in the CY 2009 OPPS/ASC final rule with comment period (73 FR 68702 through 68704), the longstanding presumption of direct physician supervision for hospital outpatient services means that direct physician supervision is the standard and we expect that hospitals are providing services in accordance with this standard.

(10) Physician Standards

The MIPPA authorizes the Secretary to establish standards to ensure that only a physician with expertise in the management of individuals with respiratory pathophysiology and who is licensed by the State where the PR program is offered shall be responsible for the program and direct the individual's progress. We propose to identify the physician who oversees or supervises the PR program in its entirety as the program medical director, and this may be the same physician providing, and billing for, the PR services. We are proposing that the program medical director must have training and proficiency in chronic respiratory disease management and exercise training of chronic respiratory disease patients. We further propose that the standards for program oversight shall include substantial involvement in the monitoring and direction of the patients' progress, and by implication, the staff that assists in furnishing the services. As part of his or her responsibility and accountability for the program, the program medical director will be expected to retain all records and documentation for each beneficiary which are ordinarily compiled in their clinical practice. We propose that the substantiation of the program medical director's expertise in respiratory pathophysiology would correlate to experience in the provision of care for individuals with chronic respiratory diseases. For purposes of referral for PR services, we are proposing to use the definition of ''physician'' specified in section 1861(r)(1) of the Act which defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) of the Act).'' We also propose that a supervising physician must be immediately available and accessible for emergencies and consultations.

(11) Sessions

Currently, PR is conducted with a widely varying number of sessions. We are unaware of any data that specifies an exact number of sessions that should be included in a PR program. However, published professional guidelines generally recommend ranges, typically 2 or 3 sessions per week over a period of 12 to 18 weeks for maximum physiological benefits. This equates to a range of approximately 24 to 54 sessions in total; the mean is 39 sessions. Since the primary goal of PR is to facilitate and encourage independent exercise at home, we believe coverage of 36 sessions in the facility setting is appropriate. Further, the current NCD (20.10) for cardiac rehabilitation allows for initial coverage of up to 36 sessions. Since the goals and objectives of these two programs are similar with respect to the patients' ability to achieve self-management of their diseases, we believe those limits are appropriate here. Therefore, we are proposing to allow up to 36 sessions for services provided in connection with a PR program. Patients should generally receive 2 to 3 sessions per week, which are a minimum of 60 minutes each. We propose to allow no more than one session per day, since these beneficiaries have significant respiratory compromise and would not typically be capable of doing more than one aerobic exercise session. We are especially interested in comments regarding the proposed optimal number of sessions, while acknowledging that each individual has a different degree of need.

(12) Other Items and Services

The MIPPA allows the inclusion of additional items and services as required elements of a PR program, under certain specific conditions. We are not proposing any additional items and services at the present time. We may consider the addition of other items and services through future rulemaking.

d. Coding

We are proposing to create one HCPCS code to describe and to bill for the services of a PR program as specified in section 144(a) of the MIPPA, GXX30, *Pulmonary rehabilitation, including aerobic exercise (includes monitoring), per session per day.* This G-code is to be billed when the patient performs physician-prescribed aerobic exercises that are targeted to improve the patient's physical functioning and may also include the other aspects of pulmonary rehabilitation, such as education and training. Because the physician's role in the PR program is defined in a similar manner to that in the cardiac rehabilitation program, we believe that the physician work component should be analogous to that of CPT code 93797, *cardiac rehab without telemetry.* Therefore we are proposing work RVUs of 0.18 RVUs for this new G-code. Using this same reference code, we are proposing that the malpractice RVUs be 0.01 RVUs.

To establish the PE RVU payment for the proposed new PR G-code, we reviewed the PE inputs of similar services, particularly those of the respiratory therapy HCPCS codes, G0237 and G0238, as well as the cardiac rehabilitation codes, CPT codes 93797 and 93798. Given the various individuals, acting under the supervision of a physician, can make up the PR multidisciplinary team, we believe that the clinical labor for the PR G-code can be best represented by the following labor types taken from the PE database: The nurse ''blend'' (RN/LPN/MTA), the respiratory therapist (RT), the social worker/psychologist and the medical/technical assistant—which we selected to represent various specialists involved in furnishing this service; these are valued at $0.37, $0.42, $0.45, and $0.26 per minute, respectively. Using an average of these values, $0.375 per minute, we are proposing to use the nurse blend labor type found in the cardiac rehabilitation CPT codes, at $0.37 per minute, as the typical value for the PR clinical labor and assigning 28 minutes of clinical labor time for the new PR G-code based on the various components of the proposed PR program.

For the equipment PE inputs, we reviewed the direct PE inputs for similar existing codes and are proposing a pulse oximeter (with printer), a 1-channel ECG, and a treadmill. Since no typical supplies were listed for similar existing codes in the PE database, we have not proposed any specific supplies for this proposed new G-code.

10. Section 152(b): Coverage of Kidney Disease Patient Education Services

Section 152(b) of the MIPPA provides for coverage of kidney disease education (KDE) services for patients. The

following is an outline of our proposals to implement the statutory amendments.

a. Background

The kidneys have several life-sustaining functions. Waste and excess fluid is removed by the kidney through filtration and the concentration of salt and minerals in the blood is maintained. Additionally, the kidneys help regulate blood pressure, are involved in the process of red blood cell production, and are needed for bone health. When kidneys are damaged, these functions are impaired.

Kidney damage can occur for a variety of reasons and may develop quickly (acute renal failure) or slowly. By definition, chronic kidney disease (CKD) is kidney damage for 3 months or longer, regardless of the cause of kidney damage. CKD typically evolves over a long period of time and patients may not have symptoms until significant, possibly irreversible, damage has been done. Complications can develop from kidneys that do not function properly, such as high blood pressure, anemia, and weak bones.

When CKD progresses, it may lead to kidney failure, which requires artificial means to perform kidney functions (that is, dialysis) or a kidney transplant to maintain life. There are tests to help detect kidney disease. Currently, the most important measurement of kidney function is called glomerular filtration rate (GFR) and is a measure of how quickly blood is filtered through the kidney's filter, which is called the glomeruli.

Patients can be classified into 5 stages based on their GFR, with Stage 1 having kidney damage with normal or increased GFR to stage 5 with kidney failure, also called end-stage renal disease (ESRD). Once patients with CKD are identified, treatment is available to help prevent complications of decreased kidney function, slow the progression of kidney disease, and reduce the risk of other diseases such as heart disease.

While predicting the timing of progression from stage IV CKD to kidney failure is difficult due to the lack of data, anticipatory objective information for the stage IV CKD patient is critical for management of comorbidities, prevention of uremic complications, and informed decision-making about renal replacement options and their respective benefits and risks. Collins notes from United States Renal Data System (USRDS) data from 2007 that ''despite the large number of patients with varying stages of CKD, only approximately 100,000 reach end-stage renal disease (ESRD) annually in the United States.'' [6] CKD primarily affects the elderly and commonly coexists with other chronic diseases including hypertension, diabetes, and cardiovascular disease. Consequently, the risk of mortality and morbidity are increased substantially with advancing CKD stages.

Individuals with CKD may benefit from educational interventions due to the large amount of medical information that could affect patient outcomes including the increasing emphasis on self-care and patients' desire for informed, autonomous decision-making. There is evidence that many pre-dialysis patients lack knowledge about their condition and may develop a sense of despair regarding their condition. Pre-dialysis education can help patients achieve better understanding of their illness, dialysis modality options, and may help delay the need for dialysis. Education interventions should be patient-centered, encourage collaboration, offer support to the patient, and be delivered consistently.

b. Statutory Authority

Section 152(b) of the MIPPA amended section 1861(s)(2) of the Act by adding a new subparagraph (EE) ''kidney disease education services'' as a Medicare-covered benefit under Part B. This new benefit is available for Medicare beneficiaries diagnosed with Stage IV CKD, who in accordance with accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. KDE services will be designed to provide comprehensive information regarding:

- The management of comorbidities, including delaying the need for dialysis;
- Prevention of uremic complications;
- Options for renal replacement therapy (including hemodialysis and peritoneal dialysis, at home and in-center, as well as vascular access options and transplantation);
- Ensuring that the beneficiary has the opportunity to actively participate in his or her choice of therapy; and
- Tailored to meet the needs of the beneficiary involved.

c. Public Meetings

Section 1861(ggg)(3), as added by section 152(b) of the MIPPA, requires that the Secretary set standards for the content of the KDE services after consulting with various stakeholders, who to the extent possible, had not received industry funding from a drug or biological manufacturer or dialysis facility. On November 6, 2008, and December 16, 2008, we held two feedback sessions to solicit stakeholder comments regarding the implementation of section 152(b) of the MIPPA. Both feedback sessions were open to the public. In addition to the feedback sessions, we conducted an internal review of the available medical evidence, literature, and currently available CKD patient education programs. Transcripts from both events are available on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/08_CKD.asp#TopOfPage*.

(1) The November 6, 2008 Feedback Session

The first feedback session was conducted as a Special Open Door Forum (ODF) at the CMS Headquarters on November 6, 2008. Approximately 200 people, representing approximately 70 organizations, participated via teleconference.

The majority of stakeholders cited the National Kidney Foundation Disease Outcomes Quality Initiative (NKF KDOQI) guidelines that define Stage IV CKD as a GFR measurement of 15–29 ml/min/1.73m^2, for purposes of classification and evaluation of CKD. Stakeholders recommended a variety of modalities for providing education services. One-on-one sessions between the educator and the patient were recommended to facilitate comprehension of the information. Stakeholders indicated that diagnoses of CKD can be devastating for some patients and patient outbursts, crying, and other disruptions can derail the educational process for large groups. Since all patients do not have the same learning styles or need for information, one stakeholder recommended that each individual be assessed by the treating physician or nonphysician practitioner (NPP) under the supervision of the treating physician for their learning needs and style preferences before or upon referral for KDE services.

Some stakeholders suggested that group education sessions would be appropriate and beneficial for patients, but did not comment specifically on the applicability to the Medicare population. Stakeholders reported that within existing programs, patients were going through a shared experience and group sessions helped facilitate discussion. Other stakeholders recommended that initial education sessions be performed in a group setting, with one-on-one follow-up sessions. We received recommendations

[6] Collins AJ, *et al.* ''Who Should be Targeted for CKD Screening? Impact of Diabetes, Hypertension, and Cardiovascular Disease.'' *American Journal of Kidney Diseases,* Vol 53, No 3, Suppl 3 (March), 2009: pg. S71.

regarding session length from 15 minutes to 2 hours, or as long as deemed necessary by the educator or the patient.

Some stakeholders recommended against using the Web or telemedicine since these modalities may not be appropriate or facilitate effective comprehension of material in older adults. Other stakeholders indicated that we needed to keep in mind that a patient's uremia may impair comprehension of the materials, that these patients are sick, and that the elderly often need to have information provided in a simplistic, repetitive manner.

Regarding the clinically appropriate topics and content standards for KDE services, various stakeholders indicated that the following information should be included in the curriculum:

- Basic overview of kidney functions and CKD pathophysiology.
- Survival rates based on choice of treatment or if the patient declines treatment.
- Quality of life and psychosocial adjustments.
- Structured, unbiased, uniform information about all renal replacement modalities, with no appropriateness assumptions presented by the educator.
- The right to decline treatment.
- Evidence-based content.
- Prolonging remaining kidney function.
- Patient participation in management of kidney disease.
- Sexuality and fertility issues.
- Transplant options.
- Smoking cessation.
- Medication compliance.
- Financial support and insurance coverage.
- Diet and exercise.
- Vocational rehabilitation.
- Treatment and management of comorbidities.

(2) The December 16, 2008 Feedback Session

On December 16, 2008, the second feedback session was hosted at the Agency for Healthcare Research and Quality (AHRQ). Approximately 60 people representing approximately 40 organizations participated. In preparing for this meeting, we researched and developed a list of approximately 30 experts and educators that are currently providing kidney disease education to individuals or treating patients with CKD, only 10 of which were able to participate. To accommodate those stakeholders that were unable to attend the AHRQ stakeholders meeting, we accepted additional feedback at the following e-mail address: *CKDEducation@cms.hhs.gov*.

We asked each meeting attendee to fill out a disclosure statement that described any industry funding he or she had received from a drug/biological manufacturer or dialysis facilities, since the MIPPA requested that we consult with various stakeholders, to the extent possible, that had not received such industry funding. The majority of the meeting participants or the organizations represented had received industry funding with few exceptions.

When asked about the accepted clinical criteria for classifying someone with Stage IV CKD, most stakeholders stated that Stage IV CKD is best defined as an individual with an estimated GFR of between 15 and 29 or 30 ml/min/1.73m^2. One stakeholder suggested that to decrease variability between creatinine methodologies, they recommended using a laboratory that traces its serum creatinine technique to IDMS (Isotope dilution mass spectrometry reference measurement procedure). This stakeholder also indicated that the MDRD (modification of diet in renal disease) study equation has been slightly modified to account for labs that are traceable to IDMS.

We asked the stakeholders to report on the different modalities of education that would be appropriate for kidney disease patient education. One stakeholder indicated that considerations need to be made regarding the educational needs of different communities and cultures. Several stakeholders indicated that face-to-face or group sessions are the preferred modalities for providing education services. One stakeholder indicated that groups larger than 20 may make it harder for all participants to ask questions. Stakeholders recommended that we allow flexibility to balance the needs of individual CKD patients that have varying degrees of need for information and education. Several stakeholders indicated that curriculum content should include information regarding all renal replacement therapy options (including no treatment), vascular access options, available support services, and management of co-morbidities including diabetes, blood pressure management, bone disease, and mineral metabolism.

Stakeholders recommended numerous frequency and duration combinations. One stakeholder recommended a variety of combinations of six 1-hour classroom group sessions including one session per week (over a 6-week period); six sessions over a weekend (3 sessions on Saturday; 3 sessions on Sunday); or all 6 sessions on 1 day during a weekend. This stakeholder also recommended that sessions should be standardized so that an individual can take sessions when they are offered to meet their scheduling needs. Stakeholders recommended sessions that lasted between 15 minutes and 2.5 hours. One stakeholder indicated that pre- and post-assessments should be included as part of the education programs.

When asked what factors in existing education programs have led to the best patient outcomes, we received a variety of responses such as varying the training format, providing information repetitively, and presenting information at the appropriate reading level for the audience. Stakeholders recommended that all aspects of the education services be provided in an objective and neutral manner, not skewing the information toward one or more renal replacement therapy modalities.

d. Implementation

Consistent with section 1861(ggg) of the Act, we are proposing to amend 42 CFR part 410 to add new § 410.48 for KDE services as a Medicare Part B benefit.

(1) Definitions (proposed § 410.48(a))

As related to the implementation of section 1861(ggg) of the Act, we are proposing the following definitions in § 410.48:

- Kidney Disease Patient Education Services: Consistent with section 1861(ggg)(1) of the Act, we are proposing to define Kidney Disease Patient Education Services as face-to-face educational services provided to patients with Stage IV CKD. We are proposing that the services be provided in a face-to-face manner based on stakeholder feedback received during the consultation meetings and our general rulemaking authority. Face-to-face education is consistent with sections 1861(ggg)(C)(ii) and (iii) of the Act, which provide that the services should be designed to ensure that the beneficiary has the opportunity to actively participate in the choice of therapy, and that the services be designed to be tailored to meet the needs of the beneficiary involved.

Some stakeholders recommended that sessions be conducted face-to-face due to varying patient literacy levels. Other stakeholders recommended against using Web-based education resources since the elderly may not be as comfortable with or lack access to the Internet. In light of these considerations, we believe that face-to-face education services are the most appropriate means for providing these services.

- *Physician:* For purposes of KDE services, a physician will be defined using the definition in section 1861(r)(1)

of the Act; it defines ''physician'' as ''a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he or she performs such function or action (including a physician within the meaning of section 1101(a)(7) [of the Act].''

• *Qualified Person:* Consistent with section 1861(ggg)(2)(A) of the Act, for purposes of KDE services, we are proposing to define a ''qualified person'' as a physician (as defined in section 1861(r)(1) of the Act); a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act, and implemented in § 410.74, § 410.75, and § 410.76 of this subpart). A provider of services located in a rural area is also included in the statute's definition of a qualified person. Section 1861(u) of the Act defines ''provider of services'' to be ''a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program or, for purposes of sections 1814(g) and section 1835(e) [of the Act], a fund''. We are proposing to define a ''qualified person'' to include a provider of services located in a rural area and would include each of these healthcare entities except for a ''fund.''

We do not believe that it would be appropriate to recognize a fund described by sections 1814(g) and 1835(e) of the Act as a ''qualified person''. These funds are defined as providers of services only for the limited purpose of paying for the services of faculty physicians when they furnish certain services under the authority of sections 1814(g) and 1835(e) of the Act. These funds are not licensed as hospitals; they do not bill Medicare and do not receive payment. Moreover, these funds do not comply with Medicare conditions of participation and do not have provider agreements with Medicare. Because we do not believe that it would be appropriate to include ''funds'' in the definition of a ''qualified person'' for purposes of the KDE benefit, we are proposing to exclude funds described by sections 1814(g) and section 1835(e) of the Act from our definition of a provider of services located in a rural area as defined in section 1886(d)(2)(D) of the Act.

In order for a provider of services to be a ''qualified person,'' the entity must be located in a rural area. We are proposing to include in the definition of a ''qualified person'', only those hospitals, critical access hospitals (CAHs), skilled nursing facilities (SNFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), and hospice programs that are located in a rural area under section 1886(d)(2)(D) of the Act (as defined in our regulations at § 412.64(b)(ii)(C)) and to include hospitals and CAHs that are reclassified from urban to rural status pursuant to section 1886(d)(8)(E) of the Act, as defined in § 412.103. Specifically, § 412.64(b)(ii)(C) defines ''rural'' to mean any area outside an urban area, which § 412.64(b)(ii)(A) defines as a metropolitan statistical area (MSA) as defined by the President's Office of Management and Budget (OMB). Therefore, we believe that a hospital, CAH, SNF, CORF, HHA, or hospice program that is not physically located in an MSA should be considered ''rural'' for this benefit.

Section 1886(d)(8)(E) of the Act, implemented in § 412.103, requires us to treat hospitals that meet specified criteria as geographically rural under section 1886(d)(2)(D) of the Act even though they are physically located in an MSA. Because the statute identifies these hospitals as rural, we believe that it is appropriate to consider these hospitals a qualified person for purposes of the KDE benefit. The Conditions of Participation for CAHs in § 485.610 also include a provision to allow a hospital located in an urban area to reclassify as rural for purposes of becoming a CAH through section 1886(d)(8)(E) of the Act, as defined in § 412.103. Because a hospital or CAH specified under section 1886(d)(8)(E) of the Act is treated as being located in a rural area under section 1886(d)(2)(D) of the Act, we are proposing to recognize those hospitals or CAHs as a ''qualified person'' for purposes of the KDE benefit.

• *Renal Dialysis Facility:* The Congress has provided in section 1861(ggg)(2)(B) of the Act that a ''renal dialysis facility'' may not be a ''qualified person.'' We are defining this term, consistent with § 405.2102 of this title, as ''a unit which is approved to furnish dialysis service(s) directly to ESRD patients.''

• *Stage IV Chronic Kidney Disease:* Section 1861(ggg)(1)(A) of the Act states that KDE services shall be furnished to beneficiaries diagnosed with Stage IV CKD, who according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant. Based on stakeholder feedback, we are proposing to define Stage IV CKD as kidney damage with a severe decrease in GFR quantitatively defined by a GFR value of 15–29 ml/min/1.73 m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.[7] Because there are currently no agreed upon accepted clinical guidelines that describe the stage IV patients who would eventually require dialysis or a kidney transplant, we are proposing to cover all stage IV patients.

During both the November 6, 2008, and the December 16, 2008 feedback sessions, the majority of stakeholders indicated that Stage IV CKD is currently determined as kidney damage with a severe decrease in the estimated GFR value (15 to 29 mL/min/1.73 m^2). While there appeared to be agreement among the stakeholders regarding the estimated GFR values for the diagnosis of Stage IV CKD, some stakeholders indicated that only using the estimated GFR value to determine the severity of a beneficiary's CKD may be insufficient. To decrease variability between creatinine methodologies, stakeholders recommended using a laboratory that traces its serum creatinine technique to IDMS and that the MDRD study equation has been slightly modified to account for labs that are traceable to IDMS.

(2) Covered Beneficiaries (Proposed § 410.48(b))

Consistent with section 1861(ggg)(1)(A) of the Act, we are proposing that KDE services be furnished to beneficiaries with Stage IV CKD based on the definition of Stage IV CKD defined in proposed § 410.48(a), and have been referred for such services by the physician managing the beneficiary's kidney condition.

(3) Standards for Qualified Persons and Exclusions (Proposed § 410.48(c))

We are proposing to require that a qualified person be able to properly receive Medicare payment under 42 CFR part 424 (Conditions for Medicare Payment). In § 410.48(c), we are proposing to establish exclusions from the term ''qualified person.'' Consistent with section 1861(ggg)(2)(B) of the Act, we specifically exclude a hospital, CAH, SNF, CORF, HHA, or hospice that is physically located outside of a rural area under § 412.64(b)(ii)(C), except for a hospital or CAH that is treated as being located in a rural area under § 412.103. In addition, consistent with section 1861(ggg)(2)(B) of the Act, a renal dialysis facility is not a qualified person.

While we are not proposing specific education, experience, training, and/or certification requirements at this time,

[7] Levey, A.S., Greene, T., Kusek, J., and Beck, G.A. J Am Soc Nephrol. 2000. 11: p. 155A.; Levey, A.S., Bosch, J.P., Lewis, J.B., Greene, T., Rogers, N., and Roth, D. Ann Intern Med. 1999 Mar 16; 130(6):461–70.

we are specifically seeking public comments on the appropriate level of education, experience, training, and/or certification appropriate for a qualified person to effectively provide KDE services and may provide such provisions in the final issuance of this rule or in future rulemaking. Factors to consider include specific education and expertise regarding the topic and ability to explain these areas for the purpose of patient education:

- General kidney physiology and test results that would be associated with CKD.
- Psychological impact of the disease on the beneficiary, and impact on family, social life, work, and finances.
- The management of comorbidities (such as cardiovascular disease, diabetes, hypertension, anemia, bone disease, and impairments in functioning) common in persons diagnosed with CKD.
- Renal replacement therapeutic options, treatment modalities and settings, and advantages and disadvantages of each treatment option.
- Diet, fluid restrictions, and medication usage to include side effects and informed decisionmaking.
- Encouragement of patient active participation in decisionmaking and the ability to tailor educational needs to the individual beneficiary.
- Other areas of health deemed important to patients with CKD.

(4) Standards for Content of Kidney Disease Patient Education Services (Proposed § 410.48(d))

We believe that patient education needs vary by severity of the disease, the age of the patient, the patient's comorbid conditions and disabilities, the patient's primary language and culture, and desire to learn more about the disease and treatment options. Education services are more effective if the services are tailored to meet an individual beneficiary's needs. We are proposing that KDE services include the content as specified in proposed § 410.48(d). According to an article by Paula Ormandy [8] in the *Journal of Renal Care*, patients are most interested in receiving information on the following topics, which was echoed by many stakeholders during the feedback sessions.

- Basic information regarding CKD, how the kidneys work, what happens when the kidneys fail, and the permanence of the disease.
- Survival rates with and without renal replacement therapy and survival rates if the patient refused treatment for their CKD.
- The need for kidney transplantation.
- Unbiased information about renal replacement therapy (RRT) options including advantages and disadvantages for all modalities.
- Adequate information regarding why some RRT options were not viable for a patient.
- How different RRT options affected the patient's co-morbid conditions.
- Effect of RRT choices on lifestyle, such as treatment flexibility and treatment session length.
- Whether a patient will need assistance based on RRT modality choice and training requirements for helpers.
- The right to refuse treatment.
- Effects of the disease, and the subsequent treatment, on the patient's physical appearance.
- Patient recognition of the symptoms that would empower the patient with the knowledge to seek help.
- Disease and treatment complications related to renal replacement therapy such as hypertension, catheter migration, temporary/permanent loss of dialysis access, and risk of infection at the access sight.
- How to control and manage consequences of complications and symptoms (*for example:* treatment for itchy skin or insomnia).
- The ability to travel and organize holidays depending on RRT choice.
- Maintenance of social relationships, activities, and commitments.
- How the disease and RRT may affect the patient's ability to continue working.
- Available support services.
- Medication management, including side effects and risks related to non-compliance to prescribed medication regimen.

(5) Session Specifications (Proposed § 410.48(e))

(a) *Limitations on the number of sessions:* Consistent with section 1861(ggg)(4) of the Act, we will limit the number of KDE sessions to six (6).

(b) *Session Length:* In the absence of supporting evidence for session length, we are proposing to define the session length as 60 minutes which coincides with the session length of some programs in existence and is the approximate average of stakeholder suggested session lengths.

(c) *Individual and Group Session Format:* Consistent with section 1861(ggg)(C)(iii) of the Act, we are proposing that the qualified person tailor the design of the education services to meet the needs of the beneficiary based on whether the beneficiary needs more individualized education, would benefit more from a group environment, or a combination; and consider any communication accessibility needs based on disability, language and health literacy.

During the feedback sessions, we received a variety of recommendations regarding how education services should be provided, including a combination of group sessions, one-on-one sessions, and multi-media presentations. Stakeholders recommended that one-on-one sessions, between the beneficiary and the educator, facilitated quicker comprehension of the education materials than group sessions, and provided the best opportunity to tailor the sessions to meet the patient's needs. Other stakeholders indicated that group sessions provide patients with the benefit of responses to questions posed by different group participants.

Medical services, generally speaking, are provided to beneficiaries on an individual basis. Beneficiaries can also benefit from the interaction in a group setting. We believe that the beneficiary, in consultation with the referring physician, will be able to best determine the education services modality that most effectively meets his or her needs.

(6) Outcomes Assessment

The intent of the education services is for the beneficiary to take the information he or she has learned during the educational sessions in order to facilitate active participation by the beneficiary in the healthcare decisionmaking process with the physician managing his or her kidney condition. We believe that it is important that beneficiaries be assessed at the conclusion of the education sessions and are proposing that program assessments be used by the educators and CMS to assess the effectiveness of the education services, to help improve the programs for future participants, and better facilitate patient understanding of the material.

During the AHRQ stakeholders meeting, various stakeholders indicated that it was important to monitor the effectiveness of the education services to improve the content and delivery of KDE services. Assessing the effectiveness of the KDE services through assessments can be an effective way of measuring how beneficiary needs are being met. Some existing education programs have pre- and post-education session assessments and are usually administered immediately

[8] Ormandy, P., ''Information Topics Important to Chronic Kidney Disease Patients: A Systematic Review.'' *Journal of Renal Care* 34(1), 19–27, 2008.

following the conclusion of the education sessions.

We are proposing, based on stakeholder feedback and our general rulemaking authority, that qualified persons develop outcomes assessments and that each beneficiary be assessed during one of the education sessions. We are proposing that the outcomes assessment measure beneficiary knowledge about CKD and its treatment for the purpose, and as a contributor to, the beneficiary's ability to make informed decisions regarding their healthcare and treatment options.

According to an article by Gerald Devins in the *Journal of Clinical Epidemiology*, an outcomes assessment or test should be able to ''measure the adaptive value of ESRD-related knowledge as a contributor to psychosocial and physical well-being, * * * reliably and validly assess patient knowledge about ESRD and its treatment,'' * * * ''be easy to administer and score,'' and * * * ''require only basic reading skills.'' [9]

After completing the KDE services, the beneficiary should be able to take the information learned and use it to make informed choices about their healthcare during future consultations with the physician managing the beneficiary's kidney condition. It is important that the assessments be tailored to the beneficiary's reading level and language if the assessment is not administered by the qualified person that provided the education services, and be made available to CMS in a summarized format upon request.

We are specifically seeking public comments regarding the development and administration of the outcomes assessments. Factors to consider include:

- Specific topics that should be included as part of the assessment;
- Whether standardization of the outcomes assessment is feasible and/or should be considered;
- The applicability of any standardized assessments that may currently be in existence;
- The feasibility of providing both pre- and post-education assessments; and
- Methods for collecting assessments and disseminating best practices for KDE services.

e. Payment for KDE Services

Section 152(b) of the MIPPA creates a new benefit category for KDE services. The MIPPA amends section 1848(j)(3) of the Act, which allows for payment of KDE services under the PFS. KDE services are covered when they are furnished by a qualified person as defined in proposed § 410.48(a) and that meets the requirements of proposed § 410.48(c). We note that there is a possibility that a beneficiary may receive services from more than one ''qualified person''; however, payment should be made to only one qualified person on the same day for the same beneficiary.

The ''incident to'' requirements for physician services at section 1861(s)(2)(A) of the Act do not apply to KDE services because the MIPPA requirements are explicit, in that the education services must be provided by a qualified person, which is defined as a physician, nurse practitioner, clinical nurse specialist or physician assistant, and also includes a provider of services located in a rural area. In the past, we have taken the position that the ''incident to'' provision does not apply to the implementation of a new service with a distinct benefit category under the PFS. Therefore, the ''incident to'' requirements will not apply to KDE services.

Rural health clinics (RHCs) do not meet the statutory definition of a provider of services (as defined in 1861(u) of the Act) and cannot be separately paid for furnishing KDE services.

Section 1861(ggg)(4) of the Act limits the number of KDE services that a beneficiary may receive to six sessions. We are proposing to create two HCPCS codes, GXX26 (individual) and GXX27 (group), to describe and to bill for KDE services. The two G-codes consist of 1-hour face-to-face KDE services for an individual or group. We are proposing to pay both GXX26 and GXX27 at the nonfacility rate. We are also proposing that GXX26 educational services related to the care of chronic kidney disease; individual per session will be crosswalked to CPT code 97802; and that GXX27, educational services related to the care of chronic kidney disease; group, per session will be crosswalked to CPT code 97804. The rationale for the proposed pricing of the G-codes is based on the similarity of this service to medical nutrition therapy in the individual (97802) and group (97804) setting.

In the CY 2010 OPPS/ASC proposed rule, we discuss our proposed payment for KDE to qualified persons who are hospitals, CAHs, SNFs, CORFs, HHAs, or hospices. Commenters should submit specific comments on our payment proposal for this benefit, including the method and amount of payment, for qualified hospitals, CAHs, SNFs, CORFs, HHAs, or hospices in response to the CY 2010 OPPS/ASC proposed rule. We will discuss our final payment policy for these qualified providers in the CY 2010 OPPS/ASC Final Rule.

f. Effective Date

Medicare Part B coverage of outpatient kidney disease patient education services will be effective for services furnished on or after January 1, 2010.

11. Section 153: Renal Dialysis Provisions

Section 153 of the MIPPA requires changes to ESRD facilities for ESRD services effective January 1, 2010. The following is a summary of these changes.

Section 153(a)(1) of the MIPPA increases the current ESRD composite rate by 1.0 percent for services furnished on or after January 1, 2010. This also requires us to update the adjusted drug add-on. Since we compute the drug add-on adjustment as a percentage of the composite rate, the drug add-on percentage is decreased to account for the higher CY 2010 composite payment rate and results in a 15.0 percent drug add-on adjustment for CY 2010. As a result, the drug add-on amount of $20.33 per treatment remains the same for CY 2010, which results in a 15.0 percent increase to the base composite payment rate of $135.15. (*See* section II.I.6. of this proposed rule for further discussion.)

The composite rate paid to hospital-based facilities will be the same as the composite rate paid to independent renal dialysis facilities for services furnished on or after January 1, 2010. In addition, section 153(a)(2) of the MIPPA requires that in applying the geographic index to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.

These MIPPA provisions are self-implementing and require no substantive exercise of discretion on the part of the Secretary. A detailed discussion of the MIPPA provisions can be found in section III. of the CY 2009 PFS final rule with comment period (73 FR 69881).

[9] Devins, G., *et al.* ''The Kidney Disease Questionnaire: A Test for Measuring Patient Knowledge about End-Stage Renal Disease.'' *J Clin Epidemiol.* Vol. 43, No. 3. pp. 297–307, 1990.

12. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-cancer Chemotherapeutic Regimen

a. Background

(1) Process for Revising the List of Statutorily Named Compendia

Generally, compendia are ''pharmacopeia providing information on drugs, their effectiveness, safety, toxicity, and dosing—are frequently used to determine whether a medication has a role in the treatment of a particular disease; these roles include both therapeutic uses approved by the U.S. Food and Drug Administration (FDA) and off-label indications'' (Agency of Healthcare Research and Quality (AHRQ), *Potential Conflict of Interest in the Production of Drug Compendia White Paper*).[10] Compendia are published by various institutions and by traditional reference book publishing houses.

Section 1861(t)(2)(B)(ii)(I) of the Act lists the following compendia as authoritative sources for use in the determination of a ''medically-accepted indication'' of drugs and biologicals used off-label in an anticancer chemotherapeutic regimen: American Medical Association Drug Evaluations (AMA–DE); United States Pharmacopoeia-Drug Information (USP–DI) or its successor publication; and American Hospital Formulary Service-Drug Information (AHFS–DI). Due to changes in the pharmaceutical reference industry, AHFS–DI is the only statutorily-named compendium that is currently in publication.

In addition to these compendia, the statute provides an alternative method for identifying medically-accepted off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Section 1861(t)(2)(B)(ii)(II) of the Act provides that local contractors may use ''supportive clinical evidence in peer-reviewed medical literature'' to make such determinations. Thus these medically-accepted uses could be identified even if there were no compendia recognized for this purpose. We discussed this in our response to comments in the CY 2008 PFS final rule with comment period (72 FR 66305).

Section 1861(t)(2)(B) of the Act provides the Secretary the authority to revise the list of compendia in section 1861(t)(2)(B)(ii)(I) for determining medically-accepted indications for off-label use of drugs and biologicals in an anti-cancer chemotherapeutic regimen. Consequently, in § 414.930, we established an annual process to revise the list and establish a definition of ''compendium'' in the CY 2008 PFS final rule with comment period (72 FR 66222, 66303 through 66306, and 66404).

On March 30, 2006, the Medicare Evidence Development and Coverage Advisory Committee or MEDCAC (formerly the Medicare Coverage Advisory Committee (MCAC)) met in public session to advise CMS on the appropriate criteria for the recognition of compendia for the identification of medically-accepted indications of drugs and biologicals used in an anti-cancer therapy, and the degree to which the then listed and other available compendia displayed those criteria. The evidence the MEDCAC considered to derive its recommendations included a presentation of the technology assessment (TA) performed for AHRQ by staff of the Tufts-New England Medical Center (Tufts-NEMC) and Duke Evidence-based Practices Centers (EPCs), scheduled stakeholder presentations, as well as testimony from members of the public. As is customary, the MEDCAC panelists elicited additional information from the presenters and discussed the evidence in preparation for a formal vote. The MEDCAC recommended that the following criteria, referred to as ''desirable characteristics,'' should be used to recognize compendia for identification of medically-accepted indications of drugs and biologicals in anti-cancer therapy:

- Extensive breadth of listings.
- Quick processing from application for inclusion to listing.
- Detailed description of the evidence reviewed for every individual listing.
- Use of pre-specified published criteria for weighing evidence.
- Use of prescribed published process for making recommendations.
- Publicly transparent process for evaluating therapies.
- Explicit ''Not recommended'' listing when validated evidence is appropriate.
- Explicit listing and recommendations regarding therapies, including sequential use or combination in relation to other therapies.
- Explicit ''Equivocal'' listing when validated evidence is equivocal.
- Process for public identification and notification of potential conflicts of interests of the compendia's parent and sibling organizations, reviewers, and committee members, with an established procedure to manage recognized conflicts.

We incorporated the MEDCAC recommended desirable characteristics into the compendia review process. All information on this MEDCAC meeting can be found on the CMS Web site at *http://www.cms.hhs.gov/mcd/viewmcac.asp?where=index&mid=33*.

Although we did not rank these ten MEDCAC desirable characteristics, the MEDCAC desirable characteristics that addressed transparency and conflict of interest of compendia were considered to be of high priority (72 FR 66304 through 66305). In addition, we considered the need to enhance transparency in the compendia review process to preserve the integrity of the review process (72 FR 66222, 66303 through 66306, and 66404).

During the 2008 compendium review cycle, we considered requests regarding the following five compendia: The AMA–DE Compendium; National Comprehensive Cancer Network Drugs and Biologics (NCCN) Compendium; Thomson Micromedex DrugDex Compendium; Thomson Micromedex DrugPoints Compendium; and Clinical Pharmacology Compendium. Our decisions are posted on the CMS Web site at *http://www.cms.hhs.gov/CoverageGenInfo/02_compendia.asp#TopOfPage*. In summary, we issued the following decisions regarding those compendia requests:

- NCCN was added to the list of compendia.
- Thomson Micromedex DrugDex was added to the list of compendia.
- Clinical Pharmacology was added to the list of compendia.
- Thomson Micromedex DrugPoints was not added to the list of compendia.
- AMA–DE was removed from the list of compendia.

(2) MIPPA Requirement for Compendia

Section 182(b) of the MIPPA amended section 1861(t)(2)(B) of the Act (42 U.S.C. 1395x(t)(2)(B)) by adding the sentence, ''On and after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.'' There is a growing body of literature, including that from the Institute of Medicine (IOM),[11] that discusses the conflict of interest between research funding and

[10] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64*.

[11] Institute of Medicine. Conflict of Interest in Medical Research, Education, and Practice. Available online at *http://www.nap.edu/catalog.php?record_id=12598*.

research results. Some authors have stated that there is a conflict of interest if an entity has a financial, legal, or political interest that is counterproductive to the performance of their legal or ethical responsibilities.[12] Although this widely discussed correlation depicts a classic representation of a financial conflict of interest, we believe nonfinancial conflicts of interests also deserve attention. Nonfinancial conflicts of interests have the potential to interfere with honest reporting, transparency and fair review of applications submitted to compendia publishers.[13] Therefore, in light of such concerns, the existence of financial and nonfinancial conflicts of interests would threaten the impartiality of the recommendations made in the compendia. We believe that section 182(b) of the MIPPA, ''Revision of definition of medically-accepted indication for drugs * * * Conflict of Interest'' is designed, in part, to address this issue in the compendia review process.

(3) Proposed Revisions of Compendia Standards

We believe that the implementation of this statutory provision that compendia have a ''publicly transparent process for evaluating therapies and for identifying potential conflicts of interests'' is best accomplished by amending the current definition of a compendium at § 414.930(a) to include the MIPPA requirements and by defining the key components of publicly transparent processes for evaluating therapies and for identifying potential conflicts of interests. In order to implement the MIPPA requirements concerning a publicly transparent process for evaluating therapies, we propose that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site. This mode of publication provides broad contemporaneous public access to relevant materials. We believe that public access to such materials will increase transparency of the process used by compendia publishers for evaluating therapies and facilitate independent review of recommendations by interested parties. In addition, as discussed in the CY 2008 PFS final rule with comment period (72 FR 66305 through 66306), such disclosure may assist beneficiaries and their physicians in choosing among treatment options.

As expressed in the February 14, 2008 letter from the U.S. Senate Committee on Finance to the CMS Acting Administrator Kerry Weems, ''conflicts of interest have been proven in peer-reviewed studies to have a significant impact on scientific outcomes and medical care.'' [14] Since compendia recommendations are generally dependent on evidence from peer-reviewed studies, we believe that conflicts of interests may arise from relationships between individuals who substantively participate, such as individuals who contribute more than a clerical role, in the development of compendia recommendations and the applicants (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium) for the inclusion of drug or biological recommendations in compendia. These relationships may involve, for example, publishers of compendia and peer-reviewed journals, their editorial or advisory boards, drug manufacturers, physicians or providers that derive income from the prescribing or administration of drugs, researchers that have a personal or academic interest in the drug study, or others who may provide incentives to influence the prescribing behaviors of physicians.[15] As illustrated in the AHRQ *Potential Conflict of Interest in the Production of Drug Compendia* White Paper, these potential financial and nonfinancial conflicts exist at the various stages of the evaluation process. The White Paper also describes compendia publication users (for example, the public, physicians, other caregivers, and public/private insurers) and the objectives of each user when referencing the compendia. Therefore, these potential financial and nonfinancial conflicts may be problematic for users of the compendia to rely on the validity of the compendia recommendations.[16]

Section 182(b) of the MIPPA requires a publicly transparent process for: (1) Evaluating therapies, and (2) identifying potential conflicts of interests. In light of these provisions, we are proposing regulatory safeguards to require that the publicly transparent process for evaluating therapies and identifying potential conflicts of interests include disclosure of certain relevant information. All currently listed compendia will be required to comply with these provisions, as of January 1, 2010, to remain on the list of recognized compendia. We view compendia publishers as generally responsible for the integrity of their publications. Therefore, we urge currently listed compendia publishers to submit evidence demonstrating compliance with the MIPPA provisions that ''no compendia may be included on the list of compendia'' unless the compendium has a publicly transparent process for therapy evaluation and conflict of interest identification to CMS no later than December 31, 2009. In addition, any compendium that is the subject of a future request for inclusion on the list of recognized compendia will be required to comply with these provisions. We believe that the statute is clear that no compendium can be on the list if it does not fully meet the standard described in section 1861(t)(2)(B) of the Act, as revised by section 182(b) of the MIPPA.

b. Revisions to § 414.930, ''Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen''

We are proposing the following amendments to § 414.930(a):

- To revise the definition of ''compendium'' by adding an additional requirement that a compendium have a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.
- To add the definition of ''publicly transparent process'' for evaluating therapies. We propose that assurance of a publicly transparent evaluation process is best achieved by establishing a process that provides for public disclosure of the evidence considered and the review of that evidence leading to the development of compendia recommendations.[17] By providing for this disclosure, we hope to ensure validity in the use of compendia for identifying medically-accepted uses of off-label treatments for purposed of section 1861(t)(2)(B) of the Act. Thus, we believe that in the interest of providing a publicly transparent process

[12] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy, Science & Law.* 7:1–16.

[13] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299–1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[14] United States Senate Committee on Finance Correspondence. (2008, February 14). CMS Process and Actions Concerning Approval of Anti-Cancer Drug Compendia.

[15] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299–1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[16] Agency for Healthcare Research and Quality. White Paper: Potential Conflict of Interest in the Production of Drug Compendia. (2009, April 27). Available online at *http://www.cms.hhs.gov/mcd/viewtechassess.asp?from2=viewtechassess.asp&where=index&tid=64&.*

[17] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy*, Science & Law. 7:1–16.

for evaluating therapies and maximizing that transparency, a compendium should publish the complete application for inclusion, exclusion, or deletion of a therapy including criteria used to evaluate the request, on its Web site. We believe that in accordance with that publicly transparent process, a compendium should similarly publish the names of the individuals who have substantively participated in the development of compendia recommendations, along with transcripts of meetings and records of votes. This provides an opportunity for the public to consider the process used by the compendia in evaluating a specific therapy and independently reach conclusions about the adequacy of the application in light of the compendium's final recommendation. We request comments on the requirement for publication of a transcript and the suitability of other alternatives such as minutes or other documents.

• To add a definition regarding a ''publicly transparent process for identifying potential conflicts of interests,'' and clarify the essential elements of such a process. We propose that a publicly transparent process for identifying potential conflicts of interests is best demonstrated by a process that requires public transparency regarding the competing financial and nonfinancial interests that may give rise to such conflicts. Thus, we believe that a compendium should have a process for disclosing by publication on its publicly accessible Web site, certain information regarding potential conflicts of interests associated with individuals who are responsible for the compendium's recommendations as well as their immediate family members (as defined in § 411.351). A process for providing disclosure of interests by *immediate family members* is necessary because such interests could represent potentially competing financial conflicts that could influence the review and individuals responsible for the compendium's recommendations.[18]

We believe that the process for identifying potential conflicts of interests should include information regarding ownership and investment interests of those individuals who are responsible for the compendium's recommendation. Such information should include the names of those entities with which the individual has an ownership or investment relationship (similar to those relationships defined in § 411.354), the nature and length of the relationships, other financial relationships that may derive fron either a direct or indirect relationship (similar to thise relationships identified in 42 CFR 411.354, and the significance (for example, dollar value) of those relationships. By requiring a process for identification of such relationships, we are providing a process for the public to have access to information regarding potential conflicts of interests. We believe that information concerning the value of financial relationships is necessary because it would permit the public to assess the degree of influence that a relationship may have over an individual's decisions or judgments.[19] We request comments on the suitability of this process or whether the compendia should prescribe its own process. In addition, we request comments specifically addressing whether information regarding immediate family members is necessary for conflict of interest determinations.

We note that the publishers of the four compendia that are currently recognized for this purpose have already adopted conflict of interest disclosure policies that are similar to our proposal. Though there are individual differences among the publishers, we note that these policies commonly include publication on the compendia publisher's Web site of the name of the individuals that participate in the generation of the compendia recommendation and the entity with which there is a relationship, the nature of the relationship (for example, salary, ownership, grant support), and the value of the relationship. Some include this information as it relates to family members of the individual.

Additional information with respect to the conflict of interest policies of those compendia we reviewed during the 2008 review cycle can be found on their Web sites. For the convenience of the reader we have listed below the Web sites where these policies may be found for each of the four currently recognized compendia.

• *AHFS Drug Information: http://www.ahfsdruginformation.com/off_label/interest_disclosure.aspx.*

• *Thomson Micromedex DrugDex: http://www.micromedex.com/about_us/editorial/ed_ConflictofInterest.pdf.*

• Gold Standard Clinical Pharmacology: *http://www.goldstandard.com/editorial_conflict.html.*

• *The National Comprehensive Cancer Network: http://www.nccn.org/about/disclosure.asp?p=about.*

In general, certain disclosure policies of the compendia provide for public disclosure of individuals involved in the recommendation to ensure against the appearance of potential conflicts of interests. We believe that a publicly transparent process which provides for the identification of potential conflicts of interest protects the interests of the public, as well as those individuals who participate in the compendia process.

Disclosures of conflicts of interests are triggered by the recommendation regarding the use of the drug or biological rather than by the application for the recommendation. Disclosures published in conjunction with compendia recommendation updates should remain publicly viewable for a reasonable period of time. Specifically, we believe that the disclosures remain available for a period of not less than 5 years. It is not uncommon that serious questions about the use of a drug do not arise until the drug has been used for several years. Thus the relevance of information regarding the development of compendia recommendations may not be recognized until several years after the clinical use in question. We believe that a period of 5 years is a reasonable balance between the burden of maintaining this information and the public's interest in timely access to this information. We welcome comments regarding whether or not a period of not less than 5 years is an adequate timeframe for this balance to occur.

We recognize that some individuals may participate substantively in the development of more than one recommendation. For example, an individual might participate in the review of several drugs or biologicals for a single compendia publisher. We recognize that a single relationship may present a significant conflict of interest in some cases but not others. For example, a process for disclosure by the compendium publisher would be required if an individual whose only conflicted relationship arises from significant income related to the use of a particular drug for lung cancer substantively participated in the compendia review of that drug for lung cancer or for a competitor treatment for lung cancer. If that same individual substantively participated in the compendia review of a different drug for a different disease, the compendia publisher might determine that there is no conflict of interest to disclose.

[18] The PloS Medicine Editors. (2008, September). Making Sense of Non-Financial Competing Interests. *PloS Medicine.* 5(9):1299-1301, Retrieved March 19, 2009 from *http://www.plosmedicine.org.*

[19] Resnik, D. (2007, April). Conflicts of Interest in Scientific Research Related to Regulation and Litigation. *The Journal of Philosophy,* Science & Law. 7:1–16.

In § 414.930(b)(1), we are revising the CMS process for listing compendia for determining medically-accepted uses of drugs and biologicals in anti-cancer treatment to include consideration of a compendium's meeting of the regulatory definitions. We are also proposing to renumber the subparagraphs of § 414.930(b)(1) to accommodate this change.

Current § 414.930(b)(2) gives CMS the authority to generate an internal request to revise the list of compendia at any time.

H. Part B Drug Payment

1. Average Sales Price (ASP) Issues

a. Immunosuppressive Drugs Period of Eligibility

Section 9335(c) of the Omnibus Budget Reconciliation Act of 1986 (Pub. L. 99–509) (OBRA '86) added subparagraph (J) to section 1861(s)(2) of the Act to define a benefit category for immunosuppressive drugs furnished to an individual who receives an organ transplant for which Medicare payment is made, for a period not to exceed 1 year after the transplant procedure. Coverage of these drugs under Medicare Part B began January 1, 1987.

Section 13565 of the Omnibus Budget Reconciliation Act of 1993 (Pub L. 103–66) (OBRA '93) amended section 1861(s)(2)(J) of the Act to specify that the benefit category included immunosuppressive drugs furnished: During 1995, within 18 months after the date of the transplant procedure; during 1996, within 24 months after the date of the transplant procedure; during 1997, within 30 months after the date of the transplant procedure; and during any year after 1997, within 36 months after the date of the transplant procedure. Beginning January 1, 2000, section 227 of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (Pub. L. 106–113) (BBRA) extended the benefit period to eligible beneficiaries whose coverage for drugs used in immunosuppressive therapy expired during the calendar year.

Section 113 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (Pub. L. 106–554) (BIPA) revised section 1861(s)(2)(J) of the Act to eliminate the time limits for coverage of prescription drugs used in immunosuppressive therapy under the Medicare program. Effective with immunosuppressive drugs furnished to an individual who receives an organ transplant for which Medicare payment is made on or after December 21, 2000, there is no longer any time limit for Medicare benefits. Although the statutory benefit category no longer includes a time limit, our regulations at § 410.30(b) continue to reflect the time limits that applied previously. Therefore, we are proposing to make conforming changes to § 410.30(b) to remove the references to the time limits that applied under previous iterations of the statute. This technical change will reduce the potential for confusion about the scope of the benefit. We note that this proposal does not substantively affect Medicare coverage or benefits because it merely conforms the regulations text to the current benefit category, as specified in section 1861(s)(2)(J) of the Act. As noted above, under section 113 of the BIPA, immunosuppressive drugs have not been subject to a time limit since December 21, 2000.

b. WAMP/AMP Threshold

Section 1847A(d)(1) of the Act states that ''the Inspector General of HHS shall conduct studies, which may include surveys to determine the widely available market prices (WAMP) 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 ASP under this section for drugs and biologicals with—

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

Section 1847A(d)(3)(A) of the Act states that, ''The Secretary may disregard the ASP for a drug or biological that exceeds the WAMP or the AMP for such drug or biological by the applicable threshold percentage (as defined in subparagraph (B)).'' The applicable threshold is specified as 5 percent for CY 2005. For CY 2006 and subsequent years, section 1847A(d)(3)(B) of the Act establishes that the applicable threshold is ''the percentage applied under this subparagraph subject to such adjustment as the Secretary may specify for the WAMP or the AMP, or both.'' In CY 2006 through CY 2009, we specified an applicable threshold percentage of 5 percent for both the WAMP and AMP. We based this decision on the limited data available to support a change in the current threshold percentage.

For CY 2010, we propose to specify an applicable threshold percentage of 5 percent for the WAMP and the AMP. At present, the OIG is continuing its comparisons of both the WAMP and the AMP. In April 2008, we implemented a change in the weighting methodology for calculating ASP. Information on how recent changes to the calculation of the ASP may affect the comparison of ASP to WAMP or AMP is limited at this time. Since we do not have sufficient data that suggest another level is more appropriate, we believe that continuing the 5 percent applicable threshold percentage for both the WAMP and AMP is appropriate for CY 2010. Therefore, we are proposing to revise § 414.904(d)(3) to include the CY 2010 date.

As we noted in the CY 2009 PFS final rule with comment period (73 FR 69752), we understand that there are complicated operational issues associated with potential payment substitutions. We will continue to proceed cautiously in this area and provide stakeholders, including providers and manufacturers of drugs impacted by potential price substitutions with adequate notice of our intentions regarding such, including the opportunity to provide input with regard to the processes for substituting the WAMP or the AMP for the ASP. We welcome comments on our proposal to continue the applicable threshold at 5 percent for both the WAMP and AMP for CY 2010.

2. Competitive Acquisition Program (CAP) Issues

Section 303(d) of the MMA requires the implementation of a competitive acquisition program (CAP) for certain Medicare Part B drugs not paid on a cost or PPS basis. The provisions for acquiring and billing drugs under the CAP were described in the Competitive Acquisition of Outpatient Drugs and Biologicals Under Part B proposed rule (March 4, 2005, 70 FR 10746) and the interim final rule (July 6, 2005, 70 FR 39022), and certain provisions were finalized in the CY 2006 PFS final rule with comment period (70 FR 70236). The CY 2007 PFS final rule with comment period (72 FR 66260) then finalized portions of the July 6, 2005 IFC that had not already been finalized.

The CAP is an alternative to the ASP (buy and bill) methodology of obtaining certain Part B drugs used incident to physicians' services. Physicians who choose to participate in the CAP obtain drugs from vendors selected through a competitive bidding process and approved by CMS. Under the CAP, participating physicians agree to obtain all of the approximately 180 drugs on the CAP drug list from an approved CAP

vendor. The approved CAP vendor retains title to the drug until it is administered, bills Medicare for the drug, and bills the beneficiary for cost sharing amounts once the drug has been administered. The participating CAP physician bills Medicare only for administering the drug to the beneficiary. The initial implementation of the CAP operated with a single CAP drug category from July 1, 2006 to December 31, 2008.

After the CAP was implemented, section 108 of the MIEA-TRHCA made changes to the CAP payment methodology. Section 108(a)(2) of the MIEA-TRHCA requires the Secretary to establish (by program instruction or otherwise) a post payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological only if the drug or biological has been administered to a beneficiary. The Secretary is required to recoup, offset, or collect any overpayments. This statutory change took effect on April 1, 2007. Conforming changes were proposed in the CY 2008 PFS proposed rule (72 FR 38153) and finalized in the CY 2008 PFS final rule with comment period (72 FR 66260).

In the CY 2009 PFS proposed rule, we proposed several refinements to the CAP regarding the annual CAP payment amount update mechanism, the definition of a CAP physician, the restriction on physician transportation of CAP drugs, and the dispute resolution process (73 FR 38522). However, after the publication of the proposed rule, we announced the postponement of the CAP for 2009 due to contractual issues with the successful bidders. As a result, CAP physician election for participation in the CAP in 2009 was put on hold, and CAP drugs have not been available from an approved CAP vendor for dates of service after December 31, 2008. Physicians who participated in the CAP have transitioned back into the Average Sales Price (ASP) method of acquiring part B drugs for dates of service after December 31, 2008.

After the postponement was announced, we solicited public feedback on the CAP from participating physicians, potential vendors, and other interested parties. We solicited public comments on several issues, including, but not limited to the following: The categories of drugs provided under the CAP; the distribution of areas that are served by the CAP; and procedural changes that may increase the program's flexibility and appeal to potential vendors and participating physicians. We also hosted a CAP Open Door Forum (ODF) on December 3, 2008, where participants had an opportunity to discuss the postponement and suggest changes to the program. We appreciate the comments that we have received.

In the CY 2009 PFS final rule with comment period, we stated that we would review the public comments and consider implementing changes to the CAP before proceeding with another bid solicitation for approved CAP vendor contracts. Based on this information, in this proposed rule, we are addressing items that were not finalized in the CY 2009 PFS final rule with comment period, and making additional proposals for the CAP. Our approach seeks to better define certain aspects of the program based on our experience. We also seek to continue to increase participation by minimizing the administrative burden for physicians and vendors who choose to participate.

a. Frequency of Drug Payment Amount Updates

As described in the July 6, 2005 IFC (70 FR 39070 through 39071) and § 414.906(c), payment amounts for drugs furnished under the CAP are set through a competitive bidding process, and as described in § 414.908(b), bids that exceed a composite bid threshold of 106 percent of the weighted ASP for the drugs in the CAP category are not accepted. The CAP payment amounts that are calculated from successful bids are updated from the time of the bidding period to the payment year. During the 2006 through 2008 CAP contract period, the initial update calculation used the change in the Producer Price Index (PPI) for prescription preparations to account for the time period between the bidding and the period in which the payment amounts were to be in effect, which was the middle of the first year of the three year CAP contract period (70 FR 39074). Finally, as specified in § 414.906(c), CAP payment amounts are updated again during the second and third year of the contract period based on the approved CAP vendor's reported reasonable net acquisition costs (RNAC). The annual updates are limited by payment amounts described in section 1847A of the Act and codified in § 414.906(c).

Section 1847B(c)(7) of the Act gives the Secretary the discretion to establish an appropriate schedule for the approved CAP vendor's disclosure of RNAC information to us, provided that disclosure is not required more frequently than quarterly. In the July 6, 2005 IFC (70 FR 39075 through 39076), we specified that each approved CAP vendor will disclose its RNAC for the drugs covered under the contract annually during the period of its contract and that we would calculate an annual payment adjustment based on this information. We specified an annual disclosure of RNAC because it imposes the minimal burden on approved CAP vendors. In 2005, some commenters suggested that more frequent updates would be desirable. Additional feedback about the CAP that was obtained after the program's postponement in 2008, as well as comments on previous rules, indicated that potential vendors would like the frequency of price adjustments to increase. Various commenters have suggested a quarterly price adjustment in order to parallel to the ASP process, to better match payment amounts with increases or decreases in drug costs, and to attract vendor interest. We believe that quarterly adjustments would also lower approved CAP vendors' financial risks because CAP payment amounts will be better able to keep up with unanticipated drug cost increases and would benefit the Medicare program by reacting to significant cost decreases more promptly.

Quarterly price updates also will eliminate the PPI-based increase that currently occurs between the time bids are submitted and the first day of CAP claims processing. The application of the PPI-based payment adjustment described in the July 6, 2005 IFC (70 FR 39074) has resulted in situations where the ASP+6 percent payment amount has been exceeded during the first year of the 3-year approved CAP vendor contract. We do not believe that CAP payment amounts should exceed ASP+6 percent. In our discussion of bid ceilings in the July 6, 2005 IFC, we stated that the bid ceiling ''ensures that the CAP will be no more costly to the Medicare program than the alternative method of paying for drugs at 106 percent of ASP. This ceiling is thus consistent with the possibility of realizing savings to the Medicare program. It would also serve to maintain a level of parity between the two systems, preventing a situation in which significant payment differentials might skew incentives and choices (70 FR 39070).'' For this reason, and to remain consistent with current regulation text at § 414.906, we believe that all payment amounts calculated under the update process should be limited by the weighted payment amount established under section 1847A of the Act. We also believe that this approach will continue to provide for an ''appropriate price adjustment'' as required under section 1847B(c)(7) of the Act by improving responsiveness to unexpected price

changes, and continuing a prudent limitation on the magnitude of payment amount adjustments.

Our approach for implementing quarterly updates consistent with the ASP+6 percent limit on payment amounts would be based on composite bid price calculations, as described in the July 6, 2005 IFC (70 FR 39072 through 39073). Additional details about the process are described in further detail in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). Briefly stated, the ASP+6 percent limit would be applied by comparing the (weighted) composite update payment amount, calculated from participating approved CAP vendors' reasonable net acquisition cost data, to most recent available weighted ASP prices for the same drugs. If the composite drug update payment amount exceeds the weighted ASP+6 percent payment limit, the composite payment amount for that group of drugs would be reduced to equal the ASP+6 percent limit by applying an equal percent reduction to each drug in the group. By way of example only, if a quarter's composite update payment was calculated as +2.3 percent, based on the median of all participating approved CAP vendors' data, but the calculated weighted ASP+6 percent limit for that group of drugs was +2.1 percent, the payment amounts for all HCPCS codes in the composite group would be increased by 2.1 percent in order to account for reported increases to the vendor's acquisition cost, but not to exceed the ASP+6 percent limit. This means that a 2.1 percent increase would be applied to CAP payment amounts for all HCPCS codes that are in the composite drug list and are being supplied under the CAP by one or more approved CAP vendors. For HCPCS codes that are priced separately, each code available through the CAP will be compared to the most recent ASP+6 percent limit for that code. CAP payment amounts for codes that exceed the ASP+6 percent limit will be reduced to ASP+6 percent. Each ''Not Otherwise Classified'' (NOC) drug described in § 414.906(f)(2)(iv), would also be updated on an individual (rather than composite) basis.

We are proposing to discontinue annual CAP payment amount updates and to implement quarterly CAP payment amount updates at § 414.906(c). Because of this proposed change, the special quarterly adjustments described at § 414.906(c)(2) (for the introduction of new drugs, expiration of drug patents or availability of generic drugs, material shortages, or withdrawal of a drug from the market) will no longer be needed, so we propose deleting those provisions from the regulation, and instead adding details about the payment amount update process described in section II.H.2.f. of this proposed rule (Annual CAP Payment Amount Update Mechanism). A quarterly RNAC reporting and payment adjustment process would begin as soon as we entered into contracts with the approved CAP vendor(s); that is, beginning with the first quarter during which CAP claims are submitted under the contract. Thus, under this proposal, we would also eliminate the PPI-based adjustment for the time period between the time bids are submitted and the time claims processing begins under the contract, because that adjustment would no longer be necessary. We believe using one payment update process will be easier to administer and would minimize the potential for CAP payment amounts to exceed ASP+6 percent for the first contract year. In order to provide sufficient time for the calculation of payment amount updates, we are proposing that approved CAP vendors report quarterly RNAC data for drug purchased for use under the CAP during the previous quarter within 30 days of the close of that quarter. We have made corresponding changes to regulation text at § 414.906(c) and we welcome comments on these proposed changes.

b. Changes to the CAP Drug List

(1) CAP Drug List

In the July 6, 2005 IFC, we responded to comments on our proposed approach for determining the CAP drug categories and how we select the specific drugs in the CAP drug list (70 FR 39026 through 39034). As stated in the CY 2006 PFS final rule with comment period (70 FR 70237), the CAP is intended to provide beneficiaries with access to Medicare Part B drugs and maintain physician flexibility when prescribing medications. Our approach incorporated drugs commonly administered by the range of physician specialties that bill for Part B drugs (70 FR 39030) and resulted in a list of about 180 drugs that were available through the CAP during the CY 2006 through CY 2008 contract period. We also developed a number of methods by which an approved CAP vendor's CAP drug list could be changed (*see* Table 26 at 70 FR 70242).

We believe that our general approach, to provide a wide variety of drugs to a variety of physicians over a large portion of the United States, is on target. Although we believe that the CAP is a means for physicians to minimize their drug inventory costs, we acknowledge that participation in the CAP cannot completely eliminate the need for participating CAP physicians to maintain at least a minimal drug inventory at the office. Many physicians who participate in Medicare also provide services to non-Medicare patients, and even physicians with a predominantly Medicare patient population may find it useful to keep a small stock of drugs on hand for unforeseen situations, such as emergencies and breakage.

During the CAP postponement, we became aware that both participating CAP physicians and potential vendors supported narrowing the CAP drug list. Both agreed that low cost drugs should be removed from the CAP. Although these items were initially included in the CAP so that an approved CAP vendor would be in a position to supply many of the Part B drugs that an office might administer, CAP physicians and the vendor community have stated that the inclusion of these items in the CAP creates an accounting, tracking, and claims submission burden for some participants. Based on these comments, we believe that low-cost, frequently utilized items, such as corticosteroid injections, could be removed from the list without significant impact on the CAP's utility to participating CAP physicians. Furthermore, it appears that physicians would be more interested in obtaining expensive products, such as biologicals, through the CAP. However, we are also mindful that narrowing the CAP drug list significantly also would decrease an approved CAP vendor's overall purchase volume, and we believe that this could limit the approved CAP vendor's ability to obtain volume-based discounts from the manufacturers or distributors from which it obtains drugs for use in the CAP. Creating a more tailored CAP drug category also could limit physician participation to one or several specialties, and may create a situation where sudden supply interruptions and unexpected changes to distribution channels could affect a greater proportion of drugs in the program than would be the case with a broader CAP drug category.

Nevertheless, we are proposing to create a new CAP drug category for the next round of CAP contracting. Our approach is intended to address comments about the administrative burden of tracking and billing low cost/high volume items while maintaining access to a variety of high cost items. We are proposing to identify the new CAP drug category using the existing CAP drug category as a starting point.

The 2008 drug list was compiled based on Part B drug claims data, the identification of specialties that frequently administer drugs under Part B, and public comment during rulemaking in 2005 (70 FR 39026 through 39033). We believe that using the 2008 CAP drug list as a starting point would maintain prescribing flexibility for a wide range of specialties and would also maintain access to a wide spectrum of drugs that have been utilized under the program previously. Furthermore, we do not believe it is necessary to develop a new approach because the 2008 CAP drug list was based on heavily utilized drugs in Medicare Part B physician practices; we believe that this approach is on target.

We propose to amend our list based on CAP physician participation, claims data, and comments indicating that the list should be narrowed to higher cost items. First, we would ''filter'' the original CAP drug category (drugs furnished in 2006 through 2009) by the specialties that most frequently prescribe drugs under the CAP, and the highest dollar volume CAP drugs (top 20 percent of allowed charges) compiled from 2008 claims data. This filtered list appears in Table 35, and we are proposing it as the starting point for the updated CAP drug category. A filtering process based on frequency of claims from a subset of physicians who might participate in the CAP cannot fully capture all drugs that may be used by certain specialties. In other words, the filtering steps described above narrow the CAP drug list based on physician specialties and dollar volume and do not necessarily preserve groups of drugs that certain prescribers may utilize, especially the less frequently utilized items in such groups. Therefore, we are also proposing to ''fill in'' groups of drugs with related items that do not appear on our list. We will consider ''filling in'' any drug or biological product that is physician-administered, has a reasonably high utilization in the Medicare population, is related to drugs already in the CAP (for example, because of similar clinical uses), and is otherwise appropriate for inclusion in the program.

For example, we could consider adding a fourth hyaluronan viscosupplement to the drugs in Table 35, expanding the list of antibiotics, or antiemetics, or by adding a list of ''new'' and unweighted drugs as in 2006 by using simple claims data thresholds (70 FR 70238). The concept of ''filling in'' drug groups is supported by feedback from former participating CAP physicians who suggested that certain categories of drugs, such as antibiotics, be more fully represented. We are seeking comments on specific drugs that should be added to the draft list in Table 35.

We also are seeking comment on the method to assess whether a particular drug should be ''filled in'' so that it is included in the new, narrowed CAP drug category. For example, one process that we have considered and would like comment on is adding drugs from the 2009 through 2011 CAP vendor bidding list that did not pass the ''filtering'' step described above. The 180 item 2009 through 2011 bidding list was used during the approved CAP vendor bidding for the 2009–2011 contract, and includes CMS-approved items added to the original contract's bid list, as well as items approved for addition during the 2006–2008 contract period. (*See* the Downloads section at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/03a_vendorbackground.asp#TopOfPage*). This list's weighting is based on claims volume data by HCPCS code units rather than dollar volume and provides a different perspective than a dollar volume sorting. We would add drugs from the 2009–2011 CAP Vendor bid list to the CAP drug category if the drug's weight is in the top 25 percent of the 2009–2011 CAP vendor bidding list, indicating frequent claims submission, and if the drug's clinical uses are similar to a drug on the proposed list in Table 35. This method would result in the addition of a number of several commonly used antibiotics, two antiemetic) and several chemotherapeutic agents. Potential additions to our draft list identified by this method appear in Table 36. Although this method helps ''fill in'' the proposed CAP drug list, this method still does not fully capture less frequently used drugs, or newly approved drugs. We welcome comments on this method and alternative methods of filling this proposed list.

In order to provide additional flexibility for participating CAP physicians and approved CAP vendors, and to allow for participants to further tailor the program to meet their needs, we are also proposing to add § 414.906(f)(2)(v) to allow approved CAP vendors to submit a request to CMS to add drugs (or biologicals) to the list of drugs furnished by the requesting vendor if there is sufficient demand and if the drug has therapeutic uses that are similar to other drugs already available through the CAP. The request and approval process would follow the existing regulations at § 414.906(f), and HCPCS code additions that are requested under this process would still be subject to CMS approval. This proposed process adds to the process for adding newly issued HCPCS codes under § 414.906(f)(2)(iii) and newly approved drugs without HCPCS codes (NOC drugs)under § 414.906(f)(2)(iv). It is intended to facilitate more complete access to groups of drugs that may be used by certain specialties, and drugs used to treat certain disease states without having to rely on rigid definitions of classes of drugs that may not apply well to actual clinical practice across a large and diverse geographic area. We believe that this addition to the methods for changing an approved CAP vendor's drug list (*see* Table 26 in the November 21, 2006 final rule (70 FR 70242)) will add to the flexibility of the program. We welcome comments on our proposal to update the CAP drug list.

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD

Code	Procedure code description
J0129	INJECTION, ABATACEPT, 10 MG
J0215	INJECTION, ALEFACEPT, 0.5 MG
J0585	BOTULINUM TOXIN TYPE A, PER UNIT
J0587	BOTULINUM TOXIN TYPE B, PER 100 UNITS
J0696	INJECTION, CEFTRIAXONE SODIUM, PER 250 MG
J0878	DAPTOMYCIN INJECTION, 1 MG
J0881	INJECTION, DARBEPOETIN ALFA, 1 MCG (NON-ESRD USE)
J0885	INJECTION, EPOETIN ALPHA, (FOR NON ESRD USE), PER 1000 UNITS
J0894	INJECTION, DECITABINE, 1MG
J1440	INJECTION, FILGRASTIM (G-CSF), 300 MCG
J1441	INJECTION, FILGRASTIM (G-CSF), 480 MCG
J1740	INJECTION, IBANDRONATE SODIUM, 1 MG

TABLE 35—DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD—Continued

Code	Procedure code description
J1745	INJECTION INFLIXIMAB, 10 MG
J2323	INJECTION, NATALIZUMAB, 1 MG
J2353	INJECTION, OCTREOTIDE, DEPOT FORM FOR INTRAMUSCULAR INJECTION, 1 MG
J2357	OMALIZUMAB INJECTION, 5 MG
J2405	INJECTION, ONDANSETRON HYDROCHLORIDE, PER 1 MG
J2469	PALONOSETRON HCL, 25MCG
J2503	PEGAPTANIB, 0.3MG
J2505	INJECTION, PEGFILGRASTIM, 6 MG
J2778	INJECTION, RANIBIZUMAB, 0.1 MG
J2794	RISPERIDONE, LONG ACTING, 0.5MG
J3240	INJECTION, THYROTROPIN ALPHA, 0.9 MG, PROVIDED IN 1.1 MG VIAL
J3315	INJECTION, TRIPTORELIN PAMOATE, 3.75 MG
J3396	INJECTION, VERTEPORFIN, 0.1 MG
J3487	INJECTION, ZOLEDRONIC ACID, 1 MG
J3488	INJECTION, ZOLEDRONIC ACID (RECLAST), 1 MG
J7321	HYALURONAN OR DERIVATIVE, HYALGAN OR SUPARTZ, FOR INTRA-ARTICULAR INJECTION, Per Dose
J7322	HYALURONAN OR DERIVATIVE, SYNVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J7324	HYALURONAN OR DERIVATIVE, ORTHOVISC, FOR INTRA-ARTICULAR INJECTION, PER DOSE
J9010	ALEMTUZUMAB, 10 MG
J9035	BEVACIZUMAB INJECTION, 10MG
J9041	BORTEZOMIB INJECTION, 0.1MG
J9055	CETUXIMAB INJECTION, 10MG
J9170	DOCETAXEL, 20 MG
J9201	GEMCITABINE HCL, 200 MG
J9206	IRINOTECAN, 20 MG
J9263	INJECTION, OXALIPLATIN, 0.5 MG
J9305	PEMETREXED INJECTION, 10MG
J9310	RITUXIMAB, 100 MG
J9355	TRASTUZUMAB, 10 MG

TABLE 36—POTENTIAL ADDITIONS TO THE DRAFT CAP DRUG LIST FOR NEXT CONTRACT PERIOD (THAT IS, TABLE 35)

Code	Procedure code description
J3370	INJECTION, VANCOMYCIN HCL, 500 MG
J9264	PACLITAXEL PROTEIN BOUND PARTICLES, 1MG
J0690	INJECTION, CEFAZOLIN SODIUM, 500 MG
J1260	INJECTION, DOLASETRON MESYLATE, 10 MG
J0692	INJECTION, CEFEPIME HYDROCHLORIDE, 500 MG
J1626	INJECTION, GRANISETRON HYDROCHLORIDE, 100 MCG
J0640	INJECTION, LEUCOVORIN CALCIUM, PER 50 MG
J9265	PACLITAXEL, 30 MG
J9190	FLUOROURACIL, 500 MG
J9045	CARBOPLATIN, 50 MG
J0290	INJECTION, AMPICILLIN SODIUM, 500 MG
J9214	INTERFERON, ALFA–2B, RECOMBINANT, 1 MILLION UNITS

2. Removing Drugs From the CAP list

Although there are several methods under the CAP to add drugs to an approved CAP vendor's drug list, the current regulations do not specify a process for removing drugs from an approved CAP vendor's list. Our experience has shown that interruptions in availability can affect an approved CAP vendor's ability to supply CAP drugs during the course of a 3-year contract. For example, during the first contract period, we became aware of long-term and permanent drug unavailability, sometimes at the HCPCS level, due to removal of drugs from the market, or interruption of supply to an approved CAP vendor for reasons beyond the approved CAP vendor's control, such as changes to drug distribution methods, changes in agreements between manufacturers and distributors and/or pharmacies regarding who may purchase certain drugs, and direct distribution arrangements.

In order to better respond to sudden, long-term changes in drug supply that are beyond the control of the approved CAP vendor, we are proposing to allow an approved CAP vendor to request the permanent removal from its CAP drug list of a HCPCS code for which no NDCs are available. Our proposal is intended to better manage situations where all NDCs from an entire HCPCS code unexpectedly become unavailable to an approved CAP vendor, and we would require the approved CAP vendor (1) to document the situation in writing, including the unavailability of all NDC codes in a HCPCS code that is supplied under the CAP, (2) to describe the reason for the unavailability and its anticipated duration, and (3) to attest that the unavailability is beyond the approved CAP vendor's control. Approval of the deletion would apply only to the approved CAP vendor or vendors that requested the deletion. Our proposal is not intended to be used frequently, or to permit an approved CAP vendor to remove a HCPCS code from its CAP drug list simply because it has become unprofitable to provide it—we believe the payment amount adjustment proposals discussed in sections II.H.2.a. and f. of this proposed rule would address that concern.

Furthermore, our proposal is also not intended to be used for managing short-term unavailability, or unavailability of a finite duration—we believe the existing drug substitution policy described in § 414.906(f) already addresses those concerns. We are proposing to add this process as § 414.906(g) because those regulations currently provide for additions and substitutions to the CAP drug list, and would therefore require a written request to CMS, as well as CMS' approval.

Participating CAP physicians who are affected by the deletion of a HCPCS code from an approved CAP vendor's drug list would have the option of remaining with their selected approved CAP vendor and using the ASP (buy and bill) methodology for obtaining the drug that has been deleted, or selecting another approved CAP vendor under the exigent circumstances provision at § 414.908(a)(2). We believe that the deletion of an expensive and highly utilized CAP drug by one approved CAP vendor in the middle of a physician election period could cause hardship for a practice if it had to revert to the ASP methodology of acquiring and billing for that drug. Such a situation would constitute an exigent circumstance. Given CAP's goal of improving access to drugs, allowing the participating CAP physician to switch approved CAP vendors outside of a regular election period in this instance would be prudent. We welcome comments on our proposals.

c. Geographic Area Served by the CAP

In the July 6, 2005 IFC (70 FR 39034 through 39036), we established a single, national competitive acquisition area for the initial stage of the CAP. This national distribution area included the 50 States, the District of Columbia, Puerto Rico, and U.S. territories. We recognized that designating a single national area might limit participation to those vendors that could compete to bid and supply drugs nationally, but we indicated this approach was a part of the phase-in plan for the CAP. We also discussed potential phase-in options for the future, stating that smaller areas might become a solution as the program expanded.

According to the vendor community, certain areas of the United States (especially Alaska, Hawaii, and the Territories) currently present logistical challenges and are associated with high drug shipping costs. Moreover, physician participation in these areas has been low; in 2008, physicians from Alaska, Hawaii, and the Territories represented less than 2 percent of total participating CAP physicians. Temporarily limiting the geographic areas served by the CAP could help limit costs and risks for approved CAP vendors associated with shipping drugs to distant parts of the country. However, we believe that the CAP is intended to provide services to all Medicare physicians (including those in distant parts of the country), and therefore, we do not believe that a limitation on the geographic area in which the CAP is available should be permanent.

Section 1847B(a)(1)(B) of the Act specifically requires the Secretary to phase-in the CAP with respect to the categories of drugs and biologicals in the program, in such a manner as the Secretary determines to be appropriate. We believe that this provision, particularly in conjunction with the statutory definition of a competitive acquisition area as ''an appropriate geographic region established by the Secretary'' provides broad authority for the Secretary to phase in the CAP with respect to the geographical areas in which the program would be implemented. As stated in the July 6, 2005 IFC, we considered several factors when defining geographic areas for the CAP, including aspects of vendors and their distribution systems, such as current geographic service areas, the density of distribution centers, the distances drugs and biologicals are typically shipped, and costs associated with shipping and handling (70 FR 39035). Taking these factors into consideration again, and considering entities who have bid on, or expressed interest in bidding on approved CAP vendor contracts, we believe that it is appropriate to use the authority granted under the Statute to temporarily narrow the area served by the CAP during the program's re-implementation. We appreciate the logistical issues associated with shipping drugs to remote areas and the uncertainties associated with transportation costs that have been described by the potential vendor community; however, we are reluctant to significantly reduce the area served by the CAP because at some point, the approved CAP vendor's volume would be affected and the likelihood of obtaining volume based discounts would decrease.

At this time, we are proposing to designate the CAP competitive acquisition area as the 48 contiguous States and the District of Columbia for the next round of CAP contracting. This change in the geographic area that is served by the CAP is meant as an interim measure under our phase-in authority and the statutory definition of a competitive acquisition area. We believe that omitting Alaska, Hawaii, and the Territories from the CAP competitive acquisition area at this time will balance the need to revise the CAP to attract more vendors with the need to offer the maximum number of physicians a meaningful opportunity to participate. We believe that this proposal will encourage potential vendors to participate in the CAP because it would temporarily omit areas associated with low physician participation, long shipping times, and high shipping costs. Furthermore, this measure is unlikely to significantly decrease CAP drug order volume relative to historical physician participation in the CAP. However, we are aware that our proposal temporarily eliminates the CAP option for physicians in the areas not included in this CAP competitive acquisition area. Therefore, we are not proposing this definition of the CAP geographical area as a permanent solution. We will continue to assess the CAP and update plans for phase in activity in future rulemaking efforts, including determining the circumstances under which CAP participation will be offered to physicians in Alaska, Hawaii, and the Territories. We will also continue to consider modifying the definition of competitive acquisition area on the basis of regions, States, or some smaller geographic area, which might expand the number of vendors that could bid to participate in the program (70 FR 39036). We welcome comments on our proposal.

d. CAP Drug Stock at the Physician's Office

Our discussion about the CAP emergency restocking option in the July 6, 2005 IFC indicated that a participating CAP physician could not maintain a stock of an approved CAP vendor's drug in his or her inventory. This was done because we had reservations about potential program integrity and drug diversion issues (70 FR 39047).

Since that time, we have gained operational experience with the CAP and a better understanding of the ordering and drug delivery process. We have also received additional public feedback about the different ways that the program could be refined. Further, our experience with the CAP indicates that our concerns over program integrity and drug diversion have not come to pass. For example, we have received no complaints and have no information indicating that diversion has been a concern. Also, we have not received any negative feedback from the vendor community indicating a concern about

storing CAP drugs in physicians' offices. Therefore, we believe at this time it is appropriate to consider allowing additional flexibility to encourage CAP participation.

Our experience with the CAP, and our increased understanding about the options approved CAP vendors might have for furnishing drugs to a participating CAP physician's office also support considering additional flexibility in this area. For example, we are aware of electronic inventory control and charge capture devices that could be utilized in ways that conform to CAP regulations and are compliant with applicable State and Federal laws. Such devices utilize an electronic transaction based on a physician's order to track the administration of drugs from inventory to a specific patient and to document appropriate charges for the drug. We believe that such systems could fit into the current CAP framework when transactions in such systems are based on a physician's order, because such systems can track inventory, and can be used to capture patient charge data.

For these reasons, we are seeking to clarify our requirements for the manner in which CAP drugs are supplied to participating CAP physicians. Specifically, we are proposing to allow approved CAP vendors to utilize electronic transactions to furnish CAP drugs from nominal quantities of approved CAP vendor-owned stock located at the physician's office in response to specific prescription orders and to capture charges related to such transactions. Our proposal is also intended to clarify that entities with alternative approaches to supplying drugs that utilize an electronic transaction are welcome to participate in the CAP bidding process. We believe that this will allow for additional flexibility and efficiency in the ordering and delivery of drugs within the program because it allows for more efficient shipping of approved CAP vendor-owned stock and provides the option of CAP participation for physicians who use or may choose to use such drug inventory management platforms. This proposal does not change our position that a participating CAP physician shall not take title to or pay for CAP drugs, nor does it alter the requirements for information that must be submitted with a prescription order under Section 414.908(a) or the application of HIPAA to such data.

Furthermore, our proposal does not affect the applicability of State licensing requirements for an approved CAP vendor. As stated in the July 6, 2005 IFC (70 FR 39066), either the approved CAP vendor, its subcontractor under the CAP, or both, must be licensed appropriately by each State to conduct its operations under the CAP. Therefore, if a State requires it, an approved CAP vendor would be required to be licensed as a pharmacy, as well as a distributor. We are not revising the requirements at § 414.908(c) and § 414.914(f)(9), and we note that sections 1847B(b)(6) and 1847B(b)(2)(B) of the Act continue to apply. In order to participate in the CAP successful bidders must continue to submit proof of pharmacy licensure, consistent with applicable State requirements.

Also, this proposal would not modify our definition of ''emergency delivery'' or its corresponding requirements at § 414.902. As we stated in our July 6, 2005 IFC, the intent of the 1-business-day timeframe for emergency deliveries is to address the participating CAP physician's need for more rapid delivery of drugs in certain clinical situations with the approved CAP vendor's ability to ship the drug and have it delivered promptly in a nationwide delivery area (70 FR 39045). The emergency delivery timeframe still applies in situations when CAP drugs are not available in the office for electronic delivery.

Moreover, this proposal does not seek to change the CAP inventory requirements. CAP drugs belong to the approved CAP vendor, and as indicated in the July 6, 2005 IFC (70 FR 39048), participating CAP physicians are required to maintain a separate electronic or paper inventory for each CAP drug obtained. CAP drugs must be tracked separately in some way (for example, an electronic spreadsheet). CAP drugs do not have to be stored separately from a physician's own stock; that is, co-mingling of CAP drug with drug from a participating CAP physician's own private stock is acceptable as long as a record of approved CAP vendor-owned drug is kept in a manner that is consistent with § 414.908(a)(3)(x) and the approved CAP vendor-owned drug can be accounted for, as needed.

Also, this proposal does not affect the CAP emergency restocking requirements. Section 1847B(b)(5) of the Act and § 414.906(e) provide criteria for the replacement of drugs taken from a participating CAP physician's inventory in the event of an emergency situation. When the emergency resupply criteria are met, a participating CAP physician can replace the drugs that were used from his or her own inventory by submitting a prescription order to the approved CAP vendor.

Our proposal seeks to clarify the potential approaches that a bidder may use (separately or in combination) to supply drugs under the CAP. Our proposal does not seek to specify a particular approach that bidders must use in future responses to CAP bid solicitations or to strictly define the types of entities that could bid on CAP vendor contracts; for example, whether bidders must be pharmacies, drug distributors, or a hybrid of the two; whether bidders must utilize just in time shipping, or electronic inventory transactions to supply CAP drugs. We will consider approving bidders' approaches that are consistent with the statutory framework, applicable laws, and regulations. We welcome comments on this issue.

e. Exclusion of CAP Sales From ASP Calculations

In response to the March 4, 2005 proposed rule, many commenters requested clarification about whether the prices determined under the CAP will be taken into account in computing the ASP under section 1847A of the Act. In the July 6, 2005 IFC, we responded that prices offered under the CAP must be included in ASP calculations (70 FR 39077). This was done because we initially believed that we did not have the statutory authority to exclude prices determined under the CAP from the computation of ASP under section 1847A of the Act. Section 1847A(c)(2) of the Act contains a specific list of sales that are exempt from the ASP calculation, and sales to approved CAP vendors operating under CAP are not included on that list (70 FR 39077). Comments received in response to the July 6, 2005 IFC opposed this policy (70 FR 70479).

Ultimately, as stated in the November 21, 2005 IFC, we recognized commenters' concerns about the effect of including CAP prices in the calculation of ASP and agreed that the best outcome for both the ASP methodology and the CAP programs would be one in which prices under CAP did not affect payment amounts under the ASP methodology. In particular, we found compelling arguments from commenters about the separation of the ASP and CAP programs and that the two programs are intended to be alternatives to each other. Therefore, we excluded units of CAP drugs that are administered to beneficiaries by participating CAP physicians from the ASP calculation for the initial 3-year approved CAP vendor contract period (70 FR 70479). Accordingly, the definition of ''Unit'' at § 414.802 was also revised to reflect this exclusion.

In our August 18, 2006 interim final rule, we further addressed concerns

pertaining to our definition of Unit. We published a PRA notice regarding a proposed modification of the OMB-approved ASP information collection requirements (CMS Form 10110 (OMB # 0938–0921) about the collection of the number of CAP units excluded from the ASP calculation. In response, a commenter expressed concern over manufacturers' reliance on approved CAP vendors for information about the number of units of CAP drugs that are administered to beneficiaries by participating CAP physicians (71 FR 48132). Since approved CAP vendors are the only entities with direct information on CAP units administered, the commenter believed that the requirement to exclude units of CAP drugs administered to beneficiaries by participating CAP physicians placed the manufacturer in the untenable position of reporting ASP and certifying reports of ASP based on second-hand information from approved CAP vendors. Further, the commenter noted that manufacturers may not have timely access to this information and that they could not independently confirm its accuracy (71 FR 48132). Additional feedback received as part of our ongoing work with manufacturers also indicated that they were concerned that they would have difficulty obtaining information from approved CAP vendors that would be necessary to accurately exclude administered CAP units from the ASP calculation (71 FR 48132).

Therefore, we further revised the definition of unit to clarify that for the initial 3-year contract period under the CAP units of CAP drugs sold to an approved CAP vendor for use under the CAP would be excluded from the calculation of ASP (70 FR 48132).

In the July 6, 2005 and August 18, 2006 IFCs, we stated that we would examine the effect of this exclusion and, if necessary, revisit our decision at the end of the initial 3-year period of the CAP (70 FR 70480 and 71 FR 48132, respectively). Since then, operational experience has not indicated a reason for changing our policy of excluding CAP units sold to approved CAP vendors for use under the CAP from ASP calculations. Therefore, we are proposing to permanently exclude drugs supplied under the CAP from ASP calculations and make conforming changes to the definition of unit at § 414.802. We believe that this proposal will continue to promote the separation and independence of the two drug payment models. We welcome comments on this proposal.

f. Annual CAP Payment Amount Update Mechanism

In the July 6, 2005 IFC (70 FR 39076), we described a two-step process to calculate RNAC-based price adjustment if there is a change in the RNAC reported by a particular approved CAP vendor. We stated that ''we would adjust the bid price that the vendor originally submitted by the percentage change indicated in the cost information that the vendor disclosed. Next, we would recompute the single price for the drug as the median of all of these adjusted bid prices.'' The two-step process contemplated that there would be more than one approved CAP vendor at the time prices were to be adjusted and that all successful bidders would participate in the CAP.

However, during the first round of CAP contracting, after offering more than one contract, we entered into a contract with only one successful bidder. Thus, during the 2008 price update calculation process, we developed an approach to account for the lack of RNAC data for bidders who chose not to participate in the CAP. In the CY 2009 PFS proposed rule, we stated that the approach we used to adjust prices for the 2008 contract year is consistent with § 414.906(c) and with the July 6, 2005 IFC because it retains a two-step calculation based on the approved CAP vendor's RNAC, as well as the calculation of a median of adjusted bid prices.

We also posted our approach on the Approved CAP Vendor page of the CMS CAP Web site at *http://www.cms.hhs.gov/CompetitiveAcquisforBios/15_Approved_Vendor.asp*. The percent change in RNAC for 2008 was calculated based on data supplied by the approved CAP vendor. This percent change in RNAC was used as a proxy for the percent change in RNAC for successful bidders that chose not to become approved CAP vendors.

Then, in the CY 2009 PFS proposed rule (73 FR 38522 through 38523), we proposed to continue using this approach for future CAP payment amount updates where the number of approved CAP vendors is less than the number of successful bidders. We proposed that the average of the approved CAP vendor-supplied RNAC data would be used as a proxy for data from vendors who bid successfully but are not participating in the CAP. For example, if the payment amounts for the first year of a CAP contract are based on five successful bidders, but only four have signed contracts to supply drugs under the CAP (that is, there are four approved CAP vendors), only RNAC data collected from the four approved CAP vendors would be used to calculate the percent change in the RNAC. The average of the four approved CAP vendors' adjusted payment amounts would be used as a proxy for the RNAC of the successful bidder that is not participating in the CAP. The updated CAP payment amount would then be calculated as the median of the five data points (one data point for each approved CAP vendor's updated payment amount, and one data point calculated using the average of the approved CAP vendors' RNAC). Similarly, if there were five successful bidders but only three chose to become approved CAP vendors, the average of the three approved CAP vendors' RNAC would be the proxy for the RNAC of the two bidders who did not participate. The median of those five data points would become the updated CAP payment amount.

Our approach in the CY 2009 PFS proposed rule was intended to provide us with a flexible method for updating CAP prices, to be consistent with our original policy as stated in the July 6, 2005 IFC, and to account for bidders or approved CAP vendors who are not participating in the program at the time the price updates are calculated. However, our approach was limited in scope because it was made during a contract period and during bidding for an upcoming contract and we did not want to make any significant changes to the CAP program which could affect contractual obligations. Furthermore, we received a comment in response to the CY 2009 PFS proposed rule that suggested the elimination of the proxy procedure so that payments would be based on actual data from participating vendors and would better reflect experience within the program. After additional consideration, we believe that it would be prudent to simplify and update our 2009 proposal in order to account for successful bidders who choose not to participate in the CAP, possible changes in the number of approved CAP vendors over the life of a 3-year CAP contract, and to allow for flexibility in setting the frequency of payment amount adjustments as described in section a. above. We believe that our updated proposal is easier for the vendor community to understand and for us to implement. Furthermore, our revised proposal is not constrained by concerns about the impact of changes on an active contract.

We are proposing to clarify that the RNAC-based adjustment calculations are intended to apply only to approved CAP vendors (not all bidders), and that the most recent CAP payment amount

(for example, the previous year's or the previous quarter's payment amount) will be the starting point for making the subsequent period's adjustment. Simply put, we are proposing to eliminate the use of proxy data for bidders that are no longer participating in the program. Instead, we propose to use RNAC data only from approved CAP vendors that are participating in the CAP at the time that an RNAC-based price update is being calculated. We are also clarifying that the starting point for the payment amount adjustment is the most recent payment amount. The percent change calculated from each participating approved CAP vendor's RNAC data will be applied to the most recent payment amount by recomputing the single price using the median of all participating vendors' adjusted prices.

For example, if quarterly adjustments beginning at the start of claims processing approved CAP vendor's contract as described in section a. above are implemented, and the post bid period's CAP payment amounts are calculated based on five successful bids, but only four approved CAP vendors are participating when CAP claims processing begins, the RNAC-based payment amount adjustment for the first quarter of CAP claims would be based on RNAC data provided by the four approved CAP vendors that will be furnishing drugs under the CAP. The four approved CAP vendors would be required to submit a quarter of RNAC data within thirty days of the close of the quarter to which the data applied, prior to the beginning of CAP claims processing for the new contract. We would apply the percentage change in RNAC reported by each of the four approved CAP vendors to the CAP payment amounts calculated from successful bids, and the adjusted payment amount would be the median of those four adjusted amounts. Assuming that these four vendors are still furnishing drugs during the second quarter, calculations for the second quarter would apply the RNAC-based adjustment calculated from the four vendors' data to the first quarter's payment amount.

This process would apply to the composite bid drug list as amended by rulemaking, meaning that a single weighted percent change in RNAC is calculated for all drugs in the composite bid list and that single percent change is applied to all drugs in the list. For drugs that are bid as separate line items, such as drugs that were included in addendum B of the 2006 bidding period (*see* 70 FR 39072 and updated as addendum G in 70 FR 70238) or for drugs that are added during a contract period, each HCPCS code will be adjusted as a separate line item. Such codes will not be included in the composite, weighted drug list. Our process will continue to assign a single payment amount to all approved CAP vendors that supply a given HCPCS code; we do not intend to have more than one payment amount for any HCPCS code under the CAP or for individual ''NOC'' drugs described in § 414.906(f)(2)(iv).

This updated approach is flexible, and we believe it can accommodate a variety of scenarios, including a changing number of approved CAP vendors and changes to the frequency with which payment amount updates are made. It provides a straightforward and accurate clarification of the price adjustment mechanism described in regulation text. We believe that this proposal remains consistent with our original preamble language and with our CY 2009 PFS proposal, because it retains the two-step calculation using the percent change in RNAC. Finally, we believe that our approach will eliminate any perception that nonparticipating vendors can significantly affect CAP payment amount adjustments. We welcome comments on our proposal and corresponding regulation text changes at § 414.906(c).

g. 2009 PFS Proposals

(1) Definition of a CAP Physician

In the July 6, 2005 IFC, we stated that section 1847B of the Act most closely describes a system for the provision of and the payment for drugs provided incident to a physician's service (70 FR 39026). In the November 21, 2005 IFC (70 FR 70258), we stated that for the purposes of the CAP, a physician includes all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act. This definition includes doctors of medicine, osteopathy, dental surgery, dental medicine, podiatry, and optometry, as well as chiropractors. However, this definition does not include other health care professionals, such as nurse practitioners (NPs), clinical nurse specialists (CNSs), and other professions such as physician assistants (PAs) who may be able to legally prescribe medications and enroll in Medicare. Our 2005 CAP definition was not intended to exclude these practitioners who are appropriately billing Medicare for legally prescribed medications administered in a capacity that would be classified as incident to a physician's services if the medications were administered by a physician. We are concerned that the existing CAP definition of a physician is unnecessarily restrictive and could potentially affect access to the CAP for a small segment of providers that should be eligible for participation in the CAP in situations where they currently bill Medicare separately and appropriately.

In the CY 2009 PFS proposed rule (73 FR 38523), we proposed to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's service. While we believed that most practitioners described in section 1861(s)(2)(K) of the Act would bill under specific physician provider numbers, it was not our intent to exclude practitioners who are able to bill independently for drugs associated with services that are covered when provided by a physician and legally authorized to be performed.

In response to our CY 2009 proposed rule, only a few commenters were concerned about the inclusion of inadequately trained practitioners and risks to patient safety under this expanded definition. Another commenter stated that this definition goes beyond the scope of the provisions in the MMA and the strict definition of ''physician'' in the statute. However, the majority of comments supported this proposal.

We did not receive any feedback during the CAP postponement that would lead us to reconsider this proposal. Therefore, we are again proposing to further clarify that, for the purposes of the CAP, the definition of a physician included all practitioners that meet the definition of a ''physician'' in section 1861(r) of the Act, as well as practitioners (such as NPs, CNSs and PAs) described in section 1861(s)(2)(K) of the Act and other practitioners who legally prescribe drugs associated with services under section 1861(s) of the Act if those services and the associated drugs are covered when furnished incident to a physician's services.

Our proposal is specific to the Part B Drug CAP and does not affect the definition of physician in section 1861(r) of the Act, or the definition of ''Medical and Other Health Services'' described in section 1861(s) of the Act. This proposal also does not seek to expand the scope of the CAP beyond

what has been described in previous rules, other than to clarify that a small number of providers who are enrolled in Medicare, and who legally prescribe drugs associated with services under section 1861(s) of the Act and can be paid by Medicare may elect to participate in the CAP if billing independently. In short, the CAP remains a program that provides Part B drugs furnished incident to a physician's services. We welcome additional comments on the proposal.

(2) Easing the Restriction on Physicians Transporting CAP Drugs

Although section 1847B(b)(4)(E) of the Act provides for the shipment of CAP drugs to settings other than a participating CAP physician's office under certain conditions, in initially implementing the CAP, we did not propose to implement the CAP in alternative settings. We implemented the CAP with a restriction that CAP drugs be shipped directly to the participating CAP physician, as stated in § 414.906(a)(4), and that participating CAP physicians may not transport CAP drugs from one location to another, as stated in § 414.908(a)(3)(xii). However, we were aware that physicians may desire to administer drugs in alternative settings. Therefore, in the July 6, 2005 IFC, we sought comment on how this could be accommodated under the CAP in a way that addresses the potential vendors' concerns about product integrity and damage to the approved CAP vendors' property (70 FR 39048). We discussed comments submitted in response to the July 6, 2005 IFC in the CY 2008 PFS proposed rule (72 FR 38158). We also requested comments in the CY 2008 PFS proposed rule (72 FR 38157) on the potential feasibility of easing the restriction on transporting CAP drugs where this is permitted by State law and other applicable laws and regulations. We responded to submitted comments in the CY 2008 PFS final rule with comment period (72 FR 66268).

In the CY 2009 PFS proposed rule (70 FR 38523), we proposed to permit the transportation of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. Because of the 2009 CAP postponement, we did not address this issue in the CY 2009 PFS final rule. However, we did receive the following comments in response to our proposed rule on easing transportation restrictions in the CAP:

- Many commenters indicated that this change would increase program flexibility and facilitate patient treatment.
- Some commenters were supportive, but also raised concerns about drug integrity and liability, and requested that appropriate safeguards be in place before transportation restrictions were eased.
- Generally, commenters wanted CMS to explicitly delineate standards about voluntary agreements that address concerns about product integrity, liability, transportation procedures, and documentation. One commenter indicated that such standards should be developed through a separate rulemaking period to allow for public comment.
- Several commenters cited State pedigree laws as possible impediments to physician transport of drugs.

We also requested and received feedback about the program during the 2009 postponement period. One member of the potential vendor community urged us to be mindful of increased legal liability for an approved CAP vendor if this policy were to be implemented, but also acknowledged that the proposal might substantially increase physician interest in the program.

We continue to be mindful of the concerns expressed by the commenters, and have evaluated both the advantages and disadvantages of easing the restriction on transportation of CAP drugs. Thus, we are again proposing to permit transport of CAP drug between a participating CAP physician's practice locations subject to voluntary agreements between the approved CAP vendor and the participating CAP physician. As indicated in our CY 2009 PFS proposed rule, we continue to propose that such agreements must comply with all applicable State and Federal laws and regulations and product liability requirements, and be documented in writing.

We would again like to reiterate the voluntary nature of these proposed agreements. Approved CAP vendors would not be required to offer and participating CAP physicians would not be required to accept such agreements when selecting an approved CAP vendor. An approved CAP vendor may not refuse to do business with a participating CAP physician because the participating CAP physician has declined to enter into such an agreement with the approved CAP vendor. Furthermore, we are not seeking to define which CAP drugs may be subject to the proposed voluntary agreements. In other words, each approved CAP vendor could specify which CAP drug(s) could be transported.

However, our proposal continues to contain certain limitations. In previous rulemaking, we have described requirements for voluntary agreements between approved CAP vendors and participating CAP physicians. In the July 6, 2005 IFC (70 FR 39050) and the CY 2006 PFS final rule (70 FR 70251 through 70252), we stated that we will not dictate the breadth of use or the specific obligations contained in voluntary arrangements between approved CAP vendors and participating CAP physicians, other than to note that they must comply with applicable law and to prohibit approved CAP vendors from coercing participating CAP physicians into entering any of these arrangements. Parties to such arrangements must also ensure that the arrangements do not violate the physician self-referral (''Stark'') prohibition (section 1877 of the Act), the Federal anti-kickback statute (section 1128B(b) of the Act), or any other Federal or State law or regulation governing billing or claims submission. We are proposing to apply these standards to any agreement for the transport of CAP drugs.

We remain concerned about opportunities for disruption in the drug's chain of custody and appropriate storage and handling conditions that may ultimately affect patient care or increase the risk of drug theft or diversion. Therefore, in order to maintain safety and drug integrity in the CAP and to protect against the fraudulent diversion of CAP drugs, we are reproposing that any voluntary agreements between an approved CAP vendor and a participating CAP physician regarding the transportation of CAP drug must include requirements that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported. We again welcome comments on these issues, including the identification of who may transport the drugs, how documentation of transportation activities could be accomplished, and how the oversight of such agreements will be carried out.

In conclusion, we believe that this proposal to ease the restriction on transporting CAP drugs between a participating CAP physician's practice locations—when agreed upon by the participating CAP physician and the approved CAP vendor—will make the CAP more flexible and ultimately more appealing to participating CAP physicians. Additionally, we believe that this proposal will facilitate the participation of CAP physicians who

have office locations in rural areas and/or have satellite offices with limited hours. Moreover, we believe that this proposal will promote beneficiary care, particularly for beneficiaries who live in rural locations. Since participating CAP physicians would be able to transport CAP drugs to another office location in accordance with a voluntary agreement with their approved CAP vendor, beneficiaries would have more flexibility in scheduling the location of their appointments. We invite comments about this proposal.

(3) Dispute Resolution Process

In the CY 2009 PFS proposed rule (73 FR 38524 through 38525), we discussed two changes to the CAP dispute resolution process. Section 1847B(b)(2)(A)(ii)(II) of the Act requires an approved CAP vendor to have a grievance and appeals process for the resolution of disputes. In the July 6, 2005 IFC (70 FR 39054 through 39058), we described the process for the resolution of participating CAP physicians' drug quality and service complaints and approved CAP vendors' complaints regarding noncompliant participating CAP physicians. We encouraged participating CAP physicians, beneficiaries, and vendors to use informal communication as a first step to resolve service-related administration issues. However, we recognized that certain disputes would require a more structured approach, and therefore, we established processes under § 414.916 and § 414.917.

(i) Approved CAP Vendor's Status During the Reconsideration Process

Section 414.917 outlines the dispute resolution process for participating CAP physicians. As discussed in the July 6, 2005 IFC (70 FR 39057 through 39058), if a participating CAP physician finds an approved CAP vendor's service or the quality of a CAP drug supplied by the approved CAP vendor to be unsatisfactory, then the physician may address the issues first through the approved CAP vendor's grievance process, and second through an alternative dispute resolution process administered by the designated carrier and CMS. In turn, the designated carrier would gather information about the issue as outlined in § 414.917(b)(2) and make a recommendation to CMS on whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. We would then review and act on that recommendation after gathering any necessary, additional information from the participating CAP physician and approved CAP vendor. If we suspend an approved CAP vendor's CAP contract for noncompliance or terminate the CAP contract in accordance with § 414.914(a), the approved CAP vendor may request a reconsideration in accordance with § 414.917(c).

In the July 6, 2005 IFC (70 FR 39058), we indicated that the approved CAP vendor's participation in the CAP would be suspended while the approved CAP vendor's appeal of our decision is pending. This suspended status is also implied in § 414.917(c)(9), which states that the ''approved CAP vendor may resume participation in CAP'' if the final reconsideration determination is favorable to the approved CAP vendor. In order to improve the clarity of our regulations, we proposed in the CY 2009 PFS proposed rule that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917 (73 FR 38525). We believed that this proposed technical change is consistent with basic contracting concepts and with our current practices for the CAP. This proposal was not finalized due to the 2009 CAP postponement.

Comments submitted in response to our CY 2009 PFS proposed rule supported this proposed clarification and we did not receive additional feedback about this issue after the CAP was postponed. Based on this and our continued need to improve the clarity of our regulations, we are reproposing that the approved CAP vendor's contract will remain suspended during the reconsideration period in § 414.917. We invite additional comments regarding this proposed issue.

(ii) Termination of CAP Drug Shipments to Suspended CAP Physicians

Section 414.916 provides a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians. As stated at § 414.916(a), ''Cases of an approved CAP vendor's dissatisfaction with denied drug claims are resolved through a voluntary alternative dispute resolution process delivered by the designated carrier, and a reconsideration process provided by CMS.'' Once the decision is made to suspend a participating CAP physician's CAP election agreement, the participating CAP physician will be suspended from the CAP as described in § 414.916(b)(3).

Physicians whose participation in the CAP has been suspended are not eligible to receive CAP drugs. This is implied in § 414.906(a)(4), which speaks of approved CAP vendors providing CAP drugs directly to ''[a] participating CAP physician.'' However, we believe that the clarity of our dispute resolution regulations would be improved if this drug delivery issue were stated explicitly. Therefore, in the CY 2009 PFS proposed rule, we proposed to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. Our proposal also applied to physicians engaged in the reconsideration process outlined in § 414.916(c) and included a conforming change at § 414.914(f)(12). We believed that these changes were in accord with the underlying intent of § 414.916, namely to provide a mechanism for approved CAP vendors to address noncompliance problems with participating CAP physicians, and we believe that these changes will increase the clarity of our regulations. We also noted that the participating CAP physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked.

Comments submitted in response to the CY 2009 PFS proposed rule agreed with our proposal. Though we did not finalize this proposal due to the 2009 CAP postponement, we received no comments from the public in response to our request for feedback during the CAP 2009 postponement. Based on positive public feedback and our continued belief that the clarity of our dispute resolution regulations would be improved by being explicit about this issue, we are reproposing to revise § 414.916 to specify that approved CAP vendors shall not deliver CAP drugs to participating CAP physicians whose participation in the CAP has been suspended after an initial determination by CMS. This suspension in drug shipment would also apply to physicians engaged in the reconsideration process outlined in § 414.916(c). We have also proposed a conforming change to § 414.914(f)(12). Physicians who are suspended from participation in the CAP will be able to obtain drugs and bill for them under the ASP payment system provided they have not been excluded from participation in Medicare and/or their billing privileges have not been revoked. We welcome comments on this proposal.

I. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

Since August 1, 1983, payment for dialysis services furnished by end-stage renal disease (ESRD) facilities has been based on a composite rate payment system that provides a fixed, prospectively determined amount per dialysis treatment, adjusted for geographic differences in area wage levels. In accordance with section 1881(b)(7) of the Act, separate composite rates were established for hospital-based and independent ESRD facilities. The composite rate is designed to cover a package of goods and services needed to furnish dialysis treatments that include, but not be limited to, certain routinely provided drugs, laboratory tests, supplies, and equipment. Unless specifically included in the composite rate, other injectable drugs and laboratory tests medically necessary for the care of the dialysis patient are separately billable. Effective on August 1, 1983, the base composite rates per treatment were $123 for independent ESRD facilities and $127 for hospital-based ESRD facilities. The Congress has enacted a number of adjustments to the composite rate since that time.

Section 623 of the MMA amended section 1881 of the Act to require changes to the composite rate payment methodology, as well as to the pricing methodology for separately billable drugs and biologicals furnished by ESRD facilities. Section 1881(b)(12) of the Act, as added by section 623(d) of the MMA, requires the establishment of a basic case-mix adjusted composite payment system that includes services comprising the composite rate and an add-on to the composite rate component to account for the difference between current payments for separately billed drugs and the revised drug pricing specified in the statute. In addition, section 1881(b)(12) of the Act requires that the composite rate be adjusted for a number of patient characteristics (case-mix) and section 1881(b)(12)(D) of the Act gives the Secretary discretion to revise the wage indices and the urban and rural definitions used to develop them. Finally, section 1881(b)(12)(E) of the Act imposes a budget neutrality (BN) adjustment, so that aggregate payments under the basic case-mix adjusted composite payment system for CY 2005 equal the aggregate payments for the same period if section 1881(b)(12) of the Act did not apply.

Before January 1, 2005, payment to both independent and hospital-based facilities for the anti-anemia drug, erythropoietin (EPO) was established under section 1881(b)(11) of the Act at $10.00 per 1,000 units. For independent ESRD facilities, payment for all other separately billable drugs and biologicals is based on the lower of actual charges or 95 percent of the average wholesale price (AWP). Hospital-based ESRD facilities were paid based on the reasonable cost methodology for separately billed drugs and biologicals (other than EPO) furnished to dialysis patients. Changes to the payment methodology for separately billed ESRD drugs and biologicals that were established by the MMA affected payments in both CY 2005 and CY 2006.

1. CY 2005 Revisions

In the CY 2005 PFS final rule with comment period (69 FR 66319 through 66334), we implemented section 1881(b) of the Act, as amended by section 623 of the MMA, and revised payments to ESRD facilities. These revisions were effective January 1, 2005, and included an update of 1.6 percent to the composite rate component of the payment system; and a drug add-on adjustment of 8.7 percent to the composite rate to account for the difference between pre-MMA payments for separately billable drugs and payments based on revised drug pricing for 2005 which used acquisition costs. Effective April 1, 2005, the CY 2005 PFS final rule with comment period also implemented case-mix adjustments to the composite rate for certain patient characteristics (that is, age, low body mass index, and body surface area).

In addition, to implement section 1881(b)(13) of the Act, we revised payments for drugs billed separately by independent ESRD facilities, paying for the top 10 ESRD drugs based on acquisition costs (as determined by the OIG) and for other separately billed drugs at the average sales price +6 percent (hereafter referred to as ASP+6 percent). Hospital-based ESRD providers continued to receive cost-based payments for all separately billable drugs and biologicals except for EPO which was paid based on average acquisition cost.

2. CY 2006 Revisions

In the CY 2006 PFS final rule with comment period (70 FR 70161), we implemented additional revisions to payments to ESRD facilities under section 623 of the MMA. For CY 2006, we further revised the drug payment methodology applicable to drugs furnished by ESRD facilities. All separately billed drugs and biologicals furnished by both hospital-based and independent ESRD facilities are now paid based on ASP+6 percent.

We recalculated the 2005 drug add-on adjustment to reflect the difference in payments between the pre-MMA AWP pricing and the revised pricing based on ASP+6 percent. The recalculation did not affect the actual add-on adjustment applied to payments in 2005, but provided an estimate of what the adjustment would have been had the 2006 payment methodology been in effect in CY 2005. The drug add-on adjustment was then updated to reflect the expected growth in expenditures for separately billable drugs in CY 2006.

As of January 1, 2006, we also implemented a revised geographic adjustment authorized by section 1881(b)(12) of the Act. As part of that change, we—

- Revised the labor market areas to incorporate the Core-Based Statistical Area (CBSA) designations established by the Office of Management and Budget (OMB);
- Eliminated the wage index ceiling and reduced the floor to 0.8500; and
- Revised the labor portion of the composite rate to which the geographic adjustment is applied.

We also provided a 4-year transition from the previous wage-adjusted composite rates to the current wage-adjusted rates. For CY 2006, 25 percent of the payment was based on the revised geographic adjustments, and the remaining 75 percent of payment was based on the old metropolitan statistical area-based (MSA-based) payments.

In addition, section 5106 of the DRA provided for a 1.6 percent update to the composite rate component of the basic case-mix adjusted composite payment system, effective January 1, 2006. As a result, the base composite rate was increased to $130.40 for independent ESRD facilities and $134.53 for hospital-based providers. For 2006, the drug add-on adjustment (including the growth update) was 14.5 percent.

3. CY 2007 Updates In the CY 2007 PFS final rule with comment period (71 FR 69681), we implemented the following updates to the basic case-mix adjusted composite payment system:

- An update to the wage index adjustments to reflect the latest hospital wage data, including a BN adjustment of 1.052818 to the wage index for CY 2007.
- A method to annually calculate the growth update to the drug add-on adjustment required by section 1881(b)(12) of the Act, as well as a growth update to the drug add-on adjustment of 0.5 percent for CY 2007. Therefore, effective January 1, 2007 the

drug add-on adjustment was increased to 15.1 percent.

In addition, section 103 of the MIEA-TRHCA established a 1.6 percent update to the composite rate portion of the payment system, effective April 1, 2007. As a result, the current base composite rate was $132.49 for independent facilities and $136.68 for hospital-based providers. Also, the effect of this increase in the composite rate portion of the payment system was a reduction in the drug add-on adjustment to 14.9 percent, effective April 1, 2007. Since the statutory increase only applied to the composite rate, an adjustment to the drug add-on percent was needed to maintain the drug add-on amount constant.

4. CY 2008 Updates

In the CY 2008 PFS final rule with comment period (72 FR 66280), we implemented the following updates to the basic case-mix adjusted payment system:

- A growth update to the drug add-on adjustment of 0.5 percent. As a result, the drug add-on adjustment to the composite payment rate increased from 14.9 percent to 15.5 percent.
- An update to the wage index adjustments to reflect the latest hospital wage data, including a wage index BN adjustment of 1.055473 to the wage index for CY 2008.

For CY 2008, consistent with the transition blends announced in the CY 2006 PFS final rule with comment period (70 FR 70170), we implemented the third year of the transition to the CBSA-based wage index. In addition, the wage index floor was reduced from 0.8000 to 0.7500. After applying the wage index BN adjustment of 1.055473, the wage index floor was 0.7916.

5. CY 2009 Updates

Subsequent to the July 7, 2008 publication of the CY 2009 PFS proposed rule, section 153 of the MIPPA mandated changes in ESRD payment including a 1 percent increase to the composite rate, effective for services furnished on or after January 1, 2009 and 2010 and before January 1, 2010.

Specifically, section 153(a) of the MIPPA updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act to revised payments to ESRD facilities. The revisions that were effective January 1, 2009, included the update of 1 percent to the composite rate component of the payment system noted above, and the establishment of a site neutral composite rate for both hospital-based and independent dialysis facilities that reflected the labor share based on the labor share otherwise applied to independent dialysis facilities. The labor share for both hospital-based and independent dialysis facilities was 53.711. In the CY 2009 final rule with comment period (73 69754 through 69761), we implemented the following updates to the basic case-mix adjusted composite payment system:

- As required by updated sections 1881(b)(12)(G) and 1881(b)(12)(A) of the Act, we applied a 1 percent increase to the independent dialysis facility's CY 2008 composite rate of $132.49, which resulted in a CY 2009 base composite rate for both hospital-based and independent dialysis facilities of $133.81;
- A zero growth update to the drug add-on adjustment of 15.2 percent to the composite rates for 2009 as required by section 1881(b)(1)(F) of the Act (resulted in a $20.33 per treatment drug add-on amount);

Prior to MIPPA, the proposed drug add-on adjustment was 15.5 percent. Since we compute the drug add-on adjustment as a percentage of the weighted average base composite rate, the effect of the one percent increase in the composite rate portion of the payment system, effective January 1, 2009, reduced the drug add-on adjustment from 15.5 to 15.2 percent. Since the statutory increase only applied to the composite rate, this adjustment to the drug add-on percent was needed to ensure that the total drug add-on dollars remained constant.

- An update to the wage index adjustment to reflect the latest available wage data, including a wage index BN adjustment of 1.056672 to the wage index for CY 2009;
- For CY 2009, the completion of the 4-year transition from the previous wage-adjusted composite rates to the CBSA wage-adjusted rates, where payment is based on 100 percent of the revised geographic adjustments; and
- A reduction of the wage index floor from 0.7500 to 0.7000. After applying the wage index BN adjustment of 1.056672, the wage index floor was 0.7397.

6. CY 2010 Proposals

For CY 2010, we are proposing the following updates to the composite rate payment system:

- An update to the drug add-on adjustment to the composite rate, using a refined methodology for projecting growth in drug expenditures;
- An update to the wage index adjustment to reflect the latest available wage data, including a revised BN adjustment; and
- A reduction to the ESRD wage index floor from 0.7000 to 0.6500.

As stated above, section 1881(b)(12)(G)(iv) of the Act, as added by section 153(a)(1) of the MIPPA, increased the composite rate by 1.0 percent for ESRD services furnished on or after January 1, 2010. The 1.0 percent increases the current composite rate of $133.81 to $135.15 for services furnished on or after January 1, 2010.

a. Proposed Update to the Drug Add-on Adjustment to the Composite Rate

Section 623(d) of the MMA added section 1881(b)(12)(B)(ii) of the Act which requires establishing an add-on to the composite rate to account for changes in the drug payment methodology stemming from enactment of the MMA. Section 1881(b)(12)(C) of the Act provides that the drug add-on must reflect the difference in aggregate payments between the revised drug payment methodology for separately billable ESRD drugs and the AWP payment methodology. In 2005, we generally paid for ESRD drugs based on average acquisition costs. Thus the difference from AWP pricing was calculated using acquisition costs. However, in 2006 when we moved to ASP pricing for ESRD drugs, we recalculated the difference from AWP pricing using ASP prices.

In addition, section 1881(b)(12)(F) of the Act requires that, beginning in CY 2006, we establish an annual increase to the drug add-on to reflect estimated growth in expenditures for separately billable drugs and biologicals furnished by ESRD facilities. This growth update applies only to the drug add-on portion of the case-mix adjusted payment system. The CY 2009 drug add-on adjustment to the composite rate was 15.2 percent. The drug add-on adjustment for CY 2009 reflected a zero increase. This computation is explained in detail below and in the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757).

(i) Estimating Growth in Expenditures for Drugs and Biologicals for CY 2009

Section 1881(b)(12)(F) of the Act specifies that the drug add-on increase must reflect ''the estimated growth in expenditures for drugs and biologicals (including erythropoietin) that are separately billable * * *'' By referring to ''expenditures'', we stated previously that we believe the statute contemplates that the update would account for both increases in drug prices, as well as increases in utilization of those drugs.

In the CY 2007 PFS final rule with comment period (71 FR 69682), we established an interim methodology for annually estimating the growth in ESRD drugs and biological expenditures that

uses the Producer Price Index (PPI) for pharmaceuticals as a proxy for pricing growth in conjunction with 2 years of ESRD drug data to estimate per patient utilization growth. We indicated that this interim methodology would be used to update the drug add-on to the composite rate until such time that we had sufficient ESRD drug expenditure data to project the growth in ESRD drug expenditures.

However, due to the declining ASP prices, we no longer believed that using the PPI as a proxy for pricing growth was appropriate. Accordingly, for CY 2009, we revised the interim methodology for estimating the growth in ESRD drug expenditures by using ASP pricing to estimate the price component of the update calculation. Due to the declining trend in ASP pricing and utilization, we calculated a decrease in the drug add-on adjustment, and applied a zero update to the drug add-on adjustment (73 FR 69755 through 69757).

(ii) Estimating Growth in Expenditures for Drugs and Biologicals in CY 2010

Since we now have 3 years of drug expenditure data based on ASP pricing, we have reevaluated our methodology for estimating growth in drug expenditures. We believe that 3 years of drug expenditure data based on ASP pricing is sufficient to project drug expenditure growth based on trend analysis. Therefore, for CY 2010, we are proposing to use trend analysis from drug expenditure data to update the per treatment drug add-on adjustment. In the CY 2008 PFS final rule with comment period, we stated that when we had 3 consecutive years of ASP-based historical drug expenditure data, we intended to reevaluate our methodology for estimating growth in drug add-on adjustment (72 FR 66281). We also stated that we expected 2010 would be the earliest we could consider using trend analysis to update the drug add-on adjustment (72 FR 66281).

For CY 2010, we propose to estimate per patient growth in drug expenditures by removing growth in ESRD enrollment from growth in total drug expenditures.

To estimate drug expenditure growth using trend analysis, we looked at the average annual growth in total drug expenditures between 2006 and 2008. First we had to estimate the total drug expenditures for all ESRD facilities in CY 2008. For this proposed rule, we used the final CY 2006 and the final CY 2007 ESRD claims data and the latest available CY 2008 ESRD facility claims, updated through December 31, 2008 (that is, claims with dates of service from January 1 through December 31, 2008, that were received, processed, paid, and passed to the National Claims History File as of December 31, 2008). For the CY 2010 PFS final rule, we plan to use additional updated CY 2008 claims with dates of service for the same timeframe. This updated CY 2008 data file will include claims received, processed, paid, and passed to the National Claims History File as of June 30, 2009.

While the December 2008 update of CY 2008 claims used in this proposed rule is the most current available claims data, we recognize that it does not reflect a complete year, as claims with dates of service towards the end of the year have not all been processed. To more accurately estimate the update to the drug add-on, aggregate drug expenditures are required. Based on an analysis of the 2007 claims data, we inflated the CY 2008 drug expenditures to estimate the June 30, 2009 update of the 2008 claims file. We used the relationship between the December 2007 and the June 2008 versions of 2007 claims to estimate the more complete 2008 claims that will be available in June 2009 and applied that ratio to the 2008 claims data from the December 2008 claims file. In previous years, we did this separately for EPO, the other top 10 Part B separately billable drugs, and the remaining separately billable drugs for independent and hospital-based ESRD facilities. All components were then combined to estimate aggregate CY 2008 ESRD drug expenditures. However, we do not believe that creating this estimate using this level of detail (by separately estimating EPO, the other top 10 separately billable drugs, and the remaining separately billable drug for independent and hospital-based ESRD facilities and then combining these components) provides more accuracy. For this reason, we are making this adjustment in aggregate for all separately billable drugs for CY 2008 ESRD drug expenditures. The net adjustment to the CY 2008 claims data is an increase of 11.1 percent to the 2008 expenditure data. This adjustment allows us to more accurately compare the 2007 and 2008 drug expenditure data to estimate per patient growth. As stated earlier in this section, we plan to use additional updated CY 2008 claims in the CY 2010 PFS final rule with comment period. We also note that the top 11 drugs continue to represent 99.7 percent of total expenditures in CY 2008 for separately billable drugs furnished to ESRD patients.

Using the full-year 2008 drug expenditure figure, we calculated the average annual change in drug expenditures from 2006 through 2008. This average annual change showed a decrease of 2.2 percent for this timeframe. We propose to use this 2.2 percent decrease to project drug expenditures for both 2009 and 2010.

(iii) Estimating Per Patient Growth

Once we had the projected growth in drug expenditures from 2009 to 2010, we then removed growth in enrollment for the same time period from the expenditure growth, so that the residual reflects per patient expenditure growth, (which includes price and utilization combined) which is what we believe that section 1881(b)(12)(F) of the Act requires us to use to update the drug add-on adjustment. As we described in section II.I.6.a.(ii) of this proposed rule, we now have 3 years of drug expenditure data based on ASP pricing, and for CY 2010 we are proposing to use trend analysis from this data to update the per treatment drug add-on adjustment. To calculate the per patient growth between CYs 2009 and 2010, we removed the enrollment component by using the estimated growth in enrollment data between CY 2009 and CY 2010. This was approximately 1.3 percent. To do this, we divided the total drug expenditure change between 2009 and 2010 (1.000–0.222 = 0.978) by enrollment growth of 1.3 percent (1.013) for the same timeframe. The result is a per patient growth factor equal to 0.965, (0.978/1.013 = 0.965). Thus we are projecting a 3.5 percent decrease in per patient growth in drug expenditures between 2009 and 2010.

b. Applying the Proposed Growth Update to the Drug Add-On Adjustment

In CY 2006, we applied the projected growth update percentage to the total amount of drug add-on dollars established for CY 2005 to establish a dollar amount for the CY 2006 growth update. In addition, we projected the growth in dialysis treatments for CY 2006 based on the projected growth in ESRD enrollment. We divided the projected total dollar amount of the CY 2006 growth by the projected growth in total dialysis treatments to develop the per treatment growth update amount. This growth update amount, combined with the CY 2005 per treatment drug add-on amount, resulted in an average drug add-on amount per treatment of $18.88 (or a 14.5 percent adjustment to the composite rate) for CY 2006.

In the CY 2007 PFS final rule with comment period (71 FR 69684), we revised our update methodology by applying the growth update to the per treatment drug add-on amount. That is, for CY 2007, we applied the growth

update factor of 4.03 percent to the $18.88 per treatment drug add-on amount for an updated amount of $19.64 per treatment (71 FR 69684). For CY 2008, the per treatment drug add-on amount was updated to $20.33. In the CY 2009 PFS final rule with comment period (73 FR 69755 through 69757), we applied a zero update to per treatment drug add-on amount which left it at $20.33. As discussed in detail below, for CY 2010, we are again proposing no update to the per treatment drug add-on amount of $20.33 established in CY 2008.

c. Proposed Update to the Drug Add-on Adjustment

As discussed previously in this section, we estimate a 2.2 percent reduction in drug expenditures between CY 2009 and CY 2010. Combining this reduction with a 1.3 percent increase in enrollment, as described in section (a)(iii) above, we are projecting a 3.5 percent decrease in per patient growth of drug expenditures between CY 2009 and CY 2010. Therefore, we are projecting that the combined growth in per patient utilization and pricing for CY 2010 would result in a negative update equal to −3.5 percent. However, similar to last year and as indicated above, we are proposing a zero update to the drug add-on adjustment.

We believe this approach is consistent with the language under section 1881(b)(12)(F) of the Act which states in part that ''the Secretary shall annually increase'' the drug add-on amount based on the growth in expenditures for separately billed ESRD drugs. Our understanding of the statute contemplates ''annually increase'' to mean a positive or zero update to the drug add-on. Therefore, we propose to apply a zero update, and to maintain the $20.33 per treatment drug add-on amount for CY 2010. The current $20.33 per treatment drug add-on reflected a 15.2 percent drug add-on adjustment to the composite rate in effect for CY 2009. Given that the MIPPA mandates a 1 percent increase to the composite rate (effective January 1, 2010), however, as discussed earlier in this section, this results in a decrease in the CY 2009 drug add-on adjustment of 15.2 to 15.0 to keep the drug add-on at $20.33. Therefore, we are proposing that the drug add-on adjustment to the composite rate for CY 2010 is 15.0 percent.

d. Proposed Update to the Geographic Adjustments to the Composite Rate

Section 1881(b)(12)(D) of the Act, as amended by section 623(d) of the MMA, gives the Secretary the authority to revise the wage indexes previously applied to the ESRD composite rate. The purpose of the wage index is to adjust the composite rates for differing wage levels covering the areas in which ESRD facilities are located. The wage indexes are calculated for each urban and rural area. In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. In addition, we generally have followed wage index policies related to these definitions as used under the inpatient hospital prospective payment system (IPPS), but without regard to any approved geographic reclassification authorized under sections 1886(d)(8) and (d)(10) of the Act or other provisions that only apply to hospitals paid under the IPPS (70 FR 70167). For purposes of the ESRD wage index methodology, the hospital wage data we use is pre-classified, pre-floor hospital data and unadjusted for occupational mix.

e. Proposed Updates to Core-Based Statistical Area (CBSA) Definitions

In the CY 2006 PFS final rule with comment period (70 FR 70167), we announced our adoption of the OMB's CBSA-based geographic area designations to develop revised urban/rural definitions and corresponding wage index values for purposes of calculating ESRD composite rates. The CBSA-based geographic area designations are described in OMB Bulletin 03–04, originally issued June 6, 2003, and is available online at *http://www.whitehouse.gov/omb/bulletins/b03-04.html.* In addition, OMB has published subsequent bulletins regarding CBSA changes, including changes in CBSA numbers and titles. We wish to point out that this and all subsequent ESRD rules and notices are considered to incorporate the CBSA changes published in the most recent OMB bulletin that applies to the hospital wage index used to determine the current ESRD wage index. The OMB bulletins may be accessed online at *http://www.whitehouse.gov/omb/bulletins/index.html.*

f. Proposed Updated Wage Index Values

In the CY 2007 PFS final rule with comment period (71 FR 69685), we stated that we intended to update the ESRD wage index values annually. The ESRD wage index values for CY 2010 were developed from FY 2006 wage and employment data obtained from the Medicare hospital cost reports. As we indicated, the ESRD wage index values are calculated without regard to geographic classifications authorized under sections 1886(d)(8) and (d)(10) of the Act and utilize pre-floor hospital data that is unadjusted for occupational mix. We propose to use the same methodology for CY 2010, with the exception that FY 2006 hospital data would be used to develop the CY 2010 wage index values. For a detailed description of the development of the proposed CY 2010 wage index values based on FY 2006 hospital data, *see* the FY 2010 IPPS proposed rule (74 FR 24145). Section III.G, of the preamble to the FY 2010 IPPS proposed rule, ''Method for Computing the Proposed FY 2010 Unadjusted Wage Index'', describes the cost report schedules, line items, data elements, adjustments, and wage index computations. The wage index data affecting the ESRD composite rate for each urban and rural locale may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage data are located in the section entitled, ''FY 2010 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-reclassified Wage Index by CBSA.''

In the CY 2009 final rule with comment period (73 FR 69758 and 69759), we indicated that the CY 2009 was the final year of the transition period and each ESRD facility's composite payment rate would be based entirely on its applicable CBSA-based wage index value.

g. Proposed Reduction to the ESRD Wage Index Floor

In the CY 2009 PFS final rule with comment period, we stated our intention to continue to reassess the need for a wage index floor (73 FR 63758). We also stated that a gradual reduction in the floor is needed to support continuing patient access to dialysis in areas that have low wage index values, especially in Puerto Rico where the wage index values are below the current wage index floor. For CY 2010, we are proposing to reduce the wage index floor from 0.70 to 0.65. We also anticipate that we may reduce the floor gradually until full implementation of the ESRD PPS required by section 1881(b)(14) of the Act.

h. Proposed Wage index Values for Areas With No Hospital Data

In CY 2006, while adopting the CBSA designations, we identified a small number of ESRD facilities in both urban and rural geographic areas where there

are no hospital wage data from which to calculate ESRD wage index values. The affected areas were rural Puerto Rico, and the urban area of Hinesville, GA (CBSA 25980), and rural Massachusetts. For CY 2006, CY 2007, CY 2008, and CY 2009, we calculated the ESRD wage index values for those areas as follows:

- For the urban area of Hinesville, GA, we calculated the CY 2006, CY 2007, CY 2008, and CY 2009 wage index value based on the average wage index value for all urban areas within the State of Georgia.
- For rural Massachusetts, because we had not determined a reasonable wage proxy, we used the FY 2005 wage index value in CY 2006 and CY 2007. As discussed below, we adopted an alternative methodology for CYs 2008 and 2009.
- For rural Puerto Rico, because all geographic areas in Puerto Rico were subject to the wage index floor in CYs 2006 through 2009, we applied the ESRD wage index floor to rural Puerto Rico as well. We note that there are currently no ESRD facilities located in rural Puerto Rico.

For CY 2008, we adopted an alternative methodology for establishing a wage index value for rural Massachusetts and continued to apply this methodology in CY 2009. Because we used the same wage index value for 2 years with no update, we believed it was appropriate to establish a methodology which employed reasonable proxy data for rural areas (including rural Massachusetts) and also permitted annual updates to the wage index based on that proxy data. For rural areas without hospital wage data, we used the average wage index values from all contiguous CBSAs as a reasonable proxy for that rural area.

In determining the imputed rural wage index, we interpreted the term ''contiguous'' to mean sharing a border. In the case of Massachusetts, the entire rural area consists of Dukes and Nantucket Counties. We determined that the borders of Dukes and Nantucket counties are contiguous with CBSA 12700, Barnstable Town, MA and CBSA 39300, Providence-New Bedford-Fall River, RI–MA. We are proposing to use the same methodology for CY 2010. Under this methodology, the CY 2010 proposed wage index values for CBSA 12700 (Barnstable Town, MA—1.2629) and CBSA 39300 (Providence-New Bedford-Fall River, RI–MA—1.0792) averages results in an imputed proposed wage index value of 1.1711 for rural Massachusetts in CY 2010.

For rural Puerto Rico, for CY 2010, all areas in Puerto Rico that have a wage index are eligible for the proposed ESRD wage index floor of 0.65. Therefore, we propose to continue applying the proposed ESRD wage index floor of 0.65 to facilities that are located in rural Puerto Rico.

For Hinesville-Fort Stewart, GA (CBSA 25980), which is an urban area without specific hospital wage data, we propose to apply the same methodology used to impute a wage index value that we used in CY 2009. Specifically, we utilize the average wage index value for all urban areas within the State of Georgia. That results in a proposed CY 2010 wage index value of 0.9029 for the Hinesville-Fort Stewart GA CBSA.

In the CY 2009 PFS final rule with comment period (73 FR 69759 through 69760), we stated that we would continue to evaluate existing hospital wage data and possibly wage data from other sources such as the Bureau of Labor Statistics, to determine if other methodologies might be appropriate for imputing wage index values for areas without hospital wage data for CY 2010 and subsequent years. To date, no data from other sources, superior to that currently used in connection with the IPPS wage index has emerged. Therefore, for ESRD purposes, we continue to believe this is an appropriate policy.

For CY 2010, we are proposing to use the FY 2010 wage index data (collected from cost reports submitted by hospital for cost reporting periods beginning FY 2006) to compute the ESRD composite payment rates effective beginning January 1, 2010.

i. Budget Neutrality Adjustment

Section 1881(b)(12)(E)(i) of the Act, as added by section 623(d) of the MMA, required that any revisions to the ESRD composite rate payment system as a result of the MMA provision (including the geographic adjustment) be made in a budget neutral manner. Given our application of the ESRD wage index, this means that aggregate payments to ESRD facilities in CY 2010 would be the same as aggregate payments that would have been made if we had not made any changes to the geographic adjusters. We note that this BN adjustment only addresses the impact of changes in the geographic adjustments. A separate BN adjustment was developed for the case-mix adjustments required by the MMA. As we are not proposing any changes to the case-mix measures for CY 2010, the current case-mix BN adjustment of 0.9116 would remain in effect for CY 2010. As in CY 2009, for CY 2010, we propose to apply the wage-index BN adjustment factor of 1.057888 directly to the ESRD wage index values. Because the ESRD wage index is only applied to the labor-related portion of the composite rate, we computed the BN adjustment factor based on that proportion (53.711 percent).

To compute the proposed CY 2010 wage index BN adjustment factor (1.057888), we used the FY 2006 pre-floor, pre-reclassified, non-occupational mix-adjusted hospital data to compute the wage index values, 2008 outpatient claims (paid and processed as of December 31, 2008), and geographic location information for each facility which may be found through Dialysis Facility Compare Web page on the CMS Web site at *http://www.cms.hhs.gov/DialysisFacilityCompare/.* The FY 2006 hospital wage index data for each urban and rural locale by CBSA may also be accessed on the CMS Web site at *http://www.cms.hhs.gov/AcuteInpatientPPS/WIFN/list.asp.* The wage index data are located in the section entitled, ''FY 2010 Proposed Rule Occupational Mix Adjusted and Unadjusted Average Hourly Wage and Pre-Reclassified Wage Index by CBSA.''

Using treatment counts from the 2008 claims and facility-specific CY 2009 composite rates, we computed the estimated total dollar amount each ESRD provider would have received in CY 2009. The total of these payments became the target amount of expenditures for all ESRD facilities for CY 2010. Next, we computed the estimated dollar amount that would have been paid for the same ESRD facilities using the proposed ESRD wage index for CY 2010. The total of these payments became the new CY 2010 amount of wage-adjusted composite rate expenditures for all ESRD facilities. Section 153(a) of the MIPPA revised section 1881(b)(12)(G) of the Act and provided for an update of 1 percent to the composite rate component of the payment system effective January 1, 2010. We note that when computing the new CY 2010 amount, we did not include this 1 percent increase because the BN adjustment would negate the increase.

After comparing these two dollar amounts (target amount divided by the new CY 2010 amount), we calculated an adjustment factor that, when multiplied by the applicable CY 2010 ESRD wage index value, would result in aggregate payments to ESRD facilities that would remain within the target amount of composite rate expenditures. When making this calculation, the ESRD wage index floor value of 0.6500 is applied whenever appropriate. The proposed wage BN adjustment factor is 1.057888.

To ensure BN, we also must apply the BN adjustment factor to the proposed

wage index floor of 0.6500 which results in a proposed adjusted wage index floor of 0.6876 (0.6500 x 1.057888) for CY 2010.

j. ESRD Wage Index Tables

The CY 2010 ESRD wage index tables are located in Addenda F and G of this proposed rule.

J. Discussion of Chiropractic Services Demonstration

1. Background

Section 651 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173) requires the Secretary to evaluate the feasibility and advisability of expanding coverage for chiropractic services under Medicare. Under Medicare, coverage for chiropractic services is limited to manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Act. The demonstration expanded current Medicare coverage to include ''care for neuromusculoskeletal conditions typical among eligible beneficiaries and diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.'' The 2-year demonstration was conducted in four geographically diverse sites, two rural and two urban regions, with each type including a Health Professional Shortage Area (HPSA). The two urban sites were 26 counties in Illinois and Scott County, Iowa, and 17 counties in Virginia. The two rural sites were the States of Maine and New Mexico. The demonstration, which ended on March 31, 2007, was required to be budget neutral as section 651(f)(1)(B) of the MMA requires the Secretary to ensure that ''the aggregate payments made by the Secretary under the Medicare program do not exceed the amount which the Secretary would have paid under the Medicare program if the demonstration projects under this section were not implemented.''

In the CY 2006, 2007, and 2008 PFS final rules with comment period (70 FR 70266, 71 FR 69707, 72 FR 66325, respectively), we included a discussion of the strategy that would be used to assess budget neutrality (BN) and how chiropractor fees would be adjusted should the demonstration result in costs higher than those that would occur in the absence of the demonstration. We stated we would assess BN by determining the change in costs based on a pre-post comparison of costs and the rate of change for specific diagnoses that are treated by chiropractors and physicians in the demonstration sites and control sites. We also stated we would not limit our analysis to reviewing only chiropractor claims because the costs of the expanded chiropractor services may have an impact on other Medicare costs. If the demonstration was not budget neutral, we anticipated making reductions in the CY 2010 and CY 2011 physician fee schedules. We proposed that if we determined that the adjustment for BN was greater than 2 percent of spending for the chiropractor fee schedule codes, we would implement the adjustment over a 2-year period. However, if the adjustment was less than 2 percent of spending under the chiropractor fee schedule codes, we would implement the adjustment over a 1-year period.

2. Analysis of Demonstration

Brandeis University, the demonstration evaluator, used two approaches in examining BN. The ''All Neuromusculoskeletal Analysis (NMS)'' reflects an intent-to-treat approach whereby the utilization of all beneficiaries who received any Medicare covered services for neuromusculoskeletal conditions in the demonstration areas was examined. This method is potentially subject to large external forces because of its inclusion of all beneficiaries including those who did not use chiropractic services and who would not become users of chiropractic services even with expanded coverage for them. Therefore, a second analysis, termed the ''Chiropractic User Analysis'' was conducted to examine only the subset of beneficiaries who used chiropractic services for the treatment of their neuromusculoskeletal conditions. Both approaches use hierarchical linear modeling of costs over 3 years—1 year prior to the demonstration and the 2 years of the demonstration. We posted a report describing these analyses on CMS Web site at *http://www.cms.hhs.gov/reports/downloads/MMA651_BudgetNeutrality.pdf*.

The results of both analyses indicate that the demonstration was not budget neutral. In the ''All NMS Analysis,'' which measured the costs of the demonstration on all beneficiaries who received services for a neuromusculoskeletal condition in the demonstration areas in comparison to beneficiaries with similar characteristics from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $114 million. In the ''Chiropractic User Analysis,'' which measured the costs of the demonstration among beneficiaries who used expanded chiropractic services to treat a neuromusculoskeletal condition in the demonstration areas, in comparison to beneficiaries with similar characteristics who used chiropractic services as currently covered by Medicare to treat a neuromusculoskeletal condition from similar geographic areas that did not participate in the demonstration, the total effect of the demonstration to Medicare was $50 million.

Both approaches to assessing BN have strengths and limitations. The ''All NMS Analysis'' provides the broadest view of the Medicare population that would have been eligible for the demonstration's expanded coverage of chiropractic services. Because it includes all beneficiaries with neuromusculoskeletal conditions, it guards against validity threats of selection. However, this approach creates a large heterogeneous group which may only include a small proportion of chiropractic service users. Basing estimates of BN on such a large heterogeneous group increases the potential for changes in the use of services seldom affected by chiropractors to be falsely attributed to the demonstration, which could result in the costs of the demonstration appearing to be larger than they actually were.

We believe the BN estimate should be based on the ''Chiropractic User Analysis'' because of its focus on users of chiropractic services rather than all Medicare beneficiaries with neuromusculoskeletal conditions, including those who did not use chiropractic services and who would not have become users of chiropractic services even with expanded coverage for them. Users of chiropractic services are most likely to have been affected by the expanded coverage provided by this demonstration. Cost increases and offsets, such as reductions in hospitalizations or other types of ambulatory care, are more likely to be observed in this group. Therefore, we are proposing to adjust the Medicare PFS for all chiropractors using the estimate provided in the ''Chiropractic User Analysis.''

The CMS Office of the Actuary (OACT) estimates chiropractic expenditures in CY 2010 to be approximately $487 million based on actual Medicare spending for chiropractic services for the most recent available year. Because the costs of this demonstration were higher than expected and we did not anticipate a reduction to the PFS of greater than 2 percent per year, we are proposing to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period.

This approach reflects a change from our BN discussion in the CY 2006, 2007, and 2008 PFS rules, which was described previously in this section. We would recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014. We believe that spreading this adjustment over a longer period of time and in equal increments will minimize its potential negative impact on chiropractic practices.

3. Payment Adjustment

To implement the required BN adjustment, we propose to reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942). Payment under the PFS for these codes would be reduced by 2 percent. As stated in prior PFS rules, application of the BN adjustment would be specific to these three codes which represent the ''chiropractic fee schedule'' because they are the only chiropractic codes recognized under the PFS. We are proposing to reflect this reduction only in the payment files used by the Medicare contractors to process Medicare claims rather than through adjusting the RVUs. This would preserve the integrity of the PFS, particularly since many private payers also base payment on the RVUs. The RVUs published in Addendum B and posted on our Web site would not show this reduction but would be annotated to state that the reduction resulting from the chiropractic demonstration is not reflected in the RVUs.

K. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

A Comprehensive Outpatient Rehabilitation Facility (CORF) is a Medicare provider that furnishes respiratory therapy services among other services. In § 485.70, we set forth the personnel qualifications that must be satisfied by a CORF as a condition of participation under § 485.58 and as a condition of coverage of CORF services, including personnel qualifications for respiratory therapists providing CORF respiratory therapy services.

In the CY 2009 PFS proposed rule (73 FR 38502) and subsequent final rule with comment period (73 FR 69942), we revised the definition of a respiratory therapist under § 485.70(j). The change in the definition of respiratory therapist was intended to ensure accuracy in reference to persons who are qualified to perform respiratory therapy and to ensure that language regarding these professionals is consistent with current industry requirements for education, training, and practice.

Prior to its modification by the CY 2009 PFS final rule with comment period, § 485.70(j) reflected the qualifications for ''Certified Respiratory Therapists (CRTs)'' and ''Registered Respiratory Therapists (RRTs)'' as terms commonly used by the professional industry to identify persons furnishing respiratory therapy services.

Since publication of the CY 2009 PFS final rule with comment, we have been informed by the industry that the changes made in the definition of respiratory therapist exclude a category of professional that has completed the requirements of a CRT, has completed a nationally accredited educational program that confers eligibility for the National Board for Respiratory Care (NBRC) registry exam for respiratory therapists (RTs), and is eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but has not yet passed the examination. These persons are referred to in the industry as Certified Respiratory Therapists (CRTs).

Because it is our policy that Medicare payment is available for respiratory services provided to Medicare beneficiaries in a CORF only if provided by a respiratory therapist meeting the qualifications set forth in § 485.70(j), payment is not available for respiratory services provided by CRTs in the CORF setting. We note that personnel qualifications for respiratory therapists previously set forth at § 485.70(j) prior to its modification by the CY 2009 PFS final rule with comment period did not exclude this category of personnel from the definition of respiratory therapist. We have also heard from CRTs and from CORFs that this change has limited the availability of respiratory therapy services to Medicare beneficiaries in certified CORFs, as many of these services were provided by CRTs. Thus, in modifying the definition of respiratory therapist in the CY 2009 PFS final rule with comment period, we may have inadvertently impacted access to respiratory therapy services for some Medicare beneficiaries.

Thus, we are proposing to modify the definition of respiratory therapist and to clarify the terms that are used to identify those persons who furnish respiratory services in CORFs in § 485.70(j) to include CRTs, that is those individuals who have completed a nationally accredited educational program for respiratory therapists and are eligible to sit for the national registry examination administered by the National Board for Respiratory Care (NBRC), but who have not yet passed the examination. The change in the definition we are proposing would permit CRTs to furnish respiratory therapy services to Medicare beneficiaries in the CORF setting.

In this proposed rule, we intend to assure that persons who were qualified to furnish respiratory therapy services to patients in CORFs prior to the finalization of CY 2009 PFS final rule with comment period (73 FR 69942), will continue to qualify to furnish RT services to CORF patients under this proposed rule.

We invite public comment on the proposed change to § 485.70(j). We are also seeking comments from the industry regarding the difference in services furnished by the different levels of professionals who provide RT services in CORFs. We welcome such comments to be descriptive and both quantitative and qualitative in nature to the extent possible.

L. Ambulance Fee Schedule: Technical Correction to the Rural Adjustment Factor Regulations (§ 414.610)

Section 1834(l)(9) of the Act provides that for ''ground ambulance services furnished on or after July 1, 2001, and before January 1, 2004, for which transportation originates in a rural area * * * or in a rural census tract of a metropolitan statistical area * * * the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 17 miles, and up to 50 miles, the rate otherwise established shall be increased by not less than ½ of the additional payment per mile established for the first 17 miles of such a trip originating in a rural area.'' Thus, the statute authorized a rural mileage bonus for miles 18 through 50 for ground ambulance services furnished on or after July 1, 2001 and prior to January 1, 2004. This provision was implemented in § 414.610(c)(5)(i), but the regulation text does not currently specify the statutory time period during which this rural mileage bonus was effective. In the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67960, 67961), we acknowledged that we inadvertently omitted from the regulation text the time period during which this statutory adjustment was applicable, and stated we were ''revising § 414.610(c) to reflect that this bonus payment applies only for services furnished during the statutory period.'' Thus, in the ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period, we

revised the regulation to include the time period during which the adjustment is applicable (68 FR 67963). However, the revised language specifying the statutory time period was dropped inadvertently from the regulation text when § 414.610(c)(5) was later republished in the ''Medicare Program; Medicare Ambulance MMA Temporary Rate Increases Beginning July 1, 2004'' interim final rule (69 FR 40288, 40292).

In this proposed rule, we are reinstating the language that was originally finalized in ''Medicare Program; Coverage and Payment of Ambulance Services; Inflation Update for CY 2004'' final rule with comment period (68 FR 67963) but then inadvertently omitted again when § 414.610(c)(5) was later republished, so that § 414.610(c)(5)(i) correctly sets forth the statutory time period during which this rural mileage bonus was applicable. This revision to the regulation is a technical correction to conform the regulation to the statute. For further information, *see* program instruction, Transmittal AB–03–110; Date August 1, 2003; Change Request 2767 which was issued to inform contractors to discontinue paying such bonuses effective January 1, 2004 in accordance with the statute.

M. Clinical Laboratory Fee Schedule: Signature on Requisition

In the March 10, 2000 **Federal Register**, we published the ''Medicare Program; Negotiated Rulemaking: Coverage and Administrative Policies for Clinical Diagnostic Laboratory Services'' proposed rule (65 FR 13082) announcing and soliciting comments on the results of our negotiated rulemaking committee tasked to establish national coverage and administrative policies for clinical diagnostic laboratory tests under Part B of Medicare. In our final rule published in the November 23, 2001 **Federal Register** (66 FR 58788), we explained our policy on ordering clinical diagnostic laboratory services and amended § 410.32 to make our policy more explicit. Our regulation at § 410.32(a) included the requirement that ''[a]ll diagnostic x-ray tests, diagnostic laboratory tests, and other diagnostic tests must be ordered by the physician who is treating the beneficiary.'' In the November 23, 2001 final rule, we added paragraph (d)(2) to § 410.32 to require that the physician or qualified nonphysician practitioner (NPP) who orders the service must maintain documentation of medical necessity in the beneficiary's medical record (66 FR 58809). In the preamble discussions to the March 10, 2000 proposed rule and November 23, 2001 final rule (65 FR 13089 and 66 FR 58802, respectively), we noted that ''[w]hile the signature of a physician on a requisition is one way of documenting that the treating physician ordered the test, it is not the only permissible way of documenting that the test has been ordered.'' In those preambles, we described the policy of not requiring physician signatures on requisitions for clinical diagnostic laboratory tests, but implicitly left in place the existing requirements for a written order to be signed by the ordering physician or NPP for clinical diagnostic laboratory tests, as well as other types of diagnostic tests. We further stated in the preambles of the proposed and final rules that we would publish an instruction to Medicare contractors clarifying that the signature of the ordering physician is not required for Medicare purposes on a requisition for a clinical diagnostic laboratory test (65 FR 13089 and 66 FR 58802).

On March 5, 2002, we published a program transmittal implementing the administrative policies set forth in the final rule, including the following instruction: ''Medicare does not require the signature of the ordering physician on a laboratory service requisition. While the signature of a physician on a requisition is one way of documenting that the treating physician ordered the service, it is not the only permissible way of documenting that the service has been ordered. For example, the physician may document the ordering of specific services in the patient's medical record.'' (Transmittal AB–02–030, Change Request 1998, dated March 5, 2002).

On January 24, 2003, we published a program transmittal in order to manualize the March 5, 2002 Transmittal. (Transmittal 1787, Change Request 2410, dated January 24, 2003). The cover note to the transmittal states, ''Section 15021, Ordering Diagnostic Tests, manualizes Transmittal AB–02–030, dated March 5, 2002. In accordance with negotiated rulemaking for outpatient clinical diagnostic laboratory services, no signature is required for the ordering of such services or for physician pathology services.'' In the manual instructions in that transmittal in a note, we stated: ''No signature is required on orders for clinical diagnostic services paid on the basis of the physician fee schedule or for physician pathology services.'' The manual instructions did not explicitly reference clinical diagnostic laboratory tests as the cover note did. Rather, the transmittal seemed to extend the policy set forth in the **Federal Register** (that no signature is required on requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule) to also apply to clinical diagnostic tests paid on the basis of the PFS and physician pathology services. In addition, the manual instructions used the term ''order'' instead of ''requisition,'' which some members of the industry have asserted caused confusion.

When we transitioned from paper manuals to the current electronic Internet Only Manual system, these manual instructions were inadvertently omitted from the new Benefit Policy Manual (BPM).

In August 2008, we issued a program transmittal (Transmittal 94, Change Request 6100, dated August 29, 2008) to update the BPM to incorporate language that was previously contained in section 15021 of the Medicare Carriers Manual. The reissued language states, ''No signature is required on orders for clinical diagnostic tests paid on the basis of the clinical laboratory fee schedule, the physician fee schedule, or for physician pathology services.'' Based on further review, we have determined that there are no clinical laboratory tests paid under the PFS. After Transmittal 94 was published, we received numerous inquiries from laboratory, diagnostic testing, and hospital representatives who had questions about whether the provision applied to all diagnostic services, including x-rays, MRIs, and other nonclinical laboratory fee schedule diagnostic services.

To resolve any existing confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we are restating and seeking public comments on our policy. We may further clarify our policy in the final rule, taking into consideration public comments. Our policy is that a physician's signature is not required on a requisition for clinical diagnostic laboratory tests paid on the basis of the Clinical Laboratory Fee Schedule; however, it must be evident, in accordance with our regulations at § 410.32(d)(2) and (3), that the physician ordered the services. The policy that signatures are not required on requisitions applies to requisitions for clinical diagnostic laboratory tests paid under the Clinical Laboratory Fee Schedule.

We note that we solicited and received comments on this signature requirement during the notice and comment period for the March 10, 2000 proposed rule in the context of our proposal to add paragraph (d)(2)(i) to § 410.32 to require that the practitioner who orders a diagnostic laboratory test

must maintain documentation of medical necessity in the beneficiary's medical record. The majority of comments supported the adoption of a policy that the signature of the practitioner on a requisition for a clinical diagnostic laboratory test paid under the Clinical Laboratory Fee Schedule is not the only way of documenting that the test has been ordered and, thus, should not be required provided such documentation exists in an alternate form.

This policy regarding requisitions for clinical diagnostic laboratory tests does not supersede other applicable Medicare requirements (such as those related to hospital Conditions of Participation (CoPs)) which require the medical record to include an order signed by the physician who is treating the beneficiary. Nor do we believe that anything in our policy regarding signatures on requisitions for clinical diagnostic lab tests supersedes other requirements mandated by professional standards of practice or obligations regarding orders and medical records promulgated by Medicare, the Joint Commission, or State law; nor do we believe the policy would require providers to change their business practices. Because of the confusion surrounding the implementation of the policy in 2001 and subsequent transmittals, we invite the general public to comment on this policy and its impacts on operations.

We also are restating and seeking public comment on our long-standing policy consistent with the principle in § 410.32(a) that a written order for diagnostic tests including those paid under the clinical laboratory fee schedule and those that are not paid under the clinical laboratory fee schedule (for example, that are paid under the PFS or under the OPPS), such as X-rays, MRIs, and the TC of physician pathology services, must be signed by the ordering physician or NPP. That is, the policy that signatures are not required on requisitions for clinical diagnostic laboratory tests paid based on the Clinical Laboratory Fee Schedule applies only to requisitions (as opposed to written orders).'' While there may be additional questions about the policy for physician pathology servicess, we are not addressing these issues in rulemaking at this time.

Additionally, we welcome comments from the public about the distinction between an order and a requisition. We note that an ''order'' as defined in our IOM, 100–02, Chapter 15, Section 80.6.1 is a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary. The order may conditionally request an additional diagnostic test for a particular beneficiary if the result of the initial diagnostic test ordered yields to a certain value determined by the treating physician/practitioner (for example, if test X is negative, then perform test Y). An order may be delivered via the following forms of communication:

- A written document signed by the treating physician/practitioner, which is hand-delivered, mailed, or faxed to the testing facility.
- A telephone call by the treating physician/practitioner or his or her office to the testing facility; or
- An electronic mail, or other electronic means, by the treating physician/practitioner or his or her office to the testing facility.

If the order is communicated via telephone, both the treating physician/practitioner, or his or her office, and the testing facility must document the telephone call in their respective copies of the beneficiary's medical records.

A ''requisition'', conversely, as we understand it, is the actual paperwork, such as a form, which is provided to a clinical diagnostic laboratory that identifies the test or tests to be performed for a patient. It may contain patient information, ordering physician information, referring institution information, information about where to send reports, billing information, specimen information, shipping addresses for specimens or tissue samples, and checkboxes for test selection. We believe it is ministerial in nature, assisting labs with billing and handling of results, and serves as an administrative convenience to providers and patients. We believe that a written order, which may be part of the medical record, and the requisition are two different documents; although a requisition that is signed may serve as an order. We welcome comments from the public about the distinction between requisitions and orders.

N. Physician Self-Referral

1. General Background

Section 1877 of the Act, also known as the physician self-referral law, prohibits the following: (1) A physician from making referrals for certain designated health services (''DHS'') payable by Medicare to an entity with which he or she (or an immediate family member) has a direct or indirect financial relationship (an ownership/investment interest or a compensation arrangement), unless an exception applies; and (2) The entity from presenting or causing a claim to be presented to Medicare (or billing another individual, entity, or third party payor) for those referred services. The statute establishes a number of exceptions and grants the Secretary the authority to create regulatory exceptions for financial relationships that pose no risk of program or patient abuse.

Determining whether an entity furnishing DHS and a physician have a direct or indirect compensation arrangement is a key step in applying the statute because it affects which compensation exceptions may apply to the arrangement. Section 411.354(c) governs when a physician ''stands in the shoes'' of his or her physician organization and may therefore, depending on the circumstances, have a direct, rather than an indirect, compensation arrangement with an entity furnishing DHS.

Our proposal seeks to clarify one aspect of the physician stand in the shoes provisions at § 411.354(c). Specifically, we are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' A detailed discussion of this proposed clarification may be found in section II.N.2.b. of this proposed rule.

2. Physician Stand in the Shoes

a. Background

One of the first significant physician stand in the shoes provisions was finalized in the ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase II),'' interim final rule with comment period published in the March 26, 2004 **Federal Register** (69 FR 16054) (''Phase II''). In Phase II, we revised the definition of ''referring physician'' at § 411.351 to clarify that a referring physician is treated as ''standing in the shoes'' of his or her professional corporation (69 FR 16058, 16060). Our revision to the definition of ''referring physician'' clarified that it was not necessary to treat a referring physician as separate from his or her wholly-owned professional corporation. We noted that the revised regulations should make it simpler for physicians and others to evaluate their financial relationships and to apply exceptions

under section 1877 of the Act. We also solicited comments on whether to permit a physician to stand in the shoes of a group practice of which he or she is a member (69 FR 16060).

We addressed certain provisions of section 1877 of the Act, including provisions relating to direct and indirect compensation arrangements, in the ''Medicare Program; Physicians' Referrals to Health Care Entities With Which They Have Financial Relationships (Phase III),'' final rule published in the September 5, 2007 **Federal Register** (72 FR 51012) (''Phase III''). Phase III extended the Phase II rule that treated referring physicians as standing in the shoes of their wholly-owned professional corporations only (72 FR 51026). Specifically, we amended § 411.354(c) to add a provision under which all referring physicians will be treated as ''standing in the shoes'' of their physician organizations for purposes of applying the rules that describe direct and indirect compensation arrangements in § 411.354 (72 FR 51026 through 51029). Phase III defined a ''physician organization'' at § 411.351 to be ''a physician (including a professional corporation of which the physician is the sole owner), a physician practice, or a group practice that complies with the requirements of § 411.352.'' Under Phase III, when determining whether a direct or indirect compensation arrangement existed between a physician and an entity to which the physician refers Medicare patients for DHS, the referring physician would stand in the shoes of: (1) Another physician who employs the referring physician; (2) his or her wholly-owned professional corporation; (3) a physician practice (that is, a medical practice) that employs or contracts with the referring physician; or (4) a group practice of which the referring physician is a member or independent contractor. We specified in § 411.354(c)(3)(i) that a physician who stands in the shoes of his or her physician organization would be considered to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization in whose shoes the referring physician stands. In addition, we specified in the second sentence of § 411.354(c)(3)(i) that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

The Phase III stand in the shoes rules were made in an effort to address two issues. First, industry representatives had asserted that resorting to the indirect compensation definition and exception added an unnecessary step when determining compliance with the physician self-referral prohibition. These representatives believed that it would be easier, more efficient, and consistent with the intent of the physician self-referral law to examine the relationship between the hospital and the group practice for compliance with a physician self-referral exception. The representatives urged that a referring physician should stand in the shoes of his or her group practice, which acts on behalf of its physician members and contractors. Depending on the circumstances, this would enable the parties to analyze the arrangement between the entity furnishing DHS and the group practice (for example, a lease of office space, a personal service arrangement, or a fair market value compensation arrangement) to determine its compliance with one of the various direct compensation arrangement exceptions, rather than the indirect compensation arrangements exception at § 411.357(p). We agreed and permitted a physician to stand in the shoes of his or her group practice, thereby permitting physicians and entities furnishing DHS to use a direct compensation arrangement exception in some circumstances.

Second, we were informed that parties may have construed the definition of an indirect compensation arrangement too narrowly, resulting in erroneous determinations that some arrangements involving financial incentives for referring physicians would fall outside the ambit of the physician self-referral law. In particular, we were concerned that some arrangements between entities furnishing DHS and group practices were viewed as outside the application of the statute. The stand in the shoes provisions set forth in Phase III were designed to address this concern by treating compensation arrangements between entities furnishing DHS and group practices as if the arrangements were with the group's referring physicians.

In response to concerns raised by some industry representatives, we published a final rule in the November 15, 2007 **Federal Register** (72 FR 64161) delaying the date of applicability of the Phase III stand in the shoes provisions with respect to certain compensation arrangements involving physician organizations and academic medical centers or certain integrated 501(c)(3) health care systems, from December 4, 2007 until December 4, 2008.

We finalized revisions to § 411.354(c)(1)(ii) to deem (so as to require) a physician who has an ownership or investment interest in a physician organization to stand in the shoes of that physician organization in the ''Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospitals; and Collection of Information Regarding Financial Relationships Between Hospitals'' final rule (''FY 2009 IPPS final rule'') published in the August 19, 2008 **Federal Register** (73 FR 48434). Physicians with only a titular ownership interest (that is, physicians without the ability or right to receive the financial benefits of ownership or investment, including, but not limited to, the distribution of profits, dividends, proceeds of sale, or similar returns on investment) are not deemed to stand in the shoes of their physician organizations. We also added § 411.354(c)(1)(iii) to permit (but not require) a titular owner and a physician who does not have an ownership or investment interest in a physician organization to stand in the shoes of his or her physician organization. This rule became effective October 1, 2008.

b. Proposed Clarification to § 411.354(c)—Applying Exceptions in § 411.355 and § 411.357 to Arrangements in Which a Physician Stands in the Shoes of His or Her Physician Organization

Section 411.354(c)(3)(i) addresses the application of the general exceptions to the referral prohibition related to both ownership/investment and compensation (§ 411.355) and the exceptions to the referral prohibition related to compensation arrangements (§ 411.357), to arrangements in which a physician stands in the shoes of his or her physician organization. Many of these exceptions require the arrangement to be in writing and signed by the parties and prohibit the compensation from taking into account the volume or value of referrals or other business generated by the referring physician.

Under § 411.354(c)(3)(i), a physician who stands in the shoes of his or her

physician organization is deemed to have the same compensation arrangements with the same parties and on the same terms as the physician organization. The second sentence of § 411.354(c)(3)(i) provides that ''[f]or purposes of applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the 'parties' to the arrangements are considered to be the entity furnishing DHS and the physician organization (including all members, employees, or independent contractor physicians).''

After the publication of Phase III, some members of the industry questioned whether the second sentence of § 411.354(c)(3)(i) defined the term ''parties'' everywhere it appears in the physician self-referral regulations, including the requirement in many exceptions that a compensation arrangement be in writing and ''signed by the parties.'' Specifically, these members believed it was necessary for everyone within a physician organization (that is, all members, employees, and independent contractor physicians) to sign a myriad of different arrangements with an entity furnishing DHS. This was not our intent. In January 2008, we posted a frequently asked question (FAQ) on our Web site to address this issue (*see* question #8885 at *https://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_adp.php?p_faqid=8885*.) In the FAQ, we explained that a physician who stands in the shoes of his or her physician organization need not become a signatory to a written agreement between the physician organization and an entity furnishing DHS because ''we consider a physician who is standing in the shoes of his or her physician organization to have signed the written agreement when the authorized signatory of the physician organization has signed the agreement.'' After the FY 2009 IPPS final rule, under which only physician owners are deemed to stand in the shoes of their physician organizations, some industry representatives questioned whether physicians who did not stand in the shoes remained ''parties'' under § 411.354(c)(3)(i) and would therefore need to become signatories to any compensation arrangement that was required to be in writing and ''signed by the parties.''

We are proposing to clarify the second sentence of § 411.354(c)(3)(i) to provide that, ''[w]hen applying the exceptions in § 411.355 and § 411.357 to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated 'between the parties' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).'' We believe this proposed language clarifies the regulation text and is consistent with our intent to minimize the potential for abuse without imposing undue burden on the provider community.

Our proposed change clarifies that we are not defining the term ''parties'' and should eliminate any possible public misconception that all physicians in a physician organization (whether or not they stand in the shoes of the physician organization) must sign the writing(s) memorializing a compensation arrangement between their physician organization and an entity furnishing DHS. Furthermore, we note that some members of the industry have erroneously applied the second sentence of § 411.354(c)(3)(i) by analyzing whether the compensation takes into account the referrals between the entity furnishing DHS and the physician who stands in the shoes of the physician organization only, not the referrals of all members, employees, and independent contractor physicians in the physician organization. As we indicated in the Phase III final rule (72 FR at 51028), the second sentence of § 411.354(c)(3)(i) was intended to require (where applicable) an analysis of whether a compensation arrangement takes into account referrals or other business generated by the physician organization as a whole and not merely referrals or other business generated by the physicians who stand in its shoes. Thus, we reiterate that the relevant referrals and other business generated between the physician organization and the entity furnishing DHS are the referrals of all physicians in the physician organization (including all members, employees, and independent contractors), not simply the referrals made by each physician who stands in the shoes of the physician organization.

We welcome public comments regarding alternative approaches to address this issue.

O. Durable Medical Equipment-Related Issues

1. Damages to Suppliers Awarded a Contract under the Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (Medicare DMEPOS Competitive Bidding Program) Caused by the Delay of the Program

Section 1847 of the Act, as amended by section 302(b)(1) of the MMA, requires the Secretary to establish and implement a Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP). On July 15, 2008, the MIPPA was enacted. Section 154 of the MIPPA amended section 1847 of the Act to make certain limited changes to the competitive bidding program, including adding a new subsection (a)(1)(D) to section 1847 of the Act. Section 1847(a)(1)(D) terminates retroactively the competitive bidding contracts that were awarded to suppliers in 2008 for the Round 1 of competitive bidding and prohibits payment based on such contracts. Section 154 of the MIPPA effectively reinstated payment for competitively bid items and services to the Medicare fee schedule amounts, as set forth in section 1834 of the Act and 42 CFR part 414, subpart D of our regulations.

Section 1847(a)(1)(D)(i)(I) of the Act, as amended by the MIPPA, stipulates that to the extent any damages may be applicable as a result of the termination of contracts, payment is to be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Act. Section 1847(a)(1)(D) of the Act also states that nothing in section 1847(a)(1)(D)(i)(I) of the Act, which includes the reference to damages, shall be construed to provide an independent cause of action or right to administrative or judicial review with the regard to the termination of the Round 1 contracts.

For further discussion of the Competitive Bidding Program and the bid evaluation process, see the Medicare Program; Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) and Other Issues final rule published in the April 10, 2007 **Federal Register** (72 FR 17992) and the Medicare Program; Changes to the Competitive Acquisition of Certain Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) by Certain Provisions of the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) interim final rule with comment period (IFC)

published on January 16, 2009 **Federal Register** (74 FR 2873).

In this proposed rule, we are proposing to add new § 414.425 to establish a process to evaluate any claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS CBP that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

We offered contracts in March of 2008 to selected suppliers for the first round of the DMEPOS CBP. The contracts that were accepted were terminated by the MIPPA retroactive to June 30, 2008. We considered the terms of the contracts and other processes of the DMEPOS CBP as we developed this proposed process to determine, on a case-by-case basis, whether to award damages and, where applicable, the amount of damages to be awarded for the termination of these contracts.

When considering whether to submit a claim for damages, suppliers may consider the following factors:

- Each contract stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program.
- Each contract indicated CMS does not guarantee any amount of business or profits.
- Each contract stipulated that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized under the contract.
- Upon termination of the contracts by the MIPPA, payments reverted to the CY 2008 fee schedule amount, which was on average 26 percent higher than payment amounts under the DMEPOS CBP.
- We will review a supplier's estimated and historic capacity and any expansion plans that were submitted as part of a supplier's bid.
- We will review a supplier's action to meet its obligation to mitigate its damages.
- We listed the winning suppliers on the Medicare.gov Web site in the supplier locator tool; a supplier is allowed to keep any new customers they may have obtained because of being listed on the supplier locator tool.
- This list is not intended to suggest that there are not legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

The provisions of this proposed rule outline the information that we are proposing suppliers provide when submitting claims for damages and the process that we will follow to review these claims. The information we propose to collect from suppliers is necessary for us to make a reasonable decision on whether damages are warranted and how much in damages should be awarded. We believe the process is not overly burdensome to those suppliers choosing to participate in this review process and will ensure a thorough review of a supplier's claim for damages.

The proposed process to file a claim for damage claims includes the following provisions:

a. Eligibility To File a Claim

Any aggrieved supplier that was awarded a contract in 2008 for the Round 1 DMEPOS CBP and believes it has suffered damages is eligible to submit a claim. The supplier must be able to demonstrate how its company was damaged. These damages must be substantiated and be as a direct result of the termination by MIPPA of their Round I DMEPOS CBP contract. Only a contract supplier, and not a subcontractor of a contract supplier, is eligible to submit a claim for damages.

b. Timeframes for Filing a Claim

A completed claim, including all documentation described below in section II.O.1.c., must be filed within 90 days of the effective date of the finalization of these damages provisions, unless the 90th day is a weekend or Federal holiday. In that case, the last date to file a claim will be the day following the weekend or Federal holiday. The date of filing is the actual date of receipt by the CBIC of a completed claim from the supplier that includes all of the information required by this rule. We strongly urge claimants to use a tracking method such as with the United States Postal Service or a carrier that requires a return receipt that indicates the date on which the claim was delivered.

c. Information That Must Be Included in a Claim

At a minimum, a claim should include all of the following:

- Supplier's name and bidding number.
- Supplier's current contact information (Name of authorized official, U.S. Post Office mailing address, phone number and e-mail address).
- A copy of the DMEPOS CBP Round I contract(s) the supplier signed with CMS.
- A detailed explanation of the damages incurred by the supplier. The explanation must document the supplier's damages through receipts and records that establish the claimant's damages directly related to meeting the terms of the DMEPOS CBP Round I contract.
- The supplier must also explain how it would be damaged if not reimbursed.
- A detailed explanation of the steps of all attempts to use for other purposes, return, or dispose of equipment or other assets purchased or rented for use in the Round I DMEPOS CBP contract performance.

Damages claimed must be specifically related to carrying out the terms of the contract, and may include, but are not limited to, the following:

- Items or equipment purchased or rented.
- Additional employee costs.
- Additional inventory costs.
- Additional facility costs.

The supplier must include a separate justification for any of these items for which it is claiming damages and explain how they were necessary in terms of meeting the requirements of the Round 1 DMEPOS CBP contract. This does not include expenses that would have occurred if the supplier had not been awarded a contract but only those expenses that were incurred for the Round 1 DMEPOS CBP contract performance. The claim must also detail steps taken by the supplier to mitigate damages that they may have incurred due to the contract termination.

d. Items That Will Not Be Considered in a Claim

CMS will not award damages for the following:

- Cost of submitting a bid.
- Cost of preparing or submitting a claim for damages under this section.
- Fees or costs incurred for consulting or marketing.
- Cost of accreditation or licensure.
- Costs incurred before March 20, 2008.
- Costs incurred after July 14, 2008 except for costs incurred to mitigate damages.
- Any profits a supplier may have expected from performance of the contract.
- Costs that would have occurred without the supplier having been awarded a contract.
- Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.
- Costs already recouped by use of personnel, material, supplies, or equipment in the supplier's business operations.

We are not considering claims for expenses incurred prior to March 20, 2008 including the purchase or rental of

items or equipment before that date, because a supplier would not have known that it was going to be offered a contract. We are not considering claims for most expenses incurred after July 14, 2008, including the purchase or rental of items or equipment, because this is the date on which MIPPA terminated all of the Round 1 contracts.

e. Filing a Claim

Suppliers should submit claims, with all supporting documentation, with the CMS Competitive Bidding Implementation Contractor (CBIC) at the following address: CBIC; Bldg 200, Suite 400; 2743 Perimeter Parkway; Augusta, Georgia 30909. The authorized official for the supplier must certify the accuracy of the information on the claim and all supporting documentation. The authorized official is appointed by the supplier and has the legal authority granted by the supplier to submit the claim for damages. This person may be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of the supplier organization, or must hold a position of similar status and authority within the supplier's organization. The CBIC will not accept electronic submissions of claims for damages.

f. Review of Claim

(1) Role of the CBIC

The CBIC will conduct the first level of review and make recommendations to CMS, hereafter referred to as the Determining Authority regarding:

- Whether the claim is complete and was filed in a timely manner. The CBIC may seek further information from the claimant when making its recommendation. The CBIC may set a deadline for receipt of additional information.

- When the claim is incomplete or was not filed in a timely manner, the CBIC will make a recommendation to the Determining Authority not to process the claim further.

- Whether the government owes damages because of the MIPPA. The CBIC will include an explanation supporting its recommendation. The CBIC will recommend a reasonable amount of damages, if any, based on the claim submitted, including all accompanying documentation. The CBIC will consider the language of the contract, as well as both costs incurred and the contract supplier's attempts and actions to limit the damages.

(2) CMS' Role as the Determining Authority

CMS is the Determining Authority because we are responsible for the final review and final determination regarding claims for damages.

- The Determining Authority shall review the recommendation of the CBIC.

- The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

- The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

- If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the determination and the reasons for the final determination.

- If the Determining Authority nonconcurs with the CBIC recommendation, the Determining Authority may:

+ Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety; or direct the CBIC to write said determination for the Determining Authority's signature.

+ Return the claim to the CBIC with further instructions.

- The Determining Authority's determination is final and binding; it is not subject to administrative or judicial review under section 1847(a)(1)(D) of the Act, as amended by section 154(a)(1) of the MIPPA.

g. Timeframe for Final Determinations

Every effort will be made to make a final determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later. In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

h. Notification to Claimant of Damage Determination

The CBIC shall mail the final determination to the claimant by certified mail return receipt requested. If CMS determines that money is due to a claimant, this notification will indicate when and how the money will be transmitted. If a monetary award is due, the supplier will be required to provide banking information for electronic deposit.

2. Notification to Beneficiaries for Suppliers Regarding Grandfathering

Section 1847(a)(4) of the Act requires that in the case of covered durable medical equipment (DME) items for which payment is made on a rental basis under section 1834(a) of the Act, and in the case of oxygen for which payment is made under section 1834(a)(5) of the Act, the Secretary shall establish a ''grandfathering'' process under which rented DME items that were furnished prior to the start of the Competitive Bidding Program (CBP) may be continued to be rented to the beneficiary by a noncontract supplier. Agreements for those covered items and supplies that were rented by the supplier to the beneficiary before the start of a CBP may be continued, regardless of whether the existing supplier participates in the CBP.

In the April 10, 2007 final rule (72 FR 17992), in § 414.408(j), we established the grandfathering process described below for rented DME and oxygen and oxygen equipment when these items are included under the Medicare DMEPOS CBP. A supplier that is furnishing DME or is furnishing oxygen or oxygen equipment on a rental basis to a beneficiary prior to the implementation of a CBP in the competitive bidding area (CBA) where the beneficiary maintains a permanent residence may elect to continue furnishing the item as a grandfathered supplier. This process only applies to suppliers that began furnishing the competitive bid items described above before the start of the CBP to beneficiaries who maintain a permanent residence in a CBA.

In the case of the rented DME and oxygen and oxygen equipment identified in this section, we established in § 414.408(j)(4) that Medicare beneficiaries have the choice of deciding whether they would like to continue receiving the rented item from a grandfathered supplier or if they would like to receive the item from a contract supplier.

Suppliers that agree to be a grandfathered supplier for an item must agree to be a grandfathered supplier for all current beneficiaries who request to continue to rent that item from them. The beneficiary's decision to use a grandfathered supplier depends on the decision of the noncontract supplier that is currently renting the competitive bidding item to continue renting the item as a grandfathered supplier after the start of the CBP in accordance with the terms we have specified. The payment rules for grandfathered suppliers are specified in existing § 414.408(j)(2).

In addition, the beneficiary may elect, at any time, to transition from a noncontract supplier to a contract supplier. The contract supplier would be required to accept the beneficiary as a customer regardless of how many rental months had already been paid for the beneficiary to receive this item. If the grandfathered supplier is not willing to continue furnishing the item, a beneficiary must select a contract supplier to furnish the item in order to receive Medicare payment for that item. The grandfathered supplier is paid based on the payment rules outlined in the final rule on Competitive Bidding at § 414.408(j).

As a result of what we learned from Round 1 of the CBP, we are proposing changes to the ''grandfathering'' rules by establishing notification requirements for noncontract suppliers that are furnishing rented DME competitive bid items at the time a CBP begins to beneficiaries residing in a CBA. We are also proposing a new definition for a grandfathered item to include all rented item(s) in a competitive bidding product category that a supplier currently provides to its beneficiaries. Under the current regulation, suppliers may choose the items within a product category for which they want to become a grandfathered supplier. Under this proposed rule, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the rented DME items within a product category that the supplier currently provides.

For further discussion of the CBP and the bid evaluation process, *see* the April 10, 2007 final rule and the January 16, 2009 interim final rule with comment period.

We are proposing to revise the definition of ''grandfathered item'' in § 414.402 so that the term would refer to all rented items within a competitive bid product category that the supplier currently rents to beneficiaries. In addition, we are proposing to redesignate the current § 414.408(j)(5) as § 414.408(j)(7) and add new § 414.408(j)(5)and (j)(6). The new § 414.408(j)(5)and (j)(6) will specify the notification requirements that apply to noncontract suppliers that are renting DME competitive bid items in a CBA at the time of implementation of the CBP.

a. Definition of a Grandfathered Item

We are proposing to revise the definition of a ''grandfathered item'' in § 414.402 to avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the current regulations, a supplier may make separate choices regarding grandfathering for each individual HCPCS code. For example, a supplier may choose to be a grandfathered supplier for a particular type of walker within the product category instead of all of the walkers included in that product category that are furnished on rental basis.

Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code. In addition, this proposed revision would prevent suppliers from choosing to be a grandfathered supplier for only the more profitable items, which could disadvantage certain beneficiaries.

b. Notification of Beneficiaries and CMS by Suppliers That Choose To Become Grandfathered Suppliers

We are proposing to add a new § 414.408(j)(5) to require suppliers furnishing items to be included in a CBP that are eligible for grandfathering to notify beneficiaries in the CBA and CMS regarding their decision whether to become grandfathered suppliers.

The notification requirements we are proposing will prohibit certain inappropriate practices of noncontract suppliers. These inappropriate practices include: (1) Suppliers attempting to receive additional monthly rental payments from Medicare by circumventing the grandfathering requirements; and (2) suppliers not formally notifying beneficiaries before picking up the rented item from the beneficiary's home. We are also proposing to require a notification process to protect beneficiaries and to ensure less confusion during the transition period prior to implementation of the CBP. The proposed requirements will help ensure that beneficiaries are contacted and informed about the grandfathering process and what choices they have concerning their choice of supplier. Moreover, the notice will help to ensure that beneficiaries do not have medically necessary DME equipment taken from them unexpectedly by a noncontract supplier.

(1) Notification of Beneficiaries by Suppliers That Choose to Become Grandfathered Suppliers

We are proposing to add § 414.408(j)(5)(i) which requires a noncontract supplier that elects to become a grandfathered supplier in a CBA to provide a written notification to each Medicare beneficiary in that CBA who is currently renting a grandfathered item from that supplier. The notification must state that the supplier is willing to continue to rent the grandfathered item(s) to the beneficiary as a grandfathered supplier. The notice must identify the DME grandfathered rented items for which the supplier will be a grandfathered supplier.

To ensure that beneficiaries are sufficiently informed and prepared for competitive bidding changes that affect rented DME, we are proposing in § 414.408(j)(5) to require that the notification of the beneficiary must meet the following requirements. The notification must:

- Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the CBP in the CBA in which the beneficiary resides. The 30-day notice is necessary to give the beneficiary sufficient time before the start of the CBP to consider whether to continue to use their current supplier. Suppliers will be given sufficient time to meet the 30-day notification requirement.
- Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.
- Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.
- State that the supplier is offering to continue to furnish certain rented DME, oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the CBP) and is willing to continue to provide these items to the beneficiary for the remaining rental months.
- State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.
- Provide the supplier's telephone number and instruct the beneficiaries to call the supplier with questions regarding grandfathering and to notify the supplier of his or her election.
- State that the beneficiary can obtain information about the CBP by calling

1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

In § 414.408(j)(i)(B), we propose that the supplier should obtain an election from the beneficiary and maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. We are also proposing that the supplier maintain a record of the beneficiary's choice, the date on which the choice was made, and how the beneficiary communicated his or her choice to the supplier. The 30-day notice to the beneficiary must be in writing to ensure that there is a record that the notification was made.

We are proposing to add paragraphs § 414.408(j)(5)(i)(C)(*1*) through (*3*) which state if the beneficiary chooses not to continue to receive a grandfathered item(s) from the noncontract supplier, the supplier must provide the beneficiary with 2 additional notices prior to picking up its equipment. These notices are described below as the 10-Day Notification and the 2-Day Notification.

(i) 10-Day Notification

Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up and that this should occur on the first anniversary date after the start of the CBP or another date agreed to by the beneficiary. The noncontract supplier must bill and will be paid for the furnishing of the equipment up to the first anniversary date after the start of the CBP and the new supplier cannot bill for furnishing the equipment prior to this anniversary date. This requirement still applies if a date other than the anniversary date is chosen.

The beneficiary's anniversary date occurs every month on the date of the month on which the item was first delivered to the beneficiary by the current supplier. The anniversary date marks the date of every month on which a new monthly rental period begins. For example, using July 1 as the beginning date of the Medicare DMEPOS CBP:

- If a beneficiary's last anniversary date before the beginning of the CBP is June 29, the noncontract supplier must submit a claim for the rental month beginning June 29 and ending July 28. The noncontract supplier should not pick up the equipment prior to July 29. In this case, the noncontract supplier has been paid up to July 29 and therefore should pick up its equipment on July 29, and the contract supplier would deliver its equipment on July 29 and begin billing for the next month's rental as of that date.
- If a beneficiary's anniversary date is July 1, also the beginning date for the CBP, the noncontract supplier should not pick up the equipment before July 1 and should not submit a claim for the July rental period. The contract supplier should deliver the equipment to the beneficiary on July 1 and submit a claim for this month.

When a DME supplier submits a monthly bill for capped rental DME items, the date of delivery (''from'' date) on the first claim must be the ''from'' or anniversary date on all subsequent claims for the item. For example, if the first claim for a wheelchair is dated September 15, all subsequent bills must be dated for the 15th of the following months (October 15, November 15, *etc.*). In cases where the anniversary date falls at the end of the month (for example, January 31) and a subsequent month does not have a day with the same date (for example, February), the final date in the calendar month (for example, February 28) will be used.

(ii) 2-Day Notification

Two business days prior to picking up the item, the supplier must contact the beneficiary by phone to remind the beneficiary of the date the supplier will pick up the item. This supplier should not pick up the item before the beneficiary's first anniversary date that occurs after the start of the CBP.

There may be unusual circumstances that make it difficult to contact certain beneficiaries. However, we do not expect this to occur often because these suppliers have been submitting monthly rental claims for providing services to these beneficiaries. Therefore, the supplier should have an ongoing relationship with the beneficiary and be aware of how to contact them and any changes in their circumstances. However, under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that they are aware of the date on which the supplier is picking up the item and that arrangements have been made to have the item replaced on that date by a contract supplier. The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date. The pick up by the noncontract supplier and the delivery by the contract supplier should occur on the first rental anniversary date of the equipment that occurs after the start of the CBP. When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, for the pickup and the delivery date but not in terms of billing. The new equipment cannot be billed for until the anniversary date and the old equipment cannot be taken from the beneficiary before the anniversary date.

c. Notification to CMS for Suppliers That Choose To Become Grandfathered

We are proposing to add § 414.408(j)(5)(ii) to state that suppliers that have chosen to become grandfathered suppliers must also notify CMS of that decision at least 30 business days before the start of the CBP. We believe that 30 business days is a reasonable period to allow us to compile a list of grandfathered suppliers and to answer questions about the availability of these suppliers. Unless the supplier notifies CMS consistent with this subsection, the supplier will not be considered a grandfathered supplier. Having a list of grandfathered suppliers is important to assist CMS in administering the grandfathering process. The list will be used to answer questions from beneficiaries concerning which suppliers have chosen the grandfathering option. The notification requirement will also help us to ensure that suppliers are not offering the grandfathering option to only a select number of beneficiaries. Also, having a list of suppliers that have chosen to be grandfathered suppliers will assist us in reviewing whether only noncontract suppliers that have elected to be grandfathered suppliers have received Medicare payment for rented competitive bid items in a CBA.

The notice that a noncontract supplier must provide to CMS if it elects to become a grandfathered supplier must meet the following requirements:

- State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the CBP) in a CBA and will continue to provide these grandfathered items to these beneficiaries for the remaining months of the rental period.
- Include all of the following: Name and address of the supplier; 6-digit NSC number of the supplier; and product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.
- Suppliers with multiple locations must submit one notification for the company rather than for each individual location.

• State that the supplier agrees to meet all the terms and conditions applicable to grandfathered suppliers.

• Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of a CBP.

d. Notifications of Beneficiaries by Suppliers That Choose Not To Become Grandfathered Suppliers

We propose to clarify under § 414.408(j)(6) that a noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notice to the beneficiary. A noncontract supplier that decides not to become a grandfathered supplier does not have the option of leaving its equipment in the beneficiary's home. The noncontract supplier is responsible for picking up the item from the beneficiary.

Proper notification by a supplier who chooses not to become a grandfathered supplier must include a 30-day, a 10-day, and a 2-day notice of its decision not to be a grandfathered supplier. These notifications must meet all of the requirements listed above for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, except for the following differences for the 30-day notice.

• The 30-day notice must indicate the items for which the supplier has decided not to become a grandfathered supplier and indicate the date upon which the equipment will be picked up.

• It must state that the supplier will only continue to rent these competitively bid item(s) up to the beneficiary's first anniversary date, as defined in § 414.408(j)(5), that occurs after the start of the Medicare DMEPOS CBP.

• It must also state that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

• It must state that the beneficiary can obtain information about the CBP by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

• It must also refer him or her to the supplier locator tool on *http://www.medicare.gov*.

The supplier must also provide the beneficiary with the 10-day and the 2-day notices prior to picking up their equipment.

When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary. This provides some latitude, but the new equipment may not be billed by the contract supplier until the first anniversary date following the start of the CBP. Also, the old equipment may not be taken from the beneficiary before proper arrangements are made and the date of service cannot occur before the anniversary date.

As discussed above, under no circumstance should a supplier pick up the rented item prior to the supplier making an arrangement with the new contract supplier for the delivery of the new equipment at a time suitable to meet the beneficiary's medical needs. The noncontract supplier has been furnishing services to the beneficiary and receiving payments from the program. To ensure that the beneficiary has continued access to medically necessary equipment, the noncontract supplier is expected to assist the beneficiary in locating a contract supplier. The noncontract supplier should communicate with the beneficiary the urgency of arranging to have the new equipment delivered as soon as possible.

P. Physician Fee Schedule Update for CY 2010

Since 1999, PFS rates have been updated under the sustainable growth rate (SGR) system. The general concept under the SGR system is that growth in total expenditures for physicians' services should be limited to sustainable levels. If expenditures exceed a statutorily determined percentage increase amount, the PFS update for the following year is reduced. If expenditures are less than the percentage increase amount, the PFS update is increased in the following year. There is a recognized tendency for physicians to increase the volume and intensity of their services over time. Incentives under SGR system were intended to encourage physicians to regulate their collective behavior in that regard in order to avoid decreases in future updates. The SGR is also a cumulative system. The update is adjusted based on a comparison of cumulative actual spending to target spending from a base period through the current year. Thus, if spending exceeds the target in a single year, the following year's update must be adjusted to reduce annual expenditures, as well as recoup the difference between target and actual spending in the prior year. Under a cumulative system, deviations between target and actual spending have the potential to result in significantly more payment rate adjustments when actual spending exceeds target spending even in a single year.[20] Further, under a cumulative system, past increases in spending levels above the target will continue to affect future PFS updates until there have been sufficient adjustments to make target and actual spending equal.

Despite the intended incentives, actual spending under the SGR system has deviated significantly from target spending. In the CY 2004 PFS final rule with comment period (68 FR 63248), we estimated CY 2003 allowed expenditures at $71.7 billion and CY 2003 actual expenditures at $77.8 billion for a difference of $6.1 billion (or 8.5 percent of allowed spending). The cumulative difference between target and actual expenditures estimated at the time was $7.8 billion (that is, the $6.1 billion plus an additional $1.7 billion for past differences between target and actual spending since the 1996/1997 base year not previously accounted for through adjustments to the PFS update). Under the statutory formula, CMS was required to announce a reduction in PFS rates of 4.5 percent for CY 2004:

> [T]he negative physician fee schedule update gives us no alternative to reducing physician fee schedule rates. Only Congress can change the law and avert a reduction in 2004 physician fee schedule rates. (68 FR 63239)

On November 25, 2003, the Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (Pub. L. 108–173). The President signed the MMA into law on December 8, 2003. Section 601 of MMA amended section 1848(d) of the Act to specify that the update to the single conversion factor (CF) for CYs 2004 and 2005 shall not be less than 1.5 percent. Thus, instead of applying an update of −4.5 percent in 2004, we applied an increase of 1.5 percent to PFS rates. The Congress took similar actions to avert reductions to PFS rates for CYs 2006 through 2009. Because the legislation did not affect the computation of the levels of allowed and actual expenditures for these years, there is now a substantial difference between cumulative target and actual spending that must be accounted for through future reductions to PFS rates. In a March 1, 2009 letter from CMS to the MedPAC, we estimated the difference between cumulative target and actual spending from the 1996/1997 base year through December 2009 at $69.7 billion. We estimated the PFS update would be

[20] The adjustments to equate allowed and actual spending do not occur in a single year. The Balanced Budget Refinement Act of 1999 specifies a formula that makes the adjustment to account for differences between target and actual spending over multiple years.

−21.5 percent for CY 2010. As there are limits to how much PFS rates can be reduced in a single year and the estimated −21.5 percent PFS update will not fully account for the difference between target and actual spending, we are estimating further reductions of between 5 and 6.5 percent for the next several years.

Although the Congress has acted to avert reductions in the past several years, these projections have led us to reexamine administrative actions that the Secretary could take to lessen the potential for repeated further reductions in the PFS update. The Administration believes that the current Medicare physician payment system, while having served to limit spending to a degree, needs to be reformed to give physicians appropriate incentives to improve the quality and efficiency of the care provided to Medicare beneficiaries. As part of health care reform, the Administration supports comprehensive, but fiscally responsible, reforms to the physician payment formula. Consistent with this goal, the Administration announced in the FY 2010 President's Budget that it would explore the breadth of options available under current authority to facilitate such reforms, including an assessment of whether the cost of physician-administered drugs should continue to be included in the payment formula.

The statutory formula for calculating the update adjustment factor, which includes the SGR, was designed to establish reasonable limits on the growth of expenditures on physicians' services, and to provide incentives for physicians to keep the growth in expenditures within those limits. The SGR system was created by section 4503 of the Balanced Budget Act of 1997 (BBA) (Pub. L. 105–33). It replaced the predecessor system, the Medicare Volume Performance System (MVPS). However, the statutory definition of ''physicians' services'' for purposes of the SGR (section 1848(f)(4)(A) of the Act) is the same as that used for the MVPS (no longer in existence, but previously at section 1848(f)(5)(A) of the Act):

> 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 by a physician or in a physician's office.

Under the MVPS, we defined ''physicians' services'' to include physician-administered drugs. Therefore, we adopted the same regulatory definition at the outset of the SGR system:

> Because the scope of physicians' services covered by the SGR is the same as the scope of services that was covered by the Medicare volume performance standards, we are using the same definition of physicians' services for the SGR in this notice as we did for the Medicare volume performance standards. * * * (63 FR 59188)

Physician-administered drugs are covered under section 1861(s)(2)(A) of the Act as ''services and supplies (including drugs and biologicals which are not usually self-administered by the patient) furnished as an incident to a physician's professional services, of kinds which are commonly furnished in physicians' offices.'' Physician-administered drugs are not paid for under the PFS (56 FR 25800). However, in identifying items and services to be included in the definition of ''physicians' services'' our ''practice has been to make adjustments to the SGR for medical and other health services * * * that meet the criterion of being ''commonly performed by a physician or in a physician's office'' (66 FR 55316). Because ''incident to'' drugs are commonly furnished in physicians' offices, we elected to continue to include them in the definition of ''physicians' services'' for the SGR. Similarly, clinical diagnostic laboratory tests, which are not paid for under the PFS, have always been included in the definition of ''physicians' services'' for purposes of the SGR.

Historically, growth in the cost of prescription drugs has far outpaced growth in the cost of other physicians' services. From the 1st quarter of 1997 through the 1st quarter of 2005, the average annual growth in Medicare spending on drugs included in the SGR was 22 percent compared to 6 percent for all services (including drugs) included in the SGR. As a result, since the inception of the SGR methodology, prescription drugs have accounted for an increasingly disproportionate amount of the growth in spending on physicians' services. At the time, we made the decision to include physician-administered drugs in the definition of ''physicians' services'' used to compute the SGR, these drugs represented a much smaller volume of Medicare spending than they have in subsequent years. In the CY 2003 PFS final rule with comment period, we estimated that drugs would represent 7.3 percent of 2001 SGR spending (67 FR 80031). In the CY 2006 PFS final rule with comment period, we estimated that drugs would represent 9.9 percent of 2004 SGR spending. In the CY 2007 PFS final rule with comment period, we stated that ''commenters noted that expenditures on these drugs increased from $1.8 billion in 1996, to $8.6 billion in 2004'' (71 FR 69755). These figures clearly demonstrate that spending on physician-administered drugs has been growing at much higher rates than spending for all other PFS services and has contributed significantly to the deviation between target and actual spending, as well as to the large projected reductions in future PFS updates. There could be many reasons for the disproportionate growth in expenditures for drugs—many of which we could not have anticipated when we decided to include drugs in the SGR. In the CY 2006 PFS final rule with comment period (70 FR 70307), we summarized public comments on the proposed rule that stated that growth in Medicare spending on drugs is driven primarily by the introduction of expensive new drugs to the Medicare population and extensive marketing (including direct-to-consumer advertising). Given the significant and disproportionate impact that the inclusion of drugs has had on the SGR system, we believe it would be appropriate to revise the definition of physicians' services for purposes of the SGR.

As previously noted, the statutory definition of ''physicians' services'' for purposes of determining allowed expenditures and the SGR (section 1848(f)(4)(A) of the Act) states:

> 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 by a physician or in a physician's office.

The statute clarifies that the term ''physicians' services'' includes items and services ''specified by the Secretary.'' Therefore, we believe the statute provides the Secretary with clear discretion to decide whether physician-administered drugs should be included or excluded from the definition of ''physicians' services.'' As the statute affords the Secretary clear discretion, we are proposing, in anticipation of enactment of legislation to provide fundamental reforms to Medicare physician payments, to remove physician-administered drugs from the definition of ''physicians' services'' in section 1848(f)(4)(A) of the Act for purposes of computing the SGR and levels of allowed expenditures and actual expenditures in all future years.

Moreover, given the past effect of spending growth for physician-administered drugs on future PFS updates, in order to effectuate fully the Secretary's policy decision to remove drugs from the definition of

''physicians' services'' in section 1848(f)(4)(A) of the Act, it is reasonable to remove drugs from the calculation of allowed and actual expenditures for all prior years.

We note the term ''actual expenditures'' is not defined in the statute nor are there any statutory limitations on the Secretary's ability to recompute actual expenditures to reflect changes in the amount of actual expenditures. On several occasions, we have made revisions to the amount of actual expenditures to reflect new information regarding spending on physicians' services. For instance, in the CY 2002 PFS final rule with comment period (66 FR 55314), we indicated that a number of new procedures were inadvertently not included in the measurement of actual expenditures beginning in 1998. We determined that spending for these codes must be included in actual expenditures for historical, current, and future periods. Similarly, in the CY 2009 PFS final rule with comment period, we discovered that fifteen procedure codes were inadvertently omitted from the measurement of actual expenditures beginning in 1998 (73 FR 69902). Again, we stated that spending for these codes must be included in actual expenditures for historical, current, and future periods.

Under section 1848(d)(3)(C)(i) of the Act, the level of allowed expenditures during the base year (April 1, 1996 through March 31, 1997) is equal to the actual expenditures for this period. Thus, as there are no statutory restrictions on the Secretary's ability to recompute actual expenditures to remove the costs associated with physician-administered drugs, the Secretary also has authority to remove these drugs from the calculation of allowed expenditures during the base year. Allowed expenditures in a year are based on the allowed expenditures in the prior year, updated by the SGR as specified in section 1848(d)(3)(C)(ii) of the Act for FY 1998 through FY 2000, and section 1848(d)(4)(C)(iii) for all subsequent years. Thus, once the Secretary has revised the level of allowed expenditures during the base year (as is authorized under the statute), it is reasonable to carry this revision through into all subsequent years. As the statute affords the Secretary flexibility to remove drugs from the calculation of allowed expenditures retrospectively to the base year, we are proposing to remove drugs from the calculation of allowed and actual expenditures under sections 1848(d)(3)(C) and 1848(d)(4) of the Act retrospectively to the 1996/1997 base year in order to eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates. Further, the proposal would remove drugs from the calculation of the SGR beginning with 2010.

We note that the Secretary may choose not to finalize the proposal described above or may choose to modify the proposal in the final rule, consistent with rulemaking principles, in light of new policy developments, new information, or changed circumstances.

We currently estimate that the statutory formula used to determine the physician update will result in a CY 2010 conversion factor of $28.3208 and a PFS update of −21.5 percent. Under this proposal, removing physician-administered drugs from allowed and actual expenditures for all prior years will not change the projected −21.5 percent physician payment rate update for services furnished on or after January 1, 2010. This proposal would, however, reduce the past discrepancy between actual and target expenditures. As a result, it would reduce the number of years in which physicians are projected to experience a negative update. We note that this proposal does not mean that we are making any changes to PFS rates applicable in prior years. Rather, we are proposing to remove drugs from the calculation of allowed and actual expenditures since the 1996/1997 base year so that past year increases in drug spending would have no affect on the determination of future PFS rates.

III. Collection of Information Requirements

Under the Paperwork Reduction Act of 1995, 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 an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork Reduction Act of 1995 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.

We are soliciting public comment on each of these issues for the following sections of this document that contain information collection requirements (ICRs):

A. ICRs Regarding Pulmonary Rehabilitation Program: Conditions for Coverage (§ 410.47)

Section 410.47(c) lists the components of a pulmonary rehabilitation program. Specifically, § 410.47(c)(3) through (c)(5) discuss psychosocial assessments, outcome assessments and individualized treatment plans, respectively, and the role of these tools in pulmonary rehabilitation programs. The burden associated with meeting the requirements for conducting psychosocial assessments, outcome assessments, and individualized treatment plans is the time and effort necessary for providers to document the necessary information in the patient record. While these requirements are subject to the PRA, we believe the associated burden is exempt as stated under 5 CFR 1320.3(b)(2). Psychosocial assessments, outcome assessments and individualized treatment plans are routine tools used in pulmonary rehabilitation programs and the practice of using these tools is generally recognized as an industry standard as part of usual and customary business practices.

B. ICRs Regarding Kidney Disease Education Services (§ 410.48)

Proposed § 410.48(f) states qualified persons will develop outcomes assessments designed to:

- Measure beneficiary knowledge about chronic kidney disease (CKD) and its treatment;
- Assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to CKD; and
- Assess program effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

We are proposing that the assessment will be administered to the beneficiary during one of the kidney disease education (KDE) sessions prescribed by the referring physician. The assessments will be made available to CMS upon request.

The burden associated with these requirements is the time and effort necessary to conduct an outcomes assessment, maintain record of the

assessment, and to make the documentation available to CMS upon request. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that must comply with these requirements. Additionally, we are trying to determine if the use and maintenance of outcome assessments in KDE services is a standard industry business practice. Our preliminary research gathered during a CMS Open Door Forum held on November 6, 2008 and a stakeholders meeting hosted by the Agency for Healthcare Research and Quality (AHRQ) on December 16, 2008 indicates that outcome assessments are used by most but not all of the entities bound by the proposed requirements in § 410.48. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

C. ICRs Regarding Cardiac Rehabilitation Program and Intensive Cardiac Rehabilitation Program: Conditions of Coverage (§ 410.49)

Proposed § 410.49(b)(2) lists the required components of a cardiac rehabilitation program. Four of the five required components, including cardiac risk factor modification, psychosocial assessments, outcomes assessments and individualized treatment plans, impose information collection burdens. The burden associated with these requirements is the time and effort necessary to providers to customize each patient's cardiac risk modification program. Additionally, there is burden associated with conducting psychosocial assessments and outcome assessments and drafting individualized treatment plans. Although section 144(a) of the MIPPA sets forth these information collection requirements, we believe the associated information collection burden is exempt as stated under 5 CFR 1320.3(b)(2). Performing cardiac risk modification, psychosocial assessments, outcome assessments, and individualized treatment plans are routine tools used in cardiac rehabilitation programs. As stated earlier in the preamble of this proposed rule, intensive cardiac rehabilitation programs typically involve the same elements as general cardiac rehabilitation programs, but are furnished in highly structured environments in which sessions of the various components may be combined for longer periods of cardiac rehabilitation and also may be more rigorous. The ICRs and associated burden are generally recognized as an industry standard as part of usual and customary business practices.

Proposed § 410.49(c)(1) states that to be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv). As required by § 410.49(c)(3), sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site to ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation.

The burden associated with the requirements in § 410.49(c) is the time and effort necessary for a program to demonstrate through peer-reviewed, published research that it accomplishes one or more of the requirements listed in § 410.49(c)(1)(i) through (iv) and the time and effort necessary to annually submit outcomes data. At this time, CMS is not able to accurately quantify the burden because we cannot estimate the number of entities that will seek designation as intensive cardiac rehabilitation programs. We welcome comments pertaining to this issue and will reevaluate all related PRA burden issues in the final rule stage of rulemaking.

D. ICRs Regarding Imaging Accreditation (§ 414.68)

Proposed § 414.68(b) contains the application and reapplication procedures for accreditation organizations. Specifically, an independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services must furnish CMS with all of the information listed in proposed § 414.68(b)(1) through (14). The requirements include but are not limited to reporting, notification, documentation, and survey requirements.

The burden associated with the proposed collection requirements in § 414.68(b) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(b)(1) through (14). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit a complete application for approval or reapproval authority to become an accrediting organization approved by CMS.

Proposed § 414.68(c) contains the information collection requirements pertaining to CMS approved accrediting organizations. An accrediting organization approved by CMS must undertake all of the activities listed in § 414.68(c)(1) through (6). The burden associated with the proposed collection requirements in § 414.68(c) is the time and effort necessary to develop, compile and submit the information listed in § 414.68(c)(1) through (6). We believe that 3 entities will choose to comply with these requirements. We estimate that it will take each of the 3 entities, 80 hours to submit the required information on an ongoing basis.

Proposed § 414.68(d)(1) states that CMS or its contractor may conduct an audit of an accredited supplier, examine the results of a CMS approved accreditation organization's survey of a supplier, or observe a CMS approved accreditation organization's onsite survey of a supplier, in order to validate the CMS approved accreditation organizations accreditation process. The burden associated with this requirement is the time and effort necessary for an accrediting organization to comply with the components of the validation audit. While this requirement is subject to the PRA, we believe the associated burden is exempt as stated in 5 CFR 1320.3(h)(6). The burden associated with a request for facts addressed to a single person, as defined in 5 CFR 1320.3(j), is not subject to the PRA.

As stated in proposed § 414.68(e)(1), an accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not to renew the approval of deeming authority to an accreditation organization if the accrediting organization files a written request for reconsideration by its authorized officials or through its legal representative. The written request must be filed within 30 calendar days of the receipt of CMS' notice of an adverse determination or nonrenewal. In addition, the request must also specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

The burden associated with this requirement is the time and effort necessary for an accrediting organization to file develop and file written request for reconsideration.

While this requirement is subject to the PRA, the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; accrediting organizations are submitting requests for reconsideration after receiving a notice of an adverse determination or nonrenewal.

E. ICRs Regarding Payment Rules (§ 414.408)

Proposed § 414.408(j)(5) contains the notification requirements for suppliers electing to become grandfathered suppliers. Specifically, § 414.408(j)(5)(i) states that a noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the requirements as listed in § 414.408(j)(5)(i)(A) through (G).

Subsequent to the initial 30-day notice to the beneficiary, as required by § 414.408(j)(5)(ii), suppliers must also obtain and maintain a record of the beneficiary's election choice, the date the choice was made, and the manner through which the beneficiary communicated his or her choice. Additionally, § 414.408(j)(5)(iii) states that if a beneficiary chooses not to continue to receive a grandfathered item(s) from his or her current supplier, the supplier must provide the beneficiary with two more notices prior to the supplier picking up its equipment. The supplier must provide a 10-day notification and a 2-day notification. These notification requirements must meet the criteria listed in § 414.408(j)(5)(iii)(A) through (C).

Section § 414.408(j)(5)(iv) requires suppliers that elect to become grandfathered suppliers to provide a written notification to CMS of its election decision. The notification must meet the requirements as specified in § 414.408(j)(5)(iv)(A) through (D).

The burden associated with the information collection requirements contained in proposed § 414.408(j)(5) is the time and effort necessary for a noncontract supplier to make the aforementioned notifications to both beneficiaries and CMS. We estimate that 1,305 suppliers will elect to become grandfathered suppliers. Similarly, we estimate that each grandfathered supplier will need to make an average of 53 notifications based on an average of 52 beneficiaries per supplier and one notice to CMS. We estimate that it will take 2 hours to develop the notification to the beneficiary and 2 hours to develop the notification to CMS. Similarly, we estimate that each notification will take 15 minutes to send. The total estimated burden associated with each of the 1305 suppliers complying with the requirements in proposed § 414.408(j)(5) is 17.25 hours per supplier for a total of 22,511 hours.

Proposed § 414.408(j)(6) contains the information collection requirements pertaining to suppliers that choose not to become grandfathered suppliers. A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification. Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA. These notifications must meet all of the requirements listed in proposed § 414.408(j)(5)(i) and (ii) for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers. However, there are exceptions regarding the 30-day notice for noncontract suppliers electing not to become grandfathered suppliers. The exceptions are listed in proposed § 414.408(j)(6)(iii)(A) through (C). In addition, suppliers must also comply with the criteria listed in proposed § 414.408(j)(6)(iv).

The burden associated with the proposed information collection requirements in § 414.408(j)(6) is the time and effort necessary for a supplier to make the required notifications to beneficiaries. We estimate that 145 suppliers will not elect to become grandfathered suppliers. Similarly, we estimate that each nongrandfathered supplier will need to make an average of 156 notifications based on an average of 52 beneficiaries per supplier. We estimate that it will take 2 hours to develop the 30-day notification to the beneficiary and 15 minutes to send out each notification. The 10-day notification will take approximately 15 minutes and the 2-day will take approximately 15 minutes. We estimate to send out all 3 notifications it will take a total of approximately 45 minutes. The total burden associated with the requirements in proposed § 414.408(j)(6) is approximately 5,945 hours.

F. ICRs Regarding Claims for Damages (§ 414.425)

Proposed § 414.425(a) states that any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP), may file a claim under this section for certain alleged damages arising out of MIPPA's termination of the Round 1 DMEPOS CBP contracts. Section 414.425(b) states that a completed claim, including all documentation, must be filed within 90 days of the effective date of the final rule on damages, unless that day is a holiday or Sunday in which case it will revert to the next business day. Section 414.425(c) lists the required documentation for submitting a claim.

The burden associated with this requirement is the time and effort necessary to gather required documentation as specified in § 414.425(c) and submit a claim for damages. This requirement is for a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their contracts by MIPPA. We awarded contracts to 329 suppliers. We expect that it will take approximately 3 hours for a supplier to gather the necessary documents and to file a claim. We anticipate that anywhere between 5 and 250 suppliers may submit a claim for damages.

While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The information in question is being collected as a result of an administrative action; suppliers are submitting claims for damages caused by the termination of contracts awarded in 2008 under the DMEPOS Competitive Bidding program that were terminated as a result of section 154(a)(1)(A)(iv) of the MIPPA.

G. ICRs Dispute Resolution and Process for Suspension or Termination of Approved CAP Contract and Termination of Physician Participation Under Exigent Circumstances (§ 414.917)

As stated in proposed § 414.97, an approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

The burden associated with this requirement is the time and effort necessary for a CAP vendor to request a reconsideration of the termination. While this requirement is subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.4. The burden associated with collecting information subsequent to an administrative action is not subject to the PRA.

H. ICRs Regarding Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen (§ 414.930)

As stated in the definition for a publicly transparent process for evaluating therapies in proposed § 414.930(a), a compendium must make the following materials available to the public on its Web site, coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.

(iii) A listing of all individuals (and their affiliations and sources of financial support) who have substantively participated in the development of compendia recommendations.

(iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

The definition for a publicly transparent process for identifying conflicts of interests in proposed § 414.930(a), states that a compendium must make the following materials available to the public, coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This may include compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations.

(ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

The requirements in proposed § 414.930(a) constitute third-party disclosures. While third-party disclosures are subject to the PRA, we believe the associated burden is exempt under 5 CFR 1320.3(c)(4). Less than 10 persons or entities within a 12-month period will be required to comply.

TABLE 37—ESTIMATED ANNUAL REPORTING AND RECORDKEEPING BURDEN

Regulation section(s)	OMB control No.	Respondents	Responses	Burden per response (hours)	Total annual burden (hours)
§ 414.68(b)	0938–New	3	3	80	240
§ 414.68(c)	0938–New	3	3	80	240
§ 414.408(j)(5)	0938–New	1305	69,165	17.25	22,511
§ 414.408(j)(6)	0938–New	145	22,620	41	5,945
Total					28,936

If you comment on these information collection and recordkeeping requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, *Attention:* CMS Desk Officer, [CMS–1413–P]; *Fax:* (202) 395–6974; or *E-mail: OIRA_submission@omb.eop.gov*.

Additional Information Collection Requirements

This proposed rule imposes collection of information requirements as outlined in the regulation text and specified above. However, this proposed rule also makes reference to several associated information collections that are not discussed in the regulation text contained in this document. The following is a discussion of these information collections, some of which have already received OMB approval.

Part B Drug Payment

The discussion of average sales price (ASP) issues in section II.H.1 of this proposed rule does not contain any new information collection requirements with respect to payment for Medicare Part B drugs and biologicals under the ASP methodology. Drug manufacturers are required to submit ASP data to us on a quarterly basis. The ASP reporting requirements are set forth in section 1927(b) of the Act. The burden associated with this requirement is the time and effort required by manufacturers of Medicare Part B drugs and biologicals to calculate, record, and submit the required data to CMS. While the burden associated with this requirement is subject to the PRA, it is currently approved under OMB control number 0938–0921. A revision of the currently approved information collection request is currently under review at OMB.

Competitive Acquisition Program (CAP)

Section II.H.2. of this proposed rule discusses issues related to the competitive acquisition program for Part B drug payment. There are no new information collection requirements associated with the CAP; however, there are several previously approved information collection requests (ICR) associated with the CAP.

TABLE 38—OMB CONTROL NUMBERS

Program component	OMB control number	Expiration date
Medicare Part B Drug and Biological CAP	0938–0954	06/30/2011

TABLE 38—OMB CONTROL NUMBERS—Continued

Program component	OMB control number	Expiration date
Medicare Part B Drug and Biological Competitive Acquisition Program Applications [1]	0938–0955	08/31/2009
Competitive Acquisition Program (CAP) for Medicare Part B Drugs: CAP Physician Election Agreement	0938–0987	12/31/2011

[1] An extension of the currently approved ICR is currently in the middle of the mandatory 60-day **Federal Register** notice and comment period. The ICR will be submitted to OMB for review and approval prior to the expiration date.

Physician Quality Reporting Initiative (PQRI)

Section II.G.2. of this proposed rule discusses the background of the PQRI, provides information about the measures proposed to be available to eligible professionals who choose to participate in the 2010 PQRI, and the proposed criteria for satisfactory reporting in 2010. Beginning on January 1, 2010, the Secretary is also required by section 1848(m)(3)(C) of the Act, to establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under the PQRI.

With respect to satisfactory submission of data on quality measures by eligible professionals, eligible professionals include physicians, other practitioners as described in section 1842(b)(18)(c) of the Act, physical and occupational therapists, qualified speech-language pathologists, and qualified audiologists. Eligible professionals may choose whether to participate and, to the extent they satisfactorily submit data on quality measures for covered professional services, they can qualify to receive an incentive payment. To qualify to receive an incentive payment for 2010, the eligible professional must meet one of the criteria for satisfactory reporting described in sections II.G.2.e. and II.G.2.f. of this proposed rule.

For individual eligible professionals, the burden associated with the requirements of this voluntary reporting initiative is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We believe it is difficult to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows.

We believe the burden associated with participating in PQRI has declined for those familiar with the program and who have satisfactorily participated in the 2007 PQRI and/or the 2008 PQRI. However, because we anticipate even greater participation in the 2010 PQRI, including participation by eligible professionals who are participating in PQRI for the first time in 2010, we will assign 3 hours as the amount of time needed for eligible professionals to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour in our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we estimate the cost for an eligible professional to review the list of PQRI quality measures, identify the applicable measures for which they can report the necessary information, review the measure specifications for those measures applicable to the eligible professional, and incorporate the use of quality data codes for the measures on which the eligible professional plans to report into the office work flows to be approximately $165 per eligible professional ($55 per hour × 3 hours).

We continue to expect the ongoing costs associated with PQRI participation to decline based on an eligible professional's familiarity with and understanding of the PQRI, experience with participating in the PQRI, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices.

In addition, for claims-based reporting, eligible professionals must gather the required information, select the appropriate quality data codes, and include the appropriate quality data codes on the claims they submit for payment. The PQRI will collect quality data codes as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate changes to the 837–P or CMS Form 1500 for CY 2010.

Because this is a voluntary program, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 PQRI, we will assume that all eligible professionals who attempted to participate in the 2007 PQRI will also attempt to participate in the 2010 PQRI.

Moreover, the time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them, and incorporate the use of quality data codes into the office work flows is expected to vary along with the number of measures that are potentially applicable to a given professional's practice. Since eligible professionals are generally required to report on at least 3 measures to earn a PQRI incentive, we will assume that each eligible professional who attempts to submit PQRI quality measures data is attempting to earn a PQRI incentive payment and that each eligible professional reports on an average of 3 measures for this burden analysis.

Based on our experience with the PVRP, we continue to estimate that the time needed to perform all the steps necessary to report each measure (that is, reporting the relevant quality data code(s) for a measure) on claims ranges from 15 seconds (0.25 minutes) to over 12 minutes for complicated cases and/

or measures, with the median time being 1.75 minutes. Information from the PVRP indicates that the cost associated with this burden ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures, with the cost for the median practice being $0.90.

The total estimated annual burden for this requirement will also vary along with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual burden per eligible professional associated with claims-based reporting to range from 191.25 minutes, or 3.2 hours [(0.25 minutes per measure × 3 measures × 15 cases per measure) + 3 hours] to 720 minutes, or 12 hours [(12 minutes per measure × 3 measures × 15 cases per measure) + 3 hours]. We estimate the total annual cost per eligible professional associated with claims-based reporting to range from $174.45 [($0.21 per measure × 3 measures × 15 cases per measure) + $165] to $617.70 [($10.06 per measure × 3 measures × 15 cases per measure) + $165].

For registry-based reporting, there would be no additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on quality measures to CMS on their behalf.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf in 2010 would need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals unless the registry was qualified to submit on behalf of eligible professionals for the 2009 PQRI and did so successfully. We estimate that the proposed self-nomination process for qualifying additional registries to submit on behalf of eligible professionals for the 2010 PQRI involves approximately 1 hour per registry to draft the letter of intent for self-nomination. It is estimated that each self-nominated entity will also spend 2 hours for the interview with CMS officials and 2 hours for the development of a measure flow. However, the time it takes to complete the measure flow could vary depending on the registry's experience. Additionally, part of the self-nomination process involves the completion of an XML submission by the registry, which is estimated to take approximately 5 hours, but may vary depending on the registry's experience. We estimate that the registry staff involved in the registry self-nomination process have an average labor cost of $50 per hour. Therefore, assuming the total burden hours per registry associated with the registry self-nomination process is 10 hours, we estimate the total cost to a registry associated with the registry self-nomination process to be approximately $500 ($50 per hour × 10 hours per registry).

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants. The number of measures that the registry intends to report to CMS and how similar the registry's measures are to CMS' PQRI measures will determine the time burden to the registry.

For EHR-based reporting, the eligible professional must review the quality measures on which we will be accepting PQRI data extracted from EHRs, select the appropriate quality measures, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new to PQRI for 2010 and participation in this reporting initiative is voluntary, we believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the PQRI through the EHR mechanism in CY 2010. The time needed for an eligible professional to review the quality measures and other information, select measures applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, 3 hours). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on PQRI quality measures should be minimal.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. We are unable to accurately quantify the burden associated with the EHR self-nomination process as there is variation regarding the technical capabilities and experience among vendors. For purposes of this burden analysis, however, we estimate that the time required for an EHR vendor to complete the self-nomination process will be similar to the time required for registries to self-nominate that is approximately 10 hours at $50 per hour for a total of $500 per EHR vendor ($50 per hour × 10 hours per EHR vendor).

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The time needed for an EHR vendor to review the quality measures and other information

and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total burden hours to be 40 hours at a rate of $50 per hour for a total burden estimate of $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately 200 hours at $50 per hour, for a total estimate of $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. Therefore, we estimate that the proposed self-nomination process for the group practices for the 2010 PQRI involves approximately 2 hours per group practice to draft the letter of intent for self-nomination, gather the requested TIN and NPI information, and provide this requested information. It is estimated that each self-nominated entity will also spend 2 hours undergoing the vetting process with CMS officials. We assume that the group practice staff involved in the group practice self-nomination process have an average practice labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice).

The burden associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011, for use in the Physician Group Practice, Medicare Care Management Performance (MCMP), and EHR demonstrations. Based on burden estimates for the PGP demonstration, which uses the same data submission methods as what we have proposed, we estimate the burden associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be $4,565 ($55 per hour × 83 hours per group practice).

We invite comments on this burden analysis, including the underlying assumptions used in developing our estimates.

The Electronic Prescribing (E-Prescribing) Incentive Program

We believe it is difficult to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program in CY 2010. Information from the ''PQRI 2007 Reporting Experience Report,'' which is available on the PQRI section of the CMS Web site at *http://www.cms.hhs.gov/PQRI*, indicates that nearly 110,000 unique TIN/NPI combinations attempted to submit PQRI quality measures data via claims for the 2007 PQRI. Therefore, for purposes of conducting a burden analysis for the 2010 E-Prescribing Incentive Program, we will assume that as many eligible professionals who attempted to participate in the 2007 PQRI will attempt to participate in the 2010 E-Prescribing Incentive Program. As such, we can estimate that nearly 110,000 unique TIN/NPI combinations will participate in the 2010 E-Prescribing Incentive Program.

Section II.G.5. of this proposed rule discusses the background of the E-Prescribing Incentive Program. Section II.G.5.c. of this proposed rule provides information on how we propose eligible professionals can qualify to be considered a successful e-prescriber in 2010 in order to earn an incentive payment. Similar to the PQRI, the E-Prescribing Incentive Program is a voluntary initiative. Eligible professionals may choose whether to participate and, to the extent they meet (1) certain thresholds with respect to the volume of covered professional services furnished and (2) the criteria to be considered a successful e-prescriber described in section II.G.5.c. of this proposed rule, they can qualify to receive an incentive payment for 2010.

For the 2010 E-Prescribing Incentive Program, as discussed in section II.G.5. of this proposed rule, we propose that each eligible professional would need to report the G-code indicating that at least one prescription generated during an encounter was electronically submitted at least 25 instances during the reporting period. Similar to PQRI, this measure would be reportable through claims-based reporting, registry-based reporting, or through EHRs, if we finalize the proposed EHR-based reporting mechanism for PQRI.

Similar to claims-based reporting for the PQRI, we estimate that the burden associated with the requirements of this new incentive program is the time and effort associated with eligible professionals determining whether the electronic prescribing quality measure applies to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. We expect the ongoing costs associated with participation in the E-Prescribing Incentive Program to decline based on an eligible professional's familiarity with and understanding of the E-Prescribing Incentive Program, experience with participating in the E-Prescribing Incentive Program, and increased efforts by CMS and stakeholders to disseminate useful educational resources and best practices. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately $55 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $55 ($55 per hour × 1 hour).

For claims-based reporting, the quality data codes will be collected as additional (optional) line items on the existing HIPAA transaction 837–P and/or CMS Form 1500. We do not anticipate any new forms and no modifications to the existing transaction or form. We also do not anticipate

changes to the 837–P or CMS Form 1500 for CY 2010.

Based on our experience with the PVRP described in section II.G.5. of this proposed rule, we estimate that the time needed to perform all the steps necessary to report the e-prescribing measure to be 1.75 minutes. We also estimate the cost to perform all the steps necessary to report the e-prescribing measure to be $0.90 based on the experience with the PVRP described above.

Based on our proposed criteria for determination of whether an eligible professional is a successful e-prescriber, we estimate that each eligible professional would report the electronic prescribing measure in 25 instances during the reporting period.

Therefore, we estimate the total annual burden per eligible professional who chooses to participate in the 2010 E-Prescribing Incentive Program through claims-based reporting of the electronic prescribing measure to be 104 minutes, or 1.73 hours [(1.75 minutes per measure × 1 measure × 25 cases per measure) + 1 hour]. The total estimated cost per eligible professional to report the electronic prescribing measure is estimated to be $77.50 [($0.90 per measure × 1 measure × 25 cases per measure) + $55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional burden for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, eligible professionals would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each eligible professional that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for a registry to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the registry self-nomination process.

The burden associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the burden associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting, the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The time needed for an eligible professional to review the electronic prescribing measure and other information and determine whether the measure is applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, 1 hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the eligible professional associated with submission of data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional burden associated with the self-nomination process.

The burden associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

Finally, with respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the

electronic prescribing measure is the number of times that a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual burden to be 73.92 hours [(1.75 minutes per measure × 1 measure × 2500 cases per measure) + 1 hour]. The total estimated cost per group practice to report the electronic prescribing measure through claims-based reporting is estimated to be $2,305 [($0.90 per measure × 1 measure × 2500 cases per measure) + $55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would not be a separate group practice self-nomination process for the E-Prescribing Incentive Program and, thus, no additional burden.

We invite comments on this burden analysis, including the underlying assumptions used in developing our burden estimates.

IV. 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.

V. Regulatory Impact Analysis

We have examined the impacts of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993, as further amended), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), and the Congressional Review Act (5 U.S.C. 804(2)).

Executive Order 12866 (as amended by Executive Order 13258) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year). We estimate, as discussed below in this section, that the PFS provisions included in this proposed rule will redistribute more than $100 million in 1 year. Therefore, we estimate that this rulemaking is ''economically significant'' as measured by the $100 million threshold, and hence also a major rule under the Congressional Review Act. Accordingly, we have prepared a Regulatory Impact Analysis that to the best of our ability presents the costs and benefits of the rulemaking.

The RFA requires agencies to analyze options for regulatory relief of small businesses and other small entities, if a rule has a significant impact on a substantial number of small entities. For purposes of the RFA, we estimate that most hospitals and most other providers are small entities as that term is used in the RFA (including small businesses, nonprofit organizations, and small governmental jurisdictions). The great majority of hospitals and most other health care providers and suppliers are small entities, either by being nonprofit organizations or by meeting the Small Business Administration (SBA) definition of a small business (having revenues of $7 million to $34.5 million in any 1 year) (for details *see* the SBA's Web site at *http://sba.gov/idc/groups/public/documents/sba_homepage/serv_sstd_tablepdf.pdf* (refer to the 620000 series).

Individuals and States are not included in the definition of a small entity. 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.

For purposes of the RFA, physicians, NPPs, and suppliers including IDTFs are considered small businesses if they generate revenues of $7 million or less based on SBA size standards. Approximately 95 percent of physicians are considered to be small entities. There are over 1 million physicians, other practitioners, and medical suppliers that receive Medicare payment under the PFS.

For purposes of the RFA approximately 85 percent of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are considered small businesses according to the SBA size standards. We estimate that approximately 66,000 entities bill Medicare for DMEPOS each year. Total annual estimated Medicare revenues for DMEPOS suppliers are approximately $10.8 billion in 2007 for which $8.3 billion was for fee-for-service (FFS) and $2.5 billion was for managed care.

For purposes of the RFA, approximately 80 percent of clinical diagnostic laboratories are considered small businesses according to the SBA size standards.

Ambulance providers and suppliers for purposes of the RFA are also considered to be small entities.

In addition, most ESRD facilities are considered small entities for purposes of the RFA, either based on nonprofit status or by having revenues of $7 million to $34.5 million or less in any year. We note that a considerable number of ESRD facilities are owned and operated by large dialysis organizations (LDOs) or regional chains, which would have total revenues more than $34.5 million in any year if revenues from all locations are combined. However, the claims data we use to estimate payments for this RFA and RIA does not identify which dialysis facilities are parts of an LDO, regional chain, or other type of ownership. Each individual dialysis facility has its own provider number and bills Medicare using this number. Therefore, we consider each ESRD to be a small entity for purposes of the RFA. We consider a substantial number of entities to be significantly affected if the proposed rule has an annual average impact on small entities of 3 to 5 percent or more. The majority of ESRD facilities will experience impacts of less than 2 percent of total revenues. There are 929 nonprofit ESRD facilities with a combined increase of 0.9 percent in overall payments relative to current overall payments. We note that although the overall effect of the wage index changes is budget neutral, there are increases and decreases based on the location of individual facilities. The analysis and discussion provided in this section and elsewhere in this proposed rule complies with the RFA requirements.

Because we acknowledge that many of the affected entities are small entities, the analysis discussed throughout the preamble of this proposed rule constitutes our regulatory flexibility analysis for the remaining provisions and addresses comments received on these issues.

In addition, section 1102(b) of the Act requires us to prepare a regulatory impact analysis, if a rule may have a significant impact on the operations of a substantial number of small rural hospitals. Any such regulatory impact 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 of a metropolitan statistical area and has fewer than 100 beds. We do not believe this proposed rule has impact on significant operations of a substantial number of small rural hospitals because most dialysis facilities are freestanding. While there are 177 rural hospital-based dialysis facilities, we do not know how many of them are based at hospitals with fewer than 100 beds. However, overall, the 177 rural hospital-based dialysis facilities will experience an estimated 1.1 percent increase in payments. As a result, this rule will not have a significant impact on small rural hospitals. Therefore, the Secretary has determined that this proposed rule will not have a significant impact on the operations of a substantial number of small rural hospitals.

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) also requires that agencies assess anticipated costs and benefits before issuing any rule whose mandates require spending in any 1 year of $100 million in 1995 dollars, updated annually for inflation. In 2009, that threshold is approximately $133 million. This proposed rule will not mandate any requirements for State, local, or Tribal governments. Medicare beneficiaries are considered to be part of the private sector and as a result a more detailed discussion is presented on the Impact of Beneficiaries in section V. of this regulatory impact analysis.

We have examined this proposed rule in accordance with Executive Order 13132 and have determined that this regulation would not have any substantial direct effect on State or local governments, preempt States, or otherwise have a Federalism implication.

We have prepared the following analysis, which together with the information provided in the rest of this preamble, meets all assessment requirements. The analysis explains the rationale for and purposes of this proposed rule; details the costs and benefits of the rule; analyzes alternatives; and presents the measures we will use to minimize the burden on small entities. As indicated elsewhere in this rule, we are implementing a variety of changes to our regulations, payments, or payment policies to ensure that our payment systems reflect changes in medical practice and the relative value of services. We provide information for each of the policy changes in the relevant sections of this proposed rule. We are unaware of any relevant Federal rules that duplicate, overlap, or conflict with this proposed rule. The relevant sections of this rule contain a description of significant alternatives if applicable.

A. RVU Impacts

1. Resource-Based Work PE and MP RVUs

Section 1848(c)(2)(B)(ii) of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, we make adjustments to preserve BN.

Our estimates of changes in Medicare revenues for PFS services compare payment rates for CY 2009 with proposed payment rates for CY 2010 using CY 2008 Medicare utilization for all years. 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 in Table 39. 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 PFS. For instance, independent laboratories receive approximately 80 percent of their Medicare revenues from clinical laboratory services that are not paid under the PFS.

Table 39 shows only the payment impact on PFS services. The following is an explanation of the information represented in Table 39

- *Specialty:* The physician specialty or type of practitioner/supplier.
- *Allowed charges:* Allowed charges are the Medicare Fee Schedule amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary.) These amounts have been summed across all services furnished by physicians, practitioners, or suppliers within a specialty to arrive at the total allowed charges for the specialty.
- Impact of Proposed Work RVU changes for the CY 2010 PFS.
- Impact of Proposed PE RVU changes for the CY 2010 PFS.
- Impact of Proposed MP RVU changes for the CY 2010 PFS.
- Combined Impact of all Proposed Changes. The impact shown is a combined impact that incorporates all proposed changes to Work RVUs, PE RVUs, and MP RVUs, prior to the

application of the CY 2010 negative PFS CF update under the current statute.

TABLE 39—CY 2010 TOTAL ALLOWED CHARGE IMPACT FOR WORK, PRACTICE EXPENSE, AND MALPRACTICE CHANGES *

	Specialty	Allowed charges (mil)	Impact of work RVU changes (%)	Impact of PE RVU changes** (%)	Impact of MP RVU changes (%)	Combined impact (%)
	(A)	(B)		(C)	(D)	(E)
1	TOTAL	$77,744	0	1	0	1
2	ALLERGY/IMMUNOLOGY	171	0	0	−2	−3
3	ANESTHESIOLOGY	1,713	0	5	1	6
4	CARDIAC SURGERY	371	−1	−1	3	−2
5	CARDIOLOGY	7,179	0	−10	−1	−11
6	COLON AND RECTAL SURGERY	129	−1	5	1	5
7	CRITICAL CARE	221	0	3	1	3
8	DERMATOLOGY	2,504	0	2	0	3
9	EMERGENCY MEDICINE	2,395	0	2	0	2
10	ENDOCRINOLOGY	370	−1	3	0	3
11	FAMILY PRACTICE	5,055	2	5	1	8
12	GASTROENTEROLOGY	1,779	−1	1	0	0
13	GENERAL PRACTICE	719	1	5	0	6
14	GENERAL SURGERY	2,213	−1	4	1	4
15	GERIATRICS	167	1	6	1	8
16	HAND SURGERY	89	−1	4	0	3
17	HEMATOLOGY/ONCOLOGY	1,888	0	−5	−1	−6
18	INFECTIOUS DISEASE	549	−1	4	1	3
19	INTERNAL MEDICINE	10,061	1	4	1	6
20	INTERVENTIONAL PAIN MANAGEMENT	352	−1	7	0	6
21	INTERVENTIONAL RADIOLOGY	227	0	−10	0	−10
22	NEPHROLOGY	1,789	0	1	1	2
23	NEUROLOGY	1,417	−2	6	0	3
24	NEUROSURGERY	586	−1	3	1	2
25	NUCLEAR MEDICINE	72	0	−12	−2	−13
26	OBSTETRICS/GYNECOLOGY	615	0	1	0	1
27	OPHTHALMOLOGY	4,736	0	11	0	11
28	ORTHOPEDIC SURGERY	3,257	0	4	0	3
29	OTOLARNGOLOGY	926	−1	3	−1	1
30	PATHOLOGY	985	0	−1	0	0
31	PEDIATRICS	64	1	4	0	4
32	PHYSICAL MEDICINE	816	0	7	0	7
33	PLASTIC SURGERY	278	−1	5	1	5
34	PSYCHIATRY	1,071	0	2	1	3
35	PULMONARY DISEASE	1,753	−1	3	1	3
36	RADIATION ONCOLOGY	1,799	0	−17	−1	−19
37	RADIOLOGY	5,254	0	−10	−1	−11
38	RHEUMATOLOGY	494	0	0	0	−1
39	THORACIC SURGERY	389	−1	0	3	2
40	UROLOGY	1,989	0	−6	0	−7
41	VASCULAR SURGERY	685	−1	−1	0	−1
42	AUDIOLOGIST	35	0	−4	−7	−10
43	CHIROPRACTOR***	700	0	4	1	5
44	CLINICAL PSYCHOLOGIST	533	0	−7	0	−7
45	CLINICAL SOCIAL WORKER	353	0	−6	1	−6
46	NURSE ANESTHETIST	772	0	2	0	2
47	NURSE PRACTITIONER	1,004	1	5	1	7
48	OPTOMETRY	834	1	11	0	12
49	ORAL/MAXILLOFACIAL SURGERY	35	−1	3	−1	1
50	PHYSICAL/OCCUPATIONAL THERAPY	1,857	0	10	0	10
51	PHYSICIAN ASSISTANT	749	0	4	0	5
52	PODIATRY	1,656	1	7	−1	6
53	DIAGNOSTIC TESTING FACILITY	1,044	0	−19	−5	−24
54	INDEPENDENT LABORATORY	960	0	−4	−1	−5
55	PORTABLE X-RAY SUPPLIER	85	0	−8	−2	−11

* Does not include the impact of the current law CY 2010 negative update. Rows may not sum to total due to rounding.

** Note: The law caps the MFS imaging payment amount at the comparable payment amount in the hospital outpatient payment system (OPPS cap). In the absence of the negative current law CY 2010 MFS update, the proposed PE change to the equipment utilization rate for expensive equipment from 50 percent to 90 percent would increase expenditures by approximately 1 percent due to a loss of savings from the OPPS cap.

*** Does not reflect the BN reduction in payments resulting from the chiropractic demonstration.

2. Resource-Based Work, PE, and MP RVUs Impacts

a. Work RVU Impacts

The work RVU impacts are almost entirely attributable to the proposed changes for consultation services. As described earlier in this proposed rule, we are proposing to no longer recognize the BILLING CODEs for consultation services so we are budget neutrally eliminating the use of all consultation codes (except for telehealth) and have allocated the work RVUs that were allotted to these services to the work RVUs for new and established office visit services, initial hospital visits, and initial nursing facility visits to reflect this change.

b. PE RVUs Impacts

The PE RVU impacts are primarily attributable to the proposed incorporation of PE data from the Physician Practice Information Survey (PPIS). For a discussion of the use of this updated survey data, see section II.A.2. of this proposed rule.

For two specialties, IDTFs and Radiation Oncology, the impact of our proposed change in the utilization rate for expensive equipment is also significant. We estimate that for these two specialties, the utilization rate change will result in impacts of −2 percent and −5 percent (respectively). These impacts are included in the −19 percent and −17 percent PE RVU impacts shown in Table 39 for these specialties. After taking into account the OPPS payment cap, the change in the utilization rate for expensive equipment does not substantially reduce overall payments for other specialties.

Our proposals on consultation codes (*see* section II.E.4. of this proposed rule) and dominant specialty (*see* section II.C.2. of this proposed rule) do not have a significant impact on PE payments to specialties.

c. Malpractice RVU Impacts

The PE RVU impacts are attributable to the changes proposed for the Five-Year Review of MP RVUs described earlier in this proposed rule. Of particular note are the impacts on the specialties of Audiology (−7 percent), and IDTFs (−5 percent). These impacts are primarily driven by the expansion of the MP premium data collection and the proposed changes to the methodology for TC services.

d. Combined Impact

Column E of Table 39 displays the proposed combined impact of all RVU changes by specialty. These changes range from increases of +12 percent for optometry to decreases of −24 percent for IDTFs. The effect of our proposals on primary care specialties such as General Practice, Family Practice, Internal Medicine, and Geriatrics are positive with increases ranging from +6 percent to +8 percent. Again, these impacts are prior to the application of the negative CY 2010 CF update under the current statute.

Table 40 shows the estimated impact on total payments for selected high-volume procedures of all of the changes discussed previously, including the effect of the CY 2010 negative PFS CF update. We selected these procedures because they are the most commonly furnished by a broad spectrum of physician specialties. There are separate columns that show the change in the facility rates and the nonfacility rates. For an explanation of facility and nonfacility PE, refer to Addendum A of this proposed rule.

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES

CPT [1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009	2010 [2]	Percent change	2009	2010 [2]	Percent change
11721		Debride nail, 6 or more	$27.77	$19.82	−29	$40.39	32.29	−20
17000		Destruct premalg lesion	48.69	40.50	−17	69.97	57.21	−18
27130		Total hip arthroplasty	1,359.71	1,113.00	−18	NA	NA	NA
27244		Treat thigh fracture	1,144.39	944.21	−17	NA	NA	NA
27447		Total knee arthroplasty	1,456.37	1,187.76	−18	NA	NA	NA
33533		CABG, arterial, single	1,892.05	1,524.78	−19	NA	NA	NA
35301		Rechanneling of artery	1,067.93	879.63	−18	NA	NA	NA
43239		Upper GI endoscopy, biopsy	165.55	130.27	−21	323.16	243.84	−25
66821		After cataract laser surgery	251.38	225.15	−10	266.53	237.89	−11
66984		Cataract surg w/iol, 1 stage	638.74	568.96	−11	NA	NA	NA
67210		Treatment of retinal lesion	561.56	502.12	−11	580.67	517.13	−11
71010		Chest x-ray	NA	NA	NA	23.80	16.14	−32
71010	26	Chest x-ray	9.02	6.80	−25	9.02	6.80	−25
77056		Mammogram, both breasts	NA	NA	NA	107.48	80.15	−25
77056	26	Mammogram, both breasts	44.36	33.98	−23	44.36	33.98	−23
77057		Mammogram, screening	NA	NA	NA	81.51	57.49	−29
77057	26	Mammogram, screening	35.71	27.47	−23	35.71	27.47	−23
77427		Radiation tx management, x5	188.27	155.48	−17	188.27	155.48	−17
78465	26	Heart image (3d), multiple	78.99	56.92	−28	78.99	56.92	−28
88305	26	Tissue exam by pathologist	37.15	29.45	−21	37.15	29.45	−21
90801		Psy dx interview	128.04	96.01	−25	152.92	118.95	−22
90862		Medication management	45.08	35.40	−21	55.18	45.31	−18
90935		Hemodialysis, one evaluation	66.36	54.09	−18	NA	NA	NA
92012		Eye exam established pat	45.80	41.35	−10	70.69	62.87	−11
92014		Eye exam & treatment	70.33	62.59	−11	103.15	91.76	−11
92980		Insert intracoronary stent	847.93	587.08	−31	NA	NA	NA
93000		Electrocardiogram, complete	20.92	13.03	−38	20.92	13.03	−38
93010		Electrocardiogram report	9.02	6.80	−25	9.02	6.80	−25
93015		Cardiovascular stress test	100.27	61.74	−38	100.27	61.74	−38
93307	26	Tte w/o doppler, complete	49.77	35.97	−28	49.77	35.97	−28
93510	26	Left heart catheterization	248.86	169.36	−32	248.86	169.36	−32
98941		Chiropractic manipulation	30.30	24.36	−20	33.90	28.04	−17

TABLE 40—IMPACT OF PROPOSED RULE AND ESTIMATED PHYSICIAN UPDATE ON 2010 PAYMENT FOR SELECTED PROCEDURES—Continued

CPT[1]/ HCPCS	MOD	Description	Facility			Non-facility		
			2009	2010[2]	Percent change	2009	2010[2]	Percent change
99203		Office/outpatient visit, new	68.17	60.04	−12	91.97	81.00	−12
99213		Office/outpatient visit, est	44.72	39.93	−11	61.31	54.09	−12
99214		Office/outpatient visit, est	69.25	61.17	−12	92.33	80.15	−13
99222		Initial hospital care	122.63	106.77	−13	NA	NA	NA
99223		Initial hospital care	180.33	156.05	−13	NA	NA	NA
99231		Subsequent hospital care	37.15	30.87	−17	NA	NA	NA
99232		Subsequent hospital care	66.72	56.07	−16	NA	NA	NA
99233		Subsequent hospital care	95.58	80.43	−16	NA	NA	NA
99236		Observ/hosp same date	207.38	170.77	−18	NA	NA	NA
99239		Hospital discharge day	96.30	81.85	−15	NA	NA	NA
99283		Emergency dept visit	61.31	49.84	−19	NA	NA	NA
99284		Emergency dept visit	114.33	92.89	−19	NA	NA	NA
99291		Critical care, first hour	212.07	173.89	−18	253.91	206.74	−19
99292		Critical care, add Æl 30 min	106.04	86.94	−18	114.69	93.74	−18
99348		Home visit, est patient	NA	NA	NA	79.35	65.42	−18
99350		Home visit, est patient	NA	NA	NA	160.86	137.92	−14
G0008		Admin influenza virus vac	NA	NA	NA	20.92	16.99	−19

[1] CPT codes and descriptions are copyright 2009 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply.
[2] Based upon projected −21.5 reduction in the conversion factor.

B. Geographic Practice Cost Indices (GPCIs)

As discussed in section II.C. of this proposed rule, the application of the 1.000 work GPCI floor, as extended by section 134(a) of the MIPPA, expires effective January 1, 2010. As a result, 54 (out of 89) PFS localities will receive a decrease in their work GPCI. Puerto Rico receives the largest decrease (−9.6 percent), followed by South Dakota (−5.8 percent), North Dakota (−5.3 percent), Rest of Missouri (−5.1 percent), and Montana (−5.0 percent).

C. Medicare Telehealth Services

In section II.D. of this proposed rule, we are proposing to add individual health behavior and assessment services (as described by HCPCS codes 96150 through 96152) to the list of telehealth services. We are also proposing to revise § 410.78 to specify that the G-codes for follow-up inpatient telehealth consultations (as described by HCPCS codes G0406 through G0408) include follow-up telehealth consultations furnished to beneficiaries in hospitals and skilled nursing facilities.

The total annual Medicare payment amount for telehealth services (including the originating site facility fee) is approximately $2 million. Previous additions to the list of telehealth services have not resulted in a significant increase in Medicare program expenditures. While we believe that these proposals will provide more beneficiaries with access to these services, we do not anticipate that these proposed changes will have a significant budgetary impact on the Medicare program.

D. MIPPA Provisions

1. Section 102: Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services

This section of the MIPPA will have a positive impact on Medicare patients because coinsurance payment percentages for outpatient mental health services will be gradually reduced from January 1, 2010 through January 1, 2014. At the conclusion of this 5-year period, Medicare patients will pay the same coinsurance payment percentage for outpatient mental health services as they currently pay for other health services under the Medicare Part B program.

Since the inception of the Medicare Part B program, Medicare patients have been required to pay for a greater percentage of the cost of outpatient mental health treatment services than for other health services because of the Medicare payment limitation (the outpatient mental health treatment limitation). While a dollar cap that previously applied to mental health services was eliminated January 1, 1991, the statute maintained the 62½ percent limitation on the recognition of incurred expenses. This limitation of 62½ percent reduces the program's payment for mental health services to 50 percent, leaving a Medicare patient responsible for paying the other half of these expenses through coinsurance. The 62½ percent limitation will remain in effect until December 31, 2009.

During the transition, the Medicare Part B program will incur increased expenditures as Medicare patients pay less out-of-pocket for outpatient mental health services until, in 2014, patients will pay only the deductible (if applicable) and 20 percent coinsurance. Section 102 of the MIPPA will shift cost-sharing for mental health services from Medicare patients to the program. This provision will result in a cost impact, to the Medicare program, of approximately $100 million for CY 2010. As section 102 of the MIPPA is implemented, the impact of the changes to the coinsurance payment percentages (that is, recognized incurred expenses) for Medicare patients and the program is as shown in Table 41.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT PERCENTAGES UNDER SECTION 102 OF THE MIPPA

CY 2009 and prior calendar years—Medicare limitation, 62.50 percent of recognized incurred expenses.
Medicare Patient pays—50%.
Medicare Part B pays—50%.
CY 2010 and CY 2011—Medicare limitation, 68.75 percent of recognized incurred expenses.
Medicare Patient pays—45%.
Medicare Part B pays—55%.
CY 2012—Medicare limitation, 75 percent of recognized incurred expenses.
Medicare Patient pays—40%.
Medicare Part B pays—60%.
CY 2014—No limitation, 100.00 percent of recognized incurred expenses.

TABLE 41—IMPACT OF THE CHANGES TO THE COINSURANCE PAYMENT PERCENTAGES UNDER SECTION 102 OF THE MIPPA—Continued

Medicare Patient pays—20%. Medicare Part B pays—80%.

2. Section 131 b: Physician Payment, Efficiency, and Quality Improvements—Physician Quality Reporting Initiative (PQRI)

As discussed in section II.G.2. of this proposed rule, the proposed 2010 PQRI measures satisfy the requirement of section 1848(k)(2)(D) of the Act that the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selection of measures applicable to services they furnish. As discussed in section II.G.2.d. of this proposed rule, we also propose to offer options in 2010 for reporting the proposed 2010 PQRI measures via submission of data to a clinical registry, options for reporting some of the proposed 2010 PQRI measures via submission of data extracted from an EHR, options for reporting on measures groups rather than individual measures, and options for group practices to be treated as satisfactorily submitting quality data under the PQRI.

Although there may be some cost incurred for maintaining the measures used in the PQRI and their associated code sets, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and EHR-based reporting for the PQRI, we do not anticipate a significant cost impact on the Medicare program.

Participation in the PQRI by eligible professionals is voluntary and eligible professionals and group practices may have different processes for integrating the PQRI into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the PQRI on providers.

With respect to satisfactory submission of data on quality measures by eligible professionals, one factor that influences the cost to eligible professionals is the time and effort associated with eligible professionals identifying applicable PQRI quality measures for which they can report the necessary information. We have no way to accurately quantify the burden because it would vary with each eligible professional by the number of measures applicable to the eligible professional, the eligible professional's familiarity and understanding of the PQRI, and experience with participating in the PQRI. In addition, eligible professionals may employ different methods for incorporating the use of quality data codes into the office work flows. Therefore, we will continue to assign 3 hours as the amount of time needed for eligible professionals to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows. Information from the Physician Voluntary Reporting Program (PVRP), which was a predecessor to the PQRI, indicated an average labor cost of approximately $50 per hour. To account for salary increases over time, we will use an average practice labor cost of $55 per hour for our estimates based on an assumption of an average annual increase of approximately 3 percent. Thus, we continue to estimate the cost for an eligible professional to review the PQRI quality measures, identify the applicable measures for which they can report the necessary information, and incorporate the use of quality data codes into the office work flows to be approximately $165 per eligible professional ($55 per hour × 3 hours).

For claims-based PQRI reporting, one factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the Medicare Part B claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Eligible professionals generally would be required to report at least 3 measures to satisfactorily report PQRI quality measures data. Therefore, for purposes of this impact analysis we will assume that eligible professionals participating in the 2010 PQRI will report an average of 3 measures each.

The cost of implementing claims-based reporting of PQRI quality measures data also varies with the volume of claims on which quality data is reported. Since we propose to require eligible professionals to report at least one of their selected measures for at least 15 Medicare Part B FFS patients in order to satisfactorily report, then, for this burden analysis, we will assume that for each measure, the eligible professional reports the quality data codes on 15 cases. The actual number of cases on which an eligible professional would be required to report quality measures data will vary, however, with the eligible professional's patient population and the types of measures on which the eligible professional chooses to report (each measure's specifications includes a required reporting frequency).

Based on the assumptions discussed above, we estimate the total annual cost per eligible professional associated with claims-based reporting to range from $174.45 [($0.21 per measure × 3 measures × 15 cases per measure) + $165] to $617.70 [($10.06 per measure × 3 measures × 15 cases per measure) + $165].

For registry-based reporting, eligible professionals must generally incur a cost to submit data to registries. Estimated fees for using a qualified registry range from a nominal charge for an eligible professional to use the registry to costing eligible professionals several thousand dollars. Thus, we conservatively estimate the cost incurred by an eligible professional to participate in PQRI via registry-based reporting to be approximately $500 per eligible professional.

In addition, an eligible professional who chooses to submit PQRI quality measures results and numerator and denominator data on quality measures through a registry more than likely is already reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 PQRI. Therefore, there should be little additional cost to the eligible professional associated with submitting data to the registry.

Registries interested in submitting quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf would need to complete a self-nomination process in order to be considered ''qualified'' to submit on behalf of eligible professionals. We estimate the registry self-nomination process to cost approximately $500 per registry ($50 per hour × 10 hours per registry). This cost estimate includes the cost of submitting the self-nomination letter to CMS and completing the CMS vetting process. Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

The cost to the registry associated with the registry-based reporting requirements of this voluntary reporting initiative is the time and effort

associated with the registry calculating quality measure results from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on quality measures to CMS on behalf of their participants. The time needed for a registry to review the quality measures and other information, calculate the measures results, and submit the measures results and numerator and denominator data on the quality measures on their participants behalf is expected to vary along with the number of eligible professionals reporting data to the registry and the number of applicable measures. However, we believe that registries already perform many of these activities for their participants.

For EHR-based reporting, an eligible professional generally would incur a cost associated with purchasing an EHR product. We estimate that it costs between $1,500 to over $5,000 to purchase an EHR product. Therefore, we conservatively estimate the average total cost to an eligible professional to be approximately $2,750.

An EHR vendor interested in having their product(s) be used by eligible professionals to submit quality measures results and numerator and denominator data on quality measures to CMS were required to complete a self-nomination process in order for the vendor's product(s) to be considered ''qualified'' for 2010. Therefore, one factor in the cost to EHR vendors is the cost associated with completing the self-nomination process in order for the vendor's EHR product(s) to be considered ''qualified.'' Similar to the estimated cost to the registry associated with the registry self-nomination process, the estimated cost for an EHR vendor to complete the self-nomination process, including the vetting process with CMS officials, is conservatively estimated to be $500 ($50 per hour × 10 hours per EHR vendor). Our estimate of a $50 per hour average labor cost for registries is based on the assumption that registry staff include IT professionals whose average hourly rates range from $36 to $84 per hour depending on experience, with an average rate of nearly $50 per hour for a mid-level programmer.

Another factor in the cost to EHR vendors is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting 2010 PQRI quality measures. The cost associated with the time and effort needed for an EHR vendor to review the quality measures and other information and program each qualified EHR product to enable eligible professionals to submit PQRI quality measures data to the CMS-designated clinical warehouse will be dependent on the EHR vendor's familiarity with PQRI, the vendor's system capabilities, as well as the vendor's programming capabilities. Some vendors already have these necessary capabilities and for such vendors, we estimate the total cost to be approximately $2,000 ($50 per hour × 40 hours per vendor). However, given the variability in the capabilities of the vendors, we believe a more conservative estimate for those vendors with minimal experience would be approximately $10,000 per vendor ($50 per hour × 200 hours per EHR vendor).

With respect to the proposed process for group practices to be treated as satisfactorily submitting quality measures data under the 2010 PQRI discussed in section II.G.2.g. of this proposed rule, group practices interested in participating in the 2010 PQRI through the group practice reporting option would need to complete a self-nomination process similar to the self-nomination process required of registries and EHR vendors. We estimate that the group practice staff involved in the group practice self-nomination process have an average labor cost of $55 per hour. Therefore, assuming the total burden hours per group practice associated with the group practice self-nomination process is 4 hours, we estimate the total cost to a group practice associated with the group practice self-nomination process to be approximately $220 ($55 per hour × 4 hours per group practice).

The cost associated with the group practice reporting requirements of this voluntary reporting initiative is the time and effort associated with the group practice submitting the quality measures data. For physician group practices, this would be the time associated with the physician group completing the proposed data collection tool. The information collection components of this data collection tool have been reviewed by OMB and are currently approved under OMB control number 0938–0941, with an expiration date of December 31, 2011. Based on cost estimates for the Physician Group Practice (PGP) demonstration, which uses the same data submission methods as what we have proposed, we estimate the cost associated with a physician group completing the data collection tool would be approximately 79 hours per physician group. Therefore, we estimate the total annual burden hours per physician group would be approximately 83 hours (4 hours for self-nomination + 79 hours for data submission). Based on an average labor cost of $55 per physician group, we estimate the cost per physician group associated with participating in the proposed PQRI group practice reporting option would be $4,565 ($55 per hour × 83 hours per group practice).

3. Section 131(c): Physician Resource Use Measurement and Reporting Program

As discussed in section II.G.3. of this proposed rule, section 131(c) of the MIPPA amends section 1848 of the Act by adding subsection (n), which requires the Secretary to establish and implement by January 1, 2009, a Physician Feedback Program using Medicare claims data and other data to provide confidential feedback reports to physicians (and as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to Medicare beneficiaries. If determined appropriate by the Secretary, the Secretary may also include information on quality of care furnished to Medicare beneficiaries by the physician (or group of physicians) in the reports. We anticipate the impact of this section to be negligible for the work completed in the phased pilot physician feedback program to date.

4. Section 132: Incentives for Electronic Prescribing (E-Prescribing)—The E-Prescribing Incentive Program

Section II.G.5. of this proposed rule describes the proposed 2010 E-Prescribing Incentive Program. To be considered a successful e-prescriber in 2010, an eligible professional would need to meet the requirements proposed in section II.G.5.c. of this proposed rule.

We anticipate that the cost impact of the E-Prescribing Incentive Program on the Medicare program would be the cost incurred for maintaining the electronic prescribing measure and its associated code set, and for expanding an existing clinical data warehouse to accommodate registry-based reporting and, potentially, EHR-based reporting for the electronic prescribing measure. We, however, do not anticipate a significant cost impact on the Medicare program since much of this infrastructure had already been established for the PQRI.

Participation in the E-Prescribing Incentive Program by eligible professionals is voluntary and eligible professionals may have different processes for integrating the E-Prescribing Incentive Program into their practices' work flows. Therefore, it is not possible to estimate with any degree of accuracy the impact of the E-

Prescribing Incentive Program on eligible professionals. Similar to claims-based reporting for PQRI, one factor in the cost to eligible professionals, for those eligible professionals who choose to report the electronic prescribing measure through claims, is the time and effort associated with eligible professionals determining whether the quality measure is applicable to them, gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims they submit for payment. Since the E-Prescribing Incentive Program consists of only 1 quality measure, we will assign 1 hour as the amount of time needed for eligible professionals to review the e-prescribing measure and incorporate the use of quality data codes into their office work flows. At an average cost of approximately $55 per hour, we estimate the total cost to eligible professionals for reviewing the e-prescribing measure and incorporating the use of quality data codes into the office work flows to be approximately $55 ($55 per hour × 1 hour).

Another factor in the cost to eligible professionals is the time and effort associated with gathering the required information, selecting the appropriate quality data codes, and including the appropriate quality data codes on the claims an eligible professional submits for payment. Information from the PVRP estimates the cost to physicians to perform all of the steps necessary to report 1 quality measure ranges from $0.21 in labor time to about $10.06 in labor time for more complicated cases and/or measures. For the median practice, the cost was about $0.90 in labor time per measure. Therefore, we estimate the costs to eligible professionals to perform all the steps necessary to report the electronic prescribing measure on a claim to be approximately $0.90.

The cost for this requirement will also vary along with the volume of claims on which quality data is reported. Based on our proposal to require an eligible professional to report the G8443 code for the electronic prescribing measure for at least 25 instances, we estimate the total annual estimated cost per eligible professional to report the electronic prescribing measure to be $77.50 [($0.90 per measure × 1 measure × 25 cases per measure) + $55].

Because registry-based reporting of the electronic prescribing measure to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the registry-based reporting mechanism in CY 2010. We do not anticipate, however, any additional cost for eligible professionals to report data to a registry as eligible professionals opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program.

One potential cost to some eligible professionals associated with either claims-based reporting or registry-based reporting would be the cost of purchasing and using an e-prescribing system. There are currently many commercial packages available for e-prescribing. One study indicated that a mid-range complete electronic medical record with electronic prescribing functionality costs $2500 per license with an annual fee of $90 per license for quarterly updates of the drug database after setup costs while a standalone prescribing, messaging, and problem list system costs $1200 per physician per year after setup costs. Hardware costs and setup fees substantially add to the final cost of any software package. (Corley, S.T. (2003). ''Electronic prescribing: a review of costs and benefits.'' Topics in Health Information Management 24(1): 29–38.). The cost to an eligible professional of obtaining and utilizing an e-prescribing system varies not only by the commercial software package selected but also by the level at which the professional currently employs information technology in his or her practice and the level of training needed.

Based on our proposal to consider only registries qualified to submit quality measures results and numerator and denominator data on quality measures to CMS on their participants' behalf for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, we do not anticipate any cost to the registry associated with becoming a registry qualified to submit the electronic prescribing measure for 2010.

The cost associated with the registry-based reporting requirements of this voluntary reporting initiative for the registry would be the time and effort associated with the registry calculating results for the electronic prescribing measure from the data submitted to the registry by its participants and submitting the quality measures results and numerator and denominator data on the electronic prescribing quality measure to CMS on behalf of their participants. The time needed for a registry to review the electronic prescribing measure and other information, calculate the measure's results, and submit the measure's results and numerator and denominator data on the measure on their participants behalf is expected to vary along with the number of eligible professionals reporting data to whom the measure applies. However, we believe that registries already perform many of these activities for their participants. Since the E-Prescribing Incentive Program consists of only one measure, we believe that the cost associated with the registry reporting the measure's results and numerator and denominator to CMS on behalf of their participants would be minimal.

For EHR-based reporting (if we finalize an EHR-based reporting mechanism for the E-Prescribing Incentive Program), the eligible professional must review the electronic prescribing measure, extract the necessary clinical data from his or her EHR, and submit the necessary data to the CMS-designated clinical data warehouse. Because this manner of reporting quality data to CMS would be new for 2010 and participation in this reporting initiative is voluntary, it is impossible to estimate with any degree of accuracy how many eligible professionals will opt to participate in the E-Prescribing Incentive Program through the EHR-based reporting mechanism in CY 2010. The cost associated with an eligible professional reviewing the electronic prescribing measure and other information and determining whether the measure is applicable to his or her patients and the services he or she furnishes to them is expected to be similar for EHR-based reporting and claims-based reporting (that is, $55 at a rate of $55 per hour). Once the EHR is programmed by the vendor to allow data submission to CMS, the cost to the eligible professional associated with the time and effort to submit data on the electronic prescribing measure should be minimal.

Based on our proposal to consider only EHR products qualified for the 2010 PQRI to be qualified to submit results and numerator and denominator data on the electronic prescribing measure for the 2010 E-Prescribing Incentive Program, there would be no need for EHR vendors to undergo a separate self-nomination process for the E-Prescribing Incentive Program and therefore, no additional cost associated with the self-nomination process.

The cost to the EHR vendor associated with the EHR-based reporting requirements of this voluntary reporting initiative is the time and effort associated with the EHR vendor programming its EHR product(s) to extract the clinical data that the eligible professional needs to submit to CMS for purposes of reporting the 2010 electronic prescribing measure. The time needed for an EHR vendor to review the measure and other information and program each qualified EHR product to enable eligible professionals to submit data on the measure to the CMS-designated clinical data warehouse will be dependent on the EHR vendor's familiarity with the electronic prescribing measure, the vendor's system capabilities, as well as the vendor's programming capabilities. Since only EHR products qualified for the 2010 PQRI would be qualified for the 2010 E-Prescribing Incentive Program and the E-Prescribing Incentive Program consists of only one measure, we believe that any burden associated with the EHR vendor to program its product(s) to enable eligible professionals to submit data on the electronic prescribing measure to the CMS-designated clinical data warehouse would be minimal.

With respect to the proposed process for group practices to be treated as successful e-prescribers under the 2010 E-Prescribing Incentive Program discussed in section II.G.5.e. of this proposed rule, a group practice would be required to report the electronic prescribing measure in at least 2500 instances. Group practices have the same options as individual eligible professionals in terms of the form and manner for reporting the electronic prescribing measure (that is, group practices have the option of reporting the measure through claims, a qualified registry, or a qualified EHR product). The only difference between an individual eligible professional and group practice reporting of the electronic prescribing measure is the number of times a group practice is required to report the electronic prescribing measure. For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through claims-based reporting of the electronic prescribing measure, we estimate the total annual estimated cost per group practice to be $2,305 [($0.90 per measure × 1 measure × 2500 cases per measure) + $55].

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through registry-based reporting of the electronic prescribing measure, we do not anticipate any additional burden to report data to a registry as group practices opting for registry-based reporting would more than likely already be reporting data to the registry. Little, if any, additional data would need to be reported to the registry for purposes of participation in the 2010 E-Prescribing Incentive Program. However, group practices would need to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf. We estimate that the time and effort associated with this would be approximately 5 minutes for each group practice that wishes to authorize or instruct the registry to submit quality measures results and numerator and denominator data on the electronic prescribing measure to CMS on their behalf.

For group practices who are selected to participate in the 2010 E-Prescribing Incentive Program group practice reporting option and choose to do so through EHR-based reporting of the electronic prescribing measure, once the EHR is programmed by the vendor to allow data submission to CMS, the burden to the group practice associated with submission of data on the electronic prescribing measure should be minimal.

In addition to the burden associated with group practices reporting the electronic prescribing measure, group practices would also be required to self-nominate in order to participate in the 2010 E-Prescribing Incentive Program under the group practice reporting option. Since we propose to limit participation in the E-Prescribing Incentive Program group practice reporting option to those group practices selected to participate in the PQRI group practice reporting option, there would be no additional burden associated with the group practice self-nomination process for the E-Prescribing Incentive Program.

5. Section 135: Implementation of Accreditation Standards for Suppliers Furnishing the Technical Component (TC) of Advanced Diagnostic Imaging Services.

As discussed in section II.G.6. of this proposed rule, suppliers that provide the TC of advanced diagnostic imaging services will have to be accredited by an approved accreditation organization in order to receive Medicare reimbursement for advanced diagnostic imaging services described in section 1848(b)(4)(B) furnished to beneficiaries. This section of the rule will impact the suppliers that provide the TC of advanced diagnostic imaging services and the organizations that accredit suppliers of such services. Suppliers that provide the TC of advanced diagnostic imaging services will incur costs for becoming accredited. Accreditation organizations will incur costs to accredit suppliers. To estimate the impact on suppliers, we calculate the total cost of accreditation as the sum of accreditation fees and other accreditation costs, and we multiply this cost by the number of providers of care requiring accreditation.

Factors Affecting the Cost Impact

According to CMS' Services Tracking and Reporting System (STARS) database for 2008, there are a total of 1,137,278 physicians, IDTFs, hospitals and others billing Part B for the TC of advanced diagnostic imaging. This total includes both suppliers and providers that furnish items under Medicare Part B as suppliers.

Currently, there are suppliers accredited by one of three of the nationally recognized accreditation. We anticipate that the following accreditation organizations will seek approval from CMS to accredit suppliers that provide the TC of advanced diagnostic imaging services:

- American College of Radiology;
- Intersocietal Accreditation Commission; and
- The Joint Commission.

Accreditation Fees

Fees vary between accreditation organizations and, in general, currently cover all of the following items: Application fee, manuals, initial accreditation fee, onsite surveys or other auditing (generally once every 3 years), and travel, when necessary for survey personnel. Accreditation costs also vary by the size of the supplier seeking accreditation, its number of locations, and the number of services it provides. Because of these factors, it is sometimes difficult to compare fees across accreditation organizations. We obtained information on total accreditation fees from the three accreditation organizations that currently accredit suppliers who provide the TC of advanced diagnostic imaging services. Based on all information we obtained, we estimate accreditation fees for each review cycle will be approximately $ 5,000 for an advanced diagnostic imaging supplier. Because accreditation is for a 3-year period, the estimated average cost per year would be approximately $1,666.

We recognize that becoming accredited may impose a burden on suppliers that provide the TC of advanced diagnostic imaging services, especially small suppliers. We have attempted to minimize that burden. We have implemented the following options to minimize the burden of accreditation on suppliers, including small businesses:

- *Multiple accreditation organizations:* We expect that more than one accrediting organization will apply to become and be designated as an advanced diagnostic imaging accrediting organization. We believe that selection of more than one accreditation organization will introduce competition resulting in reductions in accreditation costs.
- *Required plan for small businesses:* During the application process we will require accreditation organizations to include a plan that details their methodology to reduce accreditation fees and burden for small or specialty suppliers. This will need to include that the accreditation organization's fees are based on the size of the organization.
- *Reasonable quality standards:* The quality standards that will be used to evaluate the services rendered for each imaging modality are industry standards. Many suppliers that provide the TC of advanced diagnostic imaging services already comply with the standards and have incorporated these practices into their daily operations. We have been told that that those suppliers with private insurance contracts must be accredited, thus our requirements would not be duplicative. It is our belief and has been stated by those suppliers already accredited that compliance with the quality standards will result in more efficient and effective business practices and will assist suppliers in reducing overall costs.

Other Accreditation Costs

It is difficult to precisely estimate the costs of preparing for accreditation. We do recognize there is cost to the supplier in order to come into compliance initially and thus prepare for the accreditation survey. This should result in minimal preparation and cost.

Additional Considerations

There are at least two important sources of uncertainty in estimating the impact of accreditation on suppliers that provide the TC of advanced diagnostic imaging services. First, our estimates assume that all current suppliers with positive Medicare payments will seek accreditation. We assume that suppliers who currently receive no Medicare allowed charges will choose not to seek accreditation. It is also possible that many of the suppliers with allowed charges between $1 and $10,000 may decide not to incur the costs of accreditation.

Second, it is unclear what accreditation fees will be in the future. However, we are requiring the accreditation organization to submit their fees that are based on the size of the supplier, or on the amount billed. Our experience with another accreditation program has lead us to believe that the accreditation rates will go up, although minimally, if travel costs continue to rise.

In summary, suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012. In the options we have proposed we have attempted to minimize the burden of accreditation on suppliers, which include approving multiple accreditation organizations that consider the small suppliers. Also, the fact that the surveys will be either performed as a desk review or unannounced deletes the time and cost for the accreditation organization in travel, if required.

6. Section 139: Improvements for Medicare Anesthesia Teaching Programs

As discussed in section II.G.7., this proposed rule would provide for increased payments under the Medicare PFS for certain cases involving teaching anesthesiologists with anesthesia residents or for teaching CRNAs with student nurse anesthetists. This provision of the MIPPA is anticipated to have a minimal budgetary impact.

7. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Cardiac Rehabilitation Services

Current levels of coverage for CR programs will continue under this rule, and new ICR programs will likely develop and request designation by CMS to receive Medicare payments. Because section 144(a) of the MIPPA requires higher payments for ICR programs than for CR programs, this expansion of coverage will result in greater costs to the Medicare program. The requirements for ICR programs, also required in section 144(a) of the MIPPA, are extensive and will likely limit the number of programs that request designation as ICR programs by CMS. As a result, significantly fewer ICR programs than CR programs will function throughout the country; however, we currently do not know how many ICR programs may request designation.

We believe that the proposed expansion of coverage for ICR programs will enable beneficiaries to take advantage of more focused and rigorous programs that will more quickly lead to improved cardiovascular health. Having the choice of CR and ICR programs, beneficiaries eligible for coverage will be able to determine the best manner in which to achieve improved cardiovascular health, through traditional CR or more rigorous ICR programs. We also expect this proposed expansion of coverage to bring more attention to the importance of cardiac rehabilitation and the extensive benefits these programs provide to beneficiaries. As a result, the number of beneficiaries participating in CR programs may increase. We estimate that the proposed provisions for establishing coverage of cardiac rehabilitation and intensive cardiac rehabilitation programs, as discussed in section II.G.8. of this proposed rule, will have a minimal budgetary impact on the Medicare program.

8. Section 144(a): Payment and Coverage Improvements for Patients With Chronic Obstructive Pulmonary Disease and Other Conditions: Pulmonary Rehabilitation Services

As discussed in section II.G.9. of this proposed rule, the implementation of the Medicare pulmonary rehabilitation program will allow Medicare, for the first time, to provide for payment for exercise and other services as part of a comprehensive treatment plan for beneficiaries with moderate to severe COPD. We believe this program has the potential of not only improving the quality of life for beneficiaries who engage in it, but also reducing Medicare costs in the long range by decreasing the chances of exacerbations and further rehabilitation related to their chronic respiratory disease. We estimate this provision will have a minimal budgetary impact on the Medicare program.

9. Section 152(b): Coverage of Kidney Disease Patient Education Services

The implementation of Medicare coverage of kidney disease patient education services as discussed in section II.G.10. of this proposed rule will allow Medicare to provide for payment for kidney disease education services for beneficiaries with Stage IV chronic kidney disease. We believe this program can help patients achieve better

understanding of their illness, dialysis modality options, and may help delay the need for dialysis. We believe this program has the potential of improving the quality of life for beneficiaries since they will be better equipped to make informed decisions. We estimate a cost to the Medicare program of approximately $10 million for CY 2010, because the statute limits the number of kidney disease education sessions to 6, as a lifetime maximum.

10. Section 153: Renal Dialysis Provisions

A discussion of the impact of section 153 of the MIPPA is addressed in section V.F. of this regulatory impact analysis in conjunction with the other ESRD provisions of this rule.

11. Section 182(b): Revision of Definition of Medically-Accepted Indication for Drugs; Compendia for Determination of Medically-Accepted Indications for Off-Label Uses of Drugs and Biologicals in an Anti-Cancer Chemotherapeutic Regimen

We anticipate that the proposals related to the compendia discussed in section II.G.12. of this proposed rule will have a negligible cost to the Medicare program and to the public. The information that is required to be collected and published on the compendia Web sites is information that is already collected in the normal course of business by the compendia publishers, which all have Web sites. The proposed changes will enable CMS to efficiently implement the provisions of section 182(b) of the MIPPA that require transparent evaluative and conflict of interest policies and practices for current and future listed compendia on and after January 1, 2010.

E. Payment for Covered Outpatient Drugs and Biologicals

1. Average Sales Price (ASP) Issues

The proposed changes discussed in section II.F.1. of this proposed rule with respect to payment for covered outpatient drugs and biologicals, are estimated to have no impact on Medicare expenditures as we are not proposing any change to the AMP/WAMP threshold and the proposed change concerning the immunosuppressive drug period of eligibility is a comforming change to reflect the statute.

2. Competitive Acquisition Program (CAP) Issues

As discussed in section II.F.2., this proposed rule contains proposals and seeks comment on certain aspects of the CAP, specifically the frequency of drug payment amount updates, changes to the CAP drug list, the geographic area served by the CAP, CAP drug stock at the physician's office, exclusion of CAP sales from ASP calculations, the annual CAP payment amount update mechanism, and updates to proposals made in the 2009 PFS rule. Our changes and refinements may improve compliance, promote program flexibility, improve the quality, and maintain the availability of services for participating CAP physicians. We anticipate that these changes associated with the CAP will not result in significant additional cost savings or increases relative to the ASP payment system for two reasons. First, in 2006 through 2008, the dollar volume of claims paid under the CAP was small compared to the volume of claims paid under section 1847A of the Act, and although we anticipate that the CAP will continue to grow, we do not anticipate a significant change in the proportion of claims paid under these payment systems. Second, because CAP payment amounts are limited to prices calculated under section 1847A of the Act, we expect payment rates for the two programs to remain very similar.

F. Provisions Related to Payment for Renal Dialysis Services Furnished by End-Stage Renal Disease (ESRD) Facilities

The ESRD-related provisions are discussed in sections II.G.11. and II.I. of this proposed rule. To understand the impact of the changes affecting payments to different categories of ESRD facilities, it is necessary to compare estimated payments under the current year (CY 2009 payments) to estimated payments under the revisions to the composite rate payment system (CY 2010 payments) as discussed in section II.I. of this proposed rule. To estimate the impact among various classes of ESRD facilities, it is imperative that the estimates of current payments and estimates of proposed payments contain similar inputs. Therefore, we simulated payments only for those ESRD facilities that we are able to calculate both current 2009 payments and proposed 2010 payments.

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 the Healthcare Cost Report Information System (HCRIS). We also used the December 2008 update of CY 2008 National Claims History file as a basis for Medicare dialysis treatments and separately billable drugs and biologicals. Since the December 2008 update of the CY 2008 National Claims History File is incomplete, we updated the data. The description of the updates for the separately billable drugs is described in section II.I. of this proposed rule. To update the treatment counts we used the ratio of the June 2008 to the December 2007 updates of the CY 2007 National Claims History File figure for treatments. This was an increase of 11.3 percent. Due to data limitations, we are unable to estimate current and proposed payments for 57 of the 5048 ESRD facilities that bill for ESRD dialysis treatments.

Table 42 shows the impact of this year's proposed changes to CY 2010 payments to hospital-based and independent ESRD facilities. The first column of Table 42 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 all proposed changes to the ESRD wage index for CY 2010 as it affects the composite rate payments to ESRD facilities. The fourth column compares aggregate ESRD wage adjusted composite rate payments in CY 2010 to aggregate ESRD wage adjusted composite rate payments in CY 2009. In CY 2009, ESRD facilities receive 100 percent of the CBSA wage adjusted composite rate and 0 percent of the MSA wage adjusted composite rate, ending a 4-year transition period in which they had received an increasing percent of payments based on the CBSA wage adjusted composite rate. The overall effect to all ESRD providers in aggregate is zero because the CY 2010 ESRD wage index has been multiplied by a Budget Neutrality adjustment factor to comply with the statutory requirement that any wage index revisions be done in a manner that results in the same aggregate amount of expenditures as would have been made without any changes in the wage index.

The fifth column shows the effect of proposed changes to the ESRD wage index in CY 2010 and the effect of the MIPPA provisions on ESRD facilities. Section 153(a) of the MIPPA amended section 1881(b)(12)(G) of the Act to revise payments to ESRD facilities. Effective January 1, 2010, there is an update of 1 percent to the composite rate component of the payment system.

The sixth column shows the overall effect of the proposed changes in composite rate payments to ESRD providers including the drug add-on. The overall effect is measured as the difference between the proposed CY 2010 payment with all changes as

proposed in this rule and current CY 2009 payment. This payment amount is computed by multiplying the wage adjusted composite rate with the drug add-on for each provider times the number of dialysis treatments from the CY 2008 claims. The CY 2010 proposed payment is the composite rate for each provider (with the proposed 15.0 percent drug add-on) times dialysis treatments from CY 2008 claims. The CY 2009 current payment is the composite rate for each provider (with the current 15.2 percent drug add-on) times dialysis treatments from CY 2008 claims.

The overall impact to ESRD providers in aggregate is 0.8 percent as shown in Table 42. Most ESRD facilities will see an increase in payments as a result of the MIPPA provision. While the MIPPA provision includes a 1 percent increase to the ESRD composite rate, this 1 percent increase does not apply to the drug add-on to the composite rate. For this reason, the impact of all changes in this proposed rule is a 0.8 percent increase for all ESRD providers. Overall, payments to independent ESRD facilities will increase by 0.8 percent and payments to hospital-based ESRD facilities will increase by 1.0 percent.

TABLE 42—IMPACT OF CY 2010 CHANGES IN PAYMENTS TO HOSPITAL BASED AND INDEPENDENT ESRD FACILITIES

[Percent change in composite rate payments to ESRD facilities]

	Number of facilities	Number of dialysis treatments (in millions)	Effect of changes in wage index [1] (percent)	Effect of changes in wage index and of MIPPA provision [2] (percent)	Overall effect of wage index MIPPA & drug add-on [3] (percent)
1	2	3	4	5	6
All Providers	4,991	37.1	0.0	1.0	0.8
Independent	4,432	33.5	0.0	1.0	0.8
Hospital Based	559	3.6	0.2	1.2	1.0
By Facility Size:					
Less than 5,000 treatments	1,807	5.3	0.1	1.1	0.9
5,000 to 9,999 treatments	1,998	14.6	0.0	1.0	0.9
Greater than 9,999 treatments	1,186	17.2	−0.1	0.9	0.8
Type of Ownership:					
Profit	4,062	30.5	0.0	1.0	0.8
Nonprofit	929	6.5	0.1	1.1	0.9
By Geographic Location:					
Rural	1,093	6.0	0.2	1.2	1.0
Urban	3,898	31.0	0.0	1.0	0.8
By Region:					
New England	156	1.3	0.3	1.3	1.1
Middle Atlantic	571	4.6	−0.2	0.8	0.6
East North Central	808	5.8	−0.1	0.9	0.7
West North Central	382	2.0	0.3	1.3	1.1
South Atlantic	1,129	8.5	0.1	1.1	0.9
East South Central	388	2.8	0.2	1.2	1.0
West South Central	679	5.3	0.0	1.0	0.8
Mountain	279	1.6	0.9	1.9	1.7
Pacific	562	4.8	−0.1	0.9	0.7
Puerto Rico & Virgin Islands	37	0.4	−2.4	−1.4	−1.6

[1] This column shows the overall effect of wage index changes on ESRD providers. Composite rate payments are computed using the proposed CY 2010 wage indexes which are compared to composite rate payments using the current CY 2009 wage indexes.

[2] This column shows the effect of the changes in the Wage Indexes and the MIPPA provision which includes a 1 percent increase to the composite rate. This provision is effective January 1, 2010.

[3] This column shows the percent change between CY 2010 and CY 2009 composite rate payments to ESRD facilities. The CY 2010 payments include the CY 2010 wage adjusted composite rate, a 1 percent increase due to MIPPA effective January 1, 2010 and the drug add-on of 15.0 percent. The CY 2009 payments include the CY 2009 wage adjusted composite rate, a 1 percent increase and site neutral rates effective January 1, 2009 and the drug add-on of 15.2 percent. This column shows the effect of wage index, MIPPA, and drug add-on changes.

G. Chiropractic Demonstration—Application of Budget Neutrality

As discussed in section II.J. of this proposed rule, we are proposing to recoup the $50 million in expenditures from this demonstration over a 5-year period rather than over a 2-year period. We would recoup $10 million each year through adjustments to the PFS for all chiropractors in CYs 2010 through 2014.

To implement this required BN adjustment, we would reduce the payment amount under the PFS for the chiropractic CPT codes (that is, CPT codes 98940, 98941, and 98942) by 2 percent.

H. Comprehensive Outpatient Rehabilitation Facilities (CORF) and Rehabilitation Agency Issues

The revisions to the conditions of participation (CoP) discussed in section II.K. of this proposed rule make technical corrections and update the regulations to reflect current industry standards for respiratory therapists. The revisions to the regulations will clarify the qualifications necessary for respiratory therapists' to continue to qualify to furnish respiratory therapy services to CORF patients. These changes are similar to prior rules and will have no impact on CORFs cost.

I. Physician Self-Referral Provisions

As discussed in section II.N. of this proposed rule, we expect that our proposed clarification of the physician stand in the shoes provisions will assist designated health services entities in structuring legitimate compensation arrangements. Furthermore, like other physician self-referral policies, we anticipate that this clarification will

result in savings to the Medicare program by reducing overutilization and anti-competitive business arrangements. We cannot gauge with any certainty the extent of these savings to the program.

K. Durable Medical Equipment Related Issues

1. Damages Process

In section II.O.1. of this proposed rule, we propose to establish a one-time process that will only impact those suppliers who were awarded a contract and were potentially damaged by the termination of their supplier contracts by MIPPA. The DMEPOS Competitive Bidding Program that was implemented on July 1st, 2008, awarded contracts to 329 suppliers. The following factors may be considered by a contract supplier before deciding to submit a claim:

- The contract itself stipulated that the contract is subject to any changes to the statute or regulations that affect the Medicare program;
- The contract does not guarantee any amount of business or profits, therefore, an efficient business would not be expected to incur large expenses without any guaranteed increase in business and profits;
- The contract stipulates that CMS shall not pay for any expenses incurred by the supplier for the work performed under the contract other than for payment of Medicare claims authorized pursuant to the contract;
- Upon termination of the contracts by MIPPA, payments reverted back to the fee schedule amount, which was on average 26 percent higher than under the DMEPOS Competitive Bidding Program.
- There is a required responsibility under contract law for a company to take action to mitigate expenses to any stop work order.
- CMS listed the winning suppliers on the Medicare Web site at *http://www.Medicare.gov* in the supplier locator tool, a supplier is allowed to keep any new customers they may have obtained as a result of being listed on the supplier locator tool.

By mentioning the list above, we are not suggesting that there would not be legitimate claims for damages. However, these are factors that a supplier may consider when deciding whether to submit a claim for damages.

Based on these reasons and because there have been so few inquiries or responses to the reference in the MIPPA to damages (fewer than 7 suppliers), we believe that as few as 1 percent of the 329 winning suppliers may make a claim for damages. However, as a high estimate, we would estimate that approximately 76 percent of the suppliers (250) may submit a claim. We anticipate that it will take approximately 3 hours at $34/hour (3 × $34 = $102) for an accountant and a company official to review and gather the necessary documents to file a claim for a total of $25,500 (250 × $102). The hourly accountant rate was based on the Bureau of Labor Statistics data collected for June 2006 which was then adjusted to account for inflation. We estimate that this regulation will not have a large budgetary impact. The total cost range of $408 to $25,500 for potential claims from contract suppliers will not result in expenditures of $133 million or more annually. An analysis of the damage payments that may result would be dependent upon an evaluation of the actual claims once they are received.

2. Grandfathering Process

In section II.O.2. of this proposed rule, we are proposing to revise the definition of a *grandfathered item* to refer to all rented items within a competitively bid product category that the supplier currently rents. The proposed definition of a *grandfathered item* would avoid confusion, on the part of beneficiaries, regarding rented DME items for which a noncontract supplier is willing or not willing to be a grandfathered supplier. Under the revised definition, a noncontract supplier would have to choose to be either a grandfathered supplier for all or for none of the DME rented items within a product category that the supplier currently provides. We believe that it would be easier for beneficiaries to recognize which items a supplier is grandfathering or not grandfathering if the supplier's election concerning grandfathering was made by product category rather than making separate choices for each individual HCPCS code.

We also believe the revision of this definition would have a negligible impact on suppliers as product categories consist of related items routinely provided by suppliers. We are only requiring a supplier to provide those rented items within a product category that the supplier was currently furnishing at the start of the competitive bidding program.

While difficult to estimate, we believe that based on 2008 data, there were approximately 1,850 suppliers in the 9 CBAs, for which we will be doing the Round 1 rebid that rented competitively bid items, on average at different points in time during 2008. Therefore, we are using this number to indicate how many suppliers would be renting a DME competitively bid item at the start of the competitive bid program. We believe some suppliers may decide not to bid because of the cost of bidding and accreditation requirements while other suppliers may not qualify for a contract. Since not all suppliers will be awarded contracts and some may not choose to submit a bid, we estimate that in the worst case scenario there will be 1,450 suppliers that will not be awarded contracts, would be renting DME competitive bid items at the time the program is implemented.

Based on our experience from the competitive bidding demonstrations, of the 1,450 suppliers who are not awarded a contract, we expect 90 percent or 1,305 of these noncontract suppliers will offer to be grandfathered suppliers (0.90 × 1,450 = 1,305) and 10 percent or 145 (0.10 × 1,450 = 145) of the suppliers will choose not to grandfather. We believe most suppliers will not want to pick up their items before the end of the full rental period.

Based on 2008 data, we estimate that there will be 96,000 beneficiaries who reside in a CBA and are renting competitively bid items from suppliers at the start of the round 1 rebid. Based on the 2007 round 1 of the competitive bidding program, we estimate that there would be 74,880 (96,000 × 0.78 = 74,880) beneficiaries who would be renting items from a noncontract supplier.

Notification Requirement for Suppliers That Choose to Grandfather

a. Notification to CMS

For those suppliers that choose to grandfather (1,305), we estimate that it would take the supplier on average 2 hours to develop the 30-day notification that it is required to send to CMS. We estimate that the cost to the supplier to develop the 30-day notification to CMS would be $89.60 for skilled administrative staff (2 hours × $44.80 per hour). The $44.80 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate that the cost to the supplier to send the notification to CMS would be $5.51 for clerical staff (0.25 hour to send the notification × $22.02 per hour = $5.51). The $22.02 is based on 2009 data from the Bureau of Labor Statistics plus an increase for overhead of 40 percent. We estimate the cost of supplies necessary to send the notification would be $2.00. The total cost for sending the notification would be $7.51 which includes the cost of clerical staff ($5.51) and supplies ($2.00). The individual costs for all suppliers to notify CMS would be

$97.11 ($89.60 for development of the letter + $7.51 for preparing and sending each notification = $97.11). The overall cost for suppliers to notify CMS would be approximately $126,728.55 ($97.11 per supplier × 1,305 suppliers = $126,728.55).

b. Notification to the Beneficiary

We estimate based on 2008 data, we expect that there will be 74,880 beneficiaries who would have been renting competitive bid items from a noncontract supplier at the start of the round 1 rebid of the CBP. Of the 74,880, we believe that approximately 100 percent of these beneficiaries will accept the offer to continue to rent competitively bid items from the noncontract supplier that offers to be a grandfathered supplier. We believe that the beneficiaries will choose to continue to rent from a grandfathered supplier if given the choice because it would be more convenient, assure continuity of care, and eliminate the need to have equipment taken from their home.

Based upon the number of suppliers and beneficiaries, we estimate that there would be an average of 52 beneficiaries per supplier that was not awarded a contract (74,880 beneficiaries/1,450 suppliers = 52). Therefore, we estimate that each noncontract supplier that chooses to grandfather would send the 30-day notification on average to 52 beneficiaries.

We expect that the cost of developing the 30-day notification to a beneficiary would be equivalent to the cost of developing the 30-day notification to CMS ($89.60 per notification). We also expect the cost of sending the 30-day notification per beneficiary to be equivalent to sending the 30-day notification to CMS ($7.51 per notification). The total costs for the 30-day notification to beneficiaries for suppliers that choose the grandfathering option would be $89.60 for development of the letter, and $7.51 for preparing and sending each notification. To calculate the total cost we multiplied $7.51 × 52 beneficiaries and added the development cost for the letter of $89.60 for a total of $480.12 per supplier. The overall cost for these suppliers to provide the 30-day notification to their beneficiaries would be approximately $626,556.60 ($480.12 per supplier × 1,305 suppliers = $626,556.60).

Notification Requirement for Suppliers That Choose Not to Grandfather

a. 30-Day Notification to the Beneficiary

We expect that suppliers who choose not to grandfather will incur costs equivalent to the cost of developing and sending the 30-day notification to a beneficiary by those suppliers that choose to grandfather. The overall cost for all suppliers who choose not to grandfather to provide the 30-day notification to the beneficiary is approximately $69,617.40 ($480.12 total cost per supplier × 145 non-grandfathered suppliers = $69,617.40). The estimate of 145 suppliers not choosing to be grandfathered suppliers represents 10 percent of the total number of noncontract suppliers.

While the cost for the 30-day notification to beneficiaries will be exactly the same for all suppliers, those who choose not to become a grandfathered supplier will also incur the cost of the 10-day and 2-day notification.

b. 10-Day and 2-Day Notification

For the 10-day notification to a beneficiary, we estimate the supplier would make at least 1 phone call that would take an average of 15 minutes to discuss that the beneficiary must switch to a contract supplier, the schedule for picking up the current equipment by the noncontract supplier, and the delivery of new equipment by the contract supplier. For the 2-day notification to the beneficiary, we estimate that the supplier would make at least 1 phone call that would take an average of 15 minutes to ensure that all of the arrangements are finalized and to answer any last minute questions. We anticipate that clerical staff would perform both of these tasks.

The estimated cost of the 10-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). The estimated cost of the 2-day notification totals $5.51 (.25 of an hour × $22.02 per hour for clerical staff based on the 2009 Bureau of Labor Statistics including overhead = $5.51). Therefore, the 10-day and 2-day notifications for each supplier would cost approximately $11.02. The total cost for each supplier would be approximately $573.04 ($11.02 × 52 beneficiaries = $573.04). The overall impact for all suppliers to make the 10-day and 2-day notifications would be approximately $83,090.80 (145 suppliers × $573.04 per supplier = $83,090.80).

We anticipate that this proposed process will not place a greater burden on the overall small supplier community. This process is only going to affect those small suppliers that were renting items when the competitive bidding program begins and who did not win a contract. The burden on these suppliers would generally be less because small suppliers will have fewer beneficiaries to furnish notifications to.

As an alternative, we considered relying on suppliers to develop their own schedule for informing beneficiaries regarding grandfathering. This alternative would have left the beneficiaries vulnerable to having equipment removed from the home before new equipment was delivered. The process proposed in this regulation ensures the beneficiaries can make an informed decision about the transition policy that works best for them. The alternative we selected ensures the beneficiaries will have continued access to medically necessary items and be properly informed about the steps they must take so that their services will not be interrupted.

U. Alternatives Considered

This proposed rule contains a range of policies, including some provisions related to specific MIPPA provisions. The preceding preamble provides descriptions of the statutory provisions that are addressed, identifies those policies when discretion has been exercised, responds to comments on our proposals, presents rationale for our decisions and, where relevant, alternatives that were considered.

V. Impact on Beneficiaries

There are a number of changes in this proposed rule that would have an effect on beneficiaries. In general, we believe these changes, including the refinements of the PQRI with its focus on measuring, submitting, and analyzing quality data, the coding provisions related to the IPPE and consultation services, the changes with respect to telehealth services, the kidney disease patient education, pulmonary rehabilitation and intensive cardiac rehabilitation proposals will have a positive impact and improve the quality and value of care provided to Medicare beneficiaries. Additionally, the proposed grandfathering process for DME suppliers will help ensure that beneficiaries are contacted and informed about this process and the choices they have concerning whether or not to use a grandfathered supplier. Moreover, the notice will help to ensure that beneficiaries do not have necessary DME equipment taken from them unexpectedly by a noncontact supplier.

As explained in more detail subsequently in this section, the regulatory provisions may affect beneficiary liability in some cases. Most changes aggregate in beneficiary liability due to a particular provision would be a function of the coinsurance (20 percent if applicable for the particular

provision after the beneficiary has met the deductible). Beneficiary liability would also be impacted by the effect of the aggregate cost (savings) of the provision on the standard calculation of the Medicare Part B premium rate (generally 25 percent of the provision's cost or savings). In 2010, total cost sharing (coinsurance and deductible) per Part B enrollee associated with PFS services is estimated to be $399. In addition, the portion of the 2010 standard monthly Part B premium attributable to PFS services is estimated to be $25.00.

To illustrate this point, as shown in Table 39, the 2009 national payment amount in the nonfacility setting for CPT code 99203 (Office/outpatient visit, new), is $91.97 which means that in 2009 a beneficiary is responsible for 20 percent of this amount, or $18.39. Based on this rule, the 2010 national payment amount in the nonfacility setting for CPT code 99203, as shown in Table 39, is $81.00 which means that, in 2010, the beneficiary coinsurance for this service would be $16.20.

Policies discussed in this rule, such as the coding changes with respect to the RVUs for IPPE and the changes to consultation services, would similarly impact beneficiaries' coinsurance.

W. Accounting Statement

As required by OMB Circular A–4 (available at *http://www.whitehouse.gov/omb/circulars/a004/a-4.pdf*), in Table 43, we have prepared an accounting statement showing the classification of the expenditures associated with this proposed rule. This estimate includes the incurred benefit impact associated with the estimated CY 2010 PFS update based on the 2009 Trustees Report baseline, as well as certain MIPPA provisions. All estimated impacts are classified as transfers.

TABLE 43—ACCOUNTING STATEMENT: CLASSIFICATION OF ESTIMATED EXPENDITURES CY 2010

Category	Transfers
Annualized Monetized Transfers	Estimated decrease in expenditures (from CY 2009 to CY 2010) of $13.3 Billion.
From Whom To Whom?	Federal Government to physicians, other practitioners and providers and suppliers who receive payment under Medicare.
Annualized Monetized Transfers	Estimated increase in expenditures of $110 Million for MIPPA Provisions (sections 102 and 152(b)).
From Whom To Whom?	Federal Government to providers.

In accordance with the provisions of Executive Order 12866, this proposed rule was reviewed by the Office of Management and Budget.

List of Subjects

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Reporting and recordkeeping requirements, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Physician Referral, Reporting and record keeping requirements.

42 CFR Part 414

Administrative practice and procedure, Health facilities, Health professions, Kidney diseases, Medicare, Reporting and recordkeeping.

42 CFR Part 415

Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 485

Grant programs—health, Health facilities, Medicaid, Medicare, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, the Centers for Medicare & Medicaid Services would amend 42 CFR chapter IV as set forth below:

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

1. The authority citation for part 410 continues to read:

Authority: Secs. 1102, 1834, 1871, and 1893 of the Social Security Act (42 U.S.C. 1302, 1395m, 1395hh, and 1395ddd).

Subpart B—Medical and Other Health Services

2. Section 410.30 is amended by revising paragraph (b) to read as follows:

§ 410.30 Prescription drugs used in immunosuppressive therapy.

* * * * *

(b) *Eligibility.* For drugs furnished on or after December 21, 2000, coverage is available only for prescription drugs used in immunosuppressive therapy, furnished to an individual who received an organ or tissue transplant for which Medicare payment is made, provided the individual is eligible to receive Medicare Part B benefits.

* * * * *

3. Section 410.47 is added to read as follows:

§ 410.47 Pulmonary rehabilitation program: Conditions for coverage.

(a) *Definitions.*

Individualized treatment plan means a written plan established, reviewed, and signed by a physician every 30 days, that describes all of the following:

(i) The individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services under the plan.

(iii) The goals set for the individual under the plan.

Outcomes assessment means a written evaluation of the patient's progress as it relates to the individual's rehabilitation which includes the following:

(i) Beginning and end evaluations, based on patient-centered outcomes, which are conducted by the physician at the start and end of the program.

(ii) Objective clinical measures of effectiveness of the PR program for the individual patient, including exercise performance and self-reported measures of shortness of breath and behavior.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Physician-prescribed exercise means physical activity, including aerobic exercise, prescribed and supervised by a physician that improves or maintains an individual's pulmonary functional level.

Psychosocial assessment means a written evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation or respiratory condition.

Pulmonary rehabilitation means a physician-supervised program for COPD and certain other chronic respiratory diseases designed to optimize physical and social performance and autonomy.

(b) *Beneficiaries who may be covered.* (1) Medicare covers pulmonary rehabilitation for beneficiaries with moderate to severe COPD (defined as

GOLD classification II and III), when referred by the physician treating the chronic respiratory disease.

(2) Additional medical indications for coverage for pulmonary rehabilitation program services may be established through a national coverage determination (NCD).

(c) *Components.* Pulmonary rehabilitation includes all of the following components:

(1) *Physician-prescribed exercise.* This physical activity includes techniques such as exercise conditioning, breathing retraining, step and strengthening exercises. Some aerobic exercise must be included in each pulmonary rehabilitation session.

(2) *Education or training.* (i) Education or training closely and clearly related to the individual's care and treatment which is tailored to the individual's needs.

(ii) Education includes information on respiratory problem management and, if appropriate, brief smoking cessation counseling.

(iii) Any education or training prescribed must assist in achievement of individual goals towards independence in activities of daily living, adaptation to limitations and improved quality of life.

(3) *Psychosocial assessment.* The psychosocial assessment must meet the criteria as defined in paragraph (a) of this section and includes:

(i) An assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment.

(ii) A psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(4) *Outcomes assessment.* The outcomes assessment must meet the criteria as defined in paragraph (a) of this section.

(5) *Individualized treatment plan.* The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.

(d) *Settings.* (1) Medicare Part B pays for a pulmonary rehabilitation in the following settings:

(i) Physician's offices.

(ii) Hospital outpatient settings.

(2) All settings must have the following available for immediate use and accessible at all times:

(i) The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

(ii) A physician must be immediately available and accessible for medical consultations and emergencies at all times when services are being provided under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27(f) of this subpart.

(e) *Physician standards.* Medicare Part B pays for pulmonary rehabilitation services provided by a physician only if the physician meets all of the following requirements:

(1) Has expertise in the management of individuals with respiratory pathophysiology.

(2) Is licensed to practice in the State in which the pulmonary rehabilitation program is offered.

(3) Is responsible and accountable for the pulmonary rehabilitation program.

(4) Is involved substantially in consultation with staff in directing the progress of the individual in the program.

(f) *Limitations on coverage: Sessions.* Medicare Part B pays for services provided in connection with a pulmonary rehabilitation exercise program for up to 36 sessions, no more than one session per day.

(g) *Effective date.* Coverage for pulmonary rehabilitation program services is effective January 1, 2010.

4. Section 410.48 is added to read as follows:

§ 410.48 Kidney disease education services.

(a) *Definitions.*

Kidney disease patient education services means face-to-face educational services provided to patients with Stage IV chronic kidney disease.

Physician means a physician as defined in section 1861(r)(1) of the Act.

Qualified person means either of the following healthcare entities that meets the qualifications and requirements specified in this section to provide kidney disease patient education services—

(i) One of the following healthcare professionals who furnishes services for which payment may be made under the physician fee schedule:

(A) Physician (as defined in section 1861(r)(1) of the Act).

(B) Physician assistant (as defined in section 1861(aa)(5) of the Act and § 410.74 of this subpart).

(C) Nurse practitioner (as defined in section 1861(aa)(5) of the Act and § 410.75 of this subpart).

(D) Clinical nurse specialist (as defined in section 1861(aa)(5) of the Act and § 410.76 of this subpart),

(ii)(A) Hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, or hospice that is located in a rural area as defined in § 412.64(b)(ii)(C); or

(B) A hospital or critical access hospital that is treated as being rural under § 412.103 of this chapter.

Renal dialysis facility means a unit which is approved to furnish dialysis service(s) directly to end-stage renal disease (ESRD) patients, as defined in § 405.2102 of this chapter.

Stage IV chronic kidney disease means kidney damage with a severe decrease in glomerular filtration rate (GFR) quantitatively defined by a GFR value of 15–29 ml/min/1.73m^2, using the Modification of Diet in Renal Disease (MDRD) Study formula.

(b) *Covered beneficiaries.* Medicare Part B covers outpatient kidney disease patient education services if the beneficiary meets all of the conditions and requirements of this subpart, including all of the following:

(1) Is diagnosed with Stage IV chronic kidney disease.

(2) Obtains a referral from the physician (as defined in section 1861(r)(1) of the Act) managing the beneficiary's kidney condition.

(c) *Qualified person.* (1) Medicare Part B covers outpatient kidney disease patient education services provided by a qualified person as defined in paragraph (a) of this section and must be able to properly receive Medicare payment under part 424 of this chapter.

(2) A qualified person does not include either of the following:

(i) A hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice if kidney disease patient education services are provided outside of a rural area as defined in § 412.64(b)(ii)(C) of this chapter unless the services are furnished in a hospital or critical access hospital that is treated as being in a rural area under § 412.103 of this chapter.

(ii) A renal dialysis facility, as defined in § 405.2102 of this chapter.

(d) *Standards for content of kidney disease patient education services.* The content of the kidney disease patient education services includes the following:

(1) The management of comorbidities including for the purpose of delaying the need for dialysis which includes, but not limited to, the following topics:

(i) Prevention and treatment of cardiovascular disease.

(ii) Prevention and treatment of diabetes.

(iii) Hypertension management.

(iv) Anemia management.

(v) Bone disease and disorders of calcium and phosphorus metabolism management.

(vi) Symptomatic neuropathy management.

(vii) Impairments in functioning and well-being.

(2) The prevention of uremic complications which includes, but not limited to, the following topics:

(i) Information on how the kidneys work and what happens when the kidneys fail.

(ii) Understanding if remaining kidney function can be protected, preventing disease progression, and realistic chances of survival.

(iii) Diet and fluid restrictions.

(iv) Medication review, including how each medication works, possible side effects and minimization of side effects, the importance of compliance, and informed decision-making if the patient decides not to take a specific drug.

(3) Therapeutic options, treatment modalities and settings, including a discussion of the advantages and disadvantages of each treatment option and how the treatments replace the kidney:

(i) Hemodialysis, both at home and in-facility.

(ii) Peritoneal dialysis (PD), including intermittent PD, continuous ambulatory PD, and continuous cycling PD, both at home and in-facility.

(iii) All vascular access options.

(iv) Transplantation.

(4) Opportunities for beneficiaries to actively participate in the choice of therapy and be tailored to meet the needs of the individual beneficiary involved which includes, but not limited to, the following topics:

(i) Physical symptoms.

(ii) Impact on family and social life.

(iii) Exercise.

(iv) The right to refuse treatment.

(v) Impact on work and finances.

(vi) The meaning of test results.

(vii) Psychological impact.

(5) Qualified persons must develop outcomes assessments designed to measure beneficiary knowledge about chronic kidney disease and its treatment.

(i) The outcomes assessments serve to assess program effectiveness of preparing the beneficiary to make informed decisions about their healthcare options related to chronic kidney disease.

(ii) The outcomes assessments serve to assess the program's effectiveness in meeting the communication needs of underserved populations, including persons with disabilities, persons with limited English proficiency, and persons with health literacy needs.

(iii) The assessment must be administered to the beneficiary during a kidney disease education session.

(iv) The outcomes assessments must be made available to CMS upon request.

(e) *Limitations for coverage of kidney disease education services.* (1) Medicare Part B makes payment for up to 6 sessions of kidney disease patient education services.

(2) A session is 60 minutes long and may be provided individually or in group settings of 2 to 20 individuals who need not all be Medicare beneficiaries.

(f) *Effective date.* Medicare Part B covers kidney disease patient education services for dates of service on or after January 1, 2010.

5. Section 410.49 is added to read as follows:

§ 410.49 Cardiac rehabilitation program and intensive cardiac rehabilitation program: Conditions of coverage.

(a) *Definitions.*

Cardiac rehabilitation (CR) means a physician-supervised program that furnishes physician prescribed exercise, cardiac risk factor modification, psychosocial assessment, and outcomes assessment.

Individualized treatment plan means a written plan tailored to each individual patient that includes all of the following:

(i) A description of the individual's diagnosis.

(ii) The type, amount, frequency, and duration of the items and services furnished under the plan.

(iii) The goals set for the individual under the plan.

Intensive cardiac rehabilitation (ICR) means a physician-supervised program that furnishes cardiac rehabilitation and has shown, in peer-reviewed published research that it improves patients' cardiovascular disease through specific outcome measurements described in paragraph (c) of this section.

Physician means a doctor of medicine or osteopathy as defined in section 1861(r)(1) of the Act.

Outcomes assessment means an evaluation of progress as it relates to the individual's rehabilitation which includes all of the following:

(i) Minimally, assessments from the commencement and conclusion of cardiac rehabilitation and intensive cardiac rehabilitation, based on patient-centered outcomes which must be measured by the physician immediately at the beginning of the program and at the end of the program.

(ii) Objective clinical measures of exercise performance and self-reported measures of exertion and behavior.

Physician-prescribed exercise means aerobic exercise combined with other types of exercise (that is, strengthening, stretching) as determined to be appropriate for individual patients by a physician.

Psychosocial assessment means an evaluation of an individual's mental and emotional functioning as it relates to the individual's rehabilitation which includes an assessment of those aspects of an individual's family and home situation that affects the individual's rehabilitation treatment, and psychosocial evaluation of the individual's response to and rate of progress under the treatment plan.

(b) *General rule.* (1) *Covered beneficiary rehabilitation services.* Medicare part B covers cardiac rehabilitation and intensive cardiac rehabilitation programs, as defined in this section, for beneficiaries who have experienced one or more of the following:

(i) An acute myocardial infarction within the preceding 12 months.

(ii) A coronary artery bypass surgery.

(iii) Current stable angina pectoris.

(iv) Heart valve repair or replacement.

(v) Percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting.

(vi) A heart or heart-lung transplant.

(vii) For cardiac rehabilitation only, other conditions as specified through a national coverage determination.

(2) *Components of a cardiac rehabilitation program.* Cardiac rehabilitation programs must include all of the following:

(i) Physician-prescribed exercise each day cardiac rehabilitation items and services are furnished.

(ii) Cardiac risk factor modification, including education, counseling, and behavioral intervention, tailored to the patients' individual needs.

(iii) Psychosocial assessment.

(iv) Outcomes assessment.

(v) An individualized treatment plan detailing how components are utilized for each patient.

(3) *Settings.* (i) Medicare Part B pays for cardiac rehabilitation and intensive cardiac rehabilitation in one of the following settings:

(A) A physician's office.

(B) A hospital outpatient setting.

(ii) All settings must have a physician, as defined in this section, immediately available and accessible for medical

consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician meets the requirements for direct supervision for physician office services at § 410.26(b)(5) of this subpart as described in § 410.26(a)(2) of this subpart (defined through cross references to § 410.32(b)(3)(ii) of this subpart); and for hospital outpatient services at § 410.27 of this subpart.

(c) *Standards for an intensive cardiac rehabilitation program.* (1) To be designated an intensive cardiac rehabilitation program, a program in an approved setting must apply for designation. To be designated as an intensive cardiac rehabilitation program, the program must demonstrate through peer-reviewed, published research that it accomplishes one or more of the following for its patients:

(i) Positively affected the progression of coronary heart disease.

(ii) Reduces the need for coronary bypass surgery.

(iii) Reduces the need for percutaneous coronary interventions.

(iv) A statistically significant reduction in 5 or more of the following measures for patients from their levels before cardiac rehabilitation services to after cardiac rehabilitation services:

(A) Low density lipoprotein.

(B) Triglycerides.

(C) Body mass index.

(D) Systolic blood pressure.

(E) Diastolic blood pressure.

(F) The need for cholesterol, blood pressure, and diabetes medications.

(2) A list of designated intensive cardiac rehabilitation programs will be posted to the CMS Web site and listed in the **Federal Register**.

(3) To ensure that intensive cardiac rehabilitation programs maintain the designated quality of rehabilitation, sites must demonstrate that patients enrolled continue to achieve beneficial outcomes by submitting outcomes data annually from the date of approval as an intensive cardiac rehabilitation site.

(i) Sites will be notified of continued compliance via a re-evaluation date posted to the CMS Web site.

(ii) Sites that are no longer designated as approved intensive cardiac rehabilitation programs, due to poor outcomes data resulting in noncompliance, will be notified in writing and removed from the CMS Web site.

(d) *Standards for physicians responsible for cardiac rehabilitation programs.* A physician who serves as the program Medical Director responsible for general or intensive cardiac rehabilitation programs, and who, in consultation with staff, is involved in directing the progress of individuals in the program must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(e) *Standards for supervising-physicians.* Physicians acting as the supervising-physician must possess all of the following:

(1) Expertise in the management of individuals with cardiac pathophysiology.

(2) Be licensed to practice medicine in the State in which the cardiac rehabilitation program is offered.

(f) *Limitations for coverage of cardiac rehabilitation programs.* (1) *General cardiac rehabilitation.* The number of general cardiac rehabilitation program sessions are limited to a minimum of 2 1-hour sessions per week and a maximum of 2 1-hour sessions per day for up to 36 sessions over up to 18 weeks. Medicare contractors have discretion to expand these limitations to not exceed 72 sessions for 36 weeks.

(2) *Intensive cardiac rehabilitation:* Intensive cardiac rehabilitation program sessions are limited to 72 1-hour sessions (as defined in section 1848(b)(5) of the Act), up to 6 sessions per day, over a period of up to 18 weeks.

6. Section 410.78 is amended by—

A. Revising the introductory text of paragraph (b).

B. Revising paragraph (e).

The revisions read as follows:

§ 410.78 Telehealth services.

* * * * *

(b) *General rule.* Medicare Part B pays for office and other outpatient visits, professional consultation, psychiatric diagnostic interview examination, individual psychotherapy, pharmacologic management, end-stage renal disease-related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, the neurobehavioral status exam, follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals and SNFs, and individual health and behavior assessment and intervention services furnished by an interactive telecommunications system if the following conditions are met:

* * * * *

(e) *Limitations.* (1) A clinical psychologist and a clinical social worker may bill and receive payment for individual psychotherapy via a telecommunications system, but may not seek payment for medical evaluation and management services.

(2) The physician visits required under § 483.40(c) of this title may not be furnished as telehealth services.

* * * * *

Subpart I—Payment of SMI Benefits

7. Section 410.155 is amended by—

A. Revising paragraphs (a), (b)(2)(i), (b)(2)(ii), (b)(2)(iv), (b)(2)(v), and (c).

B. Adding paragraph (b)(3).

The revisions and addition read as follows:

§ 410.155 Outpatient mental health treatment limitation.

(a) *Limitation.* For services subject to the limitation as specified in paragraph (b) of this section, the percentage of the expenses incurred for such services during a calendar year that is considered incurred expenses under Medicare Part B when determining the amount of payment and deductible under § 410.152 and § 410.160, respectively, is as follows:

(1) For expenses incurred in years before 2010, 62½ percent.

(2) For expenses incurred in 2010 and 2011, 68¾ percent.

(3) For expenses incurred in 2012, 75 percent.

(4) For expenses incurred in 2013, 81¼ percent.

(5) For expenses incurred in CY 2014 and subsequent years, 100 percent.

(b) * * *

(2) *Services not subject to the limitation.* Services not subject to the limitation include the following:

(i) Services furnished to a hospital inpatient.

(ii) Brief office visits for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental, psychoneurotic, or personality disorders *billed under HCPCS code M0064 (or its successor).*

(iii) * * *

(iv) Diagnostic services, such as diagnostic psychological *and neuropsychological* testing, that are performed to establish a diagnosis.

(v) Medical management *services billed under CPT code 90862 (or its successor),* as opposed to psychotherapy, when furnished to a patient diagnosed with Alzheimer's disease or a related disorder.

(3) *Payment amounts.* The Medicare payment amount and the patient liability amounts for outpatient mental health services subject to the limitation for each year during which the limitation is phased out are as follows:

Calendar year	Recognized incurred expenses (%)	Patient pays (%)	Medicare pays (%)
CY 2009 and prior calendar years	62.50	50	50
CYs 2010 and 2011	68.75	45	55
CY 2012	75.00	40	60
CY 2013	81.25	35	65
CY 2014	100.00	20	80

(c) *General formula.* A general formula for calculating the amount of Medicare payment and the patient liability for outpatient mental health services subject to the limitation is as follows:

(1) Multiply the Medicare approved amount by the percentage of incurred expenses that is recognized as incurred expenses for Medicare payment purposes for the year involved;

(2) Subtract from this amount the amount of any remaining Part B deductible for the patient and year involved; and,

(3) Multiply this amount by 0.80 (80 percent) to obtain the Medicare payment amount.

(4) Subtract the Medicare payment amount from the Medicare-approved amount to obtain the patient liability amount.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

8. The authority citation for Part 411 continues to read as follows:

Authority: Secs. 1102, 1860D–1 through 1860D–42, 1871, and 1877 of the Social Security Act (42 U.S.C. 1302, 1395w–101 through 1395w–152, 1395hh, and 1395nn).

Subpart J—Financial Relationships Between Physicians and Entities Furnishing Designated Health Services

9. Section 411.354 is amended by revising paragraph (c)(3)(i) to read as follows:

§ 411.354 Financial relationship, compensation, and ownership or investment interest.

* * * * *

(c) * * *

(3)(i) For purposes of paragraphs (c)(1)(ii) and (c)(2)(iv), a physician who ''stands in the shoes'' of his or her physician organization is deemed to have the same compensation arrangements (with the same parties and on the same terms) as the physician organization. When applying the exceptions in § 411.355 and § 411.357 of this part to arrangements in which a physician stands in the shoes of his or her physician organization, the relevant referrals and other business generated ''between the parties'' are referrals and other business generated between the entity furnishing DHS and the physician organization (including all members, employees, and independent contractor physicians).

* * * * *

PART 414—PAYMENT FOR PART B MEDICAL AND OTHER HEALTH SERVICES

10. The authority citation for part 414 continues to read as follows:

Authority: Secs. 1102, 1871, and 1881(b)(l) of the Social Security Act (42 U.S.C. 1302, 1395hh, and 1395rr(b)(l)).

Subpart A—General Provisions

§ 414.1 [Amended]

11. Amend § 414.1 by adding ''1834(e)—Implementation of accreditation standards for suppliers furnishing the technical component of advanced imaging services'' in numerical order.

Subpart B—Physicians and Other Practitioners

12. Section 414.46 is amended by revising paragraphs (d)(2) and (e) to read as follows:

§ 414.46 Additional rules for payment of anesthesia services.

* * * * *

(d) * * *

(2) The rules for medical direction differ for certain time periods depending on the nature of the qualified individual who is directed by the physician. If more than two procedures are directed on or after January 1, 1994, the qualified individuals could be AAs, CRNAs, interns, or residents. The medical direction rules apply to student nurse anesthetists only if the physician directs two concurrent cases, each of which involves a student nurse anesthetist or the physician directs one case involving a student nurse anesthetist and the other involving a CRNA, AA, intern, or resident. For services furnished on or after January 1, 2010, the medical direction rules do not apply to a single anesthesia resident case that is concurrent to another case which is paid under the medical direction payment rules as specified in paragraph (e) of this section.

* * * * *

(e) *Special payment rule for teaching anesthesiologist involved in a single resident case or two concurrent cases.* For physicians' services furnished on or after January 1, 2010, if the teaching anesthesiologist is involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount must be 100 percent of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist and the teaching anesthesiologist fulfilled the criteria in § 415.178 of this chapter. The single anesthesia resident case is the only case or concurrent to one other anesthesia case that is being medically directed by the physician.

* * * * *

13. Section 414.61 is added to read as follows:

§ 414.61 Payment for anesthesia services furnished by a teaching CRNA.

(a) *Basis for payment.* Beginning January 1, 2010, anesthesia services furnished by a teaching CRNA may be paid under one of the following conditions:

(1) The teaching CRNA, who is not under medical direction of a physician, is present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base units payment and is continuously present during anesthesia time in a single case with a student nurse anesthetist.

(2) The teaching CRNA, who is not under the medical direction of a physician, is involved with two concurrent anesthesia cases with student nurse anesthetists. The teaching CRNA must be present with the student nurse anesthetist for the pre and post anesthesia services included in the anesthesia base unit. For the anesthesia time of the two concurrent cases, the teaching CRNA can only be involved with those two concurrent cases and may not perform services for other patients.

(b) *Level of payment.* The allowance for the service of the teaching CRNA, furnished under paragraph (a) of this section, is determined in the same way as for a physician who personally performs the anesthesia service alone as specified in 414.46(c) of this subpart.

14. 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, end-stage renal disease related services included in the monthly capitation payment (except for one visit per month to examine the access site), individual medical nutrition therapy, and individual health and behavior assessment and intervention services furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable for the service of the physician or practitioner. The Medicare payment amount for follow-up inpatient telehealth consultations furnished via an interactive telecommunications system is equal to the current fee schedule amount applicable to subsequent hospital care provided by a physician or practitioner.

* * * * *

15. Section 414.68 is added to read as follows:

§ 414.68 Imaging accreditation.

(a) *Scope and purpose.* Section 1834(e) of the Act, requires the Secretary to designate and approve independent accreditation organizations for purposes of accrediting suppliers furnishing the technical component (TC) of advanced diagnostic imaging services and establish procedures to ensure that the criteria used by an accreditation organization is specific to each imaging modality. Suppliers of the TC of advanced diagnostic imaging services for which payment is made under the fee schedule established in section 1848(b) of the Act must become accredited by an accreditation organization designated by the Secretary beginning January 1, 2012.

(b) *Definitions.* As used in this section, the following definitions are applicable:

Accredited supplier means a supplier that has been accredited by a CMS-designated accreditation organization as specified in this part.

Advanced diagnostic imaging service means any of the following diagnostic services:

(i) Magnetic resonance imaging.

(ii) Computed tomography.

(iii) Nuclear medicine.

(iv) Positron emission tomography.

CMS-approved accreditation organization means an accreditation organization designated by CMS to perform the accreditation functions specified in section 1834(e) of the Act

(c) *Application and reapplication procedures for accreditation organizations.* An independent accreditation organization applying for approval or reapproval of authority to survey suppliers for purposes of accrediting suppliers furnishing the TC of advanced diagnostic imaging services is required to furnish CMS with all of the following:

(1) A detailed description of how the organization's accreditation criteria satisfy the statutory standards at section 1834(e)(3) of the Act, specifically—

(i) Qualifications of medical personnel who are not physicians and who furnish the TC of advanced diagnostic imaging services;

(ii) Qualifications and responsibilities of medical directors and supervising physicians, such as their training in advanced diagnostic imaging services in a residency program, expertise obtained through experience, or continuing medical education courses;

(iii) Procedures to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced by the supplier; and

(iv) Procedures to ensure the safety of persons who furnish the TC of advanced diagnostic imaging services and individuals to whom such services are furnished.

(2) An agreement to conform accreditation requirements to any changes in Medicare statutory requirements in section 1834(e) of the Act.

(3) Information that demonstrates the accreditation organization's knowledge and experience in the advanced diagnostic imaging arena.

(4) The organization's proposed fees for accreditation for each modality in which the organization intends to offer accreditation, including any plans for reducing the burden and cost of accreditation to small and rural suppliers.

(5) Any specific documentation requirements and attestations requested by CMS as a condition of designation under this part.

(6) A detailed description of the organization's survey process, including the following:

(i) Type and frequency of the surveys performed.

(ii) The ability of the organization to conduct timely reviews of accreditation applications, to include the organizations national capacity.

(iii) Description of the organizations audit procedures including random site visits, site audits, or other strategies for ensuring suppliers maintain compliance during the duration of accreditation.

(iv) Procedures for performing unannounced site surveys.

(v) Copies of the organization's survey forms.

(vi) A description of the accreditation survey review process and the accreditation status decision-making process, including the process for addressing deficiencies identified with the accreditation requirements, and the procedures used to monitor the correction of deficiencies found during an accreditation survey.

(vii) Procedures for coordinating surveys with another accrediting organization if the organization does not accredit all products the supplier provides.

(viii) Detailed information about the individuals who perform evaluations for the accreditation organization, including all of the following information:

(A) The number of professional and technical staff that are available for survey.

(B) The education, current employment and experience requirements surveyors must meet.

(C) The content and length of the orientation program.

(ix) The frequency and types of in-service training provided to survey personnel.

(x) The evaluation systems used to monitor the performance of individual surveyors and survey teams.

(xi) The policies and procedures regarding an individual's participation in the survey or accreditation decision process of any organization with which the individual is professionally or financially affiliated.

(xii) The policies and procedures used when an organization has a dispute regarding survey findings or an adverse decision.

(7) Detailed information about the size and composition of survey teams for each category of advanced medical imaging service supplier accredited.

(8) A description of the organization's data management and analysis system for its surveys and accreditation decisions, including the kinds of reports, tables, and other displays generated by that system.

(9) The organization's procedures for responding to and for the investigation

of complaints against accredited facilities, including policies and procedures regarding coordination of these activities with appropriate licensing bodies and CMS.

(10) The organization's policies and procedures for the withholding or removal of accreditation status for facilities that fail to meet the accreditation organization's standards or requirements, and other actions taken by the organization in response to noncompliance with its standards and requirements. These policies and procedures must include notifying CMS of facilities that fail to meet the requirements of the accrediting organization.

(11) A list of all currently accredited suppliers, the type and category of accreditation currently held by each supplier, and the expiration date of each supplier's current accreditation.

(12) The accreditation organization must also submit the following supporting documentation:

(i) A written presentation that demonstrates the organization's ability to furnish CMS with electronic data in ASCII comparable code.

(ii) A resource analysis that demonstrates that the organization's staffing, funding, and other resources are adequate to perform the required surveys and related activities.

(iii) A statement acknowledging that, as a condition for approval of designation, the organization agrees to the following activities:

(A) Prioritize surveys for those suppliers needing to be accredited by January 1, 2012.

(B) In the case of a supplier that is accredited before January 1, 2010, the supplier must be considered accredited as of January 1, 2012.

(C) Notify CMS, in writing, of any supplier that had its accreditation revoked, withdrawn, revised, or any other remedial or adverse action taken against it by the accreditation organization within 30 calendar days of any such action taken.

(D) Notify all accredited suppliers within 10 calendar days of the organization's removal from the list of designated accreditation organizations.

(E) Notify CMS, in writing, at least 30 calendar days in advance of the effective date of any proposed changes in accreditation requirements.

(F) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(G) Notify CMS, in writing, (electronically or hard copy) within 2 calendar days of a deficiency identified in any accreditation supplier where the deficiency poses an immediate jeopardy to the supplier's beneficiaries or a hazard to the general public.

(H) Provide, on an annual basis, summary data specified by CMS that relates to the past years' accreditations and trends.

(I) Attest that the organization will not perform any accreditation surveys of Medicare participating suppliers with which it has a financial relationship with or interest in.

(J) Conform accreditation requirements to changes in Medicare requirements.

(iv) If CMS determines that additional information is necessary to make a determination for approval or denial of the accreditation organization's application for designation, the organization is notified and afforded an opportunity to provide the additional information.

(v) CMS may visit the organization's offices to verify representations made by the organization in its application, including, but not limited to, review of documents and interviews with the organization's staff.

(vi) The accreditation organization will receive a formal notice from CMS stating whether the request for designation has been approved or denied. If approval was denied the notice includes the basis for denial and reconsideration and reapplication procedures.

(d) *Ongoing responsibilities of a CMS-approved accreditation organization.* An accreditation organization approved by CMS must undertake the following activities on an ongoing basis:

(1) Provide to CMS all of the following in written format (either electronic or hard copy):

(i) Copies of all accreditation surveys, together with any survey-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements).

(ii) Notice of all accreditation decisions.

(iii) Notice of all complaints related to suppliers.

(iv) Information about any supplier furnishing the TC of advanced diagnostic imaging service against which the CMS approved accreditation organization has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation.

(v) Notice of any proposed changes in its accreditation standards or requirements or survey process. If the organization implements the changes before or without CMS' approval, CMS may withdraw its approval of the accreditation organization.

(2) Within 30 calendar days of a change in CMS requirements, an acknowledgment of CMS' notification of the change must be submitted to CMS.

(3) Permit its surveyors to serve as witnesses if CMS takes an adverse action based on accreditation findings.

(4) Within 2 calendar days of identifying a deficiency of an accredited supplier that poses immediate jeopardy to a beneficiary or to the general public, provide CMS with written notice of the deficiency and any adverse action implemented by the accreditation organization.

(5) Within 10 calendar days after CMS' notice to a CMS approved accreditation organization that CMS intends to withdraw approval of the accreditation organization, provide written notice of the withdrawal to all the CMS approved accreditation organization's accredited suppliers.

(6) Provide, on an annual basis, summary data specified by CMS that relate to the past year's accreditation activities and trends.

(d) *Continuing Federal oversight of approved accreditation organizations.* This paragraph establishes specific criteria and procedures for continuing oversight and for withdrawing approval of a CMS approved accreditation organization.

(1) *Validation audits.* CMS or its contractor may conduct an audit of an accredited supplier to validate the survey accreditation process of approved accreditation organizations in the TC of advanced diagnostic imaging services. The audits must be conducted on a representative sample of suppliers who have been accredited by a particular accrediting organization or in response to allegations of supplier noncompliance with the standards. When conducted on a representative sample basis, we are proposing that the audit would be comprehensive and address all of the standards or would focus on a specific standard in issue. When conducted in response to an allegation, we would specify that the CMS team or our contractor would audit for any standard that we determined was related to the allegations. At the conclusion of this audit, if CMS identifies any accreditation programs for which validation audit results indicate—

(i) A 10 percent rate of disparity between findings by the accreditation organization and findings by CMS or its designated survey team on standards that do not constitute immediate jeopardy to patient health and safety if unmet.

(ii) Any disparity between findings by the accreditation organization and

findings by CMS on standards that constitute immediate jeopardy to patient health and safety if unmet.

(iii) That, irrespective of the rate of disparity, there are widespread or systemic problems in an organization's accreditation process such that accreditation by that accreditation organization no longer provides CMS with adequate assurance that suppliers meet or exceed the Medicare requirements.

(2) *Notice of intent to withdraw approval.* CMS provides the organization written notice of its intent to withdraw approval if an equivalency review, validation review, onsite observation, or CMS' daily experience with the accreditation organization suggests that the accreditation organization is not meeting the requirements of this section.

(3) *Withdrawal of approval.* CMS may withdraw its approval of an accreditation organization at any time if CMS determines that—

(i) Accreditation by the organization no longer adequately assures that the suppliers furnishing the technical component of advanced diagnostic imaging service are meeting the established industry standards for each modality and that failure to meet those requirements could jeopardize the health or safety of Medicare beneficiaries and could constitute a significant hazard to the public health; or

(ii) The accreditation organization has failed to meet its obligations with respect to application or reapplication procedures.

(f) *Reconsideration.* An accreditation organization dissatisfied with a determination that its accreditation requirements do not provide or do not continue to provide reasonable assurance that the suppliers accredited by the accreditation organization meet the applicable quality standards is entitled to a reconsideration. CMS reconsiders any determination to deny, remove, or not renew the approval of designation to accreditation organizations if the accreditation organization files a written request for reconsideration by its authorized officials or through its legal representative.

(1) *Filing requirements.*

(i) The request must be filed within 30 calendar days of the receipt of CMS notice of an adverse determination or non renewal.

(ii) The request for reconsideration must specify the findings or issues with which the accreditation organization disagrees and the reasons for the disagreement.

(iii) A requestor may withdraw its request for reconsideration at any time before the issuance of a reconsideration determination.

(2) *CMS response to a filing request.* In response to a request for reconsideration, CMS provides the accreditation organization with—

(i) The opportunity for an informal hearing to be conducted by a hearing officer appointed by the Administrator of CMS and provide the accreditation organization the opportunity to present, in writing and in person, evidence or documentation to refute the determination to deny approval, or to withdraw or not renew designation; and

(ii) Written notice of the time and place of the informal hearing at least 10 business days before the scheduled date.

(3) *Hearing requirements and rules.*

(i) The informal reconsideration hearing is open to all of the following:

(A) CMS.

(B) The organization requesting the reconsideration including—

(*1*) Authorized representatives;

(*2*) Technical advisors (individuals with knowledge of the facts of the case or presenting interpretation of the facts); and

(*3*) Legal counsel.

(ii) The hearing is conducted by the hearing officer who receives testimony and documents related to the proposed action.

(iii) Testimony and other evidence may be accepted by the hearing officer even though it is inadmissible under the rules of court procedures.

(iv) The hearing officer does not have the authority to compel by subpoena the production of witnesses, papers, or other evidence.

(v) Within 45 calendar days of the close of the hearing, the hearing officer presents the findings and recommendations to the accreditation organization that requested the reconsideration.

(vi) The written report of the hearing officer includes separate numbered findings of fact and the legal conclusions of the hearing officer.

(vii) The hearing officer's decision is final.

Subpart F—Competitive Bidding for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)

16. Section 414.402 is amended by revising the definition ''Grandfathered item'' to read as follows:

§ 414.402 Definitions.

* * * * *

Grandfathered Item means all rented items within a product category for which payment was made prior to the implementation of a competitive bidding program to a grandfathered supplier that chooses to continue to furnish the items in accordance with § 414.408(j) of this subpart and that fall within the following payment categories for competitive bidding:

(1) An inexpensive or routinely purchased item described in § 414.220 of this part.

(2) An item requiring frequent and substantial servicing, as described in § 414.222 of this part.

(3) Oxygen and oxygen equipment described in § 414.226 of this part.

(4) Other DME described in § 414.229 of this part.

* * * * *

17. Section 414.408 is amended by—

(A) Redesignating paragraph (j)(5) as (j)(7).

(B) Adding a new paragraphs (j)(5) and (j)(6).

§ 414.408 Payment rules.

* * * * *

(j) * * *

(5) *Notification of beneficiaries and CMS by suppliers that choose to become grandfathered suppliers.*

(i) *Notification of beneficiaries by suppliers.*

(A) *Requirements of notification.* A noncontract supplier that elects to become a grandfathered supplier must provide a 30-day written notification to each Medicare beneficiary that resides in a competitive bidding area and is currently renting a competitively bid item from that supplier. The 30-day notification to the beneficiary must meet the following requirements:

(*1*) Be sent by the supplier to the beneficiary at least 30 business days before the start date of the implementation of the competitive bidding program for the CBA in which the beneficiary resides.

(*2*) Identify the grandfathered items that the supplier is willing to continue to rent to the beneficiary.

(*3*) Be in writing (for example, by letter or postcard) and the supplier must maintain proof of delivery.

(*4*) State that the supplier is willing to continue to furnish certain rented Durable Medical Equipment (DME), oxygen and oxygen equipment, and supplies that the supplier is currently furnishing to the beneficiary (that is, before the start of the competitive bidding program) and is willing to continue to provide these items to the beneficiary for the remaining rental months.

(*5*) State that the beneficiary has the choice to continue to receive a grandfathered item(s) from the

grandfathered supplier or may elect to receive the item(s) from a contract supplier after the end of the last month for which a rental payment is made to the noncontract supplier.

(*6*) Provide the supplier's telephone number and instruct the beneficiary to call the supplier with any questions and to notify the supplier of his or her decision to use or not use the supplier as a grandfathered supplier.

(*7*) State that the beneficiary can obtain information about the competitive bidding program by calling 1–800–MEDICARE or accessing *http://www.medicare.gov* on the Internet.

(B) *Record of beneficiary's choice.* The supplier should obtain an election from the beneficiary regarding whether to use or not use the supplier as a grandfathered supplier. The supplier must maintain a record of its attempts to communicate with the beneficiary to obtain the beneficiary's election regarding grandfathering. When the suppier obtains such an election, the supplier must maintain a record of the beneficiary decision including the date the choice was made, and how the beneficiary communicated his or her choice to the supplier.

(C) *Notification.* If the beneficiary chooses not to continue to receive a grandfathered item(s) from their current supplier, the supplier must provide the beneficiary with 2 more notices in addition to the 30-day notice prior to the supplier picking up its equipment.

(*1*) *10-day notification:* Ten business days prior to picking up the item, the supplier should have direct contact (for example, a phone call) with the beneficiary or the beneficiary's caregiver and receive acknowledgement that the beneficiary understands their equipment will be picked up. This should occur on the first anniversary date after the start of the CBP or on another date agreed to by the beneficiary or the beneficiary's caregiver. The beneficiary's anniversary date occurs every month and is the date of the month on which the item was first delivered to the beneficiary by the current supplier. When a date other than the anniversary date is chosen by the beneficiary or the beneficiary's caregiver, the noncontract supplier will still receive payment up to the anniversary date after the start of the CBP, and the new contract supplier may not bill for any period of time before the anniversary date.

(*2*) *2-day notification:* Two business days prior to picking up the item the supplier should contact the beneficiary of the beneficiary's caregiver by phone to notify the beneficiary of the date the supplier will pick up the item. This date should not be before the beneficiary's first anniversary date that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(D) *Pickup procedures.*

(*1*) The pickup of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(*2*) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(*3*) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are suitable to the beneficiary.

(*4*) The contract supplier may not submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP, and the contract supplier may not begin billing until the first anniversary date that occurs after the beginning of the CBP.

(*5*) The noncontract supplier must submit a claim to be paid up to the first anniversary date that occurs after the beginning of the CBP. Therefore, they should not pick up the equipment before that date unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(ii) *Notification to CMS by suppliers.* A noncontract supplier that elects to become a grandfathered supplier must provide a written notification to CMS of this decision. This notification must meet the following requirements:

(A) State that the supplier agrees to continue to furnish certain rented DME, oxygen and oxygen equipment that it is currently furnishing to beneficiaries (that is, before the start of the competitive bidding program) in a CBA and will continue to provide these items to these beneficiaries for the remaining months of the rental period.

(B) Include the following information:

(*1*) Name and address of the supplier.

(*2*) The 6-digit NSC number of the supplier.

(*3*) Product category(s) by CBA for which the supplier is willing to be a grandfathered supplier.

(C) State that the supplier agrees to meet all the terms and conditions pertaining to grandfathered suppliers.

(D) Be provided by the supplier to CMS in writing at least 30 business days before the start date of the implementation of the Medicare DMEPOS Competitive Bidding Program.

(*6*) *Suppliers that choose not to become grandfathered suppliers.*

(i) *Requirement for non-grandfathered supplier.* A noncontract supplier that elects not to become a grandfathered supplier is required to pick up the item it is currently renting to the beneficiary from the beneficiary's home after proper notification.

(ii) *Notification.* Proper notification includes a 30-day, a 10-day, and a 2-day notice of the supplier's decision not to become a grandfathered supplier to its Medicare beneficiaries who are currently renting certain DME competitively bid item(s) and who reside in a CBA.

(iii) *Requirements of notification.* These notifications must meet all of the requirements listed in paragraph (j)(5)(i) of this section for the 30-day, 10-day and 2-day notices that must be sent by suppliers who decide to be grandfathered suppliers, with the following exceptions for the 30-day notice.

(A) State that, for those items for which the supplier has decided not to be a grandfathered supplier, the supplier will only continue to rent these competitively bid item(s) to its beneficiaries up to the first anniversary date that occurs after the start of the Medicare DMEPOS Competitive Bidding Program.

(B) State that the beneficiary must select a contract supplier for Medicare to continue to pay for these items.

(C) Refer the beneficiary to the contract supplier locator tool on *http://www.medicare.gov* and to 1–800–MEDICARE to obtain information about the availability of contract suppliers for the beneficiary's area.

(iv) *Pickup procedures.*

(A) The pick-up of the noncontract supplier's equipment and the delivery of the new contract supplier's equipment should occur on the same date, that is, the first rental anniversary date of the equipment that occurs after the start of the competitive bidding program unless an alternative arrangement has been made with the beneficiary and the new contract supplier.

(B) Under no circumstance should a supplier pick up a rented item prior to the supplier's receiving acknowledgement from the beneficiary that the beneficiary is aware of the date on which the supplier is picking up the item and the beneficiary has made arrangements to have the item replaced on that date by a contract supplier.

(C) When a beneficiary chooses to switch to a new contract supplier, the current noncontract supplier and the new contract supplier must make arrangements that are agreeable to the beneficiary.

(D) The contract supplier cannot submit a claim with a date of delivery for the new equipment that is prior to the first anniversary date that occurs after the beginning of the CBP.

* * * * *

18. Section 414.425 is added to read as follows:

§ 414.425 Claims for damages.

(a) *Eligibility for filing a claim for damages as a result of the termination of supplier contracts by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA).* (1) Any aggrieved supplier, including a member of a network that was awarded a contract for the Round 1 Durable Medical Prosthetics, Orthotics, and Supplies Competitive Bidding Program (DMEPOS CBP) that believes it has been damaged by the termination of its competitive bid contract, may file a claim under this section.

(2) A subcontractor of a contract supplier is not eligible to submit a claim under this section.

(b) *Timeframe for filing a claim.* (1) A completed claim, including all documentation, must be filed within 90 days of the effective date of this paragraph, unless that day is a Federal holiday or Sunday in which case it will fall to the next business day.

(2) The date of filing is the actual date of receipt by the CBIC of a completed claim that includes all the information required by this rule.

(c) *Information that must be included in a claim.* (1) Supplier's name, name of authorized official, U.S. Post Office mailing address, phone number, e-mail address and bidding number, and National Supplier Clearinghouse Number;

(2) A copy of the signed contract entered into with CMS for the Round 1 DMEPOS Competitive Bidding Program;

(3) A detailed explanation of the damages incurred by this supplier as a direct result of the termination of the Round 1 competitive bid contract by MIPPA. The explanation must include all of the following:

(i) Documentation of the supplier's damages through receipts.

(ii) Records that substantiate the supplier's damages and demonstrate that the damages are directly related to performance of the Round 1 contract and are consistent with information the supplier provided as part of their bid.

(4) The supplier must explain how it would be damaged if not reimbursed.

(5) The claim must document steps the supplier took to mitigate any damages they may have incurred due to the contract termination, including a detailed explanation of the steps of all attempts to use for other purposes, return or dispose of equipment or other assets purchased or rented for the use in the Round 1 DMEPOS CBP contract performance.

(d) *Items that will not be considered in a claim.* The following items will not be considered in a claim:

(1) The cost of submitting a bid.

(2) Any fees or costs incurred for consulting or marketing.

(3) Costs associated with accreditation or licensure.

(4) Costs incurred before March 20, 2008.

(5) Costs incurred for contract performance after July 14, 2008 except for costs incurred to mitigate damages.

(6) Any profits a supplier may have expected from the contract.

(7) Costs that would have occurred without a contract having been awarded.

(8) Costs for items such as inventory, delivery vehicles, office space and equipment, personnel, which the supplier did not purchase specifically to perform the contract.

(9) Costs that the supplier has recouped by any means, and may include use of personnel, material, suppliers, or equipment in the supplier's business operations.

(e) *Filing a claim.* (1) A claim, with all supporting documentation, must be filed with the CMS Competitive Bidding Implementation Contractor (CBIC).

(2) Claims must include a statement from a supplier's authorized official certifying the accuracy of the information provided on the claim and all supporting documentation.

(3) The CBIC does not accept electronic submissions of claims for damages.

(f) *Review of claim.* (1) *Role of the CBIC.*

(i) The CBIC will review the claim to ensure it is submitted timely, complete, and by an eligible claimant. When the CBIC identifies that a claim is incomplete or not filed timely, it will make a recommendation to the Determining Authority not to process the claim further. Incomplete or untimely claims may be dismissed by the Determining Authority without further processing.

(ii) For complete, timely claims, the CBIC will review the claim on its merits to determine if damages are warranted and may seek further information from the claimant when making its recommendation to the Determining Authority. The CBIC may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iii) The CBIC will make a recommendation to the Determining Authority for each claim filed and include an explanation that supports its recommendation.

(iv) The recommendation must be either to award damages for a particular amount (which may not be the same amount requested by the claimant) or that no damages should be awarded.

(A) If the CBIC recommends that damages are warranted, the CBIC will calculate a recommended reasonable amount of damages based on the claim submitted.

(B) The reasonable amount will consider both costs incurred and the contractor's attempts and action to limit the damages;

(v) The recommendation will be sent to the Determining Authority for a final determination.

(2) *CMS' role as the Determining Authority*.

(i) The Determining Authority shall review the recommendation of the CBIC.

(ii) The Determining Authority may seek further information from the claimant or the CBIC in making a concurrence or non-concurrence determination.

(iii) The Determining Authority may set a deadline for receipt of additional information. A claimant's failure to respond timely may result in a denial of the claim.

(iv) If the Determining Authority concurs with the CBIC recommendation, the Determining Authority shall submit a final signed decision to the CBIC and direct the CBIC to notify the claimant of the decision and the reasons for the final decision.

(v) If the Determining Authority non-concurs with the CBIC recommendation, the Determining Authority may return the claim for further processing or the Determining Authority may:

(A) Write a determination granting (in whole or in part) a claim for damages or denying a claim in its entirety;

(B) Direct the CBIC to write said determination for the Determining Authority's signature; or

(C) Return the claim to the CBIC with further instructions.

(vi) The Determining Authority's determination is final and not subject to administrative or judicial review.

(g) *Timeframe for determinations.* (1) Every effort will be made to make a determination within 120 days of initial receipt of the claim for damages by the CBIC or the receipt of additional information that was requested by the CBIC, whichever is later.

(2) In the case of more complex cases, or in the event of a large workload, a decision will be issued as soon as practicable.

(h) *Notification to claimant of damage determination.* The CBIC must mail the Determining Authority's determination to the claimant by certified mail return receipt requested, at the address provided in the claim.

Subpart H—Fee Schedule for Ambulance Services

19. Section 414.610 is amended by revising paragraph (c)(5)(i) to read as follows:

§ 414.610 Basis of payment.

* * * * *

(c) * * *

(5) * * *

(i) For ground ambulance services where the point of pickup is in a rural area, the mileage rate is increased by 50 percent for each of the first 17 miles and, for services furnished before January 1, 2004, by 25 percent for miles 18 through 50. The standard mileage rate applies to every mile over 50 miles and, for services furnished after December 31, 2003, to every mile over 17 miles. For air ambulance services where the point of pickup is in a rural area, the total payment is increased by 50 percent; that is, the rural adjustment factor applies to the sum of the base rate and the mileage rate.

* * * * *

Subpart J—Submission of Manufacturer's Average Sales Price Data

20. Section 414.802 is amended by revising the definition of ''unit'' to read as follows:

§ 414.802 Definitions.

* * * * *

Unit means the product represented by the 11-digit National Drug Code. The method of counting units excludes units of CAP drugs (as defined in § 414.902) sold to an approved CAP vendor (as defined in § 414.902) for use under the CAP (as defined in § 414.902).

Subpart K—Payment for Drugs and Biologicals Under Part B

§ 414.904 [Amended]

21. Amend § 414.904(d)(3) by removing the phrase ''and 2009'' and adding in its place the phrase ''2009, and 2010.''

22. Section 414.906 is amended by—

B. Revising the introductory text of paragraph (c) and paragraph (c)(1).

C. Redesignating paragraph (c)(2) as (c)(3).

D. Adding new paragraph (c)(2).

E. Adding paragraphs (f)(2)(v), (f)(3)(iv), and (g).

The revision and additions read as follows:

§ 414.906 Competitive acquisition program as the basis for payment.

* * * * *

(c) *Computation of payment amount.* Except as specified in paragraph (c)(2) of this section, payment for CAP drugs is based on bids submitted as a result of the bidding process as described in § 414.910.

(1) *Single payment amount.*

(i) A single payment amount for each CAP drug in the competitive acquisition area is determined on the basis of the bids submitted and accepted and updated from the bidding period to the beginning of the payment year.

(ii) The single payment amount is then updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for that category as determined by CMS, and limited by the weighted payment amount established under section 1847A of the Act across all drugs for which a composite bid is required in the category.

(iii) The payment amount for each other drug for which the approved CAP vendor submits a bid in accordance with § 414.910 of this subpart and each other drug that is approved by CMS for the approved CPA vendor to furnish under the CAP is also updated quarterly based on the approved CAP vendor's reasonable net acquisition costs for each HCPCS code and limited by the payment amount established under section 1847A of the Act.

(2) *Updates to payment amount.*

(i) The first update is effective on the first day of claims processing for the first quarter of an approved CAP vendor's contract. The first quarterly contract update is based on the reasonable net acquisition cost (RNAC) data reported to CMS or its designee for any purchases of drug before the beginning of CAP claims processing for the contract period and reported to CMS no later than 30 days before the beginning of CAP claims processing.

(ii) For subsequent quarters, each approved CAP vendor must report to CMS or its designee RNAC data for a quarter of CAP drug purchases within 30 days of the close of that quarter.

(iii) For all quarters, only RNAC data from approved CAP vendors that are supplying CAP drugs under their CAP contract at the time updates are being calculated must be used to calculate updated CAP payment amounts.

(iv) CMS excludes such RNAC data submitted by an approved CAP vendor if, during the time calculations are being done, CMS knows that the approved CAP vendor will not be under contract for the applicable quarterly update.

(v) The payment amount weights must be calculated based on the more recent of the following:

(A) Contract bidding weights.

(B) CAP claims data.

(vi) The payment limit must be determined using the most recent payment limits available to CMS under section 1847A of the Act.

(vii) The following payment amount update calculation must be applied for the group of all drugs for which a composite bid is required.

(A) The most recent previous composite payment amount for the group is updated by—

(*1*) Calculating the percent change in reasonable net acquisition costs for each approved CAP vendor;

(*2*) Calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts; and

(*3*) Limiting the payment as described in paragraph (c)(1) of this section.

(B) The median percent change, subject to the limit described in paragraph (c)(1) of this section, must be the update percentage for that quarter.

(C) The single update percentage must be applied to the payment amount for each drug in the group of drugs for which a composite bid is required in the category.

(viii) The following payment amount update calculation must be applied for each of the following items: each HCPCS code not included in the composite bid list; each HCPCS code added to the drug list during the contract period; and each drug that has not yet been assigned a HCPCS code, but for which a HCPCS code will be established.

(A) The most recent previous payment amount for each drug must be updated by calculating the percent change in reasonable net acquisition costs for each approved CAP vendor, then calculating the median of all participating approved CAP vendors' adjusted CAP payment amounts.

(B) The median percent change calculated for each drug, subject to the

limit described in paragraph (c)(1) of this section, must be applied to the payment amount for each drug.

* * * * *

(f) * * *

(2) * * *

(v) On or after January 1, 2010, the proposed addition of drugs with similar therapeutic uses to drugs already supplied under the CAP by the approved CAP vendor(s).

(3) * * *

(iv) In the case of additions requested under paragraph (f)(2)(v) of this section, address and document the need for such an expansion based on demand for the product(s).

* * * * *

(g) Deletion of drugs on an approved CAP vendor's CAP drug list due to unavailability requires a written request and approval as described in paragraphs (f)(3)(i) through (iii) and (f)(4).

23. Section 414.908 is amended by revising paragraph (a)(3)(xii) to read as follows:

§ 414.908 Competitive acquisition program.

(a) * * *

(3) * * *

(xii) Agrees not to transport CAP drugs from one practice location or place of service to another location except in accordance with a written agreement between the participating CAP physician and the approved CAP vendor that requires that drugs are not subjected to conditions that will jeopardize their integrity, stability, and/or sterility while being transported.

* * * * *

24. Section 414.914 is amended by revising paragraph (f)(12) to read as follows:

§ 414.914 Terms of contract.

* * * * *

(f) * * *

(12) Supply CAP drugs upon receipt of a prescription order to all participating CAP physicians who have selected the approved CAP vendor, except when the conditions of paragraph (h) of this section or § 414.916(b) are met;

* * * * *

25. Section 414.916 is amended by —

A. Redesignating paragraph (b)(4) as (b)(5).

B. Adding new paragraph (b)(4).

The addition reads as follows:

§ 414.916 Dispute resolution for vendors and beneficiaries.

* * * * *

(b) * * *

(4) Upon notification from CMS of a participating CAP physician's suspension from the program, the approved CAP vendor must cease delivery of CAP drugs to the suspended participating CAP physician until the suspension has been lifted.

* * * * *

26. Section 414.917 is amended by revising paragraph (b)(4) to read as follows:

§ 414.917 Dispute resolution and process for suspension or termination of approved CAP contract and termination of physician participation under exigent circumstances.

* * * * *

(b) * * *

(4) The approved CAP vendor may appeal that termination by requesting a reconsideration. A determination must be made as to whether the approved CAP vendor has been meeting the service and quality obligations of its CAP contract. The approved CAP vendor's contract will remain suspended during the reconsideration process.

* * * * *

27. Section 414.930 is amended by—

A. Revising paragraph (a).

B. Redesignating paragraphs (b)(1)(v) as (vi).

C. Adding new paragraphs (b)(1)(v).

The revision and addition read as follows:

§ 414.930 Compendia for determination of medically-accepted indications for off-label uses of drugs and biologicals in an anti-cancer chemotherapeutic regimen.

(a) *Definitions.* For the purposes of this section:

Compendium means a comprehensive listing of FDA-approved drugs and biologicals or a comprehensive listing of a specific subset of drugs and biologicals in a specialty compendium, for example a compendium of anti-cancer treatment. A compendium—

(i) Includes a summary of the pharmacologic characteristics of each drug or biological and may include information on dosage, as well as recommended or endorsed uses in specific diseases.

(ii) Is indexed by drug or biological.

(iii) Has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests.

Publicly transparent process for evaluating therapies means that the following materials are available to the public on the compendium's Web site coincident with the compendium's publication of the related recommendation:

(i) The application for inclusion of a therapy including criteria used to evaluate the request.

(ii) A listing of all the evidentiary materials reviewed or considered by the compendium pursuant to the application.

(iii) A listing of all individuals who have substantively participated in the development of compendia recommendations.

(iv) Transcripts of meetings and records of the votes, including abstentions, related to the therapeutic recommendation on the application.

Publicly transparent process for identifying potential conflicts of interests means that the following materials are identified and available to the public coincident with the compendium's publication of the related recommendation:

(i) Direct or indirect financial relationships that exist between individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium). This includes compensation arrangements such as salary, grant, contract, or collaboration agreements between individuals who have substantively participated in the development of compendia recommendations and the applicant.

(ii) Ownership or investment interests of individuals who have substantively participated in the development of compendia recommendations and the applicant (for example, the manufacturer or seller of the drug or biological being reviewed by the compendium).

(b) * * *

(1) * * *

(v) Considers whether the publication that is the subject of the request meets the definition of a compendium in this section.

* * * * *

PART 415—SERVICES FURNISHED BY PHYSICIANS IN PROVIDERS, SUPERVISING PHYSICIANS IN TEACHING SETTINGS, AND RESIDENTS IN CERTAIN SETTINGS

28. The authority citation for part 415 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart D—Physician Services in Teaching Settings

29. Section 415.178 is revised to read as follows:

§ 415.178 Anesthesia services.

(a) *General rule.* (1) *For services furnished prior to January 1, 2010*, an unreduced physician fee schedule payment may be made if a physician is involved in a single anesthesia procedure involving an anesthesia resident. In the case of anesthesia services, the teaching physician must be present during all critical portions of the procedure and immediately available to furnish services during the entire service or procedure. The teaching physician cannot receive an unreduced fee if he or she performs services involving other patients during the period the anesthesia resident is furnishing services in a single case. Additional rules for payment of anesthesia services involving residents are specified in § 414.46(c)(1)(iii) of this chapter.

(2) *For services furnished on or after January 1, 2010*, payment may be made under § 414.46(e) of this chapter if the teaching anesthesiologist is present during all critical or key portions of the anesthesia service or procedure involved; and the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.

(b) *Documentation.* Documentation must indicate the physician's presence during all critical or key portions of the anesthesia procedure and the immediate availability of another teaching anesthesiologist.

PART 485—CONDITIONS OF PARTICIPATION: SPECIALIZED PROVIDERS

30. The authority citation for part 485 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

Subpart B—Conditions of Participation: Comprehensive Outpatient Rehabilitation Facilities

31. Section 485.70 is amended by revising paragraph (j) to read as follows:

§ 485.70 Personnel qualifications.

* * * * *

(j) A respiratory therapist must complete one the following criteria:

(1) *Criterion 1.* All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have successfully completed a nationally-accredited educational program for respiratory therapists.

(iii)(A) Be eligible to take the registry examination administered by the National Board for Respiratory Care for respiratory therapists; or

(B) Have passed the registry examination administered by the National Board for Respiratory Care for respiratory therapists.

(2) *Criterion 2*: All of the following must be completed:

(i) Be licensed by the State in which practicing, if applicable.

(ii) Have equivalent training and experience as determined by the National Board for Respiratory Care.

* * * * *

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

Dated: June 15, 2009.

Charlene Frizzera,

Acting Administrator, Centers for Medicare & Medicaid Services.

Approved: June 30, 2009.

Kathleen Sebelius,

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 CY 2010. Addendum B contains the RVUs for work, nonfacility PE, facility PE, and malpractice expense, and other information for all services included in the PFS.

In previous years, we have listed many services in Addendum B that are not paid under the PFS. To avoid publishing as many pages of codes for these services, we are not including clinical laboratory codes or the alphanumeric codes (Healthcare Common Procedure Coding System (HCPCS) codes not included in CPT) not paid under the PFS in Addendum B.

Addendum B 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. Please also note the following:

- An ''NA'' in the ''Non-facility PE RVUs'' column of Addendum B means that CMS has not developed a PE RVU in the nonfacility setting for the service because it is typically performed in the hospital (for example, an open heart surgery is generally performed in the hospital setting and not a physician's office). If there is an ''NA'' in the nonfacility PE RVU column, and the contractor determines that this service can be performed in the nonfacility setting, the service will be paid at the facility PE RVU rate.
- Services that have an ''NA'' in the ''Facility PE RVUs'' column of Addendum B are typically not paid using the PFS when provided in a facility setting. These services (which include ''incident to'' services and the technical portion of diagnostic tests) are generally paid under either the outpatient hospital prospective payment system or bundled into the hospital inpatient prospective payment system payment.

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. A code for: The global values (both professional and technical); modifier-26 (PC); and, 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, for example a colonoscopy that is not completed. There will be RVUs for a code with this modifier.

3. *Status indicator.* This indicator shows whether the CPT/HCPCS code is in the PFS and whether it is separately payable if the service is covered.

A = Active code. These codes are separately payable under the PFS 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 coverage determination regarding the service. Carriers remain responsible for coverage decisions in the absence of a national Medicare policy.

B = Bundled code. Payments for covered services are 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 = Carriers price the code. Carriers will establish RVUs and payment amounts for these services, generally on an individual case basis following review of documentation, such as an operative report.

D = Deleted/discontinued code.*

E = Excluded from the PFS by regulation. These codes are for items and services that CMS chose to exclude from the fee schedule payment by regulation. No RVUs are shown, and no payment may be made under the PFS for these codes. Payment for them, when covered, continues under reasonable charge procedures.

F = Deleted/discontinued codes. (Code not subject to a 90-day grace period.) These codes are deleted effective with the beginning of the year and are never subject to a grace period. This indicator is no longer effective beginning with the 2005 fee schedule as of January 1, 2005.

G = Code not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services. (Codes

subject to a 90-day grace period.) This indicator is no longer effective with the 2005 PFS as of January 1, 2005.

H* = Deleted modifier. For 2000 and later years, either the TC or PC component shown for the code has been deleted and the deleted component is shown in the database with the H status indicator.

I = Not valid for Medicare purposes. Medicare uses another code for the reporting of, and the payment for these services. (Codes not subject to a 90-day grace period.)

L = Local codes. Carriers will apply this status to all local codes in effect on January 1, 1998 or subsequently approved by central office for use. Carriers will complete the RVUs and payment amounts for these codes.

M = Measurement codes, used for reporting purposes only. There are no RVUs and no payment amounts for these codes. Medicare uses them to aid with performance measurement. No separate payment is made. These codes should be billed with a zero (($0.00) charge and are denied) on the MPFSDB.

N = Non-covered service. These codes are non-covered services. Medicare payment may not be made for these codes. If RVUs are shown, they are not used for Medicare payment.

R = Restricted coverage. Special coverage instructions apply. If the service is covered and no RVUs are shown, it is carrier-priced.

T = There are RVUs for these services, but they are only paid if there are no other services payable under the PFS billed on the same date by the same provider. If any other services payable under the PFS are billed on the same date by the same provider, these services are bundled into the service(s) for which payment is made.

X = Statutory exclusion. These codes represent an item or service that is not within the statutory definition of ''physicians' services'' for PFS payment purposes. No RVUs are shown for these codes, and no payment may be made under the PFS. (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 CY 2010.

6. *Nonfacility practice expense RVUs.* These are the 2010 resource-based PE RVUs for nonfacility settings.

7. *Facility practice expense RVUs.* These are the 2010 resource-based PE RVUs for facility settings.

8. *Malpractice expense RVUs.* These are the RVUs for the malpractice expense for the service for 2010.

Note: The budget neutrality reduction resulting from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941 and 98942. The required reduction will only be reflected in the files used for Medicare payment.

9. *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 = 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 PE are associated with intra service time and in some instances in the post service time.

*Codes with these indicators had a 90-day grace period before January 1, 2005.

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ADDENDUM B: Proposed Relative Value Units and Related Information Used in Determining Medicare Payments for CY 2010

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0016T		C	Thermotx choroid vasc lesion	0.00	0.00	0.00	0.00	XXX
0017T		C	Photocoagulat macular drusen	0.00	0.00	0.00	0.00	XXX
0019T		C	Extracorp shock wv tx,ms nos	0.00	0.00	0.00	0.00	XXX
0030T		C	Antiprothrombin antibody	0.00	0 00	0.00	0.00	XXX
0042T		C	Ct perfusion w/contrast, cbf	0.00	0.00	0.00	0.00	XXX
0048T		C	Implant ventricular device	0.00	0.00	0.00	0.00	XXX
0050T		C	Removal circulation assist	0.00	0.00	0.00	0.00	XXX
0051T		C	Implant total heart system	0.00	0.00	0.00	0.00	XXX
0052T		C	Replace component heart syst	0.00	0.00	0.00	0.00	XXX
0053T		C	Replace component heart syst	0.00	0.00	0.00	0.00	XXX
0054T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	XXX
0055T		C	Bone surgery using computer	0.00	0.00	0.00	0.00	XXX
0064T		C	Spectroscop eval expired gas	0.00	0.00	0.00	0 00	XXX
0067T		C	Ct colonography;dx	0.00	0.00	NA	0.00	XXX
0067T	TC	C	Ct colonography;dx	0.00	0.00	NA	0.00	XXX
0067T	26	C	Ct colonography;dx	0.00	0 00	0.00	0.00	XXX
0068T		C	Interp/rept heart sound	0.00	0.00	0.00	0.00	XXX
0069T		C	Analysis only heart sound	0.00	0.00	0.00	0.00	XXX
0070T		C	Interp only heart sound	0.00	0.00	0.00	0.00	XXX
0071T		C	U/s leiomyomata ablate <200	0.00	0.00	0.00	0.00	XXX
0072T		C	U/s leiomyomata ablate >200	0.00	0.00	0.00	0.00	XXX
0073T		A	Delivery, comp imrt	0.00	7.98	NA	0 00	XXX
0075T		C	Perq stent/chest vert art	0.00	0.00	NA	0.00	XXX
0075T	TC	C	Perq stent/chest vert art	0.00	0.00	NA	0.00	XXX
0075T	26	C	Perq stent/chest vert art	0.00	0.00	0.00	0.00	XXX
0076T		C	S&s stent/chest vert art	0.00	0.00	NA	0.00	XXX
0076T	TC	C	S&s stent/chest vert art	0.00	0.00	NA	0 00	XXX
0076T	26	C	S&s stent/chest vert art	0.00	0.00	0.00	0.00	XXX
0077T		C	Cereb therm perfusion probe	0.00	0.00	0.00	0.00	XXX
0078T		C	Endovasc aort repr w/device	0.00	0.00	0.00	0.00	XXX
0079T		C	Endovasc visc extnsn repr	0.00	0.00	0.00	0.00	XXX
0080T		C	Endovasc aort repr rad s&s	0.00	0.00	0.00	0.00	XXX
0081T		C	Endovasc visc extnsn s&s	0.00	0.00	0.00	0.00	XXX
0084T		C	Temp prostate urethral stent	0.00	0.00	0.00	0.00	XXX
0086T		C	L ventricle fill pressure	0.00	0.00	0.00	0.00	XXX
0087T		C	Sperm eval hyaluronan	0.00	0.00	0.00	0 00	XXX
0092T		C	Artific disc addl	0.00	0.00	0.00	0.00	XXX

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[2] If values are reflected for codes not payable by Medicare, please note that these values have been established as a courtesy to the general public and are not used for Medicare payment.
[3] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.
[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0095T		C	Artific diskectomy addl	0.00	0.00	0.00	0.00	XXX
0098T		C	Rev artific disc addl	0.00	0 00	0.00	0.00	XXX
0099T		C	Implant corneal ring	0.00	0 00	0.00	0.00	XXX
0100T		C	Prosth retina receive&gen	0 00	0 00	0.00	0.00	XXX
0101T		C	Extracorp shockwv tx,hi enrg	0.00	0.00	0.00	0.00	XXX
0102T		C	Extracorp shockwv tx,anesth	0.00	0.00	0.00	0.00	XXX
0103T		C	Holotranscobalamin	0.00	0.00	0.00	0.00	XXX
0104T		C	At rest cardio gas rebreathe	0.00	0.00	0.00	0.00	XXX
0105T		C	Exerc cardio gas rebreathe	0.00	0.00	0 00	0.00	XXX
0106T		C	Touch quant sensory test	0 00	0.00	0 00	0.00	XXX
0107T		C	Vibrate quant sensory test	0.00	0.00	0.00	0.00	XXX
0108T		C	Cool quant sensory test	0.00	0.00	0 00	0.00	XXX
0109T		C	Heat quant sensory test	0.00	0.00	0.00	0.00	XXX
0110T		C	Nos quant sensory test	0.00	0.00	0.00	0.00	XXX
0111T		C	Rbc membranes fatty acids	0.00	0.00	0 00	0.00	XXX
0123T		C	Scleral fistulization	0.00	0.00	0.00	0.00	XXX
0124T		C	Conjunctival drug placement	0.00	0.00	0.00	0 00	XXX
0126T		C	Chd risk imt study	0.00	0.00	0.00	0.00	XXX
0130T		C	Chron care drug investigatn	0.00	0.00	0.00	0.00	XXX
0140T		C	Exhaled breath condensate ph	0.00	0.00	0 00	0.00	XXX
0141T		I	Perq islet transplant	0.00	0.00	0.00	0.00	XXX
0142T		I	Open islet transplant	0.00	0.00	0.00	0.00	XXX
0143T		I	Laparoscopic islet transplnt	0.00	0.00	0.00	0.00	XXX
0144T		C	CT heart wo dye; qual calc	0.00	0.00	NA	0.00	XXX
0144T	TC	C	CT heart wo dye; qual calc	0.00	0.00	NA	0.00	XXX
0144T	26	C	CT heart wo dye; qual calc	0.00	0.00	0.00	0.00	XXX
0145T		C	CT heart w/wo dye funct	0.00	0.00	NA	0.00	XXX
0145T	TC	C	CT heart w/wo dye funct	0.00	0.00	NA	0.00	XXX
0145T	26	C	CT heart w/wo dye funct	0.00	0.00	0.00	0.00	XXX
0146T		C	CCTA w/wo dye	0.00	0.00	NA	0.00	XXX
0146T	TC	C	CCTA w/wo dye	0.00	0.00	NA	0.00	XXX
0146T	26	C	CCTA w/wo dye	0.00	0.00	0.00	0.00	XXX
0147T		C	CCTA w/wo, quan calcium	0 00	0.00	NA	0.00	XXX
0147T	TC	C	CCTA w/wo, quan calcium	0.00	0.00	NA	0.00	XXX
0147T	26	C	CCTA w/wo, quan calcium	0.00	0.00	0.00	0.00	XXX
0148T		C	CCTA w/wo, strxr	0.00	0.00	NA	0.00	XXX
0148T	TC	C	CCTA w/wo, strxr	0.00	0.00	NA	0.00	XXX
0148T	26	C	CCTA w/wo, strxr	0 00	0.00	0.00	0.00	XXX
0149T		C	CCTA w/wo, strxr quan calc	0.00	0.00	NA	0.00	XXX
0149T	TC	C	CCTA w/wo, strxr quan calc	0.00	0.00	NA	0.00	XXX
0149T	26	C	CCTA w/wo, strxr quan calc	0.00	0.00	0.00	0.00	XXX
0150T		C	CCTA w/wo, disease strxr	0.00	0.00	NA	0.00	XXX

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[3] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.
[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0150T	TC	C	CCTA w/wo, disease strxr	0 00	0.00	NA	0.00	XXX
0150T	26	C	CCTA w/wo, disease strxr	0.00	0.00	0 00	0.00	XXX
0151T		C	CT heart funct add-on	0.00	0 00	NA	0 00	XXX
0151T	TC	C	CT heart funct add-on	0.00	0.00	NA	0 00	XXX
0151T	26	C	CT heart funct add-on	0 00	0.00	0.00	0.00	XXX
0155T		C	Lap impl gast curve electrd	0.00	0.00	0.00	0.00	XXX
0156T		C	Lap remv gast curve electrd	0.00	0.00	0.00	0.00	XXX
0157T		C	Open impl gast curve electrd	0.00	0.00	0.00	0 00	XXX
0158T		C	Open remv gast curve electrd	0.00	0.00	0.00	0.00	XXX
0159T		C	Cad breast mri	0.00	0.00	NA	0.00	ZZZ
0159T	TC	C	Cad breast mri	0.00	0 00	NA	0.00	ZZZ
0159T	26	C	Cad breast mri	0.00	0 00	0.00	0.00	ZZZ
0160T		C	Tcranial magn stim tx plan	0.00	0.00	0 00	0.00	XXX
0161T		C	Tcranial magn stim tx deliv	0.00	0.00	0 00	0.00	XXX
0163T		C	Lumb artif diskectomy addl	0.00	0.00	0 00	0.00	YYY
0164T		C	Remove lumb artif disc addl	0.00	0.00	0.00	0.00	YYY
0165T		C	Revise lumb artif disc addl	0.00	0.00	0 00	0.00	YYY
0166T		C	Tcath vsd close w/o bypass	0.00	0.00	0.00	0.00	XXX
0167T		C	Tcath vsd close w bypass	0 00	0.00	0.00	0.00	XXX
0168T		C	Rhinophototx light app bilat	0 00	0.00	0.00	0.00	XXX
0169T		C	Place stereo cath brain	0.00	0.00	0 00	0.00	XXX
0170T		C	Anorectal fistula plug rpr	0.00	0.00	0.00	0.00	XXX
0171T		C	Lumbar spine proces distract	0.00	0.00	0.00	0.00	XXX
0172T		C	Lumbar spine process addl	0.00	0.00	0.00	0.00	XXX
0173T		C	Iop monit io pressure	0.00	0.00	0.00	0.00	XXX
0174T		C	Cad cxr with interp	0.00	0.00	0.00	0.00	XXX
0175T		C	Cad cxr remote	0.00	0.00	0.00	0.00	XXX
0176T		C	Aqu canal dilat w/o retent	0.00	0.00	0.00	0.00	XXX
0177T		C	Aqu canal dilat w retent	0.00	0.00	0.00	0.00	XXX
0178T		C	64 lead ecg w i&r	0.00	0.00	0 00	0.00	XXX
0179T		C	64 lead ecg w tracing	0.00	0.00	0.00	0.00	XXX
0180T		C	64 lead ecg w i&r only	0.00	0.00	0.00	0.00	XXX
0181T		C	Corneal hysteresis	0.00	0.00	0.00	0.00	XXX
0182T		C	Hdr elect brachytherapy	0.00	0.00	0.00	0.00	XXX
0183T		C	Wound ultrasound	0.00	0.00	0.00	0.00	XXX
0184T		C	Exc rectal tumor endoscopic	0.00	0.00	0.00	0.00	XXX
0185T		C	Comptr probability analysis	0.00	0.00	0.00	0.00	XXX
0186T		C	Suprachoroidal drug delivery	0.00	0.00	0.00	0.00	XXX
0187T		C	Ophthalmic dx image anterior	0.00	0.00	0.00	0.00	XXX
0190T		C	Place intraoc radiation src	0.00	0.00	0.00	0.00	XXX
0191T		C	Insert ant segment drain int	0.00	0.00	0.00	0 00	XXX
0192T		C	Insert ant segment drain ext	0.00	0.00	0.00	0.00	XXX

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[3] The budget neutrality reduction from the chiropractic demonstration is not reflected in the RVUs for CPT codes 98940, 98941, and 98942. The required reduction will only be reflected in the files used for Medicare payment.

[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
0193T		C	Rf bladder neck microremodel	0.00	0.00	0 00	0 00	XXX
0194T		C	Procalcitonin (pct)	0.00	0.00	0 00	0.00	XXX
0195T		C	Arthrod presac interbody	0.00	0.00	0.00	0.00	XXX
0196T		C	Arthrod presac interbody eac	0.00	0.00	0 00	0.00	XXX
0197T		C	Intrafraction track motion	0.00	0.00	0 00	0.00	XXX
0198T		C	Ocular blood flow measure	0.00	0.00	0.00	0.00	XXX
0528F		I	Rcmnd flw-up 10 yrs docd	0.00	0.00	0.00	0.00	XXX
0535F		I	Dyspnea mngmnt plan docd	0.00	0.00	0.00	0.00	XXX
0575F		I	HIV rna plan care docd	0 00	0.00	0.00	0.00	XXX
10021		A	Fna w/o image	1.27	2.33	0.52	0.11	XXX
10022		A	Fna w/image	1.27	2.09	0 42	0.09	XXX
10040		A	Acne surgery	1 19	1.36	1 05	0.07	010
10060		A	Drainage of skin abscess	1.19	1.69	1 22	0.08	010
10061		A	Drainage of skin abscess	2.42	2.32	1 71	0.19	010
10080		A	Drainage of pilonidal cyst	1.19	3.08	1 33	0.11	010
10081		A	Drainage of pilonidal cyst	2.47	4.19	1.85	0.28	010
10120		A	Remove foreign body	1.23	2.29	1.14	0.09	010
10121		A	Remove foreign body	2.71	4.05	1.95	0.28	010
10140		A	Drainage of hematoma/fluid	1.55	2.49	1 43	0.14	010
10160		A	Puncture drainage of lesion	1.22	2.03	1 20	0 11	010
10180		A	Complex drainage, wound	2.27	3.74	2.12	0.34	010
11000		A	Debride infected skin	0.60	0.78	0.17	0.04	000
11001		A	Debride infected skin add-on	0.30	0 25	0.09	0.02	ZZZ
11004		A	Debride genitalia & perineum	10.80	NA	3.91	1.40	000
11005		A	Debride abdom wall	14 24	NA	5.35	2.21	000
11006		A	Debride genit/per/abdom wall	13.10	NA	4.82	1.72	000
11008		A	Remove mesh from abd wall	5.00	NA	1.88	0.79	ZZZ
11010		A	Debride skin, fx	4.19	8.01	2.91	0.56	010
11011		A	Debride skin/muscle, fx	4.94	8.21	2.63	0.70	000
11012		A	Debride skin/muscle/bone, fx	6.87	10.64	3.89	0.99	000
11040		A	Debride skin, partial	0.50	0.73	0 16	0.03	000
11041		A	Debride skin, full	0.60	0.78	0 20	0.04	000
11042		A	Debride skin/tissue	0.80	1.09	0.29	0.07	000
11043		A	Debride tissue/muscle	3.04	4.10	3.08	0.34	010
11044		A	Debride tissue/muscle/bone	4.11	5.72	4.28	0.53	010
11055		R	Trim skin lesion	0.43	0.86	0 11	0.02	000
11056		R	Trim skin lesions, 2 to 4	0.61	0.93	0.15	0.03	000
11057		R	Trim skin lesions, over 4	0.79	1.04	0.19	0.04	000
11100		A	Biopsy, skin lesion	0.81	1.77	0.48	0.05	000
11101		A	Biopsy, skin add-on	0.41	0.43	0.24	0.02	ZZZ
11200		A	Removal of skin tags	0.79	1.35	1.01	0 05	010
11201		A	Remove skin tags add-on	0.29	0.20	0.15	0.02	ZZZ

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
11300		A	Shave skin lesion	0.51	1.23	0.27	0.03	000
11301		A	Shave skin lesion	0.85	1 50	0.48	0.05	000
11302		A	Shave skin lesion	1.05	1 74	0 60	0 06	000
11303		A	Shave skin lesion	1.24	2 04	0.70	0.08	000
11305		A	Shave skin lesion	0.67	1 13	0.22	0 04	000
11306		A	Shave skin lesion	0.99	1 46	0 43	0 06	000
11307		A	Shave skin lesion	1.14	1 73	0 57	0.07	000
11308		A	Shave skin lesion	1.41	1 79	0.56	0 08	000
11310		A	Shave skin lesion	0.73	1.40	0.40	0 05	000
11311		A	Shave skin lesion	1.05	1.64	0 60	0.07	000
11312		A	Shave skin lesion	1.20	1 90	0 70	0 08	000
11313		A	Shave skin lesion	1.62	2.24	0.92	0 11	000
11400		A	Exc tr-ext b9+marg 0.5 < cm	0.87	2.11	1.10	0 07	010
11401		A	Exc tr-ext b9+marg 0.6-1 cm	1.25	2.38	1.33	0.10	010
11402		A	Exc tr-ext b9+marg 1.1-2 cm	1.42	2.61	1.41	0 13	010
11403		A	Exc tr-ext b9+marg 2.1-3 cm	1.81	2.87	1.84	0.18	010
11404		A	Exc tr-ext b9+marg 3.1-4 cm	2.08	3.25	1.96	0 22	010
11406		A	Exc tr-ext b9+marg > 4.0 cm	3.47	4.16	2.60	0.45	010
11420		A	Exc h-f-nk-sp b9+marg 0.5 <	1.00	2.02	1.05	0.07	010
11421		A	Exc h-f-nk-sp b9+marg 0.6-1	1.44	2.42	1.33	0.12	010
11422		A	Exc h-f-nk-sp b9+marg 1.1-2	1.65	2.65	1.73	0.15	010
11423		A	Exc h-f-nk-sp b9+marg 2.1-3	2.03	2.96	1.91	0.20	010
11424		A	Exc h-f-nk-sp b9+marg 3.1-4	2.45	3.31	2.06	0.26	010
11426		A	Exc h-f-nk-sp b9+marg > 4 cm	4.04	4.16	2.80	0.47	010
11440		A	Exc face-mm b9+marg 0.5 < cm	1.02	2.24	1.52	0.07	010
11441		A	Exc face-mm b9+marg 0.6-1 cm	1.50	2.61	1.77	0.13	010
11442		A	Exc face-mm b9+marg 1.1-2 cm	1.74	2.88	1.89	0.16	010
11443		A	Exc face-mm b9+marg 2.1-3 cm	2.31	3 22	2.16	0.22	010
11444		A	Exc face-mm b9+marg 3.1-4 cm	3.16	3.81	2.57	0.30	010
11446		A	Exc face-mm b9+marg > 4 cm	4.75	4.91	3.43	0.47	010
11450		A	Removal, sweat gland lesion	3.14	6 05	3.00	0.47	090
11451		A	Removal, sweat gland lesion	4.35	7 37	3.58	0.66	090
11462		A	Removal, sweat gland lesion	2.92	6.16	3.01	0.43	090
11463		A	Removal, sweat gland lesion	4.35	7.59	3.66	0 64	090
11470		A	Removal, sweat gland lesion	3.66	6.40	3.27	0 53	090
11471		A	Removal, sweat gland lesion	4.81	7 59	3.79	0.68	090
1150F		I	Doc pt rsk death w/in 1yr	0.00	0.00	0.00	0 00	XXX
1151F		I	Doc no pt rsk death w/in 1yr	0.00	0.00	0.00	0.00	XXX
1152F		I	Doc advncd dis comfort 1st	0.00	0.00	0.00	0 00	XXX
1153F		I	Doc advncd dis cmfrt not 1st	0.00	0.00	0 00	0.00	XXX
1157F		I	Advnc care plan in rcrd	0.00	0 00	0 00	0 00	XXX
1158F		I	Advnc care plan tlk docd	0.00	0.00	0.00	0 00	XXX

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1159F		I	Med list docd in rcrd	0.00	0.00	0.00	0.00	XXX
11600		A	Exc tr-ext mlg+marg 0.5 < cm	1.58	3.07	1 38	0 12	010
11601		A	Exc tr-ext mlg+marg 0.6-1 cm	2.02	3.59	1 73	0.15	010
11602		A	Exc tr-ext mlg+marg 1 1-2 cm	2.22	3.88	1 91	0.16	010
11603		A	Exc tr-ext mlg+marg 2.1-3 cm	2.77	4 22	2 17	0.22	010
11604		A	Exc tr-ext mlg+marg 3.1-4 cm	3 12	4 63	2 30	0.28	010
11606		A	Exc tr-ext mlg+marg > 4 cm	4.97	6.17	3 10	0.56	010
1160F		I	Rvw meds by rx/dr in rcrd	0.00	0.00	0 00	0 00	XXX
11620		A	Exc h-f-nk-sp mlg+marg 0.5 <	1.59	3.13	1.42	0 12	010
11621		A	Exc h-f-nk-sp mlg+marg 0.6-1	2.03	3.62	1 76	0.15	010
11622		A	Exc h-f-nk-sp mlg+marg 1.1-2	2.36	3.96	1 98	0.17	010
11623		A	Exc h-f-nk-sp mlg+marg 2.1-3	3.06	4.39	2.32	0.26	010
11624		A	Exc h-f-nk-sp mlg+marg 3.1-4	3.57	4.83	2 53	0.34	010
11626		A	Exc h-f-nk-sp mlg+mar > 4 cm	4.56	5.59	2.92	0.50	010
11640		A	Exc face-mm malig+marg 0.5 <	1.62	3.26	1.50	0.13	010
11641		A	Exc face-mm malig+marg 0.6-1	2.12	3 74	1.83	0.16	010
11642		A	Exc face-mm malig+marg 1.1-2	2.57	4.15	2 11	0 20	010
11643		A	Exc face-mm malig+marg 2.1-3	3.37	4.59	2.51	0.30	010
11644		A	Exc face-mm malig+marg 3.1-4	4.29	5.54	2 99	0.41	010
11646		A	Exc face-mm mlg+marg > 4 cm	6.21	6.72	3 95	0.63	010
11719		R	Trim nail(s)	0.17	0.40	0.04	0.01	000
11720		A	Debride nail, 1-5	0.32	0.49	0.08	0.02	000
11721		A	Debride nail, 6 or more	0.54	0.57	0 13	0.03	000
11730		A	Removal of nail plate	1.10	1.41	0.27	0.06	000
11732		A	Remove nail plate, add-on	0.57	0.57	0 14	0.03	ZZZ
11740		A	Drain blood from under nail	0.37	0.86	0.46	0.02	000
11750		A	Removal of nail bed	2.40	3.16	1.99	0.14	010
11752		A	Remove nail bed/finger tip	3.48	4.47	3.04	0.28	010
11755		A	Biopsy, nail unit	1.31	2.14	0 80	0.07	000
11760		A	Repair of nail bed	1.60	4 06	1 73	0.17	010
11762		A	Reconstruction of nail bed	2.91	4.19	1.89	0.22	010
11765		A	Excision of nail fold, toe	0 71	2.88	1 07	0.04	010
11770		A	Removal of pilonidal lesion	2.63	4.11	1 92	0 37	010
11771		A	Removal of pilonidal lesion	5 98	8.03	4.69	0.92	090
11772		A	Removal of pilonidal lesion	7.23	9 66	6.87	1.09	090
1180F		I	Thromboemb risk assessed	0.00	0.00	0 00	0.00	XXX
11900		A	Injection into skin lesions	0.52	0.89	0.31	0.03	000
11901		A	Added skin lesions injection	0.80	1.00	0 48	0.04	000
11920		R	Correct skin color defects	1.61	2.68	1 34	0.22	000
11921		R	Correct skin color defects	1.93	3.06	1 54	0 28	000
11922		R	Correct skin color defects	0.49	1.05	0 28	0.07	ZZZ
11950		R	Therapy for contour defects	0.84	1.06	0.55	0 05	000

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11951		R	Therapy for contour defects	1.19	1.48	0.75	0.18	000
11952		R	Therapy for contour defects	1 69	1.45	0.67	0.10	000
11954		R	Therapy for contour defects	1.85	2.22	1.15	0.28	000
11960		A	Insert tissue expander(s)	11.01	NA	11.64	1.31	090
11970		A	Replace tissue expander	7 86	NA	7.48	1.17	090
11971		A	Remove tissue expander(s)	3.21	8.23	4.62	0.47	090
11975		N	Insert contraceptive cap	1.48	1.83	0.54	0.08	XXX
11976		R	Removal of contraceptive cap	1 78	1.81	0.68	0.12	000
11977		N	Removal/reinsert contra cap	3.30	2.52	1.20	0.18	XXX
11980		A	Implant hormone pellet(s)	1 48	1.17	0.62	0.10	000
11981		A	Insert drug implant device	1 48	1.80	0.58	0.18	XXX
11982		A	Remove drug implant device	1 78	1.82	0.67	0.18	XXX
11983		A	Remove/insert drug implant	3.30	2.14	1.12	0.26	XXX
12001		A	Repair superficial wound(s)	1.72	2.18	0.97	0.16	010
12002		A	Repair superficial wound(s)	1.88	2.25	1.09	0.18	010
12004		A	Repair superficial wound(s)	2.26	2.58	1.20	0.22	010
12005		A	Repair superficial wound(s)	2 88	3.12	1.37	0.29	010
12006		A	Repair superficial wound(s)	3.68	3.71	1.66	0.38	010
12007		A	Repair superficial wound(s)	4 13	4.07	1.85	0.45	010
12011		A	Repair superficial wound(s)	1.78	2.34	0.97	0.17	010
12013		A	Repair superficial wound(s)	2.01	2.53	1.12	0.19	010
12014		A	Repair superficial wound(s)	2.48	2.81	1.23	0.24	010
12015		A	Repair superficial wound(s)	3.21	3.39	1.41	0.31	010
12016		A	Repair superficial wound(s)	3 94	3 89	1.62	0.38	010
12017		A	Repair superficial wound(s)	4 72	NA	1.53	0.49	010
12018		A	Repair superficial wound(s)	5 54	NA	1.66	0.34	010
12020		A	Closure of split wound	2 64	4.21	2.09	0.27	010
12021		A	Closure of split wound	1.86	2.13	1.56	0.21	010
12031		A	Intmd wnd repair s/tr/ext	2.17	4.02	2.00	0.19	010
12032		A	Intmd wnd repair s/tr/ext	2.49	5.10	2.45	0.19	010
12034		A	Intmd wnd repair s/tr/ext	2 94	4.80	2.26	0.29	010
12035		A	Intmd wnd repair s/tr/ext	3.44	5.93	2.52	0.41	010
12036		A	Intmd wnd repair s/tr/ext	4.06	6.16	2.70	0.55	010
12037		A	Intmd wnd repair s/tr/ext	4.68	6.76	3.18	0.64	010
12041		A	Intmd wnd repair n-hf/genit	2 39	4 09	2.04	0.20	010
12042		A	Intmd wnd repair n-hg/genit	2.76	4.50	2.35	0.20	010
12044		A	Intmd wnd repair n-hg/genit	3.16	5.73	2.25	0.30	010
12045		A	Intmd wnd repair n-hg/genit	3 65	5.73	2.51	0.40	010
12046		A	Intmd wnd repair n-hg/genit	4.26	8.14	3.53	0.64	010
12047		A	Intmd wnd repair n-hg/genit	4.66	8.41	4.04	0.70	010
12051		A	Intmd wnd repair face/mm	2.49	4.23	2.16	0.21	010
12052		A	Intmd wnd repair face/mm	2.81	4.84	2.75	0.21	010
12053		A	Intmd wnd repair face/mm	3.14	5.45	2.38	0.26	010
12054		A	Intmd wnd repair, face/mm	3.47	5.71	2 33	0.32	010
12055		A	Intmd wnd repair face/mm	4.44	6.55	2.58	0.44	010
12056		A	Intmd wnd repair face/mm	5.25	7.98	2 08	0.79	010
12057		A	Intmd wnd repair face/mm	5.97	8.02	3.41	0.53	010
13100		A	Repair of wound or lesion	3.14	4.63	2.79	0.27	010
13101		A	Repair of wound or lesion	3.93	5 95	3.31	0.30	010
13102		A	Repair wound/lesion add-on	1.24	1 48	0.68	0 14	ZZZ
13120		A	Repair of wound or lesion	3.32	4.75	2.90	0.27	010
13121		A	Repair of wound or lesion	4.36	6 66	3.95	0.31	010
13122		A	Repair wound/lesion add-on	1.44	1.54	0.76	0.15	ZZZ
13131		A	Repair of wound or lesion	3.80	5.13	3.20	0.28	010
13132		A	Repair of wound or lesion	6.48	8.00	5 44	0.43	010
13133		A	Repair wound/lesion add-on	2.19	2.07	1.24	0.19	ZZZ
13150		A	Repair of wound or lesion	3.82	5.08	3.16	0.33	010
13151		A	Repair of wound or lesion	4.46	5.69	3.63	0.33	010
13152		A	Repair of wound or lesion	6.34	7.74	4.53	0.45	010
13153		A	Repair wound/lesion add-on	2.38	2.30	1.31	0.23	ZZZ
13160		A	Late closure of wound	11.84	NA	8.34	1.64	090
14000		A	Skin tissue rearrangement	6.19	9.19	6 40	0.82	090
14001		A	Skin tissue rearrangement	8.58	11.29	7.93	1.13	090
14020		A	Skin tissue rearrangement	7.02	10.24	7.27	0 88	090
14021		A	Skin tissue rearrangement	9.52	12.21	8.73	1.15	090
14040		A	Skin tissue rearrangement	8.44	10.73	7.76	0.97	090
14041		A	Skin tissue rearrangement	10.63	13.06	9.29	1.20	090
14060		A	Skin tissue rearrangement	9.07	10.46	8.13	1.02	090
14061		A	Skin tissue rearrangement	11.25	14.16	10.00	1.27	090
14300		A	Skin tissue rearrangement	13.26	14.78	10.91	1.69	090
14350		A	Skin tissue rearrangement	10.82	NA	7.74	1.13	090
15002		A	Wound prep, trk/arm/leg	3.65	4.95	2.16	0.47	000
15003		A	Wound prep, addl 100 cm	0.80	1 07	0.37	0.12	ZZZ
15004		A	Wound prep, f/n/hf/g	4.58	5.55	2 50	0.45	000
15005		A	Wnd prep, f/n/hf/g, addl cm	1.60	1.51	0.74	0.23	ZZZ
15040		A	Harvest cultured skin graft	2.00	4.43	1 33	0.24	000
15050		A	Skin punch graft	5.37	8.66	5.81	0.66	090
15100		A	Skin split grft, trnk/arm/leg	9.74	11.53	8.19	1.46	090
15101		A	Skin split grft t/a/l, add-on	1.72	2.86	1.08	0.26	ZZZ
15110		A	Epidrm autogrft trnk/arm/leg	10.88	10.49	7.86	1.63	090
15111		A	Epidrm autogrft t/a/l add-on	1.85	1.07	0.79	0.29	ZZZ
15115		A	Epidrm a-grft face/nck/hf/g	11.19	10.42	7 89	1.32	090
15116		A	Epidrm a-grft f/n/hf/g addl	2.50	1.85	1.48	0.37	ZZZ
15120		A	Skn split a-grft fac/nck/hf/g	10.96	13.00	8.98	1.42	090

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15121		A	Skn splt a-grft f/n/hf/g add	2.67	3.98	1.67	0.38	ZZZ
15130		A	Derm autograft, trnk/arm/leg	7.41	9.20	6.61	1.10	090
15131		A	Derm autograft t/a/l add-on	1.50	0.76	0.56	0.24	ZZZ
15135		A	Derm autograft face/nck/hf/g	10.91	10.94	8.41	1.28	090
15136		A	Derm autograft, f/n/hf/g add	1.50	0.73	0 60	0.09	ZZZ
15150		A	Cult epıderm grft t/arm/leg	9.30	7 74	6.29	1 51	090
15151		A	Cult epıderm grft t/a/l addl	2.00	0.97	0.74	0 32	ZZZ
15152		A	Cult epıderm graft t/a/l +%	2.50	1 17	0.93	0.37	ZZZ
15155		A	Cult epıderm graft, f/n/hf/g	10.05	5 79	4.62	0.55	090
15156		A	Cult epıdrm grft f/n/hfg add	2 75	1.43	1.23	0 41	ZZZ
15157		A	Cult epıderm grft f/n/hfg +%	3 00	1.35	1.09	0.16	ZZZ
15170		A	Acell graft trunk/arms/legs	5 99	5.12	3.53	0.82	090
15171		A	Acell graft t/arm/leg add-on	1.55	0.81	0.66	0.24	ZZZ
15175		A	Acellular graft, f/n/hf/g	7.99	5.27	3.80	0.77	090
15176		A	Acell graft, f/n/hf/g add-on	2.45	1.28	1.01	0.30	ZZZ
15200		A	Skın full graft, trunk	8.97	11.57	7.87	1.21	090
15201		A	Skın full graft trunk add-on	1.32	2.36	0.64	0.19	ZZZ
15220		A	Skın full graft sclp/arm/leg	7.95	11.25	7.62	1.02	090
15221		A	Skın full graft add-on	1.19	2.23	0.67	0.16	ZZZ
15240		A	Skın full grft face/genıt/hf	10.15	13.08	10.07	1.25	090
15241		A	Skın full graft add-on	1.86	2.81	1.05	0.23	ZZZ
15260		A	Skın full graft een & lıps	11.39	13 85	10.48	1.24	090
15261		A	Skın full graft add-on	2.23	3.23	1.45	0.22	ZZZ
15300		A	Apply sknallogrft, t/arm/lg	4.65	4.29	2.81	0.64	090
15301		A	Apply sknallogrft t/a/l addl	1.00	0 61	0.46	0.15	ZZZ
15320		A	Apply skin allogrft f/n/hf/g	5.36	4 30	2.71	0.54	090
15321		A	Aply sknallogrft f/n/hfg add	1.50	0.87	0.68	0.23	ZZZ
15330		A	Aply acell alogrft t/arm/leg	3.99	4.26	2.75	0.59	090
15331		A	Aply acell grft t/a/l add-on	1 00	0.61	0.47	0.15	ZZZ
15335		A	Apply acell graft, f/n/hf/g	4.50	3.66	2.25	0.36	090
15336		A	Aply acell grft f/n/hf/g add	1.43	0.55	0.35	0.08	ZZZ
15340		A	Apply cult skın substıtute	3.76	4.24	3.05	0 35	010
15341		A	Apply cult skın sub add-on	0.50	0.73	0.17	0.05	ZZZ
15360		A	Apply cult derm sub, t/a/l	3.93	5.08	3.71	0.42	090
15361		A	Aply cult derm sub t/a/l add	1 15	0.65	0.45	0.15	ZZZ
15365		A	Apply cult derm sub f/n/hf/g	4.21	4.46	3.25	0.29	090
15366		A	Apply cult derm f/hf/g add	1 45	0 63	0 43	0.11	ZZZ
15400		A	Apply skın xenograft, t/a/l	4 38	6.01	4.64	0.51	090
15401		A	Apply skn xenogrft t/a/l add	1.00	1.16	0.42	0.15	ZZZ
15420		A	Apply skın xgraft, f/n/hf/g	4 89	6.22	4.92	0.49	090
15421		A	Apply skn xgrft f/n/hf/g add	1.50	1.42	0.67	0.22	ZZZ
15430		A	Apply acellular xenograft	5.93	7.59	6.97	0.71	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
15431		C	Apply acellular xgraft add	0.00	0.00	0.00	0 00	ZZZ
15570		A	Form skın pedıcle flap	10.00	12.12	8.01	1.53	090
15572		A	Form skın pedıcle flap	9.94	11.85	8.65	1 35	090
15574		A	Form skın pedıcle flap	10 52	12.29	8.89	1.20	090
15576		A	Form skın pedıcle flap	9.24	11.04	7.92	1.02	090
15600		A	Skın graft	1.95	5.92	3.16	0 28	090
15610		A	Skın graft	2.46	6.23	3.54	0.35	090
15620		A	Skın graft	3.62	7.09	4.45	0.45	090
15630		A	Skın graft	3.95	7 38	4.73	0.48	090
15650		A	Transfer skın pedıcle flap	4.64	7.70	4.88	0.56	090
15731		A	Forehead flap w/vasc pedıcle	14.12	14.54	11.81	1.77	090
15732		A	Muscle-skın graft, head/neck	19.70	18.32	14.55	2.15	090
15734		A	Muscle-skın graft, trunk	19.62	18.52	14.33	2.98	090
15736		A	Muscle-skın graft, arm	16.92	16.40	12.28	2.52	090
15738		A	Muscle-skın graft, leg	18.92	16.58	12 72	2.86	090
15740		A	Island pedıcle flap graft	11.57	14.05	10.37	1.29	090
15750		A	Neurovascular pedıcle graft	12.73	NA	10.43	1.70	090
15756		A	Free myo/skın flap mıcrovasc	36.74	NA	23.73	4.72	090
15757		A	Free skın flap, mıcrovasc	36.95	NA	22 86	4.33	090
15758		A	Free fascıal flap, mıcrovasc	36.70	NA	22.27	4.15	090
15760		A	Composite skın graft	9.68	11.73	8 38	1.10	090
15770		A	Derma-fat-fascıa graft	8.73	NA	7 99	1.11	090
15775		R	Haır transplant punch grafts	3.95	3.57	1.79	0.21	000
15776		R	Haır transplant punch grafts	5.53	4.89	2.37	0.30	000
15780		A	Abrasıon treatment of skın	8.50	11.86	7.11	0.89	090
15781		A	Abrasıon treatment of skın	4.91	8.60	5.84	0.57	090
15782		A	Abrasıon treatment of skın	4.36	9.13	5.35	0.47	090
15783		A	Abrasıon treatment of skın	4.33	7.73	5.16	0.46	090
15786		A	Abrasıon, lesıon, sıngle	2.05	4.17	1.52	0 18	010
15787		A	Abrasıon, lesıons, add-on	0.33	0.92	0.16	0 02	ZZZ
15788		R	Chemıcal peel, face, epıderm	2.09	9.46	4.27	0.27	090
15789		R	Chemıcal peel, face, dermal	4.91	8.73	5.67	0.53	090
15792		R	Chemıcal peel, nonfacıal	1.86	9.00	4.75	0.23	090
15793		A	Chemıcal peel, nonfacıal	3.82	8.15	5.21	0 41	090
15819		A	Plastıc surgery, neck	10.45	NA	7.89	1.56	090
15820		A	Revısıon of lower eyelıd	6.09	8.03	6.76	0 32	090
15821		A	Revısıon of lower eyelıd	6.66	8.55	7.10	0.49	090
15822		A	Revısıon of upper eyelıd	4.51	6.57	5.31	0.31	090
15823		A	Revısıon of upper eyelıd	8.12	9.70	8.29	0.49	090
15824		R	Removal of forehead wrınkles	0.00	0.00	0.00	0.00	000
15825		R	Removal of neck wrınkles	0.00	0.00	0.00	0.00	000
15826		R	Removal of brow wrınkles	0.00	0.00	0.00	0.00	000

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
15828		R	Removal of face wrinkles	0.00	0.00	0.00	0.00	000
15829		R	Removal of skin wrinkles	0.00	0.00	0.00	0.00	000
15830		R	Exc skin abd	16.90	NA	12.60	2.48	090
15832		A	Excise excessive skin tissue	12.65	NA	9.94	1.88	090
15833		A	Excise excessive skin tissue	11.70	NA	10.42	1.75	090
15834		A	Excise excessive skin tissue	11.97	NA	10.59	1.79	090
15835		A	Excise excessive skin tissue	12.79	NA	8.25	2.07	090
15836		A	Excise excessive skin tissue	10.41	NA	7.30	1.56	090
15837		A	Excise excessive skin tissue	9.37	10.30	6.84	1.52	090
15838		A	Excise excessive skin tissue	8.07	NA	6.62	0.79	090
15839		A	Excise excessive skin tissue	10.32	11.51	8.07	1.44	090
15840		A	Graft for face nerve palsy	14.76	NA	11.42	1.68	090
15841		A	Graft for face nerve palsy	25.69	NA	16.17	2.51	090
15842		A	Flap for face nerve palsy	40.68	NA	28.59	3.97	090
15845		A	Skin and muscle repair, face	14.04	NA	11.90	0.89	090
15847		C	Exc skin abd add-on	0.00	0.00	0.00	0.00	YYY
15850		B	Removal of sutures	0.78	1.38	0.28	0.04	XXX
15851		A	Removal of sutures	0.86	1.56	0.34	0.06	000
15852		A	Dressing change not for burn	0.86	NA	0.33	0.09	000
15860		A	Test for blood flow in graft	1.95	NA	1.16	0.29	000
15876		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15877		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15878		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15879		R	Suction assisted lipectomy	0.00	0.00	0.00	0.00	000
15920		A	Removal of tail bone ulcer	8.15	NA	6.85	1.29	090
15922		A	Removal of tail bone ulcer	10.23	NA	9.61	1.53	090
15931		A	Remove sacrum pressure sore	9.96	NA	6.95	1.58	090
15933		A	Remove sacrum pressure sore	11.60	NA	9.44	1.81	090
15934		A	Remove sacrum pressure sore	13.54	NA	9.69	2.09	090
15935		A	Remove sacrum pressure sore	15.58	NA	12.17	2.37	090
15936		A	Remove sacrum pressure sore	13.04	NA	9.32	2.00	090
15937		A	Remove sacrum pressure sore	15.00	NA	11.10	2.28	090
15940		A	Remove hip pressure sore	10.11	NA	7.25	1.56	090
15941		A	Remove hip pressure sore	12.24	NA	10.51	1.86	090
15944		A	Remove hip pressure sore	12.27	NA	10.06	1.88	090
15945		A	Remove hip pressure sore	13.57	NA	11.28	2.05	090
15946		A	Remove hip pressure sore	23.80	NA	17.42	3.60	090
15950		A	Remove thigh pressure sore	7.91	NA	6.42	1.22	090
15951		A	Remove thigh pressure sore	11.41	NA	8.41	1.71	090
15952		A	Remove thigh pressure sore	12.14	NA	8.19	1.97	090
15953		A	Remove thigh pressure sore	13.39	NA	11.92	2.00	090
15956		A	Remove thigh pressure sore	16.59	NA	12.10	2.54	090
15958		A	Remove thigh pressure sore	16.55	NA	12.84	2.53	090
15999		C	Removal of pressure sore	0.00	0.00	0.00	0.00	YYY
16000		A	Initial treatment of burn(s)	0.89	0.91	0.33	0.07	000
16020		A	Dress/debrid p-thick burn, s	0.80	1.35	0.71	0.07	000
16025		A	Dress/debrid p-thick burn, m	1.85	2.00	1.17	0.19	000
16030		A	Dress/debrid p-thick burn, l	2.08	2.52	1.34	0.25	000
16035		A	Incision of burn scab, multi	3.74	NA	1.36	0.46	000
16036		A	Escharotomy; addl incision	1.50	NA	0.64	0.19	ZZZ
17000		A	Destruct premalg lesion	0.62	1.36	0.77	0.04	010
17003		A	Destruct premalg les, 2-14	0.07	0.10	0.04	0.00	ZZZ
17004		A	Destroy premlg lesions 15+	1.82	2.43	1.51	0.10	010
17106		A	Destruction of skin lesions	3.61	4.22	3.27	0.38	090
17107		A	Destruction of skin lesions	4.68	5.44	3.98	0.52	090
17108		A	Destruction of skin lesions	6.37	7.16	5.05	0.81	090
17110		A	Destruct b9 lesion, 1-14	0.67	2.03	1.06	0.04	010
17111		A	Destruct lesion, 15 or more	0.94	2.29	1.21	0.05	010
17250		A	Chemical cautery, tissue	0.50	1.45	0.43	0.05	000
17260		A	Destruction of skin lesions	0.93	1.39	0.78	0.05	010
17261		A	Destruction of skin lesions	1.19	2.33	1.12	0.07	010
17262		A	Destruction of skin lesions	1.60	2.69	1.37	0.09	010
17263		A	Destruction of skin lesions	1.81	2.93	1.50	0.10	010
17264		A	Destruction of skin lesions	1.96	3.13	1.57	0.11	010
17266		A	Destruction of skin lesions	2.36	3.43	1.79	0.15	010
17270		A	Destruction of skin lesions	1.34	2.36	1.19	0.08	010
17271		A	Destruction of skin lesions	1.51	2.54	1.32	0.09	010
17272		A	Destruction of skin lesions	1.79	2.84	1.49	0.10	010
17273		A	Destruction of skin lesions	2.07	3.10	1.65	0.12	010
17274		A	Destruction of skin lesions	2.61	3.53	1.95	0.15	010
17276		A	Destruction of skin lesions	3.22	3.94	2.28	0.21	010
17280		A	Destruction of skin lesions	1.19	2.26	1.10	0.07	010
17281		A	Destruction of skin lesions	1.74	2.65	1.45	0.10	010
17282		A	Destruction of skin lesions	2.06	3.04	1.64	0.12	010
17283		A	Destruction of skin lesions	2.66	3.51	1.99	0.15	010
17284		A	Destruction of skin lesions	3.23	3.97	2.31	0.19	010
17286		A	Destruction of skin lesions	4.45	4.72	2.97	0.32	010
17311		A	Mohs, 1 stage, h/n/hf/g	6.20	10.16	3.75	0.35	000
17312		A	Mohs add stage	3.30	6.40	1.99	0.19	ZZZ
17313		A	Mohs, 1 stage, t/a/l	5.56	9.34	3.36	0.32	000
17314		A	Mohs, addl stage, t/a/l	3.06	5.93	1.85	0.17	ZZZ
17315		A	Mohs surg, addl block	0.87	1.13	0.53	0.05	ZZZ
17340		A	Cryotherapy of skin	0.76	0.54	0.48	0.05	010
17360		A	Skin peel therapy	1.44	1.82	1.11	0.08	010

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17380		R	Hair removal by electrolysis	0.00	0.00	0.00	0.00	000
17999		C	Skin tissue procedure	0.00	0.00	0.00	0.00	YYY
19000		A	Drainage of breast lesion	0.84	1 86	0.28	0.09	000
19001		A	Drain breast lesion add-on	0.42	0.25	0.14	0.04	ZZZ
19020		A	Incision of breast lesion	3.74	7.66	3.68	0.58	090
19030		A	Injection for breast x-ray	1.53	2.40	0.46	0.11	000
19100		A	Bx breast percut w/o image	1 27	2.40	0.47	0.19	000
19101		A	Biopsy of breast, open	3.20	5.11	2.24	0.49	010
19102		A	Bx breast percut w/image	2 00	3.19	0.62	0.17	000
19103		A	Bx breast percut w/device	3 69	9.61	1.19	0.36	000
19105		A	Cryosurg ablate fa, each	3.69	44.65	1.31	0.28	000
19110		A	Nipple exploration	4.35	7.57	4.03	0.70	090
19112		A	Excise breast duct fistula	3.72	7.52	3 90	0.60	090
19120		A	Removal of breast lesion	5.84	6.19	4 27	0.94	090
19125		A	Excision, breast lesion	6.59	6.78	4.64	1.06	090
19126		A	Excision, addl breast lesion	2.93	NA	1.09	0.47	ZZZ
19260		A	Removal of chest wall lesion	17.60	NA	12.21	2.95	090
19271		A	Revision of chest wall	21.86	NA	18 49	3.79	090
19272		A	Extensive chest wall surgery	24.82	NA	19 36	4.45	090
19290		A	Place needle wire, breast	1.27	2.62	0.39	0.10	000
19291		A	Place needle wire, breast	0.63	1.04	0.19	0.05	ZZZ
19295		A	Place breast clip, percut	0.00	2.12	NA	0.00	ZZZ
19296		A	Place po breast cath for rad	3.63	94.74	1.62	0.57	000
19297		A	Place breast cath for rad	1.72	NA	0.64	0.27	ZZZ
19298		A	Place breast rad tube/caths	6.00	21.64	2.42	0.58	000
19300		A	Removal of breast tissue	5.20	7 44	4 78	0.83	090
19301		A	Partical mastectomy	10.00	NA	6.02	1.60	090
19302		A	P-mastectomy w/ln removal	13.88	NA	8.10	2.23	090
19303		A	Mast, simple, complete	15 67	NA	9.20	2.52	090
19304		A	Mast, subq	7.81	NA	6.17	1.24	090
19305		A	Mast, radical	17.23	NA	10.55	2.77	090
19306		A	Mast, rad, urban type	17.85	NA	11.51	2.86	090
19307		A	Mast, mod rad	17.95	NA	11.38	2.89	090
19316		A	Suspension of breast	10.98	NA	8.49	1.65	090
19318		A	Reduction of large breast	15.91	NA	12.34	2.38	090
19324		A	Enlarge breast	6.65	NA	5.28	1.08	090
19325		A	Enlarge breast with implant	8.52	NA	7.81	1.26	090
19328		A	Removal of breast implant	6.35	NA	6.08	0.95	090
19330		A	Removal of implant material	8.39	NA	7.52	1.25	090
19340		A	Immediate breast prosthesis	6.32	NA	3.70	0.94	ZZZ
19342		A	Delayed breast prosthesis	12.40	NA	10 99	1.83	090
19350		A	Breast reconstruction	8.99	11.62	8.06	1.33	090
19355		A	Correct inverted nipple(s)	8.37	8.75	5.57	1 36	090
19357		A	Breast reconstruction	20.57	NA	18 82	3.04	090
19361		A	Breast reconstr w/lat flap	23.17	NA	20.51	3.46	090
19364		A	Breast reconstruction	42.40	NA	28 54	6.19	090
19366		A	Breast reconstruction	21.70	NA	13.02	3.38	090
19367		A	Breast reconstruction	26.59	NA	19.10	3.94	090
19368		A	Breast reconstruction	33.61	NA	23.17	5 03	090
19369		A	Breast reconstruction	31.02	NA	21.63	4 64	090
19370		A	Surgery of breast capsule	8.99	NA	8.30	1 33	090
19371		A	Removal of breast capsule	10.42	NA	9.39	1.54	090
19380		A	Revise breast reconstruction	10.21	NA	9.27	1.52	090
19396		A	Design custom breast implant	2.17	4.72	1.13	0.35	000
19499		C	Breast surgery procedure	0.00	0.00	0.00	0.00	YYY
20000		A	Incision of abscess	2.14	3.03	1.69	0.17	010
20005		A	Incision of deep abscess	3.55	4.18	2 36	0.41	010
20100		A	Explore wound, neck	10.33	NA	4.78	1.37	010
20101		A	Explore wound, chest	3.22	6.58	1.70	0.52	010
20102		A	Explore wound, abdomen	3.95	8.03	2.37	0.59	010
20103		A	Explore wound, extremity	5.31	9 14	3.48	0.71	010
20150		A	Excise epiphyseal bar	14.60	NA	8.33	2 19	090
20200		A	Muscle biopsy	1.46	3.49	0.86	0 24	000
20205		A	Deep muscle biopsy	2.35	4.57	1.43	0.37	000
20206		A	Needle biopsy, muscle	0.99	3.61	0.53	0.08	000
20220		A	Bone biopsy, trocar/needle	1.27	2.50	0 62	0.09	000
20225		A	Bone biopsy, trocar/needle	1.87	8.33	0 96	0.18	000
20240		A	Bone biopsy, excisional	3.25	NA	2.33	0.33	010
20245		A	Bone biopsy, excisional	8.77	NA	6.78	1.17	010
20250		A	Open bone biopsy	5.16	NA	4.12	0 91	010
20251		A	Open bone biopsy	5.69	NA	4.49	1 02	010
20500		A	Injection of sinus tract	1.25	1.36	0.90	0 09	010
20501		A	Inject sinus tract for x-ray	0.76	2.16	0.23	0 06	000
2050F		I	Wound char size etc docd	0.00	0.00	0.00	0.00	XXX
20520		A	Removal of foreign body	1.87	3.11	1.78	0.19	010
20525		A	Removal of foreign body	3.51	8.29	2.71	0.47	010
20526		A	Ther injection, carp tunnel	0.94	0.95	0.52	0.10	000
20550		A	Inj tendon sheath/ligament	0.75	0 72	0.33	0.06	000
20551		A	Inj tendon origin/insertion	0.75	0.79	0.38	0.06	000
20552		A	Inj trigger point, 1/2 muscl	0.66	0.72	0.33	0 05	000
20553		A	Inject trigger points, =/> 3	0.75	0.85	0.37	0.04	000
20555		A	Place ndl musc/tis for rt	6.00	NA	2.57	0 48	000
20600		A	Drain/inject, joint/bursa	0.66	0 73	0.35	0.05	000
20605		A	Drain/inject, joint/bursa	0.68	0.83	0.38	0 06	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
20610		A	Drain/inject, joint/bursa	0.79	1.22	0.49	0.09	000
20612		A	Aspirate/inj ganglion cyst	0.70	0.82	0.39	0.07	000
20615		A	Treatment of bone cyst	2.30	3.06	1.67	0.19	010
20650		A	Insert and remove bone pin	2.25	2.76	1.61	0.21	010
20660		A	Apply, rem fixation device	4 00	NA	1.85	0.81	000
20661		A	Application of head brace	5.14	NA	6.62	1.22	090
20662		A	Application of pelvis brace	6 26	NA	3.98	0 45	090
20663		A	Application of thigh brace	5.62	NA	5.82	0.84	090
20664		A	Halo brace application	9.86	NA	8.81	2.68	090
20665		A	Removal of fixation device	1 33	1.33	0.99	0.09	010
20670		A	Removal of support implant	1 76	7.58	1.94	0.21	010
20680		A	Removal of support implant	5.90	9.47	4.80	0.78	090
20690		A	Apply bone fixation device	8.65	NA	6.00	1.21	090
20692		A	Apply bone fixation device	16.00	NA	11.92	2.08	090
20693		A	Adjust bone fixation device	5.97	NA	5.36	0.80	090
20694		A	Remove bone fixation device	4.20	6.25	4.19	0.58	090
20696		A	Comp multiplane ext fixation	17.32	NA	10 03	0.93	090
20697		A	Comp ext fixate strut change	0.00	39.58	NA	0.00	000
20802		A	Replantation, arm, complete	42.30	NA	19.21	2.27	090
20805		A	Replant forearm, complete	51.14	NA	30.91	7.65	090
20808		A	Replantation hand, complete	62.77	NA	42.53	9.40	090
20816		A	Replantation digit, complete	31.74	NA	19.84	2.99	090
20822		A	Replantation digit, complete	26.42	NA	17.72	3.95	090
20824		A	Replantation thumb, complete	31.74	NA	19.93	4.75	090
20827		A	Replantation thumb, complete	27.24	NA	18.12	4.08	090
20838		A	Replantation foot, complete	42.56	NA	21.27	2.21	090
20900		A	Removal of bone for graft	3.00	7.32	2.50	0.42	000
20902		A	Removal of bone for graft	4.58	NA	3.16	0.67	000
20910		A	Remove cartilage for graft	5.41	NA	5.12	0.53	090
20912		A	Remove cartilage for graft	6.42	NA	5.88	0.73	090
20920		A	Removal of fascia for graft	5.42	NA	4.78	0.39	090
20922		A	Removal of fascia for graft	6.84	7.90	5.41	0.91	090
20924		A	Removal of tendon for graft	6.59	NA	5.98	0.89	090
20926		A	Removal of tissue for graft	5.70	NA	5.21	0.86	090
20930		B	Sp bone algrft morsel add-on	0.00	0.00	0.00	0.00	XXX
20931		A	Sp bone algrft struct add-on	1 81	NA	0.85	0.42	ZZZ
20936		B	Sp bone agrft local add-on	0.00	0.00	0.00	0.00	XXX
20937		A	Sp bone agrft morsel add-on	2.79	NA	1.36	0.51	ZZZ
20938		A	Sp bone agrft struct add-on	3 02	NA	1.45	0.61	ZZZ
20950		A	Fluid pressure, muscle	1.26	4.72	1.02	0.16	000
20955		A	Fibula bone graft, microvasc	40.02	NA	23.48	4.39	090
20956		A	Iliac bone graft, microvasc	40.93	NA	25.30	6.13	090
20957		A	Mt bone graft, microvasc	42.33	NA	26.49	6.34	090
20962		A	Other bone graft, microvasc	39.21	NA	27.64	5.87	090
20969		A	Bone/skin graft, microvasc	45.11	NA	26.77	4.79	090
20970		A	Bone/skin graft, iliac crest	44.26	NA	27.31	6.63	090
20972		A	Bone/skin graft, metatarsal	44.19	NA	14.56	2.40	090
20973		A	Bone/skin graft, great toe	46.95	NA	20.75	2.51	090
20974		A	Electrical bone stimulation	0.62	1.22	0.61	0.10	000
20975		A	Electrical bone stimulation	2.60	NA	1.76	0.43	000
20979		A	Us bone stimulation	0.62	0.72	0 23	0.06	000
20982		A	Ablate, bone tumor(s) perq	7.27	77.70	2 49	0.57	000
20985		A	Cptr-asst dir ms px	2.50	NA	1 23	0.37	ZZZ
20999		C	Musculoskeletal surgery	0.00	0.00	0.00	0.00	YYY
21010		A	Incision of jaw joint	10.90	NA	8.94	0.30	090
21015		A	Resection of facial tumor	5.59	NA	5.23	0.79	090
21025		A	Excision of bone, lower jaw	7.23	10.13	7.05	0.44	090
21026		A	Excision of facial bone(s)	5.54	9.10	6.41	0.39	090
21029		A	Contour of face bone lesion	8.26	10.96	7.85	0.96	090
21030		A	Excise max/zygoma b9 tumor	4.80	7.57	5.28	0.21	090
21031		A	Remove exostosis, mandible	3.26	6.03	3.83	0.09	090
21032		A	Remove exostosis, maxilla	3.28	6.21	3.79	0.11	090
21034		A	Excise max/zygoma mlg tumor	17.17	16.08	12.35	1.62	090
21040		A	Excise mandible lesion	4.80	7.53	5.22	0.17	090
21044		A	Removal of jaw bone lesion	12.61	NA	9.62	1.17	090
21045		A	Extensive jaw surgery	18.13	NA	12.73	1.59	090
21046		A	Remove mandible cyst complex	13.97	NA	12.26	0.47	090
21047		A	Excise lwr jaw cyst w/repair	19.83	NA	9.44	0.54	090
21048		A	Remove maxilla cyst complex	14.47	NA	13.55	0.54	090
21049		A	Excis uppr jaw cyst w/repair	19.08	NA	12.72	1.86	090
21050		A	Removal of jaw joint	11.54	NA	10.10	1.73	090
21060		A	Remove jaw joint cartilage	10.91	NA	10.01	0.30	090
21070		A	Remove coronoid process	8.50	NA	5.50	0.83	090
21073		A	Mnpj of tmj w/anesth	3.33	5.99	3.11	0.09	090
21076		A	Prepare face/oral prosthesis	13.40	11.42	8.32	0.38	010
21077		A	Prepare face/oral prosthesis	33.70	27.90	21.69	0.92	090
21079		A	Prepare face/oral prosthesis	22.31	19.47	14.02	0.67	090
21080		A	Prepare face/oral prosthesis	25.06	21.95	15.36	0.75	090
21081		A	Prepare face/oral prosthesis	22.85	19.98	13.92	0.67	090
21082		A	Prepare face/oral prosthesis	20.84	20.59	14.42	0.57	090
21083		A	Prepare face/oral prosthesis	19.27	20.08	13.46	0.53	090
21084		A	Prepare face/oral prosthesis	22.48	22.68	15.41	0.61	090
21085		A	Prepare face/oral prosthesis	8.99	8.87	5.70	0.27	010
21086		A	Prepare face/oral prosthesis	24.88	19.82	15.66	0.69	090

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21087		A	Prepare face/oral prosthesis	24.88	19.37	15.21	0.75	090
21088		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	090
21089		C	Prepare face/oral prosthesis	0.00	0.00	0.00	0.00	YYY
21100		A	Maxillofacial fixation	4.56	13.17	5.03	0.48	090
21110		A	Interdental fixation	5.80	13.91	10.81	0.19	090
21116		A	Injection, jaw joint,x-ray	0.81	3.15	0.38	0.05	000
21120		A	Reconstruction of chin	4.99	11.42	8.14	0.75	090
21121		A	Reconstruction of chin	7.70	9.26	6.72	0.21	090
21122		A	Reconstruction of chin	8.59	NA	7.93	0.46	090
21123		A	Reconstruction of chin	11.22	NA	11.87	0.31	090
21125		A	Augmentation, lower jaw bone	10.68	77.93	10.07	1.60	090
21127		A	Augmentation, lower jaw bone	12.24	84.54	8.92	1.19	090
21137		A	Reduction of forehead	10.12	NA	9.11	0.54	090
21138		A	Reduction of forehead	12.73	NA	10.42	1.36	090
21139		A	Reduction of forehead	14.90	NA	9.28	0.80	090
21141		A	Reconstruct midface, lefort	19.27	NA	10.00	0.53	090
21142		A	Reconstruct midface, lefort	19.98	NA	16.27	2.99	090
21143		A	Reconstruct midface, lefort	20.75	NA	13.64	3.36	090
21145		A	Reconstruct midface, lefort	23.64	NA	11.03	0.65	090
21146		A	Reconstruct midface, lefort	24.54	NA	19.69	3.67	090
21147		A	Reconstruct midface, lefort	26.14	NA	12.14	0.71	090
21150		A	Reconstruct midface, lefort	25.78	NA	14.78	1.38	090
21151		A	Reconstruct midface, lefort	28.84	NA	19.84	2.81	090
21154		A	Reconstruct midface, lefort	31.05	NA	21.25	3.03	090
21155		A	Reconstruct midface, lefort	34.98	NA	16.69	0.96	090
21159		A	Reconstruct midface, lefort	42.90	NA	26.82	4.18	090
21160		A	Reconstruct midface, lefort	46.95	NA	22.80	2.51	090
21172		A	Reconstruct orbit/forehead	28.07	NA	20.24	1.46	090
21175		A	Reconstruct orbit/forehead	33.43	NA	21.91	9.09	090
21179		A	Reconstruct entire forehead	22.53	NA	13.50	3.37	090
21180		A	Reconstruct entire forehead	25.46	NA	14.95	2.48	090
21181		A	Contour cranial bone lesion	10.18	NA	7.19	0.99	090
21182		A	Reconstruct cranial bone	32.45	NA	18.20	3.16	090
21183		A	Reconstruct cranial bone	35.57	NA	24.08	1.85	090
21184		A	Reconstruct cranial bone	38.49	NA	23.33	5.76	090
21188		A	Reconstruction of midface	22.97	NA	21.89	2.24	090
21193		A	Reconst lwr jaw w/o graft	18.65	NA	10.20	0.51	090
21194		A	Reconst lwr jaw w/graft	21.54	NA	14.12	2.10	090
21195		A	Reconst lwr jaw w/o fixation	18.88	NA	15.74	1.84	090
21196		A	Reconst lwr jaw w/fixation	20.55	NA	15.77	1.63	090
21198		A	Reconstr lwr jaw segment	15.48	NA	13.56	1.48	090
21199		A	Reconstr lwr jaw w/advance	16.62	NA	9.89	1.62	090
21206		A	Reconstruct upper jaw bone	15.36	NA	16.28	2.30	090
21208		A	Augmentation of facial bones	11.15	27.01	6.85	0.30	090
21209		A	Reduction of facial bones	7.58	15.21	9.78	0.21	090
21210		A	Face bone graft	11.40	43.37	10.09	0.44	090
21215		A	Lower jaw bone graft	11.94	80.18	9.75	0.40	090
21230		A	Rib cartilage graft	11.06	NA	9.26	1.66	090
21235		A	Ear cartilage graft	7.31	11.00	7.15	0.79	090
21240		A	Reconstruction of jaw joint	15.77	NA	10.54	0.56	090
21242		A	Reconstruction of jaw joint	14.32	NA	7.87	1.40	090
21243		A	Reconstruction of jaw joint	24.03	NA	20.16	0.66	090
21244		A	Reconstruction of lower jaw	13.35	NA	12.95	1.14	090
21245		A	Reconstruction of jaw	12.88	15.57	10.06	1.26	090
21246		A	Reconstruction of jaw	12.78	NA	8.69	1.25	090
21247		A	Reconstruct lower jaw bone	24.05	NA	15.87	3.60	090
21248		A	Reconstruction of jaw	12.54	14.42	9.77	0.44	090
21249		A	Reconstruction of jaw	18.57	14.02	9.03	0.51	090
21255		A	Reconstruct lower jaw bone	18.14	NA	16.07	1.77	090
21256		A	Reconstruction of orbit	17.42	NA	13.94	0.91	090
21260		A	Revise eye sockets	17.74	NA	12.24	0.95	090
21261		A	Revise eye sockets	33.78	NA	23.56	5.06	090
21263		A	Revise eye sockets	30.72	NA	18.73	1.65	090
21267		A	Revise eye sockets	20.45	NA	20.48	1.06	090
21268		A	Revise eye sockets	26.78	NA	28.31	1.43	090
21270		A	Augmentation, cheek bone	10.52	14.32	8.66	1.13	090
21275		A	Revision, orbitofacial bones	11.65	NA	9.83	1.74	090
21280		A	Revision of eyelid	6.92	NA	7.43	0.45	090
21282		A	Revision of eyelid	4.11	NA	5.35	0.33	090
21295		A	Revision of jaw muscle/bone	1.82	NA	2.61	0.27	090
21296		A	Revision of jaw muscle/bone	4.67	NA	4.64	0.46	090
21299		C	Cranio/maxillofacial surgery	0.00	0.00	0.00	0.00	YYY
21310		A	Treatment of nose fracture	0.58	2.40	0.14	0.06	000
21315		A	Treatment of nose fracture	1.78	5.02	1.97	0.15	010
21320		A	Treatment of nose fracture	1.86	4.57	1.61	0.14	010
21325		A	Treatment of nose fracture	4.07	NA	7.72	0.47	090
21330		A	Treatment of nose fracture	5.68	NA	8.49	0.55	090
21335		A	Treatment of nose fracture	8.91	NA	9.77	0.91	090
21336		A	Treat nasal septal fracture	6.56	NA	9.63	0.67	090
21337		A	Treat nasal septal fracture	3.26	6.69	4.06	0.36	090
21338		A	Treat nasoethmoid fracture	6.76	NA	12.07	1.01	090
21339		A	Treat nasoethmoid fracture	8.39	NA	13.04	1.26	090
21340		A	Treatment of nose fracture	11.33	NA	8.18	1.10	090
21343		A	Treatment of sinus fracture	14.11	NA	16.71	1.38	090

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21344		A	Treatment of sinus fracture	21.36	NA	18.35	3.20	090
21345		A	Treat nose/jaw fracture	8.87	11 17	7.37	0.87	090
21346		A	Treat nose/jaw fracture	11.29	NA	12.14	1.10	090
21347		A	Treat nose/jaw fracture	13.37	NA	12.93	1.30	090
21348		A	Treat nose/jaw fracture	17.36	NA	11.14	1.69	090
21355		A	Treat cheek bone fracture	4.32	6 60	3.91	0.28	010
21356		A	Treat cheek bone fracture	4.70	7.47	4.62	0.34	010
21360		A	Treat cheek bone fracture	7.03	NA	6.28	0.69	090
21365		A	Treat cheek bone fracture	16.52	NA	11 43	1.66	090
21366		A	Treat cheek bone fracture	18 44	NA	14 38	1.80	090
21385		A	Treat eye socket fracture	9.46	NA	8.29	0.92	090
21386		A	Treat eye socket fracture	9 46	NA	6.85	1.42	090
21387		A	Treat eye socket fracture	10.00	NA	8.54	0.98	090
21390		A	Treat eye socket fracture	11.07	NA	9.14	1.02	090
21395		A	Treat eye socket fracture	14.62	NA	9.25	1.43	090
21400		A	Treat eye socket fracture	1.44	3.13	2.29	0.17	090
21401		A	Treat eye socket fracture	3.57	7.94	3.75	0.53	090
21406		A	Treat eye socket fracture	7.31	NA	6.01	0.71	090
21407		A	Treat eye socket fracture	8.91	NA	7.62	0.92	090
21408		A	Treat eye socket fracture	12.67	NA	10.46	1.90	090
21421		A	Treat mouth roof fracture	5.80	12.80	9.96	0.87	090
21422		A	Treat mouth roof fracture	8.62	NA	8.17	0.74	090
21423		A	Treat mouth roof fracture	10.71	NA	8.87	0.96	090
21431		A	Treat craniofacial fracture	7.74	NA	12.14	1.16	090
21432		A	Treat craniofacial fracture	8.76	NA	7.91	0.85	090
21433		A	Treat craniofacial fracture	26.13	NA	15.20	3.91	090
21435		A	Treat craniofacial fracture	20.02	NA	13.02	1.95	090
21436		A	Treat craniofacial fracture	30 01	NA	22.61	1.61	090
21440		A	Treat dental ridge fracture	3.28	10.24	7.85	0.09	090
21445		A	Treat dental ridge fracture	6.04	13.03	9.57	0.17	090
21450		A	Treat lower jaw fracture	3.55	10 56	8.07	0.10	090
21451		A	Treat lower jaw fracture	5.46	13.42	10.46	0.15	090
21452		A	Treat lower jaw fracture	2.29	11.34	6.03	0.34	090
21453		A	Treat lower jaw fracture	6.40	14.95	12.01	0.40	090
21454		A	Treat lower jaw fracture	7 17	NA	7.31	0.20	090
21461		A	Treat lower jaw fracture	9.07	41.24	13.65	0.71	090
21462		A	Treat lower jaw fracture	10.77	41.30	14.02	0.69	090
21465		A	Treat lower jaw fracture	12.88	NA	7.23	0.35	090
21470		A	Treat lower jaw fracture	17 24	NA	12.32	1.25	090
21480		A	Reset dislocated jaw	0.61	1.65	0.22	0.05	000
21485		A	Reset dislocated jaw	4 58	12.66	9.87	0.15	090
21490		A	Repair dislocated jaw	12.71	NA	7.14	0.35	090

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21495		A	Treat hyoid bone fracture	6 55	NA	11.40	0.35	090
21497		A	Interdental wiring	4 45	12.38	9 79	0.12	090
21499		C	Head surgery procedure	0 00	0.00	0 00	0.00	YYY
21501		A	Drain neck/chest lesion	3.87	7.35	4 10	0.55	090
21502		A	Drain chest lesion	7 43	NA	5 72	1.20	090
21510		A	Drainage of bone lesion	6 06	NA	4.79	1.08	090
21550		A	Biopsy of neck/chest	2 08	4.34	1 88	0.18	010
21555		A	Remove lesion, neck/chest	4 40	6 75	4.18	0.66	090
21556		A	Remove lesion, neck/chest	5 63	NA	5 01	0.80	090
21557		A	Remove tumor, neck/chest	8.91	NA	5 79	1 27	090
21600		A	Partial removal of rib	7.14	NA	6 92	1.17	090
21610		A	Partial removal of rib	15.76	NA	11.91	4.28	090
21615		A	Removal of rib	10.31	NA	5.90	1.86	090
21616		A	Removal of rib and nerves	12.54	NA	6.26	2.26	090
21620		A	Partial removal of sternum	7.16	NA	5.63	1.22	090
21627		A	Sternal debridement	7.18	NA	6.42	1.24	090
21630		A	Extensive sternum surgery	19.01	NA	12.35	3.02	090
21632		A	Extensive sternum surgery	19.51	NA	11.13	3 71	090
21685		A	Hyoid myotomy & suspension	14.89	NA	10.70	1.44	090
21700		A	Revision of neck muscle	6.23	NA	3.21	1.12	090
21705		A	Revision of neck muscle/rib	9.83	NA	4.26	1.77	090
21720		A	Revision of neck muscle	5.72	NA	4.76	1.56	090
21725		A	Revision of neck muscle	7.10	NA	6.20	1.06	090
21740		A	Reconstruction of sternum	17.47	NA	8.21	3.32	090
21742		C	Repair stern/nuss w/o scope	0.00	0.00	0.00	0.00	090
21743		C	Repair sternum/nuss w/scope	0.00	0.00	0 00	0.00	090
21750		A	Repair of sternum separation	11.35	NA	5 91	2.05	090
21800		A	Treatment of rib fracture	0.98	1.66	1 74	0.13	090
21805		A	Treatment of rib fracture	2.80	NA	3.70	0.50	090
21810		A	Treatment of rib fracture(s)	6.92	NA	5.50	1.23	090
21820		A	Treat sternum fracture	1 31	2.12	2.20	0.18	090
21825		A	Treat sternum fracture	7.65	NA	6.39	1.37	090
21899		C	Neck/chest surgery procedure	0.00	0.00	0 00	0.00	YYY
21920		A	Biopsy soft tissue of back	2 08	4.37	2.02	0.18	010
21925		A	Biopsy soft tissue of back	4.54	6.20	4.04	0.68	090
21930		A	Remove lesion, back or flank	5.06	7.12	4.62	0.79	090
21935		A	Remove tumor, back	18.38	NA	10.94	2.84	090
22010		A	I&d, p-spine, c/t/cerv-thor	12.57	NA	10.01	2.44	090
22015		A	I&d, p-spine, l/s/ls	12.46	NA	10 04	2.28	090
22100		A	Remove part of neck vertebra	10.80	NA	9 61	2.94	090
22101		A	Remove part, thorax vertebra	10.88	NA	10 51	2.96	090
22102		A	Remove part, lumbar vertebra	10.88	NA	8.99	2.04	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
22103		A	Remove extra spine segment	2.34	NA	1.14	0.51	ZZZ
22110		A	Remove part of neck vertebra	13.80	NA	10.81	3.75	090
22112		A	Remove part, thorax vertebra	13.87	NA	11.91	3.77	090
22114		A	Remove part, lumbar vertebra	13.87	NA	10.91	2.08	090
22116		A	Remove extra spine segment	2.32	NA	1.11	0.45	ZZZ
22206		A	Cut spine 3 col, thor	37.00	NA	22.07	5.54	090
22207		A	Cut spine 3 col, lumb	36.50	NA	21.98	6.87	090
22208		A	Cut spine 3 col, addl seg	9.66	NA	4.73	1.94	ZZZ
22210		A	Revision of neck spine	25.13	NA	17.35	5.09	090
22212		A	Revision of thorax spine	20.74	NA	15.18	3.74	090
22214		A	Revision of lumbar spine	20.77	NA	15.24	3.84	090
22216		A	Revise, extra spine segment	6.03	NA	2.95	1.14	ZZZ
22220		A	Revision of neck spine	22.69	NA	16.13	4.81	090
22222		A	Revision of thorax spine	22.84	NA	15.98	3.42	090
22224		A	Revision of lumbar spine	22.84	NA	15.71	4.02	090
22226		A	Revise, extra spine segment	6.03	NA	2.89	1.18	ZZZ
22305		A	Treat spine process fracture	2.08	2.60	2.19	0.31	090
22310		A	Treat spine fracture	3.69	3.60	3.04	0.56	090
22315		A	Treat spine fracture	9.91	11.45	8.75	1.89	090
22318		A	Treat odontoid fx w/o graft	22.54	NA	15.52	5.77	090
22319		A	Treat odontoid fx w/graft	25.15	NA	17.00	6.84	090
22325		A	Treat spine fracture	19.62	NA	14.62	4.23	090
22326		A	Treat neck spine fracture	20.64	NA	14.51	4.73	090
22327		A	Treat thorax spine fracture	20.52	NA	14.97	4.18	090
22328		A	Treat each add spine fx	4.60	NA	2.22	1.01	ZZZ
22505		A	Manipulation of spine	1.87	NA	1.16	0.15	010
22520		A	Percut vertebroplasty thor	9.17	42.28	3.90	0.82	010
22521		A	Percut vertebroplasty lumb	8.60	43.41	3.74	0.77	010
22522		A	Percut vertebroplasty addÆl	4.30	NA	1.53	0.42	ZZZ
22523		A	Percut kyphoplasty, thor	9.21	NA	5.13	1.39	010
22524		A	Percut kyphoplasty, lumbar	8.81	NA	4.97	1.32	010
22525		A	Percut kyphoplasty, add-on	4.47	NA	1.95	0.73	ZZZ
22526		N	Idet, single level	6.07	51.03	2.91	0.45	010
22527		N	Idet, 1 or more levels	3.03	43.86	1.11	0.18	ZZZ
22532		A	Lat thorax spine fusion	25.81	NA	17.01	5.75	090
22533		A	Lat lumbar spine fusion	24.61	NA	16.46	4.84	090
22534		A	Lat thor/lumb, addÆl seg	5.99	NA	2.89	1.18	ZZZ
22548		A	Neck spine fusion	26.86	NA	17.98	7.30	090
22554		A	Neck spine fusion	17.54	NA	12.63	4.11	090
22556		A	Thorax spine fusion	24.50	NA	15.66	4.98	090
22558		A	Lumbar spine fusion	23.33	NA	14.41	4.26	090
22585		A	Additional spinal fusion	5.52	NA	2.62	1.20	ZZZ
22590		A	Spine & skull spinal fusion	21.56	NA	15.49	5.30	090
22595		A	Neck spinal fusion	20.44	NA	14.91	4.93	090
22600		A	Neck spine fusion	17.20	NA	13.22	3.98	090
22610		A	Thorax spine fusion	17.08	NA	12.98	3.64	090
22612		A	Lumbar spine fusion	23.38	NA	15.27	4.69	090
22614		A	Spine fusion, extra segment	6.43	NA	3.10	1.31	ZZZ
22630		A	Lumbar spine fusion	21.89	NA	15.12	4.72	090
22632		A	Spine fusion, extra segment	5.22	NA	2.52	1.11	ZZZ
22800		A	Fusion of spine	19.30	NA	13.64	3.68	090
22802		A	Fusion of spine	31.91	NA	19.74	5.66	090
22804		A	Fusion of spine	37.30	NA	22.24	6.37	090
22808		A	Fusion of spine	27.31	NA	16.96	5.47	090
22810		A	Fusion of spine	31.30	NA	18.55	5.99	090
22812		A	Fusion of spine	34.00	NA	21.32	5.09	090
22818		A	Kyphectomy, 1-2 segments	34.18	NA	20.35	5.12	090
22819		A	Kyphectomy, 3 or more	39.18	NA	24.22	10.65	090
22830		A	Exploration of spinal fusion	11.13	NA	8.52	2.16	090
22840		A	Insert spine fixation device	12.52	NA	6.05	2.58	ZZZ
22841		B	Insert spine fixation device	0.00	0.00	0.00	0.00	XXX
22842		A	Insert spine fixation device	12.56	NA	6.07	2.56	ZZZ
22843		A	Insert spine fixation device	13.44	NA	6.50	2.62	ZZZ
22844		A	Insert spine fixation device	16.42	NA	8.04	2.76	ZZZ
22845		A	Insert spine fixation device	11.94	NA	5.71	2.70	ZZZ
22846		A	Insert spine fixation device	12.40	NA	5.93	2.80	ZZZ
22847		A	Insert spine fixation device	13.78	NA	6.47	3.75	ZZZ
22848		A	Insert pelv fixation device	5.99	NA	2.94	1.05	ZZZ
22849		A	Reinsert spinal fixation	19.08	NA	12.48	3.88	090
22850		A	Remove spine fixation device	9.74	NA	7.68	1.96	090
22851		A	Apply spine prosth device	6.70	NA	3.22	1.42	ZZZ
22852		A	Remove spine fixation device	9.29	NA	7.43	1.82	090
22855		A	Remove spine fixation device	15.77	NA	10.96	3.59	090
22856		A	Cerv artific diskectomy	23.90	NA	15.34	1.28	090
22857		R	Lumbar artif diskectomy	26.93	NA	13.82	7.32	090
22861		A	Revise cerv artific disc	33.21	NA	14.50	1.78	090
22862		R	Revise lumbar artif disc	32.43	NA	15.86	4.85	090
22864		A	Remove cerv artif disc	29.25	NA	13.06	1.57	090
22865		R	Remove lumb artif disc	31.55	NA	19.75	4.72	090
22899		C	Spine surgery procedure	0.00	0.00	0.00	0.00	YYY
22900		A	Remove abdominal wall lesion	6.14	NA	4.48	0.96	090
22999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY
23000		A	Removal of calcium deposits	4.40	9.57	4.62	0.64	090
23020		A	Release shoulder joint	9.24	NA	7.86	1.34	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
23030		A	Drain shoulder lesion	3.44	7.25	2.86	0.50	010
23031		A	Drain shoulder bursa	2.76	7.06	2.51	0.35	010
23035		A	Drain shoulder bone lesion	9.04	NA	7.76	1.35	090
23040		A	Exploratory shoulder surgery	9.63	NA	8.15	1.43	090
23044		A	Exploratory shoulder surgery	7.48	NA	6.70	1.12	090
23065		A	Biopsy shoulder tissues	2.28	3.15	1.96	0.22	010
23066		A	Biopsy shoulder tissues	4 21	9.06	4.39	0.63	090
23075		A	Removal of shoulder lesion	2.41	4.35	2.13	0.37	010
23076		A	Removal of shoulder lesion	7.77	NA	6.52	1 20	090
23077		A	Remove tumor of shoulder	18.08	NA	12.11	2.79	090
23100		A	Biopsy of shoulder joint	6.09	NA	6.14	0 91	090
23101		A	Shoulder joint surgery	5.63	NA	5.38	0.84	090
23105		A	Remove shoulder joint lining	8.36	NA	7.32	1.25	090
23106		A	Incision of collarbone joint	6.02	NA	6.11	0.90	090
23107		A	Explore treat shoulder joint	8.75	NA	7 55	1.30	090
23120		A	Partial removal, collar bone	7.23	NA	7.12	1.07	090
23125		A	Removal of collar bone	9.52	NA	7.95	1.42	090
23130		A	Remove shoulder bone, part	7 63	NA	7.28	1.14	090
23140		A	Removal of bone lesion	7.01	NA	5.84	1.03	090
23145		A	Removal of bone lesion	9.28	NA	7.83	1.39	090
23146		A	Removal of bone lesion	7.96	NA	7.28	1.19	090
23150		A	Removal of humerus lesion	8.79	NA	7.53	1.30	090
23155		A	Removal of humerus lesion	10.72	NA	8.83	1.60	090
23156		A	Removal of humerus lesion	8.99	NA	7.69	1 35	090
23170		A	Remove collar bone lesion	7.10	NA	6.64	1.06	090
23172		A	Remove shoulder blade lesion	7.20	NA	6 69	1.08	090
23174		A	Remove humerus lesion	9.90	NA	8.74	1.48	090
23180		A	Remove collar bone lesion	8.85	NA	7 59	1.34	090
23182		A	Remove shoulder blade lesion	8.47	NA	7.82	1.27	090
23184		A	Remove humerus lesion	9.76	NA	8.40	1.44	090
23190		A	Partial removal of scapula	7.36	NA	6.67	1.10	090
23195		A	Removal of head of humerus	10.24	NA	8.40	1.53	090
23200		A	Removal of collar bone	12.69	NA	9.89	1.90	090
23210		A	Removal of shoulder blade	13.16	NA	10.12	1.97	090
23220		A	Partial removal of humerus	15.36	NA	11.42	2.30	090
23221		A	Partial removal of humerus	18.41	NA	12.92	2.76	090
23222		A	Partial removal of humerus	25.44	NA	16.48	3.81	090
23330		A	Remove shoulder foreign body	1.87	4.06	1 93	0.23	010
23331		A	Remove shoulder foreign body	7.51	NA	7.02	1.11	090
23332		A	Remove shoulder foreign body	12.23	NA	9 66	1.80	090
23350		A	Injection for shoulder x-ray	1.00	2.56	0.33	0.08	000
23395		A	Muscle transfer,shoulder/arm	18.29	NA	13.64	2.69	090
23397		A	Muscle transfers	16.62	NA	11.71	2.49	090
23400		A	Fixation of shoulder blade	13.73	NA	10.31	2 06	090
23405		A	Incision of tendon & muscle	8.43	NA	7.17	1.25	090
23406		A	Incise tendon(s) & muscle(s)	10.90	NA	8.39	1.59	090
23410		A	Repair rotator cuff, acute	11.23	NA	9 10	1.67	090
23412		A	Repair rotator cuff, chronic	11.77	NA	9.37	1 75	090
23415		A	Release of shoulder ligament	10.64	NA	8.75	1 35	090
23420		A	Repair of shoulder	13.35	NA	10.64	1.99	090
23430		A	Repair biceps tendon	10.05	NA	8.22	1.49	090
23440		A	Remove/transplant tendon	10.53	NA	8.25	1 55	090
23450		A	Repair shoulder capsule	13.58	NA	9.96	2.03	090
23455		A	Repair shoulder capsule	14.55	NA	10.43	2.16	090
23460		A	Repair shoulder capsule	15.68	NA	11 36	2.35	090
23462		A	Repair shoulder capsule	15.60	NA	11 04	2.34	090
23465		A	Repair shoulder capsule	16.16	NA	11 54	2.42	090
23466		A	Repair shoulder capsule	15.55	NA	12 25	2.31	090
23470		A	Reconstruct shoulder joint	17.75	NA	12.40	2.64	090
23472		A	Reconstruct shoulder joint	22.47	NA	14.91	3.32	090
23480		A	Revision of collar bone	11.42	NA	8.89	1 71	090
23485		A	Revision of collar bone	13.79	NA	10.05	2 03	090
23490		A	Reinforce clavicle	12.04	NA	9.30	1 80	090
23491		A	Reinforce shoulder bones	14.40	NA	10 77	2.16	090
23500		A	Treat clavicle fracture	2.13	3.13	3.21	0.30	090
23505		A	Treat clavicle fracture	3.74	4.80	4.34	0.54	090
23515		A	Treat clavicle fracture	9.53	NA	8.46	1.42	090
23520		A	Treat clavicle dislocation	2.21	3.34	3.42	0.33	090
23525		A	Treat clavicle dislocation	3 67	5.58	4 90	0.55	090
23530		A	Treat clavicle dislocation	7.37	NA	6.68	1.10	090
23532		A	Treat clavicle dislocation	8.08	NA	7.24	1.21	090
23540		A	Treat clavicle dislocation	2.28	3.11	3.19	0.32	090
23545		A	Treat clavicle dislocation	3.32	4.60	3.90	0.44	090
23550		A	Treat clavicle dislocation	7.48	NA	6.60	1.10	090
23552		A	Treat clavicle dislocation	8 70	NA	7 57	1.29	090
23570		A	Treat shoulder blade fx	2.28	3.31	3.47	0.33	090
23575		A	Treat shoulder blade fx	4.12	5.56	4 96	0 62	090
23585		A	Treat scapula fracture	14.07	NA	10.42	2 07	090
23600		A	Treat humerus fracture	3.00	4.81	4.33	0.44	090
23605		A	Treat humerus fracture	4 94	6.36	5 45	0.72	090
23615		A	Treat humerus fracture	12.12	NA	9.79	1 80	090
23616		A	Treat humerus fracture	18.19	NA	12.81	2.70	090
23620		A	Treat humerus fracture	2.46	4.03	3.73	0.36	090
23625		A	Treat humerus fracture	3.99	5.25	4.65	0 59	090

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23630		A	Treat humerus fracture	10.39	NA	8.93	1.55	090
23650		A	Treat shoulder dislocation	3.44	3.93	3.37	0.44	090
23655		A	Treat shoulder dislocation	4.64	NA	4.99	0.66	090
23660		A	Treat shoulder dislocation	7.55	NA	6.87	1.12	090
23665		A	Treat dislocation/fracture	4.54	5.79	5.12	0.66	090
23670		A	Treat dislocation/fracture	12.12	NA	9.65	1.81	090
23675		A	Treat dislocation/fracture	6.13	7.16	6.01	0.88	090
23680		A	Treat dislocation/fracture	12.99	NA	10.05	1.94	090
23700		A	Fixation of shoulder	2.54	NA	2.28	0.36	010
23800		A	Fusion of shoulder joint	14.59	NA	10.83	2.18	090
23802		A	Fusion of shoulder joint	18.17	NA	13.56	2.72	090
23900		A	Amputation of arm & girdle	20.57	NA	13.98	3.08	090
23920		A	Amputation at shoulder joint	16.03	NA	11.85	2.40	090
23921		A	Amputation follow-up surgery	5.61	NA	4.84	1.01	090
23929		C	Shoulder surgery procedure	0.00	0.00	0.00	0.00	YYY
23930		A	Drainage of arm lesion	2.96	5.78	2.41	0.44	010
23931		A	Drainage of arm bursa	1.81	5.07	2.10	0.24	010
23935		A	Drain arm/elbow bone lesion	6.27	NA	5.99	0.92	090
24000		A	Exploratory elbow surgery	5.99	NA	5.75	0.87	090
24006		A	Release elbow joint	9.62	NA	8.00	1.35	090
24065		A	Biopsy arm/elbow soft tissue	2.10	4.25	2.12	0.20	010
24066		A	Biopsy arm/elbow soft tissue	5.26	9.73	4.81	0.80	090
24075		A	Remove arm/elbow lesion	3.96	8.27	3.95	0.60	090
24076		A	Remove arm/elbow lesion	6.36	NA	5.60	0.97	090
24077		A	Remove tumor of arm/elbow	11.95	NA	8.46	1.84	090
24100		A	Biopsy elbow joint lining	4.98	NA	5.22	0.75	090
24101		A	Explore/treat elbow joint	6.19	NA	6.06	0.91	090
24102		A	Remove elbow joint lining	8.15	NA	7.07	1.16	090
24105		A	Removal of elbow bursa	3.67	NA	4.81	0.54	090
24110		A	Remove humerus lesion	7.46	NA	6.94	1.12	090
24115		A	Remove/graft bone lesion	10.00	NA	6.91	1.50	090
24116		A	Remove/graft bone lesion	12.11	NA	9.23	1.81	090
24120		A	Remove elbow lesion	6.71	NA	6.24	0.97	090
24125		A	Remove/graft bone lesion	8.02	NA	7.22	1.20	090
24126		A	Remove/graft bone lesion	8.50	NA	7.45	1.27	090
24130		A	Removal of head of radius	6.31	NA	6.19	0.90	090
24134		A	Removal of arm bone lesion	10.10	NA	8.33	1.51	090
24136		A	Remove radius bone lesion	8.29	NA	7.22	1.24	090
24138		A	Remove elbow bone lesion	8.33	NA	8.15	1.25	090
24140		A	Partial removal of arm bone	9.43	NA	8.01	1.34	090
24145		A	Partial removal of radius	7.70	NA	6.84	1.15	090
24147		A	Partial removal of elbow	7.69	NA	7.53	1.12	090
24149		A	Radical resection of elbow	15.92	NA	13.13	2.21	090
24150		A	Extensive humerus surgery	13.70	NA	10.38	2.05	090
24151		A	Extensive humerus surgery	16.08	NA	11.77	2.41	090
24152		A	Extensive radius surgery	10.24	NA	8.30	1.53	090
24153		A	Extensive radius surgery	11.73	NA	6.33	0.85	090
24155		A	Removal of elbow joint	11.97	NA	9.15	1.79	090
24160		A	Remove elbow joint implant	7.89	NA	7.07	1.12	090
24164		A	Remove radius head implant	6.34	NA	5.88	0.95	090
24200		A	Removal of arm foreign body	1.78	3.24	1.68	0.20	010
24201		A	Removal of arm foreign body	4.61	9.02	4.39	0.69	090
24220		A	Injection for elbow x-ray	1.31	2.65	0.47	0.10	000
24300		A	Manipulate elbow w/anesth	3.86	NA	5.96	0.53	090
24301		A	Muscle/tendon transfer	10.26	NA	8.29	1.54	090
24305		A	Arm tendon lengthening	7.51	NA	6.85	1.02	090
24310		A	Revision of arm tendon	6.03	NA	5.75	0.89	090
24320		A	Repair of arm tendon	10.74	NA	8.55	1.61	090
24330		A	Revision of arm muscles	9.67	NA	8.02	1.45	090
24331		A	Revision of arm muscles	10.83	NA	8.59	1.62	090
24332		A	Tenolysis, triceps	7.77	NA	7.23	1.16	090
24340		A	Repair of biceps tendon	7.96	NA	7.14	1.19	090
24341		A	Repair arm tendon/muscle	9.24	NA	9.04	1.36	090
24342		A	Repair of ruptured tendon	10.74	NA	8.59	1.56	090
24343		A	Repr elbow lat ligmnt w/tiss	8.99	NA	8.51	1.25	090
24344		A	Reconstruct elbow lat ligmnt	14.97	NA	12.06	2.24	090
24345		A	Repr elbw med ligmnt w/tissu	8.99	NA	8.38	1.26	090
24346		A	Reconstruct elbow med ligmnt	14.97	NA	12.06	2.24	090
24357		A	Repair elbow, perc	5.32	NA	5.63	0.77	090
24358		A	Repair elbow w/deb, open	6.54	NA	6.34	0.93	090
24359		A	Repair elbow deb/attch open	8.86	NA	7.50	1.26	090
24360		A	Reconstruct elbow joint	12.53	NA	9.70	1.88	090
24361		A	Reconstruct elbow joint	14.27	NA	10.65	2.14	090
24362		A	Reconstruct elbow joint	15.18	NA	11.10	2.27	090
24363		A	Replace elbow joint	22.47	NA	15.10	3.17	090
24365		A	Reconstruct head of radius	8.51	NA	7.22	1.27	090
24366		A	Reconstruct head of radius	9.25	NA	7.64	1.31	090
24400		A	Revision of humerus	11.19	NA	9.16	1.64	090
24410		A	Revision of humerus	14.96	NA	11.22	2.24	090
24420		A	Revision of humerus	13.58	NA	10.91	2.03	090
24430		A	Repair of humerus	15.07	NA	11.27	2.20	090
24435		A	Repair humerus with graft	14.74	NA	11.92	2.17	090
24470		A	Revision of elbow joint	8.81	NA	7.69	1.32	090
24495		A	Decompression of forearm	8.30	NA	7.51	1.34	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
24498		A	Reinforce humerus	12.16	NA	9.31	1.82	090
24500		A	Treat humerus fracture	3.29	5.29	4.54	0.47	090
24505		A	Treat humerus fracture	5.25	6.88	5.77	0.77	090
24515		A	Treat humerus fracture	11.97	NA	9.74	1.77	090
24516		A	Treat humerus fracture	12.07	NA	9.30	1.80	090
24530		A	Treat humerus fracture	3.57	5.61	4.76	0.52	090
24535		A	Treat humerus fracture	6.96	8.12	7.01	1.02	090
24538		A	Treat humerus fracture	9.63	NA	8.60	1.43	090
24545		A	Treat humerus fracture	12.99	NA	10.07	1.91	090
24546		A	Treat humerus fracture	14.73	NA	11.08	2.16	090
24560		A	Treat humerus fracture	2.87	4.86	4.07	0.41	090
24565		A	Treat humerus fracture	5.64	7.26	6.22	0.84	090
24566		A	Treat humerus fracture	8.86	NA	8.63	1.33	090
24575		A	Treat humerus fracture	9.53	NA	8.50	1.40	090
24576		A	Treat humerus fracture	2.94	5.24	4.43	0.43	090
24577		A	Treat humerus fracture	5.87	7.43	6.34	0.88	090
24579		A	Treat humerus fracture	11.26	NA	9.38	1.65	090
24582		A	Treat humerus fracture	9.89	NA	9.79	1.48	090
24586		A	Treat elbow fracture	15.64	NA	11.37	2.27	090
24587		A	Treat elbow fracture	15.65	NA	11.54	2.20	090
24600		A	Treat elbow dislocation	4.28	4.53	3.85	0.57	090
24605		A	Treat elbow dislocation	5.50	NA	5.88	0.81	090
24615		A	Treat elbow dislocation	9.72	NA	7.96	1.38	090
24620		A	Treat elbow fracture	7.07	NA	6.39	0.99	090
24635		A	Treat elbow fracture	8.64	NA	7.94	1.25	090
24640		A	Treat elbow dislocation	1.22	2.01	1.00	0.13	010
24650		A	Treat radius fracture	2.22	4.06	3.56	0.32	090
24655		A	Treat radius fracture	4.48	6.15	5.23	0.64	090
24665		A	Treat radius fracture	8.22	NA	7.84	1.19	090
24666		A	Treat radius fracture	9.74	NA	8.44	1.39	090
24670		A	Treat ulnar fracture	2.60	4.39	3.73	0.37	090
24675		A	Treat ulnar fracture	4.79	6.27	5.33	0.70	090
24685		A	Treat ulnar fracture	8.21	NA	7.85	1.21	090
24800		A	Fusion of elbow joint	11.27	NA	9.19	1.69	090
24802		A	Fusion/graft of elbow joint	14.18	NA	10.62	2.12	090
24900		A	Amputation of upper arm	10.04	NA	7.97	1.52	090
24920		A	Amputation of upper arm	10.02	NA	8.07	1.50	090
24925		A	Amputation follow-up surgery	7.19	NA	6.68	1.08	090
24930		A	Amputation follow-up surgery	10.72	NA	8.41	1.60	090
24931		A	Amputate upper arm & implant	13.32	NA	7.03	0.71	090
24935		A	Revision of amputation	16.30	NA	12.25	2.44	090
24940		C	Revision of upper arm	0.00	NA	0.00	0.00	090
24999		C	Upper arm/elbow surgery	0.00	0.00	0.00	0.00	YYY
25000		A	Incision of tendon sheath	3.44	NA	4.72	0.47	090
25001		A	Incise flexor carpi radialis	3.68	NA	4.69	0.50	090
25020		A	Decompress forearm 1 space	5.97	NA	8.21	0.80	090
25023		A	Decompress forearm 1 space	13.69	NA	14.11	2.05	090
25024		A	Decompress forearm 2 spaces	10.62	NA	8.48	1.57	090
25025		A	Decompress forearm 2 spaces	17.77	NA	12.65	2.66	090
25028		A	Drainage of forearm lesion	5.30	NA	7.45	0.76	090
25031		A	Drainage of forearm bursa	4.18	NA	4.70	0.63	090
25035		A	Treat forearm bone lesion	7.54	NA	6.53	1.07	090
25040		A	Explore/treat wrist joint	7.41	NA	6.52	1.02	090
25065		A	Biopsy forearm soft tissues	2.01	4.32	2.13	0.17	010
25066		A	Biopsy forearm soft tissues	4.18	NA	4.54	0.59	090
25075		A	Removal forearm lesion subcu	3.78	NA	3.96	0.56	090
25076		A	Removal forearm lesion deep	4.97	NA	4.94	0.72	090
25077		A	Remove tumor, forearm/wrist	9.90	NA	7.60	1.51	090
25085		A	Incision of wrist capsule	5.55	NA	5.49	0.83	090
25100		A	Biopsy of wrist joint	3.94	NA	4.48	0.59	090
25101		A	Explore/treat wrist joint	4.74	NA	5.19	0.67	090
25105		A	Remove wrist joint lining	5.91	NA	6.02	0.82	090
25107		A	Remove wrist joint cartilage	7.50	NA	7.64	1.01	090
25109		A	Excise tendon forearm/wrist	6.81	NA	6.48	0.92	090
25110		A	Remove wrist tendon lesion	3.96	NA	4.37	0.57	090
25111		A	Remove wrist tendon lesion	3.44	NA	4.34	0.49	090
25112		A	Reremove wrist tendon lesion	4.58	NA	4.86	0.65	090
25115		A	Remove wrist/forearm lesion	9.89	NA	8.91	1.33	090
25116		A	Remove wrist/forearm lesion	4.83	NA	6.09	0.99	090
25118		A	Excise wrist tendon sheath	4.42	NA	4.96	0.60	090
25119		A	Partial removal of ulna	6.10	NA	6.05	0.91	090
25120		A	Removal of forearm lesion	6.16	NA	6.08	0.86	090
25125		A	Remove/graft forearm lesion	7.55	NA	6.98	1.13	090
25126		A	Remove/graft forearm lesion	7.62	NA	7.02	1.14	090
25130		A	Removal of wrist lesion	5.32	NA	5.71	0.73	090
25135		A	Remove & graft wrist lesion	6.96	NA	7.06	1.04	090
25136		A	Remove & graft wrist lesion	6.03	NA	6.01	0.90	090
25145		A	Remove forearm bone lesion	6.43	NA	6.21	0.96	090
25150		A	Partial removal of ulna	7.27	NA	6.65	1.01	090
25151		A	Partial removal of radius	7.57	NA	6.93	1.13	090
25170		A	Extensive forearm surgery	11.34	NA	9.01	1.70	090
25210		A	Removal of wrist bone	6.01	NA	6.07	0.80	090
25215		A	Removal of wrist bones	8.02	NA	7.32	1.05	090
25230		A	Partial removal of radius	5.28	NA	5.40	0.67	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
25240		A	Partial removal of ulna	5.22	NA	5.38	0.69	090
25246		A	Injection for wrist x-ray	1.45	2.56	0.49	0.12	000
25248		A	Remove forearm foreign body	5.20	NA	4.93	0.77	090
25250		A	Removal of wrist prosthesis	6.66	NA	6.31	1.00	090
25251		A	Removal of wrist prosthesis	9.70	NA	8.03	1.45	090
25259		A	Manipulate wrist w/anesthes	3.86	NA	6.01	0.54	090
25260		A	Repair forearm tendon/muscle	7.89	NA	7.64	1.09	090
25263		A	Repair forearm tendon/muscle	7.90	NA	7.44	1.18	090
25265		A	Repair forearm tendon/muscle	9.96	NA	8.45	1.49	090
25270		A	Repair forearm tendon/muscle	6.06	NA	6.09	0.85	090
25272		A	Repair forearm tendon/muscle	7.10	NA	6.57	0.99	090
25274		A	Repair forearm tendon/muscle	8.82	NA	7.61	1.32	090
25275		A	Repair forearm tendon sheath	8.82	NA	7.74	1.32	090
25280		A	Revise wrist/forearm tendon	7.28	NA	6.77	0.97	090
25290		A	Incise wrist/forearm tendon	5.34	NA	5.41	0.72	090
25295		A	Release wrist/forearm tendon	6.61	NA	6.34	0.88	090
25300		A	Fusion of tendons at wrist	8.88	NA	7.92	1.33	090
25301		A	Fusion of tendons at wrist	8.47	NA	7.52	1.17	090
25310		A	Transplant forearm tendon	7.94	NA	7.44	1.03	090
25312		A	Transplant forearm tendon	9.70	NA	8.21	1.32	090
25315		A	Revise palsy hand tendon(s)	10.56	NA	8.46	1.58	090
25316		A	Revise palsy hand tendon(s)	12.76	NA	10.62	1.20	090
25320		A	Repair/revise wrist joint	12.38	NA	11.93	1.66	090
25332		A	Revise wrist joint	11.60	NA	9.29	1.64	090
25335		A	Realignment of hand	13.25	NA	7.20	0.71	090
25337		A	Reconstruct ulna/radioulnar	11.44	NA	10.51	1.50	090
25350		A	Revision of radius	8.97	NA	7.77	1.21	090
25355		A	Revision of radius	10.41	NA	8.49	1.56	090
25360		A	Revision of ulna	8.62	NA	7.55	1.24	090
25365		A	Revise radius & ulna	12.77	NA	9.84	1.91	090
25370		A	Revise radius or ulna	13.93	NA	10.91	2.09	090
25375		A	Revise radius & ulna	13.41	NA	7.26	0.72	090
25390		A	Shorten radius or ulna	10.58	NA	8.66	1.41	090
25391		A	Lengthen radius or ulna	14.14	NA	10.51	2.12	090
25392		A	Shorten radius & ulna	14.44	NA	10.66	2.16	090
25393		A	Lengthen radius & ulna	16.42	NA	11.63	2.46	090
25394		A	Repair carpal bone, shorten	10.71	NA	8.60	1.60	090
25400		A	Repair radius or ulna	11.16	NA	8.90	1.56	090
25405		A	Repair/graft radius or ulna	14.87	NA	11.05	2.06	090
25415		A	Repair radius & ulna	13.66	NA	10.71	2.04	090
25420		A	Repair/graft radius & ulna	16.89	NA	12.08	2.53	090
25425		A	Repair/graft radius or ulna	13.58	NA	10.23	2.03	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
25426		A	Repair/graft radius & ulna	16.31	NA	11.58	2.44	090
25430		A	Vasc graft into carpal bone	9.57	NA	8.94	0.90	090
25431		A	Repair nonunion carpal bone	10.75	NA	8.69	1.61	090
25440		A	Repair/graft wrist bone	10.56	NA	8.46	1.43	090
25441		A	Reconstruct wrist joint	13.15	NA	10.83	1.24	090
25442		A	Reconstruct wrist joint	10.98	NA	9.24	1.03	090
25443		A	Reconstruct wrist joint	10.52	NA	8.71	1.57	090
25444		A	Reconstruct wrist joint	11.28	NA	6.47	0.60	090
25445		A	Reconstruct wrist joint	9.76	NA	8.15	1.32	090
25446		A	Wrist replacement	17.16	NA	12.32	2.21	090
25447		A	Repair wrist joint(s)	10.95	NA	9.61	1.46	090
25449		A	Remove wrist joint implant	14.80	NA	10.82	2.22	090
25450		A	Revision of wrist joint	7.94	NA	6.28	1.19	090
25455		A	Revision of wrist joint	9.57	NA	5.85	0.51	090
25490		A	Reinforce radius	9.61	NA	7.14	0.94	090
25491		A	Reinforce ulna	10.03	NA	8.20	1.50	090
25492		A	Reinforce radius and ulna	12.52	NA	9.81	1.87	090
25500		A	Treat fracture of radius	2.51	4.01	3.49	0.34	090
25505		A	Treat fracture of radius	5.30	6.95	5.97	0.76	090
25515		A	Treat fracture of radius	8.64	NA	7.83	1.25	090
25520		A	Treat fracture of radius	6.35	7.42	6.72	0.95	090
25525		A	Treat fracture of radius	10.37	NA	8.89	1.51	090
25526		A	Treat fracture of radius	12.96	NA	10.43	1.94	090
25530		A	Treat fracture of ulna	2.15	4.12	3.53	0.31	090
25535		A	Treat fracture of ulna	5.22	6.69	5.84	0.74	090
25545		A	Treat fracture of ulna	7.78	NA	7.52	1.12	090
25560		A	Treat fracture radius & ulna	2.50	4.12	3.50	0.34	090
25565		A	Treat fracture radius & ulna	5.71	7.00	5.87	0.82	090
25574		A	Treat fracture radius & ulna	8.64	NA	7.94	1.27	090
25575		A	Treat fracture radius/ulna	12.10	NA	10.12	1.76	090
25600		A	Treat fracture radius/ulna	2.69	4.37	3.78	0.38	090
25605		A	Treat fracture radius/ulna	7.02	8.14	7.29	1.02	090
25606		A	Treat fx distal radial	8.10	NA	8.03	1.19	090
25607		A	Treat fx rad extra-articul	9.35	NA	8.70	1.35	090
25608		A	Treat fx rad intra-articul	10.86	NA	9.48	1.55	090
25609		A	Treat fx radial 3+ frag	14.12	NA	11.77	2.00	090
25622		A	Treat wrist bone fracture	2.68	4.65	4.01	0.38	090
25624		A	Treat wrist bone fracture	4.62	6.63	5.65	0.66	090
25628		A	Treat wrist bone fracture	9.51	NA	8.32	1.29	090
25630		A	Treat wrist bone fracture	2.94	4.49	3.90	0.41	090
25635		A	Treat wrist bone fracture	4.47	6.49	5.55	0.67	090
25645		A	Treat wrist bone fracture	7.31	NA	6.64	1.09	090

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25650		A	Treat wrist bone fracture	3.12	4.59	4.12	0.43	090
25651		A	Pin ulnar styloid fracture	5.68	NA	6.19	0.82	090
25652		A	Treat fracture ulnar styloid	7.92	NA	7.46	1.09	090
25660		A	Treat wrist dislocation	4.84	NA	5.22	0.67	090
25670		A	Treat wrist dislocation	7.98	NA	7.04	1.12	090
25671		A	Pin radioulnar dislocation	6.32	NA	6.61	0.95	090
25675		A	Treat wrist dislocation	4.75	5.80	4.94	0.64	090
25676		A	Treat wrist dislocation	8.17	NA	7.34	1.14	090
25680		A	Treat wrist fracture	6.08	NA	5.50	0.77	090
25685		A	Treat wrist fracture	9.97	NA	8.17	1.49	090
25690		A	Treat wrist dislocation	5.58	NA	6.08	0.84	090
25695		A	Treat wrist dislocation	8.40	NA	7.18	1.26	090
25800		A	Fusion of wrist joint	9.95	NA	8.33	1.35	090
25805		A	Fusion/graft of wrist joint	11.59	NA	9.25	1.73	090
25810		A	Fusion/graft of wrist joint	11.75	NA	9.80	1.57	090
25820		A	Fusion of hand bones	7.52	NA	7.72	1.02	090
25825		A	Fuse hand bones with graft	9.54	NA	9.24	1.27	090
25830		A	Fusion, radioulnar int/ulna	10.69	NA	12.66	1.60	090
25900		A	Amputation of forearm	9.46	NA	8.04	1.37	090
25905		A	Amputation of forearm	9.48	NA	7.81	1.42	090
25907		A	Amputation follow-up surgery	7.98	NA	7.07	1.19	090
25909		A	Amputation follow-up surgery	9.20	NA	7.67	1.38	090
25915		A	Amputation of forearm	17.38	NA	6.61	2.32	090
25920		A	Amputate hand at wrist	8.92	NA	8.21	1.34	090
25922		A	Amputate hand at wrist	7.54	NA	5.23	0.40	090
25924		A	Amputation follow-up surgery	8.70	NA	8.47	1.30	090
25927		A	Amputation of hand	8.98	NA	10.85	1.34	090
25929		A	Amputation follow-up surgery	7.71	NA	6.93	1.15	090
25931		A	Amputation follow-up surgery	7.93	NA	10.31	1.19	090
25999		C	Forearm or wrist surgery	0.00	0.00	0.00	0.00	YYY
26010		A	Drainage of finger abscess	1.56	4.78	1.85	0.17	010
26011		A	Drainage of finger abscess	2.21	7.25	2.39	0.29	010
26020		A	Drain hand tendon sheath	4.97	NA	5.70	0.69	090
26025		A	Drainage of palm bursa	4.99	NA	5.47	0.69	090
26030		A	Drainage of palm bursa(s)	6.16	NA	6.06	0.86	090
26034		A	Treat hand bone lesion	6.49	NA	6.72	0.90	090
26035		A	Decompress fingers/hand	11.14	NA	9.84	1.67	090
26037		A	Decompress fingers/hand	7.48	NA	6.70	1.08	090
26040		A	Release palm contracture	3.38	NA	4.30	0.43	090
26045		A	Release palm contracture	5.62	NA	5.85	0.82	090
26055		A	Incise finger tendon sheath	3.00	10.44	4.52	0.41	090
26060		A	Incision of finger tendon	2.85	NA	3.68	0.40	090
26070		A	Explore/treat hand joint	3.73	NA	3.83	0.46	090
26075		A	Explore/treat finger joint	3.83	NA	4.16	0.49	090
26080		A	Explore/treat finger joint	4.36	NA	5.16	0.59	090
26100		A	Biopsy hand joint lining	3.71	NA	4.42	0.56	090
26105		A	Biopsy finger joint lining	3.75	NA	4.44	0.56	090
26110		A	Biopsy finger joint lining	3.57	NA	4.33	0.47	090
26115		A	Removal hand lesion subcut	3.92	11.24	4.99	0.54	090
26116		A	Removal hand lesion, deep	5.61	NA	6.36	0.75	090
26117		A	Remove tumor, hand/finger	8.62	NA	7.50	1.19	090
26121		A	Release palm contracture	7.61	NA	7.19	1.05	090
26123		A	Release palm contracture	10.63	NA	9.96	1.43	ZZZ
26125		A	Release palm contracture	4.60	NA	2.43	0.62	090
26130		A	Remove wrist joint lining	5.48	NA	5.83	0.82	090
26135		A	Revise finger joint, each	7.02	NA	6.59	0.95	090
26140		A	Revise finger joint, each	6.23	NA	6.22	0.84	090
26145		A	Tendon excision, palm/finger	6.38	NA	6.26	0.87	090
26160		A	Remove tendon sheath lesion	3.46	10.40	4.67	0.48	090
26170		A	Remove/graft bone lesion, each	4.82	NA	5.23	0.64	090
26180		A	Removal of finger tendon	5.24	NA	5.74	0.68	090
26185		A	Remove finger bone	6.32	NA	6.99	0.95	090
26200		A	Remove hand bone lesion	5.56	NA	5.54	0.77	090
26205		A	Remove/graft bone lesion	7.82	NA	6.96	1.17	090
26210		A	Removal of finger lesion	5.21	NA	5.67	0.71	090
26215		A	Remove/graft finger lesion	7.16	NA	6.63	1.07	090
26230		A	Partial removal of hand bone	6.38	NA	5.98	0.84	090
26235		A	Partial removal, finger bone	6.24	NA	6.03	0.82	090
26236		A	Partial removal, finger bone	5.37	NA	5.55	0.72	090
26250		A	Extensive hand surgery	7.61	NA	6.83	1.14	090
26255		A	Extensive hand surgery	12.80	NA	9.89	1.92	090
26260		A	Extensive finger surgery	7.09	NA	6.57	1.06	090
26261		A	Extensive finger surgery	9.28	NA	8.43	0.87	090
26262		A	Partial removal of finger	5.72	NA	5.62	0.86	090
26320		A	Removal of implant from hand	4.02	NA	4.53	0.53	090
26340		A	Manipulate finger w/anesth	2.62	NA	5.35	0.37	090
26350		A	Repair finger/hand tendon	6.07	NA	11.05	0.83	090
26352		A	Repair/graft hand tendon	7.75	NA	11.87	1.16	090
26356		A	Repair finger/hand tendon	10.22	NA	16.04	1.41	090
26357		A	Repair finger/hand tendon	8.65	NA	12.31	1.29	090
26358		A	Repair/graft hand tendon	9.22	NA	12.88	0.87	090
26370		A	Repair finger/hand tendon	7.17	NA	11.25	1.01	090
26372		A	Repair/graft hand tendon	8.89	NA	12.43	1.33	090
26373		A	Repair finger/hand tendon	8.29	NA	12.14	1.24	090

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CPT[1],] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26390		A	Revise hand/finger tendon	9.31	NA	10.92	1.39	090
26392		A	Repair/graft hand tendon	10.38	NA	13.16	1.55	090
26410		A	Repair hand tendon	4.68	NA	8.93	0.66	090
26412		A	Repair/graft hand tendon	6.37	NA	10.14	0.85	090
26415		A	Excision, hand/finger tendon	8.40	NA	8.97	0.85	090
26416		A	Graft hand or finger tendon	9.44	NA	11.95	1.41	090
26418		A	Repair finger tendon	4.33	NA	9.46	0.61	090
26420		A	Repair/graft finger tendon	6.83	NA	10.45	1.02	090
26426		A	Repair finger/hand tendon	6.21	NA	6.18	0.85	090
26428		A	Repair/graft finger tendon	7.28	NA	10.89	1.09	090
26432		A	Repair finger tendon	4.07	NA	7.95	0.55	090
26433		A	Repair finger tendon	4.61	NA	8.17	0.64	090
26434		A	Repair/graft finger tendon	6.15	NA	9.36	0.92	090
26437		A	Realignment of tendons	5.88	NA	9.16	0.77	090
26440		A	Release palm/finger tendon	5.07	NA	9.90	0.67	090
26442		A	Release palm & finger tendon	9.50	NA	13.87	1.29	090
26445		A	Release hand/finger tendon	4.36	NA	9.54	0.59	090
26449		A	Release forearm/hand tendon	8.34	NA	8.78	1.12	090
26450		A	Incision of palm tendon	3.71	NA	6.13	0.52	090
26455		A	Incision of finger tendon	3.68	NA	6.05	0.51	090
26460		A	Incise hand/finger tendon	3.50	NA	5.97	0.46	090
26471		A	Fusion of finger tendons	5.79	NA	9.11	0.77	090
26474		A	Fusion of finger tendons	5.38	NA	8.98	0.81	090
26476		A	Tendon lengthening	5.24	NA	8.91	0.78	090
26477		A	Tendon shortening	5.21	NA	8.85	0.76	090
26478		A	Lengthening of hand tendon	5.86	NA	9.17	0.82	090
26479		A	Shortening of hand tendon	5.80	NA	9.19	0.87	090
26480		A	Transplant hand tendon	6.76	NA	11.32	0.90	090
26483		A	Transplant/graft hand tendon	8.36	NA	11.93	1.18	090
26485		A	Transplant palm tendon	7.77	NA	11.78	1.05	090
26489		A	Transplant/graft palm tendon	9.74	NA	12.85	1.46	090
26490		A	Revise thumb tendon	8.48	NA	10.73	1.07	090
26492		A	Tendon transfer with graft	9.70	NA	11.61	1.45	090
26494		A	Hand tendon/muscle transfer	8.54	NA	10.76	1.28	090
26496		A	Revise thumb tendon	9.66	NA	11.43	1.25	090
26497		A	Finger tendon transfer	9.64	NA	11.30	1.44	090
26498		A	Finger tendon transfer	14.07	NA	13.76	2.11	090
26499		A	Revision of finger	9.05	NA	11.01	1.35	090
26500		A	Hand tendon reconstruction	6.02	NA	9.14	0.85	090
26502		A	Hand tendon reconstruction	7.20	NA	9.88	1.08	090
26508		A	Release thumb contracture	6.07	NA	9.02	0.91	090
26510		A	Thumb tendon transfer	5.49	NA	8.94	0.70	090

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CPT[1],] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26516		A	Fusion of knuckle joint	7.21	NA	9.84	0.96	090
26517		A	Fusion of knuckle joints	8.96	NA	10.96	1.34	090
26518		A	Fusion of knuckle joints	9.15	NA	11.06	1.37	090
26520		A	Release knuckle contracture	5.36	NA	10.34	0.73	090
26525		A	Release finger contracture	5.39	NA	10.34	0.71	090
26530		A	Revise knuckle joint	6.76	NA	6.51	0.92	090
26531		A	Revise knuckle with implant	7.99	NA	7.50	1.04	090
26535		A	Revise finger joint	5.30	NA	5.05	0.61	090
26536		A	Revise/implant finger joint	6.44	NA	10.86	0.83	090
26540		A	Repair hand joint	6.49	NA	9.47	0.88	090
26541		A	Repair hand joint with graft	8.69	NA	10.92	1.12	090
26542		A	Repair hand joint with graft	6.84	NA	9.46	0.94	090
26545		A	Reconstruct finger joint	6.99	NA	9.94	0.94	090
26546		A	Repair nonunion hand	10.53	NA	13.30	1.38	090
26548		A	Reconstruct finger joint	8.10	NA	10.40	1.10	090
26550		A	Construct thumb replacement	21.54	NA	18.80	3.22	090
26551		A	Great toe-hand transfer	48.23	NA	33.56	7.22	090
26553		A	Single transfer, toe-hand	47.92	NA	23.97	2.57	090
26554		A	Double transfer, toe-hand	56.73	NA	27.52	3.04	090
26555		A	Positional change of finger	16.94	NA	17.43	2.54	090
26556		A	Toe joint transfer	49.43	NA	13.79	6.60	090
26560		A	Repair of web finger	5.43	NA	8.57	0.81	090
26561		A	Repair of web finger	10.98	NA	9.99	1.78	090
26562		A	Repair of web finger	16.40	NA	11.37	0.88	090
26565		A	Correct metacarpal flaw	6.80	NA	9.65	1.02	090
26567		A	Correct finger deformity	6.88	NA	9.69	0.92	090
26568		A	Lengthen metacarpal/finger	9.15	NA	12.56	1.37	090
26580		A	Repair hand deformity	19.50	NA	17.40	2.92	090
26587		A	Reconstruct extra finger	14.36	NA	9.17	2.33	090
26590		A	Repair finger deformity	18.51	NA	15.96	2.77	090
26591		A	Repair muscles of hand	3.30	NA	7.03	0.45	090
26593		A	Release muscles of hand	5.38	NA	9.17	0.69	090
26596		A	Excision constricting tissue	9.02	NA	9.49	1.35	090
26600		A	Treat metacarpal fracture	2.48	4.57	4.16	0.35	090
26605		A	Treat metacarpal fracture	2.92	4.84	4.17	0.41	090
26607		A	Treat metacarpal fracture	5.40	NA	5.77	0.78	090
26608		A	Treat metacarpal fracture	5.43	NA	6.26	0.77	090
26615		A	Treat metacarpal fracture	6.91	NA	7.22	0.96	090
26641		A	Treat thumb dislocation	4.01	4.98	4.22	0.53	090
26645		A	Treat thumb fracture	4.47	5.87	5.04	0.67	090
26650		A	Treat thumb fracture	5.19	NA	6.45	0.74	090
26665		A	Treat thumb fracture	7.78	NA	7.70	1.09	090

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CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
26670		A	Treat hand dislocation	3.74	4.40	3.69	0.49	090
26675		A	Treat hand dislocation	4.71	6.27	5.41	0.70	090
26676		A	Pin hand dislocation	5.60	NA	6.64	0.78	090
26685		A	Treat hand dislocation	6.91	NA	7.21	1.03	090
26686		A	Treat hand dislocation	8.06	NA	7.25	1.21	090
26700		A	Treat knuckle dislocation	3.74	4.05	3.60	0.48	090
26705		A	Treat knuckle dislocation	4.26	5.85	5.00	0.61	090
26706		A	Pin knuckle dislocation	5.19	NA	5.63	0.71	090
26715		A	Treat knuckle dislocation	6.87	NA	7.13	0.97	090
26720		A	Treat finger fracture, each	1.70	3.07	2.75	0.23	090
26725		A	Treat finger fracture, each	3.39	4.85	4.08	0.47	090
26727		A	Treat finger fracture, each	5.30	NA	6.20	0.74	090
26735		A	Treat finger fracture, each	7.26	NA	7.42	1.02	090
26740		A	Treat finger fracture, each	1.99	3.54	3.21	0.26	090
26742		A	Treat finger fracture, each	3.90	5.09	4.29	0.53	090
26746		A	Treat finger fracture, each	9.59	NA	8.73	1.31	090
26750		A	Treat finger fracture, each	1.74	2.71	2.72	0.24	090
26755		A	Treat finger fracture, each	3.15	4.47	3.54	0.43	090
26756		A	Pin finger fracture, each	4.46	NA	5.75	0.62	090
26765		A	Treat finger fracture, each	5.70	NA	6.56	0.80	090
26770		A	Treat finger dislocation	3.07	3.58	3.13	0.40	090
26775		A	Treat finger dislocation	3.78	5.51	4.64	0.51	090
26776		A	Pin finger dislocation	4.87	NA	5.92	0.68	090
26785		A	Treat finger dislocation	6.44	NA	6.95	0.90	090
26820		A	Thumb fusion with graft	8.33	NA	10.65	1.25	090
26841		A	Fusion of thumb	7.21	NA	10.38	1.03	090
26842		A	Thumb fusion with graft	8.37	NA	10.67	1.25	090
26843		A	Fusion of hand joint	7.67	NA	10.11	1.15	090
26844		A	Fusion/graft of hand joint	8.86	NA	10.91	1.33	090
26850		A	Fusion of knuckle	7.03	NA	9.80	0.92	090
26852		A	Fusion of knuckle with graft	8.59	NA	10.83	1.09	090
26860		A	Fusion of finger joint	4.76	NA	8.80	0.63	090
26861		A	Fusion of finger jnt, add-on	1.74	NA	0.91	0.23	ZZZ
26862		A	Fusion/graft of finger joint	7.44	NA	10.26	0.98	090
26863		A	Fuse/graft added joint	3.89	NA	1.91	0.58	ZZZ
26910		A	Amputate metacarpal bone	7.67	NA	9.74	1.11	090
26951		A	Amputation of finger/thumb	5.85	NA	9.82	0.83	090
26952		A	Amputation of finger/thumb	6.37	NA	9.26	0.89	090
26989		C	Hand/finger surgery	0.00	0.00	0.00	0.00	YYY
26990		A	Drainage of pelvis lesion	7.84	NA	7.47	1.18	090
26991		A	Drainage of pelvis bursa	6.97	10.32	5.98	1.05	090
26992		A	Drainage of bone lesion	13.37	NA	10.45	2.02	090
27000		A	Incision of hip tendon	5.66	NA	5.06	0.79	090
27001		A	Incision of hip tendon	7.05	NA	6.30	1.05	090
27003		A	Incision of hip tendon	7.70	NA	6.93	1.15	090
27005		A	Incision of hip tendon	9.96	NA	8.05	1.49	090
27006		A	Incision of hip tendons	9.99	NA	8.21	1.47	090
27025		A	Incision of hip/thigh fascia	12.66	NA	9.84	1.91	090
27027		A	Buttock fasciotomy	12.90	NA	9.15	0.69	090
27030		A	Drainage of hip joint	13.54	NA	9.81	2.01	090
27033		A	Exploration of hip joint	13.99	NA	10.20	2.09	090
27035		A	Denervation of hip joint	17.23	NA	12.03	2.58	090
27036		A	Excision of hip joint/muscle	14.18	NA	10.77	2.09	090
27040		A	Biopsy of soft tissues	2.89	5.52	2.09	0.33	010
27041		A	Biopsy of soft tissues	10.07	NA	6.65	1.36	090
27047		A	Remove hip/pelvis lesion	7.51	8.49	5.66	1.18	090
27048		A	Remove hip/pelvis lesion	6.44	NA	5.63	1.00	090
27049		A	Remove tumor, hip/pelvis	15.20	NA	9.92	2.26	090
27050		A	Biopsy of sacroiliac joint	4.65	NA	5.15	0.75	090
27052		A	Biopsy of hip joint	7.27	NA	6.85	1.09	090
27054		A	Removal of hip joint lining	9.09	NA	7.84	1.36	090
27057		A	Buttock fasciotomy w/dbrdmt	14.77	NA	10.40	0.79	090
27060		A	Removal of ischial bursa	5.78	NA	4.64	0.87	090
27062		A	Remove femur lesion/bursa	5.66	NA	5.52	0.85	090
27065		A	Removal of hip bone lesion	6.44	NA	6.04	0.95	090
27066		A	Removal of hip bone lesion	11.06	NA	9.03	1.66	090
27067		A	Remove/graft hip bone lesion	14.57	NA	11.03	2.18	090
27070		A	Partial removal of hip bone	11.44	NA	9.76	1.71	090
27071		A	Partial removal of hip bone	12.25	NA	10.29	1.84	090
27075		A	Extensive hip surgery	36.77	NA	20.24	5.50	090
27076		A	Extensive hip surgery	24.25	NA	15.90	3.63	090
27077		A	Extensive hip surgery	42.54	NA	24.53	6.37	090
27078		A	Extensive hip surgery	14.54	NA	11.02	2.18	090
27079		A	Extensive hip surgery	14.91	NA	11.20	2.23	090
27080		A	Removal of tail bone	6.80	NA	5.81	1.06	090
27086		A	Remove hip foreign body	1.89	4.14	1.76	0.19	010
27087		A	Remove hip foreign body	8.72	NA	6.98	1.29	090
27090		A	Removal of hip prosthesis	11.57	NA	9.02	1.72	090
27091		A	Removal of hip prosthesis	24.15	NA	15.86	3.61	090
27093		A	Injection for hip x-ray	1.30	3.46	0.55	0.11	000
27095		A	Injection for hip x-ray	1.50	4.32	0.64	0.14	000
27096		A	Inject sacroiliac joint	1.40	3.49	0.55	0.09	000
27097		A	Revision of hip tendon	9.16	NA	7.65	1.37	090
27098		A	Transfer tendon to pelvis	9.20	NA	5.88	1.38	090

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27100		A	Transfer of abdominal muscle	11.21	NA	9.16	1.68	090
27105		A	Transfer of spinal muscle	11.90	NA	9.50	1.78	090
27110		A	Transfer of iliopsoas muscle	13.63	NA	10.35	2.04	090
27111		A	Transfer of iliopsoas muscle	12.46	NA	9.77	1.87	090
27120		A	Reconstruction of hip socket	19.10	NA	13.24	2.86	090
27122		A	Reconstruction of hip socket	15.95	NA	11.47	2.37	090
27125		A	Partial hip replacement	16.46	NA	11.72	2.46	090
27130		A	Total hip arthroplasty	21.61	NA	14.46	3.23	090
27132		A	Total hip arthroplasty	25.49	NA	16.53	3.81	090
27134		A	Revise hip joint replacement	30.13	NA	18.16	4.50	090
27137		A	Revise hip joint replacement	22.55	NA	14.44	3.37	090
27138		A	Revise hip joint replacement	23.55	NA	14.93	3.52	090
27140		A	Transplant femur ridge	12.66	NA	9.59	1.90	090
27146		A	Incision of hip bone	18.72	NA	13.17	2.80	090
27147		A	Revision of hip bone	21.87	NA	14.72	3.27	090
27151		A	Incision of hip bones	23.92	NA	15.73	3.58	090
27156		A	Revision of hip bones	26.03	NA	16.77	3.90	090
27158		A	Revision of pelvis	20.89	NA	14.04	3.13	090
27161		A	Incision of neck of femur	17.74	NA	12.51	2.64	090
27165		A	Incision/fixation of femur	20.06	NA	14.14	2.99	090
27170		A	Repair/graft femur head/neck	17.46	NA	11.93	2.61	090
27175		A	Treat slipped epiphysis	9.29	NA	7.22	1.39	090
27176		A	Treat slipped epiphysis	12.78	NA	9.93	1.91	090
27177		A	Treat slipped epiphysis	15.94	NA	11.70	2.39	090
27178		A	Treat slipped epiphysis	12.78	NA	9.93	1.91	090
27179		A	Revise head/neck of femur	13.83	NA	10.35	2.07	090
27181		A	Treat slipped epiphysis	15.98	NA	11.82	2.39	090
27185		A	Revision of femur epiphysis	9.67	NA	5.70	0.52	090
27187		A	Reinforce hip bones	14.09	NA	10.55	2.11	090
27193		A	Treat pelvic ring fracture	5.98	5.57	5.73	0.89	090
27194		A	Treat pelvic ring fracture	10.08	NA	7.14	1.21	090
27200		A	Treat tail bone fracture	1.87	2.52	2.69	0.26	090
27202		A	Treat tail bone fracture	7.25	NA	5.93	1.09	090
27215		I	Treat pelvic fracture(s)	10.45	NA	5.53	0.56	090
27216		I	Treat pelvic ring fracture	15.73	NA	8.00	0.84	090
27217		I	Treat pelvic ring fracture	14.65	NA	7.60	0.78	090
27218		I	Treat pelvic ring fracture	20.93	NA	9.89	1.12	090
27220		A	Treat hip socket fracture	6.72	6.33	6.22	1.00	090
27222		A	Treat hip socket fracture	13.97	NA	10.22	2.05	090
27226		A	Treat hip wall fracture	15.45	NA	10.95	2.31	090
27227		A	Treat hip fracture(s)	25.21	NA	16.34	3.77	090
27228		A	Treat hip fracture(s)	29.13	NA	18.27	4.36	090
27230		A	Treat thigh fracture	5.69	5.96	5.88	0.84	090
27232		A	Treat thigh fracture	11.66	NA	7.38	1.71	090
27235		A	Treat thigh fracture	12.88	NA	9.68	1.92	090
27236		A	Treat thigh fracture	17.43	NA	12.38	2.60	090
27238		A	Treat thigh fracture	5.64	NA	5.64	0.84	090
27240		A	Treat thigh fracture	13.66	NA	10.13	2.02	090
27244		A	Treat thigh fracture	18.00	NA	12.66	2.68	090
27245		A	Treat thigh fracture	18.00	NA	12.68	2.68	090
27246		A	Treat thigh fracture	4.75	4.70	4.74	0.70	090
27248		A	Treat thigh fracture	10.64	NA	7.81	1.59	090
27250		A	Treat hip dislocation	3.82	NA	0.82	0.39	000
27252		A	Treat hip dislocation	10.92	NA	7.91	1.60	090
27253		A	Treat hip dislocation	13.46	NA	9.93	2.01	090
27254		A	Treat hip dislocation	18.80	NA	12.76	2.81	090
27256		A	Treat hip dislocation	4.25	2.96	1.74	0.45	010
27257		A	Treat hip dislocation	5.35	NA	2.96	0.64	010
27258		A	Treat hip dislocation	16.04	NA	11.53	2.40	090
27259		A	Treat hip dislocation	23.03	NA	15.58	3.45	090
27265		A	Treat hip dislocation	5.12	NA	4.55	0.69	090
27266		A	Treat hip dislocation	7.67	NA	6.63	1.14	090
27267		A	Ctx thigh fx	5.38	NA	5.40	0.81	090
27268		A	Ctx thigh fx w/mnpj	7.00	NA	6.20	1.05	090
27269		A	Optx thigh fx	18.75	NA	12.33	2.78	090
27275		A	Manipulation of hip joint	2.29	NA	2.07	0.26	010
27280		A	Fusion of sacroiliac joint	14.49	NA	11.02	2.24	090
27282		A	Fusion of pubic bones	11.71	NA	9.40	1.75	090
27284		A	Fusion of hip joint	24.91	NA	15.56	3.73	090
27286		A	Fusion of hip joint	24.97	NA	16.24	3.74	090
27290		A	Amputation of leg at hip	24.38	NA	16.14	3.65	090
27295		A	Amputation of leg at hip	19.54	NA	11.90	3.04	090
27299		C	Pelvis/hip joint surgery	0.00	0.00	0.00	0.00	YYY
27301		A	Drain thigh/knee lesion	6.67	9.71	5.65	1.02	090
27303		A	Drainage of bone lesion	8.52	NA	7.29	1.27	090
27305		A	Incise thigh tendon & fascia	6.09	NA	5.67	0.92	090
27306		A	Incision of thigh tendon	4.66	NA	4.93	0.70	090
27307		A	Incision of thigh tendons	5.97	NA	5.79	0.89	090
27310		A	Exploration of knee joint	9.88	NA	8.21	1.47	090
27323		A	Biopsy, thigh soft tissues	2.30	4.45	2.17	0.27	010
27324		A	Biopsy, thigh soft tissues	4.95	NA	4.60	0.77	090
27325		A	Neurectomy, hamstring	7.09	NA	6.57	1.06	090
27326		A	Neurectomy, popliteal	6.36	NA	6.21	0.95	090
27327		A	Removal of thigh lesion	4.52	7.08	4.35	0.70	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27328		A	Removal of thigh lesion	5.62	NA	4.95	0.87	090
27329		A	Remove tumor, thigh/knee	15.68	NA	10.57	2.40	090
27330		A	Biopsy, knee joint lining	5.02	NA	4.80	0.70	090
27331		A	Explore/treat knee joint	5.93	NA	5.76	0.89	090
27332		A	Removal of knee cartilage	8.34	NA	7.46	1.24	090
27333		A	Removal of knee cartilage	7.43	NA	6.92	1.11	090
27334		A	Remove knee joint lining	9.07	NA	7.81	1.35	090
27335		A	Remove knee joint lining	10.43	NA	8.51	1.56	090
27340		A	Removal of kneecap bursa	4.23	NA	4.83	0.63	090
27345		A	Removal of knee cyst	5.98	NA	5.89	0.89	090
27347		A	Remove knee cyst	6.58	NA	6.32	0.98	090
27350		A	Removal of kneecap	8.54	NA	7.56	1.28	090
27355		A	Remove femur lesion	7.89	NA	6.97	1.18	090
27356		A	Remove femur lesion/graft	9.97	NA	8.27	1.49	090
27357		A	Remove femur lesion/graft	11.02	NA	9.05	1.65	090
27358		A	Remove femur lesion/fixation	4.73	NA	2.33	0.71	ZZZ
27360		A	Partial removal, leg bone(s)	11.34	NA	9.72	1.70	090
27365		A	Extensive leg surgery	17.93	NA	12.71	2.69	090
27370		A	Injection for knee x-ray	0.96	3.32	0.43	0.10	000
27372		A	Removal of foreign body	5.12	9.74	4.87	0.76	090
27380		A	Repair of kneecap tendon	7.34	NA	7.26	1.09	090
27381		A	Repair/graft kneecap tendon	10.64	NA	9.14	1.59	090
27385		A	Repair of thigh muscle	8.00	NA	7.60	1.19	090
27386		A	Repair/graft of thigh muscle	10.99	NA	9.56	1.64	090
27390		A	Incision of thigh tendon	5.44	NA	5.53	0.81	090
27391		A	Incision of thigh tendons	7.38	NA	6.77	1.10	090
27392		A	Incision of thigh tendons	9.51	NA	8.04	1.42	090
27393		A	Lengthening of thigh tendon	6.50	NA	6.02	0.97	090
27394		A	Lengthening of thigh tendons	8.68	NA	7.47	1.28	090
27395		A	Lengthening of thigh tendons	12.10	NA	9.59	1.81	090
27396		A	Transplant of thigh tendon	8.04	NA	7.10	1.20	090
27397		A	Transplants of thigh tendons	12.46	NA	10.09	1.87	090
27400		A	Revise thigh muscles/tendons	9.21	NA	7.89	1.38	090
27403		A	Repair of knee cartilage	8.51	NA	7.33	1.27	090
27405		A	Repair of knee ligament	8.96	NA	7.75	1.34	090
27407		A	Repair of knee ligament	10.71	NA	8.82	1.60	090
27409		A	Repair of knee ligaments	13.57	NA	10.32	2.03	090
27412		A	Autochondrocyte implant knee	24.53	NA	16.67	3.67	090
27415		A	Osteochondral knee allograft	19.79	NA	14.31	2.96	090
27416		A	Osteochondral knee autograft	14.00	NA	10.28	2.10	090
27418		A	Repair degenerated kneecap	11.46	NA	9.12	1.70	090
27420		A	Revision of unstable kneecap	10.14	NA	8.33	1.51	090
27422		A	Revision of unstable kneecap	10.09	NA	8.34	1.51	090
27424		A	Revision/removal of kneecap	10.12	NA	8.34	1.51	090
27425		A	Lat retinacular release open	5.28	NA	5.63	0.79	090
27427		A	Reconstruction, knee	9.67	NA	8.14	1.44	090
27428		A	Reconstruction, knee	15.33	NA	12.13	2.29	090
27429		A	Reconstruction, knee	17.24	NA	13.60	2.58	090
27430		A	Revision of thigh muscles	10.04	NA	8.30	1.50	090
27435		A	Incision of knee joint	10.68	NA	9.26	1.60	090
27437		A	Revise kneecap	8.82	NA	7.47	1.32	090
27438		A	Revise kneecap with implant	11.77	NA	9.14	1.76	090
27440		A	Revision of knee joint	10.97	NA	8.75	1.64	090
27441		A	Revision of knee joint	11.42	NA	8.97	1.71	090
27442		A	Revision of knee joint	12.25	NA	9.41	1.83	090
27443		A	Revision of knee joint	11.29	NA	8.90	1.69	090
27445		A	Revision of knee joint	18.52	NA	12.81	2.77	090
27446		A	Revision of knee joint	16.26	NA	11.37	2.43	090
27447		A	Total knee arthroplasty	23.04	NA	15.46	3.44	090
27448		A	Incision of thigh	11.48	NA	8.78	1.73	090
27450		A	Incision of thigh	14.47	NA	10.81	2.17	090
27454		A	Realignment of thigh bone	18.97	NA	13.29	2.84	090
27455		A	Realignment of knee	13.24	NA	10.11	1.98	090
27457		A	Realignment of knee	13.92	NA	10.00	2.08	090
27465		A	Shortening of thigh bone	18.44	NA	12.73	2.76	090
27466		A	Lengthening of thigh bone	17.13	NA	12.41	2.56	090
27468		A	Shorten/lengthen thighs	19.82	NA	13.61	2.97	090
27470		A	Repair of thigh	16.97	NA	12.39	2.53	090
27472		A	Repair/graft of thigh	18.57	NA	13.00	2.78	090
27475		A	Surgery to stop leg growth	8.82	NA	7.48	1.32	090
27477		A	Surgery to stop leg growth	10.03	NA	8.07	1.50	090
27479		A	Surgery to stop leg growth	13.04	NA	6.99	0.70	090
27485		A	Surgery to stop leg growth	9.02	NA	7.51	1.35	090
27486		A	Revise/replace knee joint	20.92	NA	14.27	3.12	090
27487		A	Revise/replace knee joint	26.91	NA	17.24	4.02	090
27488		A	Removal of knee prosthesis	17.40	NA	12.52	2.60	090
27495		A	Reinforce thigh	16.40	NA	11.73	2.45	090
27496		A	Decompression of thigh/knee	6.66	NA	6.63	1.00	090
27497		A	Decompression of thigh/knee	7.70	NA	6.64	1.15	090
27498		A	Decompression of thigh/knee	8.54	NA	7.56	1.28	090
27499		A	Decompression of thigh/knee	9.31	NA	7.94	1.39	090
27500		A	Treatment of thigh fracture	6.21	6.55	5.63	0.91	090
27501		A	Treatment of thigh fracture	6.34	6.02	5.92	0.94	090
27502		A	Treatment of thigh fracture	11.24	NA	8.22	1.65	090

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27503		A	Treatment of thigh fracture	11.13	NA	8.74	1.66	090
27506		A	Treatment of thigh fracture	19.42	NA	13.87	2.90	090
27507		A	Treatment of thigh fracture	14.39	NA	9.95	2.15	090
27508		A	Treatment of thigh fracture	6.08	6.81	6.07	0.89	090
27509		A	Treatment of thigh fracture	8.02	NA	7.85	1.20	090
27510		A	Treatment of thigh fracture	9.68	NA	7.51	1.41	090
27511		A	Treatment of thigh fracture	14.97	NA	9.93	2.23	090
27513		A	Treatment of thigh fracture	19.11	NA	11.96	2.85	090
27514		A	Treatment of thigh fracture	14.46	NA	9.67	2.16	090
27516		A	Treat thigh fx growth plate	5.45	6.87	6.13	0.82	090
27517		A	Treat thigh fx growth plate	8.98	NA	7.87	1.34	090
27519		A	Treat thigh fx growth plate	13.11	NA	9.01	1.96	090
27520		A	Treat kneecap fracture	2.93	4.86	4.19	0.43	090
27524		A	Treat kneecap fracture	10.25	NA	8.40	1.53	090
27530		A	Treat knee fracture	3.97	5.72	5.07	0.58	090
27532		A	Treat knee fracture	7.43	7.68	6.78	1.11	090
27535		A	Treat knee fracture	13.27	NA	9.09	1.98	090
27536		A	Treat knee fracture	17.19	NA	12.43	2.56	090
27538		A	Treat knee fracture(s)	4.95	6.49	5.78	0.73	090
27540		A	Treat knee fracture	11.16	NA	8.98	1.66	090
27550		A	Treat knee dislocation	5.84	6.28	5.43	0.80	090
27552		A	Treat knee dislocation	8.04	NA	7.35	1.20	090
27556		A	Treat knee dislocation	12.86	NA	8.89	1.92	090
27557		A	Treat knee dislocation	15.76	NA	10.32	2.36	090
27558		A	Treat knee dislocation	18.25	NA	11.54	2.73	090
27560		A	Treat kneecap dislocation	3.88	5.33	4.70	0.58	090
27562		A	Treat kneecap dislocation	5.86	NA	5.94	0.88	090
27566		A	Treat kneecap dislocation	12.59	NA	9.56	1.88	090
27570		A	Fixation of knee joint	1.76	NA	1.93	0.26	010
27580		A	Fusion of knee	20.90	NA	14.99	3.11	090
27590		A	Amputate leg at thigh	13.35	NA	7.37	2.21	090
27591		A	Amputate leg at thigh	13.82	NA	8.76	2.19	090
27592		A	Amputate leg at thigh	10.86	NA	6.58	1.78	090
27594		A	Amputation follow-up surgery	7.17	NA	5.67	1.16	090
27596		A	Amputation follow-up surgery	11.15	NA	7.23	1.81	090
27598		A	Amputate lower leg at knee	11.08	NA	7.63	1.76	090
27599		C	Leg surgery procedure	0.00	0.00	0.00	0.00	YYY
27600		A	Decompression of lower leg	5.94	NA	4.47	0.95	090
27601		A	Decompression of lower leg	5.94	NA	5.09	0.95	090
27602		A	Decompression of lower leg	7.71	NA	5.02	1.30	090
27603		A	Drain lower leg lesion	5.12	8.22	4.67	0.74	090
27604		A	Drain lower leg bursa	4.51	7.38	3.95	0.53	090
27605		A	Incision of achilles tendon	2.89	5.79	1.93	0.26	010
27606		A	Incision of achilles tendon	4.15	NA	3.09	0.54	010
27607		A	Treat lower leg bone lesion	8.51	NA	6.81	1.18	090
27610		A	Explore/treat ankle joint	9.01	NA	7.30	1.22	090
27612		A	Exploration of ankle joint	8.01	NA	6.06	0.85	090
27613		A	Biopsy lower leg soft tissue	2.19	4.14	1.97	0.18	010
27614		A	Biopsy lower leg soft tissue	5.71	8.79	4.55	0.76	090
27615		A	Remove tumor, lower leg	12.93	NA	8.94	1.95	090
27618		A	Remove lower leg lesion	5.14	7.44	4.53	0.74	090
27619		A	Remove lower leg lesion	8.47	11.62	6.30	1.13	090
27620		A	Explore/treat ankle joint	6.04	NA	5.44	0.78	090
27625		A	Remove ankle joint lining	8.37	NA	6.17	0.95	090
27626		A	Remove ankle joint lining	8.98	NA	6.89	1.14	090
27630		A	Removal of tendon lesion	4.85	9.02	4.32	0.58	090
27635		A	Remove lower leg bone lesion	7.91	NA	6.78	1.11	090
27637		A	Remove/graft leg bone lesion	10.17	NA	8.65	1.52	090
27638		A	Remove/graft leg bone lesion	10.87	NA	8.47	1.63	090
27640		A	Partial removal of tibia	12.10	NA	8.89	1.65	090
27641		A	Partial removal of fibula	9.73	NA	7.24	1.26	090
27645		A	Extensive lower leg surgery	14.78	NA	10.92	2.21	090
27646		A	Extensive lower leg surgery	13.21	NA	10.15	1.98	090
27647		A	Extensive ankle/heel surgery	12.85	NA	6.45	0.91	090
27648		A	Injection for ankle x-ray	0.96	3.21	0.41	0.10	000
27650		A	Repair achilles tendon	9.00	NA	7.69	1.12	090
27652		A	Repair/graft achilles tendon	10.64	NA	7.00	1.11	090
27654		A	Repair of achilles tendon	10.32	NA	7.54	1.11	090
27656		A	Repair leg fascia defect	4.62	10.75	5.06	0.69	090
27658		A	Repair of leg tendon, each	5.03	NA	4.52	0.58	090
27659		A	Repair of leg tendon, each	6.99	NA	5.14	0.72	090
27664		A	Repair of leg tendon, each	4.64	NA	4.42	0.56	090
27665		A	Repair of leg tendons, each	5.46	NA	5.01	0.66	090
27675		A	Repair lower leg tendons	7.24	NA	5.21	0.74	090
27676		A	Repair lower leg tendons	8.61	NA	6.66	1.29	090
27680		A	Release of lower leg tendon	5.79	NA	4.94	0.72	090
27681		A	Release of lower leg tendons	6.94	NA	6.47	1.04	090
27685		A	Revision of lower leg tendon	6.57	10.03	5.21	0.67	090
27686		A	Revise lower leg tendons	7.64	NA	6.14	0.97	090
27687		A	Revision of calf tendon	6.30	NA	5.23	0.73	090
27690		A	Revise lower leg tendon	8.96	NA	7.08	0.98	090
27691		A	Revise lower leg tendon	10.28	NA	8.58	1.35	090
27692		A	Revise additional leg tendon	1.87	NA	0.86	0.25	ZZZ
27695		A	Repair of ankle ligament	6.58	NA	5.63	0.79	090

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CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
27696		A	Repair of ankle ligaments	8.46	NA	5.66	0.85	090
27698		A	Repair of ankle ligament	9.49	NA	6.78	1.12	090
27700		A	Revision of ankle joint	9.54	NA	5.90	0.89	090
27702		A	Reconstruct ankle joint	14.28	NA	10.21	1.99	090
27703		A	Reconstruction, ankle joint	16.79	NA	11.78	2.40	090
27704		A	Removal of ankle implant	7.69	NA	6.62	1.05	090
27705		A	incision of tibia	10.74	NA	8.31	1.52	090
27707		A	incision of fibula	4.67	NA	5.28	0.67	090
27709		A	Incision of tibia & fibula	17.32	NA	11.99	2.55	090
27712		A	Realignment of lower leg	15.67	NA	11.68	2.35	090
27715		A	Revision of lower leg	15.36	NA	11.20	2.30	090
27720		A	Repair of tibia	12.22	NA	9.60	1.81	090
27722		A	Repair/graft of tibia	12.31	NA	9.70	1.84	090
27724		A	Repair/graft of tibia	19.18	NA	12.59	2.85	090
27725		A	Repair of lower leg	17.15	NA	12.97	2.57	090
27726		A	Repair fibula nonunion	14.20	NA	10.09	2.09	090
27727		A	Repair of lower leg	14.69	NA	11.00	2.20	090
27730		A	Repair of tibia epiphysis	7.59	NA	6.81	1.14	090
27732		A	Repair of fibula epiphysis	5.37	NA	5.57	0.29	090
27734		A	Repair lower leg epiphyses	8.72	NA	5.28	0.47	090
27740		A	Repair of leg epiphyses	9.49	NA	7.97	1.42	090
27742		A	Repair of leg epiphyses	10.49	NA	8.70	1.57	090
27745		A	Reinforce tibia	10.37	NA	8.42	1.55	090
27750		A	Treatment of tibia fracture	3.26	5.13	4.45	0.47	090
27752		A	Treatment of tibia fracture	6.15	7.04	6.07	0.91	090
27756		A	Treatment of tibia fracture	7.33	NA	6.86	1.09	090
27758		A	Treatment of tibia fracture	12.40	NA	9.73	1.85	090
27759		A	Treatment of tibia fracture	14.31	NA	10.55	2.13	090
27760		A	Clx medial ankle fx	3.09	5.03	4.33	0.42	090
27762		A	Clx med ankle fx w/mnpj	5.33	6.42	5.47	0.74	090
27766		A	Optx medial ankle fx	7.73	NA	7.31	1.11	090
27767		A	Clx post ankle fx	2.50	4.30	4.34	0.36	090
27768		A	Clx post ankle fx w/mnpj	5.00	NA	5.67	0.75	090
27769		A	Optx post ankle fx	10.00	NA	8.18	1.50	090
27780		A	Treatment of fibula fracture	2.72	4.64	3.99	0.39	090
27781		A	Treatment of fibula fracture	4.47	5.94	5.21	0.65	090
27784		A	Treatment of fibula fracture	9.51	NA	8.23	1.40	090
27786		A	Treatment of ankle fracture	2.91	4.79	4.07	0.41	090
27788		A	Treatment of ankle fracture	4.52	5.82	4.96	0.63	090
27792		A	Treatment of ankle fracture	9.55	NA	8.13	1.37	090
27808		A	Treatment of ankle fracture	2.91	5.16	4.36	0.41	090
27810		A	Treatment of ankle fracture	5.20	6.34	5.35	0.74	090
27814		A	Treatment of ankle fracture	10.46	NA	8.73	1.54	090
27816		A	Treatment of ankle fracture	2.96	4.76	3.98	0.40	090
27818		A	Treatment of ankle fracture	5.57	6.29	5.15	0.77	090
27822		A	Treatment of ankle fracture	11.03	NA	9.85	1.62	090
27823		A	Treatment of ankle fracture	12.98	NA	10.79	1.90	090
27824		A	Treat lower leg fracture	3.20	4.39	4.18	0.45	090
27825		A	Treat lower leg fracture	6.60	6.92	5.73	0.95	090
27826		A	Treat lower leg fracture	10.92	NA	9.79	1.59	090
27827		A	Treat lower leg fracture	14.56	NA	12.24	2.15	090
27828		A	Treat lower leg fracture	18.20	NA	14.08	2.70	090
27829		A	Treat lower leg joint	8.64	NA	8.36	1.26	090
27830		A	Treat lower leg dislocation	3.85	5.36	4.74	0.58	090
27831		A	Treat lower leg dislocation	4.62	NA	5.11	0.69	090
27832		A	Treat lower leg dislocation	10.01	NA	8.59	1.50	090
27840		A	Treat ankle dislocation	4.65	NA	4.25	0.61	090
27842		A	Treat ankle dislocation	6.34	NA	5.78	0.90	090
27846		A	Treat ankle dislocation	10.16	NA	8.15	1.46	090
27848		A	Treat ankle dislocation	11.56	NA	8.93	1.69	090
27860		A	Fixation of ankle joint	2.36	NA	2.00	0.28	010
27870		A	Fusion of ankle joint, open	15.21	NA	10.88	2.10	090
27871		A	Fusion of tibiofibular joint	9.42	NA	7.86	1.39	090
27880		A	Amputation of lower leg	15.24	NA	8.24	2.50	090
27881		A	Amputation of lower leg	13.32	NA	8.88	2.10	090
27882		A	Amputation of lower leg	9.67	NA	5.86	1.61	090
27884		A	Amputation follow-up surgery	8.64	NA	6.04	1.40	090
27886		A	Amputation follow-up surgery	9.88	NA	6.90	1.59	090
27888		A	Amputation of foot at ankle	10.23	NA	7.18	1.46	090
27889		A	Amputation of foot at ankle	10.72	NA	6.02	1.80	090
27892		A	Decompression of leg	7.82	NA	6.03	1.23	090
27893		A	Decompression of leg	7.78	NA	5.92	1.26	090
27894		A	Decompression of leg	12.42	NA	8.82	1.98	090
27899		C	Leg/ankle surgery procedure	0.00	0.00	0.00	0.00	YYY
28001		A	Drainage of bursa of foot	2.75	4.26	1.67	0.16	010
28002		A	Treatment of foot infection	5.78	7.34	3.89	0.48	010
28003		A	Treatment of foot infection	8.95	8.48	4.94	0.76	090
28005		A	Treat foot bone lesion	9.30	NA	5.98	0.73	090
28008		A	Incision of foot fascia	4.50	6.48	3.07	0.30	090
28010		A	Incision of toe tendon	2.89	3.04	2.47	0.19	090
28011		A	Incision of toe tendons	4.19	4.21	3.35	0.35	090
28020		A	Exploration of foot joint	5.06	8.26	3.99	0.49	090
28022		A	Exploration of foot joint	4.72	7.44	3.51	0.35	090
28024		A	Exploration of toe joint	4.43	7.06	3.30	0.30	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
28035		A	Decompression of tibia nerve	5.14	8.25	4.01	0.48	090
28043		A	Excision of foot lesion	3.58	5.23	2.96	0.27	090
28045		A	Excision of foot lesion	4.77	7.77	3.54	0.37	090
28046		A	Resection of tumor, foot	10.55	11.16	6.20	1.08	090
28050		A	Biopsy of foot joint lining	4.30	6.54	2.98	0.23	090
28052		A	Biopsy of foot joint lining	3.98	7.45	3.38	0.36	090
28054		A	Biopsy of toe joint lining	3.49	6.06	2.61	0.19	090
28055		A	Neurectomy, foot	6.20	NA	3.65	0.39	090
28060		A	Partial removal, foot fascia	5.29	7.77	3.82	0.40	090
28062		A	Removal of foot fascia	6.58	8.36	3.98	0.43	090
28070		A	Removal of foot joint lining	5.15	7.75	3.63	0.41	090
28072		A	Removal of foot joint lining	4.63	8.54	4.04	0.47	090
28080		A	Removal of foot lesion	4.65	8.40	4.54	0.34	090
28086		A	Excise foot tendon sheath	4.83	8.85	4.29	0.54	090
28088		A	Excise foot tendon sheath	3.90	7.78	3.53	0.40	090
28090		A	Removal of foot lesion	4.46	7.45	3.44	0.34	090
28092		A	Removal of toe lesions	3.69	7.10	3.24	0.29	090
28100		A	Removal of ankle/heel lesion	5.72	9.20	4.52	0.57	090
28102		A	Remove/graft foot lesion	7.80	NA	4.16	0.42	090
28103		A	Remove/graft foot lesion	6.56	NA	3.71	0.36	090
28104		A	Removal of foot lesion	5.17	7.86	3.70	0.40	090
28106		A	Remove/graft foot lesion	7.23	NA	4.02	0.39	090
28107		A	Remove/graft foot lesion	5.62	7.62	3.48	0.31	090
28108		A	Removal of toe lesions	4.21	6.88	3.18	0.28	090
28110		A	Part removal of metatarsal	4.13	7.52	3.26	0.30	090
28111		A	Part removal of metatarsal	5.06	7.81	3.50	0.43	090
28112		A	Part removal of metatarsal	4.54	7.85	3.49	0.37	090
28113		A	Part removal of metatarsal	5.88	9.09	4.95	0.44	090
28114		A	Removal of metatarsal heads	11.61	15.44	9.56	1.20	090
28116		A	Revision of foot	8.94	10.13	5.61	0.69	090
28118		A	Removal of heel bone	6.02	8.85	4.45	0.55	090
28119		A	Removal of heel spur	5.45	7.88	3.84	0.39	090
28120		A	Part removal of ankle/heel	5.64	9.26	4.54	0.58	090
28122		A	Partial removal of foot bone	7.56	9.34	5.21	0.59	090
28124		A	Partial removal of toe	4.88	7.24	3.62	0.30	090
28126		A	Partial removal of toe	3.56	6.49	2.84	0.24	090
28130		A	Removal of ankle bone	9.30	NA	6.88	1.39	090
28140		A	Removal of metatarsal	7.03	8.56	4.49	0.67	090
28150		A	Removal of toe	4.14	6.96	3.21	0.31	090
28153		A	Partial removal of toe	3.71	6.82	3.12	0.26	090
28160		A	Partial removal of toe	3.79	6.99	3.19	0.28	090
28171		A	Extensive foot surgery	9.85	NA	5.15	0.53	090
28173		A	Extensive foot surgery	9.05	9.55	5.00	0.73	090
28175		A	Extensive foot surgery	6.17	7.94	3.98	0.43	090
28190		A	Removal of foot foreign body	1.98	4.47	1.48	0.13	010
28192		A	Removal of foot foreign body	4.69	7.30	3.43	0.35	090
28193		A	Removal of foot foreign body	5.79	7.87	3.83	0.41	090
28200		A	Repair of foot tendon	4.65	7.34	3.37	0.33	090
28202		A	Repair/graft of foot tendon	6.96	8.34	4.13	0.47	090
28208		A	Repair of foot tendon	4.42	7.48	3.51	0.35	090
28210		A	Repair/graft of foot tendon	6.41	8.18	4.13	0.44	090
28220		A	Release of foot tendon	4.58	6.89	3.23	0.30	090
28222		A	Release of foot tendons	5.67	7.35	3.45	0.36	090
28225		A	Release of foot tendons	3.70	6.44	2.84	0.25	090
28226		A	Release of foot tendons	4.58	6.71	3.05	0.25	090
28230		A	Incision of foot tendon(s)	4.28	6.69	3.00	0.28	090
28232		A	Incision of toe tendon	3.43	6.44	2.85	0.24	090
28234		A	Incision of foot tendon	3.43	6.94	3.33	0.25	090
28238		A	Revision of foot tendon	7.85	9.41	4.83	0.63	090
28240		A	Release of big toe	4.40	6.93	3.16	0.32	090
28250		A	Revision of foot fascia	5.97	8.58	4.30	0.57	090
28260		A	Release of midfoot joint	8.08	9.77	5.30	0.77	090
28261		A	Revision of foot tendon	12.91	11.38	6.59	0.92	090
28262		A	Revision of foot and ankle	17.01	18.25	11.57	2.31	090
28264		A	Release of midfoot joint	10.53	8.89	4.85	0.57	090
28270		A	Release of foot contracture	4.82	7.61	3.73	0.36	090
28272		A	Release of toe joint, each	3.84	6.20	2.75	0.22	090
28280		A	Fusion of toes	5.24	7.98	3.81	0.42	090
28285		A	Repair of hammertoe	4.65	7.32	3.59	0.33	090
28286		A	Repair of hammertoe	4.61	6.97	3.18	0.28	090
28288		A	Partial removal of foot bone	5.81	9.51	5.14	0.48	090
28289		A	Repair hallux rigidus	8.11	10.49	5.88	0.72	090
28290		A	Correction of bunion	5.72	9.10	4.35	0.52	090
28292		A	Correction of bunion	8.72	11.28	6.62	0.61	090
28293		A	Correction of bunion	11.10	15.38	7.16	0.66	090
28294		A	Correction of bunion	8.63	10.44	5.17	0.69	090
28296		A	Correction of bunion	8.16	10.05	5.30	0.55	090
28297		A	Correction of bunion	9.31	11.67	5.88	0.86	090
28298		A	Correction of bunion	8.01	10.35	5.03	0.63	090
28299		A	Correction of bunion	11.39	11.52	6.12	0.81	090
28300		A	Incision of heel bone	9.61	NA	7.04	1.20	090
28302		A	Incision of ankle bone	9.62	NA	8.03	1.44	090
28304		A	Incision of midfoot bones	9.29	10.99	5.82	0.87	090
28305		A	Incise/graft midfoot bones	10.63	NA	6.72	0.58	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
28306		A	Incision of metatarsal	5.91	9.77	4.50	0.61	090
28307		A	Incision of metatarsal	6.39	12.88	6.20	0.96	090
28308		A	Incision of metatarsal	5.36	8.89	4.24	0.43	090
28309		A	Incision of metatarsals	13.96	NA	8.82	1.57	090
28310		A	Revision of big toe	5.48	8.19	3.63	0.39	090
28312		A	Revision of toe	4.60	8.19	3.53	0.36	090
28313		A	Repair deformity of toe	5.06	8.50	4.20	0.53	090
28315		A	Removal of sesamoid bone	4.91	7.27	3.44	0.35	090
28320		A	Repair of foot bones	9.25	NA	6.45	1.04	090
28322		A	Repair of metatarsals	8.41	11.55	6.33	0.97	090
28340		A	Resect enlarged toe tissue	7.04	7.93	3.83	0.38	090
28341		A	Resect enlarged toe	8.60	8.83	4.38	0.47	090
28344		A	Repair extra toe(s)	4.31	6.62	2.98	0.23	090
28345		A	Repair webbed toe(s)	5.98	7.47	3.57	0.32	090
28360		A	Reconstruct cleft foot	14.67	NA	9.79	2.38	090
28400		A	Treatment of heel fracture	2.22	3.91	3.39	0.27	090
28405		A	Treatment of heel fracture	4.63	4.99	4.14	0.50	090
28406		A	Treatment of heel fracture	6.44	NA	6.51	0.88	090
28415		A	Treat heel fracture	15.96	NA	12.04	2.09	090
28420		A	Treat graft heel fracture	17.29	NA	13.70	2.59	090
28430		A	Treatment of ankle fracture	2.14	3.64	3.01	0.26	090
28435		A	Treatment of ankle fracture	3.45	5.29	4.37	0.52	090
28436		A	Treatment of ankle fracture	4.78	NA	6.14	0.72	090
28445		A	Treat ankle fracture	15.53	NA	11.23	2.08	090
28446		A	Osteochondral talus autograft	17.50	NA	12.84	2.62	090
28450		A	Treat midfoot fracture, each	1.95	3.37	2.80	0.22	090
28455		A	Treat midfoot fracture, each	3.15	4.40	3.64	0.33	090
28456		A	Treat midfoot fracture	2.75	NA	5.13	0.41	090
28465		A	Treat midfoot fracture, each	8.64	NA	6.77	0.94	090
28470		A	Treat metatarsal fracture	1.99	3.28	2.76	0.24	090
28475		A	Treat metatarsal fracture	2.97	3.50	2.80	0.29	090
28476		A	Treat metatarsal fracture	3.46	NA	4.92	0.39	090
28485		A	Treat metatarsal fracture	7.28	NA	6.23	0.70	090
28490		A	Treat big toe fracture	1.12	2.45	1.96	0.12	090
28495		A	Treat big toe fracture	1.62	2.77	2.09	0.13	090
28496		A	Treat big toe fracture	2.39	8.24	3.31	0.26	090
28505		A	Treat big toe fracture	7.28	9.55	5.41	0.68	090
28510		A	Treatment of toe fracture	1.12	1.93	1.85	0.11	090
28515		A	Treatment of toe fracture	1.50	2.50	2.04	0.13	090
28525		A	Treat toe fracture	5.46	8.89	4.69	0.52	090
28530		A	Treat sesamoid bone fracture	1.08	1.84	1.51	0.08	090
28531		A	Treat sesamoid bone fracture	2.51	9.23	3.51	0.14	090
28540		A	Treat foot dislocation	2.10	2.95	2.46	0.14	090
28545		A	Treat foot dislocation	2.51	4.63	3.81	0.38	090
28546		A	Treat foot dislocation	3.28	10.69	4.91	0.49	090
28555		A	Repair foot dislocation	9.49	12.50	7.31	1.17	090
28570		A	Treat foot dislocation	1.70	2.42	1.85	0.09	090
28575		A	Treat foot dislocation	3.38	5.44	4.60	0.51	090
28576		A	Treat foot dislocation	4.48	NA	5.14	0.67	090
28585		A	Repair foot dislocation	10.92	13.13	7.90	1.22	090
28600		A	Treat foot dislocation	1.94	3.47	2.72	0.21	090
28605		A	Treat foot dislocation	2.78	5.10	4.31	0.42	090
28606		A	Treat foot dislocation	4.97	NA	4.85	0.64	090
28615		A	Repair foot dislocation	10.46	NA	9.07	1.29	090
28630		A	Treat toe dislocation	1.72	2.16	1.07	0.15	010
28635		A	Treat toe dislocation	1.93	2.45	1.41	0.15	010
28636		A	Treat toe dislocation	2.77	4.96	2.31	0.31	010
28645		A	Repair toe dislocation	7.28	9.11	4.97	0.59	090
28660		A	Treat toe dislocation	1.25	1.59	0.96	0.12	010
28665		A	Treat toe dislocation	1.94	2.04	1.47	0.17	010
28666		A	Treat toe dislocation	2.66	NA	2.60	0.40	010
28675		A	Repair of toe dislocation	5.46	9.29	4.98	0.56	090
28705		A	Fusion of foot bones	20.12	NA	12.69	2.59	090
28715		A	Fusion of foot bones	14.40	NA	10.04	1.86	090
28725		A	Fusion of foot bones	11.97	NA	7.86	1.40	090
28730		A	Fusion of foot bones	12.21	NA	9.02	1.43	090
28735		A	Fusion of foot bones	12.03	NA	8.04	1.30	090
28737		A	Revision of foot bones	10.83	NA	6.56	0.93	090
28740		A	Fusion of foot bones	9.09	12.51	6.89	0.99	090
28750		A	Fusion of big toe joint	8.37	12.45	6.80	0.96	090
28755		A	Fusion of big toe joint	4.79	7.97	3.62	0.38	090
28760		A	Fusion of big toe joint	8.94	11.23	5.93	0.76	090
28800		A	Amputation of midfoot	8.65	NA	5.61	0.98	090
28805		A	Amputation thru metatarsal	12.55	NA	6.68	1.58	090
28810		A	Amputation toe & metatarsal	6.52	NA	4.66	0.87	090
28820		A	Amputation of toe	4.89	8.42	3.94	0.54	090
28825		A	Partial amputation of toe	5.85	8.90	4.55	0.62	090
28890		A	High energy eswt, plantar f	3.36	5.27	2.52	0.26	090
28899		C	Foot/toes surgery procedure	0.00	0.00	0.00	0.00	YYY
29000		A	Application of body cast	2.25	3.63	1.77	0.13	000
29010		A	Application of body cast	2.06	2.36	0.86	0.31	000
29015		A	Application of body cast	2.41	3.74	1.36	0.25	000
29020		A	Application of body cast	2.11	3.34	1.29	0.07	000
29025		A	Application of body cast	2.40	4.77	2.13	0.13	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
29035		A	Application of body cast	1.77	4.03	1.66	0.26	000
29040		A	Application of body cast	2.22	3.80	1.68	0.33	000
29044		A	Application of body cast	2.12	4.27	1.84	0.32	000
29046		A	Application of body cast	2.41	4.33	1.93	0.36	000
29049		A	Application of figure eight	0.89	1.12	0.63	0.13	000
29055		A	Application of shoulder cast	1.78	3.66	1.67	0.27	000
29058		A	Application of shoulder cast	1.31	1.51	0.70	0.14	000
29065		A	Application of long arm cast	0.87	1.51	0.85	0.12	000
29075		A	Application of forearm cast	0.77	1.46	0.80	0.11	000
29085		A	Apply hand/wrist cast	0.87	1.50	0.84	0.11	000
29086		A	Apply finger cast	0.62	1.33	0.70	0.06	000
29105		A	Apply long arm splint	0.87	1.31	0.66	0.10	000
29125		A	Apply forearm splint	0.59	1.17	0.53	0.06	000
29126		A	Apply forearm splint	0.77	1.23	0.61	0.08	000
29130		A	Application of finger splint	0.50	0.53	0.24	0.05	000
29131		A	Application of finger splint	0.55	0.74	0.31	0.05	000
29200		A	Strapping of chest	0.65	0.77	0.44	0.03	000
29220		A	Strapping of low back	0.64	0.77	0.45	0.03	000
29240		A	Strapping of shoulder	0.71	0.76	0.44	0.04	000
29260		A	Strapping of elbow or wrist	0.55	0.77	0.43	0.04	000
29280		A	Strapping of hand or finger	0.51	0.77	0.43	0.03	000
29305		A	Application of hip cast	2.03	4.02	1.94	0.30	000
29325		A	Application of hip casts	2.32	4.39	2.14	0.35	000
29345		A	Application of long leg cast	1.40	1.97	1.14	0.20	000
29355		A	Application of long leg cast	1.53	1.96	1.15	0.21	000
29358		A	Apply long leg cast brace	1.43	2.51	1.17	0.21	000
29365		A	Application of long leg cast	1.18	1.85	1.02	0.17	000
29405		A	Apply short leg cast	0.86	1.39	0.77	0.11	000
29425		A	Apply short leg cast	1.01	1.40	0.75	0.10	000
29435		A	Apply short leg cast	1.18	1.77	0.96	0.16	000
29440		A	Addition of walker to cast	0.57	0.77	0.32	0.07	000
29445		A	Apply rigid leg cast	1.78	1.80	1.03	0.17	000
29450		A	Application of leg cast	2.08	1.67	0.92	0.15	000
29505		A	Application, long leg splint	0.69	1.31	0.57	0.07	000
29515		A	Application lower leg splint	0.73	1.14	0.55	0.07	000
29520		A	Strapping of hip	0.54	0.72	0.40	0.03	000
29530		A	Strapping of knee	0.57	0.76	0.42	0.04	000
29540		A	Strapping of ankle and/or ft	0.51	0.58	0.32	0.03	000
29550		A	Strapping of toes	0.47	0.60	0.31	0.03	000
29580		A	Application of paste boot	0.55	0.80	0.38	0.05	000
29590		A	Application of foot splint	0.76	0.64	0.26	0.04	000
29700		A	Removal/revision of cast	0.57	1.05	0.30	0.07	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
29705		A	Removal/revision of cast	0.76	0.92	0.45	0.10	000
29710		A	Removal/revision of cast	1.34	1.71	0.77	0.20	000
29715		A	Removal/revision of cast	0.94	1.09	0.43	0.06	000
29720		A	Repair of body cast	0.68	1.37	0.42	0.10	000
29730		A	Windowing of cast	0.75	0.89	0.42	0.09	000
29740		A	Wedging of cast	1.12	1.14	0.52	0.13	000
29750		A	Wedging of clubfoot cast	1.26	1.40	0.71	0.19	000
29799		C	Casting/strapping procedure	0.00	0.00	0.00	0.00	YYY
29800		A	Jaw arthroscopy/surgery	6.73	NA	6.22	1.01	090
29804		A	Jaw arthroscopy/surgery	8.71	NA	6.23	0.24	090
29805		A	Shoulder arthroscopy, dx	5.94	NA	5.66	0.88	090
29806		A	Shoulder arthroscopy/surgery	14.95	NA	11.36	2.22	090
29807		A	Shoulder arthroscopy/surgery	14.48	NA	11.16	2.15	090
29819		A	Shoulder arthroscopy/surgery	7.68	NA	6.79	1.14	090
29820		A	Shoulder arthroscopy/surgery	7.12	NA	6.23	1.06	090
29821		A	Shoulder arthroscopy/surgery	7.78	NA	6.85	1.16	090
29822		A	Shoulder arthroscopy/surgery	7.49	NA	6.73	1.11	090
29823		A	Shoulder arthroscopy/surgery	8.24	NA	7.31	1.23	090
29824		A	Shoulder arthroscopy/surgery	8.82	NA	7.91	1.31	090
29825		A	Shoulder arthroscopy/surgery	7.68	NA	6.81	1.14	090
29826		A	Shoulder arthroscopy/surgery	9.05	NA	7.50	1.35	090
29827		A	Arthroscop rotator cuff repr	15.44	NA	11.36	2.29	090
29828		A	Arthroscopy biceps tenodesis	13.00	NA	9.98	1.94	090
29830		A	Elbow arthroscopy	5.80	NA	5.39	0.87	090
29834		A	Elbow arthroscopy/surgery	6.33	NA	5.87	0.92	090
29835		A	Elbow arthroscopy/surgery	6.53	NA	5.97	0.98	090
29836		A	Elbow arthroscopy/surgery	7.61	NA	6.78	1.14	090
29837		A	Elbow arthroscopy/surgery	6.92	NA	6.18	1.02	090
29838		A	Elbow arthroscopy/surgery	7.77	NA	6.86	1.12	090
29840		A	Wrist arthroscopy	5.59	NA	5.51	0.84	090
29843		A	Wrist arthroscopy/surgery	6.06	NA	5.83	0.91	090
29844		A	Wrist arthroscopy/surgery	6.42	NA	5.99	0.89	090
29845		A	Wrist arthroscopy/surgery	7.58	NA	6.61	1.03	090
29846		A	Wrist arthroscopy/surgery	6.80	NA	6.18	0.92	090
29847		A	Wrist arthroscopy/surgery	7.13	NA	6.26	1.07	090
29848		A	Wrist endoscopy/surgery	6.24	NA	6.35	0.87	090
29850		A	Knee arthroscopy/surgery	8.18	NA	7.23	1.32	090
29851		A	Knee arthroscopy/surgery	13.08	NA	9.96	1.96	090
29855		A	Tibial arthroscopy/surgery	10.60	NA	8.84	1.59	090
29856		A	Tibial arthroscopy/surgery	14.12	NA	10.57	2.11	090
29860		A	Hip arthroscopy, dx	8.85	NA	7.56	1.32	090
29861		A	Hip arthroscopy/surgery	9.95	NA	8.10	1.49	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
29862		A	Hip arthroscopy/surgery	10.97	NA	9.20	1.63	090
29863		A	Hip arthroscopy/surgery	10.97	NA	9.24	1.64	090
29866		A	Autgrft implnt, knee w/scope	14.48	NA	11.46	2.17	090
29867		A	Allgrft implnt, knee w/scope	18.18	NA	13.52	2.72	090
29868		A	Meniscal trnspl, knee w/scpe	24.89	NA	16.82	3.73	090
29870		A	Knee arthroscopy, dx	5.11	NA	5.03	0.76	090
29871		A	Knee arthroscopy/drainage	6.60	NA	6.08	0.98	090
29873		A	Knee arthroscopy/surgery	6.09	NA	6.70	0.91	090
29874		A	Knee arthroscopy/surgery	7.10	NA	6.19	1.05	090
29875		A	Knee arthroscopy/surgery	6.36	NA	5.87	0.95	090
29876		A	Knee arthroscopy/surgery	8.72	NA	7.46	1.30	090
29877		A	Knee arthroscopy/surgery	8.15	NA	7.19	1.22	090
29879		A	Knee arthroscopy/surgery	8.84	NA	7.52	1.32	090
29880		A	Knee arthroscopy/surgery	9.30	NA	7.75	1.39	090
29881		A	Knee arthroscopy/surgery	8.56	NA	7.39	1.28	090
29882		A	Knee arthroscopy/surgery	9.45	NA	7.79	1.41	090
29883		A	Knee arthroscopy/surgery	11.61	NA	9.19	1.73	090
29884		A	Knee arthroscopy/surgery	8.13	NA	7.19	1.22	090
29885		A	Knee arthroscopy/surgery	10.03	NA	8.49	1.50	090
29886		A	Knee arthroscopy/surgery	8.34	NA	7.31	1.25	090
29887		A	Knee arthroscopy/surgery	9.98	NA	8.43	1.49	090
29888		A	Knee arthroscopy/surgery	14.14	NA	10.49	2.11	090
29889		A	Knee arthroscopy/surgery	17.15	NA	12.98	2.54	090
29891		A	Ankle arthroscopy/surgery	9.47	NA	7.78	1.23	090
29892		A	Ankle arthroscopy/surgery	10.07	NA	8.81	1.51	090
29893		A	Scope, plantar fasciotomy	6.08	9.36	4.84	0.35	090
29894		A	Ankle arthroscopy/surgery	7.26	NA	5.64	0.91	090
29895		A	Ankle arthroscopy/surgery	7.04	NA	5.31	0.84	090
29897		A	Ankle arthroscopy/surgery	7.23	NA	5.73	0.92	090
29898		A	Ankle arthroscopy/surgery	8.38	NA	6.08	0.96	090
29899		A	Ankle arthroscopy/surgery	15.21	NA	10.90	2.15	090
29900		A	Mcp joint arthroscopy, dx	5.74	NA	4.42	0.31	090
29901		A	Mcp joint arthroscopy, surg	6.45	NA	6.58	0.97	090
29902		A	Mcp joint arthroscopy, surg	7.02	NA	8.04	1.91	090
29904		A	Subtalar arthro w/fb rmvl	8.50	NA	7.19	1.27	090
29905		A	Subtalar arthro w/exc	9.00	NA	7.94	1.35	090
29906		A	Subtalar arthro w/deb	9.47	NA	8.38	1.42	090
29907		A	Subtalar arthro w/fusion	12.00	NA	9.63	0.65	090
29999		C	Arthroscopy of joint	0.00	0.00	0.00	0.00	YYY
30000		A	Drainage of nose lesion	1.45	4.37	1.57	0.10	010
30020		A	Drainage of nose lesion	1.45	4.40	1.60	0.10	010
30100		A	Intranasal biopsy	0.94	2.67	0.85	0.06	000
30110		A	Removal of nose polyp(s)	1.65	4.16	1.69	0.11	010
30115		A	Removal of nose polyp(s)	4.38	NA	6.61	0.43	090
30117		A	Removal of intranasal lesion	3.20	18.65	5.37	0.31	090
30118		A	Removal of intranasal lesion	9.81	NA	9.80	0.98	090
30120		A	Revision of nose	5.31	7.75	5.78	0.63	090
30124		A	Removal of nose lesion	3.14	NA	3.85	0.32	090
30125		A	Removal of nose lesion	7.21	NA	8.40	0.70	090
30130		A	Excise inferior turbinate	3.41	NA	6.25	0.32	090
30140		A	Resect inferior turbinate	3.48	NA	7.61	0.34	090
30150		A	Partial removal of nose	9.44	NA	10.28	1.06	090
30160		A	Removal of nose	9.88	NA	10.05	0.96	090
3018F		I	Pre-prvd rsk st al docd	0.00	0.00	0.00	0.00	XXX
30200		A	Injection treatment of nose	0.78	2.13	0.78	0.05	000
30210		A	Nasal sinus therapy	1.10	2.68	1.43	0.07	010
30220		A	Insert nasal septal button	1.56	6.07	1.65	0.10	010
30300		A	Remove nasal foreign body	1.06	4.71	2.13	0.07	010
30310		A	Remove nasal foreign body	1.98	NA	3.26	0.13	010
30320		A	Remove nasal foreign body	4.56	NA	6.93	0.44	090
30400		R	Reconstruction of nose	10.58	NA	14.97	1.03	090
30410		R	Reconstruction of nose	13.72	NA	16.45	1.34	090
30420		R	Reconstruction of nose	16.62	NA	18.32	1.78	090
30430		R	Revision of nose	7.96	NA	13.74	1.19	090
30435		R	Revision of nose	12.45	NA	15.85	1.21	090
30450		R	Revision of nose	19.38	NA	19.11	1.89	090
30460		A	Revision of nose	10.24	NA	10.46	1.53	090
30462		A	Revision of nose	20.12	NA	16.22	1.96	090
30465		A	Repair nasal stenosis	12.20	NA	12.92	1.30	090
30520		A	Repair of nasal septum	6.85	NA	9.02	0.67	090
30540		A	Repair nasal defect	7.81	NA	9.79	0.76	090
30545		A	Repair nasal defect	11.50	NA	10.42	0.62	090
30560		A	Release of nasal adhesions	1.28	5.50	2.22	0.09	010
30580		A	Repair upper jaw fistula	6.76	8.66	5.55	0.27	090
30600		A	Repair mouth/nose fistula	6.07	8.54	5.01	0.59	090
30620		A	Intranasal reconstruction	6.04	NA	9.71	0.67	090
30630		A	Repair nasal septum defect	7.18	NA	8.76	0.73	090
30801		A	Ablate inf turbinate, superf	1.11	4.60	2.34	0.07	010
30802		A	Cauterization, inner nose	2.05	5.28	2.81	0.14	010
30901		A	Control of nosebleed	1.21	1.47	0.42	0.10	000
30903		A	Control of nosebleed	1.54	3.57	0.58	0.12	000
30905		A	Control of nosebleed	1.97	4.35	0.69	0.16	000
30906		A	Repeat control of nosebleed	2.45	4.68	1.07	0.17	000
30915		A	Ligation, nasal sinus artery	7.36	NA	7.55	0.73	090

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CPT[1,5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
30920		A	Ligation, upper jaw artery	11.03	NA	10.50	1.08	090
30930		A	Ther fx, nasal inf turbinate	1.28	NA	1.86	0.08	010
30999		C	Nasal surgery procedure	0.00	0.00	0.00	0.00	YYY
31000		A	Irrigation, maxillary sinus	1.17	3.35	1.48	0.07	010
31002		A	Irrigation, sphenoid sinus	1.93	NA	3.13	0.13	010
31020		A	Exploration, maxillary sinus	2.99	8.92	5.90	0.28	090
31030		A	Exploration, maxillary sinus	5.95	10.77	6.96	0.47	090
31032		A	Explore sinus, remove polyps	6.61	NA	7.82	0.60	090
31040		A	Exploration behind upper jaw	9.66	NA	9.48	0.98	090
31050		A	Exploration, sphenoid sinus	5.31	NA	7.08	0.52	090
31051		A	Sphenoid sinus surgery	7.16	NA	9.34	0.70	090
31070		A	Exploration of frontal sinus	4.32	NA	6.83	0.43	090
31075		A	Exploration of frontal sinus	9.40	NA	10.65	0.92	090
31080		A	Removal of frontal sinus	12.54	NA	13.84	1.22	090
31081		A	Removal of frontal sinus	13.99	NA	20.75	3.80	090
31084		A	Removal of frontal sinus	14.75	NA	14.88	1.44	090
31085		A	Removal of frontal sinus	15.44	NA	21.43	4.20	090
31086		A	Removal of frontal sinus	14.16	NA	14.61	1.38	090
31087		A	Removal of frontal sinus	14.39	NA	13.46	1.40	090
31090		A	Exploration of sinuses	10.88	NA	15.04	1.04	090
31200		A	Removal of ethmoid sinus	5.03	NA	9.03	0.32	090
31201		A	Removal of ethmoid sinus	8.49	NA	10.39	0.78	090
31205		A	Removal of ethmoid sinus	10.47	NA	12.24	0.72	090
31225		A	Removal of upper jaw	26.44	NA	21.54	2.56	090
31230		A	Removal of upper jaw	30.56	NA	23.40	2.98	090
31231		A	Nasal endoscopy, dx	1.10	3.77	0.92	0.07	000
31233		A	Nasal/sinus endoscopy, dx	2.18	4.59	1.43	0.14	000
31235		A	Nasal/sinus endoscopy, dx	2.64	5.03	1.63	0.17	000
31237		A	Nasal/sinus endoscopy, surg	2.98	5.34	1.81	0.20	000
31238		A	Nasal/sinus endoscopy, surg	3.26	5.30	1.94	0.21	000
31239		A	Nasal/sinus endoscopy, surg	9.23	NA	8.44	0.53	010
31240		A	Nasal/sinus endoscopy, surg	2.61	NA	1.63	0.17	000
31254		A	Revision of ethmoid sinus	4.64	NA	2.60	0.31	000
31255		A	Removal of ethmoid sinus	6.95	NA	3.66	0.46	000
31256		A	Exploration maxillary sinus	3.29	NA	1.95	0.22	000
31267		A	Endoscopy, maxillary sinus	5.45	NA	2.97	0.36	000
31276		A	Sinus endoscopy, surgical	8.84	NA	4.56	0.58	000
31287		A	Nasal/sinus endoscopy, surg	3.91	NA	2.24	0.26	000
31288		A	Nasal/sinus endoscopy, surg	4.57	NA	2.56	0.30	000
31290		A	Nasal/sinus endoscopy, surg	18.50	NA	11.68	1.44	010
31291		A	Nasal/sinus endoscopy, surg	19.45	NA	12.19	1.76	010
31292		A	Nasal/sinus endoscopy, surg	15.79	NA	10.37	1.04	010
31293		A	Nasal/sinus endoscopy, surg	17.36	NA	11.12	1.13	010
31294		A	Nasal/sinus endoscopy, surg	20.20	NA	12.45	1.31	010
31299		C	Sinus surgery procedure	0.00	0.00	0.00	0.00	YYY
31300		A	Removal of larynx lesion	15.71	NA	16.99	1.53	090
31320		A	Diagnostic incision, larynx	5.62	NA	11.01	0.55	090
31360		A	Removal of larynx	29.57	NA	24.24	2.94	090
31365		A	Removal of larynx	38.47	NA	28.45	3.83	090
31367		A	Partial removal of larynx	30.23	NA	26.77	2.98	090
31368		A	Partial removal of larynx	33.85	NA	29.46	3.30	090
31370		A	Partial removal of larynx	27.23	NA	26.21	2.66	090
31375		A	Partial removal of larynx	25.73	NA	24.96	2.51	090
31380		A	Partial removal of larynx	25.23	NA	24.72	2.46	090
31382		A	Partial removal of larynx	28.23	NA	26.68	2.75	090
31390		A	Removal of larynx & pharynx	42.17	NA	31.39	4.41	090
31395		A	Reconstruct larynx & pharynx	43.46	NA	34.73	4.24	090
31400		A	Revision of larynx	11.48	NA	14.15	1.12	090
31420		A	Removal of epiglottis	11.32	NA	10.31	1.10	090
31500		A	Insert emergency airway	2.33	NA	0.51	0.19	000
31502		A	Change of windpipe airway	0.65	NA	0.28	0.05	000
31505		A	Diagnostic laryngoscopy	0.61	1.51	0.67	0.04	000
31510		A	Laryngoscopy with biopsy	1.92	3.47	1.26	0.14	000
31511		A	Remove foreign body, larynx	2.16	3.24	1.23	0.17	000
31512		A	Removal of larynx lesion	2.07	3.28	1.38	0.13	000
31513		A	Injection into vocal cord	2.10	NA	1.39	0.14	000
31515		A	Laryngoscopy for aspiration	1.80	3.50	1.09	0.14	000
31520		A	Dx laryngoscopy, newborn	2.56	NA	1.61	0.17	000
31525		A	Dx laryngoscopy excl nb	2.63	3.81	1.58	0.18	000
31526		A	Dx laryngoscopy w/oper scope	2.57	NA	1.61	0.17	000
31527		A	Laryngoscopy for treatment	3.27	NA	1.95	0.21	000
31528		A	Laryngoscopy and dilation	2.37	NA	1.47	0.16	000
31529		A	Laryngoscopy and dilation	2.68	NA	1.60	0.18	000
31530		A	Laryngoscopy w/fb removal	3.38	NA	1.86	0.24	000
31531		A	Laryngoscopy w/fb & op scope	3.58	NA	2.08	0.23	000
31535		A	Laryngoscopy w/biopsy	3.16	NA	1.88	0.21	000
31536		A	Laryngoscopy w/bx & op scope	3.55	NA	2.08	0.23	000
31540		A	Laryngoscopy w/exc of tumor	4.12	NA	2.33	0.27	000
31541		A	Laryngoscop w/tumr exc + scope	4.52	NA	2.53	0.30	000
31545		A	Remove vc lesion w/scope	6.30	NA	3.39	0.41	000
31546		A	Remove vc lesion scope/graft	9.73	NA	5.02	0.63	000
31560		A	Laryngoscop w/arytenoidectom	5.45	NA	2.93	0.35	000
31561		A	Laryngoscop, remve cart + scop	5.99	NA	3.16	0.40	000
31570		A	Laryngoscope w/vc inj	3.86	4.79	2.16	0.26	000

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31571		A	Laryngoscop w/vc inj + scope	4.26	NA	2.41	0.28	000
31575		A	Diagnostic laryngoscopy	1.10	1.85	0.91	0.07	000
31576		A	Laryngoscopy with biopsy	1.97	3.77	1.30	0.13	000
31577		A	Remove foreign body, larynx	2.47	3.75	1.48	0.17	000
31578		A	Removal of larynx lesion	2.84	4.38	1.74	0.18	000
31579		A	Diagnostic laryngoscopy	2.26	3.19	1.47	0.15	000
31580		A	Revision of larynx	14.46	NA	16.93	1.41	090
31582		A	Revision of larynx	22.87	NA	25.79	2.23	090
31584		A	Treat larynx fracture	20.35	NA	18.83	1.98	090
31587		A	Revision of larynx	15.12	NA	11.00	1.47	090
31588		A	Revision of larynx	14.62	NA	14.58	1.43	090
31590		A	Reinnervate larynx	7.63	NA	14.84	0.74	090
31595		A	Larynx nerve surgery	8.75	NA	10.89	0.85	090
31599		C	Larynx surgery procedure	0.00	0.00	0.00	0.00	YYY
31600		A	Incision of windpipe	7.17	NA	3.04	0.87	000
31601		A	Incision of windpipe	4.44	NA	2.46	0.29	000
31603		A	Incision of windpipe	4.14	NA	1.64	0.46	000
31605		A	Incision of windpipe	3.57	NA	1.09	0.42	000
31610		A	Incision of windpipe	9.29	NA	9.06	0.98	090
31611		A	Surgery/speech prosthesis	5.92	NA	7.91	0.58	090
31612		A	Puncture/clear windpipe	0.91	1.18	0.35	0.08	000
31613		A	Repair windpipe opening	4.63	NA	6.87	0.54	090
31614		A	Repair windpipe opening	8.47	NA	10.79	0.87	090
31615		A	Visualization of windpipe	2.09	2.58	1.28	0.14	000
31620		A	Endobronchial us add-on	1.40	5.32	0.40	0.10	ZZZ
31622		A	Dx bronchoscope/wash	2.78	4.96	1.04	0.24	000
31623		A	Dx bronchoscope/brush	2.88	5.36	1.02	0.19	000
31624		A	Dx bronchoscope/lavage	2.88	4.89	1.04	0.19	000
31625		A	Bronchoscopy w/biopsy(s)	3.36	5.04	1.18	0.24	000
31628		A	Bronchoscopy/lung bx, each	3.80	6.21	1.28	0.23	000
31629		A	Bronchoscopy/needle bx, each	4.09	10.54	1.37	0.26	000
31630		A	Bronchoscopy dilate/fx repr	3.81	NA	1.46	0.35	000
31631		A	Bronchoscopy, dilate w/stent	4.36	NA	1.65	0.41	000
31632		A	Bronchoscopy/lung bx, addÆ1	1.03	0.82	0.30	0.06	ZZZ
31633		A	Bronchoscopy/needle bx addÆ1	1.32	0.95	0.38	0.08	ZZZ
31635		A	Bronchoscopy w/fb removal	3.67	4.92	1.30	0.29	000
31636		A	Bronchoscopy, bronch stents	4.30	NA	1.51	0.41	000
31637		A	Bronchoscopy, stent add-on	1.58	NA	0.42	0.09	ZZZ
31638		A	Bronchoscopy, revise stent	4.88	NA	1.77	0.46	000
31640		A	Bronchoscopy w/tumor excise	4.93	NA	1.80	0.44	000
31641		A	Bronchoscopy, treat blockage	5.02	NA	1.78	0.41	000
31643		A	Diag bronchoscope/catheter	3.49	NA	1.15	0.22	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
31645		A	Bronchoscopy, clear airways	3.16	4.40	1.12	0.21	000
31646		A	Bronchoscopy, reclear airway	2.72	4.11	0.98	0.19	000
31656		A	Bronchoscopy, inj for x-ray	2.17	5.17	0.76	0.12	000
31715		A	Injection for bronchus x-ray	1.11	NA	0.30	0.06	000
31717		A	Bronchial brush biopsy	2.12	4.22	0.74	0.15	000
31720		A	Clearance of airways	1.06	NA	0.31	0.06	000
31725		A	Clearance of airways	1.96	NA	0.55	0.15	000
31730		A	Intro, windpipe wire/tube	2.85	26.35	0.99	0.32	000
31750		A	Repair of windpipe	15.19	NA	19.54	1.70	090
31755		A	Repair of windpipe	17.19	NA	26.75	1.68	090
31760		A	Repair of windpipe	23.36	NA	10.74	4.15	090
31766		A	Reconstruction of windpipe	31.58	NA	15.08	5.61	090
31770		A	Repair/graft of bronchus	23.48	NA	9.71	4.17	090
31775		A	Reconstruct bronchus	24.51	NA	10.32	4.36	090
31780		A	Reconstruct windpipe	19.70	NA	10.99	2.38	090
31781		A	Reconstruct windpipe	24.77	NA	13.67	2.42	090
31785		A	Remove windpipe lesion	18.29	NA	10.01	1.97	090
31786		A	Remove windpipe lesion	25.34	NA	10.57	4.50	090
31800		A	Repair of windpipe injury	8.10	NA	10.25	0.79	090
31805		A	Repair of windpipe injury	13.34	NA	8.05	2.37	090
31820		A	Closure of windpipe lesion	4.58	6.54	3.89	0.49	090
31825		A	Repair of windpipe defect	6.98	8.45	5.44	0.72	090
31830		A	Revise windpipe scar	4.54	6.57	4.14	0.52	090
31899		C	Airways surgical procedure	0.00	0.00	0.00	0.00	YYY
32035		A	Exploration of chest	11.20	NA	6.86	1.95	090
32036		A	Exploration of chest	12.21	NA	7.22	2.16	090
32095		A	Biopsy through chest wall	10.06	NA	5.82	1.78	090
32100		A	Exploration/biopsy of chest	16.08	NA	7.90	2.86	090
32110		A	Explore/repair chest	25.15	NA	11.48	4.23	090
32120		A	Re-exploration of chest	14.27	NA	7.59	2.55	090
32124		A	Explore chest free adhesions	15.33	NA	8.00	2.76	090
32140		A	Removal of lung lesion(s)	16.54	NA	8.50	3.14	090
32141		A	Remove/treat lung lesions	27.10	NA	11.54	4.85	090
32150		A	Removal of lung lesion(s)	16.70	NA	8.47	2.97	090
32151		A	Remove lung foreign body	16.82	NA	8.19	2.99	090
32160		A	Open chest heart massage	13.02	NA	6.66	2.26	090
32200		A	Drain, open, lung lesion	18.48	NA	9.98	3.28	090
32201		A	Drain, percut, lung lesion	3.99	14.43	1.21	0.29	000
32215		A	Treat chest lining	12.93	NA	7.17	2.27	090
32220		A	Release of lung	26.41	NA	13.43	4.74	090
32225		A	Partial release of lung	16.63	NA	8.38	2.96	090
32310		A	Removal of chest lining	15.16	NA	7.92	2.73	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
32320		A	Free/remove chest lining	27.04	NA	13.13	4.77	090
32400		A	Needle biopsy chest lining	1.76	1.96	0.53	0.13	000
32402		A	Open biopsy chest lining	8.89	NA	5.37	1.53	090
32405		A	Biopsy, lung or mediastinum	1.93	0.58	0.58	0.14	000
32420		A	Puncture/clear lung	2.18	NA	0.66	0.17	000
32421		A	Thoracentesis for aspiration	1.54	2.26	0.48	0.11	000
32422		A	Thoracentesis w/tube insert	2.19	2.70	1.01	0.16	000
32440		A	Removal of lung	27.17	NA	12.34	4.81	090
32442		A	Sleeve pneumonectomy	56.37	NA	19.00	3.21	090
32445		A	Removal of lung	63.60	NA	24.43	11.30	090
32480		A	Partial removal of lung	25.71	NA	11.62	4.58	090
32482		A	Bilobectomy	27.28	NA	12.63	4.86	090
32484		A	Segmentectomy	25.30	NA	10.94	4.48	090
32486		A	Sleeve lobectomy	42.80	NA	16.45	7.69	090
32488		A	Completion pneumonectomy	42.83	NA	17.34	7.66	090
32491		R	Lung volume reduction	25.09	NA	11.63	4.46	090
32500		A	Partial removal of lung	24.48	NA	11.65	4.38	090
32501		A	Repair bronchus add-on	4.68	NA	1.50	0.82	ZZZ
32503		A	Resect apical lung tumor	31.61	NA	13.53	5.64	090
32504		A	Resect apical lung tum/chest	36.41	NA	15.16	6.39	090
32540		A	Removal of lung lesion	30.22	NA	13.30	5.39	090
32550		A	Insert pleural cath	4.17	15.32	1.58	0.52	000
32551		A	Insertion of chest tube	3.29	NA	1.10	0.38	000
32560		A	Treat lung lining chemically	2.19	5.21	0.69	0.28	000
32601		A	Thoracoscopy, diagnostic	5.45	NA	2.31	0.94	000
32602		A	Thoracoscopy, diagnostic	5.95	NA	2.48	1.02	000
32603		A	Thoracoscopy, diagnostic	7.80	NA	3.03	1.48	000
32604		A	Thoracoscopy, diagnostic	8.77	NA	3.27	1.56	000
32605		A	Thoracoscopy, diagnostic	6.92	NA	2.71	1.23	000
32606		A	Thoracoscopy, diagnostic	8.39	NA	3.29	1.45	000
32650		A	Thoracoscopy, surgical	10.77	NA	6.01	1.88	090
32651		A	Thoracoscopy, surgical	18.70	NA	8.86	3.25	090
32652		A	Thoracoscopy, surgical	29.00	NA	12.71	5.10	090
32653		A	Thoracoscopy, surgical	18.09	NA	8.43	3.14	090
32654		A	Thoracoscopy, surgical	20.44	NA	9.29	3.52	090
32655		A	Thoracoscopy, surgical	16.09	NA	8.02	2.83	090
32656		A	Thoracoscopy, surgical	13.18	NA	6.89	2.28	090
32657		A	Thoracoscopy, surgical	12.85	NA	6.86	2.28	090
32658		A	Thoracoscopy, surgical	11.65	NA	6.11	2.07	090
32659		A	Thoracoscopy, surgical	11.86	NA	6.42	2.12	090
32660		A	Thoracoscopy, surgical	17.69	NA	8.12	3.36	090
32661		A	Thoracoscopy, surgical	13.27	NA	6.60	2.36	090
32662		A	Thoracoscopy, surgical	14.91	NA	7.57	2.63	090
32663		A	Thoracoscopy, surgical	24.56	NA	10.56	4.35	090
32664		A	Thoracoscopy, surgical	14.22	NA	6.89	2.53	090
32665		A	Thoracoscopy, surgical	21.45	NA	10.93	3.47	090
32800		A	Repair lung hernia	15.59	NA	6.32	0.89	090
32810		A	Close chest after drainage	14.83	NA	7.55	2.64	090
32815		A	Close bronchial fistula	49.79	NA	20.68	8.99	090
32820		A	Reconstruct injured chest	22.33	NA	10.69	3.97	090
32851		A	Lung transplant, single	40.94	NA	22.74	7.33	090
32852		A	Lung transplant with bypass	44.65	NA	25.63	7.93	090
32853		A	Lung transplant, double	50.11	NA	25.66	9.01	090
32854		A	Lung transplant with bypass	53.88	NA	29.20	9.63	090
32855		C	Prepare donor lung, single	0.00	0.00	0.00	0.00	XXX
32856		C	Prepare donor lung, double	0.00	0.00	0.00	0.00	XXX
32900		A	Removal of rib(s)	23.69	NA	11.00	4.16	090
32905		A	Revise & repair chest wall	23.17	NA	10.09	4.12	090
32906		A	Revise & repair chest wall	29.18	NA	11.92	5.19	090
32940		A	Revision of lung	21.22	NA	9.50	3.77	090
32960		A	Therapeutic pneumothorax	1.84	1.89	0.74	0.33	000
32997		A	Total lung lavage	7.31	NA	2.12	0.73	000
32998		A	Perq rf ablate tx, pul tumor	5.68	60.11	1.83	0.46	000
32999		C	Chest surgery procedure	0.00	0.00	0.00	0.00	YYY
33010		A	Drainage of heart sac	2.24	NA	0.72	0.18	000
33011		A	Repeat drainage of heart sac	2.24	NA	0.75	0.16	000
33015		A	Incision of heart sac	8.44	NA	4.14	1.26	090
33020		A	Incision of heart sac	14.87	NA	7.18	2.65	090
33025		A	Incision of heart sac	13.65	NA	6.54	2.47	090
33030		A	Partial removal of heart sac	22.27	NA	10.15	4.02	090
33031		A	Partial removal of heart sac	25.30	NA	10.73	4.63	090
33050		A	Removal of heart sac lesion	16.85	NA	8.32	2.99	090
33120		A	Removal of heart lesion	27.33	NA	11.89	4.96	090
33130		A	Removal of heart lesion	24.05	NA	17.56	4.57	090
33140		A	Heart revascularize (tmr)	28.26	NA	11.32	5.37	090
33141		A	Heart tmr w/other procedure	2.54	NA	0.83	0.46	ZZZ
33202		A	Insert epicard eltrd, open	13.15	NA	6.25	2.38	090
33203		A	Insert epicard eltrd, endo	13.92	NA	6.14	2.43	090
33206		A	Insertion of heart pacemaker	7.31	NA	3.78	1.19	090
33207		A	Insertion of heart pacemaker	8.00	NA	3.81	1.31	090
33208		A	Insertion of heart pacemaker	8.72	NA	4.04	1.42	090
33210		A	Insertion of heart electrode	3.30	NA	1.10	0.25	000
33211		A	Insertion of heart electrode	3.39	NA	1.11	0.36	000
33212		A	Insertion of pulse generator	5.51	NA	2.75	0.90	090

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33213		A	Insertion of pulse generator	6.36	NA	3.02	1.04	090
33214		A	Upgrade of pacemaker system	7.78	NA	3.96	1.25	090
33215		A	Reposition pacing-defib lead	4.89	NA	2.50	0.80	090
33216		A	Insert lead pace-defib, one	5.81	NA	3.25	0.94	090
33217		A	Insert lead pace-defib, dual	5.78	NA	3.25	0.95	090
33218		A	Repair lead pace-defib, one	5.97	NA	3.44	0.98	090
33218F		I	AJCC cncr 0/1A melan docd	0.00	0.00	0.00	0.00	XXX
33220		A	Repair lead pace-defib, dual	6.05	NA	3.50	0.98	090
33222		A	Revise pocket, pacemaker	5.01	NA	3.34	0.83	090
33223		A	Revise pocket, pacing-defib	6.49	NA	3.48	1.07	090
33224		A	Insert pacing lead & connect	9.04	NA	3.35	0.81	000
33225		A	L ventric pacing lead add-on	8.33	NA	2.80	0.63	ZZZ
33226		A	Reposition l ventric lead	8.68	NA	3.23	0.78	000
3322F		I	Melan >AJCC stage 0 or IA	0.00	0.00	0.00	0.00	XXX
33233		A	Removal of pacemaker system	3.33	NA	2.36	0.54	090
33234		A	Removal of pacemaker system	7.85	NA	3.94	1.28	090
33235		A	Removal pacemaker electrode	9.93	NA	5.28	1.64	090
33236		A	Remove electrode/thoracotomy	12.64	NA	7.05	2.40	090
33237		A	Remove electrode/thoracotomy	13.75	NA	6.56	2.44	090
33238		A	Remove electrode/thoracotomy	15.28	NA	8.23	2.75	090
33240		A	Insert pulse generator	7.61	NA	3.56	1.23	090
33241		A	Remove pulse generator	3.26	NA	2.11	0.53	090
33243		A	Remove elrd/thoracotomy	23.42	NA	10.79	4.19	090
33244		A	Remove elrd, transven	13.84	NA	6.73	2.28	090
33249		A	Elrd/insert pace-defib	15.02	NA	6.81	2.42	090
33250		A	Ablate heart dysrhythm focus	25.78	NA	11.09	4.90	090
33251		A	Ablate heart dysrhythm focus	28.80	NA	12.77	5.30	090
33254		A	Ablate atria, lmtd	23.58	NA	10.89	4.48	090
33255		A	Ablate atria w/o bypass, ext	28.91	NA	12.47	5.49	090
33256		A	Ablate atria w/bypass, exten	34.77	NA	14.36	6.61	090
33257		A	Ablate atria, lmtd, add-on	9.63	NA	5.25	1.74	ZZZ
33258		A	Ablate atria, x10sv, add-on	11.00	NA	5.74	1.97	ZZZ
33259		A	Ablate atria w/bypass add-on	14.14	NA	7.44	2.56	ZZZ
33261		A	Ablate heart dysrhythm focus	28.80	NA	12.03	5.47	090
33265		A	Ablate atria, lmtd, endo	23.58	NA	10.76	4.26	090
33266		A	Ablate atria, x10sv, endo	32.91	NA	13.78	6.01	090
33282		A	Implant pat-active ht record	4.70	NA	2.96	0.76	090
33284		A	Remove pat-active ht record	3.04	NA	2.41	0.49	090
33300		A	Repair of heart wound	44.89	NA	16.98	8.12	090
33305		A	Repair of heart wound	76.85	NA	27.04	13.95	090
33310		A	Exploratory heart surgery	20.22	NA	9.40	3.59	090
33315		A	Exploratory heart surgery	26.05	NA	11.36	4.76	090
33320		A	Repair major blood vessel(s)	18.46	NA	8.26	3.22	090
33321		A	Repair major vessel	20.71	NA	9.87	1.11	090
33322		A	Repair major blood vessel(s)	24.30	NA	10.97	4.44	090
33330		A	Insert major vessel graft	25.17	NA	12.64	4.78	090
33332		A	Insert major vessel graft	24.46	NA	10.53	4.65	090
33335		A	Insert major vessel graft	33.79	NA	14.24	6.20	090
33400		A	Repair of aortic valve	41.37	NA	16.42	7.44	090
33401		A	Valvuloplasty, open	24.41	NA	10.64	4.05	090
33403		A	Valvuloplasty, w/cp bypass	25.39	NA	11.83	4.82	090
33404		A	Prepare heart-aorta conduit	31.25	NA	13.24	5.55	090
33405		A	Replacement of aortic valve	41.19	NA	16.90	7.51	090
33406		A	Replacement of aortic valve	52.55	NA	20.51	9.68	090
33410		A	Replacement of aortic valve	46.28	NA	18.36	8.45	090
33411		A	Replacement of aortic valve	61.94	NA	23.64	11.31	090
33412		A	Replacement of aortic valve	43.77	NA	18.03	8.31	090
33413		A	Replacement of aortic valve	59.74	NA	21.70	10.62	090
33414		A	Repair of aortic valve	39.29	NA	15.14	6.98	090
33415		A	Revision, subvalvular tissue	37.19	NA	14.74	6.02	090
33416		A	Revise ventricle muscle	36.43	NA	15.36	6.65	090
33417		A	Repair of aortic valve	29.17	NA	13.10	5.32	090
33420		A	Revision of mitral valve	25.67	NA	11.89	2.59	090
33422		A	Revision of mitral valve	29.61	NA	12.57	5.62	090
33425		A	Repair of mitral valve	49.83	NA	19.43	9.10	090
33426		A	Repair of mitral valve	43.15	NA	17.61	7.85	090
33427		A	Repair of mitral valve	44.70	NA	17.48	8.13	090
33430		A	Replacement of mitral valve	50.75	NA	20.68	9.28	090
33460		A	Revision of tricuspid valve	44.62	NA	29.10	8.48	090
33463		A	Valvuloplasty, tricuspid	56.95	NA	21.67	10.45	090
33464		A	Valvuloplasty, tricuspid	44.49	NA	18.08	8.02	090
33465		A	Replace tricuspid valve	50.59	NA	19.57	9.29	090
33468		A	Revision of tricuspid valve	32.82	NA	13.32	6.23	090
33470		A	Revision of pulmonary valve	21.32	NA	9.42	3.79	090
33471		A	Valvotomy, pulmonary valve	22.83	NA	10.92	1.22	090
33472		A	Revision of pulmonary valve	22.90	NA	10.45	1.23	090
33474		A	Revision of pulmonary valve	39.27	NA	15.16	7.46	090
33475		A	Replacement, pulmonary valve	42.27	NA	16.42	8.03	090
33476		A	Revision of heart chamber	26.41	NA	11.76	5.02	090
33478		A	Revision of heart chamber	27.38	NA	12.06	5.20	090
33496		A	Repair, prosth valve clot	29.71	NA	12.97	5.28	090
33500		A	Repair heart vessel fistula	27.82	NA	11.72	5.28	090
33501		A	Repair heart vessel fistula	19.43	NA	8.85	3.69	090
33502		A	Coronary artery correction	21.69	NA	10.29	4.12	090

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,4]	Global
33503		A	Coronary artery graft	22.29	NA	9.94	3.70	090
33504		A	Coronary artery graft	25.30	NA	11.45	4.81	090
33505		A	Repair artery w/tunnel	38.35	NA	13.30	7.29	090
33506		A	Repair artery, translocation	37.80	NA	13.64	6.72	090
33507		A	Repair art, intramural	31.35	NA	11.81	5.57	090
33508		A	Endoscopic vein harvest	0.31	NA	0.10	0.06	ZZZ
33510		A	CABG, vein, single	34.87	NA	14.65	6.36	090
33511		A	CABG, vein, two	38.34	NA	15.95	7.01	090
33512		A	CABG, vein, three	43.87	NA	17.66	8.02	090
33513		A	CABG, vein, four	45.26	NA	18.04	8.30	090
33514		A	CABG, vein, five	47.97	NA	18.97	8.75	090
33516		A	Cabg, vein, six or more	49.65	NA	19.03	9.43	090
33517		A	CABG, artery-vein, single	3.61	NA	1.18	0.64	ZZZ
33518		A	CABG, artery-vein, two	7.93	NA	2.60	1.42	ZZZ
33519		A	CABG, artery-vein, three	10.49	NA	3.44	1.88	ZZZ
3351F		I	Neg scrn dep symp by deptool	0.00	0.00	0.00	0.00	XXX
33521		A	CABG, artery-vein, four	12.59	NA	4.14	2.25	ZZZ
33522		A	CABG, artery-vein, five	14.14	NA	4.66	2.53	ZZZ
33523		A	Cabg, art-vein, six or more	16.08	NA	5.24	2.88	ZZZ
3352F		I	No sig dep symp by dep tool	0.00	0.00	0.00	0.00	XXX
33530		A	Coronary artery, bypass/reop	10.13	NA	3.29	1.82	ZZZ
33533		A	CABG, arterial, single	33.64	NA	14.05	6.15	090
33534		A	CABG, arterial, two	39.77	NA	16.38	7.26	090
33535		A	CABG, arterial, three	44.64	NA	17.96	8.14	090
33536		A	Cabg, arterial, four or more	48.32	NA	19.38	8.86	090
3353F		I	Mild-mod dep symp by deptool	0.00	0.00	0.00	0.00	XXX
33542		A	Removal of heart lesion	48.08	NA	18.78	8.82	090
33545		A	Repair of heart damage	56.93	NA	21.28	10.37	090
33548		A	Restore/remodel, ventricle	53.96	NA	21.50	9.87	090
3354F		I	Clin sig dep sym by dep tool	0.00	0.00	0.00	0.00	XXX
33572		A	Open coronary endarterectomy	4.44	NA	1.44	0.80	ZZZ
33600		A	Closure of valve	30.15	NA	12.73	5.36	090
33602		A	Closure of valve	29.18	NA	14.68	4.73	090
33606		A	Anastomosis/artery-aorta	31.37	NA	15.38	5.08	090
33608		A	Repair anomaly w/conduit	31.72	NA	13.21	5.64	090
33610		A	Repair by enlargement	31.24	NA	13.06	5.55	090
33611		A	Repair double ventricle	35.49	NA	13.61	6.74	090
33612		A	Repair double ventricle	36.49	NA	13.81	6.06	090
33615		A	Repair, modified fontan	35.76	NA	14.13	6.35	090
33617		A	Repair single ventricle	38.96	NA	15.11	6.92	090
33619		A	Repair single ventricle	48.60	NA	19.55	8.64	090
33641		A	Repair heart septum defect	29.50	NA	12.39	5.35	090
33645		A	Revision of heart veins	27.98	NA	11.60	5.32	090
33647		A	Repair heart septum defects	29.37	NA	21.27	5.58	090
33660		A	Repair of heart defects	31.75	NA	12.45	6.03	090
33665		A	Repair of heart defects	34.77	NA	23.33	6.61	090
33670		A	Repair of heart chambers	36.58	NA	13.09	6.95	090
33675		A	Close mult vsd	35.87	NA	13.51	6.37	090
33676		A	Close mult vsd w/resection	36.87	NA	15.51	1.97	090
33677		A	Cl mult vsd w/rem pul band	38.37	NA	16.06	2.05	090
33681		A	Repair heart septum defect	32.16	NA	14.49	5.89	090
33684		A	Repair heart septum defect	34.29	NA	22.75	6.51	090
33688		A	Repair heart septum defect	34.67	NA	12.73	6.59	090
33690		A	Reinforce pulmonary artery	20.20	NA	9.69	3.59	090
33692		A	Repair of heart defects	31.38	NA	13.58	1.68	090
33694		A	Repair of heart defects	35.49	NA	13.36	6.74	090
33697		A	Repair of heart defects	37.49	NA	14.14	6.22	090
33702		A	Repair of heart defects	27.11	NA	11.70	5.15	090
33710		A	Repair of heart defects	30.28	NA	12.46	5.38	090
33720		A	Repair of heart defect	27.13	NA	11.50	4.82	090
33722		A	Repair of heart defect	29.05	NA	11.51	5.52	090
33724		A	Repair venous anomaly	27.55	NA	10.97	4.90	090
33726		A	Repair pul venous stenosis	37.04	NA	14.13	7.04	090
33730		A	Repair heart-vein defect(s)	36.01	NA	14.37	6.84	090
33732		A	Repair heart-vein defect	28.80	NA	12.54	5.47	090
33735		A	Revision of heart chamber	22.04	NA	10.26	4.19	090
33736		A	Revision of heart chamber	24.16	NA	11.10	4.59	090
33737		A	Revision of heart chamber	22.34	NA	10.04	3.97	090
33750		A	Major vessel shunt	22.06	NA	14.81	6.00	090
33755		A	Major vessel shunt	22.44	NA	9.76	3.72	090
33762		A	Major vessel shunt	22.44	NA	10.32	1.20	090
33764		A	Major vessel shunt & graft	22.44	NA	12.18	3.63	090
33766		A	Major vessel shunt	23.41	NA	9.51	3.89	090
33767		A	Major vessel shunt	25.14	NA	10.32	4.47	090
33768		A	Cavopulmonary shunting	8.00	NA	2.92	0.43	ZZZ
33770		A	Repair great vessels defect	39.02	NA	16.60	6.93	090
33771		A	Repair great vessels defect	40.58	NA	16.10	2.17	090
33774		A	Repair great vessels defect	31.54	NA	13.58	5.99	090
33775		A	Repair great vessels defect	32.83	NA	14.73	1.76	090
33776		A	Repair great vessels defect	34.53	NA	15.64	1.85	090
33777		A	Repair great vessels defect	33.95	NA	14.67	1.82	090
33778		A	Repair great vessels defect	42.62	NA	18.05	2.28	090
33779		A	Repair great vessels defect	43.15	NA	15.07	7.67	090
33780		A	Repair great vessels defect	43.85	NA	28.22	2.35	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
33781		A	Repair great vessels defect	43.16	NA	17.04	2.31	090
33786		A	Repair arterial trunk	41.74	NA	17.18	2.24	090
33788		A	Revision of pulmonary artery	27.26	NA	12.07	1.46	090
33800		A	Aortic suspension	17.23	NA	7.61	3.27	090
33802		A	Repair vessel defect	18.24	NA	8.79	3.46	090
33803		A	Repair vessel defect	20.18	NA	8.50	3.83	090
33813		A	Repair septal defect	21.23	NA	9.70	3.77	090
33814		A	Repair septal defect	26.41	NA	11.80	5.02	090
33820		A	Revise major vessel	16.61	NA	7.73	3.16	090
33822		A	Revise major vessel	17.63	NA	8.46	0.94	090
33824		A	Revise major vessel	20.10	NA	10.36	3.57	090
33840		A	Remove aorta constriction	21.21	NA	9.15	4.03	090
33845		A	Remove aorta constriction	22.77	NA	10.67	4.33	090
33851		A	Remove aorta constriction	21.85	NA	9.89	4.15	090
33852		A	Repair septal defect	24.28	NA	17.93	4.61	090
33853		A	Repair septal defect	32.35	NA	23.03	6.15	090
33860		A	Ascending aortic graft	59.33	NA	22.27	10.78	090
33861		A	Ascending aortic graft	43.94	NA	17.46	8.04	090
33863		A	Ascending aortic graft	58.71	NA	21.32	10.75	090
33864		A	Ascending aortic graft	60.00	NA	21.94	10.89	090
33870		A	Transverse aortic arch graft	45.93	NA	17.91	8.31	090
33875		A	Thoracic aortic graft	35.68	NA	14.00	6.47	090
33877		A	Thoracoabdominal graft	68.85	NA	23.54	12.40	090
33880		A	Endovasc taa repr incl subcl	34.48	NA	12.17	5.86	090
33881		A	Endovasc taa repr w/o subcl	29.48	NA	10.56	5.01	090
33883		A	Insert endovasc prosth, taa	20.99	NA	8.05	3.55	090
33884		A	Endovasc prosth, taa, add-on	8.20	NA	2.44	1.34	ZZZ
33886		A	Endovasc prosth, delayed	17.99	NA	6.43	3.24	090
33889		A	Artery transpose/endovas taa	15.92	NA	4.32	2.87	000
33891		A	Car-car bp grft/endovas taa	20.00	NA	5.43	3.61	000
33910		A	Remove lung artery emboli	29.59	NA	12.66	5.62	090
33915		A	Remove lung artery emboli	24.83	NA	11.69	4.12	090
33916		A	Surgery of great vessel	28.30	NA	11.66	5.38	090
33917		A	Repair pulmonary artery	25.14	NA	11.40	4.47	090
33920		A	Repair pulmonary atresia	32.58	NA	12.59	6.19	090
33922		A	Transect pulmonary artery	24.09	NA	10.76	4.58	090
33924		A	Remove pulmonary shunt	5.49	NA	1.68	0.98	ZZZ
33925		A	Rpr pul art unifocal w/o cpb	31.25	NA	11.78	5.55	090
33926		A	Repr pul art, unifocal w/cpb	44.68	NA	19.03	8.49	090
33933		C	Prepare donor heart/lung	0.00	0.00	0.00	0.00	XXX
33935		R	Transplantation, heart/lung	61.68	NA	24.94	11.72	090
33944		C	Prepare donor heart	0.00	0.00	0.00	0.00	XXX
33945		R	Transplantation of heart	89.08	NA	33.06	16.09	090
33960		A	External circulation assist	19.33	NA	5.90	3.67	000
33961		A	External circulation assist	10.91	NA	3.32	1.12	ZZZ
33967		A	Insert ia percut device	4.84	NA	1.61	0.44	000
33968		A	Remove aortic assist device	0.64	NA	0.23	0.08	000
33970		A	Aortic circulation assist	6.74	NA	2.20	0.97	000
33971		A	Aortic circulation assist	11.91	NA	5.95	2.10	090
33973		A	Insert balloon device	9.75	NA	3.15	1.40	000
33974		A	Remove intra-aortic balloon	14.93	NA	6.83	2.84	090
33975		A	Implant ventricular device	20.97	NA	6.78	3.45	XXX
33976		A	Implant ventricular device	22.97	NA	7.15	4.36	XXX
33977		A	Remove ventricular device	20.07	NA	10.39	3.60	090
33978		A	Remove ventricular device	22.51	NA	11.12	4.00	090
33979		A	Insert intracorporeal device	45.93	NA	14.44	8.21	XXX
33980		A	Remove intracorporeal device	64.86	NA	26.41	11.92	090
33999		C	Cardiac surgery procedure	0.00	0.00	0.00	0.00	YYY
34001		A	Removal of artery clot	17.78	NA	7.71	3.09	090
34051		A	Removal of artery clot	16.91	NA	8.14	3.21	090
34101		A	Removal of artery clot	10.85	NA	5.07	1.87	090
34111		A	Removal of arm artery clot	10.85	NA	5.10	1.85	090
34151		A	Removal of artery clot	26.41	NA	10.48	4.49	090
34201		A	Removal of artery clot	19.38	NA	7.83	3.38	090
34203		A	Removal of leg artery clot	17.73	NA	7.51	3.09	090
34401		A	Removal of vein clot	26.41	NA	10.98	4.28	090
34421		A	Removal of vein clot	13.29	NA	6.03	2.21	090
34451		A	Removal of vein clot	28.41	NA	9.38	5.12	090
34471		A	Removal of vein clot	21.00	NA	10.45	3.40	090
34490		A	Removal of vein clot	10.83	NA	5.20	1.84	090
34501		A	Repair valve, femoral vein	16.74	NA	6.78	3.02	090
34502		A	Reconstruct vena cava	27.86	NA	11.55	4.40	090
3450F		I	Dyspnea scrnd, no-mild dysp	0.00	0.00	0.00	0.00	XXX
34510		A	Transposition of vein valve	19.80	NA	10.03	3.21	090
3451F		I	Dyspnea scrnd mod-high dysp	0.00	0.00	0.00	0.00	XXX
34520		A	Cross-over vein graft	19.05	NA	6.94	3.44	090
3452F		I	Dyspnea not screened	0.00	0.00	0.00	0.00	XXX
34530		A	Leg vein fusion	17.77	NA	9.85	2.88	090
34800		A	Endovas aaa repr w/sm tube	21.46	NA	8.03	3.47	090
34802		A	Endovas aaa repr w/2-p part	23.71	NA	8.97	3.86	090
34803		A	Endovas aaa repr w/3-p part	24.74	NA	9.06	4.04	090
34804		A	Endovas aaa repr w/1-p part	23.71	NA	8.99	3.92	090
34805		A	Endovas aaa repr w/long tube	22.59	NA	8.37	3.80	090
34806		A	Aneurysm press sensor add-on	2.06	NA	0.61	0.34	ZZZ

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
34808		A	Endovas iliac a device addon	4.12	NA	1.22	0.69	ZZZ
34812		A	Xpose for endoprosth, femorl	6.74	NA	2.09	1.17	000
34813		A	Femoral endovas graft add-on	4.79	NA	1.43	0.83	ZZZ
34820		A	Xpose for endoprosth, iliac	9.74	NA	2.93	1.64	000
34825		A	Endovasc extend prosth, init	12.72	NA	5.56	2.08	090
34826		A	Endovasc exten prosth, add/E1	4.12	NA	1.28	0.65	ZZZ
34830		A	Open aortic tube prosth repr	35.10	NA	11.28	6.33	090
34831		A	Open aortoiliac prosth repr	37.85	NA	12.03	6.83	090
34832		A	Open aortofemor prosth repr	37.85	NA	12.03	6.83	090
34833		A	Xpose for endoprosth, iliac	11.98	NA	3.89	2.09	000
34834		A	Endovasc iliac repr w/graft	5.34	NA	1.82	0.94	000
34900		A	Xpose, endoprosth, brachial	16.77	NA	6.75	2.70	090
3491F		I	HIV unsure baby of HIV+moms	0.00	0.00	0.00	0.00	XXX
3497F		I	CD4+ cell percentage <15%	0.00	0.00	0.00	0.00	XXX
3498F		I	CD4+ cell percentage >=15%	0.00	0.00	0.00	0.00	XXX
35001		A	Repair defect of artery	20.70	NA	8.89	3.64	090
35002		A	Repair artery rupture, neck	22.12	NA	10.98	3.58	090
35005		A	Repair defect of artery	19.18	NA	13.28	3.46	090
35011		A	Repair defect of artery	18.50	NA	7.69	3.19	090
35013		A	Repair artery rupture, arm	23.10	NA	9.47	3.97	090
35021		A	Repair defect of artery	22.09	NA	9.58	3.93	090
35022		A	Repair artery rupture, chest	25.62	NA	10.66	4.55	090
35045		A	Repair defect of arm artery	17.94	NA	7.94	3.03	090
35081		A	Repair defect of artery	33.37	NA	12.80	5.86	090
35082		A	Repair artery rupture, aorta	41.93	NA	15.63	7.30	090
35091		A	Repair defect of artery	35.35	NA	12.22	6.22	090
35092		A	Repair artery rupture, aorta	50.81	NA	17.93	8.92	090
35102		A	Repair defect of artery	36.37	NA	13.60	6.37	090
35103		A	Repair artery rupture, groin	43.49	NA	15.65	7.53	090
3510F		I	Doc tb scrng-rslts interpd	0.00	0.00	0.00	0.00	XXX
35111		A	Repair defect of artery	26.17	NA	12.37	4.24	090
35112		A	Repair artery rupture,spleen	32.44	NA	14.83	5.25	090
3511F		I	Chlmyd/gonrh tsts docd done	0.00	0.00	0.00	0.00	XXX
35121		A	Repair defect of artery	31.41	NA	11.88	5.50	090
35122		A	Repair artery rupture, belly	37.76	NA	16.81	6.11	090
3512F		I	Syph scrng docd as done	0.00	0.00	0.00	0.00	XXX
35131		A	Repair defect of artery	26.29	NA	10.43	4.60	090
35132		A	Repair artery rupture, groin	32.44	NA	12.15	5.62	090
3513F		I	Hep B scrng docd as done	0.00	0.00	0.00	0.00	XXX
35141		A	Repair defect of artery	20.83	NA	8.31	3.65	090
35142		A	Repair artery rupture, thigh	25.03	NA	9.84	4.38	090
3514F		I	Hep C scrng docd as done	0.00	0.00	0.00	0.00	XXX
35151		A	Repair defect of artery	23.61	NA	9.24	4.13	090
35152		A	Repair artery rupture, knee	27.53	NA	9.23	4.96	090
3515F		I	Pt has docd immun to hep C	0.00	0.00	0.00	0.00	XXX
35180		A	Repair blood vessel lesion	15.01	NA	6.82	2.71	090
35182		A	Repair blood vessel lesion	31.58	NA	15.44	5.11	090
35184		A	Repair blood vessel lesion	18.72	NA	9.41	3.03	090
35188		A	Repair blood vessel lesion	15.05	NA	8.36	2.44	090
35189		A	Repair blood vessel lesion	29.85	NA	11.89	5.67	090
35190		A	Repair blood vessel lesion	13.33	NA	6.32	2.29	090
35201		A	Repair blood vessel lesion	16.84	NA	7.79	2.84	090
35206		A	Repair blood vessel lesion	13.76	NA	6.42	2.29	090
35207		A	Repair blood vessel lesion	10.85	NA	8.22	1.47	090
35211		A	Repair blood vessel lesion	24.50	NA	10.97	4.47	090
35216		A	Repair blood vessel lesion	36.47	NA	15.48	6.52	090
35221		A	Repair blood vessel lesion	26.54	NA	10.73	4.38	090
35226		A	Repair blood vessel lesion	15.22	NA	6.52	2.66	090
35231		A	Repair blood vessel lesion	21.08	NA	10.58	3.16	090
35236		A	Repair blood vessel lesion	17.94	NA	7.78	3.02	090
35241		A	Repair blood vessel lesion	25.50	NA	11.29	4.78	090
35246		A	Repair blood vessel lesion	28.15	NA	9.50	5.08	090
35251		A	Repair blood vessel lesion	31.83	NA	12.33	5.31	090
35256		A	Repair blood vessel lesion	18.98	NA	7.75	3.30	090
35261		A	Repair blood vessel lesion	18.88	NA	8.59	3.53	090
35266		A	Repair blood vessel lesion	15.75	NA	6.83	2.75	090
35271		A	Repair blood vessel lesion	24.50	NA	10.74	4.65	090
35276		A	Repair blood vessel lesion	25.72	NA	10.93	4.57	090
35281		A	Repair blood vessel lesion	29.93	NA	11.78	5.14	090
35286		A	Repair blood vessel lesion	17.06	NA	7.49	2.98	090
35301		A	Rechanneling of artery	19.53	NA	8.08	3.45	090
35302		A	Rechanneling of artery	21.27	NA	8.41	3.71	090
35303		A	Rechanneling of artery	23.52	NA	9.14	4.10	090
35304		A	Rechanneling of artery	24.52	NA	9.41	4.26	090
35305		A	Rechanneling of artery	23.52	NA	9.12	4.11	090
35306		A	Rechanneling of artery	9.25	NA	2.51	1.67	ZZZ
35311		A	Rechanneling of artery	28.52	NA	10.74	5.07	090
35321		A	Rechanneling of artery	16.51	NA	7.11	2.84	090
35331		A	Rechanneling of artery	27.61	NA	10.78	4.86	090
35341		A	Rechanneling of artery	26.10	NA	9.85	4.59	090
35351		A	Rechanneling of artery	24.53	NA	9.43	4.27	090
35355		A	Rechanneling of artery	19.78	NA	7.78	3.45	090
35361		A	Rechanneling of artery	30.11	NA	9.93	5.43	090
35363		A	Rechanneling of artery	32.22	NA	12.39	5.65	090

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35371		A	Rechanneling of artery	15.23	NA	6.45	2.66	090
35372		A	Rechanneling of artery	18.50	NA	7.45	3.23	090
35390		A	Reoperation, carotid add-on	3.19	NA	1.00	0.56	ZZZ
35400		A	Angioscopy	3.00	NA	0.91	0.52	ZZZ
35450		A	Repair arterial blockage	10.05	NA	3.32	1.61	000
35452		A	Repair arterial blockage	6.90	NA	2.46	1.17	000
35454		A	Repair arterial blockage	6.03	NA	2.11	1.00	000
35456		A	Repair arterial blockage	7.34	NA	2.58	1.23	000
35458		A	Repair arterial blockage	9.48	NA	3.36	1.58	000
35459		A	Repair arterial blockage	8.62	NA	2.99	1.46	000
35460		A	Repair venous blockage	6.03	NA	2.25	1.00	000
35470		A	Repair arterial blockage	8.62	48.20	2.93	1.03	000
35471		A	Repair arterial blockage	10.05	47.82	3.45	0.99	000
35472		A	Repair arterial blockage	6.90	36.39	2.41	0.87	000
35473		A	Repair arterial blockage	6.03	35.28	2.13	0.73	000
35474		A	Repair arterial blockage	7.35	47.75	2.54	0.88	000
35475		R	Repair arterial blockage	9.48	39.25	3.20	1.07	000
35476		A	Repair venous blockage	6.03	31.10	2.14	0.60	000
35480		A	Atherectomy, open	11.06	NA	3.21	1.99	000
35481		A	Atherectomy, open	7.60	NA	2.74	1.35	000
35482		A	Atherectomy, open	6.64	NA	2.01	1.20	000
35483		A	Atherectomy, open	8.09	NA	2.99	1.29	000
35484		A	Atherectomy, open	10.42	NA	3.03	1.88	000
35485		A	Atherectomy, open	9.48	NA	3.47	1.50	000
35490		A	Atherectomy, percutaneous	11.06	NA	4.21	1.18	000
35491		A	Atherectomy, percutaneous	7.60	NA	3.06	1.37	000
35492		A	Atherectomy, percutaneous	6.64	NA	2.68	0.74	000
35493		A	Atherectomy, percutaneous	8.09	NA	3.18	0.89	000
35494		A	Atherectomy, percutaneous	10.42	NA	3.97	1.35	000
35495		A	Atherectomy, percutaneous	9.48	NA	3.63	1.08	000
35500		A	Harvest vein for bypass	6.44	NA	2.07	1.13	ZZZ
35501		A	Artery bypass graft	28.99	NA	12.56	5.08	090
35506		A	Artery bypass graft	25.23	NA	9.70	4.55	090
35508		A	Artery bypass graft	25.99	NA	11.00	4.94	090
35509		A	Artery bypass graft	27.99	NA	10.89	5.05	090
35509F		I	Low risk thromboembolism	0.00	0.00	0.00	0.00	XXX
35510		A	Artery bypass graft	24.29	NA	8.11	4.38	090
35511		A	Artery bypass graft	22.12	NA	7.40	3.99	090
35512		A	Artery bypass graft	23.79	NA	7.98	4.29	090
35515		A	Artery bypass graft	25.99	NA	10.80	4.69	090
35516		A	Artery bypass graft	24.11	NA	8.02	4.35	090
35518		A	Artery bypass graft	22.57	NA	7.52	4.07	090
35521		A	Artery bypass graft	24.00	NA	8.27	4.33	090
35522		A	Artery bypass graft	23.05	NA	9.23	4.16	090
35523		A	Artery bypass graft	24.00	NA	9.94	4.33	090
35525		A	Artery bypass graft	21.59	NA	8.65	3.63	090
35526		A	Artery bypass graft	31.47	NA	12.43	5.98	090
3552F		I	High risk for thromboembolism	0.00	0.00	0.00	0.00	XXX
35531		A	Artery bypass graft	38.98	NA	14.36	6.75	090
35533		A	Artery bypass graft	29.79	NA	13.85	4.82	090
35535		A	Artery bypass graft	38.00	NA	14.42	2.04	090
35536		A	Artery bypass graft	33.60	NA	10.88	6.06	090
35537		A	Artery bypass graft	41.75	NA	13.16	7.42	090
35538		A	Artery bypass graft	46.82	NA	14.56	8.44	090
35539		A	Artery bypass graft	43.98	NA	13.77	7.93	090
35540		A	Artery bypass graft	49.20	NA	17.85	8.59	090
35548		A	Artery bypass graft	22.57	NA	7.88	4.07	090
35549		A	Artery bypass graft	24.34	NA	8.36	4.39	090
35551		A	Artery bypass graft	27.72	NA	13.07	4.49	090
35556		A	Artery bypass graft	26.62	NA	10.53	4.64	090
35558		A	Artery bypass graft	23.00	NA	9.44	4.02	090
3555F		I	Pt inr measurement performed	0.00	0.00	0.00	0.00	XXX
35560		A	Artery bypass graft	33.90	NA	12.72	6.11	090
35563		A	Artery bypass graft	25.99	NA	12.44	4.69	090
35565		A	Artery bypass graft	25.00	NA	9.82	4.34	090
35566		A	Artery bypass graft	32.22	NA	12.02	5.66	090
35570		A	Artery bypass graft	29.00	NA	11.62	1.55	090
35571		A	Artery bypass graft	25.39	NA	9.77	4.45	090
35572		A	Harvest femoropopliteal vein	6.81	NA	2.19	1.19	ZZZ
35583		A	Vein bypass graft	27.62	NA	10.73	4.80	090
35585		A	Vein bypass graft	32.22	NA	12.35	5.60	090
35587		A	Vein bypass graft	26.08	NA	10.10	4.56	090
35600		A	Harvest art for cabg add-on	4.94	NA	1.69	0.88	ZZZ
35601		A	Artery bypass graft	26.99	NA	12.22	4.79	090
35606		A	Artery bypass graft	22.36	NA	8.60	3.96	090
35612		A	Artery bypass graft	16.71	NA	6.28	3.01	090
35616		A	Artery bypass graft	21.74	NA	10.29	3.52	090
35621		A	Artery bypass graft	20.95	NA	8.21	3.68	090
35623		A	Bypass graft, not vein	25.79	NA	8.76	4.65	090
35626		A	Artery bypass graft	29.06	NA	11.54	5.28	090
35631		A	Artery bypass graft	35.90	NA	12.53	6.38	090
35632		A	Artery bypass graft	36.00	NA	13.78	1.93	090
35633		A	Artery bypass graft	38.98	NA	14.74	2.09	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
35634		A	Artery bypass graft	35.20	NA	13.52	1.89	090
35636		A	Artery bypass graft	31.62	NA	10.34	5.70	090
35637		A	Artery bypass graft	32.92	NA	12.69	5.78	090
35638		A	Artery bypass graft	33.47	NA	12.74	5.91	090
35642		A	Artery bypass graft	18.85	NA	7.16	3.40	090
35645		A	Artery bypass graft	18.34	NA	7.91	3.48	090
35646		A	Artery bypass graft	32.84	NA	12.51	5.74	090
35647		A	Artery bypass graft	29.62	NA	11.26	5.22	090
35650		A	Artery bypass graft	20.08	NA	8.12	3.62	090
35651		A	Artery bypass graft	25.97	NA	12.42	4.21	090
35654		A	Artery bypass graft	26.17	NA	10.10	4.59	090
35656		A	Artery bypass graft	20.39	NA	8.27	3.56	090
35661		A	Artery bypass graft	20.22	NA	8.53	3.53	090
35663		A	Artery bypass graft	23.80	NA	9.38	4.15	090
35665		A	Artery bypass graft	22.22	NA	8.83	3.87	090
35666		A	Artery bypass graft	23.53	NA	10.09	4.12	090
35671		A	Artery bypass graft	20.64	NA	9.03	3.59	090
35681		A	Composite bypass graft	1.60	NA	0.50	0.28	ZZZ
35682		A	Composite bypass graft	7.19	NA	2.14	1.26	ZZZ
35683		A	Composite bypass graft	8.49	NA	2.30	1.53	ZZZ
35685		A	Bypass graft patency/patch	4.04	NA	1.21	0.71	ZZZ
35686		A	Bypass graft/av fist patency	3.34	NA	1.02	0.56	ZZZ
35691		A	Arterial transposition	18.32	NA	6.56	3.30	090
35693		A	Arterial transposition	15.64	NA	6.36	2.82	090
35694		A	Arterial transposition	19.19	NA	6.80	3.46	090
35695		A	Arterial transposition	19.97	NA	7.01	3.60	090
35697		A	Reimplant artery each	3.00	NA	0.91	0.53	ZZZ
35700		A	Reoperation, bypass graft	3.08	NA	0.95	0.54	ZZZ
35701		A	Exploration, carotid artery	9.11	NA	5.39	1.37	090
35721		A	Exploration, femoral artery	7.66	NA	4.19	1.31	090
3572F		I	Pt consid poss risk fx	0.00	0.00	0.00	0.00	XXX
3573F		I	Pt not consid poss risk fx	0.00	0.00	0.00	0.00	XXX
35741		A	Exploration popliteal artery	8.61	NA	4.69	1.46	090
35761		A	Exploration of artery/vein	5.84	NA	4.14	0.97	090
35800		A	Explore neck vessels	7.99	NA	4.75	1.29	090
35820		A	Explore chest vessels	36.81	NA	14.18	6.68	090
35840		A	Explore abdominal vessels	10.87	NA	5.90	1.77	090
35860		A	Explore limb vessels	6.72	NA	3.97	1.16	090
35870		A	Repair vessel graft defect	24.39	NA	8.37	4.40	090
35875		A	Removal of clot in graft	10.64	NA	5.03	1.84	090
35876		A	Removal of clot in graft	17.74	NA	7.30	3.08	090
35879		A	Revise graft w/vein	17.28	NA	7.27	3.03	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
35881		A	Revise graft w/vein	19.22	NA	7.68	3.39	090
35883		A	Revise graft w/nonauto graft	23.07	NA	8.82	4.04	090
35884		A	Revise graft w/vein	24.57	NA	8.13	4.43	090
35901		A	Excision, graft, neck	8.26	NA	4.92	1.43	090
35903		A	Excision, graft, extremity	9.44	NA	5.43	1.62	090
35905		A	Excision, graft, thorax	33.39	NA	10.82	6.02	090
35907		A	Excision, graft, abdomen	37.14	NA	13.23	6.50	090
36000		A	Place needle in vein	0.18	0.41	0.07	0.01	XXX
36002		A	Pseudoaneurysm injection trt	1.96	2.12	0.81	0.21	000
36005		A	Injection ext venography	0.95	4.54	0.30	0.08	000
36010		A	Place catheter in vein	2.43	8.54	0.75	0.25	XXX
36011		A	Place catheter in vein	3.14	14.13	1.01	0.28	XXX
36012		A	Place catheter in vein	3.51	13.79	1.10	0.31	XXX
36013		A	Place catheter in artery	2.52	12.62	0.79	0.24	XXX
36014		A	Place catheter in artery	3.02	13.22	0.95	0.23	XXX
36015		A	Place catheter in artery	3.51	13.94	1.09	0.26	XXX
36100		A	Establish access to artery	3.02	7.81	0.97	0.38	XXX
36120		A	Establish access to artery	2.01	7.42	0.58	0.22	XXX
36140		A	Establish access to artery	2.01	7.52	0.63	0.24	XXX
36145		A	Artery to vein shunt	2.01	8.35	0.63	0.18	XXX
36160		A	Establish access to aorta	2.52	7.72	0.76	0.23	XXX
36200		A	Place catheter in aorta	3.02	9.83	0.93	0.40	XXX
36215		A	Place catheter in artery	4.67	16.69	1.54	0.43	XXX
36216		A	Place catheter in artery	5.27	18.01	1.74	0.55	XXX
36217		A	Place catheter in artery	6.29	34.68	2.10	0.69	XXX
36218		A	Place catheter in artery	1.01	3.18	0.33	0.11	ZZZ
36245		A	Place catheter in artery	4.67	16.52	1.53	0.42	XXX
36246		A	Place catheter in artery	5.27	17.20	1.66	0.58	XXX
36247		A	Place catheter in artery	6.29	32.08	1.98	0.71	XXX
36248		A	Place catheter in artery	1.01	2.47	0.31	0.10	ZZZ
36260		A	Insertion of infusion pump	9.82	NA	6.18	1.59	090
36261		A	Revision of infusion pump	5.55	NA	3.55	1.00	090
36262		A	Removal of infusion pump	4.05	NA	3.36	0.60	090
36299		C	Vessel injection procedure	0.00	0.00	0.00	0.00	YYY
36400		A	Bl draw < 3 yrs fem/jugular	0.38	0.37	0.14	0.02	XXX
36405		A	Bl draw < 3 yrs scalp vein	0.31	0.38	0.11	0.05	XXX
36406		A	Bl draw < 3 yrs other vein	0.18	0.31	0.07	0.01	XXX
36410		A	Non-routine bl draw > 3 yrs	0.18	0.35	0.07	0.01	XXX
36415		X	Routine venipuncture	0.00	0.21	NA	0.00	XXX
36416		B	Capillary blood draw	0.00	0.21	NA	0.00	XXX
36420		A	Vein access cutdown < 1 yr	1.01	NA	0.38	0.07	XXX
36425		A	Vein access cutdown > 1 yr	0.76	NA	0.28	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
36430		A	Blood transfusion service	0.00	0.74	NA	0.00	XXX
36440		A	Bl push transfuse, 2 yr or <	1.03	NA	0.39	0.19	XXX
36450		A	Bl exchange/transfuse, nb	2.23	NA	0.87	0.16	XXX
36455		A	Bl exchange/transfuse non-nb	2.43	NA	0.96	0.11	XXX
36460		A	Transfusion service, fetal	6.58	NA	2.44	1.07	XXX
36468		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	000
36469		R	Injection(s), spider veins	0.00	0.00	0.00	0.00	000
36470		A	Injection therapy of vein	1.09	2.65	0.78	0.13	010
36471		A	Injection therapy of veins	1.60	2.82	0.94	0.21	010
36475		A	Endovenous rf, 1st vein	6.72	39.14	2.39	1.05	000
36476		A	Endovenous rf, vein add-on	3.38	6.71	1.08	0.55	ZZZ
36478		A	Endovenous laser, 1st vein	6.72	27.72	2.36	0.92	000
36479		A	Endovenous laser vein addon	3.38	6.76	1.11	0.48	ZZZ
36481		A	Insertion of catheter, vein	6.98	3.03	NA	0.60	000
36500		A	Insertion of catheter, vein	3.51	NA	1.14	0.39	000
36510		A	Insertion of catheter, vein	1.09	1.28	0.43	0.08	000
36511		A	Apheresis wbc	1.74	NA	0.72	0.10	000
36512		A	Apheresis rbc	1.74	NA	0.71	0.11	000
36513		A	Apheresis platelets	1.74	NA	0.74	0.22	000
36514		A	Apheresis plasma	1.74	10.52	0.65	0.11	000
36515		A	Apheresis, adsorp/reinfuse	1.74	45.35	0.66	0.12	000
36516		A	Apheresis, selective	1.22	47.33	0.46	0.08	000
36522		A	Photopheresis	1.67	29.97	0.99	0.09	000
36555		A	Insert non-tunnel cv cath	2.68	3.64	0.45	0.16	000
36556		A	Insert non-tunnel cv cath	2.50	3.32	0.69	0.22	000
36557		A	Insert tunneled cv cath	5.11	19.99	3.09	0.83	010
36558		A	Insert tunneled cv cath	4.81	14.84	2.42	0.54	010
36560		A	Insert tunneled cv cath	6.26	18.18	2.66	0.45	010
36561		A	Insert tunneled cv cath	6.01	23.75	3.10	0.82	010
36563		A	Insert tunneled cv cath	6.21	26.07	3.32	0.96	010
36565		A	Insert tunneled cv cath	6.01	19.21	2.92	0.96	010
36566		A	Insert tunneled cv cath	6.51	124.70	3.22	0.93	010
36568		A	Insert picc cath	1.92	5.00	0.61	0.14	000
36569		A	Insert picc cath	1.82	4.29	0.62	0.14	000
36570		A	Insert picvad cath	5.33	21.12	2.52	0.39	010
36571		A	Insert picvad cath	5.31	26.80	2.88	0.74	010
36575		A	Repair tunneled cv cath	0.67	3.37	0.25	0.06	000
36576		A	Repair tunneled cv cath	3.21	6.36	1.79	0.43	010
36578		A	Replace tunneled cv cath	3.51	9.29	2.04	0.40	010
36580		A	Replace cvad cath	1.31	4.01	0.46	0.12	000
36581		A	Replace tunneled cv cath	3.45	15.33	1.68	0.30	010
36582		A	Replace tunneled cv cath	5.21	22.46	2.68	0.67	010
36583		A	Replace tunneled cv cath	5.26	28.34	3.15	0.85	010
36584		A	Replace picc cath	1.20	3.79	0.56	0.09	000
36585		A	Replace picvad cath	4.81	22.15	2.42	0.50	010
36589		A	Removal tunneled cv cath	2.27	2.00	1.35	0.26	010
36590		A	Removal tunneled cv cath	3.32	4.08	1.91	0.47	010
36591		T	Draw blood off venous device	0.00	0.51	NA	0.00	XXX
36592		T	Collect blood from picc	0.00	0.57	NA	0.00	XXX
36593		A	Declot vascular device	0.00	0.68	NA	0.00	XXX
36595		A	Mech remov tunneled cv cath	3.59	10.22	1.28	0.30	000
36596		A	Mech remov tunneled cv cath	0.75	2.48	0.41	0.07	000
36597		A	Reposition venous catheter	1.21	1.90	0.40	0.10	000
36598		T	Inj w/fluor, eval cv device	0.74	2.00	0.23	0.05	000
36600		A	Withdrawal of arterial blood	0.32	0.46	0.09	0.02	XXX
36620		A	Insertion catheter, artery	1.15	NA	0.21	0.07	000
36625		A	Insertion catheter, artery	2.11	NA	0.61	0.32	000
36640		A	Insertion catheter, artery	2.10	NA	1.04	0.26	000
36660		A	Insertion catheter, artery	1.40	NA	0.22	0.27	000
36680		A	Insert needle, bone cavity	1.20	NA	0.29	0.12	000
36800		A	Insertion of cannula	2.43	NA	1.77	0.28	000
36810		A	Insertion of cannula	3.96	NA	1.60	0.52	000
36815		A	Insertion of cannula	2.62	NA	1.29	0.42	000
36818		A	Av fuse, uppr arm, cephalic	11.81	NA	5.58	2.01	090
36819		A	Av fuse, uppr arm, basilic	14.39	NA	6.32	2.46	090
36820		A	Av fusion/forearm vein	14.39	NA	6.55	2.44	090
36821		A	Av fusion direct any site	12.00	NA	5.98	2.03	090
36822		A	Insertion of cannula(s)	5.51	NA	4.19	0.97	090
36823		A	Insertion of cannula(s)	22.82	NA	11.08	3.76	090
36825		A	Artery-vein autograft	10.00	NA	5.18	1.68	090
36830		A	Artery-vein nonautograft	12.00	NA	5.14	2.05	090
36831		A	Open thrombect av fistula	8.01	NA	3.93	1.35	090
36832		A	Av fistula revision, open	10.50	NA	4.66	1.78	090
36833		A	Av fistula revision	11.95	NA	5.16	2.03	090
36834		A	Repair A-V aneurysm	11.11	NA	5.17	1.89	090
36835		A	Artery to vein shunt	7.43	NA	5.10	1.34	090
36838		A	Dist revas ligation, hemo	21.59	NA	8.67	3.73	090
36860		A	External cannula declotting	2.01	3.28	0.80	0.15	000
36861		A	Cannula declotting	2.52	NA	1.48	0.36	000
36870		A	Percut thrombect av fistula	5.17	32.07	2.66	0.52	090
37140		A	Revision of circulation	25.12	NA	12.10	4.07	090
37145		A	Revision of circulation	26.13	NA	12.39	4.34	090
37160		A	Revision of circulation	23.13	NA	11.36	4.17	090
37180		A	Revision of circulation	26.13	NA	12.48	4.23	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
37181		A	Splice spleen/kidney veins	28.26	NA	13.27	4.58	090
37182		A	Insert hepatic shunt (tips)	16.97	NA	5.21	1.26	000
37183		A	Remove hepatic shunt (tips)	7.99	NA	2.48	0.58	000
37184		A	Prim art mech thrombectomy	8.66	40.87	3.01	0.98	000
37185		A	Prim art m-thrombect add-on	3.28	12.44	1.03	0.38	ZZZ
37186		A	Sec art m-thrombect add-on	4.92	26.45	1.54	0.53	ZZZ
37187		A	Venous mech thrombectomy	8.03	39.69	2.71	0.78	000
37188		A	Venous m-thrombectomy add-on	5.71	34.71	2.00	0.51	000
37195		C	Thrombolytic therapy, stroke	0.00	NA	NA	0.00	XXX
37200		A	Transcatheter biopsy	4.55	NA	1.35	0.33	000
37201		A	Transcatheter therapy infuse	4.99	NA	2.12	0.53	000
37202		A	Transcatheter therapy infuse	5.67	NA	2.75	0.56	000
37203		A	Transcatheter retrieval	5.02	22.14	1.77	0.48	000
37204		A	Transcatheter occlusion	18.11	NA	5.45	1.63	000
37205		A	Transcath iv stent, percut	8.27	88.97	2.63	0.90	000
37206		A	Transcath iv stent/perc addl	4.12	55.62	1.29	0.48	ZZZ
37207		A	Transcath iv stent, open	8.27	NA	2.90	1.40	000
37208		A	Transcath iv stent/open addl	4.12	NA	1.24	0.71	ZZZ
37209		A	Change iv cath at thromb tx	2.27	NA	0.68	0.24	000
37210		A	Embolization uterine fibroid	10.60	70.84	3.20	0.78	000
37215		R	Transcath stent, cca w/eps	19.58	NA	7.68	3.13	090
37216		N	Transcath stent, cca w/o eps	18.85	NA	8.41	1.01	090
37250		A	Iv us first vessel add-on	2.10	NA	0.65	0.28	ZZZ
37251		A	Iv us each add vessel add-on	1.60	NA	0.47	0.25	ZZZ
37500		A	Endoscopy ligate perf veins	11.54	NA	6.49	1.97	090
37501		C	Vascular endoscopy procedure	0.00	0.00	0.00	0.00	YYY
37565		A	Ligation of neck vein	11.97	NA	6.66	1.94	090
37600		A	Ligation of neck artery	12.34	NA	6.25	1.95	090
37605		A	Ligation of neck artery	14.20	NA	6.66	2.52	090
37606		A	Ligation of neck artery	8.72	NA	5.67	1.41	090
37607		A	Ligation of a-v fistula	6.19	NA	3.62	1.03	090
37609		A	Temporal artery procedure	3.02	4.89	2.29	0.42	010
37615		A	Ligation of neck artery	7.72	NA	5.20	1.25	090
37616		A	Ligation of chest artery	18.89	NA	9.24	3.06	090
37617		A	Ligation of abdomen artery	23.71	NA	10.22	3.53	090
37618		A	Ligation of extremity artery	5.95	NA	3.92	1.00	090
37620		A	Revision of major vein	11.49	NA	5.11	1.31	090
37650		A	Revision of major vein	8.41	NA	4.39	1.41	090
37660		A	Revision of major vein	22.20	NA	10.47	3.60	090
37700		A	Revise leg vein	3.76	NA	2.76	0.63	090
37718		A	Ligate/strip short leg vein	7.05	NA	4.26	1.18	090
37722		A	Ligate/strip long leg vein	8.08	NA	4.49	1.35	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
37735		A	Removal of leg veins/lesion	10.81	NA	5.31	1.80	090
37760		A	Ligation, leg veins, open	10.69	NA	5.71	1.75	090
37765		A	Phleb veins - extrem - to 20	7.63	NA	4.13	1.18	090
37766		A	Phleb veins - extrem 20+	9.58	NA	4.81	1.52	090
37780		A	Revision of leg vein	3.87	NA	2.85	0.65	090
37785		A	Ligate/divide/excise vein	3.87	5.37	2.91	0.64	090
37788		A	Revascularization, penis	23.21	NA	11.11	3.76	090
37790		A	Penile venous occlusion	8.37	NA	4.21	0.61	090
37799		C	Vascular surgery procedure	0.00	0.00	0.00	0.00	YYY
38100		A	Removal of spleen, total	19.47	NA	9.25	3.06	090
38101		A	Removal of spleen, partial	19.47	NA	9.46	3.15	090
38102		A	Removal of spleen, total	4.79	NA	1.77	0.69	ZZZ
38115		A	Repair of ruptured spleen	21.80	NA	10.09	3.22	090
38120		A	Laparoscopy, splenectomy	16.97	NA	9.23	2.72	090
38129		C	Laparoscope proc, spleen	0.00	0.00	0.00	0.00	YYY
38200		A	Injection for spleen x-ray	2.64	NA	1.05	0.48	000
38204		B	Bl donor search management	2.00	NA	0.73	0.11	XXX
38205		R	Harvest allogenic stem cells	1.50	NA	0.65	0.09	000
38206		R	Harvest auto stem cells	1.50	NA	0.63	0.09	000
38207		I	Cryopreserve stem cells	0.89	NA	0.43	0.05	XXX
38208		I	Thaw preserved stem cells	0.56	NA	0.27	0.03	XXX
38209		I	Wash harvest stem cells	0.24	NA	0.12	0.01	XXX
38210		I	T-cell depletion of harvest	1.57	NA	0.76	0.08	XXX
38211		I	Tumor cell deplete of harvst	1.42	NA	0.69	0.08	XXX
38212		I	Rbc depletion of harvest	0.94	NA	0.45	0.05	XXX
38213		I	Platelet deplete of harvest	0.24	NA	0.12	0.01	XXX
38214		I	Volume deplete of harvest	0.81	NA	0.39	0.04	XXX
38215		I	Harvest stem cell concentrte	0.94	NA	0.45	0.05	XXX
38220		A	Bone marrow aspiration	1.08	2.40	0.50	0.09	XXX
38221		A	Bone marrow biopsy	1.37	2.44	0.63	0.07	XXX
38230		R	Bone marrow collection	4.80	NA	3.55	0.73	010
38240		R	Bone marrow/stem transplant	2.24	NA	1.03	0.12	XXX
38241		R	Bone marrow/stem transplant	2.24	NA	1.05	0.12	XXX
38242		A	Lymphocyte infuse transplant	1.71	NA	0.82	0.08	000
38300		A	Drainage, lymph node lesion	2.28	4.35	2.21	0.26	010
38305		A	Drainage, lymph node lesion	6.55	NA	4.90	0.97	090
38308		A	Incision of lymph channels	6.73	NA	4.48	1.08	090
38380		A	Thoracic duct procedure	8.34	NA	6.54	0.81	090
38381		A	Thoracic duct procedure	13.32	NA	6.76	2.37	090
38382		A	Thoracic duct procedure	10.51	NA	7.11	1.70	090
38500		A	Biopsy/removal, lymph nodes	3.76	4.46	2.56	0.58	010
38505		A	Needle biopsy, lymph nodes	1.14	2.00	0.71	0.09	000

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
38510		A	Biopsy/removal, lymph nodes	6.69	6.43	3.99	0.82	010
38520		A	Biopsy/removal, lymph nodes	6.95	NA	4.66	1.06	090
38525		A	Biopsy/removal, lymph nodes	6.35	NA	4.41	1.02	090
38530		A	Biopsy/removal, lymph nodes	8.26	NA	5.33	1.37	090
38542		A	Explore deep node(s), neck	7.85	NA	5.39	1.00	090
38550		A	Removal, neck/armpit lesion	6.99	NA	5.48	1.13	090
38555		A	Removal, neck/armpit lesion	15.42	NA	9.07	2.50	090
38562		A	Removal, pelvic lymph nodes	10.92	NA	6.51	1.29	090
38564		A	Removal, abdomen lymph nodes	11.29	NA	6.34	1.59	090
38570		A	Laparoscopy, lymph node biop	9.28	NA	4.42	0.95	010
38571		A	Laparoscopy, lymphadenectomy	14.70	NA	5.91	1.05	010
38572		A	Laparoscopy, lymphadenectomy	16.86	NA	7.47	1.00	010
38589		C	Laparoscope proc, lymphatic	0.00	0.00	0.00	0.00	YYY
38700		A	Removal of lymph nodes, neck	12.68	NA	8.32	1.30	090
38720		A	Removal of lymph nodes, neck	21.72	NA	12.97	2.48	090
38724		A	Removal of lymph nodes, neck	23.72	NA	14.21	2.48	090
38740		A	Remove armpit lymph nodes	10.57	NA	6.50	1.70	090
38745		A	Remove armpit lymph nodes	13.71	NA	7.93	2.20	090
38746		A	Remove thoracic lymph nodes	4.88	NA	1.58	0.86	ZZZ
38747		A	Remove abdominal lymph nodes	4.88	NA	1.80	0.77	ZZZ
38760		A	Remove groin lymph nodes	13.49	NA	7.43	1.96	090
38765		A	Remove groin lymph nodes	21.78	NA	10.56	3.10	090
38770		A	Remove pelvis lymph nodes	13.98	NA	6.63	1.23	090
38780		A	Remove abdomen lymph nodes	17.56	NA	8.68	1.68	090
38790		A	Inject for lymphatic x-ray	1.29	NA	0.82	0.18	000
38792		A	Identify sentinel node	0.52	NA	0.51	0.07	000
38794		A	Access thoracic lymph duct	4.51	NA	2.82	0.33	090
38999		C	Blood/lymph system procedure	0.00	0.00	0.00	0.00	YYY
39000		A	Exploration of chest	7.49	NA	4.96	1.27	090
39010		A	Exploration of chest	13.11	NA	6.77	2.36	090
39200		A	Removal chest lesion	15.04	NA	7.06	2.67	090
39220		A	Removal chest lesion	19.47	NA	9.27	3.34	090
39400		A	Visualization of chest	8.00	NA	4.67	1.40	010
39499		C	Chest procedure	0.00	0.00	0.00	0.00	YYY
39501		A	Repair diaphragm laceration	13.89	NA	7.33	2.21	090
39502		A	Repair paraesophageal hernia	17.09	NA	8.73	2.76	090
39503		A	Repair of diaphragm hernia	108.67	NA	19.79	17.60	090
39520		A	Repair of diaphragm hernia	16.63	NA	8.35	2.80	090
39530		A	Repair of diaphragm hernia	16.22	NA	7.93	2.71	090
39531		A	Repair of diaphragm hernia	17.23	NA	8.78	2.79	090
39540		A	Repair of diaphragm hernia	14.51	NA	7.25	2.35	090
39541		A	Repair of diaphragm hernia	15.67	NA	7.95	2.56	090
39545		A	Revision of diaphragm	14.58	NA	7.80	2.59	090
39560		A	Resect diaphragm, simple	12.97	NA	6.80	1.94	090
39561		A	Resect diaphragm, complex	19.75	NA	11.54	3.22	090
39599		C	Diaphragm surgery procedure	0.00	0.00	0.00	0.00	YYY
40490		A	Biopsy of lip	1.22	2.01	0.72	0.07	000
40500		A	Partial excision of lip	4.35	8.26	4.85	0.46	090
40510		A	Partial excision of lip	4.74	7.34	4.30	0.45	090
40520		A	Partial excision of lip	4.71	7.56	4.43	0.51	090
40525		A	Reconstruct lip with flap	7.61	NA	6.54	0.91	090
40527		A	Reconstruct lip with flap	9.20	NA	7.00	0.90	090
40530		A	Partial removal of lip	5.45	8.27	4.97	0.63	090
40650		A	Repair lip	3.69	6.77	3.66	0.46	090
40652		A	Repair lip	4.32	7.94	4.62	0.55	090
40654		A	Repair lip	5.37	8.84	5.38	0.66	090
40700		A	Repair cleft lip/nasal	13.97	NA	9.73	1.36	090
40701		A	Repair cleft lip/nasal	17.03	NA	11.17	1.66	090
40702		A	Repair cleft lip/nasal	14.09	NA	7.62	0.75	090
40720		A	Repair cleft lip/nasal	14.54	NA	11.96	2.18	090
40761		A	Repair cleft lip/nasal	15.69	NA	12.36	2.35	090
40799		C	Lip surgery procedure	0.00	0.00	0.00	0.00	YYY
40800		A	Drainage of mouth lesion	1.19	3.85	2.00	0.05	010
40801		A	Drainage of mouth lesion	2.57	4.95	2.82	0.12	010
40804		A	Removal, foreign body, mouth	1.26	4.19	2.14	0.08	010
40805		A	Removal, foreign body, mouth	2.73	5.39	3.24	0.18	010
40806		A	Incision of lip fold	0.31	2.24	0.56	0.01	000
40808		A	Biopsy of mouth lesion	0.98	3.55	1.70	0.05	010
40810		A	Excision of mouth lesion	1.33	3.73	1.87	0.07	010
40812		A	Excise/repair mouth lesion	2.33	4.63	2.55	0.09	010
40814		A	Excise/repair mouth lesion	3.45	5.95	4.11	0.18	090
40816		A	Excision of mouth lesion	3.70	6.24	4.24	0.24	090
40818		A	Excise oral mucosa for graft	2.72	6.09	4.06	0.21	090
40819		A	Excise lip or cheek fold	2.45	5.10	3.41	0.12	090
40820		A	Treatment of mouth lesion	1.30	5.22	2.99	0.07	010
40830		A	Repair mouth laceration	1.78	4.56	2.30	0.15	010
40831		A	Repair mouth laceration	2.50	5.71	3.05	0.22	010
40840		R	Reconstruction of mouth	9.03	11.23	6.76	0.88	090
40842		R	Reconstruction of mouth	9.03	13.27	8.23	0.88	090
40843		R	Reconstruction of mouth	12.62	12.86	7.24	0.68	090
40844		R	Reconstruction of mouth	16.57	16.43	10.60	2.48	090
40845		R	Reconstruction of mouth	19.13	18.55	12.88	1.87	090
40899		C	Mouth surgery procedure	0.00	0.00	0.00	0.00	YYY
41000		A	Drainage of mouth lesion	1.32	2.64	1.47	0.07	010

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41005		A	Drainage of mouth lesion	1.28	4.55	1.97	0.08	010
41006		A	Drainage of mouth lesion	3.28	5.94	3.30	0.32	090
41007		A	Drainage of mouth lesion	3.14	5.92	3.24	0.31	090
41008		A	Drainage of mouth lesion	3.40	5.60	3.15	0.18	090
41009		A	Drainage of mouth lesion	3.63	5.91	3.50	0.14	090
41010		A	Incision of tongue fold	1.08	4.10	1.73	0.07	010
41015		A	Drainage of mouth lesion	4.00	6.93	4.85	0.11	090
41016		A	Drainage of mouth lesion	4.11	6.94	4.98	0.11	090
41017		A	Drainage of mouth lesion	4.11	6.27	4.30	0.15	090
41018		A	Drainage of mouth lesion	5.14	7.65	5.61	0.14	090
41019		A	Place needles h&n for rt	8.84	NA	3.66	0.55	000
41100		A	Biopsy of tongue	1.39	2.79	1.35	0.08	010
41105		A	Biopsy of tongue	1.44	2.79	1.38	0.08	010
41108		A	Biopsy of floor of mouth	1.07	2.60	1.22	0.06	010
41110		A	Excision of tongue lesion	1.53	3.81	1.84	0.09	010
41112		A	Excision of tongue lesion	2.77	5.42	3.52	0.18	090
41113		A	Excision of tongue lesion	3.23	5.75	3.77	0.20	090
41114		A	Excision of tongue lesion	8.71	NA	7.46	0.64	090
41115		A	Excision of tongue fold	1.76	4.46	2.17	0.11	010
41116		A	Excision of mouth lesion	2.47	5.72	3.08	0.19	090
41120		A	Partial removal of tongue	10.91	NA	15.84	1.07	090
41130		A	Partial removal of tongue	15.51	NA	17.93	1.53	090
41135		A	Tongue and neck surgery	29.83	NA	26.03	2.97	090
41140		A	Removal of tongue	28.81	NA	27.91	2.81	090
41145		A	Tongue removal, neck surgery	37.59	NA	34.38	3.67	090
41150		A	Tongue, mouth, jaw surgery	29.52	NA	27.27	2.92	090
41153		A	Tongue, mouth, neck surgery	33.28	NA	28.68	3.24	090
41155		A	Tongue, jaw, & neck surgery	43.96	NA	33.50	4.28	090
41250		A	Repair tongue laceration	1.93	4.46	1.92	0.18	010
41251		A	Repair tongue laceration	2.29	4.65	2.15	0.15	010
41252		A	Repair tongue laceration	2.99	5.02	2.49	0.26	010
41500		A	Fixation of tongue	3.74	NA	8.04	0.36	090
41510		A	Tongue to lip surgery	3.45	NA	7.30	0.34	090
41512		A	Tongue suspension	6.75	NA	9.70	0.36	090
41520		A	Reconstruction, tongue fold	2.77	6.12	3.82	0.08	090
41530		A	Tongue base vol reduction	4.38	74.78	6.07	0.23	010
41599		C	Tongue and mouth surgery	0.00	0.00	0.00	0.00	YYY
41800		A	Drainage of gum lesion	1.21	5.18	2.34	0.09	010
41805		A	Removal foreign body, gum	1.28	4.84	2.99	0.03	010
41806		A	Removal foreign body,jawbone	2.73	6.19	3.92	0.07	010
41820		R	Excision, gum, each quadrant	0.00	0.00	0.00	0.00	000
41821		R	Excision of gum flap	0.00	0.00	0.00	0.00	000
41822		R	Excision of gum lesion	2.35	4.98	2.36	0.06	010
41823		R	Excision of gum lesion	3.63	7.11	4.60	0.10	090
41825		A	Excision of gum lesion	1.35	3.65	1.61	0.06	010
41826		A	Excision of gum lesion	2.35	5.07	2.80	0.08	010
41827		A	Excision of gum lesion	3.72	7.04	3.96	0.21	090
41828		R	Excision of gum lesion	3.11	4.74	2.49	0.08	010
41830		R	Removal of gum tissue	3.38	6.56	3.93	0.09	010
41850		R	Treatment of gum lesion	0.00	0.00	0.00	0.00	000
41870		R	Gum graft	0.00	0.00	0.00	0.00	000
41872		R	Repair gum	2.90	6.24	3.76	0.08	090
41874		R	Repair tooth socket	3.13	5.87	3.20	0.10	090
41899		C	Dental surgery procedure	0.00	0.00	0.00	0.00	YYY
42000		A	Drainage mouth roof lesion	1.25	2.71	1.43	0.08	010
42100		A	Biopsy roof of mouth	1.33	2.39	1.43	0.07	010
42104		A	Excision lesion, mouth roof	1.66	3.69	1.87	0.09	010
42106		A	Excision lesion, mouth roof	2.12	4.50	2.32	0.09	010
42107		A	Excision lesion, mouth roof	4.48	7.00	4.31	0.29	090
42120		A	Remove palate/lesion	11.70	NA	13.87	1.13	090
42140		A	Excision of uvula	1.65	4.81	2.35	0.16	090
42145		A	Repair palate, pharynx/uvula	9.63	NA	8.76	0.94	090
42160		A	Treatment mouth roof lesion	1.82	4.00	1.94	0.11	010
42180		A	Repair palate	2.52	3.82	2.31	0.16	010
42182		A	Repair palate	3.84	4.54	2.93	0.25	010
42200		A	Reconstruct cleft palate	12.41	NA	9.96	1.21	090
42205		A	Reconstruct cleft palate	13.57	NA	9.88	1.32	090
42210		A	Reconstruct cleft palate	14.91	NA	12.79	0.41	090
42215		A	Reconstruct cleft palate	8.88	NA	8.01	1.33	090
42220		A	Reconstruct cleft palate	7.07	NA	5.11	0.19	090
42225		A	Reconstruct cleft palate	9.66	NA	13.16	0.94	090
42226		A	Lengthening of palate	10.24	NA	13.02	1.00	090
42227		A	Lengthening of palate	9.81	NA	12.04	0.96	090
42235		A	Repair palate	7.92	NA	11.15	0.77	090
42260		A	Repair nose to lip fistula	10.10	11.07	7.27	0.98	090
42280		A	Preparation, palate mold	1.56	2.59	1.29	0.04	010
42281		A	Insertion, palate prosthesis	1.95	3.36	2.01	0.13	010
42299		C	Palate/uvula surgery	0.00	0.00	0.00	0.00	YYY
42300		A	Drainage of salivary gland	1.95	3.41	2.00	0.14	010
42305		A	Drainage of salivary gland	6.23	NA	4.96	0.59	090
42310		A	Drainage of salivary gland	1.58	2.59	1.66	0.10	010
42320		A	Drainage of salivary gland	2.37	4.10	2.24	0.15	010
42330		A	Removal of salivary stone	2.23	3.68	2.04	0.13	010
42335		A	Removal of salivary stone	3.35	6.15	3.30	0.29	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
42340		A	Removal of salivary stone	4.64	7.37	4.15	0.45	090
42400		A	Biopsy of salivary gland	0.78	2.00	0.70	0.05	000
42405		A	Biopsy of salivary gland	3.31	4.31	2.56	0.23	010
42408		A	Excision of salivary cyst	4.58	7.12	3.95	0.40	090
42409		A	Drainage of salivary cyst	2.85	5.73	2.94	0.28	090
42410		A	Excise parotid gland/lesion	9.46	NA	6.68	1.07	090
42415		A	Excise parotid gland/lesion	17.99	NA	11.18	1.82	090
42420		A	Excise parotid gland/lesion	20.87	NA	12.52	2.11	090
42425		A	Excise parotid gland/lesion	13.31	NA	8.63	1.37	090
42426		A	Excise parotid gland/lesion	22.54	NA	13.05	2.35	090
42440		A	Excise submaxillary gland	6.88	NA	5.06	0.71	090
42450		A	Excise sublingual gland	4.66	6.92	4.62	0.44	090
42500		A	Repair salivary duct	4.34	6.45	4.28	0.36	090
42505		A	Repair salivary duct	6.23	8.11	5.56	0.61	090
42507		A	Parotid duct diversion	6.16	NA	7.21	0.60	090
42508		A	Parotid duct diversion	9.22	NA	9.42	0.90	090
42509		A	Parotid duct diversion	11.65	NA	10.56	1.74	090
42510		A	Parotid duct diversion	8.26	NA	8.20	0.81	090
42550		A	Injection for salivary x-ray	1.25	2.03	0.37	0.09	000
42600		A	Closure of salivary fistula	4.86	7.54	4.25	0.47	090
4260F		I	Wound srfc culturetech used	0.00	0.00	0.00	0.00	XXX
4261F		I	Tech other than surfc cultr	0.00	0.00	0.00	0.00	XXX
42650		A	Dilation of salivary duct	0.77	1.39	0.77	0.05	000
4265F		I	Wet-dry dressings Rx-recmd	0.00	0.00	0.00	0.00	XXX
42660		A	Dilation of salivary duct	1.13	1.66	0.95	0.06	000
42665		A	Ligation of salivary duct	2.57	5.49	2.81	0.25	090
4266F		I	No wet-dry drssings Rx-recmd	0.00	0.00	0.00	0.00	XXX
4268F		I	Pt ed re comp thxpy rcvd	0.00	0.00	0.00	0.00	XXX
42699		C	Salivary surgery procedure	0.00	0.00	0.00	0.00	YYY
4269F		I	Appropos mthd offloading Rxd	0.00	0.00	0.00	0.00	XXX
42700		A	Drainage of tonsil abscess	1.64	3.22	1.88	0.11	010
4270F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	XXX
4271F		I	Pt rcvng anti r-viral thxpy	0.00	0.00	0.00	0.00	XXX
42720		A	Drainage of throat abscess	6.31	5.54	4.02	0.42	010
42725		A	Drainage of throat abscess	12.28	NA	8.80	1.22	090
4275F		I	Hep b vac inj admin/ rcvd	0.00	0.00	0.00	0.00	XXX
4279F		I	PCP prophylaxis Rxd	0.00	0.00	0.00	0.00	XXX
42800		A	Biopsy of throat	1.41	2.66	1.49	0.09	010
42802		A	Biopsy of throat	1.56	4.37	1.90	0.11	010
42804		A	Biopsy of upper nose/throat	1.26	3.78	1.68	0.08	010
42806		A	Biopsy of upper nose/throat	1.60	4.06	1.83	0.11	010
42808		A	Excise pharynx lesion	2.32	3.56	1.93	0.15	010

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
42809		A	Remove pharynx foreign body	1.83	2.55	1.58	0.14	010
4280F		I	PCP prophylax Rxd 3mon low %	0.00	0.00	0.00	0.00	XXX
42810		A	Excision of neck cyst	3.30	6.69	4.20	0.32	090
42815		A	Excision of neck cyst	7.23	NA	7.29	0.74	090
42820		A	Remove tonsils and adenoids	4.17	NA	3.45	0.41	090
42821		A	Remove tonsils and adenoids	4.31	NA	3.59	0.42	090
42825		A	Removal of tonsils	3.45	NA	3.38	0.34	090
42826		A	Removal of tonsils	3.40	NA	3.16	0.33	090
42830		A	Removal of adenoids	2.60	NA	2.80	0.25	090
42831		A	Removal of adenoids	2.75	NA	3.04	0.27	090
42835		A	Removal of adenoids	2.33	NA	2.67	0.23	090
42836		A	Removal of adenoids	3.21	NA	3.08	0.31	090
42842		A	Extensive surgery of throat	12.02	NA	13.78	1.18	090
42844		A	Extensive surgery of throat	17.57	NA	18.07	1.71	090
42845		A	Extensive surgery of throat	32.35	NA	25.97	3.15	090
42860		A	Excision of tonsil tags	2.25	NA	2.63	0.22	090
42870		A	Excision of lingual tonsil	5.44	NA	9.48	0.53	090
42890		A	Partial removal of pharynx	18.92	NA	17.92	1.89	090
42892		A	Revision of pharyngeal walls	25.77	NA	23.09	2.56	090
42894		A	Revision of pharyngeal walls	33.61	NA	28.34	3.32	090
42900		A	Repair throat wound	5.26	NA	3.71	0.34	010
4290F		I	Pt scrned for inj drug use	0.00	0.00	0.00	0.00	XXX
4293F		I	Pt scrnd - hgh-rsk sex behav	0.00	0.00	0.00	0.00	XXX
42950		A	Reconstruction of throat	8.16	NA	12.28	0.84	090
42953		A	Repair throat, esophagus	9.33	NA	15.23	0.97	090
42955		A	Surgical opening of throat	7.92	NA	11.59	0.77	090
42960		A	Control throat bleeding	2.35	NA	2.07	0.14	010
42961		A	Control throat bleeding	5.69	NA	5.30	0.55	090
42962		A	Control throat bleeding	7.31	NA	6.23	0.70	090
42970		A	Control nose/throat bleeding	5.76	NA	4.52	0.50	090
42971		A	Control nose/throat bleeding	6.54	NA	5.50	0.64	090
42972		A	Control nose/throat bleeding	7.53	NA	5.96	0.73	090
42999		C	Throat surgery procedure	0.00	0.00	0.00	0.00	YYY
4300F		I	Pt rcvng warf thxpy	0.00	0.00	0.00	0.00	XXX
4301F		I	Pt not rcvng warf thxpy	0.00	0.00	0.00	0.00	XXX
43020		A	Incision of esophagus	8.14	NA	6.05	0.79	090
43030		A	Throat muscle surgery	7.91	NA	5.60	0.87	090
43045		A	Incision of esophagus	21.70	NA	10.62	3.86	090
4305F		I	Pt ed re ft care inspct rcvd	0.00	0.00	0.00	0.00	XXX
4306F		I	Pt tlk psych & Rx opd addic	0.00	0.00	0.00	0.00	XXX
43100		A	Excision of esophagus lesion	9.55	NA	6.94	0.93	090
43101		A	Excision of esophagus lesion	16.99	NA	8.08	3.02	090

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43107		A	Removal of esophagus	43.97	NA	19.73	7.46	090
43108		A	Removal of esophagus	82.66	NA	34.36	14.69	090
43112		A	Removal of esophagus	47.27	NA	20.04	8.11	090
43113		A	Removal of esophagus	79.85	NA	34.53	12.93	090
43116		A	Partial removal of esophagus	92.78	NA	46.78	9.05	090
43117		A	Partial removal of esophagus	43.52	NA	18.36	7.46	090
43118		A	Partial removal of esophagus	66.86	NA	23.77	10.83	090
43121		A	Partial removal of esophagus	51.22	NA	20.07	9.10	090
43122		A	Partial removal of esophagus	43.97	NA	20.13	7.28	090
43123		A	Partial removal of esophagus	82.91	NA	35.67	13.43	090
43124		A	Removal of esophagus	68.83	NA	26.18	12.23	090
43130		A	Removal of esophagus pouch	12.41	NA	7.99	1.50	090
43135		A	Removal of esophagus pouch	26.09	NA	11.37	4.51	090
43200		A	Esophagus endoscopy	1.59	3.81	1.13	0.12	000
43201		A	Esoph scope w/submucous inj	2.09	5.19	1.20	0.15	000
43202		A	Esophagus endoscopy, biopsy	1.89	5.12	1.08	0.15	000
43204		A	Esoph scope w/sclerosis inj	3.76	NA	1.92	0.29	000
43205		A	Esophagus endoscopy/ligation	3.78	NA	1.92	0.27	000
4320F		I	Pt talk psychsoc+rx oh dpnd	0.00	0.00	0.00	0.00	XXX
43215		A	Esophagus endoscopy	2.60	NA	1.37	0.24	000
43216		A	Esophagus endoscopy/lesion	2.40	3.06	1.30	0.24	000
43217		A	Esophagus endoscopy	2.90	6.41	1.48	0.28	000
43219		A	Esophagus endoscopy	2.80	NA	1.54	0.27	000
43220		A	Esoph endoscopy, dilation	2.10	NA	1.18	0.17	000
43226		A	Esoph endoscopy, dilation	2.34	NA	1.27	0.20	000
43227		A	Esoph endoscopy, repair	3.59	NA	1.80	0.28	000
43228		A	Esoph endoscopy, ablation	3.76	NA	1.90	0.29	000
43231		A	Esoph endoscopy w/us exam	3.19	NA	1.65	0.24	000
43232		A	Esoph endoscopy w/us fn bx	4.47	NA	2.17	0.36	000
43234		A	Upper GI endoscopy, exam	2.01	4.90	1.09	0.20	000
43235		A	Uppr gi endoscopy, diagnosis	2.39	4.80	1.30	0.19	000
43236		A	Uppr gi scope w/submuc inj	2.92	5.96	1.55	0.21	000
43237		A	Endoscopic us exam, esoph	3.98	NA	2.00	0.29	000
43238		A	Uppr gi endoscopy w/us fn bx	5.02	NA	2.44	0.38	000
43239		A	Upper GI endoscopy, biopsy	2.87	5.52	1.51	0.22	000
43240		A	Esoph endoscope w/drain cyst	6.85	NA	3.26	0.49	000
43241		A	Upper GI endoscopy with tube	2.59	NA	1.39	0.21	000
43242		A	Uppr gi endoscopy w/us fn bx	7.30	NA	3.48	0.50	000
43243		A	Upper gi endoscopy & inject	4.56	NA	2.26	0.33	000
43244		A	Upper GI endoscopy/ligation	5.04	NA	2.49	0.35	000
43245		A	Uppr gi scope dilate stricture	3.18	NA	1.62	0.27	000
43246		A	Place gastrostomy tube	4.32	NA	2.10	0.39	000
43247		A	Operative upper GI endoscopy	3.38	NA	1.73	0.27	000
43248		A	Uppr gi endoscopy/guide wire	3.15	NA	1.65	0.22	000
43249		A	Esoph endoscopy, dilation	2.90	NA	1.54	0.21	000
43250		A	Upper GI endoscopy/tumor	3.20	NA	1.63	0.29	000
43251		A	Operative upper GI endoscopy	3.69	NA	1.87	0.28	000
43255		A	Operative upper GI endoscopy	4.81	NA	2.38	0.34	000
43256		A	Uppr gi endoscopy w/stent	4.34	NA	2.13	0.35	000
43257		A	Uppr gi scope w/thrml txmnt	5.50	NA	2.76	0.37	000
43258		A	Operative upper GI endoscopy	4.54	NA	2.25	0.33	000
43259		A	Endoscopic ultrasound exam	5.19	NA	2.55	0.36	000
43260		A	Endo cholangiopancreatograph	5.95	NA	2.88	0.41	000
43261		A	Endo cholangiopancreatograph	6.26	NA	3.02	0.43	000
43262		A	Endo cholangiopancreatograph	7.38	NA	3.52	0.51	000
43263		A	Endo cholangiopancreatograph	7.28	NA	3.44	0.50	000
43264		A	Endo cholangiopancreatograph	8.89	NA	4.19	0.61	000
43265		A	Endo cholangiopancreatograph	10.00	NA	4.68	0.69	000
43267		A	Endo cholangiopancreatograph	7.38	NA	3.50	0.51	000
43268		A	Endo cholangiopancreatograph	7.38	NA	3.65	0.51	000
43269		A	Endo cholangiopancreatograph	8.20	NA	3.88	0.57	000
43271		A	Endo cholangiopancreatograph	7.38	NA	3.51	0.51	000
43272		A	Endo cholangiopancreatograph	7.38	NA	3.53	0.50	000
43273		A	Endoscopic pancreatoscopy	2.24	NA	0.98	0.15	ZZZ
43279		A	Lap myotomy, heller	22.00	NA	10.46	3.55	090
43280		A	Laparoscopy, fundoplasty	18.00	NA	8.95	2.90	090
43289		C	Laparoscope proc, esoph	0.00	0.00	0.00	0.00	YYY
43300		A	Repair of esophagus	9.21	NA	6.95	0.90	090
43305		A	Repair esophagus and fistula	17.98	NA	10.94	1.75	090
43310		A	Repair of esophagus	26.18	NA	11.70	4.65	090
43312		A	Repair esophagus and fistula	29.23	NA	10.70	5.19	090
43313		A	Esophagoplasty congenital	48.17	NA	19.86	2.58	090
43314		A	Tracheo-esophagoplasty cong	53.15	NA	28.62	5.18	090
43320		A	Fuse esophagus & stomach	23.18	NA	11.32	3.75	090
43324		A	Revise esophagus & stomach	22.86	NA	10.98	3.76	090
43325		A	Revise esophagus & stomach	22.47	NA	11.19	3.64	090
43326		A	Revise esophagus & stomach	22.15	NA	10.96	3.83	090
43330		A	Repair of esophagus	22.06	NA	10.70	3.61	090
43331		A	Repair of esophagus	22.93	NA	10.46	4.07	090
43340		A	Fuse esophagus & intestine	22.86	NA	11.33	3.70	090
43341		A	Fuse esophagus & intestine	24.10	NA	12.72	3.90	090
43350		A	Surgical opening, esophagus	19.31	NA	10.59	3.13	090
43351		A	Surgical opening, esophagus	21.87	NA	10.84	3.89	090
43352		A	Surgical opening, esophagus	17.68	NA	8.86	3.14	090

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43360		A	Gastrointestinal repair	39.90	NA	16.26	7.09	090
43361		A	Gastrointestinal repair	45.50	NA	21.43	7.37	090
43400		A	Ligate esophagus veins	25.47	NA	13.81	2.84	090
43401		A	Esophagus surgery for veins	26.36	NA	12.63	4.27	090
43405		A	Ligate/staple esophagus	24.55	NA	13.65	3.98	090
43410		A	Repair esophagus wound	16.28	NA	8.43	2.89	090
43415		A	Repair esophagus wound	28.70	NA	14.26	4.96	090
43420		A	Repair esophagus openng	16.65	NA	10.29	1.62	090
43425		A	Repair esophagus opening	24.91	NA	13.02	4.03	090
43450		A	Dilate esophagus	1.38	2.41	0.87	0.10	000
43453		A	Dilate esophagus	1.51	5.53	0.93	0.11	000
43456		A	Dilate esophagus	2.57	11.65	1.39	0.19	000
43458		A	Dilate esophagus	3.06	6.42	1.60	0.23	000
43460		A	Pressure treatment esophagus	3.79	NA	1.94	0.26	000
43496		C	Free jejunum flap, microvasc	0.00	0.00	0.00	0.00	090
43499		C	Esophagus surgery procedure	0.00	0.00	0.00	0.00	YYY
43500		A	Surgical opening of stomach	12.71	NA	6.81	2.01	090
43501		A	Surgical repair of stomach	22.47	NA	10.96	3.61	090
43502		A	Surgical repair of stomach	25.56	NA	12.29	4.14	090
43510		A	Surgical opening of stomach	15.01	NA	9.10	2.43	090
43520		A	Incision of pyloric muscle	11.21	NA	5.91	1.89	090
43600		A	Biopsy of stomach	1.91	NA	0.80	0.15	000
43605		A	Biopsy of stomach	13.64	NA	7.13	2.17	090
43610		A	Excision of stomach lesion	16.26	NA	8.16	2.59	090
43611		A	Excision of stomach lesion	20.25	NA	10.16	3.22	090
43620		A	Removal of stomach	33.91	NA	15.12	5.47	090
43621		A	Removal of stomach	39.40	NA	17.20	6.35	090
43622		A	Removal of stomach	39.90	NA	17.43	6.46	090
43631		A	Removal of stomach, partial	24.38	NA	11.72	3.91	090
43632		A	Removal of stomach, partial	35.01	NA	15.66	5.62	090
43633		A	Removal of stomach, partial	33.01	NA	14.85	5.28	090
43634		A	Removal of stomach, partial	36.51	NA	16.36	5.91	090
43635		A	Removal of stomach, partial	2.06	NA	0.76	0.33	ZZZ
43640		A	Vagotomy & pylorus repair	19.43	NA	9.93	3.10	090
43641		A	Vagotomy & pylorus repair	19.68	NA	10.11	3.19	090
43644		A	Lap gastric bypass/roux-en-y	29.24	NA	13.95	4.71	090
43645		A	Lap gastr bypass incl smll i	31.37	NA	14.83	5.08	090
43647		C	Lap impl electrode, antrum	0.00	0.00	0.00	0.00	YYY
43648		C	Lap revise/remv elctrd antrum	0.00	0.00	0.00	0.00	YYY
43651		A	Laparoscopy, vagus nerve	10.13	NA	6.18	1.64	090
43652		A	Laparoscopy, vagus nerve	12.13	NA	6.92	1.96	090
43653		A	Laparoscopy, gastrostomy	8.38	NA	5.75	1.35	090
43659		C	Laparoscope proc, stom	0.00	0.00	0.00	0.00	YYY
43752		A	Nasal/orogastric w/stent	0.81	NA	0.26	0.06	000
43760		A	Change gastrostomy tube	0.90	10.44	0.34	0.09	000
43761		A	Reposition gastrostomy tube	2.01	1.01	0.68	0.16	000
43770		A	Lap place gastr adj device	17.85	NA	9.92	2.87	090
43771		A	Lap revise gastr adj device	20.64	NA	11.01	3.34	090
43772		A	Lap rmvl gastr adj device	15.62	NA	8.11	2.53	090
43773		A	Lap replace gastr adj device	20.64	NA	11.01	3.34	090
43774		A	Lap rmvl gastr adj all parts	15.66	NA	8.22	2.53	090
43800		A	Reconstruction of pylorus	15.35	NA	7.82	2.49	090
43810		A	Fusion of stomach and bowel	16.80	NA	8.47	2.72	090
43820		A	Fusion of stomach and bowel	22.40	NA	10.98	3.59	090
43825		A	Fusion of stomach and bowel	21.63	NA	10.73	3.50	090
43830		A	Place gastrostomy tube	10.75	NA	6.62	1.68	090
43831		A	Place gastrostomy tube	8.38	NA	6.29	1.36	090
43832		A	Place gastrostomy tube	17.26	NA	8.96	2.71	090
43840		A	Repair of stomach lesion	22.70	NA	11.09	3.63	090
43842		N	V-band gastroplasty	20.90	NA	9.72	1.12	090
43843		A	Gastroplasty w/o v-band	21.08	NA	10.29	3.41	090
43845		A	Gastroplasty duodenal switch	33.12	NA	15.91	5.35	090
43846		A	Gastric bypass for obesity	27.23	NA	13.51	4.37	090
43847		A	Gastric bypass incl small i	30.10	NA	14.61	4.87	090
43848		A	Revision gastroplasty	32.57	NA	15.45	5.23	090
43850		A	Revise stomach-bowel fusion	27.45	NA	12.99	4.45	090
43855		A	Revise stomach-bowel fusion	28.56	NA	12.49	4.63	090
43860		A	Revise stomach-bowel fusion	27.76	NA	13.09	4.43	090
43865		A	Revise stomach-bowel fusion	28.92	NA	13.54	4.68	090
43870		A	Repair stomach opening	11.36	NA	6.35	1.78	090
43880		A	Repair stomach-bowel fistula	27.05	NA	12.76	4.27	090
43881		C	Implr/redo electrd, antrum	0.00	0.00	0.00	0.00	YYY
43882		C	Revise/remove electrd antrum	0.00	0.00	0.00	0.00	YYY
43886		A	Revise gastric port, open	4.54	NA	4.35	0.74	090
43887		A	Remove gastric port, open	4.24	NA	3.80	0.69	090
43888		A	Change gastric port, open	6.34	NA	5.02	1.03	090
43999		C	Stomach surgery procedure	0.00	0.00	0.00	0.00	YYY
44005		A	Freeing of bowel adhesion	18.38	NA	8.92	2.88	090
44010		A	Incision of small bowel	14.18	NA	7.33	2.26	090
44015		A	Insert needle cath bowel	2.62	NA	0.95	0.42	ZZZ
44020		A	Explore small intestine	16.14	NA	8.06	2.54	090
44021		A	Decompress small bowel	16.23	NA	8.11	2.57	090
44025		A	Incision of large bowel	16.43	NA	8.23	2.54	090
44050		A	Reduce bowel obstruction	15.44	NA	7.86	2.45	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
44055		A	Correct malrotation of bowel	25.53	NA	11.70	4.06	090
44100		A	Biopsy of bowel	2.01	NA	0.88	0.15	000
44110		A	Excise intestine lesion(s)	13.96	NA	7.26	2.11	090
44111		A	Excision of bowel lesion(s)	16.44	NA	8.21	2.52	090
44120		A	Removal of small intestine	20.74	NA	9.80	3.24	090
44121		A	Removal of small intestine	4.44	NA	1.64	0.68	ZZZ
44125		A	Removal of small intestine	19.93	NA	9.63	3.05	090
44126		A	Enterectomy w/o taper, cong	42.02	NA	19.23	6.80	090
44127		A	Enterectomy w/taper, cong	49.09	NA	21.77	7.95	090
44128		A	Enterectomy cong, add-on	4.44	NA	1.65	0.72	ZZZ
44130		A	Bowel to bowel fusion	21.98	NA	10.77	3.42	090
44132		R	Enterectomy, cadaver donor	0.00	0.00	0.00	0.00	XXX
44133		R	Enterectomy, live donor	0.00	0.00	0.00	0.00	XXX
44135		R	Intestine transplnt, cadaver	0.00	0.00	0.00	0.00	XXX
44136		R	Intestine transplant, live	0.00	0.00	0.00	0.00	XXX
44137		C	Remove intestinal allograft	0.00	0.00	0.00	0.00	XXX
44139		A	Mobilization of colon	2.23	NA	0.83	0.34	ZZZ
44140		A	Partial removal of colon	22.46	NA	11.04	3.48	090
44141		A	Partial removal of colon	29.75	NA	15.84	4.61	090
44143		A	Partial removal of colon	27.63	NA	13.94	4.31	090
44144		A	Partial removal of colon	29.75	NA	14.49	4.64	090
44145		A	Partial removal of colon	28.45	NA	13.26	4.20	090
44146		A	Partial removal of colon	35.14	NA	18.21	5.11	090
44147		A	Partial removal of colon	33.56	NA	15.09	5.09	090
44150		A	Removal of colon	29.99	NA	16.86	4.61	090
44151		A	Removal of colon/ileostomy	34.73	NA	18.52	5.62	090
44155		A	Removal of colon/ileostomy	34.23	NA	18.31	4.89	090
44156		A	Removal of colon/ileostomy	37.23	NA	20.24	6.03	090
44157		A	Colectomy w/ileoanal anast	35.49	NA	18.96	5.75	090
44158		A	Colectomy w/neo-rectum pouch	36.49	NA	19.01	5.91	090
44160		A	Removal of colon	20.78	NA	10.30	3.21	090
44180		A	Lap, enterolysis	15.19	NA	7.74	2.37	090
44186		A	Lap, jejunostomy	10.30	NA	5.88	1.67	090
44187		A	Lap, ileo/jejuno-stomy	17.27	NA	10.62	2.46	090
44188		A	Lap, colostomy	19.20	NA	11.53	2.87	090
44202		A	Lap, enterectomy	23.26	NA	11.41	3.64	090
44203		A	Lap resect s/intestine, addl	4.44	NA	1.65	0.72	ZZZ
44204		A	Laparo partial colectomy	26.29	NA	12.46	3.94	090
44205		A	Lap colectomy part w/ileum	22.86	NA	10.93	3.41	090
44206		A	Lap part colectomy w/stoma	29.63	NA	14.38	4.56	090
44207		A	L colectomy/coloproctostomy	31.79	NA	14.41	4.66	090
44208		A	L colectomy/coloproctostomy	33.86	NA	16.68	4.78	090

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44210		A	Laparo total proctocolectomy	29.88	NA	15.39	4.37	090
44211		A	Lap colectomy w/proctectomy	36.87	NA	19.21	5.97	090
44212		A	Laparo total proctocolectomy	34.37	NA	17.92	4.79	090
44213		A	Lap, mobil splenic fl add-on	3.50	NA	1.30	0.51	ZZZ
44227		A	Lap, close enterostomy	28.49	NA	13.43	4.40	090
44238		C	Laparoscope proc, intestine	0.00	0.00	0.00	0.00	YYY
44300		A	Open bowel to skin	13.65	NA	7.30	2.18	090
44310		A	Ileostomy/jejunostomy	17.49	NA	8.74	2.56	090
44312		A	Revision of ileostomy	9.33	NA	5.51	1.31	090
44314		A	Revision of ileostomy	16.61	NA	8.73	2.36	090
44316		A	Devise bowel pouch	23.46	NA	11.63	3.80	090
44320		A	Colostomy	19.75	NA	10.23	3.00	090
44322		A	Colostomy with biopsies	13.15	NA	11.58	2.13	090
44340		A	Revision of colostomy	9.12	NA	6.34	1.39	090
44345		A	Revision of colostomy	17.06	NA	9.24	2.54	090
44346		A	Revision of colostomy	19.47	NA	10.20	2.92	090
44360		A	Small bowel endoscopy	2.59	NA	1.41	0.18	000
44361		A	Small bowel endoscopy/biopsy	2.87	NA	1.54	0.20	000
44363		A	Small bowel endoscopy	3.49	NA	1.77	0.25	000
44364		A	Small bowel endoscopy	3.73	NA	1.90	0.27	000
44365		A	Small bowel endoscopy	3.31	NA	1.72	0.24	000
44366		A	Small bowel endoscopy	4.40	NA	2.21	0.30	000
44369		A	Small bowel endoscopy	4.51	NA	2.26	0.31	000
44370		A	Small bowel endoscopy/stent	4.79	NA	2.54	0.32	000
44372		A	Small bowel endoscopy	4.40	NA	2.13	0.38	000
44373		A	Small bowel endoscopy	3.49	NA	1.76	0.28	000
44376		A	Small bowel endoscopy	5.25	NA	2.50	0.45	000
44377		A	Small bowel endoscopy/biopsy	5.52	NA	2.68	0.40	000
44378		A	Small bowel endoscopy	7.12	NA	3.39	0.49	000
44379		A	S bowel endoscope w/stent	7.46	NA	3.73	0.50	000
44380		A	Small bowel endoscopy	1.05	NA	0.70	0.08	000
44382		A	Small bowel endoscopy	1.27	NA	0.82	0.10	000
44383		A	Ileoscopy w/stent	2.94	NA	1.35	0.22	000
44385		A	Endoscopy of bowel pouch	1.82	4.62	0.94	0.18	000
44386		A	Endoscopy, bowel pouch/biop	2.12	6.51	1.14	0.20	000
44388		A	Colonoscopy	2.82	5.93	1.44	0.28	000
44389		A	Colonoscopy with biopsy	3.13	6.67	1.60	0.26	000
44390		A	Colonoscopy for foreign body	3.82	7.72	1.97	0.26	000
44391		A	Colonoscopy for bleeding	4.31	7.99	2.10	0.33	000
44392		A	Colonoscopy & polypectomy	3.81	7.16	1.83	0.36	000
44393		A	Colonoscopy, lesion removal	4.83	7.75	2.30	0.43	000
44394		A	Colonoscopy w/snare	4.42	8.01	2.14	0.39	000

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44397		A	Colonoscopy w/stent	4.70	NA	2.34	0.32	000
44500		A	Intro, gastrointestinal tube	0.49	NA	0.16	0.04	000
44602		A	Suture, small intestine	24.64	NA	10.64	3.80	090
44603		A	Suture, small intestine	28.03	NA	12.46	4.25	090
44604		A	Suture, large intestine	18.06	NA	8.32	2.71	090
44605		A	Repair of bowel lesion	22.00	NA	10.76	3.43	090
44615		A	Intestinal stricturoplasty	18.08	NA	8.85	2.80	090
44620		A	Repair bowel opening	14.35	NA	7.46	2.12	090
44625		A	Repair bowel opening	17.20	NA	8.52	2.51	090
44626		A	Repair bowel opening	27.82	NA	12.49	4.30	090
44640		A	Repair bowel-skin fistula	24.12	NA	11.06	3.68	090
44650		A	Repair bowel fistula	25.04	NA	11.35	3.79	090
44660		A	Repair bowel-bladder fistula	23.83	NA	10.27	2.87	090
44661		A	Repair bowel-bladder fistula	27.27	NA	12.01	3.83	090
44680		A	Surgical revision, intestine	17.88	NA	8.90	2.90	090
44700		A	Suspend bowel w/prosthesis	17.40	NA	8.52	2.11	090
44701		A	Intraop colon lavage add-on	3.10	NA	1.15	0.43	ZZZ
44715		C	Prepare donor intestine	0.00	0.00	0.00	0.00	XXX
44720		A	Prep donor intestine/venous	5.00	NA	1.82	0.27	XXX
44721		A	Prep donor intestine/artery	7.00	NA	2.60	1.13	XXX
44799		C	Unlisted procedure intestine	0.00	0.00	0.00	0.00	YYY
44800		A	Excision of bowel pouch	11.94	NA	7.04	1.81	090
44820		A	Excision of mesentery lesion	13.63	NA	7.27	2.11	090
44850		A	Repair of mesentery	12.03	NA	6.46	1.90	090
44899		C	Bowel surgery procedure	0.00	0.00	0.00	0.00	YYY
44900		A	Drain app abscess, open	12.44	NA	6.73	1.98	090
44901		A	Drain app abscess, percut	3.37	14.70	1.03	0.28	000
44950		A	Appendectomy	10.52	NA	5.43	1.68	090
44955		A	Appendectomy add-on	1.53	NA	0.57	0.21	ZZZ
44960		A	Appendectomy	14.39	NA	7.31	2.30	090
44970		A	Laparoscopy, appendectomy	9.35	NA	5.52	1.49	090
44979		C	Laparoscope proc, app	0.00	0.00	0.00	0.00	YYY
45000		A	Drainage of pelvic abscess	6.20	NA	4.36	0.81	090
45005		A	Drainage of rectal abscess	2.00	4.56	1.93	0.26	010
45020		A	Drainage of rectal abscess	8.43	NA	5.65	1.21	090
45100		A	Biopsy of rectum	3.96	NA	3.47	0.54	090
45108		A	Removal of anorectal lesion	5.04	NA	4.04	0.82	090
45110		A	Removal of rectum	30.57	NA	16.19	4.39	090
45111		A	Partial removal of rectum	17.89	NA	9.46	2.66	090
45112		A	Removal of rectum	33.05	NA	14.84	4.59	090
45113		A	Partial proctectomy	33.09	NA	16.67	5.36	090
45114		A	Partial removal of rectum	30.63	NA	14.49	4.96	090
45116		A	Partial removal of rectum	27.56	NA	12.92	2.99	090
45119		A	Remove rectum w/reservoir	33.35	NA	16.54	4.42	090
45120		A	Removal of rectum	26.25	NA	13.22	4.25	090
45121		A	Removal of rectum and colon	28.93	NA	14.21	4.69	090
45123		A	Partial proctectomy	18.70	NA	9.78	2.38	090
45126		A	Pelvic exenteration	48.89	NA	22.21	7.92	090
45130		A	Excision of rectal prolapse	18.37	NA	9.47	2.34	090
45135		A	Excision of rectal prolapse	22.15	NA	11.91	3.59	090
45136		A	Excise ileoanal reservoir	30.63	NA	16.83	4.96	090
45150		A	Excision of rectal stricture	5.77	NA	4.21	0.63	090
45160		A	Excision of rectal lesion	16.17	NA	8.99	2.21	090
45170		A	Excision of rectal lesion	12.48	NA	7.23	1.75	090
45190		A	Destruction, rectal tumor	10.29	NA	7.08	1.42	090
45300		A	Proctosigmoidoscopy dx	0.80	2.25	0.59	0.10	000
45303		A	Proctosigmoidoscopy dilate	1.50	21.59	0.85	0.19	000
45305		A	Proctosigmoidoscopy w/bx	1.25	3.53	0.76	0.15	000
45307		A	Proctosigmoidoscopy fb	1.70	3.78	0.92	0.23	000
45308		A	Proctosigmoidoscopy removal	1.40	3.82	0.82	0.18	000
45309		A	Proctosigmoidoscopy removal	1.50	3.89	0.86	0.19	000
45315		A	Proctosigmoidoscopy removal	1.80	4.25	0.98	0.23	000
45317		A	Proctosigmoidoscopy bleed	2.00	3.84	1.04	0.24	000
45320		A	Proctosigmoidoscopy ablate	1.78	3.68	0.97	0.22	000
45321		A	Proctosigmoidoscopy volvul	1.75	NA	0.97	0.22	000
45327		A	Proctosigmoidoscopy w/stent	2.00	NA	1.16	0.32	000
45330		A	Diagnostic sigmoidoscopy	0.96	2.48	0.66	0.09	000
45331		A	Sigmoidoscopy and biopsy	1.15	3.00	0.77	0.09	000
45332		A	Sigmoidoscopy w/fb removal	1.79	5.27	1.02	0.16	000
45333		A	Sigmoidoscopy & polypectomy	1.79	5.40	1.02	0.16	000
45334		A	Sigmoidoscopy for bleeding	2.73	NA	1.46	0.20	000
45335		A	Sigmoidoscopy w/submuc inj	1.46	4.93	0.89	0.13	000
45337		A	Sigmoidoscopy & decompress	2.36	NA	1.27	0.21	000
45338		A	Sigmoidoscopy w/tumr remove	2.34	5.44	1.27	0.19	000
45339		A	Sigmoidoscopy w/ablate tumr	3.14	5.25	1.62	0.25	000
45340		A	Sig w/balloon dilation	1.89	9.65	1.06	0.18	000
45341		A	Sigmoidoscopy w/ultrasound	2.60	NA	1.40	0.19	000
45342		A	Sigmoidoscopy w/us guide bx	4.05	NA	2.05	0.28	000
45345		A	Sigmoidoscopy w/stent	2.92	NA	1.53	0.23	000
45355		A	Surgical colonoscopy	3.51	NA	1.71	0.34	000
45378		A	Diagnostic colonoscopy	3.69	6.00	1.84	0.31	000
45378		A	Diagnostic colonoscopy	0.96	2.48	0.66	0.08	000
45379	53	A	Colonoscopy w/fb removal	4.68	7.74	2.26	0.39	000
45380		A	Colonoscopy and biopsy	4.43	7.10	2.19	0.33	000

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45381		A	Colonoscopy, submucous inj	4.19	7.00	2.09	0.31	000
45382		A	Colonoscopy/control bleeding	5.68	9.28	2.75	0.41	000
45383		A	Lesion removal colonoscopy	5.86	8.20	2.73	0.51	000
45384		A	Lesion remove colonoscopy	4.69	6.87	2.25	0.41	000
45385		A	Lesion removal colonoscopy	5.30	7.72	2.56	0.41	000
45386		A	Colonoscopy dilate stricture	4.57	11.46	2.20	0.40	000
45387		A	Colonoscopy w/stent	5.90	NA	2.93	0.47	000
45391		A	Colonoscopy w/endoscope us	5.09	NA	2.48	0.37	000
45392		A	Colonoscopy w/endoscopic fnb	6.54	NA	3.10	0.50	000
45395		A	Lap, removal of rectum	32.79	NA	17.80	4.44	090
45397		A	Lap, remove rectum w/pouch	36.29	NA	18.84	4.54	090
45400		A	Laparoscopic proc	19.31	NA	9.90	2.68	090
45402		A	Lap proctopexy w/sig resect	26.38	NA	12.57	3.61	090
45499		C	Laparoscope proc, rectum	0.00	0.00	0.00	0.00	YYY
45500		A	Repair of rectum	7.64	NA	5.64	0.90	090
45505		A	Repair of rectum	8.20	NA	6.49	1.12	090
45520		A	Treatment of rectal prolapse	0.55	3.28	0.49	0.06	000
45540		A	Correct rectal prolapse	18.02	NA	8.91	2.34	090
45541		A	Correct rectal prolapse	14.72	NA	8.78	1.93	090
45550		A	Repair rectum/remove sigmoid	24.67	NA	12.59	3.34	090
45560		A	Repair of rectocele	11.42	NA	6.32	1.33	090
45562		A	Exploration/repair of rectum	17.82	NA	10.09	2.51	090
45563		A	Exploration/repair of rectum	26.22	NA	14.61	4.25	090
45800		A	Repair rect/bladder fistula	20.18	NA	9.99	2.54	090
45805		A	Repair fistula w/colostomy	23.19	NA	13.04	3.76	090
45820		A	Repair rectourethral fistula	20.24	NA	9.01	1.47	090
45825		A	Repair fistula w/colostomy	24.01	NA	13.79	2.61	090
45900		A	Reduction of rectal prolapse	2.96	NA	2.10	0.40	010
45905		A	Dilation of anal sphincter	2.32	NA	1.91	0.30	010
45910		A	Dilation of rectal narrowing	2.82	NA	2.07	0.34	010
45915		A	Remove rectal obstruction	3.16	4.82	2.45	0.32	010
45990		A	Surg dx exam, anorectal	1.80	NA	0.94	0.24	000
45999		C	Rectum surgery procedure	0.00	0.00	0.00	0.00	YYY
46020		A	Placement of seton	2.94	3.88	2.88	0.40	010
46030		A	Removal of rectal marker	1.24	2.20	1.02	0.16	010
46040		A	Incision of rectal abscess	5.26	7.78	4.92	0.78	090
46045		A	Incision of rectal abscess	5.79	NA	4.94	0.87	090
46050		A	Incision of anal abscess	1.21	3.72	1.21	0.16	010
46060		A	Incision of rectal abscess	6.24	NA	5.54	0.87	090
46070		A	Incision of anal septum	2.74	NA	2.85	0.15	090
46080		A	Incision of anal sphincter	2.59	3.66	1.49	0.36	010
46083		A	Incise external hemorrhoid	1.42	2.83	1.23	0.14	010
46200		A	Removal of anal fissure	3.48	7.36	4.51	0.46	090
46210		A	Removal of anal crypt	2.73	7.12	4.12	0.44	090
46211		A	Removal of anal crypts	4.31	8.32	4.94	0.70	090
46220		A	Removal of anal tag	1.58	3.49	1.37	0.21	010
46221		A	Ligation of hemorrhoid(s)	2.31	4.32	2.42	0.30	010
46230		A	Removal of anal tags	2.59	4.19	1.75	0.35	010
46250		A	Hemorrhoidectomy	4.17	7.12	3.58	0.61	090
46255		A	Hemorrhoidectomy	4.88	7.54	3.87	0.72	090
46257		A	Remove hemorrhoids & fissure	5.68	NA	4.85	0.79	090
46258		A	Remove hemorrhoids & fistula	6.28	NA	5.23	1.02	090
46260		A	Hemorrhoidectomy	6.65	NA	5.17	0.95	090
46261		A	Remove hemorrhoids & fissure	7.63	NA	5.57	1.03	090
46262		A	Remove hemorrhoids & fistula	7.80	NA	6.01	1.07	090
46270		A	Removal of anal fistula	4.81	7.60	4.82	0.72	090
46275		A	Removal of anal fistula	5.31	7.92	4.96	0.72	090
46280		A	Removal of anal fistula	6.28	NA	5.39	0.83	090
46285		A	Removal of anal fistula	5.31	7.85	4.97	0.68	090
46288		A	Repair anal fistula	7.68	NA	6.01	1.00	090
46320		A	Removal of hemorrhoid clot	1.62	2.90	1.15	0.20	010
46500		A	Injection into hemorrhoid(s)	1.64	4.19	1.57	0.20	010
46505		A	Chemodenervation anal musc	3.13	3.98	2.86	0.41	010
46600		A	Diagnostic anoscopy	0.55	1.61	0.49	0.06	000
46604		A	Anoscopy and dilation	1.03	13.88	0.67	0.12	000
46606		A	Anoscopy and biopsy	1.20	4.32	0.74	0.15	000
46608		A	Anoscopy, remove for body	1.30	4.42	0.71	0.16	000
46610		A	Anoscopy, remove lesion	1.28	4.29	0.78	0.17	000
46611		A	Anoscopy	1.30	2.97	0.77	0.13	000
46612		A	Anoscopy, remove lesions	1.50	5.01	0.87	0.19	000
46614		A	Anoscopy, control bleeding	1.00	2.17	0.66	0.11	000
46615		A	Anoscopy	1.50	2.03	0.84	0.19	000
46700		A	Repair of anal stricture	9.68	NA	6.78	1.23	090
46705		A	Repair of anal stricture	7.32	NA	5.24	0.39	090
46706		A	Repr of anal fistula w/glue	2.41	NA	1.82	0.32	010
46710		A	Repr per/vag pouch sngl proc	17.01	NA	10.31	2.75	090
46712		A	Repr per/vag pouch dbl proc	36.32	NA	17.34	1.95	090
46715		A	Rep perf anoper fistu	7.54	NA	4.93	0.40	090
46716		A	Rep perf anoper/vestib fistu	17.14	NA	13.18	1.84	090
46730		A	Construction of absent anus	30.17	NA	24.76	1.62	090
46735		A	Construction of absent anus	35.66	NA	18.01	1.91	090
46740		A	Construction of absent anus	33.42	NA	19.27	5.41	090
46742		A	Repair of imperforated anus	39.66	NA	21.26	2.12	090
46744		A	Repair of cloacal anomaly	58.46	NA	27.68	6.34	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
46746		A	Repair of cloacal anomaly	64.93	NA	28.81	3.48	090
46748		A	Repair of cloacal anomaly	70.91	NA	30.99	3.80	090
46750		A	Repair of anal sphincter	12.02	NA	7.31	1.47	090
46751		A	Repair of anal sphincter	9.19	NA	5.69	1.18	090
46753		A	Reconstruction of anus	8.81	NA	5.94	1.09	090
46754		A	Removal of suture from anus	2.88	4.35	2.79	0.20	010
46760		A	Repair of anal sphincter	17.21	NA	10.67	1.87	090
46761		A	Repair of anal sphincter	15.16	NA	8.67	1.79	090
46762		A	Implant artificial sphincter	14.66	NA	8.93	1.59	090
46900		A	Destruction, anal lesion(s)	1.91	4.11	1.62	0.20	010
46910		A	Destruction, anal lesion(s)	1.88	4.40	1.50	0.23	010
46916		A	Cryosurgery, anal lesion(s)	1.88	3.84	1.78	0.12	010
46917		A	Laser surgery, anal lesions	1.88	9.31	1.45	0.22	010
46922		A	Excision of anal lesion(s)	1.88	4.71	1.50	0.26	010
46924		A	Destruction, anal lesion(s)	2.78	10.45	1.91	0.31	010
46930		A	Destroy internal hemorrhoids	1.56	3.33	2.01	0.17	090
46937		A	Cryotherapy of rectal lesion	2.70	3.60	1.72	0.18	010
46938		A	Cryotherapy of rectal lesion	4.70	7.07	4.59	0.76	090
46940		A	Treatment of anal fissure	2.33	3.39	1.41	0.26	010
46942		A	Treatment of anal fissure	2.05	3.36	1.30	0.24	010
46945		A	Ligation of hemorrhoids	2.13	5.33	3.37	0.28	090
46946		A	Ligation of hemorrhoids	2.60	5.01	2.96	0.32	090
46947		A	Hemorrhoidopexy by stapling	5.49	NA	4.01	0.81	090
46999		C	Anus surgery procedure	0.00	0.00	0.00	0.00	YYY
47000		A	Needle biopsy of liver	1.90	4.89	0.60	0.14	000
47001		A	Needle biopsy, liver add-on	1.90	NA	0.70	0.30	ZZZ
47010		A	Open drainage, liver lesion	19.27	NA	10.49	2.96	090
47011		A	Percut drain, liver lesion	3.69	NA	1.12	0.27	000
47015		A	Inject/aspirate liver cyst	18.37	NA	10.43	2.97	090
47100		A	Wedge biopsy of liver	12.78	NA	8.14	2.01	090
47120		A	Partial removal of liver	38.82	NA	19.08	6.21	090
47122		A	Extensive removal of liver	59.35	NA	26.16	9.57	090
47125		A	Partial removal of liver	52.91	NA	23.73	8.49	090
47130		A	Partial removal of liver	57.06	NA	25.10	9.13	090
47135		R	Transplantation of liver	83.29	NA	38.29	13.37	090
47136		R	Transplantation of liver	70.39	NA	33.74	11.40	090
47140		A	Partial removal, donor liver	59.22	NA	29.48	9.59	090
47141		A	Partial removal, donor liver	71.27	NA	32.10	3.82	090
47142		A	Partial removal, donor liver	79.21	NA	37.67	12.83	090
47143		C	Prep donor liver, whole	0.00	0.00	0.00	0.00	XXX
47144		C	Prep donor liver, 3-segment	0.00	0.00	0.00	0.00	090
47145		C	Prep donor liver, lobe split	0.00	0.00	0.00	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
47146		A	Prep donor liver/venous	6.00	NA	2.23	0.97	XXX
47147		A	Prep donor liver/arterial	7.00	NA	2.60	1.13	XXX
47300		A	Surgery for liver lesion	18.01	NA	10.19	2.91	090
47350		A	Repair liver wound	22.36	NA	11.73	3.52	090
47360		A	Repair liver wound	31.18	NA	14.95	5.05	090
47361		A	Repair liver wound	52.47	NA	22.84	8.04	090
47362		A	Repair liver wound	23.41	NA	12.43	3.73	090
47370		A	Laparo ablate liver tumor rf	20.67	NA	10.16	3.18	090
47371		A	Laparo ablate liver cryosurg	20.67	NA	10.46	3.35	090
47379		C	Laparoscope procedure, liver	0.00	0.00	0.00	0.00	YYY
47380		A	Open ablate liver tumor rf	24.43	NA	11.44	3.72	090
47381		A	Open ablate liver tumor cryo	24.72	NA	11.97	4.00	090
47382		A	Percut ablate liver rf	15.19	NA	5.06	1.14	010
47399		C	Liver surgery procedure	0.00	0.00	0.00	0.00	YYY
47400		A	Incision of liver duct	36.23	NA	17.31	5.87	090
47420		A	Incision of bile duct	21.92	NA	11.43	3.53	090
47425		A	Incision of bile duct	22.20	NA	11.72	3.60	090
47460		A	Incise bile duct sphincter	20.41	NA	11.05	3.31	090
47480		A	Incision of gallbladder	13.12	NA	8.45	2.07	090
47490		A	Incision of gallbladder	8.05	NA	4.63	0.59	090
47500		A	Injection for liver x-rays	1.96	NA	0.59	0.15	000
47505		A	Injection for liver x-rays	0.76	NA	0.23	0.06	000
47510		A	Insert catheter, bile duct	7.94	NA	4.04	0.61	090
47511		A	Insert bile duct drain	10.74	NA	4.28	0.79	090
47525		A	Change bile duct catheter	1.54	8.39	0.68	0.11	000
47530		A	Revise/reinsert bile tube	5.96	20.71	3.01	0.46	090
47550		A	Bile duct endoscopy add-on	3.02	NA	1.13	0.47	ZZZ
47552		A	Biliary endoscopy thru skin	6.03	NA	2.19	0.47	000
47553		A	Biliary endoscopy thru skin	6.34	NA	1.93	0.47	000
47554		A	Biliary endoscopy thru skin	9.05	NA	3.44	1.15	000
47555		A	Biliary endoscopy thru skin	7.55	NA	2.22	0.56	000
47556		A	Biliary endoscopy thru skin	8.55	NA	2.55	0.62	000
47560		A	Laparoscopy w/cholangio	4.88	NA	1.81	0.79	000
47561		A	Laparo w/cholangio/biopsy	5.17	NA	2.18	0.84	000
47562		A	Laparoscopic cholecystectomy	11.63	NA	6.93	1.87	090
47563		A	Laparo cholecystectomy/graph	12.03	NA	6.76	1.94	090
47564		A	Laparo cholecystectomy/explr	14.21	NA	7.31	2.28	090
47570		A	Laparo cholecystoenterostomy	12.56	NA	6.76	2.03	090
47579		C	Laparoscope proc, biliary	0.00	0.00	0.00	0.00	YYY
47600		A	Removal of gallbladder	17.35	NA	9.58	2.78	090
47605		A	Removal of gallbladder	15.90	NA	8.52	2.56	090
47610		A	Removal of gallbladder	20.84	NA	10.40	3.36	090

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CPT-1/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
47612		A	Removal of gallbladder	21.13	NA	10.40	3.42	090
47620		A	Removal of gallbladder	22.99	NA	11.12	3.72	090
47630		A	Remove bile duct stone	9.57	NA	4.40	0.91	090
47700		A	Exploration of bile ducts	16.39	NA	9.68	2.65	090
47701		A	Bile duct revision	28.62	NA	14.47	4.63	090
47711		A	Excision of bile duct tumor	25.77	NA	12.90	4.15	090
47712		A	Excision of bile duct tumor	33.59	NA	16.08	5.44	090
47715		A	Excision of bile duct cyst	21.42	NA	11.56	3.47	090
47720		A	Fuse gallbladder & bowel	18.21	NA	10.37	2.94	090
47721		A	Fuse upper gi structures	21.86	NA	11.72	3.54	090
47740		A	Fuse gallbladder & bowel	21.10	NA	11.44	3.42	090
47741		A	Fuse gallbladder & bowel	24.08	NA	12.55	3.90	090
47760		A	Fuse bile ducts and bowel	38.14	NA	17.92	6.11	090
47765		A	Fuse liver ducts & bowel	52.01	NA	23.55	8.42	090
47780		A	Fuse bile ducts and bowel	42.14	NA	19.43	6.80	090
47785		A	Fuse bile ducts and bowel	56.01	NA	24.87	9.08	090
47800		A	Reconstruction of bile ducts	26.04	NA	13.17	4.19	090
47801		A	Placement, bile duct support	17.47	NA	8.22	1.84	090
47802		A	Fuse liver duct & intestine	24.80	NA	13.07	4.02	090
47900		A	Suture bile duct injury	22.31	NA	11.72	3.55	090
47999		C	Bile tract surgery procedure	0.00	0.00	0.00	0.00	YYY
48000		A	Drainage of abdomen	31.82	NA	14.35	5.15	090
48001		A	Placement of drain, pancreas	39.56	NA	17.86	6.41	090
48020		A	Removal of pancreatic stone	18.96	NA	10.21	3.07	090
48100		A	Biopsy of pancreas, open	14.38	NA	7.65	2.26	090
48102		A	Needle biopsy, pancreas	4.68	6.26	1.62	0.35	010
48105		A	Resect/debride pancreas	49.05	NA	22.01	7.85	090
48120		A	Removal of pancreas lesion	18.33	NA	9.22	2.96	090
48140		A	Partial removal of pancreas	26.19	NA	12.67	4.20	090
48145		A	Partial removal of pancreas	27.26	NA	13.29	4.41	090
48146		A	Pancreatectomy	30.42	NA	16.19	4.93	090
48148		A	Removal of pancreatic duct	20.26	NA	10.69	3.28	090
48150		A	Partial removal of pancreas	52.63	NA	24.62	8.50	090
48152		A	Pancreatectomy	48.47	NA	23.27	7.85	090
48153		A	Pancreatectomy	52.61	NA	24.56	8.49	090
48154		A	Pancreatectomy	48.70	NA	23.36	7.89	090
48155		A	Removal of pancreas	29.27	NA	15.68	4.74	090
48400		A	Injection, intraop add-on	1.95	NA	0.87	0.13	ZZZ
48500		A	Surgery of pancreatic cyst	18.03	NA	10.48	2.92	090
48510		A	Drain pancreatic pseudocyst	17.06	NA	9.87	2.70	090
48511		A	Drain pancreatic pseudocyst	3.99	14.77	1.20	0.30	000
48520		A	Fuse pancreas cyst and bowel	18.07	NA	9.14	2.90	090
48540		A	Fuse pancreas cyst and bowel	21.86	NA	10.71	3.54	090
48545		A	Pancreatorrhaphy	22.10	NA	11.26	3.58	090
48547		A	Duodenal exclusion	30.25	NA	14.29	4.90	090
48548		A	Fuse pancreas and bowel	27.96	NA	13.29	4.53	090
48551		C	Prep donor pancreas	0.00	0.00	0.00	0.00	XXX
48552		A	Prep donor pancreas/venous	4.30	NA	1.60	0.70	XXX
48554		R	Transpl allograft pancreas	37.03	NA	25.79	5.86	090
48556		A	Removal, allograft pancreas	19.24	NA	12.20	3.12	090
48999		C	Pancreas surgery procedure	0.00	0.00	0.00	0.00	YYY
49000		A	Exploration of abdomen	12.44	NA	6.72	1.92	090
49002		A	Reopening of abdomen	17.55	NA	8.56	2.73	090
49010		A	Exploration behind abdomen	15.98	NA	7.52	2.35	090
49020		A	Drain abdominal abscess	26.46	NA	13.11	4.05	090
49021		A	Drain abdominal abscess	3.37	14.36	1.02	0.25	000
49040		A	Drain, open, abdom abscess	16.41	NA	8.53	2.54	090
49041		A	Drain, percut, abdom abscess	3.99	14.52	1.20	0.29	000
49060		A	Drain, open, retrop abscess	18.42	NA	8.99	2.76	090
49061		A	Drain, percut, retroper absc	3.69	14.42	1.11	0.27	000
49062		A	Drain to peritoneal cavity	12.12	NA	6.19	1.83	090
49080		A	Puncture, peritoneal cavity	1.35	2.56	0.44	0.10	000
49081		A	Removal of abdominal fluid	1.26	2.84	0.47	0.10	000
49180		A	Biopsy, abdominal mass	1.73	2.25	0.52	0.13	000
49203		A	Exc abd tum 5 cm or less	20.00	NA	9.85	2.73	090
49204		A	Exc abd tum over 5 cm	26.00	NA	12.07	3.35	090
49205		A	Exc abd tum over 10 cm	30.00	NA	13.65	3.93	090
49215		A	Excise sacral spine tumor	37.66	NA	17.08	5.53	090
49220		A	Multiple surgery, abdomen	15.70	NA	8.37	2.54	090
49250		A	Excision of umbilicus	8.93	NA	5.48	1.24	090
49255		A	Removal of omentum	12.41	NA	7.16	1.72	090
49320		A	Diag laparo separate proc	5.09	NA	3.04	0.68	010
49321		A	Laparoscopy, biopsy	5.39	NA	3.23	0.79	010
49322		A	Laparoscopy, aspiration	5.96	NA	3.29	0.69	010
49323		A	Laparo drain lymphocele	10.13	NA	5.63	1.60	090
49324		A	Lap insertion perm ip cath	6.27	NA	3.57	0.99	010
49325		A	Lap revision perm ip cath	6.77	NA	3.73	1.09	010
49326		A	Lap w/omentopexy add-on	3.50	NA	1.27	0.55	ZZZ
49329		C	Laparo proc, abdm/per/oment	0.00	0.00	0.00	0.00	YYY
49400		A	Air injection into abdomen	1.88	2.41	0.60	0.17	000
49402		A	Remove foreign body, adbomen	14.01	NA	7.26	2.17	090
49419		A	Insrt abdom cath for chemotx	7.03	NA	4.03	0.64	090
49420		A	Insert abdom drain, temp	2.22	NA	1.19	0.23	000
49421		A	Insert abdom drain, perm	5.87	NA	3.71	0.87	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
49422		A	Remove perm cannula/catheter	6.26	NA	3.31	0.94	010
49423		A	Exchange drainage catheter	1.46	9.07	0.46	0.11	000
49424		A	Assess cyst, contrast inject	0.76	2.87	0.26	0.06	000
49425		A	Insert abdomen-venous drain	12.13	NA	6.49	2.03	090
49426		A	Revise abdomen-venous shunt	10.33	NA	5.44	1.55	090
49427		A	Injection, abdominal shunt	0.89	NA	0.28	0.08	000
49428		A	Ligation of shunt	6.79	NA	3.86	1.10	010
49429		A	Removal of shunt	7.41	NA	3.63	1.19	010
49435		A	Insert subq exten to ip cath	2.25	NA	0.76	0.34	ZZZ
49436		A	Embedded ip cath exit-site	2.69	NA	1.96	0.43	010
49440		A	Place gastrostomy tube perc	4.18	18.61	1.68	0.35	010
49441		A	Place duod/jej tube perc	4.77	19.77	1.86	0.41	010
49442		A	Place cecostomy tube perc	4.00	16.27	1.66	0.29	010
49446		A	Change g-tube to g-j perc	3.31	17.74	1.00	0.24	000
49450		A	Replace g/c tube perc	1.36	13.68	0.43	0.10	000
49451		A	Replace duod/jej tube perc	1.84	14.26	0.57	0.15	000
49452		A	Replace g-j tube perc	2.86	17.08	0.87	0.21	000
49460		A	Fix g/colon tube w/device	0.96	15.17	0.31	0.08	000
49465		A	Fluoro exam of g/colon tube	0.62	2.45	0.19	0.04	000
49491		A	Rpr hern preemie reduc	12.42	NA	7.18	2.01	090
49492		A	Rpr ing hern premie, blocked	15.32	NA	6.62	2.48	090
49495		A	Rpr ing hernia baby, reduc	6.15	NA	3.99	1.00	090
49496		A	Rpr ing hernia baby, blocked	9.32	NA	5.82	1.66	090
49500		A	Rpr ing hernia, init, reduce	5.76	NA	4.37	0.93	090
49501		A	Rpr ing hernia, init blocked	9.28	NA	5.67	1.50	090
49505		A	Prp i/hern init reduc >5 yr	7.88	NA	5.00	1.25	090
49507		A	Prp i/hern init block >5 yr	9.97	NA	5.84	1.59	090
49520		A	Rerepair ing hernia, reduce	9.91	NA	5.74	1.59	090
49521		A	Rerepair ing hernia, blocked	12.36	NA	6.62	1.97	090
49525		A	Repair ing hernia, sliding	8.85	NA	5.34	1.40	090
49540		A	Repair lumbar hernia	10.66	NA	6.11	1.69	090
49550		A	Rpr rem hernia, init, reduce	8.91	NA	5.36	1.43	090
49553		A	Rpr fem hernia, init blocked	9.84	NA	5.81	1.58	090
49555		A	Rerepair fem hernia, reduce	9.31	NA	5.56	1.49	090
49557		A	Rerepair fem hernia, blocked	11.54	NA	6.43	1.85	090
49560		A	Rpr ventral hern init, reduc	11.84	NA	6.48	1.87	090
49561		A	Rpr ventral hern init, block	15.30	NA	7.81	2.44	090
49565		A	Rerepair ventrl hern, reduce	12.29	NA	6.78	1.96	090
49566		A	Rerepair ventrl hern, block	15.45	NA	7.90	2.48	090
49568		A	Hernia repair w/mesh	4.88	NA	1.81	0.78	ZZZ
49570		A	Rpr epigastric hern, reduce	5.97	NA	4.29	0.96	090
49572		A	Rpr epigastric hern, blocked	7.79	NA	4.95	1.25	090

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
49580		A	Rpr umbil hern, reduc < 5 yr	4.39	NA	3.77	0.71	090
49582		A	Rpr umbil hern, block < 5 yr	7.05	NA	4.85	1.14	090
49585		A	Rpr umbil hern, reduc > 5 yr	6.51	NA	4.47	1.03	090
49587		A	Rpr umbil hern, block > 5 yr	7.96	NA	5.02	1.27	090
49590		A	Repair spigelian hernia	8.82	NA	5.33	1.41	090
49600		A	Repair umbilical lesion	11.47	NA	6.60	1.86	090
49605		A	Repair umbilical lesion	86.85	NA	35.93	14.06	090
49606		A	Repair umbilical lesion	18.92	NA	9.18	3.06	090
49610		A	Repair umbilical lesion	10.83	NA	6.18	0.58	090
49611		A	Repair umbilical lesion	9.26	NA	5.05	0.50	090
49650		A	Lap ing hernia repair init	6.30	NA	4.31	1.01	090
49651		A	Lap ing hernia repair recur	8.29	NA	5.49	1.33	090
49652		A	Lap vent/abd hernia repair	12.80	NA	7.01	0.69	090
49653		A	Lap vent/abd hern proc comp	16.10	NA	8.68	0.86	090
49654		A	Lap inc hernia repair	14.95	NA	7.81	0.80	090
49655		A	Lap inc hern repair comp	18.00	NA	9.38	0.96	090
49656		A	Lap inc hernia repair recur	15.00	NA	7.83	0.80	090
49657		A	Lap inc hern recur comp	22.00	NA	10.87	1.18	090
49659		C	Laparo proc, hernia repair	0.00	0.00	0.00	0.00	YYY
49900		A	Repair of abdominal wall	12.26	NA	7.98	1.88	090
49904		A	Omental flap, extra-abdom	22.16	NA	13.67	3.55	090
49905		A	Omental flap, intra-abdom	6.54	NA	2.39	0.92	ZZZ
49906		C	Free omental flap, microvasc	0.00	0.00	0.00	0.00	090
49999		C	Abdomen surgery procedure	0.00	0.00	0.00	0.00	YYY
50010		A	Exploration of kidney	12.13	NA	6.37	1.28	090
50020		A	Renal abscess, open drain	17.88	NA	9.00	1.80	090
50021		A	Renal abscess, percut drain	3.37	15.13	1.01	0.24	000
50040		A	Drainage of kidney	16.48	NA	7.33	1.26	090
50045		A	Exploration of kidney	16.67	NA	7.45	1.21	090
50060		A	Removal of kidney stone	20.80	NA	8.80	1.51	090
50065		A	Incision of kidney	22.17	NA	9.25	1.61	090
50070		A	Incision of kidney	21.70	NA	9.09	1.57	090
50075		A	Removal of kidney stone	26.91	NA	10.99	1.95	090
50080		A	Removal of kidney stone	15.61	NA	6.91	1.15	090
50081		A	Removal of kidney stone	23.32	NA	9.84	1.72	090
50100		A	Revise kidney blood vessels	17.30	NA	9.35	2.80	090
50120		A	Exploration of kidney	17.06	NA	7.52	1.24	090
50125		A	Explore and drain kidney	17.67	NA	9.49	1.28	090
50130		A	Removal of kidney stone	18.67	NA	8.10	1.35	090
50135		A	Exploration of kidney	20.44	NA	8.68	1.48	090
50200		A	Biopsy of kidney	2.63	NA	1.10	0.20	000
50205		A	Biopsy of kidney	12.19	NA	6.51	1.80	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
5020F		I	Txmnts 2 main Dr by 1 mon	0.00	0.00	0.00	0.00	XXX
50220		A	Remove kidney, open	18.53	NA	8.28	1.64	090
50225		A	Removal kidney open, complex	21.73	NA	9.32	1.79	090
50230		A	Removal kidney open, radical	23.68	NA	9.63	1.83	090
50234		A	Removal of kidney & ureter	23.90	NA	9.90	1.82	090
50236		A	Removal of kidney & ureter	26.74	NA	11.33	1.96	090
50240		A	Partial removal of kidney	24.01	NA	10.31	1.80	090
50250		A	Cryoablate renal mass open	22.06	NA	9.64	1.61	090
50280		A	Removal of kidney lesion	16.94	NA	7.66	1.37	090
50290		A	Removal of kidney lesion	16.00	NA	7.23	1.16	090
50320		A	Remove kidney, living donor	22.28	NA	13.48	2.91	090
50323		C	Prep cadaver renal allograft	0.00	0.00	0.00	0.00	XXX
50325		C	Prep donor renal graft	0.00	0.00	0.00	0.00	XXX
50327		A	Prep renal graft/venous	4.00	NA	1.45	0.59	XXX
50328		A	Prep renal graft/arterial	3.50	NA	1.26	0.50	XXX
50329		A	Prep renal graft/ureteral	3.34	NA	1.14	0.34	XXX
50340		A	Removal of kidney	13.86	NA	9.48	2.24	090
50360		A	Transplantation of kidney	40.45	NA	23.23	6.22	090
50365		A	Transplantation of kidney	45.68	NA	24.93	7.40	090
50370		A	Remove transplanted kidney	18.68	NA	11.01	2.80	090
50380		A	Reimplantation of kidney	29.66	NA	19.55	4.80	090
50382		A	Change ureter stent, percut	5.50	18.91	1.71	0.40	000
50384		A	Remove ureter stent, percut	5.00	14.19	1.56	0.36	000
50385		A	Change stent via transureth	4.44	19.36	1.62	0.33	000
50386		A	Remove stent via transureth	3.30	12.29	1.30	0.24	000
50387		A	Change ext/int ureter stent	2.00	9.28	0.59	0.15	000
50389		A	Remove renal tube w/fluoro	1.10	5.58	0.33	0.08	000
50390		A	Drainage of kidney lesion	1.96	NA	0.59	0.14	000
50391		A	Instll rx agnt into rnal tub	1.96	1.27	0.69	0.14	000
50392		A	Insert kidney drain	3.37	NA	1.29	0.24	000
50393		A	Insert ureteral tube	4.15	NA	1.52	0.30	000
50394		A	Injection for kidney x-ray	0.76	1.70	0.51	0.06	000
50395		A	Create passage to kidney	3.37	NA	1.32	0.25	000
50396		A	Measure kidney pressure	2.09	NA	0.90	0.15	000
50398		A	Change kidney tube	1.46	8.22	0.47	0.11	000
50400		A	Revision of kidney/ureter	21.12	NA	8.93	1.56	090
50405		A	Revision of kidney/ureter	25.68	NA	10.59	1.86	090
50500		A	Repair of kidney wound	21.07	NA	10.30	3.41	090
50520		A	Close kidney-skin fistula	18.73	NA	8.12	1.36	090
50525		A	Repair renal-abdomen fistula	24.21	NA	12.12	3.92	090
50526		A	Repair renal-abdomen fistula	26.13	NA	11.84	1.40	090
50540		A	Revision of horseshoe kidney	20.95	NA	8.85	1.52	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
50541		A	Laparo ablate renal cyst	16.76	NA	7.18	1.27	090
50542		A	Laparo ablate renal mass	21.18	NA	9.13	1.56	090
50543		A	Laparo partial nephrectomy	27.18	NA	11.50	2.01	090
50544		A	Laparoscopy, pyeloplasty	23.27	NA	9.27	1.73	090
50545		A	Laparo radical nephrectomy	24.93	NA	10.04	1.88	090
50546		A	Laparoscopic nephrectomy	21.69	NA	9.41	1.70	090
50547		A	Laparo removal donor kidney	26.24	NA	14.00	3.63	090
50548		A	Laparo remove w/ureter	25.26	NA	9.95	1.87	090
50549		C	Laparoscope proc, renal	0.00	0.00	0.00	0.00	YYY
50551		A	Kidney endoscopy	5.59	3.64	2.16	0.41	000
50553		A	Kidney endoscopy	5.98	3.87	2.23	0.44	000
50555		A	Kidney endoscopy & biopsy	6.52	4.05	2.45	0.47	000
50557		A	Kidney endoscopy & treatment	6.61	4.15	2.49	0.48	000
50561		A	Kidney endoscopy & treatment	7.58	4.65	2.80	0.56	000
50562		A	Renal scope w/tumor resect	10.90	NA	4.34	0.79	090
50570		A	Kidney endoscopy	9.53	NA	3.41	0.69	000
50572		A	Kidney endoscopy	10.33	NA	3.67	0.75	000
50574		A	Kidney endoscopy & biopsy	11.00	NA	3.89	0.80	000
50575		A	Kidney endoscopy	13.96	NA	4.86	1.01	000
50576		A	Kidney endoscopy & treatment	10.97	NA	3.88	0.79	000
50580		A	Kidney endoscopy & treatment	11.84	NA	4.16	0.86	000
50590		A	Fragmenting of kidney stone	9.64	13.18	4.88	0.70	090
50592		A	Perc rf ablate renal tumor	6.77	62.27	2.60	0.49	010
50593		A	Perc cryo ablate renal tum	9.08	92.65	3.51	0.66	010
50600		A	Exploration of ureter	17.04	NA	7.32	1.23	090
50605		A	Insert ureteral support	16.66	NA	7.83	1.95	090
50610		A	Removal of ureter stone	17.12	NA	7.40	1.24	090
50620		A	Removal of ureter stone	16.30	NA	7.13	1.18	090
50630		A	Removal of ureter stone	16.08	NA	7.06	1.16	090
50650		A	Removal of ureter	18.67	NA	8.17	1.40	090
50660		A	Removal of ureter	20.87	NA	8.82	1.51	090
50684		A	Injection for ureter x-ray	0.76	3.38	0.52	0.06	000
50686		A	Measure ureter pressure	1.51	2.32	0.89	0.09	000
50688		A	Change of ureter tube/stent	1.18	NA	0.83	0.09	010
50690		A	Injection for ureter x-ray	1.16	1.26	0.64	0.08	000
50700		A	Revision of ureter	16.54	NA	7.64	1.20	090
50715		A	Release of ureter	20.49	NA	9.69	1.76	090
50722		A	Release of ureter	17.80	NA	8.70	2.28	090
50725		A	Release/revise ureter	20.05	NA	8.55	1.45	090
50727		A	Revise ureter	8.17	NA	4.71	0.63	090
50728		A	Revise ureter	12.00	NA	5.92	0.87	090
50740		A	Fusion of ureter & kidney	19.92	NA	10.33	3.23	090

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50750		A	Fusion of ureter & kidney	21.07	NA	8.89	1.53	090
50760		A	Fusion of ureters	19.92	NA	8.92	1.95	090
50770		A	Splicing of ureters	21.07	NA	8.89	1.53	090
50780		A	Reimplant ureter in bladder	19.80	NA	8.75	1.72	090
50782		A	Reimplant ureter in bladder	19.51	NA	8.38	3.16	090
50783		A	Reimplant ureter in bladder	20.52	NA	10.55	1.49	090
50785		A	Reimplant ureter in bladder	22.08	NA	9.35	1.66	090
50800		A	Implant ureter in bowel	16.23	NA	7.55	1.29	090
50810		A	Fusion of ureter & bowel	22.38	NA	12.10	3.62	090
50815		A	Urine shunt to intestine	22.06	NA	9.60	1.60	090
50820		A	Construct bowel bladder	23.89	NA	10.25	1.96	090
50825		A	Construct bowel bladder	30.48	NA	12.50	2.32	090
50830		A	Revise urine flow	33.57	NA	13.36	2.43	090
50840		A	Replace ureter by bowel	22.19	NA	9.64	1.61	090
50845		A	Appendico-vesicostomy	22.21	NA	10.04	1.61	090
50860		A	Transplant ureter to skin	16.93	NA	7.53	1.23	090
50900		A	Repair of ureter	14.89	NA	7.18	1.08	090
50920		A	Closure ureter/skin fistula	15.66	NA	7.12	1.13	090
50930		A	Closure ureter/bowel fistula	20.04	NA	8.55	3.25	090
50940		A	Release of ureter	15.78	NA	7.16	1.14	090
50945		A	Laparoscopy ureterolithotomy	17.87	NA	7.45	1.29	090
50947		A	Laparo new ureter/bladder	25.63	NA	10.38	1.86	090
50948		A	Laparo new ureter/bladder	23.69	NA	9.52	1.72	090
50949		C	Laparoscope proc, ureter	0.00	0.00	0.00	0.00	YYY
50951		A	Endoscopy of ureter	5.83	3.81	2.24	0.43	000
50953		A	Endoscopy of ureter	6.23	3.98	2.65	0.45	000
50955		A	Ureter endoscopy & biopsy	6.74	4.18	2.83	0.49	000
50957		A	Ureter endoscopy & treatment	6.78	4.25	2.55	0.49	000
50961		A	Ureter endoscopy & treatment	6.04	3.87	2.30	0.44	000
50970		A	Ureter endoscopy	7.13	NA	2.62	0.52	000
50972		A	Ureter endoscopy & catheter	6.88	NA	2.54	0.50	000
50974		A	Ureter endoscopy & biopsy	9.16	NA	3.29	0.66	000
50976		A	Ureter endoscopy & treatment	9.03	NA	3.25	0.65	000
50980		A	Ureter endoscopy & treatment	6.84	NA	2.53	0.50	000
5100F		I	Rsk fx ref w/n 24 hrs x-ray	0.00	0.00	0.00	0.00	XXX
51020		A	Incise & treat bladder	7.56	NA	4.39	0.58	090
51030		A	Incise & treat bladder	7.68	NA	4.02	0.56	090
51040		A	Incise & drain bladder	4.43	NA	2.94	0.33	090
51045		A	Incise bladder/drain ureter	7.68	NA	4.64	0.75	090
51050		A	Removal of bladder stone	7.87	NA	4.25	0.58	090
51060		A	Removal of ureter stone	9.82	NA	5.09	0.71	090
51065		A	Remove ureter calculus	9.82	NA	5.03	0.71	090

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51080		A	Drainage of bladder abscess	6.61	NA	3.83	0.48	090
51100		A	Drain bladder by needle	0.78	0.80	0.25	0.06	000
51101		A	Drain bladder by trocar/cath	1.02	2.13	0.36	0.08	000
51102		A	Drain bl w/cath insertion	2.70	3.01	1.10	0.20	000
51500		A	Removal of bladder cyst	10.92	NA	5.45	0.79	090
51520		A	Removal of bladder lesion	10.08	NA	5.18	0.73	090
51525		A	Removal of bladder lesion	15.29	NA	6.96	1.16	090
51530		A	Removal of bladder lesion	13.58	NA	6.56	1.17	090
51535		A	Repair of ureter lesion	13.77	NA	6.37	1.00	090
51550		A	Partial removal of bladder	17.10	NA	7.77	1.58	090
51555		A	Partial removal of bladder	23.03	NA	9.84	1.88	090
51565		A	Revise bladder & ureter(s)	23.50	NA	10.08	1.78	090
51570		A	Removal of bladder	27.31	NA	11.16	2.07	090
51575		A	Removal of bladder & nodes	34.00	NA	13.53	2.46	090
51580		A	Remove bladder/revise tract	35.14	NA	14.18	2.55	090
51585		A	Removal of bladder & nodes	39.41	NA	15.58	2.86	090
51590		A	Remove bladder/revise tract	36.15	NA	14.22	2.71	090
51595		A	Remove bladder/revise tract	41.12	NA	16.02	3.04	090
51596		A	Remove bladder/create pouch	44.01	NA	17.33	3.22	090
51597		A	Removal of pelvic structures	42.61	NA	17.07	3.33	090
51600		A	Injection for bladder x-ray	0.88	3.63	0.28	0.06	000
51605		A	Preparation for bladder xray	0.64	NA	0.36	0.05	000
51610		A	Injection for bladder x-ray	1.05	1.62	0.60	0.08	000
51700		A	Irrigation of bladder	0.88	1.20	0.30	0.06	000
51701		A	Insert bladder catheter	0.50	0.86	0.22	0.04	000
51702		A	Insert temp bladder cath	0.50	1.25	0.29	0.04	000
51703		A	Insert bladder cath, complex	1.47	1.80	0.67	0.11	000
51705		A	Change of bladder tube	1.03	1.59	0.68	0.08	010
51710		A	Change of bladder tube	1.50	2.13	0.94	0.11	010
51715		A	Endoscopic injection/implant	3.73	3.57	1.49	0.27	000
51720		A	Treatment of bladder lesion	1.50	1.28	0.61	0.11	000
51725		A	Simple cystometrogram	1.51	3.39	3.39	0.11	000
51725	TC	A	Simple cystometrogram	0.00	2.87	2.87	0.00	000
51725	26	A	Simple cystometrogram	1.51	0.52	0.52	0.10	000
51726		A	Complex cystometrogram	1.71	5.63	5.63	0.12	000
51726	TC	A	Complex cystometrogram	0.00	5.05	5.05	0.00	000
51726	26	A	Complex cystometrogram	1.71	0.59	0.59	0.12	000
51736		A	Urine flow measurement	0.61	0.73	0.73	0.04	000
51736	TC	A	Urine flow measurement	0.00	0.53	0.53	0.00	000
51736	26	A	Urine flow measurement	0.61	0.21	0.21	0.04	000
51741		A	Electro-uroflowmetry, first	1.14	1.00	1.00	0.08	000
51741	TC	A	Electro-uroflowmetry, first	0.00	0.62	0.62	0.00	000

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CPT[1],[3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
51741	26	A	Electro-uroflowmetry, first	1.14	0.38	0.38	0.08	000
51772		A	Urethra pressure profile	1.61	4.27	4.27	0.11	000
51772	TC	A	Urethra pressure profile	0.00	3.70	3.70	0.00	000
51772	26	A	Urethra pressure profile	1.61	0.57	0.57	0.11	000
51784		A	Anal/urinary muscle study	1.53	3.35	3.35	0.11	000
51784	TC	A	Anal/urinary muscle study	0.00	2.83	2.83	0.00	000
51784	26	A	Anal/urinary muscle study	1.53	0.53	0.53	0.11	000
51785		A	Anal/urinary muscle study	1.53	3.83	3.83	0.11	000
51785	TC	A	Anal/urinary muscle study	0.00	3.30	3.30	0.00	000
51785	26	A	Anal/urinary muscle study	1.53	0.53	0.53	0.11	000
51792		A	Urinary reflex study	1.10	4.09	4.09	0.08	000
51792	TC	A	Urinary reflex study	0.00	3.71	3.71	0.00	000
51792	26	A	Urinary reflex study	1.10	0.38	0.38	0.08	000
51795		A	Urine voiding pressure study	1.53	5.35	5.35	0.11	000
51795	TC	A	Urine voiding pressure study	0.00	4.83	4.83	0.00	000
51795	26	A	Urine voiding pressure study	1.53	0.52	0.52	0.10	000
51797		A	Intraabdominal pressure test	0.80	1.96	1.96	0.06	ZZZ
51797	TC	A	Intraabdominal pressure test	0.00	1.69	1.69	0.00	ZZZ
51797	26	A	Intraabdominal pressure test	0.80	0.27	0.27	0.05	ZZZ
51798		A	Us urine capacity measure	0.00	0.44	NA	0.00	XXX
51800		A	Revision of bladder/urethra	18.74	NA	8.30	1.43	090
51820		A	Revision of urinary tract	19.41	NA	8.62	1.41	090
51840		A	Attach bladder/urethra	11.28	NA	5.73	1.08	090
51841		A	Attach bladder/urethra	13.60	NA	6.60	1.29	090
51845		A	Repair bladder neck	10.07	NA	5.08	0.89	090
51860		A	Repair of bladder wound	12.49	NA	6.49	1.36	090
51865		A	Repair of bladder wound	15.69	NA	7.37	1.43	090
51880		A	Repair of bladder opening	7.81	NA	4.21	0.70	090
51900		A	Repair bladder/vagina lesion	14.48	NA	7.08	1.05	090
51920		A	Close bladder-uterus fistula	13.26	NA	6.40	0.96	090
51925		A	Hysterectomy/bladder repair	17.35	NA	8.93	2.22	090
51940		A	Correction of bladder defect	30.48	NA	12.25	2.21	090
51960		A	Revision of bladder & bowel	25.20	NA	10.80	1.97	090
51980		A	Construct bladder opening	12.44	NA	5.95	0.90	090
51990		A	Laparo urethral suspension	13.26	NA	6.40	1.32	090
51992		A	Laparo sling operation	14.77	NA	7.02	1.66	090
51999		C	Laparoscope proc, bla	0.00	0.00	0.00	0.00	YYY
52000		A	Cystoscopy	2.23	2.84	1.05	0.16	000
52001		A	Cystoscopy, removal of clots	5.44	4.01	2.11	0.40	000
52005		A	Cystoscopy & ureter catheter	2.37	4.40	1.10	0.17	000
52007		A	Cystoscopy and biopsy	3.02	8.26	1.31	0.22	000
52010		A	Cystoscopy & duct catheter	3.02	6.22	1.31	0.22	000
52204		A	Cystoscopy w/biopsy(s)	2.59	6.37	1.11	0.19	000
52214		A	Cystoscopy and treatment	3.70	12.01	1.47	0.27	000
52224		A	Cystoscopy and treatment	3.14	11.41	1.29	0.23	000
52234		A	Cystoscopy and treatment	4.62	NA	1.83	0.34	000
52235		A	Cystoscopy and treatment	5.44	NA	2.13	0.40	000
52240		A	Cystoscopy and radiotracer	4.49	NA	1.88	0.32	000
52250		A	Cystoscopy and treatment	3.91	NA	1.60	0.28	000
52265		A	Cystoscopy and treatment	2.94	6.07	1.33	0.21	000
52270		A	Cystoscopy & revise urethra	3.36	5.40	1.40	0.24	000
52275		A	Cystoscopy & revise urethra	4.69	7.16	1.84	0.34	000
52276		A	Cystoscopy and treatment	4.99	NA	1.97	0.36	000
52277		A	Cystoscopy and treatment	6.16	NA	2.68	0.43	000
52281		A	Cystoscopy and treatment	2.80	4.08	1.24	0.20	000
52282		A	Cystoscopy, implant stent	6.39	NA	2.46	0.47	000
52283		A	Cystoscopy and treatment	3.73	3.27	1.56	0.28	000
52285		A	Cystoscopy and treatment	3.60	3.42	1.52	0.26	000
52290		A	Cystoscopy and treatment	4.58	NA	1.83	0.33	000
52300		A	Cystoscopy and treatment	5.30	NA	2.15	0.39	000
52301		A	Cystoscopy and treatment	5.50	NA	2.18	0.40	000
52305		A	Cystoscopy and treatment	5.30	NA	2.02	0.39	000
52310		A	Cystoscopy and treatment	2.81	3.12	1.16	0.21	000
52315		A	Cystoscopy and treatment	5.20	5.15	2.00	0.38	000
52317		A	Remove bladder stone	6.71	13.08	2.43	0.49	000
52318		A	Remove bladder stone	9.18	NA	3.28	0.67	000
52320		A	Cystoscopy and treatment	4.69	NA	1.79	0.34	000
52325		A	Cystoscopy, stone removal	6.15	NA	2.28	0.45	000
52327		A	Cystoscopy, inject material	5.18	NA	1.71	0.37	000
52330		A	Cystoscopy and treatment	5.03	7.19	1.90	0.37	000
52332		A	Cystoscopy and treatment	2.83	9.48	1.25	0.21	000
52334		A	Create passage to kidney	4.82	NA	1.90	0.35	000
52341		A	Cysto w/ureter stricture tx	5.20	NA	2.17	0.39	000
52342		A	Cysto w/up stricture tx	5.63	NA	2.30	0.43	000
52343		A	Cysto w/renal stricture tx	6.55	NA	2.61	0.47	000
52344		A	Cysto/uretero, stricture tx	6.83	NA	2.83	0.51	000
52345		A	Cysto/uretero w/up stricture	8.51	NA	3.38	0.55	000
52346		A	Cystouretero w/renal strict	9.02	NA	3.54	0.62	000
52351		A	Cystouretero & or pyeloscope	5.85	NA	2.38	0.43	000
52352		A	Cystouretero w/stone remove	6.87	NA	2.79	0.50	000
52353		A	Cystouretero w/lithotripsy	7.96	NA	3.15	0.58	000
52354		A	Cystouretero w/biopsy	7.33	NA	2.94	0.53	000
52355		A	Cystouretero w/excise tumor	8.81	NA	3.43	0.64	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
52400		A	Cystouretero w/congen repr	8.25	NA	3.65	0.63	090
52402		A	Cystourethro cut ejacul duct	5.27	NA	1.76	0.38	000
52450		A	Incision of prostate	7.63	NA	4.34	0.56	090
52500		A	Revision of bladder neck	8.49	NA	4.62	0.58	090
52601		A	Prostatectomy (TURP)	15.13	NA	6.76	1.11	090
52630		A	Remove prostate regrowth	7.65	NA	3.82	0.56	090
52640		A	Relieve bladder contracture	4.28	NA	2.66	0.34	090
52647		A	Laser surgery of prostate	11.15	31.99	5.49	0.81	090
52648		A	Laser surgery of prostate	12.00	32.48	5.77	0.88	090
52649		A	Prostate laser enucleation	17.16	NA	7.48	1.25	090
52700		A	Drainage of prostate abscess	7.39	NA	3.92	0.54	090
53000		A	Incision of urethra	2.30	NA	1.50	0.17	010
53010		A	Incision of urethra	4.35	NA	3.09	0.32	090
53020		A	Incision of urethra	1.77	NA	0.77	0.13	000
53025		A	Incision of urethra	1.13	NA	0.71	0.06	000
53040		A	Drainage of urethra abscess	6.49	NA	3.60	0.47	090
53060		A	Drainage of urethra abscess	2.65	2.01	1.58	0.17	010
53080		A	Drainage of urinary leakage	6.82	NA	3.92	0.49	090
53085		A	Drainage of urinary leakage	11.05	NA	5.42	1.09	090
53200		A	Biopsy of urethra	2.59	1.42	1.11	0.19	000
53210		A	Removal of urethra	13.59	NA	6.39	1.06	090
53215		A	Removal of urethra	16.72	NA	7.35	1.22	090
53220		A	Treatment of urethra lesion	7.53	NA	4.13	0.58	090
53230		A	Removal of urethra lesion	10.31	NA	5.27	0.86	090
53235		A	Removal of urethra lesion	10.86	NA	5.41	0.79	090
53240		A	Surgery for urethra pouch	6.98	NA	3.88	0.51	090
53250		A	Removal of urethra gland	6.42	NA	3.51	1.07	090
53260		A	Treatment of urethra lesion	3.00	2.12	1.63	0.21	010
53265		A	Treatment of urethra lesion	3.14	2.38	1.65	0.22	010
53270		A	Removal of urethra gland	3.11	2.23	1.75	0.20	010
53275		A	Repair of urethra defect	4.54	NA	2.24	0.33	010
53400		A	Revise urethra, stage 1	13.98	NA	6.67	1.04	090
53405		A	Revise urethra, stage 2	15.51	NA	7.06	1.12	090
53410		A	Reconstruction of urethra	17.53	NA	7.83	1.29	090
53415		A	Reconstruction of urethra	20.55	NA	8.85	1.55	090
53420		A	Reconstruct urethra, stage 1	15.04	NA	6.73	1.09	090
53425		A	Reconstruct urethra, stage 2	16.94	NA	7.35	1.23	090
53430		A	Reconstruction of urethra	17.30	NA	7.74	1.46	090
53431		A	Reconstruct urethra/bladder	21.03	NA	8.94	1.52	090
53440		A	Male sling procedure	15.34	NA	7.43	1.12	090
53442		A	Remove/revise male sling	13.29	NA	6.79	0.97	090
53444		A	Insert tandem cuff	14.06	NA	6.48	1.01	090
53445		A	Insert uro/ves neck sphincter	17.02	NA	7.98	1.11	090
53446		A	Remove uro sphincter	10.89	NA	5.63	0.80	090
53447		A	Remove/replace ur sphincter	14.15	NA	6.76	1.04	090
53448		A	Remov/reple ur sphincter comp	23.26	NA	9.95	1.69	090
53449		A	Repair uro sphincter	10.43	NA	5.30	0.77	090
53450		A	Revision of urethra	6.67	NA	3.79	0.49	090
53460		A	Revision of urethra	7.65	NA	4.09	0.55	090
53500		A	Urethrlys, transvag w/ scope	12.87	NA	6.41	1.09	090
53502		A	Repair of urethra injury	8.16	NA	4.33	0.59	090
53505		A	Repair of urethra injury	8.16	NA	4.32	0.59	090
53510		A	Repair of urethra injury	10.83	NA	5.40	0.78	090
53515		A	Repair of urethra injury	14.09	NA	6.47	1.02	090
53520		A	Repair of urethra defect	9.35	NA	4.92	0.68	090
53600		A	Dilate urethra stricture	1.21	0.92	0.47	0.09	000
53601		A	Dilate urethra stricture	0.98	1.06	0.42	0.07	000
53605		A	Dilate urethra stricture	1.28	NA	0.42	0.10	000
53620		A	Dilate urethra stricture	1.62	1.33	0.67	0.12	000
53621		A	Dilate urethra stricture	1.35	1.41	0.54	0.10	000
53660		A	Dilation of urethra	0.71	1.05	0.37	0.05	000
53661		A	Dilation of urethra	0.72	1.01	0.34	0.05	000
53665		A	Dilation of urethra	0.76	NA	0.26	0.06	000
53850		A	Prostatic microwave thermotx	9.98	37.54	4.69	0.73	090
53852		A	Prostatic rf thermotx	10.68	35.36	5.31	0.78	090
53899		C	Urology surgery procedure	0.00	0.00	0.00	0.00	YYY
54000		A	Slitting of prepuce	1.56	2.09	1.17	0.11	010
54001		A	Slitting of prepuce	2.21	2.40	1.33	0.17	010
54015		A	Drain penis lesion	5.33	NA	2.69	0.41	010
54050		A	Destruction, penis lesion(s)	1.26	2.02	1.39	0.08	010
54055		A	Destruction, penis lesion(s)	1.23	1.72	1.12	0.09	010
54056		A	Cryosurgery, penis lesion(s)	1.26	2.27	1.54	0.07	010
54057		A	Laser surg, penis lesion(s)	1.26	2.13	1.13	0.10	010
54060		A	Excision of penis lesion(s)	1.95	2.52	1.37	0.15	010
54065		A	Destruction, penis lesion(s)	2.44	3.08	1.98	0.16	010
54100		A	Biopsy of penis	1.90	3.03	1.38	0.12	000
54105		A	Biopsy of penis	3.51	3.15	1.97	0.26	010
54110		A	Treatment of penis lesion	10.79	NA	5.27	0.78	090
54111		A	Treat penis lesion, graft	14.29	NA	6.42	1.04	090
54112		A	Treat penis lesion, graft	16.83	NA	7.44	1.22	090
54115		A	Treatment of penis lesion	6.82	4.60	3.98	0.49	090
54120		A	Partial removal of penis	10.88	NA	5.39	0.80	090
54125		A	Removal of penis	14.43	NA	6.61	1.09	090
54130		A	Remove penis & nodes	21.66	NA	9.27	1.57	090

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54135		A	Remove penis & nodes	27.99	NA	11.34	2.03	090
54150		A	Circumcision w/regional block	1.90	2.04	0.68	0.16	000
54160		A	Circumcision, neonate	2.50	2.98	1.21	0.18	010
54161		A	Circum 28 days or older	3.29	NA	1.77	0.25	010
54162		A	Lysis penil circumic lesion	3.27	3.17	1.83	0.24	010
54163		A	Repair of circumcision	3.27	NA	2.28	0.24	010
54164		A	Frenulotomy of penis	2.77	NA	2.12	0.20	010
54200		A	Treatment of penis lesion	1.08	1.57	1.03	0.08	010
54205		A	Treatment of penis lesion	8.84	NA	4.79	0.64	090
54220		A	Treatment of penis lesion	2.42	2.63	1.10	0.18	000
54230		A	Prepare penis study	1.34	1.12	0.73	0.10	000
54231		A	Dynamic cavernosometry	2.04	1.54	0.99	0.15	000
54235		A	Penile injection	1.19	1.11	0.73	0.09	000
54240		A	Penis study	1.31	1.23	1.23	0.10	000
54240	TC	A	Penis study	0.00	0.80	0.00	0.00	000
54240	26	A	Penis study	1.31	0.43	0.43	0.09	000
54250		A	Penis study	2.22	1.02	1.02	0.16	000
54250	TC	A	Penis study	0.00	0.28	0.28	0.01	000
54250	26	A	Penis study	2.22	0.74	0.74	0.15	000
54300		A	Revision of penis	11.07	NA	5.47	0.80	090
54304		A	Revision of penis	13.15	NA	6.21	0.95	090
54308		A	Reconstruction of urethra	12.49	NA	5.96	0.90	090
54312		A	Reconstruction of urethra	14.36	NA	6.76	1.04	090
54316		A	Reconstruction of urethra	17.90	NA	7.95	1.30	090
54318		A	Reconstruction of urethra	12.28	NA	6.65	0.66	090
54322		A	Reconstruction of urethra	13.85	NA	6.34	1.00	090
54324		A	Reconstruction of urethra	17.40	NA	7.69	1.26	090
54326		A	Reconstruction of urethra	16.87	NA	7.61	1.22	090
54328		A	Revise penis/urethra	16.74	NA	7.57	1.21	090
54332		A	Revise penis/urethra	18.22	NA	8.05	1.32	090
54336		A	Revise penis/urethra	21.44	NA	9.38	1.55	090
54340		A	Secondary urethral surgery	9.58	NA	5.04	0.69	090
54344		A	Secondary urethral surgery	16.91	NA	7.62	1.23	090
54348		A	Secondary urethral surgery	18.17	NA	8.96	0.97	090
54352		A	Reconstruct urethra/penis	25.95	NA	10.86	1.88	090
54360		A	Penis plastic surgery	12.65	NA	5.97	0.92	090
54380		A	Repair penis	14.03	NA	6.59	1.02	090
54385		A	Repair penis	16.38	NA	10.10	1.83	090
54390		A	Repair penis and bladder	22.59	NA	9.60	1.64	090
54400		A	Insert semi-rigid prosthesis	9.09	NA	4.58	0.66	090
54401		A	Insert self-contd prosthesis	10.26	NA	6.41	0.75	090
54405		A	Insert multi-comp penis pros	14.39	NA	6.55	1.05	090
54406		A	Remove multi-comp penis pros	12.76	NA	6.09	0.93	090
54408		A	Repair multi-comp penis pros	13.73	NA	6.63	1.02	090
54410		A	Remove/replace penis prosth	16.01	NA	7.50	1.09	090
54411		A	Remov/replc penis pros, comp	18.14	NA	8.40	1.31	090
54415		A	Remove self-contd penis pros	8.75	NA	4.78	0.64	090
54416		A	Remv/repl penis contain pros	11.87	NA	6.29	0.86	090
54417		A	Remv/replc penis pros, compl	15.94	NA	7.28	1.15	090
54420		A	Revision of penis	12.26	NA	5.91	0.89	090
54430		A	Revision of penis	10.93	NA	5.53	0.79	090
54435		A	Revision of penis	6.71	NA	3.93	0.49	090
54440		C	Repair of penis	0.00	NA	0.00	0.00	090
54450		A	Preputial stretching	1.12	0.68	0.40	0.08	000
54500		A	Biopsy of testis	1.31	NA	0.63	0.09	000
54505		A	Biopsy of testis	3.47	NA	1.93	0.25	010
54512		A	Excise lesion testis	9.23	NA	4.63	0.69	090
54520		A	Removal of testis	5.25	NA	3.10	0.45	090
54522		A	Orchiectomy, partial	10.15	NA	5.06	0.74	090
54530		A	Removal of testis	8.65	NA	4.71	0.65	090
54535		A	Extensive testis surgery	13.06	NA	6.15	0.95	090
54550		A	Exploration for testis	8.31	NA	4.33	0.60	090
54560		A	Exploration for testis	11.97	NA	5.73	0.87	090
54600		A	Reduce testis torsion	7.54	NA	4.08	0.55	090
54620		A	Suspension of testis	5.16	NA	2.57	0.37	010
54640		A	Suspension of testis	7.57	NA	4.54	0.65	090
54650		A	Orchiopexy (Fowler-Stephens)	12.24	NA	6.07	0.89	090
54660		A	Revision of testis	5.64	NA	3.45	0.41	090
54670		A	Repair testis injury	6.57	NA	3.81	0.48	090
54680		A	Relocation of testis(es)	13.91	NA	6.43	1.01	090
54690		A	Laparoscopy, orchiectomy	11.60	NA	6.66	1.88	090
54692		A	Laparoscopy, orchiopexy	13.64	NA	6.04	2.21	090
54699		C	Laparoscope proc, testis	0.00	0.00	0.00	0.00	YYY
54700		A	Drainage of scrotum	3.44	NA	2.05	0.29	010
54800		A	Biopsy of epididymis	2.33	NA	1.68	0.17	000
54830		A	Remove epididymis lesion	5.91	NA	3.61	0.46	090
54840		A	Remove epididymis lesion	5.22	NA	3.02	0.39	090
54860		A	Removal of epididymis	6.85	NA	3.86	0.50	090
54861		A	Removal of epididymis	9.57	NA	4.95	0.69	090
54865		A	Explore epididymis	5.67	NA	3.46	0.41	090
54900		A	Fusion of spermatic ducts	14.05	NA	7.29	0.75	090
54901		A	Fusion of spermatic ducts	18.92	NA	9.30	1.01	090
55000		A	Drainage of hydrocele	1.43	1.54	0.78	0.11	000
55040		A	Removal of hydrocele	5.39	NA	3.26	0.45	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
55041		A	Removal of hydroceles	8.41	NA	4.63	0.67	090
55060		A	Repair of hydrocele	6.05	NA	3.66	0.50	090
55100		A	Drainage of scrotum abscess	2.40	2.94	1.80	0.21	010
55110		A	Explore scrotum	6.23	NA	3.65	0.50	090
55120		A	Removal of scrotum lesion	5.62	NA	3.48	0.45	090
55150		A	Removal of scrotum	8.01	NA	4.52	0.63	090
55175		A	Revision of scrotum	5.77	NA	3.48	0.44	090
55180		A	Revision of scrotum	11.63	NA	6.02	0.94	090
55200		A	Incision of sperm duct	4.50	6.29	2.63	0.33	090
55250		A	Removal of sperm duct(s)	3.32	6.09	2.44	0.24	090
55300		A	Prepare, sperm duct x-ray	3.50	NA	1.41	0.25	000
55400		A	Repair of sperm duct	8.53	NA	4.32	0.62	090
55450		A	Ligation of sperm duct	4.38	4.59	2.24	0.32	010
55500		A	Removal of hydrocele	6.12	NA	3.88	0.66	090
55520		A	Removal of sperm cord lesion	6.56	NA	4.63	1.01	090
55530		A	Revise spermatic cord veins	5.69	NA	3.35	0.46	090
55535		A	Revise spermatic cord veins	7.09	NA	3.93	0.51	090
55540		A	Revise hernia & sperm veins	8.20	NA	5.15	1.23	090
55550		A	Laparo ligate spermatic vein	7.10	NA	3.87	0.51	090
55559		C	Laparo proc, spermatic cord	0.00	0.00	0.00	0.00	YYY
55600		A	Incise sperm duct pouch	6.91	NA	3.87	0.50	090
55605		A	Incise sperm duct pouch	8.63	NA	4.71	0.63	090
55650		A	Remove sperm duct pouch	12.52	NA	6.04	0.91	090
55680		A	Remove sperm pouch lesion	5.59	NA	3.26	0.40	090
55700		A	Biopsy of prostate	2.58	2.89	1.07	0.19	000
55705		A	Biopsy of prostate	4.58	NA	2.30	0.34	010
55706		A	Prostate saturation sampling	6.15	NA	3.40	0.33	010
55720		A	Drainage of prostate abscess	7.67	NA	3.99	0.56	090
55725		A	Drainage of prostate abscess	9.90	NA	5.29	0.72	090
55801		A	Removal of prostate	19.62	NA	8.68	1.42	090
55810		A	Extensive prostate surgery	24.14	NA	10.13	1.86	090
55812		A	Extensive prostate surgery	29.69	NA	12.15	2.15	090
55815		A	Extensive prostate surgery	32.75	NA	13.16	2.37	090
55821		A	Removal of prostate	15.63	NA	7.02	1.14	090
55831		A	Removal of prostate	17.06	NA	7.50	1.24	090
55840		A	Extensive prostate surgery	24.45	NA	10.32	1.79	090
55842		A	Extensive prostate surgery	26.31	NA	10.92	1.92	090
55845		A	Extensive prostate surgery	30.52	NA	12.17	2.25	090
55860		A	Surgical exposure, prostate	15.71	NA	6.93	1.13	090
55862		A	Extensive prostate surgery	19.89	NA	10.36	1.44	090
55865		A	Extensive prostate surgery	24.39	NA	10.26	1.77	090
55866		A	Laparo radical prostatectomy	32.25	NA	13.11	2.36	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
55870		A	Electroejaculation	2.58	1.90	1.14	0.19	000
55873		A	Cryoablate prostate	20.25	NA	9.06	1.50	090
55875		A	Transperi needle place, pros	13.31	NA	6.37	0.96	090
55876		A	Place rt device/marker, pros	1.73	1.70	0.89	0.12	000
55899		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY
55920		A	Place needles pelvic for rt	8.31	NA	3.43	0.53	000
56405		A	I & D of vulva/perineum	1.46	1.27	1.25	0.11	010
56420		A	Drainage of gland abscess	1.41	1.61	0.90	0.11	010
56440		A	Surgery for vulva lesion	2.86	NA	1.78	0.20	010
56441		A	Lysis of labial lesion(s)	1.99	1.61	1.49	0.13	010
56442		A	Hymenotomy	0.68	NA	0.54	0.04	000
56501		A	Destroy, vulva lesions, sim	1.55	1.68	1.31	0.10	010
56515		A	Destroy vulva lesion/s compl	3.03	2.56	1.99	0.20	010
56605		A	Biopsy of vulva/perineum	1.10	0.97	0.46	0.07	000
56606		A	Biopsy of vulva/perineum	0.55	0.40	0.21	0.04	ZZZ
56620		A	Partial removal of vulva	7.35	NA	5.22	0.69	090
56625		A	Complete removal of vulva	9.55	NA	5.73	0.80	090
56630		A	Extensive vulva surgery	14.67	NA	7.87	1.18	090
56631		A	Extensive vulva surgery	18.81	NA	9.89	1.42	090
56632		A	Extensive vulva surgery	21.61	NA	11.71	1.68	090
56633		A	Extensive vulva surgery	19.47	NA	10.02	1.62	090
56634		A	Extensive vulva surgery	20.48	NA	10.69	0.99	090
56637		A	Extensive vulva surgery	24.57	NA	11.94	1.93	090
56640		A	Extensive vulva surgery	24.65	NA	11.97	1.20	090
56700		A	Partial removal of hymen	2.79	NA	1.91	0.18	010
56740		A	Remove vagina gland lesion	4.83	NA	2.73	0.39	010
56800		A	Repair of vagina	3.90	NA	2.22	0.27	010
56805		A	Repair clitoris	19.75	NA	9.52	2.53	090
56810		A	Repair of perineum	4.26	NA	2.36	0.30	010
56820		A	Exam of vulva w/scope	1.50	1.28	0.69	0.09	000
56821		A	Exam/biopsy of vulva w/scope	2.05	1.65	0.90	0.13	000
57000		A	Exploration of vagina	2.99	NA	1.80	0.20	010
57010		A	Drainage of pelvic abscess	6.74	NA	4.21	0.86	090
57020		A	Drainage of pelvic fluid	1.50	0.88	0.60	0.10	000
57022		A	I & d vaginal hematoma, pp	2.70	NA	1.56	0.18	010
57023		A	I & d vag hematoma, non-ob	5.13	NA	2.77	0.34	010
57061		A	Destroy vag lesions, simple	1.27	1.53	1.17	0.08	010
57065		A	Destroy vag lesions, complex	2.63	2.17	1.70	0.17	010
57100		A	Biopsy of vagina	1.20	1.02	0.50	0.08	000
57105		A	Biopsy of vagina	1.71	1.63	1.40	0.11	010
57106		A	Remove vagina wall, partial	7.35	NA	4.80	0.77	090
57107		A	Remove vagina tissue, part	24.43	NA	11.57	2.20	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
57109		A	Vaginectomy partial w/nodes	28.25	NA	13.64	1.37	090
57110		A	Remove vagina wall, complete	15.38	NA	7.53	1.90	090
57111		A	Remove vagina tissue, compl	28.25	NA	13.64	3.61	090
57112		A	Vaginectomy w/nodes, compl	30.37	NA	14.50	1.47	090
57120		A	Closure of vagina	8.18	NA	4.75	1.01	090
57130		A	Remove vagina lesion	2.44	2.01	1.59	0.16	010
57135		A	Remove vagina lesion	2.68	2.13	1.69	0.18	010
57150		A	Treat vagina infection	0.55	0.59	0.21	0.04	000
57155		A	Insert uteri tandems/ovoids	6.79	NA	3.76	0.44	090
57160		A	Insert pessary/other device	0.89	1.03	0.34	0.06	000
57170		A	Fitting of diaphragm/cap	0.91	0.63	0.35	0.06	000
57180		A	Treat vaginal bleeding	1.60	1.88	1.05	0.11	010
57200		A	Repair of vagina	4.34	NA	3.14	0.51	090
57210		A	Repair vagina/perineum	5.63	NA	3.60	0.68	090
57220		A	Revision of urethra	4.77	NA	3.27	0.60	090
57230		A	Repair of urethral lesion	6.22	NA	3.77	0.80	090
57240		A	Repair bladder & vagina	11.42	NA	5.75	1.23	090
57250		A	Repair rectum & vagina	11.42	NA	5.88	1.39	090
57260		A	Repair of vagina	14.36	NA	7.00	1.75	090
57265		A	Extensive repair of vagina	15.86	NA	7.54	1.91	090
57267		A	Insert mesh/pelvic flr addon	4.88	NA	1.80	0.33	ZZZ
57268		A	Repair of bowel bulge	7.47	NA	4.72	0.89	090
57270		A	Repair of bowel pouch	13.57	NA	6.86	1.62	090
57280		A	Suspension of vagina	16.62	NA	7.84	1.89	090
57282		A	Colpopexy, extraperitoneal	7.84	NA	4.83	0.91	090
57283		A	Extensive repair of vagina	11.58	NA	6.04	1.43	090
57284		A	Repair paravag defect, open	14.25	NA	6.69	1.61	090
57285		A	Repair paravag defect, vag	11.52	NA	5.73	1.33	090
57287		A	Revise/remove sling repair	10.36	NA	6.07	1.07	090
57288		A	Repair bladder defect	12.00	NA	5.97	1.19	090
57289		A	Repair bladder & vagina	12.69	NA	6.13	0.92	090
57291		A	Construction of vagina	8.54	NA	4.89	1.09	090
57292		A	Construct vagina with graft	13.91	NA	7.34	0.67	090
57295		A	Revise vag graft via vagina	7.74	NA	4.44	0.88	090
57296		A	Revise vag graft, open abd	16.46	NA	7.87	2.10	090
57300		A	Repair rectum-vagina fistula	8.58	NA	5.51	1.10	090
57305		A	Repair rectum-vagina fistula	15.24	NA	8.19	2.17	090
57307		A	Fistula repair & colostomy	17.02	NA	9.44	2.76	090
57308		A	Fistula repair, transperine	10.48	NA	5.76	1.34	090
57310		A	Repair urethrovaginal lesion	7.55	NA	4.24	0.55	090
57311		A	Repair urethrovaginal lesion	8.81	NA	5.04	0.64	090
57320		A	Repair bladder-vagina lesion	8.78	NA	4.81	0.75	090
57330		A	Repair bladder-vagina lesion	13.11	NA	6.02	0.95	090
57335		A	Repair vagina	19.87	NA	9.66	2.54	090
57400		A	Dilation of vagina	2.27	NA	1.14	0.15	000
57410		A	Pelvic examination	1.75	NA	0.99	0.12	000
57415		A	Remove vaginal foreign body	2.44	NA	1.58	0.17	010
57420		A	Exam of vagina w/scope	1.60	1.33	0.73	0.10	000
57421		A	Exam/biopsy of vag w/scope	2.20	1.73	0.96	0.14	000
57423		A	Repair paravag defect, lap	16.00	NA	7.45	2.05	090
57425		A	Laparoscopy, surg, colpopexy	16.93	NA	8.02	1.95	090
57452		A	Exam of cervix w/scope	1.50	1.24	0.85	0.10	000
57454		A	Bx/curett of cervix w/scope	2.33	1.57	1.17	0.15	000
57455		A	Biopsy of cervix w/scope	1.99	1.61	0.87	0.13	000
57456		A	Endocerv curettage w/scope	1.85	1.55	0.81	0.12	000
57460		A	Bx of cervix w/scope, leep	2.83	4.19	1.36	0.18	000
57461		A	Conz of cervix w/scope, leep	3.43	4.52	1.42	0.22	000
57500		A	Biopsy of cervix	1.20	1.96	0.74	0.08	000
57505		A	Endocervical curettage	1.16	1.34	1.11	0.08	010
57510		A	Cauterization of cervix	1.90	1.42	1.06	0.13	010
57511		A	Cryocautery of cervix	1.92	1.70	1.40	0.13	010
57513		A	Laser surgery of cervix	1.92	1.66	1.40	0.13	010
57520		A	Conization of cervix	4.06	3.56	2.80	0.47	090
57522		A	Conization of cervix	3.62	2.94	2.49	0.45	090
57530		A	Removal of cervix	5.19	NA	3.47	0.59	090
57531		A	Removal of cervix, radical	29.77	NA	14.43	3.81	090
57540		A	Removal of residual cervix	13.19	NA	6.68	1.69	090
57545		A	Remove cervix/repair pelvis	14.00	NA	6.99	1.79	090
57550		A	Removal of residual cervix	6.24	NA	4.02	0.80	090
57555		A	Remove cervix/repair vagina	9.84	NA	5.42	1.26	090
57556		A	Remove cervix, repair bowel	9.26	NA	5.16	1.05	090
57558		A	D&c of cervical stump	1.69	1.42	1.16	0.11	010
57700		A	Revision of cervix	4.22	NA	3.48	0.54	090
57720		A	Revision of cervix	4.53	NA	3.19	0.58	090
57800		A	Dilation of cervical canal	0.77	0.74	0.47	0.05	000
58100		A	Biopsy of uterus lining	1.53	1.23	0.73	0.10	000
58110		A	Bx done w/colposcopy add-on	0.77	0.46	0.30	0.05	ZZZ
58120		A	Dilation and curettage	3.54	2.89	1.96	0.24	010
58140		A	Myomectomy abdom method	15.69	NA	7.71	2.09	090
58145		A	Myomectomy vag method	8.81	NA	4.97	1.09	090
58146		A	Myomectomy abdom complex	20.24	NA	9.31	2.59	090
58150		A	Total hysterectomy	17.21	NA	8.27	1.97	090
58152		A	Total hysterectomy	21.73	NA	10.14	2.66	090
58180		A	Partial hysterectomy	16.50	NA	7.97	1.95	090

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58200		A	Extensive hysterectomy	23.00	NA	10.73	2.05	090
58210		A	Extensive hysterectomy	30.76	NA	14.36	2.36	090
58240		A	Removal of pelvis contents	49.02	NA	22.40	4.02	090
58260		A	Vaginal hysterectomy	14.02	NA	7.04	1.76	090
58262		A	Vag hyst including t/o	15.81	NA	7.71	1.98	090
58263		A	Vag hyst w/t/o & vag repair	17.10	NA	8.24	2.12	090
58267		A	Vag hyst w/urinary repair	18.23	NA	8.74	2.26	090
58270		A	Vag hyst w/enterocele repair	15.20	NA	7.32	1.90	090
58275		A	Hysterectomy/revise vagina	16.90	NA	8.22	2.08	090
58280		A	Hysterectomy/revise vagina	18.20	NA	8.75	2.20	090
58285		A	Extensive hysterectomy	23.30	NA	10.36	1.13	090
58290		A	Vag hyst complex	20.17	NA	9.30	2.53	090
58291		A	Vag hyst incl t/o, complex	21.96	NA	9.97	2.81	090
58292		A	Vag hyst t/o & repair, compl	23.25	NA	10.46	2.97	090
58293		A	Vag hyst w/uro repair, compl	24.23	NA	10.84	3.10	090
58294		A	Vag hyst w/enterocele, compl	21.45	NA	9.77	2.74	090
58300		N	Insert intrauterine device	1.01	0.80	0.37	0.05	XXX
58301		A	Remove intrauterine device	1.27	1.13	0.48	0.08	000
58321		A	Artificial insemination	0.92	1.07	0.34	0.05	000
58322		A	Artificial insemination	1.10	1.06	0.42	0.07	000
58323		A	Sperm washing	0.23	0.16	0.09	0.02	000
58340		A	Catheter for hysterography	0.88	2.00	0.60	0.06	000
58345		A	Reopen fallopian tube	4.67	NA	2.45	0.31	010
58346		A	Insert heyman uteri capsule	7.48	NA	4.06	0.47	090
58350		A	Reopen fallopian tube	1.03	1.33	0.92	0.07	010
58353		A	Endometr ablate, thermal	3.57	20.53	2.00	0.24	010
58356		A	Endometrial cryoablation	6.36	38.91	2.52	0.42	010
58400		A	Suspension of uterus	7.06	NA	4.14	0.80	090
58410		A	Suspension of uterus	13.70	NA	6.82	1.75	090
58520		A	Repair of ruptured uterus	13.38	NA	7.42	2.17	090
58540		A	Revision of uterus	15.61	NA	7.61	2.00	090
58541		A	Lsh, uterus 250 g or less	14.57	NA	7.44	1.84	090
58542		A	Lsh w/t/o ut 250 g or less	16.43	NA	8.17	2.06	090
58543		A	Lsh uterus above 250 g	16.74	NA	8.33	2.14	090
58544		A	Lsh w/t/o uterus above 250 g	18.24	NA	8.87	2.33	090
58545		A	Laparoscopic myomectomy	15.45	NA	7.40	1.81	090
58546		A	Laparo-myomectomy, complex	19.84	NA	9.00	2.54	090
58548		A	Lap radical hyst	31.45	NA	14.92	2.20	090
58550		A	Laparo-asst vag hysterectomy	14.97	NA	7.50	1.88	090
58552		A	Laparo-vag hyst incl t/o	16.78	NA	8.22	1.91	090
58553		A	Laparo-vag hyst, complex	19.96	NA	9.08	2.55	090
58554		A	Laparo-vag hyst w/t/o, compl	22.98	NA	10.63	2.54	090
58555		A	Hysteroscopy, dx, sep proc	3.33	NA	1.55	0.22	000
58558		A	Hysteroscopy, biopsy	4.74	3.85	2.12	0.31	000
58559		A	Hysteroscopy, lysis	6.16	NA	2.66	0.41	000
58560		A	Hysteroscopy, resect septum	6.99	NA	2.98	0.46	000
58561		A	Hysteroscopy, remove myoma	9.99	NA	4.13	0.65	000
58562		A	Hysteroscopy, remove fb	5.20	3.81	2.27	0.34	000
58563		A	Hysteroscopy, ablation	6.16	33.55	2.66	0.40	000
58565		A	Hysteroscopy, sterilization	7.06	37.75	3.95	0.90	090
58570		A	Tlh, uterus 250 g or less	15.75	NA	7.96	1.81	090
58571		A	Tlh w/t/o 250 g or less	17.56	NA	8.85	1.56	090
58572		A	Tlh, uterus over 250 g	19.96	NA	9.49	2.55	090
58573		A	Tlh w/t/o uterus over 250 g	22.98	NA	10.98	2.09	090
58578		C	Laparo proc, uterus	0.00	0.00	0.00	0.00	YYY
58579		C	Hysteroscope procedure	0.00	0.00	0.00	0.00	YYY
58600		A	Division of fallopian tube	5.86	NA	3.39	0.75	090
58605		A	Division of fallopian tube	5.25	NA	3.13	0.67	090
58611		A	Ligate oviduct(s) add-on	1.45	NA	0.55	0.09	ZZZ
58615		A	Occlude fallopian tube(s)	3.91	NA	2.28	0.26	010
58660		A	Laparoscopy, lysis	11.54	NA	5.62	1.52	090
58661		A	Laparoscopy, remove adnexa	11.30	NA	5.16	0.77	010
58662		A	Laparoscopy, excise lesions	12.08	NA	5.91	1.50	090
58670		A	Laparoscopy, tubal cautery	5.86	NA	3.43	0.75	090
58671		A	Laparoscopy, tubal block	5.86	NA	3.41	0.76	090
58672		A	Laparoscopy, fimbrioplasty	12.88	NA	6.20	1.65	090
58673		A	Laparoscopy, salpingostomy	13.99	NA	6.51	1.79	090
58679		C	Laparo proc, oviduct-ovary	0.00	0.00	0.00	0.00	YYY
58700		A	Removal of fallopian tube	12.84	NA	6.83	1.80	090
58720		A	Removal of ovary/tube(s)	12.08	NA	6.29	1.44	090
58740		A	Adhesiolysis tube, ovary	14.79	NA	7.49	1.89	090
58750		A	Repair oviduct	15.56	NA	7.50	1.99	090
58752		A	Revise ovarian tube(s)	15.56	NA	7.39	0.83	090
58760		A	Fimbrioplasty	13.85	NA	6.84	1.77	090
58770		A	Create new tubal opening	14.69	NA	7.11	1.88	090
58800		A	Drainage of ovarian cyst(s)	4.54	3.41	2.96	0.58	090
58805		A	Drainage of ovarian cyst(s)	6.34	NA	4.62	1.03	090
58820		A	Drain ovary abscess, open	4.62	NA	3.22	0.59	090
58822		A	Drain ovary abscess, percut	11.71	NA	6.89	1.90	090
58823		A	Drain pelvic abscess, percut	3.37	14.89	1.05	0.28	000
58825		A	Transposition, ovary(s)	11.70	NA	6.02	1.50	090
58900		A	Biopsy of ovary(s)	6.51	NA	4.68	1.05	090
58920		A	Partial removal of ovary(s)	11.87	NA	6.00	1.52	090
58925		A	Removal of ovarian cyst(s)	12.33	NA	6.47	1.65	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
58940		A	Removal of ovary(s)	8.12	NA	4.86	1.10	090
58943		A	Removal of ovary(s)	19.42	NA	9.37	1.84	090
58950		A	Resect ovarian malignancy	18.24	NA	9.27	1.60	090
58951		A	Resect ovarian malignancy	24.15	NA	11.37	2.00	090
58952		A	Resect ovarian malignancy	27.15	NA	12.94	2.21	090
58953		A	Tah, rad dissect for debulk	33.97	NA	15.74	2.61	090
58954		A	Tah rad debulk/lymph remove	36.97	NA	16.93	2.93	090
58956		A	Bso, omentectomy w/tah	22.65	NA	11.12	2.08	090
58957		A	Resect recurrent gyn mal	26.06	NA	12.58	2.21	090
58958		A	Resect recur gyn mal w/lym	29.06	NA	13.86	2.35	090
58960		A	Exploration of abdomen	15.68	NA	7.98	1.49	090
58970		A	Retrieval of oocyte	3.52	2.21	1.63	0.19	000
58974		C	Transfer of embryo	0.00	0.00	0.00	0.00	000
58976		A	Transfer of embryo	3.82	2.54	1.74	0.20	000
58999		C	Genital surgery procedure	0.00	0.00	0.00	0.00	YYY
59000		A	Amniocentesis, diagnostic	1.30	1.72	0.66	0.28	000
59001		A	Amniocentesis, therapeutic	3.00	NA	1.36	0.65	000
59012		A	Fetal cord puncture,prenatal	3.44	NA	1.48	0.75	000
59015		A	Chorion biopsy	2.20	1.56	1.01	0.48	000
59020		A	Fetal contract stress test	0.66	1.04	1.04	0.14	000
59020	TC	A	Fetal contract stress test	0.00	0.79	0.00	0.00	000
59020	26	A	Fetal contract stress test	0.66	0.25	0.25	0.14	000
59025		A	Fetal non-stress test	0.53	0.63	0.63	0.11	000
59025	TC	A	Fetal non-stress test	0.00	0.43	0.00	0.00	000
59025	26	A	Fetal non-stress test	0.53	0.20	0.20	0.11	000
59030		A	Fetal scalp blood sample	1.99	NA	0.73	0.11	000
59050		A	Fetal monitor w/report	0.89	NA	0.34	0.09	XXX
59051		A	Fetal monitor/interpret only	0.74	NA	0.28	0.16	XXX
59070		A	Transabdom amnioinfus w/us	5.24	4.68	2.29	1.14	000
59072		A	Umbilical cord occlud w/us	8.99	NA	3.63	0.48	000
59074		A	Fetal fluid drainage w/us	5.24	4.95	2.46	1.14	000
59076		A	Fetal shunt placement, w/us	8.99	NA	3.75	1.96	000
59100		A	Remove uterus lesion	13.26	NA	6.78	2.89	090
59120		A	Treat ectopic pregnancy	12.56	NA	6.52	2.74	090
59121		A	Treat ectopic pregnancy	12.64	NA	6.47	2.76	090
59130		A	Treat ectopic pregnancy	14.98	NA	7.34	0.80	090
59135		A	Treat ectopic pregnancy	14.82	NA	7.22	0.79	090
59136		A	Treat ectopic pregnancy	14.15	NA	6.99	3.09	090
59140		A	Treat ectopic pregnancy	5.86	NA	3.83	0.31	090
59150		A	Treat ectopic pregnancy	12.19	NA	6.30	2.66	090
59151		A	Treat ectopic pregnancy	12.01	NA	5.97	2.62	090
59160		A	D & c after delivery	2.73	2.14	1.42	0.60	010
59200		A	Insert cervical dilator	0.79	0.94	0.30	0.17	000
59300		A	Episiotomy or vaginal repair	2.41	2.24	1.20	0.53	000
59320		A	Revision of cervix	2.48	NA	1.22	0.53	000
59325		A	Revision of cervix	4.06	NA	1.80	0.22	000
59350		A	Repair of uterus	4.94	NA	1.87	1.08	000
59400		A	Obstetrical care	26.80	NA	16.34	5.59	MMM
59409		A	Obstetrical care	13.48	NA	5.19	2.78	MMM
59410		A	Obstetrical care	15.29	NA	6.52	3.19	MMM
59412		A	Antepartum manipulation	1.71	NA	0.80	0.37	MMM
59414		A	Deliver placenta	1.61	NA	0.62	0.35	MMM
59425		A	Antepartum care only	6.22	4.70	2.37	1.27	MMM
59426		A	Antepartum care only	11.04	8.61	4.21	2.20	MMM
59430		A	Care after delivery	2.13	1.27	0.93	0.44	MMM
59510		A	Cesarean delivery	30.34	NA	18.33	6.54	MMM
59514		A	Cesarean delivery only	15.95	NA	6.17	3.43	MMM
59515		A	Cesarean delivery	18.26	NA	7.99	3.90	MMM
59525		A	Remove uterus after cesarean	8.53	NA	3.27	1.86	ZZZ
59610		A	Vbac delivery	28.21	NA	17.12	6.16	MMM
59612		A	Vbac delivery only	15.04	NA	5.81	3.28	MMM
59614		A	Vbac care after delivery	16.59	NA	6.82	3.62	MMM
59618		A	Attempted vbac delivery	31.78	NA	18.97	6.94	MMM
59620		A	Attempted vbac delivery only	17.50	NA	6.76	3.82	MMM
59622		A	Attempted vbac after care	19.70	NA	8.69	4.30	MMM
59812		A	Treatment of miscarriage	4.39	3.34	2.69	0.95	090
59820		A	Care of miscarriage	4.68	4.23	3.70	1.02	090
59821		A	Treatment of miscarriage	4.97	4.07	3.49	1.08	090
59830		A	Treat uterus infection	6.51	NA	3.93	1.42	090
59840		R	Abortion	3.01	2.25	2.04	0.60	010
59841		R	Abortion	5.57	3.55	3.05	1.22	010
59850		R	Abortion	5.90	NA	3.34	0.32	090
59851		R	Abortion	5.92	NA	3.71	1.29	090
59852		R	Abortion	8.23	NA	5.08	0.44	090
59855		R	Abortion	6.38	NA	3.59	1.39	090
59856		R	Abortion	7.74	NA	3.99	1.69	090
59857		R	Abortion	9.30	NA	4.48	0.50	090
59866		R	Abortion (mpr)	3.99	NA	1.80	0.21	000
59870		A	Evacuate mole of uterus	6.40	NA	4.76	1.40	090
59871		A	Remove cerclage suture	2.13	NA	1.12	0.46	000
59897		C	Fetal invas px w/us	0.00	0.00	0.00	0.00	YYY
59898		C	Laparo proc, ob care/deliver	0.00	0.00	0.00	0.00	YYY
59899		C	Maternity care procedure	0.00	0.00	0.00	0.00	YYY
60000		A	Drain thyroid/tongue cyst	1.78	2.39	1.98	0.12	010

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
60100		A	Biopsy of thyroid	1.56	1.25	0.50	0.12	000
60200		A	Remove thyroid lesion	9.91	NA	6.84	1.29	090
60210		A	Partial thyroid excision	11.15	NA	6.77	1.55	090
60212		A	Partial thyroid excision	16.32	NA	9.29	2.30	090
60220		A	Partial removal of thyroid	12.29	NA	7.38	1.62	090
60225		A	Partial removal of thyroid	14.67	NA	8.93	1.99	090
60240		A	Removal of thyroid	16.18	NA	8.61	2.23	090
60252		A	Removal of thyroid	21.88	NA	11.80	2.94	090
60254		A	Extensive thyroid surgery	28.29	NA	14.99	3.41	090
60260		A	Repeat thyroid surgery	18.18	NA	9.89	2.36	090
60270		A	Removal of thyroid	23.07	NA	11.80	3.29	090
60271		A	Removal of thyroid	17.54	NA	9.57	2.27	090
60280		A	Remove thyroid duct lesion	6.05	NA	5.36	0.63	090
60281		A	Remove thyroid duct lesion	8.71	NA	6.65	0.85	090
60300		A	Aspir/inj thyroid cyst	0.97	1.84	0.31	0.08	000
60500		A	Explore parathyroid glands	16.69	NA	9.14	2.44	090
60502		A	Re-explore parathyroids	21.01	NA	11.31	3.14	090
60505		A	Explore parathyroid glands	22.91	NA	12.46	3.25	090
60512		A	Autotransplant parathyroid	4.44	NA	1.76	0.59	ZZZ
60520		A	Removal of thymus gland	17.07	NA	8.89	2.62	090
60521		A	Removal of thymus gland	19.11	NA	9.26	3.44	090
60522		A	Removal of thymus gland	23.37	NA	11.06	4.14	090
60540		A	Explore adrenal gland	17.91	NA	8.74	2.28	090
60545		A	Explore adrenal gland	20.82	NA	9.91	2.75	090
60600		A	Remove carotid body lesion	24.99	NA	10.79	3.99	090
60605		A	Remove carotid body lesion	31.86	NA	18.65	3.11	090
60650		A	Laparoscopy adrenalectomy	20.63	NA	9.52	2.80	090
60659		C	Laparo proc, endocrine	0.00	0.00	0.00	0.00	YYY
60699		C	Endocrine surgery procedure	0.00	0.00	0.00	0.00	YYY
61000		A	Remove cranial cavity fluid	1.58	NA	1.33	0.11	000
61001		A	Remove cranial cavity fluid	1.49	NA	2.02	0.41	000
61020		A	Remove brain cavity fluid	1.51	NA	1.71	0.30	000
61026		A	Injection into brain canal	1.69	NA	1.44	0.22	000
61050		A	Remove brain canal fluid	1.51	NA	1.18	0.13	000
61055		A	Injection into brain canal	2.10	NA	1.33	0.20	000
61070		A	Brain canal shunt procedure	0.89	NA	1.20	0.14	000
61105		A	Twist drill hole	5.40	NA	5.22	1.47	090
61107		A	Drill skull for implantation	4.99	NA	2.33	1.31	000
61108		A	Drill skull for drainage	11.51	NA	9.47	3.09	090
61120		A	Burr hole for puncture	9.52	NA	7.82	2.59	090
61140		A	Pierce skull for biopsy	17.10	NA	12.02	4.58	090
61150		A	Pierce skull for drainage	18.80	NA	12.59	5.11	090
61151		A	Pierce skull for drainage	13.41	NA	9.64	3.65	090
61154		A	Pierce skull & remove clot	16.92	NA	12.46	4.57	090
61156		A	Pierce skull for drainage	17.37	NA	11.40	4.72	090
61210		A	Pierce skull, implant device	5.83	NA	2.71	1.52	000
61215		A	Insert brain-fluid device	5.77	NA	5.96	1.55	090
61250		A	Pierce skull & explore	11.41	NA	8.70	3.10	090
61253		A	Pierce skull & explore	13.41	NA	8.18	1.31	090
61304		A	Open skull for exploration	23.31	NA	14.85	6.11	090
61305		A	Open skull for exploration	28.51	NA	18.03	7.75	090
61312		A	Open skull for drainage	30.07	NA	18.16	8.13	090
61313		A	Open skull for drainage	27.94	NA	18.00	7.56	090
61314		A	Open skull for drainage	25.77	NA	16.64	6.98	090
61315		A	Open skull for drainage	29.52	NA	18.41	8.03	090
61316		A	Implt cran bone flap to abdo	1.39	NA	0.65	0.37	ZZZ
61320		A	Open skull for drainage	27.32	NA	16.85	7.28	090
61321		A	Open skull for drainage	30.40	NA	18.92	8.27	090
61322		A	Decompressive craniotomy	34.08	NA	20.87	9.14	090
61323		A	Decompressive lobectomy	34.93	NA	20.24	9.24	090
61330		A	Decompress eye socket	25.17	NA	17.53	6.84	090
61332		A	Explore/biopsy eye socket	28.50	NA	17.48	7.75	090
61333		A	Explore orbit/remove lesion	29.17	NA	19.63	1.52	090
61334		A	Explore orbit/remove object	19.50	NA	13.26	5.30	090
61340		A	Subtemporal decompression	20.01	NA	13.50	5.44	090
61343		A	Incise skull (press relief)	31.73	NA	19.25	8.53	090
61345		A	Relieve cranial pressure	29.10	NA	18.13	7.91	090
61440		A	Incise skull for surgery	28.53	NA	17.86	7.76	090
61450		A	Incise skull for surgery	27.59	NA	16.95	7.50	090
61458		A	Incise skull for brain wound	28.71	NA	17.77	7.76	090
61460		A	Incise skull for surgery	30.11	NA	18.60	8.19	090
61470		A	Incise skull for surgery	27.52	NA	16.92	7.48	090
61480		A	Incise skull for surgery	27.95	NA	12.05	1.50	090
61490		A	Incise skull for surgery	27.12	NA	16.73	7.37	090
61500		A	Removal of skull lesion	19.05	NA	12.85	4.38	090
61501		A	Remove infected skull bone	16.22	NA	11.56	3.55	090
61510		A	Removal of brain lesion	30.63	NA	19.91	8.28	090
61512		A	Remove brain lining lesion	36.99	NA	22.10	10.01	090
61514		A	Removal of brain abscess	27.10	NA	17.05	7.31	090
61516		A	Removal of brain lesion	26.45	NA	16.40	7.19	090
61517		A	Implt brain chemotx add-on	1.38	NA	0.64	0.37	ZZZ
61518		A	Removal of brain lesion	39.69	NA	24.24	10.76	090
61519		A	Remove brain lining lesion	43.28	NA	24.97	11.69	090
61520		A	Removal of brain lesion	56.89	NA	31.53	13.77	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
61521		A	Removal of brain lesion	46.84	NA	26.86	12.73	090
61522		A	Removal of brain abscess	31.41	NA	19.21	8.54	090
61524		A	Removal of brain lesion	29.76	NA	18.44	8.09	090
61526		A	Removal of brain lesion	53.90	NA	28.27	14.65	090
61530		A	Removal of brain lesion	45.43	NA	25.80	12.35	090
61531		A	Implant brain electrodes	16.28	NA	12.02	4.43	090
61533		A	Implant brain electrodes	21.36	NA	13.89	5.79	090
61534		A	Removal of brain lesion	22.88	NA	15.21	6.22	090
61535		A	Remove brain electrodes	13.05	NA	10.12	3.55	090
61536		A	Removal of brain lesion	37.59	NA	22.11	10.22	090
61537		A	Removal of brain tissue	36.35	NA	20.58	9.82	090
61538		A	Removal of brain tissue	39.35	NA	22.47	10.70	090
61539		A	Removal of brain tissue	34.15	NA	20.50	9.28	090
61540		A	Removal of brain tissue	31.30	NA	19.24	8.51	090
61541		A	Incision of brain tissue	30.81	NA	18.93	8.38	090
61542		A	Removal of brain tissue	33.03	NA	19.84	8.98	090
61543		A	Removal of brain tissue	31.18	NA	19.10	8.48	090
61544		A	Remove & treat brain lesion	27.26	NA	16.80	1.46	090
61545		A	Excision of brain tumor	46.23	NA	27.44	12.57	090
61546		A	Removal of pituitary gland	33.31	NA	20.10	9.06	090
61548		A	Removal of pituitary gland	23.27	NA	14.12	5.04	090
61550		A	Release of skull seams	15.44	NA	11.98	0.83	090
61552		A	Release of skull seams	20.27	NA	9.53	1.09	090
61556		A	Incise skull/sutures	24.00	NA	15.49	6.53	090
61557		A	Incise skull/sutures	23.16	NA	15.74	6.30	090
61558		A	Excision of skull/sutures	26.35	NA	17.11	7.16	090
61559		A	Excision of skull/sutures	33.82	NA	15.02	1.81	090
61563		A	Excision of skull tumor	28.35	NA	17.53	7.71	090
61564		A	Excision of skull tumor	34.59	NA	21.11	9.40	090
61566		A	Removal of brain tissue	32.32	NA	19.72	8.79	090
61567		A	Incision of brain tissue	36.84	NA	22.48	10.02	090
61570		A	Remove foreign body, brain	26.38	NA	16.85	7.17	090
61571		A	Incise skull for brain wound	28.29	NA	17.75	7.69	090
61575		A	Skull base/brainstem surgery	36.43	NA	21.57	9.90	090
61576		A	Skull base/brainstem surgery	55.11	NA	35.28	5.37	090
61580		A	Craniofacial approach, skull	34.34	NA	27.53	4.27	090
61581		A	Craniofacial approach, skull	38.88	NA	31.38	3.79	090
61582		A	Craniofacial approach, skull	34.93	NA	36.42	9.50	090
61583		A	Craniofacial approach, skull	38.41	NA	29.45	9.90	090
61584		A	Orbitocranial approach/skull	37.61	NA	28.82	9.49	090
61585		A	Orbitocranial approach/skull	42.46	NA	33.03	11.54	090
61586		A	Resect nasopharynx, skull	27.28	NA	30.04	7.42	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
61590		A	Infratemporal approach/skull	46.87	NA	31.01	6.31	090
61591		A	Infratemporal approach/skull	46.87	NA	31.12	6.99	090
61592		A	Orbitocranial approach/skull	42.98	NA	31.24	10.74	090
61595		A	Transtemporal approach/skull	33.57	NA	25.41	5.31	090
61596		A	Transcochlear approach/skull	39.31	NA	25.52	3.83	090
61597		A	Transcondylar approach/skull	40.73	NA	28.27	11.07	090
61598		A	Transpetrosal approach/skull	36.41	NA	29.66	9.90	090
61600		A	Resect/excise cranial lesion	29.84	NA	23.98	4.62	090
61601		A	Resect/excise cranial lesion	31.04	NA	25.15	7.67	090
61605		A	Resect/excise cranial lesion	32.40	NA	24.18	3.63	090
61606		A	Resect/excise cranial lesion	41.94	NA	28.99	10.40	090
61607		A	Resect/excise cranial lesion	40.82	NA	27.02	11.10	090
61608		A	Resect/excise cranial lesion	45.45	NA	30.32	11.57	090
61609		A	Transect artery, sinus	9.88	NA	4.64	0.64	ZZZ
61610		A	Transect artery, sinus	29.63	NA	13.91	1.59	ZZZ
61611		A	Transect artery, sinus	7.41	NA	2.70	0.40	ZZZ
61612		A	Transect artery, sinus	27.84	NA	.	1.49	ZZZ
61613		A	Remove aneurysm, sinus	44.94	NA	31.40	12.22	090
61615		A	Resect/excise lesion, skull	35.63	NA	23.92	3.47	090
61616		A	Resect/excise lesion, skull	46.60	NA	32.23	10.89	090
61618		A	Repair dura	18.58	NA	12.34	4.33	090
61619		A	Repair dura	22.01	NA	13.71	4.78	090
61623		A	Endovasc tempory vessel occl	9.95	NA	3.76	1.31	000
61624		A	Transcath occlusion, cns	20.12	NA	7.14	2.74	000
61626		A	Transcath occlusion, non-cns	16.60	NA	5.26	1.52	000
61630		R	Intracranial angioplasty	22.07	NA	9.12	2.67	XXX
61635		R	Intracran angioplsty w/stent	24.28	NA	9.87	2.92	XXX
61640		N	Dilate ic vasospasm, init	12.32	NA	4.50	0.66	000
61641		N	Dilate ic vasospasm add-on	4.33	NA	1.58	0.23	ZZZ
61642		N	Dilate ic vasospasm add-on	8.66	NA	3.16	0.46	ZZZ
61680		A	Intracranial vessel surgery	32.40	NA	19.95	8.81	090
61682		A	Intracranial vessel surgery	63.31	NA	33.40	17.21	090
61684		A	Intracranial vessel surgery	41.49	NA	24.35	11.28	090
61686		A	Intracranial vessel surgery	67.32	NA	36.85	18.30	090
61690		A	Intracranial vessel surgery	31.18	NA	19.39	8.48	090
61692		A	Intracranial vessel surgery	54.43	NA	30.31	14.80	090
61697		A	Brain aneurysm repr, complx	63.22	NA	34.47	17.00	090
61698		A	Brain aneurysm repr, complx	69.45	NA	37.85	18.88	090
61700		A	Brain aneurysm repr, simple	50.44	NA	28.76	13.61	090
61702		A	Inner skull vessel surgery	59.86	NA	33.35	16.27	090
61703		A	Clamp neck artery	18.70	NA	12.78	5.08	090
61705		A	Revise circulation to head	37.97	NA	22.29	10.32	090

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CPT[1],[5] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
61708		A	Revise circulation to head	37.07	NA	15.83	2.31	090
61710		A	Revise circulation to head	31.19	NA	13.91	5.32	090
61711		A	Fusion of skull arteries	38.10	NA	21.85	10.36	090
61720		A	Incise skull/brain surgery	17.52	NA	11.89	4.76	090
61735		A	Incise skull/brain surgery	22.22	NA	14.57	6.04	090
61750		A	Incise skull/brain biopsy	19.73	NA	12.82	5.34	090
61751		A	Brain biopsy w/ct/mr guide	18.64	NA	13.11	4.99	090
61760		A	Implant brain electrodes	22.24	NA	14.29	6.05	090
61770		A	Incise skull for treatment	23.09	NA	13.99	6.17	090
61790		A	Treat trigeminal nerve	11.50	NA	8.78	3.10	090
61791		A	Treat trigeminal tract	15.31	NA	10.11	3.93	090
61795		A	Brain surgery using computer	4.03	NA	1.88	0.74	ZZZ
61796		A	Srs, cranial lesion simple	10.79	NA	7.68	2.71	090
61797		A	Srs, cran les simple, addl	3.48	NA	1.56	0.86	ZZZ
61798		A	Srs, cranial lesion complex	10.79	NA	7.68	2.71	090
61799		A	Srs, cran les complex, addl	4.81	NA	2.15	1.18	ZZZ
61800		A	Apply srs headframe add-on	2.25	NA	1.26	0.55	ZZZ
61850		A	Implant neuroelectrodes	13.26	NA	9.49	3.61	090
61860		A	Implant neuroelectrodes	22.16	NA	14.07	6.02	090
61863		A	Implant neuroelectrode	20.56	NA	14.20	5.58	090
61864		A	Implant neuroelecrde, addl	4.49	NA	2.11	1.22	ZZZ
61867		A	Implant neuroelectrode	32.88	NA	19.98	8.93	090
61868		A	Implant neuroelecrde, add/El	7.91	NA	3.72	2.12	ZZZ
61870		A	Implant neuroelectrodes	16.24	NA	11.16	4.42	090
61875		A	Implant neuroelectrodes	16.36	NA	7.66	0.88	090
61880		A	Revise/remove neuroelectrode	6.87	NA	6.36	1.85	090
61885		A	Insrt/redo neurostim 1 array	7.37	NA	8.26	1.90	090
61886		A	Implant neurostim arrays	9.73	NA	9.78	2.61	090
61888		A	Revise/remove neuroreceiver	5.20	NA	3.93	1.27	010
62000		A	Treat skull fracture	13.83	NA	10.03	1.00	090
62005		A	Treat skull fracture	17.53	NA	11.90	4.77	090
62010		A	Treatment of head injury	21.30	NA	14.14	5.79	090
62100		A	Repair brain fluid leakage	23.40	NA	14.51	5.63	090
62115		A	Reduction of skull defect	22.71	NA	10.81	1.22	090
62116		A	Reduction of skull defect	24.90	NA	16.16	6.77	090
62117		A	Reduction of skull defect	28.26	NA	15.49	2.76	090
62120		A	Repair skull cavity lesion	24.39	NA	19.27	2.38	090
62121		A	Incise skull repair	22.93	NA	19.84	6.23	090
62140		A	Repair of skull defect	14.45	NA	9.97	3.54	090
62141		A	Repair of skull defect	15.97	NA	10.89	4.01	090
62142		A	Remove skull plate/flap	11.73	NA	8.96	3.05	090
62143		A	Replace skull plate/flap	14.05	NA	10.09	3.75	090
62145		A	Repair of skull & brain	19.99	NA	12.59	5.43	090
62146		A	Repair of skull with graft	17.18	NA	11.73	4.67	090
62147		A	Repair of skull with graft	20.57	NA	13.32	5.59	090
62148		A	Retr bone flap to fix skull	2.00	NA	0.94	0.54	ZZZ
62160		A	Neuroendoscopy add-on	3.00	NA	1.40	0.80	ZZZ
62161		A	Dissect brain w/scope	21.10	NA	14.14	5.74	090
62162		A	Remove colloid cyst w/scope	26.67	NA	17.09	7.25	090
62163		A	Neuroendoscopy w/fb removal	16.40	NA	11.94	4.46	090
62164		A	Remove brain tumor w/scope	29.27	NA	19.09	7.96	090
62165		A	Remove pituit tumor w/scope	23.10	NA	14.48	4.92	090
62180		A	Establish brain cavity shunt	22.45	NA	14.58	6.10	090
62190		A	Establish brain cavity shunt	12.07	NA	9.33	3.28	090
62192		A	Establish brain cavity shunt	13.25	NA	9.62	3.46	090
62194		A	Replace/irrigate catheter	5.68	NA	5.16	1.54	010
62200		A	Establish brain cavity shunt	19.19	NA	12.68	5.22	090
62201		A	Brain cavity shunt w/scope	15.89	NA	11.96	4.30	090
62220		A	Establish brain cavity shunt	14.00	NA	9.72	3.66	090
62223		A	Establish brain cavity shunt	13.90	NA	10.70	3.64	090
62225		A	Replace/irrigate catheter	6.11	NA	5.99	1.63	090
62230		A	Replace/revise brain shunt	11.35	NA	8.29	2.98	090
62252		A	Csf shunt reprogram	0.74	1.82	NA	0.18	XXX
62252	TC	A	Csf shunt reprogram	0.00	1.47	NA	0.00	XXX
62252	26	A	Csf shunt reprogram	0.74	0.35	0.35	0.18	XXX
62256		A	Remove brain cavity shunt	7.30	NA	6.57	1.97	090
62258		A	Replace brain cavity shunt	15.54	NA	10.69	4.12	090
62263		A	Epidural lysis mult sessions	6.04	12.41	4.17	0.40	010
62264		A	Epidural lysis on single day	4.42	6.77	2.08	0.28	010
62267		A	Interdiscal perg aspir, dx	3.00	4.24	1.50	0.23	000
62268		A	Drain spinal cord cyst	4.73	5.79	1.92	0.35	000
62269		A	Needle biopsy, spinal cord	5.01	5.57	1.69	0.45	000
62270		A	Spinal fluid tap, diagnostic	1.37	2.46	0.60	0.11	000
62272		A	Drain cerebro spinal fluid	1.35	3.54	0.71	0.19	000
62273		A	Inject epidural patch	2.15	2.25	0.84	0.15	000
62280		A	Treat spinal cord lesion	2.63	5.35	1.46	0.39	010
62281		A	Treat spinal cord lesion	2.66	5.19	1.48	0.17	010
62282		A	Treat spinal canal lesion	2.33	5.02	1.46	0.20	010
62284		A	Injection for myelogram	1.54	3.59	0.67	0.13	000
62287		A	Percutaneous diskectomy	8.88	NA	5.29	0.63	090
62290		A	Inject for spine disk x-ray	3.00	5.59	1.56	0.23	000
62291		A	Inject for spine disk x-ray	2.91	5.32	1.52	0.21	000
62292		A	Injection into disk lesion	9.14	NA	4.20	0.59	090
62294		A	Injection into spinal artery	12.77	NA	3.32	0.92	090

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62310		A	Inject spine c/t	1.91	4.28	0.96	0.12	000
62311		A	Inject spine l/s (cd)	1.54	3.64	0.79	0.10	000
62318		A	Inject spine w/cath, c/t	2.04	3.98	0.63	0.12	000
62319		A	Inject spine w/cath l/s (cd)	1.87	3.77	0.68	0.12	000
62350		A	Implant spinal canal cath	1.29	NA	2.15	0.93	010
62351		A	Implant spinal canal cath	11.54	NA	9.43	2.54	090
62355		A	Remove spinal canal catheter	4.30	NA	3.38	0.64	010
62360		A	Insert spine infusion device	4.28	NA	3.47	0.72	010
62361		A	Implant spine infusion pump	5.60	NA	4.22	0.86	010
62362		A	Implant spine infusion pump	6.05	NA	4.29	1.06	010
62365		A	Remove spine infusion device	4.60	NA	3.67	0.77	010
62367		A	Analyze spine infusion pump	0.48	0.62	0.20	0.03	XXX
62368		A	Analyze spine infusion pump	0.75	0.86	0.31	0.05	XXX
63001		A	Removal of spinal lamina	17.51	NA	11.57	4.28	090
63003		A	Removal of spinal lamina	17.64	NA	11.65	4.24	090
63005		A	Removal of spinal lamina	16.28	NA	11.77	3.82	090
63011		A	Removal of spinal lamina	15.78	NA	10.88	3.02	090
63012		A	Removal of spinal lamina	16.72	NA	11.57	3.84	090
63015		A	Removal of spinal lamina	20.70	NA	14.01	5.27	090
63016		A	Removal of spinal lamina	21.90	NA	14.06	5.04	090
63017		A	Removal of spinal lamina	17.18	NA	12.25	4.20	090
63020		A	Neck spine disk surgery	16.05	NA	11.67	3.82	090
63030		A	Low back disk surgery	13.03	NA	10.13	2.91	090
63035		A	Spinal disk surgery add-on	3.15	NA	1.52	0.67	ZZZ
63040		A	Laminotomy, single cervical	20.18	NA	13.23	4.74	090
63042		A	Laminotomy, single lumbar	18.61	NA	12.74	3.91	090
63043		C	Laminotomy, add£l cervical	0.00	NA	0.00	0.00	ZZZ
63044		C	Laminotomy, add£l lumbar	0.00	NA	0.00	0.00	ZZZ
63045		A	Removal of spinal lamina	17.82	NA	12.20	4.30	090
63046		A	Removal of spinal lamina	17.12	NA	11.77	3.87	090
63047		A	Removal of spinal lamina	15.22	NA	11.15	3.30	090
63048		A	Remove spinal lamina add-on	3.47	NA	1.67	0.75	ZZZ
63050		A	Cervical laminoplasty	21.88	NA	14.11	5.95	090
63051		A	C-laminoplasty w/graft/plate	25.38	NA	15.85	5.43	090
63055		A	Decompress spinal cord	23.42	NA	14.89	5.79	090
63056		A	Decompress spinal cord	21.73	NA	13.84	4.69	090
63057		A	Decompress spine cord add-on	5.25	NA	2.53	1.14	ZZZ
63064		A	Decompress spinal cord	26.09	NA	16.06	5.98	090
63066		A	Decompress spine cord add-on	3.26	NA	1.60	0.49	ZZZ
63075		A	Neck spine disk surgery	19.47	NA	13.11	4.61	090
63076		A	Neck spine disk surgery	4.04	NA	1.93	0.93	ZZZ
63077		A	Spine disk surgery, thorax	22.75	NA	13.67	4.44	090
63078		A	Spine disk surgery, thorax	3.28	NA	1.57	0.57	ZZZ
63081		A	Removal of vertebral body	25.97	NA	16.26	5.92	090
63082		A	Remove vertebral body add-on	4.36	NA	2.09	0.98	ZZZ
63085		A	Removal of vertebral body	29.34	NA	16.69	5.94	090
63086		A	Remove vertebral body add-on	3.19	NA	1.48	0.66	ZZZ
63087		A	Removal of vertebral body	37.38	NA	20.84	7.30	090
63088		A	Remove vertebral body add-on	4.32	NA	2.06	0.79	ZZZ
63090		A	Removal of vertebral body	30.78	NA	17.76	5.42	090
63091		A	Remove vertebral body add-on	3.03	NA	1.43	0.51	ZZZ
63101		A	Removal of vertebral body	33.92	NA	21.05	8.02	090
63102		A	Removal of vertebral body	33.92	NA	20.81	6.45	090
63103		A	Remove vertebral body add-on	4.82	NA	2.31	0.91	ZZZ
63170		A	Incise spinal cord tract(s)	22.08	NA	14.79	6.00	090
63172		A	Drainage of spinal cyst	19.66	NA	12.77	4.99	090
63173		A	Drainage of spinal cyst	24.18	NA	15.78	6.57	090
63180		A	Revise spinal cord ligaments	20.40	NA	10.44	5.55	090
63182		A	Revise spinal cord ligaments	22.69	NA	15.08	6.17	090
63185		A	Incise spinal column/nerves	16.36	NA	11.97	4.45	090
63190		A	Incise spinal column/nerves	18.76	NA	12.63	3.25	090
63191		A	Incise spinal column/nerves	18.79	NA	13.94	2.81	090
63194		A	Incise spinal column & cord	21.97	NA	12.97	2.14	090
63195		A	Incise spinal column & cord	21.54	NA	14.07	5.86	090
63196		A	Incise spinal column & cord	25.14	NA	11.22	1.35	090
63197		A	Incise spinal column & cord	23.95	NA	15.67	6.51	090
63198		A	Incise spinal column & cord	29.75	NA	13.10	1.59	090
63199		A	Incise spinal column & cord	31.32	NA	13.67	1.68	090
63200		A	Release of spinal cord	21.31	NA	14.18	5.70	090
63250		A	Revise spinal cord vessels	43.73	NA	25.00	11.89	090
63251		A	Revise spinal cord vessels	44.49	NA	25.75	12.10	090
63252		A	Revise spinal cord vessels	44.48	NA	25.75	12.09	090
63265		A	Excise intraspinal lesion	23.69	NA	15.36	6.11	090
63266		A	Excise intraspinal lesion	24.55	NA	15.76	6.34	090
63267		A	Excise intraspinal lesion	19.32	NA	13.18	4.72	090
63268		A	Excise intraspinal lesion	19.89	NA	13.80	5.41	090
63270		A	Excise intraspinal lesion	29.67	NA	18.40	8.07	090
63271		A	Excise intraspinal lesion	29.79	NA	18.32	7.95	090
63272		A	Excise intraspinal lesion	27.37	NA	17.13	7.19	090
63273		A	Excise intraspinal lesion	26.34	NA	16.83	7.16	090
63275		A	Biopsy/excise spinal tumor	25.73	NA	16.33	6.63	090
63276		A	Biopsy/excise spinal tumor	25.56	NA	16.16	6.55	090
63277		A	Biopsy/excise spinal tumor	22.26	NA	14.51	5.25	090
63278		A	Biopsy/excise spinal tumor	21.99	NA	14.79	5.98	090

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63280		A	Biopsy/excise spinal tumor	30.14	NA	18.92	8.19	090
63281		A	Biopsy/excise spinal tumor	29.84	NA	18.65	8.04	090
63282		A	Biopsy/excise spinal tumor	28.00	NA	17.84	7.52	090
63283		A	Biopsy/excise spinal tumor	26.61	NA	17.36	7.23	090
63285		A	Biopsy/excise spinal tumor	37.90	NA	22.58	10.30	090
63286		A	Biopsy/excise spinal tumor	37.47	NA	22.33	9.92	090
63287		A	Biopsy/excise spinal tumor	39.93	NA	23.61	10.86	090
63290		A	Biopsy/excise spinal tumor	40.67	NA	23.96	11.06	090
63295		A	Repair of laminectomy defect	5.25	NA	2.46	1.43	ZZZ
63300		A	Removal of vertebral body	26.67	NA	16.53	6.63	090
63301		A	Removal of vertebral body	31.42	NA	19.62	8.54	090
63302		A	Removal of vertebral body	31.00	NA	19.42	8.43	090
63303		A	Removal of vertebral body	33.42	NA	18.40	9.09	090
63304		A	Removal of vertebral body	33.70	NA	20.69	9.16	090
63305		A	Removal of vertebral body	36.09	NA	21.81	9.81	090
63306		A	Removal of vertebral body	35.40	NA	13.70	6.29	090
63307		A	Removal of vertebral body	34.81	NA	15.87	9.46	090
63308		A	Remove vertebral body add-on	5.24	NA	2.43	1.15	ZZZ
63600		A	Remove spinal cord lesion	15.02	NA	6.86	0.91	090
63610		A	Stimulation of spinal cord	8.72	14.04	1.68	2.37	000
63615		A	Remove lesion of spinal cord	17.22	NA	8.55	4.68	090
63620		A	Srs, spinal lesion	10.79	NA	7.68	2.71	090
63621		A	Srs, spinal lesion, addl	4.00	NA	1.79	0.98	ZZZ
63650		A	Implant neuroelectrodes	4.18	NA	3.11	0.50	010
63655		A	Implant neuroelectrodes	11.43	NA	9.02	2.73	090
63660		A	Revise/remove neuroelectrode	6.87	NA	4.89	0.85	090
63685		A	Insrt/redo spine n generator	4.27	NA	3.43	0.93	010
63688		A	Revise/remove neuroreceiver	5.25	NA	3.96	0.85	010
63700		A	Repair of spinal herniation	17.32	NA	12.71	4.71	090
63702		A	Repair of spinal herniation	19.26	NA	13.62	5.24	090
63704		A	Repair of spinal herniation	22.23	NA	15.89	6.04	090
63706		A	Repair of spinal herniation	25.15	NA	17.26	6.84	090
63707		A	Repair spinal fluid leakage	12.52	NA	9.37	2.64	090
63709		A	Repair spinal fluid leakage	15.52	NA	10.88	3.36	090
63710		A	Graft repair of spine defect	15.27	NA	10.92	3.68	090
63740		A	Install spinal shunt	12.50	NA	9.59	3.21	090
63741		A	Install spinal shunt	9.02	NA	5.71	1.65	090
63744		A	Revision of spinal shunt	8.86	NA	6.91	2.22	090
63746		A	Removal of spinal shunt	7.25	NA	6.67	1.97	090
64400		A	N block inj, trigeminal	1.11	1.85	0.65	0.08	000
64402		A	N block inj, facial	1.25	1.78	0.73	0.09	000
64405		A	N block inj, occipital	1.32	1.64	0.74	0.09	000
64408		A	N block inj, vagus	1.41	1.77	0.96	0.09	000
64410		A	N block inj, phrenic	1.43	2.42	0.66	0.25	000
64412		A	N block inj, spinal accessor	1.18	2.90	0.79	0.07	000
64413		A	N block inj, cervical plexus	1.40	1.64	0.66	0.09	000
64415		A	N block inj, brachial plexus	1.48	1.76	0.41	0.09	000
64416		A	N block cont infuse, b plex	1.81	NA	0.30	0.11	000
64417		A	N block inj, axillary	1.44	1.77	0.41	0.09	000
64418		A	N block inj, suprascapular	1.32	2.28	0.68	0.08	000
64420		A	N block inj, intercost, sng	1.18	3.07	0.63	0.09	000
64421		A	N block inj, intercost, mlt	1.68	4.58	0.79	0.15	000
64425		A	N block inj, ilio-ing/hypogi	1.75	1.74	0.79	0.14	000
64430		A	N block inj, pudendal	1.46	1.94	0.66	0.11	000
64435		A	N block inj, paracervical	1.45	1.93	0.70	0.10	000
64445		A	N block inj, sciatic, sng	1.48	1.95	0.64	0.09	000
64446		A	N blk inj, sciatic, cont inf	1.81	NA	0.33	0.12	000
64447		A	N block inj fem, single	1.50	NA	0.25	0.09	000
64448		A	N block inj fem, cont inf	1.63	NA	0.27	0.10	000
64449		A	N block inj, lumbar plexus	1.81	NA	0.37	0.11	000
64450		A	N block, other peripheral	1.27	1.44	0.55	0.08	000
64455		A	N block inj, plantar digit	0.75	0.60	0.27	0.06	000
64470		A	Inj paravertebral c/t	1.85	4.94	1.04	0.13	000
64472		A	Inj paravertebral c/t add-on	1.29	1.72	0.56	0.09	ZZZ
64475		A	Inj paravertebral l/s	1.41	4.82	0.86	0.10	000
64476		A	Inj paravertebral l/s add-on	0.98	1.55	0.39	0.07	ZZZ
64479		A	Inj foramen epidural c/t	2.20	5.09	1.23	0.18	000
64480		A	Inj foramen epidural add-on	1.54	2.19	0.65	0.18	ZZZ
64483		A	Inj foramen epidural l/s	1.90	5.12	1.11	0.12	000
64484		A	Inj foramen epidural add-on	1.33	2.30	0.56	0.09	ZZZ
64505		A	N block, spenopalatine gangl	1.36	1.16	0.81	0.07	000
64508		A	N block, carotid sinus s/p	1.12	3.16	0.86	0.18	000
64510		A	N block, stellate ganglion	1.22	2.73	0.72	0.07	000
64517		A	N block inj, hypogas plxs	2.20	2.58	1.17	0.13	000
64520		A	N block, lumbar/thoracic	1.35	3.63	0.82	0.08	000
64530		A	N block inj, celiac pelus	1.58	3.46	0.90	0.10	000
64550		A	Apply neurostimulator	0.18	0.24	0.07	0.01	000
64553		A	Implant neuroelectrodes	2.33	3.07	1.78	0.20	010
64555		A	Implant neuroelectrodes	2.29	2.55	1.43	0.16	010
64560		A	Implant neuroelectrodes	2.38	2.63	1.51	0.13	010
64561		A	Implant neuroelectrodes	7.07	15.46	3.22	0.50	010
64565		A	Implant neuroelectrodes	1.78	2.87	1.53	0.11	010
64573		A	Implant neuroelectrodes	8.15	NA	6.33	1.82	090
64575		A	Implant neuroelectrodes	4.37	NA	3.21	0.35	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
64577		A	Implant neuroelectrodes	4.64	NA	5.15	1.26	090
64580		A	Implant neuroelectrodes	4.14	NA	3.38	0.67	090
64581		A	Implant neuroelectrodes	14.15	NA	5.75	1.18	090
64585		A	Revise/remove neuroelectrode	2.08	4.06	1.59	0.18	010
64590		A	Instr/redo pn/gastr stimul	2.42	4.05	1.64	0.19	010
64595		A	Revise/rmv pn/gastr stimul	1.75	4.26	1.44	0.14	010
64600		A	Injection treatment of nerve	3.46	6.70	2.24	0.27	010
64605		A	Injection treatment of nerve	5.62	13.80	4.10	1.53	010
64610		A	Injection treatment of nerve	7.17	11.04	4.40	1.58	010
64612		A	Destroy nerve, face muscle	1.98	2.14	1.84	0.12	010
64613		A	Destroy nerve, neck muscle	1.98	1.92	1.60	0.15	010
64614		A	Destroy nerve, extrem musc	2.20	2.18	1.75	0.13	010
64620		A	Injection treatment of nerve	2.86	4.75	1.78	0.21	010
64622		A	Destr paravertebrl nerve l/s	3.02	5.87	2.06	0.18	010
64623		A	Destr paravertebral n add-on	0.99	2.35	0.41	0.06	ZZZ
64626		A	Destr paravertebrl nerve c/t	3.82	6.83	2.98	0.23	010
64627		A	Destr paravertebral n add-on	1.16	3.35	0.48	0.07	ZZZ
64630		A	Injection treatment of nerve	3.02	2.56	1.72	0.22	010
64632		A	N block inj, common digit	1.20	1.09	0.70	0.07	010
64640		A	Injection treatment of nerve	2.78	2.72	1.59	0.15	010
64650		A	Chemodenerv eccrine glands	0.70	1.14	0.35	0.04	000
64653		A	Chemodenerv eccrine glands	0.88	1.32	0.39	0.06	000
64680		A	Injection treatment of nerve	2.64	5.39	1.64	0.20	010
64681		A	Injection treatment of nerve	3.78	4.94	1.20	0.23	010
64702		A	Revise finger/toe nerve	6.10	NA	6.29	0.78	090
64704		A	Revise hand/foot nerve	4.61	NA	3.68	0.40	090
64708		A	Revise arm/leg nerve	7.36	NA	6.54	0.86	090
64712		A	Revision of sciatic nerve	7.98	NA	5.80	1.00	090
64713		A	Revision of arm nerve(s)	11.29	NA	7.80	1.80	090
64714		A	Revise low back nerve(s)	10.44	NA	7.18	1.36	090
64716		A	Revision of cranial nerve	6.86	NA	6.52	0.80	090
64718		A	Revise ulnar nerve at elbow	7.06	NA	7.39	1.09	090
64719		A	Revise ulnar nerve at wrist	4.89	NA	4.97	0.70	090
64721		A	Carpal tunnel surgery	4.84	5.61	5.55	0.72	090
64722		A	Relieve pressure on nerve(s)	4.74	NA	3.98	0.55	090
64726		A	Release foot/toe nerve	4.21	NA	2.95	0.29	090
64727		A	Internal nerve revision	3.10	NA	1.54	0.45	ZZZ
64732		A	Incision of brow nerve	4.81	NA	5.39	1.31	090
64734		A	Incision of cheek nerve	5.45	NA	6.09	1.48	090
64736		A	Incision of chin nerve	5.13	NA	5.94	1.39	090
64738		A	Incision of jaw nerve	6.26	NA	6.47	1.70	090
64740		A	Incision of tongue nerve	6.12	NA	5.70	0.60	090
64742		A	Incision of facial nerve	6.75	NA	6.00	0.35	090
64744		A	Incise nerve, back of head	5.64	NA	5.78	1.53	090
64746		A	Incise diaphragm nerve	6.46	NA	5.09	1.15	090
64752		A	Incision of vagus nerve	7.59	NA	4.50	1.35	090
64755		A	Incision of stomach nerves	14.97	NA	7.80	2.42	090
64760		A	Incision of vagus nerve	7.49	NA	5.16	1.21	090
64761		A	Incision of pelvis nerve	6.94	NA	4.63	0.75	090
64763		A	Incise hip/thigh nerve	7.46	NA	5.06	1.21	090
64766		A	Incise hip/thigh nerve	9.34	NA	6.06	0.68	090
64771		A	Sever cranial nerve	8.02	NA	6.09	0.78	090
64772		A	Incision of spinal nerve	7.74	NA	6.42	1.36	090
64774		A	Remove skin nerve lesion	5.70	NA	4.73	0.77	090
64776		A	Remove digit nerve lesion	5.52	NA	4.40	0.63	090
64778		A	Digit nerve surgery add-on	3.11	NA	1.53	0.47	ZZZ
64782		A	Remove limb nerve lesion	6.76	NA	4.91	0.68	090
64783		A	Limb nerve surgery add-on	3.71	NA	2.10	0.35	ZZZ
64784		A	Remove nerve lesion	10.49	NA	7.87	1.51	090
64786		A	Remove sciatic nerve lesion	16.12	NA	10.80	2.41	090
64787		A	Implant nerve end	4.29	NA	1.96	0.52	ZZZ
64788		A	Remove skin nerve lesion	5.14	NA	4.68	0.80	090
64790		A	Removal of nerve lesion	11.97	NA	8.48	2.06	090
64792		A	Removal of nerve lesion	15.71	NA	11.78	4.27	090
64795		A	Biopsy of nerve	3.01	NA	1.81	0.55	000
64802		A	Remove sympathetic nerves	10.24	NA	7.13	0.62	090
64804		A	Remove sympathetic nerves	15.78	NA	4.18	0.95	090
64809		A	Remove sympathetic nerves	14.61	NA	3.80	0.88	090
64818		A	Remove sympathetic nerves	11.24	NA	5.47	1.65	090
64820		A	Remove sympathetic nerves	10.64	NA	8.42	1.43	090
64821		A	Remove sympathetic nerves	9.19	NA	7.85	1.38	090
64822		A	Remove sympathetic nerves	9.19	NA	7.85	1.38	090
64823		A	Remove sympathetic nerves	10.80	NA	8.64	1.62	090
64831		A	Repair of digit nerve	9.74	NA	8.45	1.23	090
64832		A	Repair nerve add-on	5.65	NA	3.01	0.75	ZZZ
64834		A	Repair of hand or foot nerve	10.71	NA	7.99	1.38	090
64835		A	Repair of hand or foot nerve	11.60	NA	8.58	1.74	090
64836		A	Repair of hand or foot nerve	11.60	NA	8.58	1.74	090
64837		A	Repair nerve add-on	6.25	NA	3.55	0.94	ZZZ
64840		A	Repair of leg nerve	13.87	NA	5.56	0.75	090
64856		A	Repair/transpose nerve	14.94	NA	10.63	2.14	090
64857		A	Repair arm/leg nerve	15.69	NA	11.06	2.17	090
64858		A	Repair sciatic nerve	17.69	NA	11.67	2.65	090
64859		A	Nerve surgery	4.25	NA	2.09	0.64	ZZZ

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
64861		A	Repair of arm nerves	20.74	NA	13.46	5.64	090
64862		A	Repair of low back nerves	20.94	NA	14.23	5.69	090
64864		A	Repair of facial nerve	13.31	NA	9.08	1.30	090
64865		A	Repair of facial nerve	15.96	NA	13.11	1.56	090
64866		A	Fusion of facial/other nerve	16.70	NA	16.31	1.63	090
64868		A	Fusion of facial/other nerve	14.80	NA	11.86	1.44	090
64870		A	Fusion of facial/other nerve	16.95	NA	10.21	3.01	090
64872		A	Subsequent repair of nerve	1.99	NA	1.13	0.19	ZZZ
64874		A	Repair & revise nerve add-on	2.98	NA	1.40	0.81	ZZZ
64876		A	Repair nerve/shorten bone	3.37	NA	2.01	0.50	ZZZ
64885		A	Nerve graft, head or neck	17.50	NA	11.20	1.71	090
64886		A	Nerve graft, head or neck	20.72	NA	12.76	2.02	090
64890		A	Nerve graft, hand or foot	16.11	NA	10.80	2.41	090
64891		A	Nerve graft, hand or foot	17.22	NA	11.44	2.58	090
64892		A	Nerve graft, arm or leg	15.61	NA	10.55	2.34	090
64893		A	Nerve graft, arm or leg	16.74	NA	11.20	1.21	090
64895		A	Nerve graft, hand or foot	20.26	NA	12.93	3.03	090
64896		A	Nerve graft, hand or foot	21.81	NA	15.48	5.93	090
64897		A	Nerve graft, arm or leg	19.25	NA	12.44	2.88	090
64898		A	Nerve graft, arm or leg	20.82	NA	13.50	3.12	090
64901		A	Nerve graft add-on	10.20	NA	6.09	1.53	ZZZ
64902		A	Nerve graft add-on	11.81	NA	7.05	1.77	ZZZ
64905		A	Nerve pedicle transfer	14.98	NA	11.47	2.24	090
64907		A	Nerve pedicle transfer	19.90	NA	9.17	1.07	090
64910		A	Nerve repair w/allograft	11.21	NA	9.64	1.47	090
64911		A	Neurorraphy w/vein autograft	14.21	NA	11.84	2.13	090
64999		C	Nervous system surgery	0.00	0.00	0.00	0.00	YYY
65091		A	Revise eye	7.13	NA	8.88	0.37	090
65093		A	Revise eye with implant	6.93	NA	8.90	0.38	090
65101		A	Removal of eye	8.10	NA	10.42	0.42	090
65103		A	Remove eye/insert implant	8.64	NA	10.71	0.46	090
65105		A	Remove eye/attach implant	9.70	NA	11.68	0.53	090
65110		A	Removal of eye	15.42	NA	15.38	1.00	090
65112		A	Remove eye/revise socket	18.18	NA	17.96	0.95	090
65114		A	Remove eye/revise socket	19.32	NA	18.64	1.00	090
65125		A	Revise ocular implant	3.18	7.97	4.15	0.17	090
65130		A	Insert ocular implant	8.22	NA	10.17	0.43	090
65135		A	Insert ocular implant	8.40	NA	10.28	0.44	090
65140		A	Attach ocular implant	9.23	NA	11.09	0.48	090
65150		A	Revise ocular implant	6.32	NA	8.22	0.33	090
65155		A	Reinsert ocular implant	9.87	NA	11.47	0.51	090
65175		A	Removal of ocular implant	7.22	NA	9.23	0.38	090
65205		A	Remove foreign body from eye	0.71	0.72	0.44	0.04	000
65210		A	Remove foreign body from eye	0.84	0.93	0.57	0.04	000
65220		A	Remove foreign body from eye	0.71	0.76	0.39	0.05	000
65222		A	Remove foreign body from eye	0.93	1.02	0.61	0.04	000
65235		A	Remove foreign body from eye	8.78	NA	9.21	0.46	090
65260		A	Remove foreign body from eye	12.29	NA	12.14	0.64	090
65265		A	Remove foreign body from eye	14.06	NA	13.49	0.74	090
65270		A	Repair of eye wound	1.92	4.62	1.70	0.09	010
65272		A	Repair of eye wound	4.49	7.92	4.42	0.23	090
65273		A	Repair of eye wound	5.03	NA	4.68	0.26	090
65275		A	Repair of eye wound	6.14	8.36	5.66	0.32	090
65280		A	Repair of eye wound	8.87	NA	8.23	0.47	090
65285		A	Repair of eye wound	14.43	NA	12.15	0.75	090
65286		A	Repair of eye wound	6.45	10.98	6.15	0.34	090
65290		A	Repair of eye socket wound	6.35	NA	6.11	0.33	090
65400		A	Removal of eye lesion	7.27	9.71	7.93	0.38	090
65410		A	Biopsy of cornea	1.47	2.13	1.24	0.07	000
65420		A	Removal of eye lesion	4.24	8.47	5.25	0.22	090
65426		A	Removal of eye lesion	5.93	10.27	6.24	0.31	090
65430		A	Corneal smear	1.47	1.48	1.22	0.07	000
65435		A	Curette/treat cornea	0.92	1.12	0.88	0.04	000
65436		A	Curette/treat cornea	4.72	5.11	4.74	0.25	090
65450		A	Treatment of corneal lesion	3.35	4.74	4.66	0.18	090
65600		A	Revision of cornea	4.07	5.74	4.58	0.22	090
65710		A	Corneal transplant	14.09	NA	14.06	0.73	090
65730		A	Corneal transplant	15.99	NA	15.35	0.83	090
65750		A	Corneal transplant	16.60	NA	15.07	0.86	090
65755		A	Corneal transplant	16.49	NA	15.00	0.86	090
65756		A	Corneal trnspl, endothelial	16.60	NA	13.96	0.89	090
65757		C	Prep corneal endo allograft	0.00	NA	0.00	0.00	ZZZ
65770		A	Revise cornea with implant	19.41	NA	16.73	1.03	090
65772		A	Correction of astigmatism	4.96	6.36	5.33	0.26	090
65775		A	Correction of astigmatism	6.73	NA	7.22	0.35	090
65780		A	Ocular reconst, transplant	10.43	NA	11.92	0.55	090
65781		A	Ocular reconst, transplant	17.84	NA	16.41	0.93	090
65782		A	Ocular reconst, transplant	15.16	NA	14.34	0.80	090
65800		A	Drainage of eye	1.91	1.92	1.51	0.09	000
65805		A	Drainage of eye	1.91	2.26	1.51	0.09	000
65810		A	Drainage of eye	5.67	NA	6.29	0.30	090
65815		A	Drainage of eye	5.85	9.96	6.24	0.31	090
65820		A	Relieve inner eye pressure	8.72	NA	10.22	0.45	090
65850		A	Incision of eye	11.24	NA	10.34	0.59	090

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
65855		A	Laser surgery of eye	3.90	4.65	3.69	0.18	010
65860		A	Incise inner eye adhesions	3.56	4.32	3.01	0.19	090
65865		A	Incise inner eye adhesions	5.66	NA	6.34	0.29	090
65870		A	Incise inner eye adhesions	7.21	NA	7.75	0.38	090
65875		A	Incise inner eye adhesions	7.61	NA	8.32	0.40	090
65880		A	Incise inner eye adhesions	8.16	NA	8.63	0.42	090
65900		A	Remove eye lesion	12.26	NA	12.32	0.64	090
65920		A	Remove implant of eye	9.74	NA	10.22	0.51	090
65930		A	Remove blood clot from eye	8.24	NA	8.03	0.43	090
66020		A	Injection treatment of eye	1.61	3.01	1.73	0.07	010
66030		A	Injection treatment of eye	1.27	2.80	1.53	0.06	010
66130		A	Remove eye lesion	7.74	9.89	6.94	0.40	090
66150		A	Glaucoma surgery	10.18	NA	11.82	0.53	090
66155		A	Glaucoma surgery	10.17	NA	11.81	0.53	090
66160		A	Glaucoma surgery	12.04	NA	12.92	0.63	090
66165		A	Glaucoma surgery	9.89	NA	11.65	0.51	090
66170		A	Glaucoma surgery	14.57	NA	15.71	0.76	090
66172		A	Incision of eye	18.26	NA	19.88	0.95	090
66180		A	Implant eye shunt	16.02	NA	13.91	0.83	090
66185		A	Revise eye shunt	9.35	NA	9.68	0.49	090
66220		A	Repair eye lesion	8.98	NA	9.85	0.47	090
66225		A	Repair/graft eye lesion	12.38	NA	11.48	0.65	090
66250		A	Follow-up surgery of eye	6.92	11.64	7.20	0.36	090
66500		A	Incision of iris	3.75	NA	5.14	0.20	090
66505		A	Incision of iris	4.13	NA	5.61	0.21	090
66600		A	Remove iris and lesion	9.89	NA	11.17	0.51	090
66605		A	Removal of iris	13.99	NA	13.13	0.73	090
66625		A	Removal of iris	5.19	NA	5.70	0.27	090
66630		A	Removal of iris	7.10	NA	7.35	0.37	090
66635		A	Removal of iris	7.19	NA	7.40	0.37	090
66680		A	Repair iris & ciliary body	6.24	NA	6.85	0.33	090
66682		A	Repair iris & ciliary body	7.15	NA	8.87	0.37	090
66700		A	Destruction, ciliary body	5.06	6.34	5.01	0.26	090
66710		A	Ciliary transscleral therapy	5.06	6.11	5.00	0.27	090
66711		A	Ciliary endoscopic ablation	7.70	NA	8.53	0.40	090
66720		A	Destruction, ciliary body	4.86	6.91	5.72	0.28	090
66740		A	Destruction, ciliary body	5.06	6.04	5.01	0.26	090
66761		A	Revision of iris	4.87	6.54	5.62	0.25	090
66762		A	Revision of iris	5.25	6.71	5.56	0.27	090
66770		A	Removal of inner eye lesion	5.98	7.34	6.29	0.31	090
66820		A	Incision, secondary cataract	3.93	NA	5.92	0.20	090
66821		A	After cataract laser surgery	3.32	4.91	4.46	0.17	090
66825		A	Reposition intraocular lens	8.82	NA	10.36	0.46	090
66830		A	Removal of lens lesion	9.27	NA	8.93	0.48	090
66840		A	Removal of lens material	8.98	NA	8.77	0.47	090
66850		A	Removal of lens material	10.32	NA	9.90	0.54	090
66852		A	Removal of lens material	11.18	NA	10.41	0.58	090
66920		A	Extraction of lens	9.93	NA	9.36	0.52	090
66930		A	Extraction of lens	11.38	NA	10.52	0.59	090
66940		A	Extraction of lens	10.14	NA	9.80	0.53	090
66982		A	Cataract surgery, complex	14.83	NA	12.41	0.77	090
66983		A	Cataract surg w/iol, 1 stage	10.20	NA	8.82	0.53	090
66984		A	Cataract surg w/iol, 1 stage	10.36	NA	9.19	0.54	090
66985		A	Insert lens prosthesis	9.73	NA	9.83	0.51	090
66986		A	Exchange lens prosthesis	12.26	NA	11.36	0.64	090
66990		A	Ophthalmic endoscope add-on	1.51	NA	0.90	0.07	ZZZ
66999		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY
67005		A	Partial removal of eye fluid	5.77	NA	6.22	0.30	090
67010		A	Partial removal of eye fluid	6.94	NA	6.91	0.36	090
67015		A	Release of eye fluid	7.00	NA	7.71	0.37	090
67025		A	Replace eye fluid	7.91	10.29	8.12	0.41	090
67027		A	Implant eye drug system	11.43	NA	10.42	0.60	090
67028		A	Injection eye drug	2.52	2.89	1.87	0.12	000
67030		A	Incise inner eye strands	5.91	NA	7.41	0.31	090
67031		A	Laser surgery, eye strands	4.34	5.41	4.66	0.23	090
67036		A	Removal of inner eye fluid	13.09	NA	11.54	0.68	090
67039		A	Laser treatment of retina	16.39	NA	15.15	0.85	090
67040		A	Laser treatment of retina	19.23	NA	17.13	1.00	090
67041		A	Vit for macular packer	19.00	NA	15.27	0.99	090
67042		A	Vit for macular hole	22.13	NA	17.14	1.15	090
67043		A	Vit for membrane dissect	22.94	NA	18.28	1.20	090
67101		A	Repair detached retina	8.60	11.13	8.55	0.45	090
67105		A	Repair detached retina	8.35	9.89	8.08	0.43	090
67107		A	Repair detached retina	16.35	NA	14.73	0.85	090
67108		A	Repair detached retina	22.49	NA	18.83	1.17	090
67110		A	Repair detached retina	10.02	11.90	9.71	0.52	090
67112		A	Rerepair detached retina	18.45	NA	15.68	0.96	090
67113		A	Repair retinal detach, cplx	25.00	NA	20.10	1.30	090
67115		A	Release encircling material	5.93	NA	6.66	0.31	090
67120		A	Remove eye implant material	6.92	9.52	7.21	0.36	090
67121		A	Remove eye implant material	12.00	NA	11.22	0.63	090
67141		A	Treatment of retina	6.00	7.21	6.36	0.31	090
67145		A	Treatment of retina	6.17	7.16	6.46	0.32	090
67208		A	Treatment of retinal lesion	7.50	7.76	7.26	0.39	090

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
67210		A	Treatment of retinal lesion	9.35	8.42	7.89	0.49	090
67218		A	Treatment of retinal lesion	20.22	NA	15.82	1.05	090
67220		A	Treatment of choroid lesion	14.19	13.05	11.87	0.74	090
67221		R	Ocular photodynamic ther	3.45	3.92	2.21	0.16	000
67225		A	Eye photodynamic ther add-on	0.47	0.32	0.28	0.02	ZZZ
67227		A	Treatment of retinal lesion	7.38	8.13	7.19	0.38	090
67228		A	Treatment of retinal lesion	13.67	17.81	14.03	0.71	090
67229		A	Tr retinal les preterm inf	16.00	NA	13.50	0.83	090
67250		A	Reinforce eye wall	9.46	NA	10.40	0.49	090
67255		A	Reinforce/graft eye wall	9.97	NA	11.33	0.52	090
67299		C	Eye surgery procedure	0.00	0.00	0.00	0.00	YYY
67311		A	Revise eye muscle	7.59	NA	7.61	0.40	090
67312		A	Revise two eye muscles	9.48	NA	8.75	0.50	090
67314		A	Revise eye muscle	8.59	NA	8.53	0.45	090
67316		A	Revise two eye muscles	10.73	NA	9.73	0.57	090
67318		A	Revise eye muscle(s)	8.92	NA	9.04	0.46	090
67320		A	Revise eye muscle(s) add-on	5.40	NA	3.19	0.25	ZZZ
67331		A	Eye surgery follow-up add-on	5.13	NA	3.01	0.24	ZZZ
67332		A	Rerevise eye muscles add-on	5.56	NA	3.29	0.26	ZZZ
67334		A	Revise eye muscle w/suture	5.05	NA	3.00	0.23	ZZZ
67335		A	Eye suture during surgery	2.49	NA	1.47	0.12	ZZZ
67340		A	Revise eye muscle add-on	6.00	NA	3.56	0.28	ZZZ
67343		A	Release eye tissue	8.29	NA	8.30	0.45	090
67345		A	Destroy nerve of eye muscle	2.98	2.95	2.41	0.17	010
67346		A	Biopsy, eye muscle	2.87	NA	2.38	0.13	000
67399		C	Eye muscle surgery procedure	0.00	0.00	0.00	0.00	YYY
67400		A	Explore/biopsy eye socket	10.97	NA	12.56	0.63	090
67405		A	Explore/drain eye socket	9.00	NA	10.95	0.52	090
67412		A	Explore/treat eye socket	10.17	NA	11.46	0.58	090
67413		A	Explore/treat eye socket	10.09	NA	11.63	0.61	090
67414		A	Explr/decompress eye socket	17.78	NA	16.38	0.95	090
67415		A	Aspiration, orbital contents	1.76	NA	1.04	0.08	000
67420		A	Explore/treat eye socket	21.62	NA	19.81	1.25	090
67430		A	Explore/treat eye socket	14.99	NA	16.62	0.78	090
67440		A	Explore/drain eye socket	14.56	NA	16.04	0.76	090
67445		A	Explr/decompress eye socket	18.96	NA	17.13	1.05	090
67450		A	Explore/biopsy eye socket	15.11	NA	16.69	0.79	090
67500		A	Inject/treat eye socket	1.44	0.85	0.68	0.08	000
67505		A	Inject/treat eye socket	1.27	1.06	0.88	0.06	000
67515		A	Inject/treat eye socket	1.40	1.14	0.96	0.06	000
67550		A	Insert eye socket implant	11.52	NA	12.90	0.83	090
67560		A	Revise eye socket implant	11.93	NA	13.05	0.73	090
67570		A	Decompress optic nerve	14.21	NA	14.83	0.74	090
67599		C	Orbit surgery procedure	0.00	0.00	0.00	0.00	YYY
67700		A	Drainage of eyelid abscess	1.37	5.06	1.55	0.07	010
67710		A	Incision of eyelid	1.04	4.32	1.40	0.05	010
67715		A	Incision of eyelid fold	1.24	4.45	1.50	0.07	010
67800		A	Remove eyelid lesion	1.39	1.82	1.27	0.07	010
67801		A	Remove eyelid lesions	1.89	2.24	1.57	0.09	010
67805		A	Remove eyelid lesions	2.24	2.87	2.01	0.11	010
67808		A	Remove eyelid lesion(s)	4.47	NA	4.82	0.26	090
67810		A	Biopsy of eyelid	1.48	3.84	0.88	0.08	000
67820		A	Revise eyelashes	0.71	0.60	0.68	0.03	000
67825		A	Revise eyelashes	1.40	1.82	1.67	0.07	010
67830		A	Revise eyelashes	1.72	4.76	1.79	0.08	010
67835		A	Revise eyelashes	5.61	NA	5.62	0.29	090
67840		A	Remove eyelid lesion	2.06	4.70	2.00	0.10	010
67850		A	Treat eyelid lesion	1.71	3.60	1.75	0.09	010
67875		A	Closure of eyelid by suture	1.35	2.90	1.18	0.07	000
67880		A	Revision of eyelid	4.47	6.90	4.83	0.25	090
67882		A	Revision of eyelid	5.87	8.22	6.10	0.32	090
67900		A	Repair brow defect	6.69	9.36	6.31	0.44	090
67901		A	Repair eyelid defect	7.47	11.36	7.27	0.42	090
67902		A	Repair eyelid defect	9.68	NA	8.85	0.63	090
67903		A	Repair eyelid defect	6.42	8.53	6.00	0.37	090
67904		A	Repair eyelid defect	7.83	10.57	7.46	0.46	090
67906		A	Repair eyelid defect	6.84	NA	6.25	0.36	090
67908		A	Repair eyelid defect	5.19	7.19	5.60	0.28	090
67909		A	Revise eyelid defect	5.46	7.93	5.68	0.35	090
67911		A	Revise eyelid defect	7.38	NA	7.02	0.42	090
67912		A	Correction eyelid w/implant	6.23	15.41	6.25	0.45	090
67914		A	Repair eyelid defect	3.70	5.97	3.67	0.22	090
67915		A	Repair eyelid defect	3.21	5.38	3.26	0.21	090
67916		A	Repair eyelid defect	5.37	8.07	5.61	0.31	090
67917		A	Repair eyelid defect	6.08	8.61	6.04	0.36	090
67921		A	Repair eyelid defect	3.42	5.80	3.51	0.18	090
67922		A	Repair eyelid defect	3.09	5.22	3.15	0.22	090
67923		A	Repair eyelid defect	5.94	8.31	5.96	0.33	090
67924		A	Repair eyelid defect	5.84	8.82	5.65	0.32	090
67930		A	Repair eyelid wound	3.62	5.55	2.66	0.20	010
67935		A	Repair eyelid wound	6.27	8.64	5.13	0.39	090
67938		A	Remove eyelid foreign body	1.35	4.53	1.58	0.07	010
67950		A	Revision of eyelid	5.88	8.45	5.93	0.37	090
67961		A	Revision of eyelid	5.75	8.64	5.85	0.34	090

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
67966		A	Revision of eyelid	8.83	10.61	8.05	0.52	090
67971		A	Reconstruction of eyelid	9.87	NA	8.76	0.54	090
67973		A	Reconstruction of eyelid	12.96	NA	11.10	0.75	090
67974		A	Reconstruction of eyelid	12.93	NA	11.06	0.70	090
67975		A	Reconstruction of eyelid	9.21	NA	8.39	0.54	090
67999		C	Revision of eyelid	0.00	0.00	0.00	0.00	YYY
68020		A	Incise/drain eyelid lining	1.39	1.62	1.41	0.06	010
68040		A	Treatment of eyelid lesions	0.85	0.82	0.54	0.04	000
68100		A	Biopsy of eyelid lining	1.35	2.85	1.20	0.07	000
68110		A	Remove eyelid lining lesion	1.79	3.76	1.99	0.08	010
68115		A	Remove eyelid lining lesion	2.38	5.28	2.34	0.11	010
68130		A	Remove eyelid lining lesion	4.99	8.39	5.47	0.26	090
68135		A	Remove eyelid lining lesion	1.86	2.12	1.99	0.09	010
68200		A	Treat eyelid by injection	0.49	0.59	0.42	0.02	000
68320		A	Revise/graft eyelid lining	6.44	11.45	7.16	0.36	090
68325		A	Revise/graft eyelid lining	8.43	NA	8.31	0.49	090
68326		A	Revise/graft eyelid lining	8.22	NA	8.19	0.44	090
68328		A	Revise/graft eyelid lining	9.25	NA	8.86	0.61	090
68330		A	Revise eyelid lining	5.63	9.37	6.05	0.32	090
68335		A	Revise/graft eyelid lining	8.26	NA	8.24	0.45	090
68340		A	Separate eyelid adhesions	4.84	8.62	5.27	0.25	090
68360		A	Revise eyelid lining	5.04	8.14	5.38	0.28	090
68362		A	Revise eyelid lining	8.41	NA	8.27	0.44	090
68371		A	Harvest eye tissue, alograft	4.97	NA	5.50	0.23	010
68399		C	Eyelid lining surgery	0.00	0.00	0.00	0.00	YYY
68400		A	Incise/drain tear gland	1.71	5.17	1.66	0.08	010
68420		A	Incise/drain tear sac	2.32	5.54	2.02	0.12	010
68440		A	Incise tear duct opening	0.96	1.57	1.50	0.05	010
68500		A	Removal of tear gland	12.49	NA	12.36	0.65	090
68505		A	Partial removal, tear gland	12.41	NA	12.31	0.65	090
68510		A	Biopsy of tear gland	4.60	6.65	3.11	0.23	000
68520		A	Removal of tear sac	8.58	NA	8.87	0.50	090
68525		A	Biopsy of tear sac	4.42	NA	2.62	0.22	000
68530		A	Clearance of tear duct	3.67	6.93	3.01	0.18	010
68540		A	Remove tear gland lesion	11.93	NA	11.77	0.62	090
68550		A	Remove tear gland lesion	14.86	NA	12.39	1.45	090
68700		A	Repair tear ducts	7.67	NA	7.68	0.43	090
68705		A	Revise tear duct opening	2.08	3.78	2.17	0.10	010
68720		A	Create tear sac drain	9.78	NA	9.51	0.56	090
68745		A	Create tear duct drain	9.70	NA	9.68	0.50	090
68750		A	Create tear duct drain	9.87	NA	10.13	0.58	090
68760		A	Close tear duct opening	1.75	3.22	1.96	0.08	010

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68761		A	Close tear duct opening	1.38	2.29	1.63	0.06	010
68770		A	Close tear system fistula	8.09	NA	7.92	0.42	090
68801		A	Dilate tear duct opening	0.96	2.13	1.73	0.05	010
68810		A	Probe nasolacrimal duct	2.09	3.88	2.61	0.10	010
68811		A	Probe nasolacrimal duct	2.39	NA	2.82	0.12	010
68815		A	Probe nasolacrimal duct	3.24	7.75	3.32	0.16	010
68816		A	Probe nl duct w/balloon	3.00	14.79	3.38	0.16	010
68840		A	Explore/irrigate tear ducts	1.27	1.92	1.66	0.06	010
68850		A	Injection for tear sac x-ray	0.80	0.77	0.65	0.05	000
68899		C	Tear duct system surgery	0.00	0.00	0.00	0.00	YYY
69000		A	Drain external ear lesion	1.47	3.21	1.58	0.10	010
69005		A	Drain external ear lesion	2.13	3.33	1.92	0.15	010
69020		A	Drain outer ear canal lesion	1.50	4.43	2.17	0.10	010
69100		A	Biopsy of external ear	0.81	1.72	0.48	0.05	000
69105		A	Biopsy of external ear canal	0.85	2.73	0.82	0.05	000
69110		A	Remove external ear, partial	3.47	8.04	4.79	0.40	090
69120		A	Removal of external ear	4.08	NA	6.25	0.43	090
69140		A	Remove ear canal lesion(s)	8.03	NA	14.42	0.78	090
69145		A	Remove ear canal lesion(s)	2.65	7.41	3.76	0.26	090
69150		A	Extensive ear canal surgery	13.49	NA	13.51	1.47	090
69155		A	Extensive ear/neck surgery	23.06	NA	20.32	2.25	090
69200		A	Clear outer ear canal	0.77	2.37	0.73	0.05	000
69205		A	Clear outer ear canal	1.20	NA	1.42	0.08	010
69210		A	Remove impacted ear wax	0.61	0.71	0.26	0.04	000
69220		A	Clean out mastoid cavity	0.83	2.69	0.80	0.05	000
69222		A	Clean out mastoid cavity	1.42	4.17	2.10	0.09	010
69300		R	Revise external ear	6.69	11.19	5.81	0.44	YYY
69310		A	Rebuild outer ear canal	10.85	NA	16.99	1.07	090
69320		A	Rebuild outer ear canal	17.03	NA	22.47	1.66	090
69399		C	Outer ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69400		A	Inflate middle ear canal	0.83	2.94	0.80	0.05	000
69401		A	Inflate middle ear canal	0.63	1.60	0.66	0.04	000
69405		A	Catheterize middle ear canal	2.65	4.08	2.36	0.17	010
69420		A	Incision of eardrum	1.35	3.52	1.75	0.09	010
69421		A	Incision of eardrum	1.75	NA	2.10	0.11	010
69424		A	Remove ventilating tube	0.85	2.44	0.79	0.06	000
69433		A	Create eardrum opening	1.54	3.54	1.81	0.10	010
69436		A	Create eardrum opening	1.98	NA	2.18	0.13	010
69440		A	Exploration of middle ear	7.62	NA	10.20	0.74	090
69450		A	Eardrum revision	5.61	NA	8.42	0.55	090
69501		A	Mastoidectomy	9.12	NA	9.91	0.89	090
69502		A	Mastoidectomy	12.44	NA	12.71	1.27	090

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69505		A	Remove mastoid structures	13.05	NA	17.99	1.27	090
69511		A	Extensive mastoid surgery	13.58	NA	18.28	1.32	090
69530		A	Extensive mastoid surgery	20.24	NA	22.70	1.97	090
69535		A	Remove part of temporal bone	37.27	NA	32.17	3.95	090
69540		A	Remove ear lesion	1.22	4.08	2.03	0.08	010
69550		A	Remove ear lesion	11.04	NA	15.81	1.08	090
69552		A	Remove ear lesion	19.69	NA	21.15	1.92	090
69554		A	Remove ear lesion	35.71	NA	28.81	3.48	090
69601		A	Mastoid surgery revision	13.31	NA	13.92	1.30	090
69602		A	Mastoid surgery revision	13.64	NA	14.70	1.33	090
69603		A	Mastoid surgery revision	14.08	NA	18.51	1.37	090
69604		A	Mastoid surgery revision	14.08	NA	14.90	1.37	090
69605		A	Mastoid surgery revision	18.55	NA	21.91	1.81	090
69610		A	Repair of eardrum	4.44	5.54	3.21	0.29	010
69620		A	Repair of eardrum	5.94	11.75	6.67	0.58	090
69631		A	Repair eardrum structures	9.93	NA	12.93	0.97	090
69632		A	Rebuild eardrum structures	12.82	NA	15.13	1.25	090
69633		A	Rebuild eardrum structures	12.17	NA	14.83	1.20	090
69635		A	Repair eardrum structures	13.39	NA	18.06	1.32	090
69636		A	Rebuild eardrum structures	15.29	NA	20.38	1.49	090
69637		A	Rebuild eardrum structures	15.18	NA	20.18	1.49	090
69641		A	Revise middle ear & mastoid	12.77	NA	14.27	1.26	090
69642		A	Revise middle ear & mastoid	16.91	NA	17.90	1.65	090
69643		A	Revise middle ear & mastoid	15.45	NA	16.36	1.52	090
69644		A	Revise middle ear & mastoid	17.09	NA	21.19	1.68	090
69645		A	Revise middle ear & mastoid	16.57	NA	20.97	1.63	090
69646		A	Revise middle ear & mastoid	18.23	NA	21.77	1.78	090
69650		A	Release middle ear bone	9.71	NA	11.18	0.95	090
69660		A	Revise middle ear bone	11.94	NA	12.20	1.17	090
69661		A	Revise middle ear bone	15.80	NA	15.59	1.51	090
69662		A	Revise middle ear bone	15.49	NA	14.67	1.52	090
69666		A	Repair middle ear structures	9.80	NA	11.17	0.96	090
69667		A	Repair middle ear structures	9.81	NA	11.17	0.96	090
69670		A	Remove mastoid air cells	11.62	NA	12.92	1.13	090
69676		A	Remove middle ear nerve	9.58	NA	11.96	0.93	090
69700		A	Close mastoid fistula	8.28	NA	9.52	0.81	090
69711		A	Remove/repair hearing aid	10.50	NA	11.89	1.02	090
69714		A	Implant temple bone w/stimul	14.31	NA	13.71	1.40	090
69715		A	Temple bne implnt w/stimulat	18.80	NA	15.98	1.83	090
69717		A	Temple bone implant revision	15.29	NA	14.20	1.49	090
69718		A	Revise temple bone implant	19.05	NA	16.10	1.86	090
69720		A	Release facial nerve	14.57	NA	15.95	1.59	090

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
69725		A	Release facial nerve	27.44	NA	21.90	2.68	090
69740		A	Repair facial nerve	16.18	NA	14.41	1.58	090
69745		A	Repair facial nerve	16.91	NA	15.59	1.65	090
69799		C	Middle ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69801		A	Incise inner ear	8.61	NA	10.85	0.84	090
69802		A	Incise inner ear	13.39	NA	13.75	1.31	090
69805		A	Explore inner ear	14.55	NA	12.97	1.42	090
69806		A	Explore inner ear	12.52	NA	12.13	1.22	090
69820		A	Establish inner ear window	10.40	NA	11.84	1.01	090
69840		A	Revise inner ear window	10.32	NA	14.44	0.54	090
69905		A	Remove inner ear	11.15	NA	12.70	1.09	090
69910		A	Remove inner ear & mastoid	13.80	NA	12.78	1.36	090
69915		A	Incise inner ear nerve	22.65	NA	14.35	2.23	090
69930		A	Implant cochlear device	17.60	NA	14.43	1.72	090
69949		C	Inner ear surgery procedure	0.00	0.00	0.00	0.00	YYY
69950		A	Incise inner ear nerve	27.44	NA	19.46	2.68	090
69955		A	Release facial nerve	29.22	NA	22.75	2.85	090
69960		A	Release inner ear canal	29.22	NA	21.40	2.85	090
69970		A	Remove inner ear lesion	32.21	NA	24.14	3.14	090
69979		C	Temporal bone surgery	0.00	0.00	0.00	0.00	YYY
69990		R	Microsurgery add-on	3.46	NA	1.62	0.85	ZZZ
70010		A	Contrast x-ray of brain	1.19	2.48	NA	0.18	XXX
70010	TC	A	Contrast x-ray of brain	0.00	2.12	NA	0.00	XXX
70010	26	A	Contrast x-ray of brain	1.19	0.36	0.36	0.17	XXX
70015		A	Contrast x-ray of brain	1.19	2.64	NA	0.09	XXX
70015	TC	A	Contrast x-ray of brain	0.00	2.26	NA	0.00	XXX
70015	26	A	Contrast x-ray of brain	1.19	0.38	0.38	0.08	XXX
70030		A	X-ray eye for foreign body	0.17	0.54	NA	0.01	XXX
70030	TC	A	X-ray eye for foreign body	0.00	0.49	NA	0.00	XXX
70030	26	A	X-ray eye for foreign body	0.17	0.05	0.05	0.01	XXX
70100		A	X-ray exam of jaw	0.18	0.59	NA	0.01	XXX
70100	TC	A	X-ray exam of jaw	0.00	0.54	NA	0.00	XXX
70100	26	A	X-ray exam of jaw	0.18	0.05	0.05	0.01	XXX
70110		A	X-ray exam of jaw	0.25	0.72	NA	0.02	XXX
70110	TC	A	X-ray exam of jaw	0.00	0.64	NA	0.00	XXX
70110	26	A	X-ray exam of jaw	0.25	0.08	0.08	0.01	XXX
70120		A	X-ray exam of mastoids	0.18	0.76	NA	0.01	XXX
70120	TC	A	X-ray exam of mastoids	0.00	0.69	NA	0.00	XXX
70120	26	A	X-ray exam of mastoids	0.18	0.07	0.07	0.01	XXX
70130		A	X-ray exam of mastoids	0.34	1.08	NA	0.02	XXX
70130	TC	A	X-ray exam of mastoids	0.00	0.97	NA	0.00	XXX
70130	26	A	X-ray exam of mastoids	0.34	0.11	0.11	0.02	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70134		A	X-ray exam of middle ear	0.34	0.81	NA	0.02	XXX
70134	TC	A	X-ray exam of middle ear	0.00	0.70	NA	0.00	XXX
70134	26	A	X-ray exam of middle ear	0.34	0.10	0.10	0.02	XXX
70140		A	X-ray exam of facial bones	0.19	0.49	NA	0.01	XXX
70140	TC	A	X-ray exam of facial bones	0.00	0.44	NA	0.00	XXX
70140	26	A	X-ray exam of facial bones	0.19	0.05	0.05	0.01	XXX
70150		A	X-ray exam of facial bones	0.26	0.76	NA	0.02	XXX
70150	TC	A	X-ray exam of facial bones	0.00	0.69	NA	0.00	XXX
70150	26	A	X-ray exam of facial bones	0.26	0.07	0.07	0.02	XXX
70160		A	X-ray exam of nasal bones	0.17	0.63	NA	0.01	XXX
70160	TC	A	X-ray exam of nasal bones	0.00	0.58	NA	0.00	XXX
70160	26	A	X-ray exam of nasal bones	0.17	0.05	0.05	0.01	XXX
70170		C	X-ray exam of tear duct	0.00	NA	NA	0.00	XXX
70170	TC	C	X-ray exam of tear duct	0.00	NA	NA	0.00	XXX
70170	26	A	X-ray exam of tear duct	0.30	0.09	0.09	0.02	XXX
70190		A	X-ray exam of eye sockets	0.21	0.64	NA	0.02	XXX
70190	TC	A	X-ray exam of eye sockets	0.00	0.58	NA	0.00	XXX
70190	26	A	X-ray exam of eye sockets	0.21	0.06	0.06	0.02	XXX
70200		A	X-ray exam of eye sockets	0.28	0.78	NA	0.02	XXX
70200	TC	A	X-ray exam of eye sockets	0.00	0.70	NA	0.00	XXX
70200	26	A	X-ray exam of eye sockets	0.28	0.08	0.08	0.02	XXX
70210		A	X-ray exam of sinuses	0.17	0.60	NA	0.01	XXX
70210	TC	A	X-ray exam of sinuses	0.00	0.54	NA	0.00	XXX
70210	26	A	X-ray exam of sinuses	0.17	0.06	0.06	0.01	XXX
70220		A	X-ray exam of sinuses	0.25	0.72	NA	0.01	XXX
70220	TC	A	X-ray exam of sinuses	0.00	0.63	NA	0.00	XXX
70220	26	A	X-ray exam of sinuses	0.25	0.08	0.08	0.01	XXX
70240		A	X-ray exam, pituitary saddle	0.19	0.53	NA	0.01	XXX
70240	TC	A	X-ray exam, pituitary saddle	0.00	0.47	NA	0.00	XXX
70240	26	A	X-ray exam, pituitary saddle	0.19	0.06	0.06	0.01	XXX
70250		A	X-ray exam of skull	0.24	0.62	NA	0.02	XXX
70250	TC	A	X-ray exam of skull	0.00	0.56	NA	0.00	XXX
70250	26	A	X-ray exam of skull	0.24	0.06	0.06	0.02	XXX
70260		A	X-ray exam of skull	0.34	0.78	NA	0.02	XXX
70260	TC	A	X-ray exam of skull	0.00	0.69	NA	0.00	XXX
70260	26	A	X-ray exam of skull	0.34	0.09	0.09	0.02	XXX
70300		A	X-ray exam of teeth	0.10	0.24	NA	0.00	XXX
70300	TC	A	X-ray exam of teeth	0.00	0.19	NA	0.00	XXX
70300	26	A	X-ray exam of teeth	0.10	0.05	0.05	0.00	XXX
70310		A	X-ray exam of teeth	0.16	0.81	NA	0.00	XXX
70310	TC	A	X-ray exam of teeth	0.00	0.72	NA	0.00	XXX
70310	26	A	X-ray exam of teeth	0.16	0.09	0.09	0.00	XXX
70320		A	Full mouth x-ray of teeth	0.22	1.03	NA	0.01	XXX
70320	TC	A	Full mouth x-ray of teeth	0.00	0.93	NA	0.00	XXX
70320	26	A	Full mouth x-ray of teeth	0.22	0.10	0.10	0.01	XXX
70328		A	X-ray exam of jaw joint	0.18	0.59	NA	0.01	XXX
70328	TC	A	X-ray exam of jaw joint	0.00	0.53	NA	0.00	XXX
70328	26	A	X-ray exam of jaw joint	0.18	0.06	0.06	0.01	XXX
70330		A	X-ray exam of jaw joints	0.24	0.95	NA	0.01	XXX
70330	TC	A	X-ray exam of jaw joints	0.00	0.86	NA	0.00	XXX
70330	26	A	X-ray exam of jaw joints	0.24	0.09	0.09	0.01	XXX
70332		A	X-ray exam of jaw joint	0.54	1.44	NA	0.01	XXX
70332	TC	A	X-ray exam of jaw joint	0.00	1.24	NA	0.00	XXX
70332	26	A	X-ray exam of jaw joint	0.54	0.20	0.20	0.01	XXX
70336		A	Magnetic image, jaw joint	1.48	6.64	NA	0.11	XXX
70336	TC	A	Magnetic image, jaw joint	0.00	6.19	NA	0.00	XXX
70336	26	A	Magnetic image, jaw joint	1.48	0.45	0.45	0.10	XXX
70350		A	X-ray head for orthodontia	0.17	0.36	NA	0.00	XXX
70350	TC	A	X-ray head for orthodontia	0.00	0.26	NA	0.00	XXX
70350	26	A	X-ray head for orthodontia	0.17	0.09	0.09	0.00	XXX
70355		A	Panoramic x-ray of jaws	0.20	0.30	NA	0.01	XXX
70355	TC	A	Panoramic x-ray of jaws	0.00	0.21	NA	0.00	XXX
70355	26	A	Panoramic x-ray of jaws	0.20	0.09	0.09	0.01	XXX
70360		A	X-ray exam of neck	0.17	0.52	NA	0.01	XXX
70360	TC	A	X-ray exam of neck	0.00	0.46	NA	0.00	XXX
70360	26	A	X-ray exam of neck	0.17	0.05	0.05	0.01	XXX
70370		A	Throat x-ray & fluoroscopy	0.32	1.80	NA	0.02	XXX
70370	TC	A	Throat x-ray & fluoroscopy	0.00	1.69	NA	0.00	XXX
70370	26	A	Throat x-ray & fluoroscopy	0.32	0.11	0.11	0.02	XXX
70371		A	Speech evaluation, complex	0.84	1.51	NA	0.04	XXX
70371	TC	A	Speech evaluation, complex	0.00	1.21	NA	0.00	XXX
70371	26	A	Speech evaluation, complex	0.84	0.30	0.30	0.04	XXX
70373		A	Contrast x-ray of larynx	0.44	1.67	NA	0.02	XXX
70373	TC	A	Contrast x-ray of larynx	0.00	1.52	NA	0.00	XXX
70373	26	A	Contrast x-ray of larynx	0.44	0.16	0.16	0.02	XXX
70380		A	X-ray exam of salivary gland	0.17	0.79	NA	0.01	XXX
70380	TC	A	X-ray exam of salivary gland	0.00	0.71	NA	0.00	XXX
70380	26	A	X-ray exam of salivary gland	0.17	0.08	0.08	0.00	XXX
70390		A	X-ray exam of salivary duct	0.38	2.09	NA	0.03	XXX
70390	TC	A	X-ray exam of salivary duct	0.00	1.97	NA	0.00	XXX
70390	26	A	X-ray exam of salivary duct	0.38	0.12	0.12	0.03	XXX
70450		A	Ct head/brain w/o dye	0.85	2.87	NA	0.06	XXX
70450	TC	A	Ct head/brain w/o dye	0.00	2.61	NA	0.00	XXX
70450	26	A	Ct head/brain w/o dye	0.85	0.26	0.26	0.06	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70460		A	Ct head/brain w/dye	1.13	3.79	NA	0.08	XXX
70460	TC	A	Ct head/brain w/dye	0.00	3.44	NA	0.00	XXX
70460	26	A	Ct head/brain w/dye	1.13	0.35	0.35	0.07	XXX
70470		A	Ct head/brain w/o & w/dye	1.27	4.62	NA	0.09	XXX
70470	TC	A	Ct head/brain w/o & w/dye	0.00	4.23	NA	0.00	XXX
70470	26	A	Ct head/brain w/o & w/dye	1.27	0.39	0.39	0.08	XXX
70480		A	Ct orbit/ear/fossa w/o dye	1.28	4.98	NA	0.08	XXX
70480	TC	A	Ct orbit/ear/fossa w/o dye	0.00	4.57	NA	0.00	XXX
70480	26	A	Ct orbit/ear/fossa w/o dye	1.28	0.40	0.40	0.08	XXX
70481		A	Ct orbit/ear/fossa w/dye	1.38	5.83	NA	0.10	XXX
70481	TC	A	Ct orbit/ear/fossa w/dye	0.00	5.41	NA	0.00	XXX
70481	26	A	Ct orbit/ear/fossa w/dye	1.38	0.42	0.42	0.09	XXX
70482		A	Ct orbit/ear/fossa w/o&w/dye	1.45	6.59	NA	0.10	XXX
70482	TC	A	Ct orbit/ear/fossa w/o&w/dye	0.00	6.14	NA	0.00	XXX
70482	26	A	Ct orbit/ear/fossa w/o&w/dye	1.45	0.45	0.45	0.10	XXX
70486		A	Ct maxillofacial w/o dye	1.14	4.02	NA	0.07	XXX
70486	TC	A	Ct maxillofacial w/o dye	0.00	3.66	NA	0.00	XXX
70486	26	A	Ct maxillofacial w/o dye	1.14	0.36	0.36	0.07	XXX
70487		A	Ct maxillofacial w/dye	1.30	4.88	NA	0.09	XXX
70487	TC	A	Ct maxillofacial w/dye	0.00	4.49	NA	0.00	XXX
70487	26	A	Ct maxillofacial w/dye	1.30	0.40	0.40	0.09	XXX
70488		A	Ct maxillofacial w/o & w/dye	1.42	5.98	NA	0.10	XXX
70488	TC	A	Ct maxillofacial w/o & w/dye	0.00	5.55	NA	0.00	XXX
70488	26	A	Ct maxillofacial w/o & w/dye	1.42	0.44	0.44	0.09	XXX
70490		A	Ct soft tissue neck w/o dye	1.28	3.79	NA	0.09	XXX
70490	TC	A	Ct soft tissue neck w/o dye	0.00	3.40	NA	0.00	XXX
70490	26	A	Ct soft tissue neck w/o dye	1.28	0.39	0.39	0.09	XXX
70491		A	Ct soft tissue neck w/dye	1.38	4.69	NA	0.09	XXX
70491	TC	A	Ct soft tissue neck w/dye	0.00	4.26	NA	0.00	XXX
70491	26	A	Ct soft tissue neck w/dye	1.38	0.43	0.43	0.09	XXX
70492		A	Ct sft tsue nck w/o & w/dye	1.45	5.77	NA	0.10	XXX
70492	TC	A	Ct sft tsue nck w/o & w/dye	0.00	5.33	NA	0.00	XXX
70492	26	A	Ct sft tsue nck w/o & w/dye	1.45	0.45	0.45	0.10	XXX
70496		A	Ct angiography, head	1.75	9.83	NA	0.13	XXX
70496	TC	A	Ct angiography, head	0.00	9.30	NA	0.00	XXX
70496	26	A	Ct angiography, head	1.75	0.53	0.53	0.12	XXX
70498		A	Ct angiography, neck	1.75	9.77	NA	0.12	XXX
70498	TC	A	Ct angiography, neck	0.00	9.23	NA	0.00	XXX
70498	26	A	Ct angiography, neck	1.75	0.54	0.54	0.12	XXX
70540		A	Mri orbit/face/neck w/o dye	1.35	7.65	NA	0.10	XXX
70540	TC	A	Mri orbit/face/neck w/o dye	0.00	7.24	NA	0.00	XXX
70540	26	A	Mri orbit/face/neck w/o dye	1.35	0.42	0.42	0.09	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70542		A	Mri orbit/face/neck w/dye	1.62	8.50	NA	0.12	XXX
70542	TC	A	Mri orbit/face/neck w/dye	0.00	8.00	NA	0.00	XXX
70542	26	A	Mri orbit/face/neck w/dye	1.62	0.50	0.50	0.11	XXX
70543		A	Mri orbt/fac/nck w/o & w/dye	2.15	10.37	NA	0.16	XXX
70543	TC	A	Mri orbt/fac/nck w/o & w/dye	0.00	9.71	NA	0.01	XXX
70543	26	A	Mri orbt/fac/nck w/o & w/dye	2.15	0.66	0.66	0.15	XXX
70544		A	Mr angiography head w/o dye	1.20	8.81	NA	0.09	XXX
70544	TC	A	Mr angiography head w/o dye	0.00	8.44	NA	0.00	XXX
70544	26	A	Mr angiography head w/o dye	1.20	0.37	0.37	0.08	XXX
70545		A	Mr angiography head w/dye	1.20	8.81	NA	0.09	XXX
70545	TC	A	Mr angiography head w/dye	0.00	8.44	NA	0.00	XXX
70545	26	A	Mr angiography head w/dye	1.20	0.37	0.37	0.08	XXX
70546		A	Mr angiograph head w/o&w/dye	1.80	13.34	NA	0.13	XXX
70546	TC	A	Mr angiograph head w/o&w/dye	0.00	12.78	NA	0.01	XXX
70546	26	A	Mr angiograph head w/o&w/dye	1.80	0.55	0.55	0.13	XXX
70547		A	Mr angiography neck w/o dye	1.20	8.79	NA	0.09	XXX
70547	TC	A	Mr angiography neck w/o dye	0.00	8.42	NA	0.00	XXX
70547	26	A	Mr angiography neck w/o dye	1.20	0.37	0.37	0.08	XXX
70548		A	Mr angiography neck w/dye	1.20	9.41	NA	0.08	XXX
70548	TC	A	Mr angiography neck w/dye	0.00	9.04	NA	0.00	XXX
70548	26	A	Mr angiography neck w/dye	1.20	0.37	0.37	0.08	XXX
70549		A	Mr angiograph neck w/o&w/dye	1.80	13.31	NA	0.13	XXX
70549	TC	A	Mr angiograph neck w/o&w/dye	0.00	12.76	NA	0.01	XXX
70549	26	A	Mr angiograph neck w/o&w/dye	1.80	0.55	0.55	0.12	XXX
70551		A	Mri brain w/o dye	1.48	7.99	NA	0.11	XXX
70551	TC	A	Mri brain w/o dye	0.00	7.53	NA	0.00	XXX
70551	26	A	Mri brain w/o dye	1.48	0.46	0.46	0.10	XXX
70552		A	Mri brain w/dye	1.78	8.86	NA	0.13	XXX
70552	TC	A	Mri brain w/dye	0.00	8.31	NA	0.01	XXX
70552	26	A	Mri brain w/dye	1.78	0.55	0.55	0.13	XXX
70553		A	Mri brain w/o & w/dye	2.36	10.19	NA	0.17	XXX
70553	TC	A	Mri brain w/o & w/dye	0.00	9.47	NA	0.01	XXX
70553	26	A	Mri brain w/o & w/dye	2.36	0.73	0.73	0.16	XXX
70554		A	Fmri brain by tech	2.11	9.41	NA	0.15	XXX
70554	TC	A	Fmri brain by tech	0.00	8.74	NA	0.01	XXX
70554	26	A	Fmri brain by tech	2.11	0.68	0.68	0.15	XXX
70555		C	Fmri brain by phys/psych	0.00	NA	NA	0.00	XXX
70555	TC	C	Fmri brain by phys/psych	0.00	NA	NA	0.00	XXX
70555	26	A	Fmri brain by phys/psych	2.54	0.77	0.77	0.18	XXX
70557		C	Mri brain w/o dye	0.00	NA	NA	0.00	XXX
70557	TC	C	Mri brain w/o dye	0.00	NA	NA	0.00	XXX
70557	26	A	Mri brain w/o dye	2.90	1.36	1.36	0.79	XXX

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
70558		C	Mri brain w/dye	0.00	NA	NA	0.00	XXX
70558	TC	C	Mri brain w/dye	0.00	NA	NA	0.00	XXX
70558	26	A	Mri brain w/dye	3.20	0.97	0.97	0.23	XXX
70559		C	Mri brain w/o & w/dye	0.00	NA	NA	0.00	XXX
70559	TC	C	Mri brain w/o & w/dye	0.00	NA	NA	0.00	XXX
70559	26	A	Mri brain w/o & w/dye	3.20	1.07	1.07	0.23	XXX
71010		A	Chest x-ray	0.18	0.38	NA	0.01	XXX
71010	TC	A	Chest x-ray	0.00	0.33	NA	0.00	XXX
71010	26	A	Chest x-ray	0.18	0.05	0.05	0.01	XXX
71015		A	Chest x-ray	0.21	0.55	NA	0.01	XXX
71015	TC	A	Chest x-ray	0.00	0.48	NA	0.00	XXX
71015	26	A	Chest x-ray	0.21	0.07	0.07	0.01	XXX
71020		A	Chest x-ray	0.22	0.52	NA	0.01	XXX
71020	TC	A	Chest x-ray	0.00	0.46	NA	0.00	XXX
71020	26	A	Chest x-ray	0.22	0.07	0.07	0.01	XXX
71021		A	Chest x-ray	0.27	0.65	NA	0.02	XXX
71021	TC	A	Chest x-ray	0.00	0.57	NA	0.00	XXX
71021	26	A	Chest x-ray	0.27	0.08	0.08	0.01	XXX
71022		A	Chest x-ray	0.31	0.85	NA	0.02	XXX
71022	TC	A	Chest x-ray	0.00	0.75	NA	0.00	XXX
71022	26	A	Chest x-ray	0.31	0.10	0.10	0.02	XXX
71023		A	Chest x-ray and fluoroscopy	0.38	1.39	NA	0.02	XXX
71023	TC	A	Chest x-ray and fluoroscopy	0.00	1.26	NA	0.00	XXX
71023	26	A	Chest x-ray and fluoroscopy	0.38	0.13	0.13	0.02	XXX
71030		A	Chest x-ray	0.31	0.82	NA	0.02	XXX
71030	TC	A	Chest x-ray	0.00	0.73	NA	0.00	XXX
71030	26	A	Chest x-ray	0.31	0.10	0.10	0.02	XXX
71034		A	Chest x-ray and fluoroscopy	0.46	1.66	NA	0.03	XXX
71034	TC	A	Chest x-ray and fluoroscopy	0.00	1.51	NA	0.00	XXX
71034	26	A	Chest x-ray and fluoroscopy	0.46	0.15	0.15	0.02	XXX
71035		A	Chest x-ray	0.18	0.69	NA	0.01	XXX
71035	TC	A	Chest x-ray	0.00	0.64	NA	0.00	XXX
71035	26	A	Chest x-ray	0.18	0.05	0.05	0.01	XXX
71040		A	Contrast x-ray of bronchi	0.58	1.85	NA	0.02	XXX
71040	TC	A	Contrast x-ray of bronchi	0.00	1.67	NA	0.00	XXX
71040	26	A	Contrast x-ray of bronchi	0.58	0.18	0.18	0.02	XXX
71060		A	Contrast x-ray of bronchi	0.74	2.87	NA	0.05	XXX
71060	TC	A	Contrast x-ray of bronchi	0.00	2.63	NA	0.00	XXX
71060	26	A	Contrast x-ray of bronchi	0.74	0.24	0.24	0.05	XXX
71090		C	X-ray & pacemaker insertion	0.00	NA	NA	0.00	XXX
71090	TC	C	X-ray & pacemaker insertion	0.00	NA	NA	0.00	XXX
71090	26	A	X-ray & pacemaker insertion	0.54	0.18	0.18	0.03	XXX
71100		A	X-ray exam of ribs	0.22	0.57	NA	0.02	XXX
71100	TC	A	X-ray exam of ribs	0.00	0.50	NA	0.00	XXX
71100	26	A	X-ray exam of ribs	0.22	0.07	0.07	0.02	XXX
71101		A	X-ray exam of ribs/chest	0.27	0.70	NA	0.02	XXX
71101	TC	A	X-ray exam of ribs/chest	0.00	0.61	NA	0.00	XXX
71101	26	A	X-ray exam of ribs/chest	0.27	0.08	0.08	0.02	XXX
71110		A	X-ray exam of ribs	0.27	0.71	NA	0.02	XXX
71110	TC	A	X-ray exam of ribs	0.00	0.63	NA	0.00	XXX
71110	26	A	X-ray exam of ribs	0.27	0.08	0.08	0.02	XXX
71111		A	X-ray exam of ribs/chest	0.32	0.96	NA	0.02	XXX
71111	TC	A	X-ray exam of ribs/chest	0.00	0.87	NA	0.00	XXX
71111	26	A	X-ray exam of ribs/chest	0.32	0.09	0.09	0.02	XXX
71120		A	X-ray exam of breastbone	0.20	0.57	NA	0.01	XXX
71120	TC	A	X-ray exam of breastbone	0.00	0.51	NA	0.00	XXX
71120	26	A	X-ray exam of breastbone	0.20	0.06	0.06	0.01	XXX
71130		A	X-ray exam of breastbone	0.22	0.70	NA	0.02	XXX
71130	TC	A	X-ray exam of breastbone	0.00	0.63	NA	0.00	XXX
71130	26	A	X-ray exam of breastbone	0.22	0.07	0.07	0.02	XXX
71250		A	Ct thorax w/o dye	1.16	3.76	NA	0.08	XXX
71250	TC	A	Ct thorax w/o dye	0.00	3.40	NA	0.00	XXX
71250	26	A	Ct thorax w/o dye	1.16	0.35	0.35	0.08	XXX
71260		A	Ct thorax w/dye	1.24	4.66	NA	0.09	XXX
71260	TC	A	Ct thorax w/dye	0.00	4.28	NA	0.00	XXX
71260	26	A	Ct thorax w/dye	1.24	0.38	0.38	0.08	XXX
71270		A	Ct thorax w/o & w/dye	1.38	5.80	NA	0.10	XXX
71270	TC	A	Ct thorax w/o & w/dye	0.00	5.37	NA	0.00	XXX
71270	26	A	Ct thorax w/o & w/dye	1.38	0.42	0.42	0.09	XXX
71275		A	Ct angiography, chest	1.92	7.19	NA	0.13	XXX
71275	TC	A	Ct angiography, chest	0.00	6.61	NA	0.01	XXX
71275	26	A	Ct angiography, chest	1.92	0.58	0.58	0.13	XXX
71550		A	Mri chest w/o dye	1.46	8.86	NA	0.11	XXX
71550	TC	A	Mri chest w/o dye	0.00	8.41	NA	0.00	XXX
71550	26	A	Mri chest w/o dye	1.46	0.45	0.45	0.10	XXX
71551		A	Mri chest w/dye	1.73	9.97	NA	0.12	XXX
71551	TC	A	Mri chest w/dye	0.00	9.43	NA	0.00	XXX
71551	26	A	Mri chest w/dye	1.73	0.54	0.54	0.12	XXX
71552		A	Mri chest w/o & w/dye	2.26	12.31	NA	0.16	XXX
71552	TC	A	Mri chest w/o & w/dye	0.00	11.62	NA	0.01	XXX
71552	26	A	Mri chest w/o & w/dye	2.26	0.69	0.69	0.15	XXX
71555		R	Mri angio chest w or w/o dye	1.81	8.69	NA	0.12	XXX
71555	TC	R	Mri angio chest w or w/o dye	0.00	8.13	NA	0.01	XXX
71555	26	R	Mri angio chest w or w/o dye	1.81	0.56	0.56	0.12	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72010		A	X-ray exam of spine	0.45	1.50	NA	0.03	XXX
72010	TC	A	X-ray exam of spine	0.00	1.33	NA	0.00	XXX
72010	26	A	X-ray exam of spine	0.45	0.17	0.17	0.03	XXX
72020		A	X-ray exam of spine	0.15	0.43	NA	0.02	XXX
72020	TC	A	X-ray exam of spine	0.00	0.38	NA	0.00	XXX
72020	26	A	X-ray exam of spine	0.15	0.05	0.05	0.01	XXX
72040		A	X-ray exam of neck spine	0.22	0.75	NA	0.02	XXX
72040	TC	A	X-ray exam of neck spine	0.00	0.67	NA	0.00	XXX
72040	26	A	X-ray exam of neck spine	0.22	0.08	0.08	0.02	XXX
72050		A	X-ray exam of neck spine	0.31	0.99	NA	0.03	XXX
72050	TC	A	X-ray exam of neck spine	0.00	0.89	NA	0.00	XXX
72050	26	A	X-ray exam of neck spine	0.31	0.10	0.10	0.03	XXX
72052		A	X-ray exam of neck spine	0.36	1.32	NA	0.03	XXX
72052	TC	A	X-ray exam of neck spine	0.00	1.20	NA	0.00	XXX
72052	26	A	X-ray exam of neck spine	0.36	0.12	0.12	0.03	XXX
72069		A	X-ray exam of trunk spine	0.22	0.72	NA	0.03	XXX
72069	TC	A	X-ray exam of trunk spine	0.00	0.64	NA	0.00	XXX
72069	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX
72070		A	X-ray exam of thoracic spine	0.22	0.60	NA	0.02	XXX
72070	TC	A	X-ray exam of thoracic spine	0.00	0.53	NA	0.00	XXX
72070	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX
72072		A	X-ray exam of thoracic spine	0.22	0.69	NA	0.02	XXX
72072	TC	A	X-ray exam of thoracic spine	0.00	0.63	NA	0.00	XXX
72072	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.01	XXX
72074		A	X-ray exam of thoracic spine	0.22	0.87	NA	0.02	XXX
72074	TC	A	X-ray exam of thoracic spine	0.00	0.80	NA	0.00	XXX
72074	26	A	X-ray exam of thoracic spine	0.22	0.07	0.07	0.02	XXX
72080		A	X-ray exam of trunk spine	0.22	0.69	NA	0.03	XXX
72080	TC	A	X-ray exam of trunk spine	0.00	0.61	NA	0.00	XXX
72080	26	A	X-ray exam of trunk spine	0.22	0.08	0.08	0.03	XXX
72090		A	X-ray exam of trunk spine	0.28	0.98	NA	0.04	XXX
72090	TC	A	X-ray exam of trunk spine	0.00	0.88	NA	0.00	XXX
72090	26	A	X-ray exam of trunk spine	0.28	0.10	0.10	0.03	XXX
72100		A	X-ray exam of lower spine	0.22	0.79	NA	0.03	XXX
72100	TC	A	X-ray exam of lower spine	0.00	0.72	NA	0.00	XXX
72100	26	A	X-ray exam of lower spine	0.22	0.08	0.08	0.02	XXX
72110		A	X-ray exam of lower spine	0.31	1.07	NA	0.03	XXX
72110	TC	A	X-ray exam of lower spine	0.00	0.96	NA	0.00	XXX
72110	26	A	X-ray exam of lower spine	0.31	0.10	0.10	0.03	XXX
72114		A	X-ray exam of lower spine	0.36	1.54	NA	0.04	XXX
72114	TC	A	X-ray exam of lower spine	0.00	1.40	NA	0.00	XXX
72114	26	A	X-ray exam of lower spine	0.36	0.13	0.13	0.04	XXX
72120		A	X-ray exam of lower spine	0.22	1.10	NA	0.03	XXX
72120	TC	A	X-ray exam of lower spine	0.00	1.01	NA	0.00	XXX
72120	26	A	X-ray exam of lower spine	0.22	0.09	0.09	0.03	XXX
72125		A	Ct neck spine w/o dye	1.16	3.79	NA	0.09	XXX
72125	TC	A	Ct neck spine w/o dye	0.00	3.44	NA	0.00	XXX
72125	26	A	Ct neck spine w/o dye	1.16	0.35	0.35	0.08	XXX
72126		A	Ct neck spine w/dye	1.22	4.68	NA	0.09	XXX
72126	TC	A	Ct neck spine w/dye	0.00	4.31	NA	0.00	XXX
72126	26	A	Ct neck spine w/dye	1.22	0.37	0.37	0.09	XXX
72127		A	Ct neck spine w/o & w/dye	1.27	5.78	NA	0.09	XXX
72127	TC	A	Ct neck spine w/o & w/dye	0.00	5.39	NA	0.00	XXX
72127	26	A	Ct neck spine w/o & w/dye	1.27	0.39	0.39	0.09	XXX
72128		A	Ct chest spine w/o dye	1.16	3.78	NA	0.08	XXX
72128	TC	A	Ct chest spine w/o dye	0.00	3.42	NA	0.00	XXX
72128	26	A	Ct chest spine w/o dye	1.16	0.35	0.35	0.08	XXX
72129		A	Ct chest spine w/dye	1.22	4.69	NA	0.09	XXX
72129	TC	A	Ct chest spine w/dye	0.00	4.32	NA	0.00	XXX
72129	26	A	Ct chest spine w/dye	1.22	0.37	0.37	0.09	XXX
72130		A	Ct chest spine w/o & w/dye	1.27	5.83	NA	0.09	XXX
72130	TC	A	Ct chest spine w/o & w/dye	0.00	5.44	NA	0.00	XXX
72130	26	A	Ct chest spine w/o & w/dye	1.27	0.39	0.39	0.08	XXX
72131		A	Ct lumbar spine w/o dye	1.16	3.77	NA	0.08	XXX
72131	TC	A	Ct lumbar spine w/o dye	0.00	3.42	NA	0.00	XXX
72131	26	A	Ct lumbar spine w/o dye	1.16	0.36	0.36	0.08	XXX
72132		A	Ct lumbar spine w/dye	1.22	4.67	NA	0.09	XXX
72132	TC	A	Ct lumbar spine w/dye	0.00	4.30	NA	0.00	XXX
72132	26	A	Ct lumbar spine w/dye	1.22	0.37	0.37	0.09	XXX
72133		A	Ct lumbar spine w/o & w/dye	1.27	5.78	NA	0.09	XXX
72133	TC	A	Ct lumbar spine w/o & w/dye	0.00	5.39	NA	0.00	XXX
72133	26	A	Ct lumbar spine w/o & w/dye	1.27	0.39	0.39	0.09	XXX
72141		A	Mri neck spine w/o dye	1.60	6.92	NA	0.12	XXX
72141	TC	A	Mri neck spine w/o dye	0.00	6.42	NA	0.00	XXX
72141	26	A	Mri neck spine w/o dye	1.60	0.50	0.50	0.12	XXX
72142		A	Mri neck spine w/dye	1.92	8.96	NA	0.14	XXX
72142	TC	A	Mri neck spine w/dye	0.00	8.36	NA	0.01	XXX
72142	26	A	Mri neck spine w/dye	1.92	0.60	0.60	0.14	XXX
72146		A	Mri chest spine w/o dye	1.60	6.94	NA	0.12	XXX
72146	TC	A	Mri chest spine w/o dye	0.00	6.44	NA	0.00	XXX
72146	26	A	Mri chest spine w/o dye	1.60	0.50	0.50	0.12	XXX
72147		A	Mri chest spine w/dye	1.92	7.78	NA	0.14	XXX
72147	TC	A	Mri chest spine w/dye	0.00	7.19	NA	0.01	XXX
72147	26	A	Mri chest spine w/dye	1.92	0.60	0.60	0.13	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72148		A	Mri lumbar spine w/o dye	1.48	6.90	NA	0.11	XXX
72148	TC	A	Mri lumbar spine w/o dye	0.00	6.43	NA	0.00	XXX
72148	26	A	Mri lumbar spine w/o dye	1.48	0.47	0.47	0.11	XXX
72149		A	Mri lumbar spine w/dye	1.78	8.80	NA	0.14	XXX
72149	TC	A	Mri lumbar spine w/dye	0.00	8.24	NA	0.01	XXX
72149	26	A	Mri lumbar spine w/dye	1.78	0.56	0.56	0.13	XXX
72156		A	Mri neck spine w/o & w/dye	2.57	10.08	NA	0.19	XXX
72156	TC	A	Mri neck spine w/o & w/dye	0.00	9.28	NA	0.01	XXX
72156	26	A	Mri neck spine w/o & w/dye	2.57	0.80	0.80	0.19	XXX
72157		A	Mri chest spine w/o & w/dye	2.57	9.21	NA	0.19	XXX
72157	TC	A	Mri chest spine w/o & w/dye	0.00	8.42	NA	0.01	XXX
72157	26	A	Mri chest spine w/o & w/dye	2.57	0.79	0.79	0.18	XXX
72158		A	Mri lumbar spine w/o & w/dye	2.36	9.96	NA	0.18	XXX
72158	TC	A	Mri lumbar spine w/o & w/dye	0.00	9.22	NA	0.01	XXX
72158	26	A	Mri lumbar spine w/o & w/dye	2.36	0.74	0.74	0.18	XXX
72159		N	Mr angio spine w/o&w/dye	1.80	10.37	NA	0.10	XXX
72159	TC	N	Mr angio spine w/o&w/dye	0.00	9.71	NA	0.01	XXX
72159	26	N	Mr angio spine w/o&w/dye	1.80	0.66	0.66	0.09	XXX
72170		A	X-ray exam of pelvis	0.17	0.48	NA	0.02	XXX
72170	TC	A	X-ray exam of pelvis	0.00	0.42	NA	0.00	XXX
72170	26	A	X-ray exam of pelvis	0.17	0.06	0.06	0.02	XXX
72190		A	X-ray exam of pelvis	0.21	0.83	NA	0.03	XXX
72190	TC	A	X-ray exam of pelvis	0.00	0.75	NA	0.00	XXX
72190	26	A	X-ray exam of pelvis	0.21	0.08	0.08	0.03	XXX
72191		A	Ct angiograph pelv w/o&w/dye	1.81	6.81	NA	0.15	XXX
72191	TC	A	Ct angiograph pelv w/o&w/dye	0.00	6.27	NA	0.01	XXX
72191	26	A	Ct angiograph pelv w/o&w/dye	1.81	0.55	0.55	0.14	XXX
72192		A	Ct pelvis w/o dye	1.09	3.50	NA	0.08	XXX
72192	TC	A	Ct pelvis w/o dye	0.00	3.17	NA	0.00	XXX
72192	26	A	Ct pelvis w/o dye	1.09	0.33	0.33	0.07	XXX
72193		A	Ct pelvis w/dye	1.16	4.39	NA	0.08	XXX
72193	TC	A	Ct pelvis w/dye	0.00	4.03	NA	0.00	XXX
72193	26	A	Ct pelvis w/dye	1.16	0.36	0.36	0.08	XXX
72194		A	Ct pelvis w/o & w/dye	1.22	5.82	NA	0.09	XXX
72194	TC	A	Ct pelvis w/o & w/dye	0.00	5.45	NA	0.00	XXX
72194	26	A	Ct pelvis w/o & w/dye	1.22	0.37	0.37	0.08	XXX
72195		A	Mri pelvis w/o dye	1.46	7.93	NA	0.11	XXX
72195	TC	A	Mri pelvis w/o dye	0.00	7.47	NA	0.00	XXX
72195	26	A	Mri pelvis w/o dye	1.46	0.46	0.46	0.11	XXX
72196		A	Mri pelvis w/dye	1.73	8.75	NA	0.13	XXX
72196	TC	A	Mri pelvis w/dye	0.00	8.22	NA	0.00	XXX
72196	26	A	Mri pelvis w/dye	1.73	0.54	0.54	0.12	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
72197		A	Mri pelvis w/o & w/dye	2.26	10.51	NA	0.16	XXX
72197	TC	A	Mri pelvis w/o & w/dye	0.00	9.82	NA	0.01	XXX
72197	26	A	Mri pelvis w/o & w/dye	2.26	0.69	0.69	0.16	XXX
72198		A	Mr angio pelvis w/o & w/dye	1.80	8.69	NA	0.13	XXX
72198	TC	A	Mr angio pelvis w/o & w/dye	0.00	8.14	NA	0.01	XXX
72198	26	A	Mr angio pelvis w/o & w/dye	1.80	0.55	0.55	0.12	XXX
72200		A	X-ray exam sacroiliac joints	0.17	0.56	NA	0.01	XXX
72200	TC	A	X-ray exam sacroiliac joints	0.00	0.50	NA	0.00	XXX
72200	26	A	X-ray exam sacroiliac joints	0.17	0.06	0.06	0.01	XXX
72202		A	X-ray exam sacroiliac joints	0.19	0.66	NA	0.01	XXX
72202	TC	A	X-ray exam sacroiliac joints	0.00	0.60	NA	0.00	XXX
72202	26	A	X-ray exam sacroiliac joints	0.19	0.06	0.06	0.01	XXX
72220		A	X-ray exam of tailbone	0.17	0.52	NA	0.01	XXX
72220	TC	A	X-ray exam of tailbone	0.00	0.47	NA	0.00	XXX
72220	26	A	X-ray exam of tailbone	0.17	0.05	0.05	0.01	XXX
72240		A	Contrast x-ray of neck spine	0.91	2.35	NA	0.07	XXX
72240	TC	A	Contrast x-ray of neck spine	0.00	2.07	NA	0.00	XXX
72240	26	A	Contrast x-ray of neck spine	0.91	0.28	0.28	0.06	XXX
72255		A	Contrast x-ray, thorax spine	0.91	2.29	NA	0.06	XXX
72255	TC	A	Contrast x-ray, thorax spine	0.00	1.98	NA	0.00	XXX
72255	26	A	Contrast x-ray, thorax spine	0.91	0.31	0.31	0.06	XXX
72265		A	Contrast x-ray, lower spine	0.83	2.36	NA	0.06	XXX
72265	TC	A	Contrast x-ray, lower spine	0.00	2.09	NA	0.00	XXX
72265	26	A	Contrast x-ray, lower spine	0.83	0.27	0.27	0.06	XXX
72270		A	Contrast x-ray, spine	1.33	3.63	NA	0.09	XXX
72270	TC	A	Contrast x-ray, spine	0.00	3.21	NA	0.00	XXX
72270	26	A	Contrast x-ray, spine	1.33	0.42	0.42	0.08	XXX
72275		A	Epidurography	0.76	2.24	NA	0.05	XXX
72275	TC	A	Epidurography	0.00	1.94	NA	0.00	XXX
72275	26	A	Epidurography	0.76	0.31	0.31	0.05	XXX
72285		A	X-ray c/t spine disk	1.16	1.92	NA	0.08	XXX
72285	TC	A	X-ray c/t spine disk	0.00	1.43	NA	0.00	XXX
72285	26	A	X-ray c/t spine disk	1.16	0.49	0.49	0.08	XXX
72291		C	Perq vertebroplasty, fluor	0.00	NA	NA	0.00	XXX
72291	TC	C	Perq vertebroplasty, fluor	0.00	NA	NA	0.00	XXX
72291	26	A	Perq vertebroplasty, fluor	1.31	0.49	0.49	0.16	XXX
72292		C	Perq vertebroplasty, ct	0.00	NA	NA	0.00	XXX
72292	TC	C	Perq vertebroplasty, ct	0.00	NA	NA	0.00	XXX
72292	26	A	Perq vertebroplasty, ct	1.38	0.49	0.49	0.15	XXX
72295		A	X-ray of lower spine disk	0.83	1.79	NA	0.05	XXX
72295	TC	A	X-ray of lower spine disk	0.00	1.45	NA	0.00	XXX
72295	26	A	X-ray of lower spine disk	0.83	0.34	0.34	0.05	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73000		A	X-ray exam of collar bone	0.16	0.55	NA	0.02	XXX
73000	TC	A	X-ray exam of collar bone	0.00	0.50	NA	0.00	XXX
73000	26	A	X-ray exam of collar bone	0.16	0.06	0.06	0.02	XXX
73010		A	X-ray exam of shoulder blade	0.17	0.60	NA	0.02	XXX
73010	TC	A	X-ray exam of shoulder blade	0.00	0.53	NA	0.00	XXX
73010	26	A	X-ray exam of shoulder blade	0.17	0.07	0.07	0.02	XXX
73020		A	X-ray exam of shoulder	0.15	0.44	NA	0.02	XXX
73020	TC	A	X-ray exam of shoulder	0.00	0.38	NA	0.00	XXX
73020	26	A	X-ray exam of shoulder	0.15	0.05	0.05	0.02	XXX
73030		A	X-ray exam of shoulder	0.18	0.57	NA	0.02	XXX
73030	TC	A	X-ray exam of shoulder	0.00	0.50	NA	0.00	XXX
73030	26	A	X-ray exam of shoulder	0.18	0.07	0.07	0.02	XXX
73040		A	Contrast x-ray of shoulder	0.54	2.13	NA	0.05	XXX
73040	TC	A	Contrast x-ray of shoulder	0.00	1.94	NA	0.00	XXX
73040	26	A	Contrast x-ray of shoulder	0.54	0.18	0.18	0.05	XXX
73050		A	X-ray exam of shoulders	0.20	0.78	NA	0.03	XXX
73050	TC	A	X-ray exam of shoulders	0.00	0.70	NA	0.00	XXX
73050	26	A	X-ray exam of shoulders	0.20	0.08	0.08	0.03	XXX
73060		A	X-ray exam of humerus	0.17	0.54	NA	0.02	XXX
73060	TC	A	X-ray exam of humerus	0.00	0.48	NA	0.00	XXX
73060	26	A	X-ray exam of humerus	0.17	0.05	0.05	0.02	XXX
73070		A	X-ray exam of elbow	0.15	0.55	NA	0.02	XXX
73070	TC	A	X-ray exam of elbow	0.00	0.50	NA	0.00	XXX
73070	26	A	X-ray exam of elbow	0.15	0.05	0.05	0.02	XXX
73080		A	X-ray exam of elbow	0.17	0.72	NA	0.02	XXX
73080	TC	A	X-ray exam of elbow	0.00	0.66	NA	0.00	XXX
73080	26	A	X-ray exam of elbow	0.17	0.06	0.06	0.02	XXX
73085		A	Contrast x-ray of elbow	0.54	1.87	NA	0.04	XXX
73085	TC	A	Contrast x-ray of elbow	0.00	1.68	NA	0.00	XXX
73085	26	A	Contrast x-ray of elbow	0.54	0.20	0.20	0.04	XXX
73090		A	X-ray exam of forearm	0.16	0.51	NA	0.02	XXX
73090	TC	A	X-ray exam of forearm	0.00	0.46	NA	0.00	XXX
73090	26	A	X-ray exam of forearm	0.16	0.05	0.05	0.02	XXX
73092		A	X-ray exam of arm, infant	0.16	0.59	NA	0.01	XXX
73092	TC	A	X-ray exam of arm, infant	0.00	0.54	NA	0.00	XXX
73092	26	A	X-ray exam of arm, infant	0.16	0.05	0.05	0.01	XXX
73100		A	X-ray exam of wrist	0.16	0.63	NA	0.02	XXX
73100	TC	A	X-ray exam of wrist	0.00	0.56	NA	0.00	XXX
73100	26	A	X-ray exam of wrist	0.16	0.07	0.07	0.02	XXX
73110		A	X-ray exam of wrist	0.17	0.76	NA	0.02	XXX
73110	TC	A	X-ray exam of wrist	0.00	0.70	NA	0.00	XXX
73110	26	A	X-ray exam of wrist	0.17	0.06	0.06	0.02	XXX
73115		A	Contrast x-ray of wrist	0.54	2.26	NA	0.04	XXX
73115	TC	A	Contrast x-ray of wrist	0.00	2.06	NA	0.00	XXX
73115	26	A	Contrast x-ray of wrist	0.54	0.20	0.20	0.04	XXX
73120		A	X-ray exam of hand	0.16	0.52	NA	0.01	XXX
73120	TC	A	X-ray exam of hand	0.00	0.46	NA	0.00	XXX
73120	26	A	X-ray exam of hand	0.16	0.06	0.06	0.01	XXX
73130		A	X-ray exam of hand	0.17	0.62	NA	0.02	XXX
73130	TC	A	X-ray exam of hand	0.00	0.57	NA	0.00	XXX
73130	26	A	X-ray exam of hand	0.17	0.06	0.06	0.02	XXX
73140		A	X-ray exam of finger(s)	0.13	0.70	NA	0.02	XXX
73140	TC	A	X-ray exam of finger(s)	0.00	0.65	NA	0.00	XXX
73140	26	A	X-ray exam of finger(s)	0.13	0.05	0.05	0.02	XXX
73200		A	Ct upper extremity w/o dye	1.09	3.73	NA	0.08	XXX
73200	TC	A	Ct upper extremity w/o dye	0.00	3.40	NA	0.00	XXX
73200	26	A	Ct upper extremity w/o dye	1.09	0.34	0.34	0.08	XXX
73201		A	Ct upper extremity w/dye	1.16	4.61	NA	0.08	XXX
73201	TC	A	Ct upper extremity w/dye	0.00	4.26	NA	0.00	XXX
73201	26	A	Ct upper extremity w/dye	1.16	0.35	0.35	0.08	XXX
73202		A	Ct upper extremity w/o&w/dye	1.22	6.10	NA	0.09	XXX
73202	TC	A	Ct upper extremity w/o&w/dye	0.00	5.72	NA	0.00	XXX
73202	26	A	Ct upper extremity w/o&w/dye	1.22	0.37	0.37	0.08	XXX
73206		A	Ct angio upr extrm w/o&w/dye	1.81	6.47	NA	0.12	XXX
73206	TC	A	Ct angio upr extrm w/o&w/dye	0.00	5.91	NA	0.01	XXX
73206	26	A	Ct angio upr extrm w/o&w/dye	1.81	0.55	0.55	0.11	XXX
73218		A	Mri upper extremity w/o dye	1.35	7.92	NA	0.09	XXX
73218	TC	A	Mri upper extremity w/o dye	0.00	7.49	NA	0.00	XXX
73218	26	A	Mri upper extremity w/o dye	1.35	0.43	0.43	0.09	XXX
73219		A	Mri upper extremity w/dye	1.62	8.72	NA	0.12	XXX
73219	TC	A	Mri upper extremity w/dye	0.00	8.21	NA	0.00	XXX
73219	26	A	Mri upper extremity w/dye	1.62	0.51	0.51	0.12	XXX
73220		A	Mri upper extremity w/o&w/dye	2.15	10.61	NA	0.16	XXX
73220	TC	A	Mri upper extremity w/o&w/dye	0.00	9.94	NA	0.01	XXX
73220	26	A	Mri upper extremity w/o&w/dye	2.15	0.67	0.67	0.15	XXX
73221		A	Mri joint upr extrem w/o dye	1.35	7.51	NA	0.11	XXX
73221	TC	A	Mri joint upr extrem w/o dye	0.00	7.06	NA	0.00	XXX
73221	26	A	Mri joint upr extrem w/o dye	1.35	0.44	0.44	0.11	XXX
73222		A	Mri joint upr extrem w/dye	1.62	8.06	NA	0.12	XXX
73222	TC	A	Mri joint upr extrem w/dye	0.00	7.55	NA	0.00	XXX
73222	26	A	Mri joint upr extrem w/dye	1.62	0.51	0.51	0.12	XXX
73223		A	Mri joint upr extr w/o&w/dye	2.15	9.90	NA	0.16	XXX
73223	TC	A	Mri joint upr extr w/o&w/dye	0.00	9.23	NA	0.01	XXX
73223	26	A	Mri joint upr extr w/o&w/dye	2.15	0.67	0.67	0.16	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73225		N	Mr angio upr extr w/o&w/dye	1.73	10.34	NA	0.09	XXX
73225	TC	N	Mr angio upr extr w/o&w/dye	0.00	9.71	NA	0.00	XXX
73225	26	N	Mr angio upr extr w/o&w/dye	1.73	0.63	0.63	0.09	XXX
73500		A	X-ray exam of hip	0.17	0.49	NA	0.02	XXX
73500	TC	A	X-ray exam of hip	0.00	0.42	NA	0.00	XXX
73500	26	A	X-ray exam of hip	0.17	0.06	0.06	0.02	XXX
73510		A	X-ray exam of hip	0.21	0.74	NA	0.03	XXX
73510	TC	A	X-ray exam of hip	0.00	0.67	NA	0.00	XXX
73510	26	A	X-ray exam of hip	0.21	0.07	0.07	0.03	XXX
73520		A	X-ray exam of hips	0.26	0.75	NA	0.03	XXX
73520	TC	A	X-ray exam of hips	0.00	0.66	NA	0.00	XXX
73520	26	A	X-ray exam of hips	0.26	0.09	0.09	0.03	XXX
73525		A	Contrast x-ray of hip	0.54	2.01	NA	0.04	XXX
73525	TC	A	Contrast x-ray of hip	0.00	1.80	NA	0.00	XXX
73525	26	A	Contrast x-ray of hip	0.54	0.21	0.21	0.04	XXX
73530		C	X-ray exam of hip	0.00	NA	NA	0.00	XXX
73530	TC	C	X-ray exam of hip	0.00	NA	NA	0.00	XXX
73530	26	A	X-ray exam of hip	0.29	0.09	0.09	0.02	XXX
73540		A	X-ray exam of pelvis & hips	0.20	0.90	NA	0.03	XXX
73540	TC	A	X-ray exam of pelvis & hips	0.00	0.82	NA	0.00	XXX
73540	26	A	X-ray exam of pelvis & hips	0.20	0.09	0.09	0.03	XXX
73542		A	X-ray exam, sacroiliac joint	0.59	1.60	NA	0.03	XXX
73542	TC	A	X-ray exam, sacroiliac joint	0.00	1.35	NA	0.00	XXX
73542	26	A	X-ray exam, sacroiliac joint	0.59	0.25	0.25	0.03	XXX
73550		A	X-ray exam of thigh	0.17	0.51	NA	0.02	XXX
73550	TC	A	X-ray exam of thigh	0.00	0.45	NA	0.00	XXX
73550	26	A	X-ray exam of thigh	0.17	0.05	0.05	0.02	XXX
73560		A	X-ray exam of knee, 1 or 2	0.17	0.59	NA	0.02	XXX
73560	TC	A	X-ray exam of knee, 1 or 2	0.00	0.52	NA	0.00	XXX
73560	26	A	X-ray exam of knee, 1 or 2	0.17	0.06	0.06	0.02	XXX
73562		A	X-ray exam of knee, 3	0.18	0.75	NA	0.02	XXX
73562	TC	A	X-ray exam of knee, 3	0.00	0.68	NA	0.00	XXX
73562	26	A	X-ray exam of knee, 3	0.18	0.07	0.07	0.02	XXX
73564		A	X-ray exam, knee, 4 or more	0.22	0.86	NA	0.03	XXX
73564	TC	A	X-ray exam, knee, 4 or more	0.00	0.78	NA	0.00	XXX
73564	26	A	X-ray exam, knee, 4 or more	0.22	0.09	0.09	0.03	XXX
73565		A	X-ray exam of knees	0.17	0.71	NA	0.02	XXX
73565	TC	A	X-ray exam of knees	0.00	0.64	NA	0.00	XXX
73565	26	A	X-ray exam of knees	0.17	0.08	0.08	0.02	XXX
73580		A	Contrast x-ray of knee joint	0.54	2.93	NA	0.06	XXX
73580	TC	A	Contrast x-ray of knee joint	0.00	2.68	NA	0.00	XXX
73580	26	A	Contrast x-ray of knee joint	0.54	0.25	0.25	0.06	XXX
73590		A	X-ray exam of lower leg	0.17	0.50	NA	0.02	XXX
73590	TC	A	X-ray exam of lower leg	0.00	0.45	NA	0.00	XXX
73590	26	A	X-ray exam of lower leg	0.17	0.05	0.05	0.02	XXX
73592		A	X-ray exam of leg, infant	0.16	0.62	NA	0.02	XXX
73592	TC	A	X-ray exam of leg, infant	0.00	0.57	NA	0.00	XXX
73592	26	A	X-ray exam of leg, infant	0.16	0.06	0.06	0.02	XXX
73600		A	X-ray exam of ankle	0.16	0.56	NA	0.02	XXX
73600	TC	A	X-ray exam of ankle	0.00	0.50	NA	0.00	XXX
73600	26	A	X-ray exam of ankle	0.16	0.06	0.06	0.02	XXX
73610		A	X-ray exam of ankle	0.17	0.65	NA	0.02	XXX
73610	TC	A	X-ray exam of ankle	0.00	0.60	NA	0.00	XXX
73610	26	A	X-ray exam of ankle	0.17	0.06	0.06	0.02	XXX
73615		A	Contrast x-ray of ankle	0.54	2.17	NA	0.05	XXX
73615	TC	A	Contrast x-ray of ankle	0.00	1.95	NA	0.00	XXX
73615	26	A	Contrast x-ray of ankle	0.54	0.22	0.22	0.05	XXX
73620		A	X-ray exam of foot	0.16	0.53	NA	0.01	XXX
73620	TC	A	X-ray exam of foot	0.00	0.49	NA	0.00	XXX
73620	26	A	X-ray exam of foot	0.16	0.04	0.04	0.01	XXX
73630		A	X-ray exam of foot	0.17	0.64	NA	0.01	XXX
73630	TC	A	X-ray exam of foot	0.00	0.59	NA	0.00	XXX
73630	26	A	X-ray exam of foot	0.17	0.05	0.05	0.01	XXX
73650		A	X-ray exam of heel	0.16	0.55	NA	0.02	XXX
73650	TC	A	X-ray exam of heel	0.00	0.50	NA	0.00	XXX
73650	26	A	X-ray exam of heel	0.16	0.05	0.05	0.02	XXX
73660		A	X-ray exam of toe(s)	0.13	0.62	NA	0.01	XXX
73660	TC	A	X-ray exam of toe(s)	0.00	0.57	NA	0.00	XXX
73660	26	A	X-ray exam of toe(s)	0.13	0.04	0.04	0.01	XXX
73700		A	Ct lower extremity w/o dye	1.09	3.74	NA	0.08	XXX
73700	TC	A	Ct lower extremity w/o dye	0.00	3.41	NA	0.00	XXX
73700	26	A	Ct lower extremity w/o dye	1.09	0.33	0.33	0.08	XXX
73701		A	Ct lower extremity w/dye	1.16	4.67	NA	0.08	XXX
73701	TC	A	Ct lower extremity w/dye	0.00	4.32	NA	0.00	XXX
73701	26	A	Ct lower extremity w/dye	1.16	0.35	0.35	0.08	XXX
73702		A	Ct lwr extremity w/o&w/dye	1.22	6.13	NA	0.08	XXX
73702	TC	A	Ct lwr extremity w/o&w/dye	0.00	5.76	NA	0.00	XXX
73702	26	A	Ct lwr extremity w/o&w/dye	1.22	0.37	0.37	0.08	XXX
73706		A	Ct angio lwr extr w/o&w/dye	1.90	7.36	NA	0.13	XXX
73706	TC	A	Ct angio lwr extr w/o&w/dye	0.00	6.78	NA	0.01	XXX
73706	26	A	Ct angio lwr extr w/o&w/dye	1.90	0.59	0.59	0.13	XXX
73718		A	Mri lower extremity w/o dye	1.35	7.81	NA	0.10	XXX
73718	TC	A	Mri lower extremity w/o dye	0.00	7.38	NA	0.00	XXX
73718	26	A	Mri lower extremity w/o dye	1.35	0.42	0.42	0.10	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
73719		A	Mri lower extremity w/dye	1.62	8.62	NA	0.12	XXX
73719	TC	A	Mri lower extremity w/dye	0.00	8.12	NA	0.00	XXX
73719	26	A	Mri lower extremity w/dye	1.62	0.50	0.50	0.11	XXX
73720		A	Mri lwr extremity w/o&w/dye	2.15	10.62	NA	0.15	XXX
73720	TC	A	Mri lwr extremity w/o&w/dye	0.00	9.96	NA	0.01	XXX
73720	26	A	Mri lwr extremity w/o&w/dye	2.15	0.66	0.66	0.15	XXX
73721		A	Mri jnt of lwr extre w/o dye	1.35	7.70	NA	0.11	XXX
73721	TC	A	Mri jnt of lwr extre w/o dye	0.00	7.26	NA	0.00	XXX
73721	26	A	Mri jnt of lwr extre w/o dye	1.35	0.44	0.44	0.11	XXX
73722		A	Mri joint of lwr extr w/dye	1.62	8.25	NA	0.13	XXX
73722	TC	A	Mri joint of lwr extr w/dye	0.00	7.73	NA	0.00	XXX
73722	26	A	Mri joint of lwr extr w/dye	1.62	0.52	0.52	0.13	XXX
73723		A	Mri joint lwr extr w/o&w/dye	2.15	9.88	NA	0.16	XXX
73723	TC	A	Mri joint lwr extr w/o&w/dye	0.00	9.22	NA	0.01	XXX
73723	26	A	Mri joint lwr extr w/o&w/dye	2.15	0.66	0.66	0.15	XXX
73725		R	Mr ang lwr ext w or w/o dye	1.82	8.71	NA	0.13	XXX
73725	TC	R	Mr ang lwr ext w or w/o dye	0.00	8.16	NA	0.01	XXX
73725	26	R	Mr ang lwr ext w or w/o dye	1.82	0.55	0.55	0.12	XXX
74000		A	X-ray exam of abdomen	0.18	0.41	NA	0.01	XXX
74000	TC	A	X-ray exam of abdomen	0.00	0.36	NA	0.00	XXX
74000	26	A	X-ray exam of abdomen	0.18	0.05	0.05	0.01	XXX
74010		A	X-ray exam of abdomen	0.23	0.71	NA	0.01	XXX
74010	TC	A	X-ray exam of abdomen	0.00	0.64	NA	0.00	XXX
74010	26	A	X-ray exam of abdomen	0.23	0.07	0.07	0.01	XXX
74020		A	X-ray exam of abdomen	0.27	0.72	NA	0.02	XXX
74020	TC	A	X-ray exam of abdomen	0.00	0.64	NA	0.00	XXX
74020	26	A	X-ray exam of abdomen	0.27	0.08	0.08	0.02	XXX
74022		A	X-ray exam series, abdomen	0.32	0.87	NA	0.02	XXX
74022	TC	A	X-ray exam series, abdomen	0.00	0.78	NA	0.00	XXX
74022	26	A	X-ray exam series, abdomen	0.32	0.10	0.10	0.02	XXX
74150		A	Ct abdomen w/o dye	1.19	3.53	NA	0.08	XXX
74150	TC	A	Ct abdomen w/o dye	0.00	3.17	NA	0.00	XXX
74150	26	A	Ct abdomen w/o dye	1.19	0.36	0.36	0.08	XXX
74160		A	Ct abdomen w/dye	1.27	5.12	NA	0.09	XXX
74160	TC	A	Ct abdomen w/dye	0.00	4.73	NA	0.00	XXX
74160	26	A	Ct abdomen w/dye	1.27	0.39	0.39	0.09	XXX
74170		A	Ct abdomen w/o & w/dye	1.40	7.02	NA	0.10	XXX
74170	TC	A	Ct abdomen w/o & w/dye	0.00	6.59	NA	0.00	XXX
74170	26	A	Ct abdomen w/o & w/dye	1.40	0.43	0.43	0.09	XXX
74175		A	Ct angio abdom w/o & w/dye	1.90	7.27	NA	0.15	XXX
74175	TC	A	Ct angio abdom w/o & w/dye	0.00	6.70	NA	0.01	XXX
74175	26	A	Ct angio abdom w/o & w/dye	1.90	0.58	0.58	0.14	XXX
CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74181		A	Mri abdomen w/o dye	1.46	6.88	NA	0.10	XXX
74181	TC	A	Mri abdomen w/o dye	0.00	6.43	NA	0.00	XXX
74181	26	A	Mri abdomen w/o dye	1.46	0.44	0.44	0.10	XXX
74182		A	Mri abdomen w/dye	1.73	9.72	NA	0.12	XXX
74182	TC	A	Mri abdomen w/dye	0.00	9.19	NA	0.00	XXX
74182	26	A	Mri abdomen w/dye	1.73	0.52	0.52	0.12	XXX
74183		A	Mri abdomen w/o & w/dye	2.26	10.56	NA	0.16	XXX
74183	TC	A	Mri abdomen w/o & w/dye	0.00	9.87	NA	0.01	XXX
74183	26	A	Mri abdomen w/o & w/dye	2.26	0.69	0.69	0.16	XXX
74185		R	Mri angio, abdom w orw/o dye	1.80	8.64	NA	0.13	XXX
74185	TC	R	Mri angio, abdom w orw/o dye	0.00	8.10	NA	0.01	XXX
74185	26	R	Mri angio, abdom w orw/o dye	1.80	0.55	0.55	0.12	XXX
74190		C	X-ray exam of peritoneum	0.00	NA	NA	0.00	XXX
74190	TC	C	X-ray exam of peritoneum	0.00	NA	NA	0.00	XXX
74190	26	A	X-ray exam of peritoneum	0.48	0.15	0.15	0.04	XXX
74210		A	Contrst x-ray exam of throat	0.36	1.58	NA	0.03	XXX
74210	TC	A	Contrst x-ray exam of throat	0.00	1.47	NA	0.00	XXX
74210	26	A	Contrst x-ray exam of throat	0.36	0.11	0.11	0.02	XXX
74220		A	Contrast x-ray, esophagus	0.46	1.82	NA	0.03	XXX
74220	TC	A	Contrast x-ray, esophagus	0.00	1.68	NA	0.00	XXX
74220	26	A	Contrast x-ray, esophagus	0.46	0.14	0.14	0.03	XXX
74230		A	Cine/vid x-ray, throat/esoph	0.53	1.75	NA	0.04	XXX
74230	TC	A	Cine/vid x-ray, throat/esoph	0.00	1.59	NA	0.00	XXX
74230	26	A	Cine/vid x-ray, throat/esoph	0.53	0.16	0.16	0.04	XXX
74235		C	Remove esophagus obstruction	0.00	NA	NA	0.00	XXX
74235	TC	C	Remove esophagus obstruction	0.00	NA	NA	0.00	XXX
74235	26	A	Remove esophagus obstruction	1.19	0.36	0.36	0.09	XXX
74240		A	X-ray exam, upper gi tract	0.69	2.08	NA	0.05	XXX
74240	TC	A	X-ray exam, upper gi tract	0.00	1.87	NA	0.00	XXX
74240	26	A	X-ray exam, upper gi tract	0.69	0.21	0.21	0.05	XXX
74241		A	X-ray exam, upper gi tract	0.69	2.31	NA	0.04	XXX
74241	TC	A	X-ray exam, upper gi tract	0.00	2.10	NA	0.00	XXX
74241	26	A	X-ray exam, upper gi tract	0.69	0.21	0.21	0.04	XXX
74245		A	X-ray exam, upper gi tract	0.91	3.53	NA	0.06	XXX
74245	TC	A	X-ray exam, upper gi tract	0.00	3.25	NA	0.00	XXX
74245	26	A	X-ray exam, upper gi tract	0.91	0.28	0.28	0.06	XXX
74246		A	Contrst x-ray upper gi tract	0.69	2.49	NA	0.05	XXX
74246	TC	A	Contrst x-ray upper gi tract	0.00	2.28	NA	0.00	XXX
74246	26	A	Contrst x-ray upper gi tract	0.69	0.21	0.21	0.05	XXX
74247		A	Contrst x-ray upper gi tract	0.69	2.87	NA	0.05	XXX
74247	TC	A	Contrst x-ray upper gi tract	0.00	2.66	NA	0.00	XXX
74247	26	A	Contrst x-ray upper gi tract	0.69	0.21	0.21	0.05	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74249		A	Contrst x-ray uppr gi tract	0.91	3.89	NA	0.06	XXX
74249	TC	A	Contrst x-ray uppr gi tract	0.00	3.61	NA	0.00	XXX
74249	26	A	Contrst x-ray uppr gi tract	0.91	0.28	0.28	0.06	XXX
74250		A	X-ray exam of small bowel	0.47	2.22	NA	0.03	XXX
74250	TC	A	X-ray exam of small bowel	0.00	2.08	NA	0.00	XXX
74250	26	A	X-ray exam of small bowel	0.47	0.14	0.14	0.03	XXX
74251		A	X-ray exam of small bowel	0.69	9.02	NA	0.05	XXX
74251	TC	A	X-ray exam of small bowel	0.00	8.82	NA	0.00	XXX
74251	26	A	X-ray exam of small bowel	0.69	0.21	0.21	0.05	XXX
74260		A	X-ray exam of small bowel	0.50	7.53	NA	0.04	XXX
74260	TC	A	X-ray exam of small bowel	0.00	7.38	NA	0.00	XXX
74260	26	A	X-ray exam of small bowel	0.50	0.15	0.15	0.03	XXX
74270		A	Contrast x-ray exam of colon	0.69	3.20	NA	0.05	XXX
74270	TC	A	Contrast x-ray exam of colon	0.00	2.99	NA	0.00	XXX
74270	26	A	Contrast x-ray exam of colon	0.69	0.21	0.21	0.05	XXX
74280		A	Contrast x-ray exam of colon	0.99	4.43	NA	0.07	XXX
74280	TC	A	Contrast x-ray exam of colon	0.00	4.13	NA	0.00	XXX
74280	26	A	Contrast x-ray exam of colon	0.99	0.30	0.30	0.07	XXX
74283		A	Contrast x-ray exam of colon	2.02	3.19	NA	0.09	XXX
74283	TC	A	Contrast x-ray exam of colon	0.00	2.56	NA	0.01	XXX
74283	26	A	Contrast x-ray exam of colon	2.02	0.63	0.63	0.09	XXX
74290		A	Contrast x-ray, gallbladder	0.32	1.44	NA	0.02	XXX
74290	TC	A	Contrast x-ray, gallbladder	0.00	1.34	NA	0.00	XXX
74290	26	A	Contrast x-ray, gallbladder	0.32	0.10	0.10	0.02	XXX
74291		A	Contrast x-rays, gallbladder	0.20	1.50	NA	0.01	XXX
74291	TC	A	Contrast x-rays, gallbladder	0.00	1.44	NA	0.00	XXX
74291	26	A	Contrast x-rays, gallbladder	0.20	0.07	0.07	0.01	XXX
74300		C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74300	TC	C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74300	26	A	X-ray bile ducts/pancreas	0.36	0.11	0.11	0.03	XXX
74301		C	X-rays at surgery add-on	0.00	NA	0.00	0.00	ZZZ
74301	TC	C	X-rays at surgery add-on	0.00	NA	0.00	0.00	ZZZ
74301	26	A	X-rays at surgery add-on	0.21	0.07	0.07	0.02	ZZZ
74305		C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74305	TC	C	X-ray bile ducts/pancreas	0.00	NA	NA	0.00	XXX
74305	26	A	X-ray bile ducts/pancreas	0.42	0.13	0.13	0.03	XXX
74320		A	Contrast x-ray of bile ducts	0.54	1.34	NA	0.04	XXX
74320	TC	A	Contrast x-ray of bile ducts	0.00	1.18	NA	0.00	XXX
74320	26	A	Contrast x-ray of bile ducts	0.54	0.16	0.16	0.04	XXX
74327		A	X-ray bile stone removal	0.70	2.08	NA	0.11	XXX
74327	TC	A	X-ray bile stone removal	0.00	1.87	NA	0.00	XXX
74327	26	A	X-ray bile stone removal	0.70	0.21	0.21	0.11	XXX
74328		C	X-ray bile duct endoscopy	0.00	NA	NA	0.00	XXX
74328	TC	C	X-ray bile duct endoscopy	0.00	NA	NA	0.00	XXX
74328	26	A	X-ray bile duct endoscopy	0.70	0.23	0.23	0.05	XXX
74329		C	X-ray for pancreas endoscopy	0.00	NA	NA	0.00	XXX
74329	TC	C	X-ray for pancreas endoscopy	0.00	NA	NA	0.00	XXX
74329	26	A	X-ray for pancreas endoscopy	0.70	0.23	0.23	0.05	XXX
74330		C	X-ray bile/panc endoscopy	0.00	NA	NA	0.00	XXX
74330	TC	C	X-ray bile/panc endoscopy	0.00	NA	NA	0.00	XXX
74330	26	A	X-ray bile/panc endoscopy	0.90	0.29	0.29	0.06	XXX
74340		C	X-ray guide for GI tube	0.00	NA	NA	0.00	XXX
74340	TC	C	X-ray guide for GI tube	0.00	NA	NA	0.00	XXX
74340	26	A	X-ray guide for GI tube	0.54	0.17	0.17	0.04	XXX
74355		C	X-ray guide, intestinal tube	0.00	NA	NA	0.00	XXX
74355	TC	C	X-ray guide, intestinal tube	0.00	NA	NA	0.00	XXX
74355	26	A	X-ray guide, intestinal tube	0.76	0.25	0.25	0.05	XXX
74360		C	X-ray guide, GI dilation	0.00	NA	NA	0.00	XXX
74360	TC	C	X-ray guide, GI dilation	0.00	NA	NA	0.00	XXX
74360	26	A	X-ray guide, GI dilation	0.54	0.22	0.22	0.04	XXX
74363		C	X-ray, bile duct dilation	0.00	NA	NA	0.00	XXX
74363	TC	C	X-ray, bile duct dilation	0.00	NA	NA	0.00	XXX
74363	26	A	X-ray, bile duct dilation	0.88	0.26	0.26	0.06	XXX
74400		A	Contrst x-ray, urinary tract	0.49	2.27	NA	0.04	XXX
74400	TC	A	Contrst x-ray, urinary tract	0.00	2.12	NA	0.00	XXX
74400	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74410		A	Contrst x-ray, urinary tract	0.49	2.29	NA	0.04	XXX
74410	TC	A	Contrst x-ray, urinary tract	0.00	2.13	NA	0.00	XXX
74410	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74415		A	Contrst x-ray, urinary tract	0.49	2.87	NA	0.04	XXX
74415	TC	A	Contrst x-ray, urinary tract	0.00	2.72	NA	0.00	XXX
74415	26	A	Contrst x-ray, urinary tract	0.49	0.15	0.15	0.03	XXX
74420		C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74420	TC	C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74420	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.11	0.03	XXX
74425		C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74425	TC	C	Contrst x-ray, urinary tract	0.00	NA	NA	0.00	XXX
74425	26	A	Contrst x-ray, urinary tract	0.36	0.11	0.11	0.03	XXX
74430		A	Contrast x-ray, bladder	0.32	1.70	NA	0.02	XXX
74430	TC	A	Contrast x-ray, bladder	0.00	1.60	NA	0.00	XXX
74430	26	A	Contrast x-ray, bladder	0.32	0.10	0.10	0.02	XXX
74440		A	X-ray, male genital tract	0.38	1.75	NA	0.03	XXX
74440	TC	A	X-ray, male genital tract	0.00	1.62	NA	0.00	XXX
74440	26	A	X-ray, male genital tract	0.38	0.13	0.13	0.03	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
74445		C	X-ray exam of penis	0.00	NA	NA	0.00	XXX
74445	TC	C	X-ray exam of penis	0.00	NA	NA	0.00	XXX
74445	26	A	X-ray exam of penis	1.14	0.37	0.37	0.08	XXX
74450		C	X-ray, urethra/bladder	0.00	NA	NA	0.00	XXX
74450	TC	C	X-ray, urethra/bladder	0.00	NA	NA	0.00	XXX
74450	26	A	X-ray, urethra/bladder	0.33	0.10	0.10	0.02	XXX
74455		A	X-ray, urethra/bladder	0.33	1.82	NA	0.02	XXX
74455	TC	A	X-ray, urethra/bladder	0.00	1.71	NA	0.00	XXX
74455	26	A	X-ray, urethra/bladder	0.33	0.11	0.11	0.02	XXX
74470		C	X-ray exam of kidney lesion	0.00	NA	NA	0.00	XXX
74470	TC	C	X-ray exam of kidney lesion	0.00	NA	NA	0.00	XXX
74470	26	A	X-ray exam of kidney lesion	0.54	0.16	0.16	0.04	XXX
74475		A	X-ray control, cath insert	0.54	1.32	NA	0.04	XXX
74475	TC	A	X-ray control, cath insert	0.00	1.16	NA	0.00	XXX
74475	26	A	X-ray control, cath insert	0.54	0.16	0.16	0.04	XXX
74480		A	X-ray control, cath insert	0.54	1.32	NA	0.04	XXX
74480	TC	A	X-ray control, cath insert	0.00	1.16	NA	0.00	XXX
74480	26	A	X-ray control, cath insert	0.54	0.16	0.16	0.04	XXX
74485		A	X-ray guide, GU dilation	0.54	1.35	NA	0.04	XXX
74485	TC	A	X-ray guide, GU dilation	0.00	1.19	NA	0.00	XXX
74485	26	A	X-ray guide, GU dilation	0.54	0.17	0.17	0.04	XXX
74710		A	X-ray measurement of pelvis	0.34	0.58	NA	0.02	XXX
74710	TC	A	X-ray measurement of pelvis	0.00	0.47	NA	0.00	XXX
74710	26	A	X-ray measurement of pelvis	0.34	0.10	0.10	0.02	XXX
74740		A	X-ray, female genital tract	0.38	1.59	NA	0.02	XXX
74740	TC	A	X-ray, female genital tract	0.00	1.47	NA	0.00	XXX
74740	26	A	X-ray, female genital tract	0.38	0.12	0.12	0.02	XXX
74742		C	X-ray, fallopian tube	0.00	NA	NA	0.00	XXX
74742	TC	C	X-ray, fallopian tube	0.00	NA	NA	0.00	XXX
74742	26	A	X-ray, fallopian tube	0.61	0.19	0.19	0.04	XXX
74775		C	X-ray exam of perineum	0.00	NA	NA	0.00	XXX
74775	TC	C	X-ray exam of perineum	0.00	NA	NA	0.00	XXX
74775	26	A	X-ray exam of perineum	0.62	0.19	0.19	0.04	XXX
75557		A	Cardiac mri for morph	2.35	6.11	NA	0.14	XXX
75557	TC	A	Cardiac mri for morph	0.00	5.37	NA	0.01	XXX
75557	26	A	Cardiac mri for morph	2.35	0.74	0.74	0.13	XXX
75558		N	Cardiac mri flow/velocity	2.60	8.79	NA	0.14	XXX
75558	TC	N	Cardiac mri flow/velocity	0.00	7.84	NA	0.01	XXX
75558	26	N	Cardiac mri flow/velocity	2.60	0.95	0.95	0.13	XXX
75559		A	Cardiac mri w/stress img	2.95	9.15	NA	0.18	XXX
75559	TC	A	Cardiac mri w/stress img	0.00	8.20	NA	0.01	XXX
75559	26	A	Cardiac mri w/stress img	2.95	0.95	0.95	0.17	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75560		N	Cardiac mri flow/vel/stress	3.00	11.98	NA	0.16	XXX
75560	TC	N	Cardiac mri flow/vel/stress	0.00	10.89	NA	0.01	XXX
75560	26	N	Cardiac mri flow/vel/stress	3.00	1.09	1.09	0.15	XXX
75561		A	Cardiac mri for morph w/dye	2.60	8.63	NA	0.15	XXX
75561	TC	A	Cardiac mri for morph w/dye	0.00	7.80	NA	0.01	XXX
75561	26	A	Cardiac mri for morph w/dye	2.60	0.83	0.83	0.14	XXX
75562		N	Card mri flow/vel w/dye	2.86	11.71	NA	0.15	XXX
75562	TC	N	Card mri flow/vel w/dye	0.00	10.66	NA	0.01	XXX
75562	26	N	Card mri flow/vel w/dye	2.86	1.04	1.04	0.15	XXX
75563		A	Card mri w/stress img & dye	3.00	10.40	NA	0.17	XXX
75563	TC	A	Card mri w/stress img & dye	0.00	9.43	NA	0.01	XXX
75563	26	A	Card mri w/stress img & dye	3.00	0.97	0.97	0.16	XXX
75564		N	Ht mri w/flo/vel/strs & dye	3.35	14.01	NA	0.18	XXX
75564	TC	N	Ht mri w/flo/vel/strs & dye	0.00	12.78	NA	0.01	XXX
75564	26	N	Ht mri w/flo/vel/strs & dye	3.35	1.22	1.22	0.17	XXX
75600		A	Contrast x-ray exam of aorta	0.49	4.32	NA	0.03	XXX
75600	TC	A	Contrast x-ray exam of aorta	0.00	4.16	NA	0.00	XXX
75600	26	A	Contrast x-ray exam of aorta	0.49	0.16	0.16	0.03	XXX
75605		A	Contrast x-ray exam of aorta	1.14	2.24	NA	0.09	XXX
75605	TC	A	Contrast x-ray exam of aorta	0.00	1.87	NA	0.00	XXX
75605	26	A	Contrast x-ray exam of aorta	1.14	0.36	0.36	0.08	XXX
75625		A	Contrast x-ray exam of aorta	1.14	2.29	NA	0.11	XXX
75625	TC	A	Contrast x-ray exam of aorta	0.00	1.94	NA	0.00	XXX
75625	26	A	Contrast x-ray exam of aorta	1.14	0.35	0.35	0.10	XXX
75630		A	X-ray aorta, leg arteries	1.79	2.51	NA	0.12	XXX
75630	TC	A	X-ray aorta, leg arteries	0.00	1.94	NA	0.01	XXX
75630	26	A	X-ray aorta, leg arteries	1.79	0.57	0.57	0.11	XXX
75635		A	Ct angio abdominal arteries	2.40	7.90	NA	0.16	XXX
75635	TC	A	Ct angio abdominal arteries	0.00	7.16	NA	0.01	XXX
75635	26	A	Ct angio abdominal arteries	2.40	0.74	0.74	0.15	XXX
75650		A	Artery x-rays, head & neck	1.49	2.41	NA	0.11	XXX
75650	TC	A	Artery x-rays, head & neck	0.00	1.94	NA	0.00	XXX
75650	26	A	Artery x-rays, head & neck	1.49	0.47	0.47	0.11	XXX
75658		A	Artery x-rays, arm	1.31	2.93	NA	0.10	XXX
75658	TC	A	Artery x-rays, arm	0.00	2.52	NA	0.00	XXX
75658	26	A	Artery x-rays, arm	1.31	0.41	0.41	0.10	XXX
75660		A	Artery x-rays, head & neck	1.31	2.89	NA	0.07	XXX
75660	TC	A	Artery x-rays, head & neck	0.00	2.45	NA	0.00	XXX
75660	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.06	XXX
75662		A	Artery x-rays, head & neck	1.66	3.57	NA	0.10	XXX
75662	TC	A	Artery x-rays, head & neck	0.00	3.02	NA	0.00	XXX
75662	26	A	Artery x-rays, head & neck	1.66	0.56	0.56	0.09	XXX

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75665		A	Artery x-rays, head & neck	1.31	3.10	NA	0.12	XXX
75665	TC	A	Artery x-rays, head & neck	0.00	2.66	NA	0.00	XXX
75665	26	A	Artery x-rays, head & neck	1.31	0.44	0.44	0.12	XXX
75671		A	Artery x-rays, head & neck	1.66	3.85	NA	0.12	XXX
75671	TC	A	Artery x-rays, head & neck	0.00	3.31	NA	0.00	XXX
75671	26	A	Artery x-rays, head & neck	1.66	0.54	0.54	0.11	XXX
75676		A	Artery x-rays, neck	1.31	2.83	NA	0.12	XXX
75676	TC	A	Artery x-rays, neck	0.00	2.40	NA	0.00	XXX
75676	26	A	Artery x-rays, neck	1.31	0.43	0.43	0.12	XXX
75680		A	Artery x-rays, neck	1.66	3.32	NA	0.12	XXX
75680	TC	A	Artery x-rays, neck	0.00	2.78	NA	0.00	XXX
75680	26	A	Artery x-rays, neck	1.66	0.54	0.54	0.12	XXX
75685		A	Artery x-rays, spine	1.31	2.86	NA	0.10	XXX
75685	TC	A	Artery x-rays, spine	0.00	2.43	NA	0.00	XXX
75685	26	A	Artery x-rays, spine	1.31	0.43	0.43	0.10	XXX
75705		A	Artery x-rays, spine	2.18	3.20	NA	0.11	XXX
75705	TC	A	Artery x-rays, spine	0.00	2.49	NA	0.01	XXX
75705	26	A	Artery x-rays, spine	2.18	0.71	0.71	0.11	XXX
75710		A	Artery x-rays, arm/leg	1.14	2.83	NA	0.07	XXX
75710	TC	A	Artery x-rays, arm/leg	0.00	2.47	NA	0.00	XXX
75710	26	A	Artery x-rays, arm/leg	1.14	0.36	0.36	0.07	XXX
75716		A	Artery x-rays, arms/legs	1.31	3.57	NA	0.11	XXX
75716	TC	A	Artery x-rays, arms/legs	0.00	3.16	NA	0.00	XXX
75716	26	A	Artery x-rays, arms/legs	1.31	0.41	0.41	0.11	XXX
75722		A	Artery x-rays, kidney	1.14	2.52	NA	0.08	XXX
75722	TC	A	Artery x-rays, kidney	0.00	2.16	NA	0.00	XXX
75722	26	A	Artery x-rays, kidney	1.14	0.36	0.36	0.08	XXX
75724		A	Artery x-rays, kidneys	1.49	3.15	NA	0.08	XXX
75724	TC	A	Artery x-rays, kidneys	0.00	2.66	NA	0.00	XXX
75724	26	A	Artery x-rays, kidneys	1.49	0.49	0.49	0.08	XXX
75726		A	Artery x-rays, abdomen	1.14	2.72	NA	0.10	XXX
75726	TC	A	Artery x-rays, abdomen	0.00	2.38	NA	0.00	XXX
75726	26	A	Artery x-rays, abdomen	1.14	0.34	0.34	0.09	XXX
75731		A	Artery x-rays, adrenal gland	1.14	2.57	NA	0.06	XXX
75731	TC	A	Artery x-rays, adrenal gland	0.00	2.19	NA	0.00	XXX
75731	26	A	Artery x-rays, adrenal gland	1.14	0.38	0.38	0.05	XXX
75733		A	Artery x-rays, adrenals	1.31	3.37	NA	0.07	XXX
75733	TC	A	Artery x-rays, adrenals	0.00	2.93	NA	0.00	XXX
75733	26	A	Artery x-rays, adrenals	1.31	0.44	0.44	0.06	XXX
75736		A	Artery x-rays, pelvis	1.14	2.70	NA	0.08	XXX
75736	TC	A	Artery x-rays, pelvis	0.00	2.35	NA	0.00	XXX
75736	26	A	Artery x-rays, pelvis	1.14	0.35	0.35	0.07	XXX
75741		A	Artery x-rays, lung	1.31	2.20	NA	0.10	XXX
75741	TC	A	Artery x-rays, lung	0.00	1.81	NA	0.00	XXX
75741	26	A	Artery x-rays, lung	1.31	0.39	0.39	0.09	XXX
75743		A	Artery x-rays, lungs	1.66	2.57	NA	0.12	XXX
75743	TC	A	Artery x-rays, lungs	0.00	2.06	NA	0.00	XXX
75743	26	A	Artery x-rays, lungs	1.66	0.51	0.51	0.12	XXX
75746		A	Artery x-rays, lung	1.14	2.54	NA	0.08	XXX
75746	TC	A	Artery x-rays, lung	0.00	2.19	NA	0.00	XXX
75746	26	A	Artery x-rays, lung	1.14	0.35	0.35	0.08	XXX
75756		A	Artery x-rays, chest	1.14	2.71	NA	0.19	XXX
75756	TC	A	Artery x-rays, chest	0.00	2.36	NA	0.00	XXX
75756	26	A	Artery x-rays, chest	1.14	0.35	0.35	0.18	XXX
75774		A	Artery x-ray, each vessel	0.36	1.58	1.58	0.03	ZZZ
75774	TC	A	Artery x-ray, each vessel	0.00	1.47	1.47	0.00	ZZZ
75774	26	A	Artery x-ray, each vessel	0.36	0.11	0.11	0.03	ZZZ
75790		A	Visualize A-V shunt	1.84	2.39	NA	0.13	XXX
75790	TC	A	Visualize A-V shunt	0.00	1.82	NA	0.01	XXX
75790	26	A	Visualize A-V shunt	1.84	0.57	0.57	0.12	XXX
75801		C	Lymph vessel x-ray, arm/leg	0.00	NA	NA	0.00	XXX
75801	TC	C	Lymph vessel x-ray, arm/leg	0.00	NA	NA	0.00	XXX
75801	26	A	Lymph vessel x-ray, arm/leg	0.81	0.30	0.30	0.13	XXX
75803		C	Lymph vessel x-ray,arms/legs	0.00	NA	NA	0.00	XXX
75803	TC	C	Lymph vessel x-ray,arms/legs	0.00	NA	NA	0.00	XXX
75803	26	A	Lymph vessel x-ray,arms/legs	1.17	0.36	0.36	0.08	XXX
75805		C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75805	TC	C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75805	26	A	Lymph vessel x-ray, trunk	0.81	0.25	0.25	0.06	XXX
75807		C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75807	TC	C	Lymph vessel x-ray, trunk	0.00	NA	NA	0.00	XXX
75807	26	A	Lymph vessel x-ray, trunk	1.17	0.36	0.36	0.08	XXX
75809		A	Nonvascular shunt, x-ray	0.47	1.45	NA	0.04	XXX
75809	TC	A	Nonvascular shunt, x-ray	0.00	1.30	NA	0.00	XXX
75809	26	A	Nonvascular shunt, x-ray	0.47	0.15	0.15	0.04	XXX
75810		C	Vein x-ray, spleen/liver	0.00	NA	NA	0.00	XXX
75810	TC	C	Vein x-ray, spleen/liver	0.00	NA	NA	0.00	XXX
75810	26	A	Vein x-ray, spleen/liver	1.14	0.34	0.34	0.08	XXX
75820		A	Vein x-ray, arm/leg	0.70	1.94	NA	0.05	XXX
75820	TC	A	Vein x-ray, arm/leg	0.00	1.71	NA	0.00	XXX
75820	26	A	Vein x-ray, arm/leg	0.70	0.22	0.22	0.05	XXX
75822		A	Vein x-ray, arms/legs	1.06	2.30	NA	0.08	XXX
75822	TC	A	Vein x-ray, arms/legs	0.00	1.97	NA	0.00	XXX
75822	26	A	Vein x-ray, arms/legs	1.06	0.32	0.32	0.08	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75825		A	Vein x-ray, trunk	1.14	2.09	NA	0.09	XXX
75825	TC	A	Vein x-ray, trunk	0.00	1.75	NA	0.00	XXX
75825	26	A	Vein x-ray, trunk	1.14	0.34	0.34	0.09	XXX
75827		A	Vein x-ray, chest	1.14	2.21	NA	0.08	XXX
75827	TC	A	Vein x-ray, chest	0.00	1.86	NA	0.00	XXX
75827	26	A	Vein x-ray, chest	1.14	0.35	0.35	0.08	XXX
75831		A	Vein x-ray, kidney	1.14	2.21	NA	0.21	XXX
75831	TC	A	Vein x-ray, kidney	0.00	1.87	NA	0.00	XXX
75831	26	A	Vein x-ray, kidney	1.14	0.34	0.34	0.20	XXX
75833		A	Vein x-ray, kidneys	1.49	2.76	NA	0.11	XXX
75833	TC	A	Vein x-ray, kidneys	0.00	2.32	NA	0.00	XXX
75833	26	A	Vein x-ray, kidneys	1.49	0.44	0.44	0.10	XXX
75840		A	Vein x-ray, adrenal gland	1.14	2.07	NA	0.21	XXX
75840	TC	A	Vein x-ray, adrenal gland	0.00	1.76	NA	0.00	XXX
75840	26	A	Vein x-ray, adrenal gland	1.14	0.31	0.31	0.20	XXX
75842		A	Vein x-ray, adrenal glands	1.49	2.71	NA	0.11	XXX
75842	TC	A	Vein x-ray, adrenal glands	0.00	2.24	NA	0.00	XXX
75842	26	A	Vein x-ray, adrenal glands	1.49	0.46	0.46	0.10	XXX
75860		A	Vein x-ray, neck	1.14	2.17	NA	0.09	XXX
75860	TC	A	Vein x-ray, neck	0.00	1.81	NA	0.00	XXX
75860	26	A	Vein x-ray, neck	1.14	0.36	0.36	0.09	XXX
75870		A	Vein x-ray, skull	1.14	2.32	NA	0.08	XXX
75870	TC	A	Vein x-ray, skull	0.00	1.94	NA	0.00	XXX
75870	26	A	Vein x-ray, skull	1.14	0.38	0.38	0.08	XXX
75872		A	Vein x-ray, skull	1.14	4.62	NA	0.08	XXX
75872	TC	A	Vein x-ray, skull	0.00	4.09	NA	0.00	XXX
75872	26	A	Vein x-ray, skull	1.14	0.53	0.53	0.08	XXX
75880		A	Vein x-ray, eye socket	0.70	2.03	NA	0.05	XXX
75880	TC	A	Vein x-ray, eye socket	0.00	1.81	NA	0.00	XXX
75880	26	A	Vein x-ray, eye socket	0.70	0.22	0.22	0.05	XXX
75885		A	Vein x-ray, liver	1.44	2.27	NA	0.10	XXX
75885	TC	A	Vein x-ray, liver	0.00	1.84	NA	0.00	XXX
75885	26	A	Vein x-ray, liver	1.44	0.43	0.43	0.10	XXX
75887		A	Vein x-ray, liver	1.44	2.35	NA	0.08	XXX
75887	TC	A	Vein x-ray, liver	0.00	1.90	NA	0.00	XXX
75887	26	A	Vein x-ray, liver	1.44	0.45	0.45	0.08	XXX
75889		A	Vein x-ray, liver	1.14	2.17	NA	0.08	XXX
75889	TC	A	Vein x-ray, liver	0.00	1.83	NA	0.00	XXX
75889	26	A	Vein x-ray, liver	1.14	0.34	0.34	0.08	XXX
75891		A	Vein x-ray, liver	1.14	2.17	NA	0.08	XXX
75891	TC	A	Vein x-ray, liver	0.00	1.83	NA	0.00	XXX
75891	26	A	Vein x-ray, liver	1.14	0.34	0.34	0.08	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75893		A	Venous sampling by catheter	0.54	1.95	NA	0.03	XXX
75893	TC	A	Venous sampling by catheter	0.00	1.78	NA	0.00	XXX
75893	26	A	Venous sampling by catheter	0.54	0.16	0.16	0.03	XXX
75894		C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75894	TC	C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75894	26	A	X-rays, transcath therapy	1.31	0.40	0.40	0.12	XXX
75896		C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75896	TC	C	X-rays, transcath therapy	0.00	NA	NA	0.00	XXX
75896	26	A	X-rays, transcath therapy	1.31	0.41	0.41	0.12	XXX
75898		C	Follow-up angiography	0.00	NA	NA	0.00	XXX
75898	TC	C	Follow-up angiography	0.00	NA	NA	0.00	XXX
75898	26	A	Follow-up angiography	1.65	0.52	0.52	0.15	XXX
75900		C	Intravascular cath exchange	0.00	NA	NA	0.00	XXX
75900	TC	C	Intravascular cath exchange	0.00	NA	NA	0.00	XXX
75900	26	A	Intravascular cath exchange	0.49	0.15	0.15	0.05	XXX
75901		A	Remove cva device obstruct	0.49	3.89	NA	0.04	XXX
75901	TC	A	Remove cva device obstruct	0.00	3.74	NA	0.00	XXX
75901	26	A	Remove cva device obstruct	0.49	0.15	0.15	0.04	XXX
75902		A	Remove cva lumen obstruct	0.39	1.55	NA	0.05	XXX
75902	TC	A	Remove cva lumen obstruct	0.00	1.43	NA	0.00	XXX
75902	26	A	Remove cva lumen obstruct	0.39	0.12	0.12	0.04	XXX
75940		C	X-ray placement, vein filter	0.00	NA	NA	0.00	XXX
75940	TC	C	X-ray placement, vein filter	0.00	NA	NA	0.00	XXX
75940	26	A	X-ray placement, vein filter	0.54	0.16	0.16	0.05	XXX
75945		C	Intravascular us	0.00	NA	NA	0.00	XXX
75945	TC	C	Intravascular us	0.00	NA	NA	0.00	XXX
75945	26	A	Intravascular us	0.40	0.12	0.12	0.05	XXX
75946		C	Intravascular us add-on	0.00	NA	0.00	0.00	ZZZ
75946	TC	C	Intravascular us add-on	0.00	NA	0.00	0.00	ZZZ
75946	26	A	Intravascular us add-on	0.40	0.12	0.12	0.06	ZZZ
75952		C	Endovasc repair abdom aorta	0.00	NA	NA	0.00	XXX
75952	TC	C	Endovasc repair abdom aorta	0.00	NA	NA	0.00	XXX
75952	26	A	Endovasc repair abdom aorta	4.49	1.36	1.36	0.66	XXX
75953		C	Abdom aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75953	TC	C	Abdom aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75953	26	A	Abdom aneurysm endovas rpr	1.36	0.41	0.41	0.20	XXX
75954		C	Iliac aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75954	TC	C	Iliac aneurysm endovas rpr	0.00	NA	NA	0.00	XXX
75954	26	A	Iliac aneurysm endovas rpr	2.25	0.68	0.68	0.32	XXX
75956		C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75956	TC	C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75956	26	A	Xray, endovasc thor ao repr	7.00	2.07	2.07	1.10	XXX

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
75957		C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75957	TC	C	Xray, endovasc thor ao repr	0.00	NA	NA	0.00	XXX
75957	26	A	Xray, endovasc thor ao repr	6.00	1.77	1.77	0.93	XXX
75958		C	Xray, place prox ext thor ao	0.00	NA	NA	0.00	XXX
75958	TC	C	Xray, place prox ext thor ao	0.00	NA	NA	0.00	XXX
75958	26	A	Xray, place prox ext thor ao	4.00	1.17	1.17	0.62	XXX
75959		C	Xray, place dist ext thor ao	0.00	NA	NA	0.00	XXX
75959	TC	C	Xray, place dist ext thor ao	0.00	NA	NA	0.00	XXX
75959	26	A	Xray, place dist ext thor ao	3.50	0.95	0.95	0.63	XXX
75960		A	Transcath iv stent rs&i	0.82	1.72	NA	0.06	XXX
75960	TC	A	Transcath iv stent rs&i	0.00	1.46	NA	0.00	XXX
75960	26	A	Transcath iv stent rs&i	0.82	0.26	0.26	0.06	XXX
75961		A	Retrieval, broken catheter	4.24	3.52	NA	0.31	XXX
75961	TC	A	Retrieval, broken catheter	0.00	2.24	NA	0.01	XXX
75961	26	A	Retrieval, broken catheter	4.24	1.28	1.28	0.29	XXX
75962		A	Repair arterial blockage	0.54	2.44	NA	0.04	XXX
75962	TC	A	Repair arterial blockage	0.00	2.27	NA	0.00	XXX
75962	26	A	Repair arterial blockage	0.54	0.17	0.17	0.04	XXX
75964		A	Repair artery blockage, each	0.36	1.47	1.47	0.04	ZZZ
75964	TC	A	Repair artery blockage, each	0.00	1.36	1.36	0.00	ZZZ
75964	26	A	Repair artery blockage, each	0.36	0.11	0.11	0.04	ZZZ
75966		A	Repair arterial blockage	1.31	2.68	NA	0.09	XXX
75966	TC	A	Repair arterial blockage	0.00	2.26	NA	0.00	XXX
75966	26	A	Repair arterial blockage	1.31	0.42	0.42	0.08	XXX
75968		A	Repair artery blockage, each	0.36	1.36	1.36	0.02	ZZZ
75968	TC	A	Repair artery blockage, each	0.00	1.24	1.24	0.00	ZZZ
75968	26	A	Repair artery blockage, each	0.36	0.11	0.11	0.02	ZZZ
75970		C	Vascular biopsy	0.00	NA	NA	0.00	XXX
75970	TC	C	Vascular biopsy	0.00	NA	NA	0.00	XXX
75970	26	A	Vascular biopsy	0.83	0.25	0.25	0.06	XXX
75978		A	Repair venous blockage	0.54	2.52	NA	0.04	XXX
75978	TC	A	Repair venous blockage	0.00	2.35	NA	0.00	XXX
75978	26	A	Repair venous blockage	0.54	0.17	0.17	0.03	XXX
75980		C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75980	TC	C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75980	26	A	Contrast xray exam bile duct	1.44	0.43	0.43	0.10	XXX
75982		C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75982	TC	C	Contrast xray exam bile duct	0.00	NA	NA	0.00	XXX
75982	26	A	Contrast xray exam bile duct	1.44	0.43	0.43	0.11	XXX
75984		A	Xray control catheter change	0.72	1.51	NA	0.05	XXX
75984	TC	A	Xray control catheter change	0.00	1.29	NA	0.00	XXX
75984	26	A	Xray control catheter change	0.72	0.22	0.22	0.05	XXX
75989		A	Abscess drainage under x-ray	1.19	1.48	NA	0.08	XXX
75989	TC	A	Abscess drainage under x-ray	0.00	1.12	NA	0.00	XXX
75989	26	A	Abscess drainage under x-ray	1.19	0.36	0.36	0.08	XXX
75992		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75992	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75992	26	A	Atherectomy, x-ray exam	0.54	0.17	0.17	0.05	XXX
75993		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75993	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75993	26	A	Atherectomy, x-ray exam	0.36	0.11	0.11	0.04	ZZZ
75994		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75994	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75994	26	A	Atherectomy, x-ray exam	1.31	0.31	0.31	0.10	XXX
75995		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75995	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	XXX
75995	26	A	Atherectomy, x-ray exam	1.31	0.44	0.44	0.07	XXX
75996		C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75996	TC	C	Atherectomy, x-ray exam	0.00	NA	NA	0.00	ZZZ
75996	26	A	Atherectomy, x-ray exam	0.36	0.10	0.10	0.06	XXX
76000		A	Fluoroscope examination	0.17	2.74	NA	0.02	XXX
76000	TC	A	Fluoroscope examination	0.00	2.68	NA	0.00	XXX
76000	26	A	Fluoroscope examination	0.17	0.06	0.06	0.02	XXX
76001		C	Fluoroscope exam, extensive	0.00	NA	NA	0.00	XXX
76001	TC	C	Fluoroscope exam, extensive	0.00	NA	NA	0.00	XXX
76001	26	A	Fluoroscope exam, extensive	0.67	0.24	0.24	0.07	XXX
76010		A	X-ray, nose to rectum	0.18	0.47	NA	0.01	XXX
76010	TC	A	X-ray, nose to rectum	0.00	0.42	NA	0.00	XXX
76010	26	A	X-ray, nose to rectum	0.18	0.05	0.05	0.01	XXX
76080		A	X-ray exam of fistula	0.54	0.98	NA	0.03	XXX
76080	TC	A	X-ray exam of fistula	0.00	0.82	NA	0.00	XXX
76080	26	A	X-ray exam of fistula	0.54	0.16	0.16	0.03	XXX
76098		A	X-ray exam, breast specimen	0.16	0.29	NA	0.01	XXX
76098	TC	A	X-ray exam, breast specimen	0.00	0.24	NA	0.00	XXX
76098	26	A	X-ray exam, breast specimen	0.16	0.05	0.05	0.01	XXX
76100		A	X-ray exam of body section	0.58	3.46	NA	0.05	XXX
76100	TC	A	X-ray exam of body section	0.00	3.21	NA	0.00	XXX
76100	26	A	X-ray exam of body section	0.58	0.24	0.24	0.05	XXX
76101		A	Complex body section x-ray	0.58	5.23	NA	0.02	XXX
76101	TC	A	Complex body section x-ray	0.00	4.92	NA	0.00	XXX
76101	26	A	Complex body section x-ray	0.58	0.32	0.32	0.01	XXX
76102		A	Complex body section x-rays	0.58	7.62	NA	0.02	XXX
76102	TC	A	Complex body section x-rays	0.00	7.28	NA	0.00	XXX
76102	26	A	Complex body section x-rays	0.58	0.34	0.34	0.02	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76120		A	Cine/video x-rays	0.38	1.52	NA	0.04	XXX
76120	TC	A	Cine/video x-rays	0.00	1.39	NA	0.00	XXX
76120	26	A	Cine/video x-rays	0.38	0.13	0.13	0.04	XXX
76125		C	Cine/video x-rays add-on	0.00	NA	NA	0.00	ZZZ
76125	TC	C	Cine/video x-rays add-on	0.00	NA	NA	0.00	ZZZ
76125	26	A	Cine/video x-rays add-on	0.27	0.09	0.09	0.02	ZZZ
76140		I	X-ray consultation	0.00	0.00	0.00	0.00	XXX
76150		A	X-ray exam, dry process	0.00	0.56	NA	0.00	XXX
76350		C	Special x-ray contrast study	0.00	NA	NA	0.00	XXX
76376		A	3d render w/o postprocess	0.20	1.25	NA	0.01	XXX
76376	TC	A	3d render w/o postprocess	0.00	1.19	NA	0.00	XXX
76376	26	A	3d render w/o postprocess	0.20	0.06	0.06	0.01	XXX
76377		A	3d rendering w/postprocess	0.79	1.22	NA	0.05	XXX
76377	TC	A	3d rendering w/postprocess	0.00	0.97	NA	0.00	XXX
76377	26	A	3d rendering w/postprocess	0.79	0.25	0.25	0.05	XXX
76380		A	CAT scan follow-up study	0.98	2.78	NA	0.06	XXX
76380	TC	A	CAT scan follow-up study	0.00	2.47	NA	0.00	XXX
76380	26	A	CAT scan follow-up study	0.98	0.31	0.31	0.06	XXX
76390		N	Mr spectroscopy	1.40	6.42	NA	0.07	XXX
76390	TC	N	Mr spectroscopy	0.00	5.91	NA	0.00	XXX
76390	26	N	Mr spectroscopy	1.40	0.51	0.51	0.07	XXX
76496		C	Fluoroscopic procedure	0.00	0.00	NA	0.00	XXX
76496	TC	C	Fluoroscopic procedure	0.00	0.00	NA	0.00	XXX
76496	26	C	Fluoroscopic procedure	0.00	0.00	0.00	0.00	XXX
76497		C	Ct procedure	0.00	0.00	NA	0.00	XXX
76497	TC	C	Ct procedure	0.00	0.00	NA	0.00	XXX
76497	26	C	Ct procedure	0.00	0.00	0.00	0.00	XXX
76498		C	Mri procedure	0.00	0.00	NA	0.00	XXX
76498	TC	C	Mri procedure	0.00	0.00	NA	0.00	XXX
76498	26	C	Mri procedure	0.00	0.00	0.00	0.00	XXX
76499		C	Radiographic procedure	0.00	0.00	NA	0.00	XXX
76499	TC	C	Radiographic procedure	0.00	0.00	NA	0.00	XXX
76499	26	C	Radiographic procedure	0.00	0.00	0.00	0.00	XXX
76506		A	Echo exam of head	0.63	2.53	NA	0.03	XXX
76506	TC	A	Echo exam of head	0.00	2.32	NA	0.00	XXX
76506	26	A	Echo exam of head	0.63	0.21	0.21	0.03	XXX
76510		A	Ophth us, b & quant a	1.55	2.82	NA	0.05	XXX
76510	TC	A	Ophth us, b & quant a	0.00	1.90	NA	0.00	XXX
76510	26	A	Ophth us, b & quant a	1.55	0.92	0.92	0.04	XXX
76511		A	Ophth us, quant a only	0.94	1.66	NA	0.03	XXX
76511	TC	A	Ophth us, quant a only	0.00	1.14	NA	0.00	XXX
76511	26	A	Ophth us, quant a only	0.94	0.52	0.52	0.02	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76512		A	Ophth us, b w/non-quant a	0.94	1.46	NA	0.03	XXX
76512	TC	A	Ophth us, b w/non-quant a	0.00	0.93	NA	0.00	XXX
76512	26	A	Ophth us, b w/non-quant a	0.94	0.54	0.54	0.03	XXX
76513		A	Echo exam of eye, water bath	0.66	1.70	NA	0.02	XXX
76513	TC	A	Echo exam of eye, water bath	0.00	1.38	NA	0.00	XXX
76513	26	A	Echo exam of eye, water bath	0.66	0.32	0.32	0.02	XXX
76514		A	Echo exam of eye, thickness	0.17	0.21	NA	0.00	XXX
76514	TC	A	Echo exam of eye, thickness	0.00	0.12	NA	0.00	XXX
76514	26	A	Echo exam of eye, thickness	0.17	0.09	0.09	0.00	XXX
76516		A	Echo exam of eye	0.54	1.40	NA	0.02	XXX
76516	TC	A	Echo exam of eye	0.00	1.10	NA	0.00	XXX
76516	26	A	Echo exam of eye	0.54	0.30	0.30	0.01	XXX
76519		A	Echo exam of eye	0.54	1.54	NA	0.02	XXX
76519	TC	A	Echo exam of eye	0.00	1.23	NA	0.00	XXX
76519	26	A	Echo exam of eye	0.54	0.32	0.32	0.01	XXX
76529		A	Echo exam of eye	0.57	1.42	NA	0.02	XXX
76529	TC	A	Echo exam of eye	0.00	1.08	NA	0.00	XXX
76529	26	A	Echo exam of eye	0.57	0.34	0.34	0.02	XXX
76536		A	Us exam of head and neck	0.56	2.48	NA	0.03	XXX
76536	TC	A	Us exam of head and neck	0.00	2.30	NA	0.00	XXX
76536	26	A	Us exam of head and neck	0.56	0.18	0.18	0.03	XXX
76604		A	Us exam, chest	0.55	1.63	NA	0.04	XXX
76604	TC	A	Us exam, chest	0.00	1.47	NA	0.00	XXX
76604	26	A	Us exam, chest	0.55	0.17	0.17	0.04	XXX
76645		A	Us exam, breast(s)	0.54	1.89	NA	0.05	XXX
76645	TC	A	Us exam, breast(s)	0.00	1.73	NA	0.00	XXX
76645	26	A	Us exam, breast(s)	0.54	0.17	0.17	0.04	XXX
76700		A	Us exam, abdom, complete	0.81	2.73	NA	0.05	XXX
76700	TC	A	Us exam, abdom, complete	0.00	2.47	NA	0.00	XXX
76700	26	A	Us exam, abdom, complete	0.81	0.25	0.25	0.05	XXX
76705		A	Echo exam of abdomen	0.59	2.09	NA	0.04	XXX
76705	TC	A	Echo exam of abdomen	0.00	1.91	NA	0.00	XXX
76705	26	A	Echo exam of abdomen	0.59	0.18	0.18	0.04	XXX
76770		A	Us exam abdo back wall, comp	0.74	2.58	NA	0.05	XXX
76770	TC	A	Us exam abdo back wall, comp	0.00	2.35	NA	0.00	XXX
76770	26	A	Us exam abdo back wall, comp	0.74	0.23	0.23	0.05	XXX
76775		A	Us exam abdo back wall, lim	0.58	2.10	NA	0.04	XXX
76775	TC	A	Us exam abdo back wall, lim	0.00	1.92	NA	0.00	XXX
76775	26	A	Us exam abdo back wall, lim	0.58	0.18	0.18	0.04	XXX
76776		A	Us exam k transpl w/doppler	0.76	3.04	NA	0.05	XXX
76776	TC	A	Us exam k transpl w/doppler	0.00	2.81	NA	0.00	XXX
76776	26	A	Us exam k transpl w/doppler	0.76	0.23	0.23	0.05	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76800		A	Us exam, spinal canal	1.13	2.42	NA	0.06	XXX
76800	TC	A	Us exam, spinal canal	0.00	2.01	NA	0.00	XXX
76800	26	A	Us exam, spinal canal	1.13	0.41	0.41	0.06	XXX
76801		A	Ob us < 14 wks, single fetus	0.99	2.24	NA	0.05	XXX
76801	TC	A	Ob us < 14 wks, single fetus	0.00	1.91	NA	0.00	XXX
76801	26	A	Ob us < 14 wks, single fetus	0.99	0.33	0.33	0.05	XXX
76802		A	Ob us < 14 wks, add£l fetus	0.83	0.93	0.93	0.04	ZZZ
76802	TC	A	Ob us < 14 wks, add£l fetus	0.00	0.64	0.64	0.00	ZZZ
76802	26	A	Ob us < 14 wks, add£l fetus	0.83	0.29	0.29	0.04	ZZZ
76805		A	Ob us >/= 14 wks, sngl fetus	0.99	2.78	NA	0.05	XXX
76805	TC	A	Ob us >/= 14 wks, sngl fetus	0.00	2.43	NA	0.00	XXX
76805	26	A	Ob us >/= 14 wks, sngl fetus	0.99	0.34	0.34	0.05	XXX
76810		A	Ob us >/= 14 wks, addl fetus	0.98	1.55	1.55	0.05	ZZZ
76810	TC	A	Ob us >/= 14 wks, addl fetus	0.00	1.21	1.21	0.00	ZZZ
76810	26	A	Ob us >/= 14 wks, addl fetus	0.98	0.34	0.34	0.04	ZZZ
76811		A	Ob us, detailed, sngl fetus	1.90	2.94	NA	0.09	XXX
76811	TC	A	Ob us, detailed, sngl fetus	0.00	2.22	NA	0.01	XXX
76811	26	A	Ob us, detailed, sngl fetus	1.90	0.71	0.71	0.08	XXX
76812		A	Ob us, detailed, addl fetus	1.78	3.72	3.72	0.08	ZZZ
76812	TC	A	Ob us, detailed, addl fetus	0.00	3.05	3.05	0.01	ZZZ
76812	26	A	Ob us, detailed, addl fetus	1.78	0.67	0.67	0.08	ZZZ
76813		A	Ob us nuchal meas, 1 gest	1.18	2.07	NA	0.06	XXX
76813	TC	A	Ob us nuchal meas, 1 gest	0.00	1.63	NA	0.00	XXX
76813	26	A	Ob us nuchal meas, 1 gest	1.18	0.44	0.44	0.05	XXX
76814		A	Ob us nuchal meas, add-on	0.99	1.15	NA	0.05	XXX
76814	TC	A	Ob us nuchal meas, add-on	0.00	0.77	NA	0.00	XXX
76814	26	A	Ob us nuchal meas, add-on	0.99	0.38	0.38	0.04	XXX
76815		A	Ob us, limited, fetus(s)	0.65	1.65	NA	0.03	XXX
76815	TC	A	Ob us, limited, fetus(s)	0.00	1.43	NA	0.00	XXX
76815	26	A	Ob us, limited, fetus(s)	0.65	0.22	0.22	0.03	XXX
76816		A	Ob us, follow-up, per fetus	0.85	2.20	NA	0.04	XXX
76816	TC	A	Ob us, follow-up, per fetus	0.00	1.89	NA	0.00	XXX
76816	26	A	Ob us, follow-up, per fetus	0.85	0.31	0.31	0.04	XXX
76817		A	Transvaginal us, obstetric	0.75	1.84	NA	0.04	XXX
76817	TC	A	Transvaginal us, obstetric	0.00	1.59	NA	0.00	XXX
76817	26	A	Transvaginal us, obstetric	0.75	0.26	0.26	0.03	XXX
76818		A	Fetal biophys profile w/nst	1.05	2.09	NA	0.05	XXX
76818	TC	A	Fetal biophys profile w/nst	0.00	1.70	NA	0.00	XXX
76818	26	A	Fetal biophys profile w/nst	1.05	0.39	0.39	0.05	XXX
76819		A	Fetal biophys profil w/o nst	0.77	1.51	NA	0.04	XXX
76819	TC	A	Fetal biophys profil w/o nst	0.00	1.24	NA	0.00	XXX
76819	26	A	Fetal biophys profil w/o nst	0.77	0.27	0.27	0.03	XXX
76820		A	Umbilical artery echo	0.50	0.56	NA	0.02	XXX
76820	TC	A	Umbilical artery echo	0.00	0.38	NA	0.00	XXX
76820	26	A	Umbilical artery echo	0.50	0.19	0.19	0.02	XXX
76821		A	Middle cerebral artery echo	0.70	1.73	NA	0.03	XXX
76821	TC	A	Middle cerebral artery echo	0.00	1.47	NA	0.00	XXX
76821	26	A	Middle cerebral artery echo	0.70	0.26	0.26	0.03	XXX
76825		A	Echo exam of fetal heart	1.67	4.00	NA	0.08	XXX
76825	TC	A	Echo exam of fetal heart	0.00	3.40	NA	0.00	XXX
76825	26	A	Echo exam of fetal heart	1.67	0.61	0.61	0.07	XXX
76826		A	Echo exam of fetal heart	0.83	2.52	NA	0.04	XXX
76826	TC	A	Echo exam of fetal heart	0.00	2.21	NA	0.00	XXX
76826	26	A	Echo exam of fetal heart	0.83	0.30	0.30	0.04	XXX
76827		A	Echo exam of fetal heart	0.58	1.01	NA	0.03	XXX
76827	TC	A	Echo exam of fetal heart	0.00	0.80	NA	0.00	XXX
76827	26	A	Echo exam of fetal heart	0.58	0.21	0.21	0.03	XXX
76828		A	Echo exam of fetal heart	0.56	0.63	NA	0.03	XXX
76828	TC	A	Echo exam of fetal heart	0.00	0.42	NA	0.00	XXX
76828	26	A	Echo exam of fetal heart	0.56	0.21	0.21	0.03	XXX
76830		A	Transvaginal us, non-ob	0.69	2.48	NA	0.04	XXX
76830	TC	A	Transvaginal us, non-ob	0.00	2.26	NA	0.00	XXX
76830	26	A	Transvaginal us, non-ob	0.69	0.23	0.23	0.04	XXX
76831		A	Echo exam, uterus	0.72	2.50	NA	0.04	XXX
76831	TC	A	Echo exam, uterus	0.00	2.23	NA	0.00	XXX
76831	26	A	Echo exam, uterus	0.72	0.27	0.27	0.03	XXX
76856		A	Us exam, pelvic, complete	0.69	2.46	NA	0.04	XXX
76856	TC	A	Us exam, pelvic, complete	0.00	2.24	NA	0.00	XXX
76856	26	A	Us exam, pelvic, complete	0.69	0.22	0.22	0.04	XXX
76857		A	Us exam, pelvic, limited	0.38	2.02	NA	0.03	XXX
76857	TC	A	Us exam, pelvic, limited	0.00	1.90	NA	0.00	XXX
76857	26	A	Us exam, pelvic, limited	0.38	0.12	0.12	0.03	XXX
76870		A	Us exam, scrotum	0.64	2.46	NA	0.05	XXX
76870	TC	A	Us exam, scrotum	0.00	2.27	NA	0.00	XXX
76870	26	A	Us exam, scrotum	0.64	0.20	0.20	0.04	XXX
76872		A	Us, transrectal	0.69	2.64	NA	0.05	XXX
76872	TC	A	Us, transrectal	0.00	2.42	NA	0.00	XXX
76872	26	A	Us, transrectal	0.69	0.23	0.23	0.05	XXX
76873		A	Echograp trans r, pros study	1.55	2.94	NA	0.10	XXX
76873	TC	A	Echograp trans r, pros study	0.00	2.39	NA	0.00	XXX
76873	26	A	Echograp trans r, pros study	1.55	0.55	0.55	0.10	XXX
76880		A	Us exam, extremity	0.59	3.04	NA	0.03	XXX
76880	TC	A	Us exam, extremity	0.00	2.86	NA	0.00	XXX
76880	26	A	Us exam, extremity	0.59	0.18	0.18	0.03	XXX

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76885		A	Us exam infant hips, dynamic	0.74	2.97	NA	0.05	XXX
76885	TC	A	Us exam infant hips, dynamic	0.00	2.73	NA	0.00	XXX
76885	26	A	Us exam infant hips, dynamic	0.74	0.23	0.23	0.05	XXX
76886		A	Us exam infant hips, static	0.62	2.59	NA	0.03	XXX
76886	TC	A	Us exam infant hips, static	0.00	2.34	NA	0.00	XXX
76886	26	A	Us exam infant hips, static	0.62	0.25	0.25	0.03	XXX
76930		A	Echo guide, cardiocentesis	0.67	1.43	NA	0.03	XXX
76930	TC	A	Echo guide, cardiocentesis	0.00	1.21	NA	0.00	XXX
76930	26	A	Echo guide, cardiocentesis	0.67	0.22	0.22	0.03	XXX
76932		C	Echo guide for heart biopsy	0.00	NA	NA	0.00	XXX
76932	TC	C	Echo guide for heart biopsy	0.00	NA	NA	0.00	XXX
76932	26	A	Echo guide for heart biopsy	0.67	0.23	0.23	0.04	XXX
76936		A	Echo guide for artery repair	1.99	5.46	NA	0.22	XXX
76936	TC	A	Echo guide for artery repair	0.00	4.85	NA	0.01	XXX
76936	26	A	Echo guide for artery repair	1.99	0.62	0.62	0.21	XXX
76937		A	Us guide, vascular access	0.30	0.58	0.58	0.02	ZZZ
76937	TC	A	Us guide, vascular access	0.00	0.49	0.49	0.00	ZZZ
76937	26	A	Us guide, vascular access	0.30	0.09	0.09	0.02	ZZZ
76940		C	Us guide, tissue ablation	0.00	NA	NA	0.00	XXX
76940	TC	C	Us guide, tissue ablation	0.00	NA	NA	0.00	XXX
76940	26	A	Us guide, tissue ablation	2.00	0.67	0.67	0.21	XXX
76941		C	Echo guide for transfusion	0.00	NA	NA	0.00	XXX
76941	TC	C	Echo guide for transfusion	0.00	NA	NA	0.00	XXX
76941	26	A	Echo guide for transfusion	1.34	0.51	0.51	0.10	XXX
76942		A	Echo guide for biopsy	0.67	4.25	NA	0.05	XXX
76942	TC	A	Echo guide for biopsy	0.00	4.03	NA	0.00	XXX
76942	26	A	Echo guide for biopsy	0.67	0.21	0.21	0.04	XXX
76945		C	Echo guide, villus sampling	0.00	NA	NA	0.00	XXX
76945	TC	C	Echo guide, villus sampling	0.00	NA	NA	0.00	XXX
76945	26	A	Echo guide, villus sampling	0.67	0.26	0.26	0.03	XXX
76946		A	Echo guide for amniocentesis	0.38	0.44	NA	0.02	XXX
76946	TC	A	Echo guide for amniocentesis	0.00	0.30	NA	0.00	XXX
76946	26	A	Echo guide for amniocentesis	0.38	0.14	0.14	0.02	XXX
76948		A	Echo guide, ova aspiration	0.38	0.53	NA	0.03	XXX
76948	TC	A	Echo guide, ova aspiration	0.00	0.39	NA	0.00	XXX
76948	26	A	Echo guide, ova aspiration	0.38	0.14	0.14	0.03	XXX
76950		A	Echo guidance radiotherapy	0.58	1.11	NA	0.04	XXX
76950	TC	A	Echo guidance radiotherapy	0.00	0.89	NA	0.00	XXX
76950	26	A	Echo guidance radiotherapy	0.58	0.22	0.22	0.04	XXX
76965		A	Echo guidance radiotherapy	1.34	1.02	NA	0.10	XXX
76965	TC	A	Echo guidance radiotherapy	0.00	0.56	NA	0.00	XXX
76965	26	A	Echo guidance radiotherapy	1.34	0.47	0.47	0.09	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
76970		A	Ultrasound exam follow-up	0.40	2.26	NA	0.05	XXX
76970	TC	A	Ultrasound exam follow-up	0.00	2.11	NA	0.00	XXX
76970	26	A	Ultrasound exam follow-up	0.40	0.15	0.15	0.05	XXX
76975		C	GI endoscopic ultrasound	0.00	NA	NA	0.00	XXX
76975	TC	C	GI endoscopic ultrasound	0.00	NA	NA	0.00	XXX
76975	26	A	GI endoscopic ultrasound	0.81	0.32	0.32	0.07	XXX
76977		A	Us bone density measure	0.05	0.12	NA	0.00	XXX
76977	TC	A	Us bone density measure	0.00	0.10	NA	0.00	XXX
76977	26	A	Us bone density measure	0.05	0.02	0.02	0.00	XXX
76998		C	Us guide, intraop	0.00	NA	NA	0.00	XXX
76998	TC	C	Us guide, intraop	0.00	NA	NA	0.00	XXX
76998	26	A	Us guide, intraop	1.20	0.40	0.40	0.19	XXX
76999		C	Echo examination procedure	0.00	0.00	NA	0.00	XXX
76999	TC	C	Echo examination procedure	0.00	0.00	NA	0.00	XXX
76999	26	C	Echo examination procedure	0.00	0.00	0.00	0.00	XXX
77001		A	Fluoroguide for vein device	0.38	2.62	NA	0.03	ZZZ
77001	TC	A	Fluoroguide for vein device	0.00	2.50	NA	0.00	ZZZ
77001	26	A	Fluoroguide for vein device	0.38	0.12	0.12	0.03	ZZZ
77002		A	Needle localization by xray	0.54	1.38	NA	0.04	XXX
77002	TC	A	Needle localization by xray	0.00	1.18	NA	0.00	XXX
77002	26	A	Needle localization by xray	0.54	0.21	0.21	0.04	XXX
77003		A	Fluoroguide for spine inject	0.60	1.04	NA	0.04	XXX
77003	TC	A	Fluoroguide for spine inject	0.00	0.81	NA	0.00	XXX
77003	26	A	Fluoroguide for spine inject	0.60	0.23	0.23	0.04	XXX
77011		A	Ct scan for localization	1.21	16.85	NA	0.06	XXX
77011	TC	A	Ct scan for localization	0.00	16.41	NA	0.00	XXX
77011	26	A	Ct scan for localization	1.21	0.44	0.44	0.06	XXX
77012		A	Ct scan for needle biopsy	1.16	1.55	NA	0.08	XXX
77012	TC	A	Ct scan for needle biopsy	0.00	1.20	NA	0.00	XXX
77012	26	A	Ct scan for needle biopsy	1.16	0.35	0.35	0.07	XXX
77013		C	Ct guide for tissue ablation	0.00	NA	NA	0.00	XXX
77013	TC	C	Ct guide for tissue ablation	0.00	NA	NA	0.00	XXX
77013	26	A	Ct guide for tissue ablation	3.99	1.19	1.19	0.29	XXX
77014		A	Ct scan for therapy guide	0.85	2.60	NA	0.05	XXX
77014	TC	A	Ct scan for therapy guide	0.00	2.28	NA	0.00	XXX
77014	26	A	Ct scan for therapy guide	0.85	0.32	0.32	0.05	XXX
77021		A	Mr guidance for needle place	1.50	5.25	NA	0.14	XXX
77021	TC	A	Mr guidance for needle place	0.00	4.79	NA	0.00	XXX
77021	26	A	Mr guidance for needle place	1.50	0.47	0.47	0.13	XXX
77022		C	Mri for tissue ablation	0.00	NA	NA	0.00	XXX
77022	TC	C	Mri for tissue ablation	0.00	NA	NA	0.00	XXX
77022	26	A	Mri for tissue ablation	4.24	1.29	1.29	0.31	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
77031		A	Stereotact guide for brst bx	1.59	1.72	NA	0.14	XXX
77031	TC	A	Stereotact guide for brst bx	0.00	1.22	NA	0.00	XXX
77031	26	A	Stereotact guide for brst bx	1.59	0.50	0.50	0.14	XXX
77032		A	Guidance for needle, breast	0.56	0.74	NA	0.04	XXX
77032	TC	A	Guidance for needle, breast	0.00	0.57	NA	0.00	XXX
77032	26	A	Guidance for needle, breast	0.56	0.17	0.17	0.04	XXX
77051		A	Computer dx mammogram add-on	0.06	0.18	0.18	0.00	ZZZ
77051	TC	A	Computer dx mammogram add-on	0.00	0.16	0.16	0.00	ZZZ
77051	26	A	Computer dx mammogram add-on	0.06	0.02	0.02	0.00	ZZZ
77052		A	Comp screen mammogram add-on	0.06	0.18	0.18	0.00	ZZZ
77052	TC	A	Comp screen mammogram add-on	0.00	0.16	0.16	0.00	ZZZ
77052	26	A	Comp screen mammogram add-on	0.06	0.02	0.02	0.00	ZZZ
77053		A	X-ray of mammary duct	0.36	1.09	NA	0.03	XXX
77053	TC	A	X-ray of mammary duct	0.00	0.98	NA	0.00	XXX
77053	26	A	X-ray of mammary duct	0.36	0.11	0.11	0.02	XXX
77054		A	X-ray of mammary ducts	0.45	1.48	NA	0.03	XXX
77054	TC	A	X-ray of mammary ducts	0.00	1.35	NA	0.00	XXX
77054	26	A	X-ray of mammary ducts	0.45	0.14	0.14	0.03	XXX
77055		A	Mammogram, one breast	0.70	1.45	NA	0.05	XXX
77055	TC	A	Mammogram, one breast	0.00	1.24	NA	0.00	XXX
77055	26	A	Mammogram, one breast	0.70	0.21	0.21	0.05	XXX
77056		A	Mammogram, both breasts	0.87	1.89	NA	0.07	XXX
77056	TC	A	Mammogram, both breasts	0.00	1.63	NA	0.00	XXX
77056	26	A	Mammogram, both breasts	0.87	0.27	0.27	0.06	XXX
77057		A	Mammogram, screening	0.70	1.28	NA	0.05	XXX
77057	TC	A	Mammogram, screening	0.00	1.07	NA	0.00	XXX
77057	26	A	Mammogram, screening	0.70	0.22	0.22	0.05	XXX
77058		A	Mri, one breast	1.63	11.95	NA	0.12	XXX
77058	TC	A	Mri, one breast	0.00	11.45	NA	0.00	XXX
77058	26	A	Mri, one breast	1.63	0.50	0.50	0.11	XXX
77059		A	Mri, both breasts	1.63	11.83	NA	0.12	XXX
77059	TC	A	Mri, both breasts	0.00	11.33	NA	0.00	XXX
77059	26	A	Mri, both breasts	1.63	0.50	0.50	0.11	XXX
77071		A	X-ray stress view	0.41	0.87	0.87	0.06	XXX
77072		A	X-rays for bone age	0.19	0.38	NA	0.02	XXX
77072	TC	A	X-rays for bone age	0.00	0.32	NA	0.00	XXX
77072	26	A	X-rays for bone age	0.19	0.06	0.06	0.01	XXX
77073		A	X-rays, bone length studies	0.27	0.70	NA	0.04	XXX
77073	TC	A	X-rays, bone length studies	0.00	0.58	NA	0.00	XXX
77073	26	A	X-rays, bone length studies	0.27	0.11	0.11	0.04	XXX
77074		A	X-rays, bone survey, limited	0.45	1.27	NA	0.03	XXX
77074	TC	A	X-rays, bone survey, limited	0.00	1.13	NA	0.00	XXX
77074	26	A	X-rays, bone survey, limited	0.45	0.14	0.14	0.03	XXX
77075		A	X-rays, bone survey complete	0.54	2.02	NA	0.04	XXX
77075	TC	A	X-rays, bone survey complete	0.00	1.85	NA	0.00	XXX
77075	26	A	X-rays, bone survey complete	0.54	0.17	0.17	0.04	XXX
77076		A	X-rays, bone survey, infant	0.70	1.90	NA	0.05	XXX
77076	TC	A	X-rays, bone survey, infant	0.00	1.69	NA	0.00	XXX
77076	26	A	X-rays, bone survey, infant	0.70	0.21	0.21	0.05	XXX
77077		A	Joint survey, single view	0.31	0.70	NA	0.04	XXX
77077	TC	A	Joint survey, single view	0.00	0.58	NA	0.00	XXX
77077	26	A	Joint survey, single view	0.31	0.12	0.12	0.04	XXX
77078		A	Ct bone density, axial	0.25	2.59	NA	0.02	XXX
77078	TC	A	Ct bone density, axial	0.00	2.51	NA	0.00	XXX
77078	26	A	Ct bone density, axial	0.25	0.08	0.08	0.02	XXX
77079		A	Ct bone density, peripheral	0.22	0.80	NA	0.01	XXX
77079	TC	A	Ct bone density, peripheral	0.00	0.71	NA	0.00	XXX
77079	26	A	Ct bone density, peripheral	0.22	0.08	0.08	0.01	XXX
77080		A	Dxa bone density, axial	0.20	1.04	NA	0.01	XXX
77080	TC	A	Dxa bone density, axial	0.00	0.97	NA	0.00	XXX
77080	26	A	Dxa bone density, axial	0.20	0.07	0.07	0.01	XXX
77081		A	Dxa bone density/peripheral	0.22	0.47	NA	0.01	XXX
77081	TC	A	Dxa bone density/peripheral	0.00	0.39	NA	0.00	XXX
77081	26	A	Dxa bone density/peripheral	0.22	0.08	0.08	0.01	XXX
77082		A	Dxa bone density, vert fx	0.17	0.52	NA	0.01	XXX
77082	TC	A	Dxa bone density, vert fx	0.00	0.45	NA	0.00	XXX
77082	26	A	Dxa bone density, vert fx	0.17	0.06	0.06	0.01	XXX
77083		A	Radiographic absorptiometry	0.20	0.41	NA	0.01	XXX
77083	TC	A	Radiographic absorptiometry	0.00	0.33	NA	0.00	XXX
77083	26	A	Radiographic absorptiometry	0.20	0.07	0.07	0.01	XXX
77084		A	Magnetic image, bone marrow	1.60	8.21	NA	0.12	XXX
77084	TC	A	Magnetic image, bone marrow	0.00	7.70	NA	0.00	XXX
77084	26	A	Magnetic image, bone marrow	1.60	0.50	0.50	0.11	XXX
77261		A	Radiation therapy planning	1.39	0.56	0.56	0.08	XXX
77262		A	Radiation therapy planning	2.11	0.80	0.80	0.13	XXX
77263		A	Radiation therapy planning	3.14	1.19	1.19	0.20	XXX
77280		A	Set radiation therapy field	0.70	3.96	NA	0.04	XXX
77280	TC	A	Set radiation therapy field	0.00	3.69	NA	0.00	XXX
77280	26	A	Set radiation therapy field	0.70	0.27	0.27	0.04	XXX
77285		A	Set radiation therapy field	1.05	7.16	NA	0.07	XXX
77285	TC	A	Set radiation therapy field	0.00	6.77	NA	0.00	XXX
77285	26	A	Set radiation therapy field	1.05	0.40	0.40	0.06	XXX
77290		A	Set radiation therapy field	1.56	11.94	NA	0.10	XXX
77290	TC	A	Set radiation therapy field	0.00	11.35	NA	0.00	XXX
77290	26	A	Set radiation therapy field	1.56	0.59	0.59	0.10	XXX

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77290	26	A	Set radiation therapy field	1.56	0.59	0.59	0.09	XXX
77295		A	Set radiation therapy field	4.56	6.92	NA	0.29	XXX
77295	TC	A	Set radiation therapy field	0.00	5.19	NA	0.01	XXX
77295	26	A	Set radiation therapy field	4.56	1.73	1.73	0.27	XXX
77299		C	Radiation therapy planning	0.00	0.00	NA	0.00	XXX
77299	TC	C	Radiation therapy planning	0.00	0.00	NA	0.00	XXX
77299	26	C	Radiation therapy planning	0.00	0.00	0.00	0.00	XXX
77300		A	Radiation therapy dose plan	0.62	1.09	NA	0.04	XXX
77300	TC	A	Radiation therapy dose plan	0.00	0.86	NA	0.00	XXX
77300	26	A	Radiation therapy dose plan	0.62	0.24	0.24	0.04	XXX
77301		A	Radiotherapy dose plan, imrt	7.99	51.05	NA	0.50	XXX
77301	TC	A	Radiotherapy dose plan, imrt	0.00	48.03	NA	0.02	XXX
77301	26	A	Radiotherapy dose plan, imrt	7.99	3.02	3.02	0.48	XXX
77305		A	Teletx isodose plan simple	0.70	0.85	NA	0.04	XXX
77305	TC	A	Teletx isodose plan simple	0.00	0.58	NA	0.00	XXX
77305	26	A	Teletx isodose plan simple	0.70	0.26	0.26	0.04	XXX
77310		A	Teletx isodose plan intermed	1.05	1.19	NA	0.07	XXX
77310	TC	A	Teletx isodose plan intermed	0.00	0.79	NA	0.00	XXX
77310	26	A	Teletx isodose plan intermed	1.05	0.40	0.40	0.06	XXX
77315		A	Teletx isodose plan complex	1.56	1.97	NA	0.10	XXX
77315	TC	A	Teletx isodose plan complex	0.00	1.38	NA	0.00	XXX
77315	26	A	Teletx isodose plan complex	1.56	0.59	0.59	0.09	XXX
77321		A	Special teletx port plan	0.95	1.41	NA	0.06	XXX
77321	TC	A	Special teletx port plan	0.00	1.05	NA	0.00	XXX
77321	26	A	Special teletx port plan	0.95	0.36	0.36	0.06	XXX
77326		A	Brachytx isodose calc simp	0.93	2.69	NA	0.06	XXX
77326	TC	A	Brachytx isodose calc simp	0.00	2.34	NA	0.00	XXX
77326	26	A	Brachytx isodose calc simp	0.93	0.35	0.35	0.06	XXX
77327		A	Brachytx isodose calc interm	1.39	3.70	NA	0.09	XXX
77327	TC	A	Brachytx isodose calc interm	0.00	3.18	NA	0.00	XXX
77327	26	A	Brachytx isodose calc interm	1.39	0.53	0.53	0.08	XXX
77328		A	Brachytx isodose plan compl	2.09	4.76	NA	0.13	XXX
77328	TC	A	Brachytx isodose plan compl	0.00	3.96	NA	0.01	XXX
77328	26	A	Brachytx isodose plan compl	2.09	0.79	0.79	0.13	XXX
77331		A	Special radiation dosimetry	0.87	0.78	NA	0.05	XXX
77331	TC	A	Special radiation dosimetry	0.00	0.45	NA	0.00	XXX
77331	26	A	Special radiation dosimetry	0.87	0.33	0.33	0.05	XXX
77332		A	Radiation treatment aid(s)	0.54	1.41	NA	0.03	XXX
77332	TC	A	Radiation treatment aid(s)	0.00	1.20	NA	0.00	XXX
77332	26	A	Radiation treatment aid(s)	0.54	0.21	0.21	0.03	XXX
77333		A	Radiation treatment aid(s)	0.84	0.53	NA	0.05	XXX
77333	TC	A	Radiation treatment aid(s)	0.00	0.21	NA	0.00	XXX
77334		A	Radiation treatment aid(s)	1.24	2.50	NA	0.08	XXX
77334	TC	A	Radiation treatment aid(s)	0.00	2.03	NA	0.00	XXX
77334	26	A	Radiation treatment aid(s)	1.24	0.47	0.47	0.07	XXX
77336		A	Radiation physics consult	0.00	0.99	NA	0.00	XXX
77370		A	Radiation physics consult	0.00	2.64	NA	0.00	XXX
77371		C	Srs, multisource	0.00	0.00	NA	0.00	XXX
77372		A	Srs, linear based	0.00	12.82	NA	0.00	XXX
77373		A	Sbrt delivery	0.00	22.92	NA	0.00	XXX
77399		C	External radiation dosimetry	0.00	0.00	NA	0.00	XXX
77399	TC	C	External radiation dosimetry	0.00	0.00	NA	0.00	XXX
77399	26	C	External radiation dosimetry	0.00	0.00	0.00	0.00	XXX
77401		A	Radiation treatment delivery	0.00	0.42	NA	0.00	XXX
77402		A	Radiation treatment delivery	0.00	3.07	NA	0.00	XXX
77403		A	Radiation treatment delivery	0.00	2.70	NA	0.00	XXX
77404		A	Radiation treatment delivery	0.00	2.92	NA	0.00	XXX
77406		A	Radiation treatment delivery	0.00	2.98	NA	0.00	XXX
77407		A	Radiation treatment delivery	0.00	5.63	NA	0.00	XXX
77408		A	Radiation treatment delivery	0.00	3.71	NA	0.00	XXX
77409		A	Radiation treatment delivery	0.00	3.99	NA	0.00	XXX
77411		A	Radiation treatment delivery	0.00	3.99	NA	0.00	XXX
77412		A	Radiation treatment delivery	0.00	4.88	NA	0.00	XXX
77413		A	Radiation treatment delivery	0.00	4.92	NA	0.00	XXX
77414		A	Radiation treatment delivery	0.00	5.34	NA	0.00	XXX
77416		A	Radiation treatment delivery	0.00	5.37	NA	0.00	XXX
77417		A	Radiology port film(s)	0.00	0.32	NA	0.00	XXX
77418		A	Radiation tx delivery, imrt	0.00	7.98	NA	0.00	XXX
77421		A	Stereoscopic x-ray guidance	0.39	2.13	NA	0.02	XXX
77421	TC	A	Stereoscopic x-ray guidance	0.00	1.98	NA	0.00	XXX
77421	26	A	Stereoscopic x-ray guidance	0.39	0.15	0.15	0.02	XXX
77422		A	Neutron beam tx, simple	0.00	6.28	NA	0.00	XXX
77423		A	Neutron beam tx, complex	0.00	6.55	NA	0.00	XXX
77427		A	Radiation tx management, x5	3.70	1.56	1.56	0.23	XXX
77431		A	Radiation therapy management	1.81	0.85	0.85	0.11	XXX
77432		A	Stereotactic radiation trmt	7.92	3.03	3.03	0.50	XXX
77435		A	Sbrt management	13.00	5.21	NA	0.81	XXX
77470		A	Special radiation treatment	2.09	1.87	NA	0.13	XXX
77470	TC	A	Special radiation treatment	0.00	1.08	NA	0.01	XXX
77470	26	A	Special radiation treatment	2.09	0.79	0.79	0.13	XXX
77499		C	Radiation therapy management	0.00	0.00	NA	0.00	XXX
77499	TC	C	Radiation therapy management	0.00	0.00	NA	0.00	XXX
77499	26	C	Radiation therapy management	0.00	0.00	0.00	0.00	XXX

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77520		C	Proton trmt, simple w/o comp	0.00	0.00	0.00	0.00	XXX
77522		C	Proton trmt, simple w/comp	0.00	0.00	0.00	0.00	XXX
77523		C	Proton trmt, intermediate	0.00	0.00	0.00	0.00	XXX
77525		C	Proton treatment, complex	0.00	0.00	0.00	0.00	XXX
77600		R	Hyperthermia treatment	1.56	9.09	NA	0.10	XXX
77600	TC	R	Hyperthermia treatment	0.00	8.49	NA	0.00	XXX
77600	26	R	Hyperthermia treatment	1.56	0.60	0.60	0.09	XXX
77605		R	Hyperthermia treatment	2.09	26.47	NA	0.34	XXX
77605	TC	R	Hyperthermia treatment	0.00	25.70	NA	0.01	XXX
77605	26	R	Hyperthermia treatment	2.09	0.78	0.78	0.33	XXX
77610		R	Hyperthermia treatment	1.56	14.91	NA	0.09	XXX
77610	TC	R	Hyperthermia treatment	0.00	14.32	NA	0.00	XXX
77610	26	R	Hyperthermia treatment	1.56	0.60	0.60	0.09	XXX
77615		R	Hyperthermia treatment	2.09	23.01	NA	0.13	XXX
77615	TC	R	Hyperthermia treatment	0.00	22.21	NA	0.01	XXX
77615	26	R	Hyperthermia treatment	2.09	0.80	0.80	0.12	XXX
77620		R	Hyperthermia treatment	1.56	12.54	NA	0.07	XXX
77620	TC	R	Hyperthermia treatment	0.00	11.97	NA	0.00	XXX
77620	26	R	Hyperthermia treatment	1.56	0.58	0.58	0.07	XXX
77750		A	Infuse radioactive materials	4.94	4.41	4.41	0.31	090
77750	TC	A	Infuse radioactive materials	0.00	2.54	2.54	0.01	090
77750	26	A	Infuse radioactive materials	4.94	1.87	1.87	0.29	090
77761		A	Apply intrcav radiat simple	3.82	5.84	5.84	0.24	090
77761	TC	A	Apply intrcav radiat simple	0.00	4.43	4.43	0.01	090
77761	26	A	Apply intrcav radiat simple	3.82	1.41	1.41	0.23	090
77762		A	Apply intrcav radiat interm	5.73	7.22	7.22	0.36	090
77762	TC	A	Apply intrcav radiat interm	0.00	5.06	5.06	0.02	090
77762	26	A	Apply intrcav radiat interm	5.73	2.16	2.16	0.34	090
77763		A	Apply intrcav radiat compl	8.60	9.77	9.77	0.54	090
77763	TC	A	Apply intrcav radiat compl	0.00	6.57	6.57	0.02	090
77763	26	A	Apply intrcav radiat compl	8.60	3.20	3.20	0.51	090
77776		A	Apply intersti radiat simpl	4.67	6.39	6.39	0.34	090
77776	TC	A	Apply intersti radiat simpl	0.00	4.74	4.74	0.01	090
77776	26	A	Apply intersti radiat simpl	4.67	1.65	1.65	0.33	090
77777		A	Apply intersti radiat inter	7.49	7.59	7.59	0.54	090
77777	TC	A	Apply intersti radiat inter	0.00	4.87	4.87	0.02	090
77777	26	A	Apply intersti radiat inter	7.49	2.72	2.72	0.52	090
77778		A	Apply intersti radiat compl	11.23	10.84	10.84	0.72	090
77778	TC	A	Apply intersti radiat compl	0.00	6.63	6.63	0.03	090
77778	26	A	Apply intersti radiat compl	11.23	4.21	4.21	0.68	090
77785		A	Hdr brachytx, 1 channel	1.42	3.29	NA	0.09	XXX
77785	TC	A	Hdr brachytx, 1 channel	0.00	2.75	NA	0.00	XXX
77785	26	A	Hdr brachytx, 1 channel	1.42	0.54	0.54	0.09	XXX
77786		A	Hdr brachytx, 2-12 channel	3.25	7.98	NA	0.20	XXX
77786	TC	A	Hdr brachytx, 2-12 channel	0.00	6.74	NA	0.01	XXX
77786	26	A	Hdr brachytx, 2-12 channel	3.25	1.24	1.24	0.19	XXX
77787		A	Hdr brachytx over 12 chan	4.89	14.57	NA	0.31	XXX
77787	TC	A	Hdr brachytx over 12 chan	0.00	12.70	NA	0.01	XXX
77787	26	A	Hdr brachytx over 12 chan	4.89	1.86	1.86	0.29	XXX
77789		A	Apply surface radiation	1.14	1.86	1.86	0.06	000
77789	TC	A	Apply surface radiation	0.00	1.40	1.40	0.00	000
77789	26	A	Apply surface radiation	1.14	0.46	0.46	0.06	000
77790		A	Radiation handling	1.05	1.37	NA	0.06	XXX
77790	TC	A	Radiation handling	0.00	0.98	NA	0.00	XXX
77790	26	A	Radiation handling	1.05	0.39	0.39	0.06	XXX
77799		C	Radium/radioisotope therapy	0.00	0.00	NA	0.00	XXX
77799	TC	C	Radium/radioisotope therapy	0.00	0.00	NA	0.00	XXX
77799	26	C	Radium/radioisotope therapy	0.00	0.00	0.00	0.00	XXX
78000		A	Thyroid, single uptake	0.19	1.53	NA	0.01	XXX
78000	TC	A	Thyroid, single uptake	0.00	1.47	NA	0.00	XXX
78000	26	A	Thyroid, single uptake	0.19	0.05	0.05	0.01	XXX
78001		A	Thyroid, multiple uptakes	0.26	1.96	NA	0.01	XXX
78001	TC	A	Thyroid, multiple uptakes	0.00	1.89	NA	0.00	XXX
78001	26	A	Thyroid, multiple uptakes	0.26	0.08	0.08	0.01	XXX
78003		A	Thyroid suppress/stimul	0.33	1.65	NA	0.01	XXX
78003	TC	A	Thyroid suppress/stimul	0.00	1.55	NA	0.00	XXX
78003	26	A	Thyroid suppress/stimul	0.33	0.10	0.10	0.01	XXX
78006		A	Thyroid imaging with uptake	0.49	5.43	NA	0.03	XXX
78006	TC	A	Thyroid imaging with uptake	0.00	5.29	NA	0.00	XXX
78006	26	A	Thyroid imaging with uptake	0.49	0.14	0.14	0.03	XXX
78007		A	Thyroid image, mult uptakes	0.50	2.58	NA	0.03	XXX
78007	TC	A	Thyroid image, mult uptakes	0.00	2.44	NA	0.00	XXX
78007	26	A	Thyroid image, mult uptakes	0.50	0.15	0.15	0.03	XXX
78010		A	Thyroid imaging	0.39	3.66	NA	0.02	XXX
78010	TC	A	Thyroid imaging	0.00	3.55	NA	0.00	XXX
78010	26	A	Thyroid imaging	0.39	0.11	0.11	0.02	XXX
78011		A	Thyroid imaging with flow	0.45	3.90	NA	0.03	XXX
78011	TC	A	Thyroid imaging with flow	0.00	3.77	NA	0.00	XXX
78011	26	A	Thyroid imaging with flow	0.45	0.13	0.13	0.03	XXX
78015		A	Thyroid met imaging	0.67	4.57	NA	0.05	XXX
78015	TC	A	Thyroid met imaging	0.00	4.40	NA	0.00	XXX
78015	26	A	Thyroid met imaging	0.67	0.17	0.17	0.05	XXX
78016		A	Thyroid met imaging/studies	0.82	6.08	NA	0.04	XXX
78016	TC	A	Thyroid met imaging/studies	0.00	5.97	NA	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78016	26	A	Thyroid met imaging/studies	0.82	0.11	0.11	0.03	XXX
78018		A	Thyroid met imaging, body	0.86	6.77	NA	0.05	XXX
78018	TC	A	Thyroid met imaging, body	0.00	6.55	NA	0.00	XXX
78018	26	A	Thyroid met imaging, body	0.86	0.22	0.22	0.05	XXX
78020		A	Thyroid met uptake	0.60	1.42	1.42	0.03	ZZZ
78020	TC	A	Thyroid met uptake	0.00	1.28	1.28	0.00	ZZZ
78020	26	A	Thyroid met uptake	0.60	0.14	0.14	0.03	ZZZ
78070		A	Parathyroid nuclear imaging	0.82	2.92	NA	0.05	XXX
78070	TC	A	Parathyroid nuclear imaging	0.00	2.69	NA	0.00	XXX
78070	26	A	Parathyroid nuclear imaging	0.82	0.23	0.23	0.05	XXX
78075		A	Adrenal nuclear imaging	0.74	9.64	NA	0.05	XXX
78075	TC	A	Adrenal nuclear imaging	0.00	9.45	NA	0.00	XXX
78075	26	A	Adrenal nuclear imaging	0.74	0.18	0.18	0.05	XXX
78099		C	Endocrine nuclear procedure	0.00	0.00	NA	0.00	XXX
78099	TC	C	Endocrine nuclear procedure	0.00	0.00	NA	0.00	XXX
78099	26	C	Endocrine nuclear procedure	0.00	0.00	0.00	0.00	XXX
78102		A	Bone marrow imaging, ltd	0.55	3.49	NA	0.03	XXX
78102	TC	A	Bone marrow imaging, ltd	0.00	3.36	NA	0.00	XXX
78102	26	A	Bone marrow imaging, ltd	0.55	0.14	0.14	0.03	XXX
78103		A	Bone marrow imaging, mult	0.75	4.59	NA	0.05	XXX
78103	TC	A	Bone marrow imaging, mult	0.00	4.39	NA	0.00	XXX
78103	26	A	Bone marrow imaging, mult	0.75	0.19	0.19	0.05	XXX
78104		A	Bone marrow imaging, body	0.80	5.22	NA	0.06	XXX
78104	TC	A	Bone marrow imaging, body	0.00	5.00	NA	0.00	XXX
78104	26	A	Bone marrow imaging, body	0.80	0.21	0.21	0.06	XXX
78110		A	Plasma volume, single	0.19	1.88	NA	0.01	XXX
78110	TC	A	Plasma volume, single	0.00	1.82	NA	0.00	XXX
78110	26	A	Plasma volume, single	0.19	0.06	0.06	0.01	XXX
78111		A	Plasma volume, multiple	0.22	1.53	NA	0.01	XXX
78111	TC	A	Plasma volume, multiple	0.00	1.50	NA	0.00	XXX
78111	26	A	Plasma volume, multiple	0.22	0.04	0.04	0.01	XXX
78120		A	Red cell mass, single	0.23	1.70	NA	0.01	XXX
78120	TC	A	Red cell mass, single	0.00	1.64	NA	0.00	XXX
78120	26	A	Red cell mass, single	0.23	0.06	0.06	0.01	XXX
78121		A	Red cell mass, multiple	0.32	1.42	NA	0.01	XXX
78121	TC	A	Red cell mass, multiple	0.00	1.38	NA	0.00	XXX
78121	26	A	Red cell mass, multiple	0.32	0.04	0.04	0.01	XXX
78122		A	Blood volume	0.45	1.74	NA	0.02	XXX
78122	TC	A	Blood volume	0.00	1.64	NA	0.00	XXX
78122	26	A	Blood volume	0.45	0.10	0.10	0.02	XXX
78130		A	Red cell survival study	0.61	3.06	NA	0.04	XXX
78130	TC	A	Red cell survival study	0.00	2.87	NA	0.00	XXX
78135		A	Red cell survival kinetics	0.64	7.88	NA	0.05	XXX
78135	TC	A	Red cell survival kinetics	0.00	7.68	NA	0.00	XXX
78135	26	A	Red cell survival kinetics	0.64	0.20	0.20	0.04	XXX
78140		A	Red cell sequestration	0.61	2.47	NA	0.04	XXX
78140	TC	A	Red cell sequestration	0.00	2.29	NA	0.00	XXX
78140	26	A	Red cell sequestration	0.61	0.18	0.18	0.04	XXX
78185		A	Spleen imaging	0.40	4.57	NA	0.02	XXX
78185	TC	A	Spleen imaging	0.00	4.46	NA	0.00	XXX
78185	26	A	Spleen imaging	0.40	0.11	0.11	0.02	XXX
78190		A	Platelet survival, kinetics	1.09	9.17	NA	0.06	XXX
78190	TC	A	Platelet survival, kinetics	0.00	8.78	NA	0.00	XXX
78190	26	A	Platelet survival, kinetics	1.09	0.40	0.40	0.06	XXX
78191		A	Platelet survival	0.61	3.04	NA	0.04	XXX
78191	TC	A	Platelet survival	0.00	2.85	NA	0.00	XXX
78191	26	A	Platelet survival	0.61	0.19	0.19	0.04	XXX
78195		A	Lymph system imaging	1.20	7.60	NA	0.09	XXX
78195	TC	A	Lymph system imaging	0.00	7.26	NA	0.00	XXX
78195	26	A	Lymph system imaging	1.20	0.33	0.33	0.09	XXX
78199		C	Blood/lymph nuclear exam	0.00	0.00	NA	0.00	XXX
78199	TC	C	Blood/lymph nuclear exam	0.00	0.00	NA	0.00	XXX
78199	26	C	Blood/lymph nuclear exam	0.00	0.00	0.00	0.00	XXX
78201		A	Liver imaging	0.44	4.29	NA	0.04	XXX
78201	TC	A	Liver imaging	0.00	4.17	NA	0.00	XXX
78201	26	A	Liver imaging	0.44	0.12	0.12	0.04	XXX
78202		A	Liver imaging with flow	0.51	4.36	NA	0.02	XXX
78202	TC	A	Liver imaging with flow	0.00	4.24	NA	0.00	XXX
78202	26	A	Liver imaging with flow	0.51	0.12	0.12	0.02	XXX
78205		A	Liver imaging (3D)	0.71	4.50	NA	0.05	XXX
78205	TC	A	Liver imaging (3D)	0.00	4.31	NA	0.00	XXX
78205	26	A	Liver imaging (3D)	0.71	0.19	0.19	0.05	XXX
78206		A	Liver image (3d) with flow	0.96	7.63	NA	0.06	XXX
78206	TC	A	Liver image (3d) with flow	0.00	7.35	NA	0.00	XXX
78206	26	A	Liver image (3d) with flow	0.96	0.28	0.28	0.06	XXX
78215		A	Liver and spleen imaging	0.49	4.18	NA	0.03	XXX
78215	TC	A	Liver and spleen imaging	0.00	4.04	NA	0.00	XXX
78215	26	A	Liver and spleen imaging	0.49	0.14	0.14	0.03	XXX
78216		A	Liver & spleen image/flow	0.57	2.38	NA	0.03	XXX
78216	TC	A	Liver & spleen image/flow	0.00	2.22	NA	0.00	XXX
78216	26	A	Liver & spleen image/flow	0.57	0.16	0.16	0.03	XXX
78220		A	Liver function study	0.49	2.58	NA	0.03	XXX
78220	TC	A	Liver function study	0.00	2.44	NA	0.00	XXX

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CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78220	26	A	Liver function study	0.49	0.14	0.14	0.03	XXX
78223		A	Hepatobiliary imaging	0.84	7.48	NA	0.06	XXX
78223	TC	A	Hepatobiliary imaging	0.00	7.23	NA	0.00	XXX
78223	26	A	Hepatobiliary imaging	0.84	0.24	0.24	0.05	XXX
78230		A	Salivary gland imaging	0.45	3.67	NA	0.03	XXX
78230	TC	A	Salivary gland imaging	0.00	3.53	NA	0.00	XXX
78230	26	A	Salivary gland imaging	0.45	0.14	0.14	0.03	XXX
78231		A	Serial salivary imaging	0.52	2.44	NA	0.02	XXX
78231	TC	A	Serial salivary imaging	0.00	2.28	NA	0.00	XXX
78231	26	A	Serial salivary imaging	0.52	0.16	0.16	0.02	XXX
78232		A	Salivary gland function exam	0.47	1.84	NA	0.03	XXX
78232	TC	A	Salivary gland function exam	0.00	1.77	NA	0.00	XXX
78232	26	A	Salivary gland function exam	0.47	0.06	0.06	0.03	XXX
78258		A	Esophageal motility study	0.74	5.22	NA	0.04	XXX
78258	TC	A	Esophageal motility study	0.00	4.97	NA	0.00	XXX
78258	26	A	Esophageal motility study	0.74	0.24	0.24	0.04	XXX
78261		A	Gastric mucosa imaging	0.69	5.40	NA	0.03	XXX
78261	TC	A	Gastric mucosa imaging	0.00	5.19	NA	0.00	XXX
78261	26	A	Gastric mucosa imaging	0.69	0.21	0.21	0.03	XXX
78262		A	Gastroesophageal reflux exam	0.68	5.33	NA	0.03	XXX
78262	TC	A	Gastroesophageal reflux exam	0.00	5.13	NA	0.00	XXX
78262	26	A	Gastroesophageal reflux exam	0.68	0.19	0.19	0.03	XXX
78264		A	Gastric emptying study	0.78	6.23	NA	0.05	XXX
78264	TC	A	Gastric emptying study	0.00	6.01	NA	0.00	XXX
78264	26	A	Gastric emptying study	0.78	0.22	0.22	0.05	XXX
78270		A	Vit B-12 absorption exam	0.20	1.73	NA	0.01	XXX
78270	TC	A	Vit B-12 absorption exam	0.00	1.67	NA	0.00	XXX
78270	26	A	Vit B-12 absorption exam	0.20	0.06	0.06	0.01	XXX
78271		A	Vit b-12 absrp exam, int fac	0.20	2.03	NA	0.01	XXX
78271	TC	A	Vit b-12 absrp exam, int fac	0.00	1.96	NA	0.00	XXX
78271	26	A	Vit b-12 absrp exam, int fac	0.20	0.07	0.07	0.01	XXX
78272		A	Vit B-12 absorp, combined	0.27	1.88	NA	0.01	XXX
78272	TC	A	Vit B-12 absorp, combined	0.00	1.79	NA	0.00	XXX
78272	26	A	Vit B-12 absorp, combined	0.27	0.08	0.08	0.01	XXX
78278		A	Acute GI blood loss imaging	0.99	7.51	NA	0.07	XXX
78278	TC	A	Acute GI blood loss imaging	0.00	7.23	NA	0.00	XXX
78278	26	A	Acute GI blood loss imaging	0.99	0.28	0.28	0.07	XXX
78282		C	GI protein loss exam	0.00	0.00	NA	0.00	XXX
78282	TC	C	GI protein loss exam	0.00	0.00	NA	0.00	XXX
78282	26	A	GI protein loss exam	0.38	0.12	0.12	0.03	XXX
78290		A	Meckel√Es divert exam	0.68	7.44	NA	0.05	XXX
78290	TC	A	Meckel√Es divert exam	0.00	7.24	NA	0.00	XXX
78291		A	Leveen/shunt patency exam	0.88	5.38	NA	0.06	XXX
78291	TC	A	Leveen/shunt patency exam	0.00	5.14	NA	0.00	XXX
78291	26	A	Leveen/shunt patency exam	0.88	0.24	0.24	0.06	XXX
78299		C	GI nuclear procedure	0.00	0.00	NA	0.00	XXX
78299	TC	C	GI nuclear procedure	0.00	0.00	NA	0.00	XXX
78299	26	C	GI nuclear procedure	0.00	0.00	0.00	0.00	XXX
78300		A	Bone imaging, limited area	0.62	3.73	NA	0.04	XXX
78300	TC	A	Bone imaging, limited area	0.00	3.34	NA	0.00	XXX
78300	26	A	Bone imaging, limited area	0.62	0.19	0.19	0.04	XXX
78305		A	Bone imaging, multiple areas	0.83	4.86	NA	0.05	XXX
78305	TC	A	Bone imaging, multiple areas	0.00	4.62	NA	0.00	XXX
78305	26	A	Bone imaging, multiple areas	0.83	0.24	0.24	0.05	XXX
78306		A	Bone imaging, whole body	0.86	5.26	NA	0.06	XXX
78306	TC	A	Bone imaging, whole body	0.00	5.02	NA	0.00	XXX
78306	26	A	Bone imaging, whole body	0.86	0.25	0.25	0.06	XXX
78315		A	Bone imaging, 3 phase	1.02	7.48	NA	0.07	XXX
78315	TC	A	Bone imaging, 3 phase	0.00	7.20	NA	0.00	XXX
78315	26	A	Bone imaging, 3 phase	1.02	0.29	0.29	0.07	XXX
78320		A	Bone imaging (3D)	1.04	4.56	NA	0.07	XXX
78320	TC	A	Bone imaging (3D)	0.00	4.28	NA	0.00	XXX
78320	26	A	Bone imaging (3D)	1.04	0.28	0.28	0.06	XXX
78350		N	Bone mineral, single photon	0.22	0.58	NA	0.01	XXX
78350	TC	N	Bone mineral, single photon	0.00	0.50	NA	0.00	XXX
78350	26	N	Bone mineral, single photon	0.22	0.08	0.08	0.01	XXX
78351		N	Bone mineral, dual photon	0.30	NA	0.11	0.02	XXX
78399		C	Musculoskeletal nuclear exam	0.00	0.00	NA	0.00	XXX
78399	TC	C	Musculoskeletal nuclear exam	0.00	0.00	NA	0.00	XXX
78399	26	C	Musculoskeletal nuclear exam	0.00	0.00	0.00	0.00	XXX
78414		C	Non-imaging heart function	0.00	0.00	NA	0.00	XXX
78414	TC	C	Non-imaging heart function	0.00	0.00	NA	0.00	XXX
78414	26	A	Non-imaging heart function	0.45	0.17	0.17	0.02	XXX
78428		A	Cardiac shunt imaging	0.78	4.01	NA	0.04	XXX
78428	TC	A	Cardiac shunt imaging	0.00	3.81	NA	0.00	XXX
78428	26	A	Cardiac shunt imaging	0.78	0.21	0.21	0.04	XXX
78445		A	Vascular flow imaging	0.49	3.71	NA	0.03	XXX
78445	TC	A	Vascular flow imaging	0.00	3.59	NA	0.00	XXX
78445	26	A	Vascular flow imaging	0.49	0.13	0.13	0.03	XXX
78456		A	Acute venous thrombus image	1.00	7.26	NA	0.05	XXX
78456	TC	A	Acute venous thrombus image	0.00	6.93	NA	0.00	XXX
78456	26	A	Acute venous thrombus image	1.00	0.34	0.34	0.05	XXX
78457		A	Venous thrombosis imaging	0.77	4.08	NA	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78457	TC	A	Venous thrombosis imaging	0.00	3.85	NA	0.00	XXX
78457	26	A	Venous thrombosis imaging	0.77	0.23	0.23	0.05	XXX
78458		A	Ven thrombosis images, bilat	0.90	3.63	NA	0.04	XXX
78458	TC	A	Ven thrombosis images, bilat	0.00	3.43	NA	0.00	XXX
78458	26	A	Ven thrombosis images, bilat	0.90	0.20	0.20	0.04	XXX
78459		C	Heart muscle imaging (PET)	0.00	0.00	NA	0.00	XXX
78459	TC	C	Heart muscle imaging (PET)	0.00	0.00	NA	0.00	XXX
78459	26	A	Heart muscle imaging (PET)	1.50	0.37	0.37	0.08	XXX
78460		A	Heart muscle blood, single	0.86	4.01	NA	0.06	XXX
78460	TC	A	Heart muscle blood, single	0.00	3.74	NA	0.00	XXX
78460	26	A	Heart muscle blood, single	0.86	0.27	0.27	0.06	XXX
78461		A	Heart muscle blood, multiple	1.23	3.38	NA	0.07	XXX
78461	TC	A	Heart muscle blood, multiple	0.00	3.00	NA	0.00	XXX
78461	26	A	Heart muscle blood, multiple	1.23	0.37	0.37	0.07	XXX
78464		A	Heart image (3d), single	1.09	4.39	NA	0.06	XXX
78464	TC	A	Heart image (3d), single	0.00	4.05	NA	0.00	XXX
78464	26	A	Heart image (3d), single	1.09	0.34	0.34	0.05	XXX
78465		A	Heart image (3d), multiple	1.46	8.54	NA	0.08	XXX
78465	TC	A	Heart image (3d), multiple	0.00	8.06	NA	0.00	XXX
78465	26	A	Heart image (3d), multiple	1.46	0.48	0.48	0.07	XXX
78466		A	Heart infarct image	0.69	3.61	NA	0.04	XXX
78466	TC	A	Heart infarct image	0.00	3.40	NA	0.00	XXX
78466	26	A	Heart infarct image	0.69	0.22	0.22	0.03	XXX
78468		A	Heart infarct image (ef)	0.80	4.29	NA	0.04	XXX
78468	TC	A	Heart infarct image (ef)	0.00	4.03	NA	0.00	XXX
78468	26	A	Heart infarct image (ef)	0.80	0.26	0.26	0.04	XXX
78469		A	Heart infarct image (3D)	0.92	5.06	NA	0.04	XXX
78469	TC	A	Heart infarct image (3D)	0.00	4.75	NA	0.00	XXX
78469	26	A	Heart infarct image (3D)	0.92	0.31	0.31	0.04	XXX
78472		A	Gated heart, planar, single	0.98	4.80	NA	0.05	XXX
78472	TC	A	Gated heart, planar, single	0.00	4.51	NA	0.00	XXX
78472	26	A	Gated heart, planar, single	0.98	0.29	0.29	0.05	XXX
78473		A	Gated heart, multiple	1.47	6.02	NA	0.08	XXX
78473	TC	A	Gated heart, multiple	0.00	5.56	NA	0.00	XXX
78473	26	A	Gated heart, multiple	1.47	0.46	0.46	0.07	XXX
78478		A	Heart wall motion add-on	0.50	0.56	NA	0.03	XXX
78478	TC	A	Heart wall motion add-on	0.00	0.40	NA	0.00	XXX
78478	26	A	Heart wall motion add-on	0.50	0.16	0.16	0.02	XXX
78480		A	Heart function add-on	0.30	0.49	NA	0.02	XXX
78480	TC	A	Heart function add-on	0.00	0.40	NA	0.00	XXX
78480	26	A	Heart function add-on	0.30	0.10	0.10	0.01	XXX
78481		A	Heart first pass, single	0.98	3.68	NA	0.05	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78481	TC	A	Heart first pass, single	0.00	3.35	NA	0.00	XXX
78481	26	A	Heart first pass, single	0.98	0.33	0.33	0.05	XXX
78483		A	Heart first pass, multiple	1.47	4.86	NA	0.08	XXX
78483	TC	A	Heart first pass, multiple	0.00	4.37	NA	0.00	XXX
78483	26	A	Heart first pass, multiple	1.47	0.49	0.49	0.07	XXX
78491		C	Heart image (pet), single	0.00	0.00	NA	0.00	XXX
78491	TC	C	Heart image (pet), single	0.00	0.00	NA	0.00	XXX
78491	26	A	Heart image (pet), single	1.50	0.42	0.42	0.08	XXX
78492		C	Heart image (pet), multiple	0.00	0.00	NA	0.00	XXX
78492	TC	C	Heart image (pet), multiple	0.00	0.00	NA	0.00	XXX
78492	26	A	Heart image (pet), multiple	1.87	0.55	0.55	0.10	XXX
78494		A	Heart image, spect	1.19	4.84	NA	0.06	XXX
78494	TC	A	Heart image, spect	0.00	4.44	NA	0.00	XXX
78494	26	A	Heart image, spect	1.19	0.40	0.40	0.06	XXX
78496		A	Heart first pass add-on	0.50	0.64	0.64	0.03	ZZZ
78496	TC	A	Heart first pass add-on	0.00	0.48	0.48	0.00	ZZZ
78496	26	A	Heart first pass add-on	0.50	0.16	0.16	0.02	ZZZ
78499		C	Cardiovascular nuclear exam	0.00	0.00	NA	0.00	XXX
78499	TC	C	Cardiovascular nuclear exam	0.00	0.00	NA	0.00	XXX
78499	26	C	Cardiovascular nuclear exam	0.00	0.00	0.00	0.00	XXX
78580		A	Lung perfusion imaging	0.74	4.37	NA	0.04	XXX
78580	TC	A	Lung perfusion imaging	0.00	4.16	NA	0.00	XXX
78580	26	A	Lung perfusion imaging	0.74	0.21	0.21	0.04	XXX
78584		A	Lung V/Q image single breath	0.99	2.58	NA	0.07	XXX
78584	TC	A	Lung V/Q image single breath	0.00	2.28	NA	0.00	XXX
78584	26	A	Lung V/Q image single breath	0.99	0.30	0.30	0.06	XXX
78585		A	Lung V/Q imaging	1.09	7.51	NA	0.07	XXX
78585	TC	A	Lung V/Q imaging	0.00	7.20	NA	0.00	XXX
78585	26	A	Lung V/Q imaging	1.09	0.31	0.31	0.06	XXX
78586		A	Aerosol lung image, single	0.40	3.67	NA	0.02	XXX
78586	TC	A	Aerosol lung image, single	0.00	3.55	NA	0.00	XXX
78586	26	A	Aerosol lung image, single	0.40	0.12	0.12	0.02	XXX
78587		A	Aerosol lung image, multiple	0.49	4.61	NA	0.03	XXX
78587	TC	A	Aerosol lung image, multiple	0.00	4.48	NA	0.00	XXX
78587	26	A	Aerosol lung image, multiple	0.49	0.13	0.13	0.03	XXX
78588		A	Perfusion lung image	1.09	7.58	NA	0.07	XXX
78588	TC	A	Perfusion lung image	0.00	7.27	NA	0.00	XXX
78588	26	A	Perfusion lung image	1.09	0.31	0.31	0.07	XXX
78591		A	Vent image, 1 breath, 1 proj	0.40	3.67	NA	0.02	XXX
78591	TC	A	Vent image, 1 breath, 1 proj	0.00	3.55	NA	0.00	XXX
78591	26	A	Vent image, 1 breath, 1 proj	0.40	0.12	0.12	0.02	XXX
78593		A	Vent image, 1 proj, gas	0.49	4.19	NA	0.04	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78593	TC	A	Vent image, 1 proj, gas	0.00	4.06	NA	0.00	XXX
78593	26	A	Vent image, 1 proj, gas	0.49	0.14	0.14	0.03	XXX
78594		A	Vent image, mult proj, gas	0.53	4.45	NA	0.02	XXX
78594	TC	A	Vent image, mult proj, gas	0.00	4.31	NA	0.00	XXX
78594	26	A	Vent image, mult proj, gas	0.53	0.13	0.13	0.02	XXX
78596		A	Lung differential function	1.27	7.70	NA	0.07	XXX
78596	TC	A	Lung differential function	0.00	7.35	NA	0.00	XXX
78596	26	A	Lung differential function	1.27	0.35	0.35	0.06	XXX
78599		C	Respiratory nuclear exam	0.00	0.00	NA	0.00	XXX
78599	TC	C	Respiratory nuclear exam	0.00	0.00	NA	0.00	XXX
78599	26	C	Respiratory nuclear exam	0.00	0.00	0.00	0.00	XXX
78600		A	Brain image < 4 views	0.44	3.94	NA	0.02	XXX
78600	TC	A	Brain image < 4 views	0.00	3.81	NA	0.00	XXX
78600	26	A	Brain image < 4 views	0.44	0.13	0.13	0.02	XXX
78601		A	Brain image w/flow < 4 views	0.51	4.62	NA	0.03	XXX
78601	TC	A	Brain image w/flow < 4 views	0.00	4.48	NA	0.00	XXX
78601	26	A	Brain image w/flow < 4 views	0.51	0.14	0.14	0.03	XXX
78605		A	Brain image 4+ views	0.53	4.20	NA	0.04	XXX
78605	TC	A	Brain image 4+ views	0.00	4.05	NA	0.00	XXX
78605	26	A	Brain image 4+ views	0.53	0.15	0.15	0.04	XXX
78606		A	Brain image w/flow 4 + views	0.64	7.69	NA	0.03	XXX
78606	TC	A	Brain image w/flow 4 + views	0.00	7.50	NA	0.00	XXX
78606	26	A	Brain image w/flow 4 + views	0.64	0.19	0.19	0.03	XXX
78607		A	Brain imaging (3D)	1.23	7.38	NA	0.07	XXX
78607	TC	A	Brain imaging (3D)	0.00	7.07	NA	0.00	XXX
78607	26	A	Brain imaging (3D)	1.23	0.31	0.31	0.07	XXX
78608		C	Brain imaging (PET)	0.00	0.00	NA	0.00	XXX
78608	TC	C	Brain imaging (PET)	0.00	0.00	NA	0.00	XXX
78608	26	A	Brain imaging (PET)	1.50	0.39	0.39	0.09	XXX
78609		N	Brain imaging (PET)	1.50	0.55	NA	0.08	XXX
78609	26	N	Brain imaging (PET)	1.50	0.55	0.55	0.08	XXX
78610		A	Brain flow imaging only	0.30	3.77	NA	0.01	XXX
78610	TC	A	Brain flow imaging only	0.00	3.68	NA	0.00	XXX
78610	26	A	Brain flow imaging only	0.30	0.08	0.08	0.01	XXX
78630		A	Cerebrospinal fluid scan	0.68	7.59	NA	0.04	XXX
78630	TC	A	Cerebrospinal fluid scan	0.00	7.40	NA	0.00	XXX
78630	26	A	Cerebrospinal fluid scan	0.68	0.19	0.19	0.04	XXX
78635		A	CSF ventriculography	0.61	7.61	NA	0.03	XXX
78635	TC	A	CSF ventriculography	0.00	7.42	NA	0.00	XXX
78635	26	A	CSF ventriculography	0.61	0.19	0.19	0.03	XXX
78645		A	CSF shunt evaluation	0.57	7.28	NA	0.04	XXX
78645	TC	A	CSF shunt evaluation	0.00	7.13	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
78645	26	A	CSF shunt evaluation	0.57	0.15	0.15	0.04	XXX
78647		A	Cerebrospinal fluid scan	0.90	5.91	NA	0.07	XXX
78647	TC	A	Cerebrospinal fluid scan	0.00	5.79	NA	0.00	XXX
78647	26	A	Cerebrospinal fluid scan	0.90	0.11	0.11	0.06	XXX
78650		A	CSF leakage imaging	0.61	7.34	NA	0.04	XXX
78650	TC	A	CSF leakage imaging	0.00	7.19	NA	0.00	XXX
78650	26	A	CSF leakage imaging	0.61	0.16	0.16	0.04	XXX
78660		A	Nuclear exam of tear flow	0.53	3.84	NA	0.02	XXX
78660	TC	A	Nuclear exam of tear flow	0.00	3.67	NA	0.00	XXX
78660	26	A	Nuclear exam of tear flow	0.53	0.17	0.17	0.01	XXX
78699		C	Nervous system nuclear exam	0.00	0.00	NA	0.00	XXX
78699	TC	C	Nervous system nuclear exam	0.00	0.00	NA	0.00	XXX
78699	26	C	Nervous system nuclear exam	0.00	0.00	0.00	0.00	XXX
78700		A	Kidney imaging, morphol	0.45	3.70	NA	0.03	XXX
78700	TC	A	Kidney imaging, morphol	0.00	3.57	NA	0.00	XXX
78700	26	A	Kidney imaging, morphol	0.45	0.13	0.13	0.03	XXX
78701		A	Kidney imaging with flow	0.49	4.70	NA	0.03	XXX
78701	TC	A	Kidney imaging with flow	0.00	4.56	NA	0.00	XXX
78701	26	A	Kidney imaging with flow	0.49	0.14	0.14	0.03	XXX
78707		A	K flow/funct image w/o drug	0.96	4.70	NA	0.06	XXX
78707	TC	A	K flow/funct image w/o drug	0.00	4.44	NA	0.00	XXX
78707	26	A	K flow/funct image w/o drug	0.96	0.26	0.26	0.06	XXX
78708		A	K flow/funct image w/drug	1.21	2.87	NA	0.08	XXX
78708	TC	A	K flow/funct image w/drug	0.00	2.53	NA	0.00	XXX
78708	26	A	K flow/funct image w/drug	1.21	0.33	0.33	0.08	XXX
78709		A	K flow/funct image, multiple	1.41	7.67	NA	0.09	XXX
78709	TC	A	K flow/funct image, multiple	0.00	7.28	NA	0.00	XXX
78709	26	A	K flow/funct image, multiple	1.41	0.39	0.39	0.08	XXX
78710		A	Kidney imaging (3D)	0.66	4.20	NA	0.03	XXX
78710	TC	A	Kidney imaging (3D)	0.00	4.05	NA	0.00	XXX
78710	26	A	Kidney imaging (3D)	0.66	0.15	0.15	0.03	XXX
78725		A	Kidney function study	0.38	2.18	NA	0.02	XXX
78725	TC	A	Kidney function study	0.00	2.06	NA	0.00	XXX
78725	26	A	Kidney function study	0.38	0.12	0.12	0.02	XXX
78730		A	Urinary bladder retention	0.15	1.51	NA	0.01	ZZZ
78730	TC	A	Urinary bladder retention	0.00	1.46	NA	0.00	ZZZ
78730	26	A	Urinary bladder retention	0.15	0.05	0.05	0.01	ZZZ
78740		A	Ureteral reflux study	0.57	4.98	NA	0.04	XXX
78740	TC	A	Ureteral reflux study	0.00	4.80	NA	0.00	XXX
78740	26	A	Ureteral reflux study	0.57	0.18	0.18	0.03	XXX
78761		A	Testicular imaging w/flow	0.71	4.44	NA	0.05	XXX
78761	TC	A	Testicular imaging w/flow	0.00	4.22	NA	0.00	XXX

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78761	26	A	Testicular imaging w/flow	0.71	0.22	0.22	0.05	XXX
78799		C	Genitourinary nuclear exam	0.00	0.00	NA	0.00	XXX
78799	TC	C	Genitourinary nuclear exam	0.00	0.00	NA	0.00	XXX
78799	26	C	Genitourinary nuclear exam	0.00	0.00	0.00	0.00	XXX
78800		A	Tumor imaging, limited area	0.66	3.99	NA	0.04	XXX
78800	TC	A	Tumor imaging, limited area	0.00	3.78	NA	0.00	XXX
78800	26	A	Tumor imaging, limited area	0.66	0.20	0.20	0.04	XXX
78801		A	Tumor imaging, mult areas	0.79	5.31	NA	0.05	XXX
78801	TC	A	Tumor imaging, mult areas	0.00	5.08	NA	0.00	XXX
78801	26	A	Tumor imaging, mult areas	0.79	0.23	0.23	0.05	XXX
78802		A	Tumor imaging, whole body	0.86	6.94	NA	0.06	XXX
78802	TC	A	Tumor imaging, whole body	0.00	6.71	NA	0.00	XXX
78802	26	A	Tumor imaging, whole body	0.86	0.23	0.23	0.05	XXX
78803		A	Tumor imaging (3D)	1.09	7.20	NA	0.07	XXX
78803	TC	A	Tumor imaging (3D)	0.00	6.92	NA	0.00	XXX
78803	26	A	Tumor imaging (3D)	1.09	0.27	0.27	0.06	XXX
78804		A	Tumor imaging, whole body	1.07	12.81	NA	0.07	XXX
78804	TC	A	Tumor imaging, whole body	0.00	12.52	NA	0.00	XXX
78804	26	A	Tumor imaging, whole body	1.07	0.29	0.29	0.06	XXX
78805		A	Abscess imaging, ltd area	0.73	3.65	NA	0.05	XXX
78805	TC	A	Abscess imaging, ltd area	0.00	3.45	NA	0.00	XXX
78805	26	A	Abscess imaging, ltd area	0.73	0.20	0.20	0.04	XXX
78806		A	Abscess imaging, whole body	0.86	7.19	NA	0.05	XXX
78806	TC	A	Abscess imaging, whole body	0.00	6.96	NA	0.00	XXX
78806	26	A	Abscess imaging, whole body	0.86	0.23	0.23	0.05	XXX
78807		A	Nuclear localization/abscess	1.09	7.11	NA	0.07	XXX
78807	TC	A	Nuclear localization/abscess	0.00	6.85	NA	0.00	XXX
78807	26	A	Nuclear localization/abscess	1.09	0.26	0.26	0.06	XXX
78808		A	Iv inj ra drug dx study	0.18	0.84	NA	0.01	XXX
78811		C	Pet image, ltd area	0.00	0.00	NA	0.00	XXX
78811	TC	C	Pet image, ltd area	0.00	0.00	NA	0.00	XXX
78811	26	A	Pet image, ltd area	1.54	0.45	0.45	0.14	XXX
78812		C	Pet image, skull-thigh	0.00	0.00	NA	0.00	XXX
78812	TC	C	Pet image, skull-thigh	0.00	0.00	NA	0.00	XXX
78812	26	A	Pet image, skull-thigh	1.93	0.54	0.54	0.13	XXX
78813		C	Pet image, full body	0.00	0.00	NA	0.00	XXX
78813	TC	C	Pet image, full body	0.00	0.00	NA	0.00	XXX
78813	26	A	Pet image, full body	2.00	0.55	0.55	0.14	XXX
78814		C	Pet image w/ct, lmtd	0.00	0.00	NA	0.00	XXX
78814	TC	C	Pet image w/ct, lmtd	0.00	0.00	NA	0.00	XXX
78814	26	A	Pet image w/ct, lmtd	2.20	0.61	0.61	0.15	XXX
78815		C	Pet image w/ct, skull-thigh	0.00	0.00	NA	0.00	XXX

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78815	TC	C	Pet image w/ct, skull-thigh	0.00	0.00	NA	0.00	XXX
78815	26	A	Pet image w/ct, skull-thigh	2.44	0.68	0.68	0.17	XXX
78816		C	Pet image w/ct, full body	0.00	0.00	NA	0.00	XXX
78816	TC	C	Pet image w/ct, full body	0.00	0.00	NA	0.00	XXX
78816	26	A	Pet image w/ct, full body	2.50	0.68	0.68	0.17	XXX
78999		C	Nuclear diagnostic exam	0.00	0.00	NA	0.00	XXX
78999	TC	C	Nuclear diagnostic exam	0.00	0.00	NA	0.00	XXX
78999	26	C	Nuclear diagnostic exam	0.00	0.00	0.00	0.00	XXX
79005		A	Nuclear rx, oral admin	1.80	1.61	NA	0.10	XXX
79005	TC	A	Nuclear rx, oral admin	0.00	1.08	NA	0.01	XXX
79005	26	A	Nuclear rx, oral admin	1.80	0.53	0.53	0.09	XXX
79101		A	Nuclear rx, iv admin	1.96	1.84	NA	0.10	XXX
79101	TC	A	Nuclear rx, iv admin	0.00	1.13	NA	0.01	XXX
79101	26	A	Nuclear rx, iv admin	1.96	0.72	0.72	0.09	XXX
79200		A	Nuclear rx, intracav admin	1.99	2.07	NA	0.14	XXX
79200	TC	A	Nuclear rx, intracav admin	0.00	1.45	NA	0.01	XXX
79200	26	A	Nuclear rx, intracav admin	1.99	0.62	0.62	0.14	XXX
79300		C	Nuclr rx, interstit colloid	0.00	0.00	NA	0.00	XXX
79300	TC	C	Nuclr rx, interstit colloid	0.00	0.00	NA	0.00	XXX
79300	26	A	Nuclr rx, interstit colloid	1.60	0.48	0.48	0.12	XXX
79403		A	Hematopoietic nuclear tx	2.25	2.43	NA	0.14	XXX
79403	TC	A	Hematopoietic nuclear tx	0.00	1.79	NA	0.01	XXX
79403	26	A	Hematopoietic nuclear tx	2.25	0.64	0.64	0.13	XXX
79440		A	Nuclear rx, intra-articular	1.99	1.66	NA	0.14	XXX
79440	TC	A	Nuclear rx, intra-articular	0.00	1.04	NA	0.01	XXX
79440	26	A	Nuclear rx, intra-articular	1.99	0.62	0.62	0.14	XXX
79445		C	Nuclear rx, intra-arterial	0.00	NA	NA	0.00	XXX
79445	TC	C	Nuclear rx, intra-arterial	0.00	NA	NA	0.00	XXX
79445	26	A	Nuclear rx, intra-arterial	2.40	0.62	0.62	0.15	XXX
79999		C	Nuclear medicine therapy	0.00	0.00	NA	0.00	XXX
79999	TC	C	Nuclear medicine therapy	0.00	0.00	NA	0.00	XXX
79999	26	C	Nuclear medicine therapy	0.00	0.00	0.00	0.00	XXX
80055		I	Obstetric panel	0.00	0.00	0.00	0.00	XXX
80500		A	Lab pathology consultation	0.37	0.17	0.11	0.02	XXX
80502		A	Lab pathology consultation	1.33	0.41	0.36	0.06	XXX
83020		X	Hemoglobin electrophoresis	0.00	0.10	NA	0.00	XXX
83020	26	A	Hemoglobin electrophoresis	0.37	0.15	0.15	0.02	XXX
83912		X	Genetic examination	0.00	0.08	NA	0.00	XXX
83912	26	A	Genetic examination	0.37	0.13	0.13	0.02	XXX
84165		X	Protein e-phoresis, serum	0.00	0.10	NA	0.00	XXX
84165	26	A	Protein e-phoresis, serum	0.37	0.14	0.14	0.02	XXX
84166		X	Protein e-phoresis/urine/csf	0.00	0.10	NA	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
84166	26	A	Protein e-phoresis/urine/csf	0.37	0.14	0.14	0.02	XXX
84181		X	Western blot test	0.00	0.10	NA	0.00	XXX
84181	26	A	Western blot test	0.37	0.15	0.15	0.02	XXX
84182		X	Protein, western blot test	0.00	0.10	NA	0.00	XXX
84182	26	A	Protein, western blot test	0.37	0.15	0.15	0.02	XXX
85060		A	Blood smear interpretation	0.45	0.18	0.18	0.02	XXX
85097		A	Bone marrow interpretation	0.94	1.16	0.32	0.04	XXX
85390		X	Fibrinolysins screen	0.00	0.09	NA	0.00	XXX
85390	26	A	Fibrinolysins screen	0.37	0.15	0.15	0.02	XXX
85396		A	Clotting assay, whole blood	0.37	NA	0.13	0.02	XXX
85576		X	Blood platelet aggregation	0.00	0.10	NA	0.00	XXX
85576	26	A	Blood platelet aggregation	0.37	0.15	0.15	0.02	XXX
86077		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86078		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86079		A	Physician blood bank service	0.94	0.45	0.37	0.04	XXX
86255		X	Fluorescent antibody, screen	0.00	0.11	NA	0.00	XXX
86255	26	A	Fluorescent antibody, screen	0.37	0.15	0.15	0.02	XXX
86256		X	Fluorescent antibody, titer	0.00	0.10	NA	0.00	XXX
86256	26	A	Fluorescent antibody, titer	0.37	0.14	0.14	0.02	XXX
86320		X	Serum immunoelectrophoresis	0.00	0.09	NA	0.00	XXX
86320	26	A	Serum immunoelectrophoresis	0.37	0.14	0.14	0.02	XXX
86325		X	Other immunoelectrophoresis	0.00	0.10	NA	0.00	XXX
86325	26	A	Other immunoelectrophoresis	0.37	0.14	0.14	0.02	XXX
86327		X	Immunoelectrophoresis assay	0.00	0.10	NA	0.00	XXX
86327	26	A	Immunoelectrophoresis assay	0.42	0.17	0.17	0.02	XXX
86334		X	Immunofix e-phoresis, serum	0.00	0.10	NA	0.00	XXX
86334	26	A	Immunofix e-phoresis, serum	0.37	0.14	0.14	0.02	XXX
86335		X	Immunfix e-phorsis/urine/csf	0.00	0.10	NA	0.00	XXX
86335	26	A	Immunfix e-phorsis/urine/csf	0.37	0.15	0.15	0.02	XXX
86485		C	Skin test, candida	0.00	0.00	NA	0.00	XXX
86486		A	Coccidioidomycosis skin test	0.00	0.11	NA	0.00	XXX
86490		A	Histoplasmosis skin test	0.00	0.14	NA	0.00	XXX
86510		A	TB intradermal test	0.00	0.17	NA	0.00	XXX
86580		X	Dark field examination	0.00	0.10	NA	0.00	XXX
87164	26	A	Dark field examination	0.37	0.15	0.15	0.02	XXX
87207		X	Smear, special stain	0.00	0.10	NA	0.00	XXX
87207	26	A	Smear, special stain	0.37	0.15	0.15	0.02	XXX
88104		A	Cytopath fl nongyn, smears	0.56	1.13	NA	0.03	XXX
88104	TC	A	Cytopath fl nongyn, smears	0.00	0.93	NA	0.00	XXX
88104	26	A	Cytopath fl nongyn, smears	0.56	0.20	0.20	0.03	XXX
88106		A	Cytopath fl nongyn, filter	0.56	1.51	NA	0.03	XXX
88106	TC	A	Cytopath fl nongyn, filter	0.00	0.31	0.31	0.00	XXX
88106	26	A	Cytopath fl nongyn, filter	0.56	0.20	0.20	0.02	XXX
88107		A	Cytopath fl nongyn, sm/fltr	0.76	1.89	NA	0.04	XXX
88107	TC	A	Cytopath fl nongyn, sm/fltr	0.00	1.61	NA	0.00	XXX
88107	26	A	Cytopath fl nongyn, sm/fltr	0.76	0.28	0.28	0.03	XXX
88108		A	Cytopath, concentrate tech	0.56	1.34	NA	0.03	XXX
88108	TC	A	Cytopath, concentrate tech	0.00	1.15	NA	0.00	XXX
88108	26	A	Cytopath, concentrate tech	0.56	0.19	0.19	0.03	XXX
88112		A	Cytopath, cell enhance tech	1.18	1.38	NA	0.06	XXX
88112	TC	A	Cytopath, cell enhance tech	0.00	1.02	NA	0.00	XXX
88112	26	A	Cytopath, cell enhance tech	1.18	0.36	0.36	0.06	XXX
88125		A	Forensic cytopathology	0.26	0.31	NA	0.01	XXX
88125	TC	A	Forensic cytopathology	0.00	0.21	NA	0.00	XXX
88125	26	A	Forensic cytopathology	0.26	0.10	0.10	0.01	XXX
88141		A	Cytopath, c/v, interpret	0.42	0.35	0.35	0.02	XXX
88150		X	Cytopath, c/v, manual	0.00	1.06	NA	0.00	XXX
88160		A	Cytopath smear, other source	0.50	0.85	NA	0.02	XXX
88160	TC	A	Cytopath smear, other source	0.00	0.68	NA	0.00	XXX
88160	26	A	Cytopath smear, other source	0.50	0.16	0.16	0.02	XXX
88161		A	Cytopath smear, other source	0.50	0.85	NA	0.02	XXX
88161	TC	A	Cytopath smear, other source	0.00	0.69	NA	0.00	XXX
88161	26	A	Cytopath smear, other source	0.50	0.15	0.15	0.02	XXX
88162		A	Cytopath smear, other source	0.76	1.00	NA	0.04	XXX
88162	TC	A	Cytopath smear, other source	0.00	0.81	NA	0.00	XXX
88162	26	A	Cytopath smear, other source	0.76	0.19	0.19	0.03	XXX
88172		A	Cytopathology eval of fna	0.60	0.85	NA	0.03	XXX
88172	TC	A	Cytopathology eval of fna	0.00	0.62	NA	0.00	XXX
88172	26	A	Cytopathology eval of fna	0.60	0.23	0.23	0.03	XXX
88173		A	Cytopath eval, fna, report	1.39	2.14	NA	0.07	XXX
88173	TC	A	Cytopath eval, fna, report	0.00	1.66	NA	0.00	XXX
88173	26	A	Cytopath eval, fna, report	1.39	0.48	0.48	0.06	XXX
88182		A	Cell marker study	0.77	1.79	NA	0.04	XXX
88182	TC	A	Cell marker study	0.00	1.62	NA	0.00	XXX
88182	26	A	Cell marker study	0.77	0.18	0.18	0.03	XXX
88184		A	Flowcytometry/ tc, 1 marker	0.00	2.00	NA	0.00	XXX
88185		A	Flowcytometry/tc, add-on	0.00	1.22	NA	0.00	ZZZ
88187		A	Flowcytometry/read, 2-8	1.36	0.47	0.47	0.06	XXX
88188		A	Flowcytometry/read, 9-15	1.69	0.60	0.60	0.08	XXX
88189		A	Flowcytometry/read, 16 & >	2.23	0.57	0.57	0.11	XXX
88199		C	Cytopathology procedure	0.00	0.00	NA	0.00	XXX
88199	TC	C	Cytopathology procedure	0.00	0.00	NA	0.00	XXX
88199	26	C	Cytopathology procedure	0.00	0.00	0.00	0.00	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
88291		A	Cyto/molecular report	0.52	0.25	0.25	0.02	XXX
88299		C	Cytogenetic study	0.00	0.00	0.00	0.00	XXX
88300		A	Surgical path, gross	0.08	0.54	NA	0.00	XXX
88300	TC	A	Surgical path, gross	0.00	0.51	NA	0.00	XXX
88300	26	A	Surgical path, gross	0.08	0.03	0.03	0.00	XXX
88302		A	Tissue exam by pathologist	0.13	1.16	NA	0.01	XXX
88302	TC	A	Tissue exam by pathologist	0.00	1.12	NA	0.00	XXX
88302	26	A	Tissue exam by pathologist	0.13	0.05	0.05	0.01	XXX
88304		A	Tissue exam by pathologist	0.22	1.39	NA	0.01	XXX
88304	TC	A	Tissue exam by pathologist	0.00	1.31	NA	0.00	XXX
88304	26	A	Tissue exam by pathologist	0.22	0.08	0.08	0.01	XXX
88305		A	Tissue exam by pathologist	0.75	1.91	NA	0.03	XXX
88305	TC	A	Tissue exam by pathologist	0.00	1.66	NA	0.00	XXX
88305	26	A	Tissue exam by pathologist	0.75	0.26	0.26	0.03	XXX
88307		A	Tissue exam by pathologist	1.59	4.25	NA	0.07	XXX
88307	TC	A	Tissue exam by pathologist	0.00	3.66	NA	0.00	XXX
88307	26	A	Tissue exam by pathologist	1.59	0.60	0.60	0.07	XXX
88309		A	Tissue exam by pathologist	2.80	6.14	NA	0.13	XXX
88309	TC	A	Tissue exam by pathologist	0.00	5.09	NA	0.01	XXX
88309	26	A	Tissue exam by pathologist	2.80	1.06	1.06	0.12	XXX
88311		A	Decalcify tissue	0.24	0.25	NA	0.01	XXX
88311	TC	A	Decalcify tissue	0.00	0.16	NA	0.00	XXX
88311	26	A	Decalcify tissue	0.24	0.09	0.09	0.01	XXX
88312		A	Special stains	0.54	2.13	NA	0.02	XXX
88312	TC	A	Special stains	0.00	1.96	NA	0.00	XXX
88312	26	A	Special stains	0.54	0.18	0.18	0.02	XXX
88313		A	Special stains	0.24	1.67	NA	0.01	XXX
88313	TC	A	Special stains	0.00	1.59	NA	0.00	XXX
88313	26	A	Special stains	0.24	0.08	0.08	0.01	XXX
88314		A	Histochemical stain	0.45	1.72	NA	0.02	XXX
88314	TC	A	Histochemical stain	0.00	1.56	NA	0.00	XXX
88314	26	A	Histochemical stain	0.45	0.17	0.17	0.02	XXX
88318		A	Chemical histochemistry	0.42	2.14	NA	0.02	XXX
88318	TC	A	Chemical histochemistry	0.00	2.01	NA	0.00	XXX
88318	26	A	Chemical histochemistry	0.42	0.12	0.12	0.02	XXX
88319		A	Enzyme histochemistry	0.53	3.01	NA	0.03	XXX
88319	TC	A	Enzyme histochemistry	0.00	2.82	NA	0.00	XXX
88319	26	A	Enzyme histochemistry	0.53	0.19	0.19	0.03	XXX
88321		A	Microslide consultation	1.63	0.79	0.58	0.07	XXX
88323		A	Microslide consultation	1.83	1.88	NA	0.08	XXX
88323	TC	A	Microslide consultation	0.00	1.38	NA	0.01	XXX
88323	26	A	Microslide consultation	1.83	0.50	0.50	0.08	XXX
88325		A	Comprehensive review of data	2.50	2.78	1.02	0.11	XXX
88329		A	Path consult introp	0.67	0.69	0.25	0.03	XXX
88331		A	Path consult intraop, 1 bloc	1.19	1.25	NA	0.04	XXX
88331	TC	A	Path consult intraop, 1 bloc	0.00	0.79	NA	0.00	XXX
88331	26	A	Path consult intraop, 1 bloc	1.19	0.47	0.47	0.04	XXX
88332		A	Path consult intraop, addÆl	0.59	0.49	NA	0.03	XXX
88332	TC	A	Path consult intraop, addÆl	0.00	0.27	NA	0.00	XXX
88332	26	A	Path consult intraop, addÆl	0.59	0.22	0.22	0.03	XXX
88333		A	Intraop cyto path consult, 1	1.20	1.34	NA	0.06	XXX
88333	TC	A	Intraop cyto path consult, 1	0.00	0.89	NA	0.00	XXX
88333	26	A	Intraop cyto path consult, 1	1.20	0.45	0.45	0.05	XXX
88334		A	Intraop cyto path consult, 2	0.73	0.83	NA	0.03	XXX
88334	TC	A	Intraop cyto path consult, 2	0.00	0.55	NA	0.00	XXX
88334	26	A	Intraop cyto path consult, 2	0.73	0.28	0.28	0.03	XXX
88342		A	Immunohistochemistry	0.85	1.81	NA	0.04	XXX
88342	TC	A	Immunohistochemistry	0.00	1.54	NA	0.00	XXX
88342	26	A	Immunohistochemistry	0.85	0.28	0.28	0.04	XXX
88346		A	Immunofluorescent study	0.86	1.73	NA	0.04	XXX
88346	TC	A	Immunofluorescent study	0.00	1.45	NA	0.00	XXX
88346	26	A	Immunofluorescent study	0.86	0.28	0.28	0.03	XXX
88347		A	Immunofluorescent study	0.86	1.13	NA	0.03	XXX
88347	TC	A	Immunofluorescent study	0.00	0.92	NA	0.00	XXX
88347	26	A	Immunofluorescent study	0.86	0.21	0.21	0.03	XXX
88348		A	Electron microscopy	1.51	15.15	NA	0.07	XXX
88348	TC	A	Electron microscopy	0.00	14.67	NA	0.00	XXX
88348	26	A	Electron microscopy	1.51	0.49	0.49	0.07	XXX
88349		A	Scanning electron microscopy	0.76	8.92	NA	0.05	XXX
88349	TC	A	Scanning electron microscopy	0.00	8.62	NA	0.00	XXX
88349	26	A	Scanning electron microscopy	0.76	0.30	0.30	0.04	XXX
88355		A	Analysis, skeletal muscle	1.85	2.63	NA	0.05	XXX
88355	TC	A	Analysis, skeletal muscle	0.00	2.23	NA	0.01	XXX
88355	26	A	Analysis, skeletal muscle	1.85	0.40	0.40	0.05	XXX
88356		A	Analysis, nerve	3.02	4.02	NA	0.18	XXX
88356	TC	A	Analysis, nerve	0.00	3.52	NA	0.01	XXX
88356	26	A	Analysis, nerve	3.02	0.50	0.50	0.17	XXX
88358		A	Analysis, tumor	0.95	0.97	NA	0.05	XXX
88358	TC	A	Analysis, tumor	0.00	0.78	NA	0.00	XXX
88358	26	A	Analysis, tumor	0.95	0.19	0.19	0.04	XXX
88360		A	Tumor immunohistochem/manual	1.10	2.09	NA	0.05	XXX
88360	TC	A	Tumor immunohistochem/manual	0.00	1.75	NA	0.00	XXX
88360	26	A	Tumor immunohistochem/manual	1.10	0.35	0.35	0.05	XXX
88361		A	Tumor immunohistochem/comput	1.18	2.50	NA	0.06	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
88361	TC	A	Tumor immunohistochem/comput	0.00	2.16	NA	0.00	XXX
88361	26	A	Tumor immunohistochem/comput	1.18	0.34	0.34	0.05	XXX
88362		A	Nerve teasing preparations	2.17	5.22	NA	0.13	XXX
88362	TC	A	Nerve teasing preparations	0.00	4.45	NA	0.01	XXX
88362	26	A	Nerve teasing preparations	2.17	0.77	0.77	0.12	XXX
88365		A	Insitu hybridization (fish)	1.20	3.03	NA	0.06	XXX
88365	TC	A	Insitu hybridization (fish)	0.00	2.66	NA	0.00	XXX
88365	26	A	Insitu hybridization (fish)	1.20	0.37	0.37	0.05	XXX
88367		A	Insitu hybridization, auto	1.30	4.92	NA	0.08	XXX
88367	TC	A	Insitu hybridization, auto	0.00	4.59	NA	0.00	XXX
88367	26	A	Insitu hybridization, auto	1.30	0.33	0.33	0.07	XXX
88368		A	Insitu hybridization, manual	1.40	4.07	NA	0.07	XXX
88368	TC	A	Insitu hybridization, manual	0.00	3.80	NA	0.00	XXX
88368	26	A	Insitu hybridization, manual	1.40	0.28	0.28	0.06	XXX
88371		X	Protein, western blot tissue	0.00	0.10	NA	0.00	XXX
88371	26	A	Protein, western blot tissue	0.37	0.15	0.15	0.02	XXX
88372		X	Protein analysis w/probe	0.00	0.10	NA	0.00	XXX
88372	26	A	Protein analysis w/probe	0.37	0.15	0.15	0.02	XXX
88380		A	Microdissection, laser	1.56	3.59	NA	0.07	XXX
88380	TC	A	Microdissection, laser	0.00	2.99	NA	0.00	XXX
88380	26	A	Microdissection, laser	1.56	0.60	0.60	0.07	XXX
88381		A	Microdissection, manual	1.18	2.43	NA	0.06	XXX
88381	TC	A	Microdissection, manual	0.00	2.23	NA	0.00	XXX
88381	26	A	Microdissection, manual	1.18	0.21	0.21	0.05	XXX
88384		C	Eval molecular probes, 11-50	0.00	0.00	NA	0.00	XXX
88384	TC	C	Eval molecular probes, 11-50	0.00	0.00	NA	0.00	XXX
88384	26	C	Eval molecular probes, 11-50	0.00	0.00	0.00	0.00	XXX
88385		A	Eval molecul probes, 51-250	1.50	23.03	NA	0.07	XXX
88385	TC	A	Eval molecul probes, 51-250	0.00	22.44	NA	0.00	XXX
88385	26	A	Eval molecul probes, 51-250	1.50	0.59	0.59	0.07	XXX
88386		A	Eval molecul probes, 251-500	1.88	14.49	NA	0.09	XXX
88386	TC	A	Eval molecul probes, 251-500	0.00	13.94	NA	0.01	XXX
88386	26	A	Eval molecul probes, 251-500	1.88	0.55	0.55	0.08	XXX
88399		C	Surgical pathology procedure	0.00	0.00	NA	0.00	XXX
88399	TC	C	Surgical pathology procedure	0.00	0.00	NA	0.00	XXX
88399	26	C	Surgical pathology procedure	0.00	0.00	0.00	0.00	XXX
89049		A	Chct for mal hyperthermia	1.40	5.43	0.51	0.07	XXX
89060		X	Exam,synovial fluid crystals	0.00	0.10	NA	0.00	XXX
89060	26	A	Exam,synovial fluid crystals	0.37	0.14	0.14	0.02	XXX
89100		A	Sample intestinal contents	0.60	7.69	0.54	0.03	XXX
89105		A	Sample intestinal contents	0.50	6.89	0.44	0.02	XXX
89130		A	Sample stomach contents	0.45	6.41	0.40	0.02	XXX
89132		A	Sample stomach contents	0.19	6.44	0.30	0.01	XXX
89135		A	Sample stomach contents	0.79	7.67	0.61	0.04	XXX
89136		A	Sample stomach contents	0.21	6.41	0.31	0.01	XXX
89140		A	Sample stomach contents	0.94	6.81	0.58	0.05	XXX
89141		A	Sample stomach contents	0.85	6.77	0.54	0.05	XXX
89220		A	Sputum specimen collection	0.00	0.37	NA	0.00	XXX
89230		A	Collect sweat for test	0.00	0.16	NA	0.00	XXX
89240		C	Pathology lab procedure	0.00	0.00	0.00	0.00	XXX
90281		I	Human ig, im	0.00	0.00	0.00	0.00	XXX
90283		I	Human ig, iv	0.00	0.00	0.00	0.00	XXX
90287		I	Botulinum antitoxin	0.00	0.00	0.00	0.00	XXX
90288		I	Botulism ig, iv	0.00	0.00	0.00	0.00	XXX
90291		I	Cmv ig, iv	0.00	0.00	0.00	0.00	XXX
90379		I	Rsv ig, iv	0.00	0.00	0.00	0.00	XXX
90384		I	Rh ig, full-dose, im	0.00	0.00	0.00	0.00	XXX
90386		I	Rh ig, iv	0.00	0.00	0.00	0.00	XXX
90389		I	Tetanus ig, im	0.00	0.00	0.00	0.00	XXX
90399		I	Immune globulin	0.00	0.00	0.00	0.00	XXX
90465		A	Immune admin 1 inj, < 8 yrs	0.17	0.42	NA	0.01	XXX
90466		A	Immune admin addl inj, < 8 y	0.15	0.16	0.06	0.01	ZZZ
90467		R	Immune admin o or n, < 8 yrs	0.17	0.27	0.10	0.01	XXX
90468		R	Immune admin o/n, addl < 8 y	0.15	0.15	0.06	0.01	ZZZ
90471		A	Immunization admin	0.17	0.42	NA	0.01	XXX
90472		A	Immunization admin, each add	0.15	0.17	0.06	0.01	ZZZ
90473		R	Immune admin oral/nasal	0.17	0.26	0.07	0.01	XXX
90474		R	Immune admin oral/nasal addl	0.15	0.12	0.06	0.01	ZZZ
90723		I	Dtap-hep b-ipv vaccine, im	0.00	0.00	0.00	0.00	XXX
90738		I	Inactivated je vacc im	0.00	0.00	0.00	0.00	XXX
90748		I	Hep b/hib vaccine, im	0.00	0.00	0.00	0.00	XXX
90801		A	Psy dx interview	2.80	1.31	0.50	0.09	XXX
90802		A	Intac psy dx interview	3.01	1.49	0.59	0.10	XXX
90804		A	Psytx, office, 20-30 min	1.21	0.47	0.15	0.04	XXX
90805		A	Psytx, off, 20-30 min w/e&m	1.37	0.59	0.23	0.05	XXX
90806		A	Psytx, off, 45-50 min	1.86	0.38	0.20	0.05	XXX
90807		A	Psytx, off, 45-50 min w/e&m	2.02	0.69	0.34	0.07	XXX
90808		A	Psytx, office, 75-80 min	2.79	0.49	0.31	0.08	XXX
90809		A	Psytx, off, 75-80, w/e&m	2.95	0.85	0.52	0.10	XXX
90810		A	Intac psytx, off, 20-30 min	1.32	0.44	0.17	0.04	XXX
90811		A	Intac psytx, 20-30, w/e&m	1.48	0.71	0.26	0.05	XXX
90812		A	Intac psytx, off, 45-50 min	1.97	0.48	0.21	0.06	XXX
90813		A	Intac psytx, 45-50 min w/e&m	2.13	0.81	0.35	0.07	XXX
90814		A	Intac psytx, off, 75-80 min	2.90	0.65	0.32	0.09	XXX

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
90815		A	Intac psytx, 75-80 w/e&m	3.06	1.01	0.55	0.11	XXX
90816		A	Psytx, hosp, 20-30 min	1.25	NA	0.22	0.03	XXX
90817		A	Psytx, hosp, 20-30 min w/e&m	1.41	NA	0.34	0.05	XXX
90818		A	Psytx, hosp, 45-50 min	1.89	NA	0.28	0.05	XXX
90819		A	Psytx, hosp, 45-50 min w/e&m	2.05	NA	0.45	0.07	XXX
90821		A	Psytx, hosp, 75-80 min	2.83	NA	0.40	0.08	XXX
90822		A	Psytx, hosp, 75-80 min w/e&m	2.99	NA	0.60	0.10	XXX
90823		A	Intac psytx, hosp, 20-30 min	1.36	NA	0.22	0.04	XXX
90824		A	Intac psytx, hsp 20-30 w/e&m	1.52	NA	0.36	0.05	XXX
90826		A	Intac psytx, hosp, 45-50 min	2.01	NA	0.30	0.06	XXX
90827		A	Intac psytx, hsp 45-50 w/e&m	2.16	NA	0.46	0.07	XXX
90828		A	Intac psytx, hosp, 75-80 min	2.94	NA	0.38	0.08	XXX
90829		A	Intac psytx, hsp 75-80 w/e&m	3.10	NA	0.61	0.10	XXX
90845		A	Psychoanalysis	1.79	0.39	0.33	0.06	XXX
90846		R	Family psytx w/o patient	1.83	0.41	0.33	0.06	XXX
90847		R	Family psytx w/patient	2.21	0.59	0.36	0.07	XXX
90849		R	Multiple family group psytx	0.59	0.30	0.18	0.02	XXX
90853		A	Group psychotherapy	0.59	0.27	0.21	0.02	XXX
90857		A	Intac group psytx	0.63	0.33	0.19	0.02	XXX
90862		A	Medication management	0.95	0.62	0.27	0.03	XXX
90865		A	Narcosynthesis	2.84	1.47	0.57	0.10	XXX
90870		A	Electroconvulsive therapy	1.88	1.88	0.37	0.06	000
90875		N	Psychophysiological therapy	1.20	0.71	0.44	0.06	XXX
90876		N	Psychophysiological therapy	1.90	0.95	0.69	0.10	XXX
90880		A	Hypnotherapy	2.19	0.42	0.28	0.06	XXX
90885		B	Psy evaluation of records	0.97	0.35	0.35	0.05	XXX
90887		B	Consultation with family	1.48	0.83	0.54	0.08	XXX
90889		B	Preparation of report	0.00	0.00	0.00	0.00	XXX
90899		C	Psychiatric service/therapy	0.00	0.00	0.00	0.00	XXX
90901		A	Biofeedback train, any meth	0.41	0.54	0.13	0.02	000
90911		A	Biofeedback peri/uro/rectal	0.89	1.23	0.30	0.05	000
90935		A	Hemodialysis, one evaluation	1.22	NA	0.64	0.05	000
90937		A	Hemodialysis, repeated eval	2.11	NA	0.95	0.09	000
90940		X	Hemodialysis access study	0.00	0.37	NA	0.00	XXX
90945		A	Dialysis, one evaluation	1.28	NA	0.66	0.06	000
90947		A	Dialysis, repeated eval	2.16	NA	0.96	0.10	000
90951		A	Esrd serv, 4 visits p mo, <2	18.46	8.45	8.45	0.77	XXX
90952		C	Esrd serv, 2-3 vsts p mo, <2	0.00	0.00	0.00	0.00	XXX
90953		C	Esrd serv, 1 visit p mo, <2	0.00	0.00	0.00	0.00	XXX
90954		A	Esrd serv, 4 vsts p mo, 2-11	15.98	6.64	6.64	0.69	XXX
90955		A	Esrd srv 2-3 vsts p mo, 2-11	8.79	3.71	3.71	0.38	XXX
90956		A	Esrd srv, 1 visit p mo, 2-11	5.95	2.31	2.31	0.26	XXX
90957		A	Esrd srv, 4 vsts p mo, 12-19	12.52	5.61	5.61	0.55	XXX
90958		A	Esrd srv 2-3 vsts p mo 12-19	8.34	3.68	3.68	0.37	XXX
90959		A	Esrd serv, 1 vst p mo, 12-19	5.50	2.17	2.17	0.24	XXX
90960		A	Esrd srv, 4 visits p mo, 20+	5.18	2.73	2.73	0.23	XXX
90961		A	Esrd srv, 2-3 vsts p mo, 20+	4.26	2.06	2.06	0.19	XXX
90962		A	Esrd serv, 1 visit p mo, 20+	3.15	1.32	1.32	0.14	XXX
90963		A	Esrd home pt, serv p mo, <2	10.56	3.87	3.87	0.45	XXX
90964		A	Esrd home pt serv p mo, 2-11	9.14	3.41	3.41	0.40	XXX
90965		A	Esrd home pt serv p mo 12-19	8.69	3.27	3.27	0.38	XXX
90966		A	Esrd home pt, serv p mo, 20+	4.26	1.94	1.94	0.19	XXX
90967		A	Esrd home pt serv p day, <2	0.35	0.20	0.20	0.02	XXX
90968		A	Esrd home pt srv p day, 2-11	0.30	0.13	0.13	0.01	XXX
90969		A	Esrd home pt srv p day 12-19	0.29	0.13	0.13	0.01	XXX
90970		A	Esrd home pt serv p day, 20+	0.14	0.07	0.07	0.01	XXX
90997		A	Hemoperfusion	1.84	NA	0.61	0.08	000
90999		C	Dialysis procedure	0.00	0.00	0.00	0.00	XXX
91000		A	Esophageal intubation	0.73	2.14	2.14	0.04	000
91000	TC	A	Esophageal intubation	0.00	1.87	1.87	0.00	000
91000	26	A	Esophageal intubation	0.73	0.27	0.27	0.04	000
91010		A	Esophagus motility study	1.25	3.26	3.26	0.08	000
91010	TC	A	Esophagus motiity study	0.00	2.72	2.72	0.00	000
91010	26	A	Esophagus motility study	1.25	0.54	0.54	0.08	000
91011		A	Esophagus motility study	1.50	4.59	4.59	0.08	000
91011	TC	A	Esophagus motility study	0.00	3.92	3.92	0.00	000
91011	26	A	Esophagus motility study	1.50	0.67	0.67	0.08	000
91012		A	Esophagus motility study	1.46	4.68	4.68	0.08	000
91012	TC	A	Esophagus motility study	0.00	4.04	4.04	0.00	000
91012	26	A	Esophagus motility study	1.46	0.64	0.64	0.08	000
91020		A	Gastric motility studies	1.44	4.37	4.37	0.09	000
91020	TC	A	Gastric motility studies	0.00	3.75	3.75	0.00	000
91020	26	A	Gastric motility studies	1.44	0.62	0.62	0.08	000
91022		A	Duodenal motility study	1.44	2.88	2.88	0.08	000
91022	TC	A	Duodenal motility study	0.00	2.24	2.24	0.00	000
91022	26	A	Duodenal motility study	1.44	0.64	0.64	0.08	000
91030		A	Acid perfusion of esophagus	0.91	2.51	2.51	0.05	000
91030	TC	A	Acid perfusion of esophagus	0.00	2.11	2.11	0.00	000
91030	26	A	Acid perfusion of esophagus	0.91	0.40	0.40	0.05	000
91034		A	Gastroesophageal reflux test	0.97	3.70	3.70	0.05	000
91034	TC	A	Gastroesophageal reflux test	0.00	3.28	3.28	0.00	000
91034	26	A	Gastroesophageal reflux test	0.97	0.42	0.42	0.05	000
91035		A	G-esoph reflx tst w/electrod	1.59	10.10	10.10	0.10	000
91035	TC	A	G-esoph reflx tst w/electrod	0.00	9.41	9.41	0.00	000

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CPT[1]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
91035	26	A	G-esoph reflx tst w/electrod	1.59	0.69	0.69	0.09	000
91037		A	Esoph imped function test	0.97	3.03	3.03	0.08	000
91037	TC	A	Esoph imped function test	0.00	2.61	2.61	0.00	000
91037	26	A	Esoph imped function test	0.97	0.42	0.42	0.08	000
91038		A	Esoph imped funct test > 1h	1.10	2.43	2.43	0.07	000
91038	TC	A	Esoph imped funct test > 1h	0.00	1.95	1.95	0.00	000
91038	26	A	Esoph imped funct test > 1h	1.10	0.48	0.48	0.07	000
91040		A	Esoph balloon distension tst	0.97	6.23	6.23	0.04	000
91040	TC	A	Esoph balloon distension tst	0.00	5.91	5.91	0.00	000
91040	26	A	Esoph balloon distension tst	0.97	0.32	0.32	0.04	000
91052		A	Gastric analysis test	0.79	2.55	2.55	0.03	000
91052	TC	A	Gastric analysis test	0.00	2.19	2.19	0.00	000
91052	26	A	Gastric analysis test	0.79	0.35	0.35	0.03	000
91055		A	Gastric intubation for smear	0.94	2.92	2.92	0.04	000
91055	TC	A	Gastric intubation for smear	0.00	2.46	2.46	0.00	000
91055	26	A	Gastric intubation for smear	0.94	0.46	0.46	0.04	000
91065		A	Breath hydrogen test	0.20	1.55	1.55	0.01	000
91065	TC	A	Breath hydrogen test	0.00	1.46	1.46	0.00	000
91065	26	A	Breath hydrogen test	0.20	0.09	0.09	0.01	000
91105		A	Gastric intubation treatment	0.37	1.99	0.09	0.02	000
91110		A	Gi tract capsule endoscopy	3.64	18.12	NA	0.21	XXX
91110	TC	A	Gi tract capsule endoscopy	0.00	16.52	NA	0.01	XXX
91110	26	A	Gi tract capsule endoscopy	3.64	1.60	1.60	0.20	XXX
91111		A	Esophageal capsule endoscopy	1.00	16.32	NA	0.05	XXX
91111	TC	A	Esophageal capsule endoscopy	0.00	15.88	NA	0.00	XXX
91111	26	A	Esophageal capsule endoscopy	1.00	0.44	0.44	0.05	XXX
91120		A	Rectal sensation test	0.97	8.82	8.82	0.09	XXX
91120	TC	A	Rectal sensation test	0.00	8.45	8.45	0.00	XXX
91120	26	A	Rectal sensation test	0.97	0.38	0.38	0.09	XXX
91122		A	Anal pressure record	1.77	3.78	3.78	0.12	000
91122	TC	A	Anal pressure record	0.00	3.14	3.14	0.01	000
91122	26	A	Anal pressure record	1.77	0.64	0.64	0.11	000
91123		B	Irrigate fecal impaction	0.00	NA	NA	0.00	XXX
91132		C	Electrogastrography	0.00	0.00	NA	0.00	XXX
91132	TC	C	Electrogastrography	0.00	0.00	NA	0.00	XXX
91132	26	A	Electrogastrography	0.52	0.21	0.21	0.02	XXX
91133		C	Electrogastrography w/test	0.00	0.00	NA	0.00	XXX
91133	TC	C	Electrogastrography w/test	0.00	0.00	NA	0.00	XXX
91133	26	A	Electrogastrography w/test	0.66	0.29	0.29	0.04	XXX
91299		C	Gastroenterology procedure	0.00	0.00	NA	0.00	XXX
91299	TC	C	Gastroenterology procedure	0.00	0.00	NA	0.00	XXX
91299	26	C	Gastroenterology procedure	0.00	0.00	0.00	0.00	XXX
92002		A	Eye exam, new patient	0.88	1.18	0.41	0.03	XXX
92004		A	Eye exam, new patient	1.82	2.04	0.89	0.05	XXX
92012		A	Eye exam established pat	0.92	1.27	0.51	0.03	XXX
92014		A	Eye exam & treatment	1.42	1.78	0.75	0.04	XXX
92015		N	Refraction	0.38	0.15	0.14	0.02	XXX
92018		A	New eye exam & treatment	2.50	NA	1.42	0.08	XXX
92019		A	Eye exam & treatment	1.31	NA	0.58	0.04	XXX
92020		A	Special eye evaluation	0.37	0.34	0.20	0.01	XXX
92025		A	Corneal topography	0.35	0.61	0.61	0.01	XXX
92025	TC	A	Corneal topography	0.00	0.42	0.42	0.00	XXX
92025	26	A	Corneal topography	0.35	0.19	0.19	0.01	XXX
92060		A	Special eye evaluation	0.69	0.98	NA	0.02	XXX
92060	TC	A	Special eye evaluation	0.00	0.62	NA	0.00	XXX
92060	26	A	Special eye evaluation	0.69	0.36	0.36	0.02	XXX
92065		A	Orthoptic/pleoptic training	0.37	1.00	NA	0.01	XXX
92065	TC	A	Orthoptic/pleoptic training	0.00	0.87	NA	0.00	XXX
92065	26	A	Orthoptic/pleoptic training	0.37	0.13	0.13	0.01	XXX
92070		A	Fitting of contact lens	0.70	1.12	0.36	0.02	XXX
92081		A	Visual field examination(s)	0.36	1.13	NA	0.01	XXX
92081	TC	A	Visual field examination(s)	0.00	0.96	NA	0.00	XXX
92081	26	A	Visual field examination(s)	0.36	0.17	0.17	0.01	XXX
92082		A	Visual field examination(s)	0.44	1.55	NA	0.01	XXX
92082	TC	A	Visual field examination(s)	0.00	1.33	NA	0.00	XXX
92082	26	A	Visual field examination(s)	0.44	0.22	0.22	0.01	XXX
92083		A	Visual field examination(s)	0.50	1.79	NA	0.01	XXX
92083	TC	A	Visual field examination(s)	0.00	1.52	NA	0.00	XXX
92083	26	A	Visual field examination(s)	0.50	0.27	0.27	0.01	XXX
92100		A	Serial tonometry exam(s)	0.92	1.56	0.46	0.03	XXX
92120		A	Tonography & eye evaluation	0.81	1.21	0.40	0.02	XXX
92130		A	Water provocation tonography	0.81	1.46	0.44	0.03	XXX
92135		A	Ophth dx imaging post seg	0.35	0.95	NA	0.01	XXX
92135	TC	A	Ophth dx imaging post seg	0.00	0.76	NA	0.00	XXX
92135	26	A	Ophth dx imaging post seg	0.35	0.19	0.19	0.01	XXX
92136		A	Ophthalmic biometry	0.54	1.69	NA	0.02	XXX
92136	TC	A	Ophthalmic biometry	0.00	1.38	NA	0.00	XXX
92136	26	A	Ophthalmic biometry	0.54	0.32	0.32	0.01	XXX
92140		A	Glaucoma provocative tests	0.50	1.09	0.24	0.02	XXX
92225		A	Special eye exam, initial	0.38	0.33	0.20	0.01	XXX
92226		A	Special eye exam, subsequent	0.33	0.32	0.19	0.01	XXX
92230		A	Eye exam with photos	0.60	0.88	0.32	0.02	XXX
92235		A	Eye exam with photos	0.81	2.69	NA	0.02	XXX
92235	TC	A	Eye exam with photos	0.00	2.21	NA	0.00	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92235	26	A	Eye exam with photos	0.81	0.48	0.48	0.02	XXX
92240		A	Icg angiography	1.10	5.11	NA	0.03	XXX
92240	TC	A	Icg angiography	0.00	4.46	NA	0.00	XXX
92240	26	A	Icg angiography	1.10	0.65	0.65	0.03	XXX
92250		A	Eye exam with photos	0.44	1.52	NA	0.01	XXX
92250	TC	A	Eye exam with photos	0.00	1.30	NA	0.00	XXX
92250	26	A	Eye exam with photos	0.44	0.22	0.22	0.01	XXX
92260		A	Ophthalmoscopy/dynamometry	0.20	0.29	0.11	0.01	XXX
92265		A	Eye muscle evaluation	0.81	1.36	NA	0.02	XXX
92265	TC	A	Eye muscle evaluation	0.00	0.89	NA	0.00	XXX
92265	26	A	Eye muscle evaluation	0.81	0.47	0.47	0.02	XXX
92270		A	Electro-oculography	0.81	1.49	NA	0.04	XXX
92270	TC	A	Electro-oculography	0.00	1.16	NA	0.00	XXX
92270	26	A	Electro-oculography	0.81	0.33	0.33	0.03	XXX
92275		A	Electroretinography	1.01	2.94	NA	0.03	XXX
92275	TC	A	Electroretinography	0.00	2.36	NA	0.00	XXX
92275	26	A	Electroretinography	1.01	0.58	0.58	0.03	XXX
92283		A	Color vision examination	0.17	1.17	NA	0.00	XXX
92283	TC	A	Color vision examination	0.00	1.08	NA	0.00	XXX
92283	26	A	Color vision examination	0.17	0.08	0.08	0.00	XXX
92284		A	Dark adaptation eye exam	0.24	1.25	NA	0.01	XXX
92284	TC	A	Dark adaptation eye exam	0.00	1.15	NA	0.00	XXX
92284	26	A	Dark adaptation eye exam	0.24	0.10	0.10	0.01	XXX
92285		A	Eye photography	0.20	0.92	NA	0.01	XXX
92285	TC	A	Eye photography	0.00	0.82	NA	0.00	XXX
92285	26	A	Eye photography	0.20	0.10	0.10	0.01	XXX
92286		A	Internal eye photography	0.66	2.45	NA	0.02	XXX
92286	TC	A	Internal eye photography	0.00	2.09	NA	0.00	XXX
92286	26	A	Internal eye photography	0.66	0.36	0.36	0.02	XXX
92287		A	Internal eye photography	0.81	2.30	0.47	0.02	XXX
92310		N	Contact lens fitting	1.17	1.28	0.43	0.06	XXX
92311		A	Contact lens fitting	1.08	1.60	0.49	0.04	XXX
92312		A	Contact lens fitting	1.26	1.85	0.55	0.04	XXX
92313		A	Contact lens fitting	0.92	1.75	0.50	0.03	XXX
92314		N	Prescription of contact lens	0.69	1.31	0.25	0.04	XXX
92315		A	Prescription of contact lens	0.45	1.48	0.19	0.01	XXX
92316		A	Prescription of contact lens	0.68	2.00	0.40	0.02	XXX
92317		A	Prescription of contact lens	0.45	2.22	0.07	0.02	XXX
92325		A	Modification of contact lens	0.00	0.95	NA	0.00	XXX
92326		A	Replacement of contact lens	0.00	0.82	NA	0.00	XXX
92340		N	Fitting of spectacles	0.37	0.52	0.14	0.02	XXX
92341		N	Fitting of spectacles	0.47	0.56	0.17	0.03	XXX
92342		N	Fitting of spectacles	0.53	0.58	0.19	0.03	XXX
92352		B	Special spectacles fitting	0.37	0.65	0.14	0.02	XXX
92353		B	Special spectacles fitting	0.50	0.70	0.18	0.03	XXX
92354		B	Special spectacles fitting	0.00	0.31	NA	0.00	XXX
92355		B	Special spectacles fitting	0.00	0.48	NA	0.00	XXX
92358		B	Eye prosthesis service	0.00	0.26	NA	0.00	XXX
92370		N	Repair & adjust spectacles	0.32	0.46	0.12	0.02	XXX
92371		B	Repair & adjust spectacles	0.00	0.26	NA	0.00	XXX
92499		C	Eye service or procedure	0.00	0.00	NA	0.00	XXX
92499	TC	C	Eye service or procedure	0.00	0.00	NA	0.00	XXX
92499	26	C	Eye service or procedure	0.00	0.00	0.00	0.00	XXX
92502		A	Ear and throat examination	1.51	NA	1.12	0.06	000
92504		A	Ear microscopy examination	0.18	0.63	0.08	0.01	XXX
92506		A	Speech/hearing evaluation	0.86	3.68	0.38	0.04	XXX
92507		A	Speech/hearing therapy	0.52	1.37	0.21	0.02	XXX
92508		A	Speech/hearing therapy	0.26	0.77	0.12	0.01	XXX
92511		A	Nasopharyngoscopy	0.84	3.23	0.78	0.04	000
92512		A	Nasal function studies	0.55	1.04	0.25	0.02	XXX
92516		A	Facial nerve function test	0.43	1.27	0.19	0.02	XXX
92520		A	Laryngeal function studies	0.75	1.10	0.36	0.03	XXX
92526		A	Oral function therapy	0.55	1.89	0.21	0.02	XXX
92531		B	Spontaneous nystagmus study	0.00	0.00	0.00	0.00	XXX
92532		B	Positional nystagmus test	0.00	0.00	0.00	0.00	XXX
92533		B	Caloric vestibular test	0.00	0.00	0.00	0.00	XXX
92534		B	Optokinetic nystagmus test	0.00	0.00	0.00	0.00	XXX
92541		A	Spontaneous nystagmus test	0.40	1.34	NA	0.02	XXX
92541	TC	A	Spontaneous nystagmus test	0.00	1.18	NA	0.00	XXX
92541	26	A	Spontaneous nystagmus test	0.40	0.16	0.16	0.02	XXX
92542		A	Positional nystagmus test	0.33	1.52	NA	0.02	XXX
92542	TC	A	Positional nystagmus test	0.00	1.38	NA	0.00	XXX
92542	26	A	Positional nystagmus test	0.33	0.13	0.13	0.01	XXX
92543		A	Caloric vestibular test	0.10	0.75	NA	0.00	XXX
92543	TC	A	Caloric vestibular test	0.00	0.71	NA	0.00	XXX
92543	26	A	Caloric vestibular test	0.10	0.04	0.04	0.00	XXX
92544		A	Optokinetic nystagmus test	0.26	1.22	NA	0.01	XXX
92544	TC	A	Optokinetic nystagmus test	0.00	1.12	NA	0.00	XXX
92544	26	A	Optokinetic nystagmus test	0.26	0.11	0.11	0.01	XXX
92545		A	Oscillating tracking test	0.23	1.21	NA	0.01	XXX
92545	TC	A	Oscillating tracking test	0.00	1.11	NA	0.00	XXX
92545	26	A	Oscillating tracking test	0.23	0.09	0.09	0.01	XXX
92546		A	Sinusoidal rotational test	0.29	2.17	NA	0.01	XXX
92546	TC	A	Sinusoidal rotational test	0.00	2.06	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92546	26	A	Sinusoidal rotational test	0.29	0.11	0.11	0.01	XXX
92547		A	Supplemental electrical test	0.00	0.12	0.12	0.00	ZZZ
92548		A	Posturography	0.50	2.12	NA	0.02	XXX
92548	TC	A	Posturography	0.00	1.93	NA	0.00	XXX
92548	26	A	Posturography	0.50	0.19	0.19	0.02	XXX
92551		N	Pure tone hearing test, air	0.00	0.27	NA	0.00	XXX
92552		A	Pure tone audiometry, air	0.00	0.65	NA	0.00	XXX
92553		A	Audiometry, air & bone	0.00	0.79	NA	0.00	XXX
92555		A	Speech threshold audiometry	0.00	0.43	NA	0.00	XXX
92556		A	Speech audiometry, complete	0.00	0.68	NA	0.00	XXX
92557		A	Comprehensive hearing test	0.60	0.35	0.25	0.02	XXX
92561		A	Bekesy audiometry, diagnosis	0.00	0.86	NA	0.00	XXX
92562		A	Loudness balance test	0.00	0.82	NA	0.00	XXX
92563		A	Tone decay hearing test	0.00	0.62	NA	0.00	XXX
92564		A	Sisi hearing test	0.00	0.59	NA	0.00	XXX
92565		A	Stenger test, pure tone	0.00	0.31	NA	0.00	XXX
92567		A	Tympanometry	0.20	0.15	0.08	0.01	XXX
92568		A	Acoustic refl threshold tst	0.29	0.12	0.12	0.01	XXX
92569		A	Acoustic reflex decay test	0.20	0.08	0.08	0.01	XXX
92571		A	Filtered speech hearing test	0.00	0.46	NA	0.00	XXX
92572		A	Staggered spondaic word test	0.00	0.88	NA	0.00	XXX
92575		A	Sensorineural acuity test	0.00	1.23	NA	0.00	XXX
92576		A	Synthetic sentence test	0.00	0.63	NA	0.00	XXX
92577		A	Stenger test, speech	0.00	0.32	NA	0.00	XXX
92579		A	Visual audiometry (vra)	0.70	0.49	0.33	0.03	XXX
92582		A	Conditioning play audiometry	0.00	1.26	NA	0.00	XXX
92583		A	Select picture audiometry	0.00	0.88	NA	0.00	XXX
92584		A	Electrocochleography	0.00	1.48	NA	0.00	XXX
92585		A	Auditor evoke potent, compre	0.50	2.43	NA	0.02	XXX
92585	TC	A	Auditor evoke potent, compre	0.00	2.22	NA	0.00	XXX
92585	26	A	Auditor evoke potent, compre	0.50	0.21	0.21	0.02	XXX
92586		A	Auditor evoke potent, limit	0.00	1.70	NA	0.00	XXX
92587		A	Evoked auditory test	0.13	0.71	NA	0.01	XXX
92587	TC	A	Evoked auditory test	0.00	0.65	NA	0.00	XXX
92587	26	A	Evoked auditory test	0.13	0.05	0.05	0.01	XXX
92588		A	Evoked auditory test	0.36	1.24	NA	0.01	XXX
92588	TC	A	Evoked auditory test	0.00	1.09	NA	0.00	XXX
92588	26	A	Evoked auditory test	0.36	0.15	0.15	0.01	XXX
92596		A	Ear protector evaluation	0.00	1.13	NA	0.00	XXX
92597		A	Oral speech device eval	0.86	2.12	0.40	0.04	XXX
92601		A	Cochlear implt f/up exam < 7	2.30	1.49	1.00	0.09	XXX
92602		A	Reprogram cochlear implt < 7	1.30	0.94	0.40	0.05	XXX
92603		A	Cochlear implt f/up exam 7 >	2.25	1.40	0.92	0.09	XXX
92604		A	Reprogram cochlear implt 7 >	1.25	0.90	0.51	0.05	XXX
92605		B	Eval for nonspeech device rx	0.00	5.85	NA	0.00	XXX
92606		B	Non-speech device service	0.00	2.03	NA	0.00	XXX
92607		A	Ex for speech device rx, 1hr	0.00	4.70	NA	0.00	XXX
92608		A	Ex for speech device rx addl	0.00	1.22	NA	0.00	XXX
92609		A	Use of speech device service	0.00	2.73	NA	0.00	XXX
92610		A	Evaluate swallowing function	0.00	1.79	NA	0.00	XXX
92611		A	Motion fluoroscopy/swallow	0.00	2.13	NA	0.00	XXX
92612		A	Endoscopy swallow tst (fees)	1.27	3.12	0.59	0.05	XXX
92613		A	Endoscopy swallow tst (fees)	0.71	0.32	0.32	0.03	XXX
92614		A	Laryngoscopic sensory test	1.27	2.68	0.61	0.05	XXX
92615		A	Eval laryngoscopy sense tst	0.63	0.30	0.29	0.03	XXX
92616		A	Fees w/laryngeal sense test	1.88	3.35	0.84	0.08	XXX
92617		A	Interprt fees/laryngeal test	0.79	0.35	0.35	0.03	XXX
92620		A	Auditory function, 60 min	1.50	0.93	0.71	0.05	XXX
92621		A	Auditory function, + 15 min	0.35	0.18	0.11	0.01	ZZZ
92625		A	Tinnitus assessment	1.15	0.61	0.46	0.05	XXX
92626		A	Eval aud rehab status	1.40	0.77	0.51	0.06	XXX
92627		A	Eval aud status rehab add-on	0.33	0.21	0.13	0.01	ZZZ
92630		I	Aud rehab pre-ling hear loss	0.00	1.29	NA	0.00	XXX
92633		I	Aud rehab postling hear loss	0.00	1.35	NA	0.00	XXX
92640		A	Aud brainstem implt programg	1.76	0.98	0.65	0.29	XXX
92700		C	Ent procedure/service	0.00	0.00	0.00	0.00	XXX
92950		A	Heart/lung resuscitation cpr	3.79	3.55	0.88	0.23	000
92953		A	Temporary external pacing	0.23	NA	0.06	0.01	000
92960		A	Cardioversion electric, ext	2.25	3.18	0.98	0.12	000
92961		A	Cardioversion, electric, int	4.59	NA	1.77	0.35	000
92970		A	Cardioassist, internal	3.51	NA	1.17	0.18	000
92971		A	Cardioassist, external	1.77	NA	0.71	0.09	000
92973		A	Percut coronary thrombectomy	3.28	NA	1.10	0.17	ZZZ
92974		A	Cath place, cardio brachytx	3.00	NA	1.01	0.17	ZZZ
92975		A	Dissolve clot, heart vessel	7.24	NA	2.47	0.38	000
92977		A	Dissolve clot, heart vessel	0.00	1.27	NA	0.00	XXX
92978		C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92978	TC	C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92978	26	A	Intravasc us, heart add-on	1.80	0.60	0.60	0.10	ZZZ
92979		C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92979	TC	C	Intravasc us, heart add-on	0.00	NA	NA	0.00	ZZZ
92979	26	A	Intravasc us, heart add-on	1.44	0.48	0.48	0.08	ZZZ
92980		A	Insert intracoronary stent	14.82	NA	5.14	0.77	000
92981		A	Insert intracoronary stent	4.16	NA	1.40	0.22	ZZZ

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CPT[1,7]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
92982		A	Coronary artery dilation	10.96	NA	3.84	0.57	000
92984		A	Coronary artery dilation	2.97	NA	1.00	0.15	ZZZ
92986		A	Revision of aortic valve	22.70	NA	10.06	1.22	090
92987		A	Revision of mitral valve	23.48	NA	10.36	1.19	090
92990		A	Revision of pulmonary valve	18.12	NA	8.40	0.92	090
92992		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090
92993		C	Revision of heart chamber	0.00	0.00	0.00	0.00	090
92995		A	Coronary atherectomy	12.07	NA	4.21	0.62	000
92996		A	Coronary atherectomy add-on	3.26	NA	1.09	0.17	ZZZ
92997		A	Pul art balloon repr, percut	11.98	NA	4.16	0.61	000
92998		A	Pul art balloon repr, percut	5.99	NA	2.00	0.31	ZZZ
93000		A	Electrocardiogram, complete	0.17	0.28	0.28	0.01	XXX
93005		A	Electrocardiogram, tracing	0.00	0.22	NA	0.00	XXX
93010		A	Electrocardiogram report	0.17	0.06	0.06	0.01	XXX
93012		A	Transmission of ecg	0.00	3.60	NA	0.00	XXX
93014		A	Report on transmitted ecg	0.52	0.18	0.18	0.03	XXX
93015		A	Cardiovascular stress test	0.75	1.39	1.39	0.04	XXX
93016		A	Cardiovascular stress test	0.45	0.15	0.15	0.02	XXX
93017		A	Cardiovascular stress test	0.00	1.13	NA	0.00	XXX
93018		A	Cardiovascular stress test	0.30	0.10	0.10	0.01	XXX
93024		A	Cardiac drug stress test	1.17	1.71	NA	0.06	XXX
93024	TC	A	Cardiac drug stress test	0.00	1.31	NA	0.00	XXX
93024	26	A	Cardiac drug stress test	1.17	0.40	0.40	0.06	XXX
93025		A	Microvolt t-wave assess	0.75	3.22	NA	0.04	XXX
93025	TC	A	Microvolt t-wave assess	0.00	2.97	NA	0.00	XXX
93025	26	A	Microvolt t-wave assess	0.75	0.25	0.25	0.04	XXX
93040		A	Rhythm ECG with report	0.16	0.17	0.17	0.01	XXX
93041		A	Rhythm ECG, tracing	0.00	0.13	NA	0.00	XXX
93042		A	Rhythm ECG, report	0.16	0.04	0.04	0.01	XXX
93224		A	ECG monitor/report, 24 hrs	0.52	1.45	1.45	0.03	XXX
93225		A	ECG monitor/record, 24 hrs	0.00	0.63	NA	0.00	XXX
93226		A	ECG monitor/report, 24 hrs	0.00	0.89	NA	0.00	XXX
93227		A	ECG monitor/review, 24 hrs	0.52	0.21	0.21	0.03	XXX
93228		A	Remote 30 day ecg rev/report	0.52	0.19	0.19	0.03	XXX
93229		C	Remote 30 day ecg tech supp	0.00	0.00	NA	0.00	XXX
93230		A	ECG monitor/report, 24 hrs	0.52	1.35	1.35	0.03	XXX
93231		A	Ecg monitor/record, 24 hrs	0.00	0.55	NA	0.00	XXX
93232		A	ECG monitor/report, 24 hrs	0.00	1.04	NA	0.00	XXX
93233		A	ECG monitor/review, 24 hrs	0.52	0.18	0.18	0.02	XXX
93235		C	ECG monitor/report, 24 hrs	0.00	0.00	0.00	0.00	XXX
93236		C	ECG monitor/report, 24 hrs	0.00	0.00	NA	0.00	XXX
93237		A	ECG monitor/review, 24 hrs	0.45	0.15	0.15	0.02	XXX

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93268		A	ECG record/review	0.52	0.58	0.58	0.03	XXX
93270		A	ECG recording	0.00	0.21	NA	0.00	XXX
93271		A	Ecg/monitorng and analysis	0.00	4.59	NA	0.00	XXX
93272		A	Ecg/review, interpret only	0.52	0.17	0.17	0.03	XXX
93278		A	ECG/signal-averaged	0.25	0.52	NA	0.01	XXX
93278	TC	A	ECG/signal-averaged	0.00	0.43	NA	0.00	XXX
93278	26	A	ECG/signal-averaged	0.25	0.09	0.09	0.01	XXX
93279		A	Pm device progr eval, sngl	0.65	0.62	NA	0.03	XXX
93279	TC	A	Pm device progr eval, sngl	0.00	0.40	NA	0.00	XXX
93279	26	A	Pm device progr eval, sngl	0.65	0.22	0.22	0.03	XXX
93280		A	Pm device progr eval, dual	0.77	0.71	NA	0.04	XXX
93280	TC	A	Pm device progr eval, dual	0.00	0.45	NA	0.00	XXX
93280	26	A	Pm device progr eval, dual	0.77	0.26	0.26	0.04	XXX
93281		A	Pm device progr eval, multi	0.90	0.83	NA	0.05	XXX
93281	TC	A	Pm device progr eval, multi	0.00	0.52	NA	0.00	XXX
93281	26	A	Pm device progr eval, multi	0.90	0.31	0.31	0.05	XXX
93282		A	Icd device prog eval, 1 sngl	0.85	0.74	NA	0.04	XXX
93282	TC	A	Icd device prog eval, 1 sngl	0.00	0.46	NA	0.00	XXX
93282	26	A	Icd device prog eval, 1 sngl	0.85	0.29	0.29	0.04	XXX
93283		A	Icd device progr eval, dual	1.05	0.89	NA	0.05	XXX
93283	TC	A	Icd device progr eval, dual	0.00	0.53	NA	0.00	XXX
93283	26	A	Icd device progr eval, dual	1.05	0.36	0.36	0.05	XXX
93284		A	Icd device progr eval, mult	1.25	1.03	NA	0.07	XXX
93284	TC	A	Icd device progr eval, mult	0.00	0.61	NA	0.00	XXX
93284	26	A	Icd device progr eval, mult	1.25	0.42	0.42	0.06	XXX
93285		A	Ilr device eval progr	0.52	0.53	NA	0.03	XXX
93285	TC	A	Ilr device eval progr	0.00	0.36	NA	0.00	XXX
93285	26	A	Ilr device eval progr	0.52	0.18	0.18	0.03	XXX
93286		A	Pre-op pm device eval	0.30	0.42	NA	0.02	XXX
93286	TC	A	Pre-op pm device eval	0.00	0.31	NA	0.00	XXX
93286	26	A	Pre-op pm device eval	0.30	0.11	0.11	0.02	XXX
93287		A	Pre-op icd device eval	0.45	0.51	NA	0.02	XXX
93287	TC	A	Pre-op icd device eval	0.00	0.34	NA	0.00	XXX
93287	26	A	Pre-op icd device eval	0.45	0.16	0.16	0.02	XXX
93288		A	Pm device eval in person	0.43	0.51	NA	0.02	XXX
93288	TC	A	Pm device eval in person	0.00	0.36	NA	0.00	XXX
93288	26	A	Pm device eval in person	0.43	0.15	0.15	0.02	XXX
93289		A	Icd device interrogate	0.78	0.71	NA	0.04	XXX
93289	TC	A	Icd device interrogate	0.00	0.44	NA	0.00	XXX
93289	26	A	Icd device interrogate	0.78	0.26	0.26	0.04	XXX
93290		A	Icm device eval	0.43	0.41	NA	0.02	XXX
93290	TC	A	Icm device eval	0.00	0.26	NA	0.00	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93290	26	A	Icm device eval	0.43	0.16	0.16	0.02	XXX
93291		A	Ilr device interrogate	0.43	0.48	NA	0.02	XXX
93291	TC	A	Ilr device interrogate	0.00	0.33	NA	0.00	XXX
93291	26	A	Ilr device interrogate	0.43	0.15	0.15	0.02	XXX
93292		A	Wcd device interrogate	0.43	0.39	NA	0.02	XXX
93292	TC	A	Wcd device interrogate	0.00	0.25	NA	0.00	XXX
93292	26	A	Wcd device interrogate	0.43	0.15	0.15	0.02	XXX
93293		A	Pm phone r-strip device eval	0.32	1.01	NA	0.02	XXX
93293	TC	A	Pm phone r-strip device eval	0.00	0.91	NA	0.00	XXX
93293	26	A	Pm phone r-strip device eval	0.32	0.11	0.11	0.02	XXX
93294		A	Pm device interrogate remote	0.65	0.22	0.22	0.03	XXX
93295		A	Icd device interrogat remote	1.17	0.40	0.40	0.06	XXX
93296		A	Pm/icd remote tech serv	0.00	0.72	NA	0.00	XXX
93297		A	Icm device interrogat remote	0.52	0.19	0.19	0.03	XXX
93298		A	Ilr device interrogat remote	0.52	0.18	0.18	0.03	XXX
93299		C	Icm/ilr remote tech serv	0.00	0.00	NA	0.00	XXX
93303		A	Echo transthoracic	1.30	3.62	NA	0.06	XXX
93303	TC	A	Echo transthoracic	0.00	3.18	NA	0.00	XXX
93303	26	A	Echo transthoracic	1.30	0.44	0.44	0.06	XXX
93304		A	Echo transthoracic	0.75	2.52	NA	0.04	XXX
93304	TC	A	Echo transthoracic	0.00	2.27	NA	0.00	XXX
93304	26	A	Echo transthoracic	0.75	0.25	0.25	0.04	XXX
93306		A	Tte w/doppler, complete	1.30	2.94	NA	0.07	XXX
93306	TC	A	Tte w/doppler, complete	0.00	2.49	NA	0.00	XXX
93306	26	A	Tte w/doppler, complete	1.30	0.44	0.44	0.06	XXX
93307		A	Tte w/o doppler, complete	0.92	2.76	NA	0.05	XXX
93307	TC	A	Tte w/o doppler, complete	0.00	2.45	NA	0.00	XXX
93307	26	A	Tte w/o doppler, complete	0.92	0.31	0.31	0.04	XXX
93308		A	Tte, f-up or lmtd	0.53	1.90	NA	0.03	XXX
93308	TC	A	Tte, f-up or lmtd	0.00	1.72	NA	0.00	XXX
93308	26	A	Tte, f-up or lmtd	0.53	0.18	0.18	0.03	XXX
93312		A	Echo transesophageal	2.20	5.72	NA	0.11	XXX
93312	TC	A	Echo transesophageal	0.00	5.05	NA	0.01	XXX
93312	26	A	Echo transesophageal	2.20	0.66	0.66	0.11	XXX
93313		A	Echo transesophageal	0.95	NA	0.17	0.06	XXX
93314		A	Echo transesophageal	1.25	5.82	NA	0.06	XXX
93314	TC	A	Echo transesophageal	0.00	5.42	NA	0.00	XXX
93314	26	A	Echo transesophageal	1.25	0.40	0.40	0.06	XXX
93315		C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93315	TC	C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93315	26	A	Echo transesophageal	2.78	0.89	0.89	0.17	XXX
93316		A	Echo transesophageal	0.95	NA	0.22	0.05	XXX

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93317		C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93317	TC	C	Echo transesophageal	0.00	NA	NA	0.00	XXX
93317	26	A	Echo transesophageal	1.83	0.60	0.60	0.19	XXX
93318		C	Echo transesophageal intraop	0.00	NA	NA	0.00	XXX
93318	TC	C	Echo transesophageal intraop	0.00	NA	NA	0.00	XXX
93318	26	A	Echo transesophageal intraop	2.20	0.68	0.68	0.23	XXX
93320		A	Doppler echo exam, heart	0.38	1.23	1.23	0.02	ZZZ
93320	TC	A	Doppler echo exam, heart	0.00	1.10	1.10	0.00	ZZZ
93320	26	A	Doppler echo exam, heart	0.38	0.13	0.13	0.02	ZZZ
93321		A	Doppler echo exam, heart	0.15	0.45	0.45	0.01	ZZZ
93321	TC	A	Doppler echo exam, heart	0.00	0.40	0.40	0.00	ZZZ
93321	26	A	Doppler echo exam, heart	0.15	0.05	0.05	0.01	ZZZ
93325		A	Doppler color flow add-on	0.07	0.50	0.50	0.00	ZZZ
93325	TC	A	Doppler color flow add-on	0.00	0.47	0.47	0.00	ZZZ
93325	26	A	Doppler color flow add-on	0.07	0.02	0.02	0.00	ZZZ
93350		A	Stress tte only	1.46	3.68	NA	0.07	XXX
93350	TC	A	Stress tte only	0.00	3.18	NA	0.00	XXX
93350	26	A	Stress tte only	1.46	0.50	0.50	0.07	XXX
93351		A	Stress tte complete	1.75	4.18	NA	0.09	XXX
93351	TC	A	Stress tte complete	0.00	3.59	NA	0.16	XXX
93351	26	A	Stress tte complete	1.75	0.59	NA	0.06	XXX
93352		A	Admin ecg contrast agent	0.19	0.63	NA	0.01	ZZZ
93501		A	Right heart catheterization	3.02	11.37	NA	0.16	000
93501	TC	A	Right heart catheterization	0.00	10.36	NA	0.01	000
93501	26	A	Right heart catheterization	3.02	1.01	1.01	0.15	000
93503		A	Insert/place heart catheter	2.91	NA	NA	0.19	000
93505		A	Biopsy of heart lining	4.37	11.06	NA	0.32	000
93505	TC	A	Biopsy of heart lining	0.00	9.58	NA	0.01	000
93505	26	A	Biopsy of heart lining	4.37	1.47	1.47	0.31	000
93508		A	Cath placement, angiography	4.09	15.55	NA	0.21	000
93508	TC	A	Cath placement, angiography	0.00	14.17	NA	0.01	000
93508	26	A	Cath placement, angiography	4.09	1.37	1.37	0.20	000
93510		A	Left heart catheterization	4.32	15.24	NA	0.22	000
93510	TC	A	Left heart catheterization	0.00	13.79	NA	0.01	000
93510	26	A	Left heart catheterization	4.32	1.45	1.45	0.21	000
93511		C	Left heart catheterization	0.00	NA	NA	0.00	000
93511	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93511	26	A	Left heart catheterization	5.02	1.68	1.68	0.26	000
93514		C	Left heart catheterization	0.00	NA	NA	0.00	000
93514	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93514	26	A	Left heart catheterization	7.04	2.36	2.36	0.36	000
93524		C	Left heart catheterization	0.00	NA	NA	0.00	000

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93524	TC	C	Left heart catheterization	0.00	NA	NA	0.00	000
93524	26	A	Left heart catheterization	6.94	2.35	2.35	0.35	000
93526		A	Rt & Lt heart catheters	5.98	19.20	NA	0.31	000
93526	TC	A	Rt & Lt heart catheters	0.00	17.20	NA	0.02	000
93526	26	A	Rt & Lt heart catheters	5.98	2.01	2.01	0.29	000
93527		C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93527	TC	C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93527	26	A	Rt & Lt heart catheters	7.27	2.44	2.44	0.38	000
93528		C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93528	TC	C	Rt & Lt heart catheters	0.00	NA	NA	0.00	000
93528	26	A	Rt & Lt heart catheters	8.99	3.10	3.10	0.46	000
93529		C	Rt, lt heart catheterization	0.00	NA	NA	0.00	000
93529	TC	C	Rt, lt heart catheterization	0.00	NA	NA	0.00	000
93529	26	A	Rt, lt heart catheterization	4.79	1.64	1.64	0.25	000
93530		C	Rt heart cath, congenital	0.00	NA	NA	0.00	000
93530	TC	C	Rt heart cath, congenital	0.00	NA	NA	0.00	000
93530	26	A	Rt heart cath, congenital	4.22	1.43	1.43	0.25	000
93531		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93531	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93531	26	A	R & l heart cath, congenital	8.34	2.80	2.80	0.42	000
93532		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93532	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93532	26	A	R & l heart cath, congenital	9.99	3.36	3.36	0.51	000
93533		C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93533	TC	C	R & l heart cath, congenital	0.00	NA	NA	0.00	000
93533	26	A	R & l heart cath, congenital	6.69	2.23	2.23	0.34	000
93539		A	Injection, cardiac cath	0.40	1.20	0.13	0.02	000
93540		A	Injection, cardiac cath	0.43	3.95	0.14	0.02	000
93541		A	Injection for lung angiogram	0.29	0.10	0.10	0.01	000
93542		A	Injection for heart x-rays	0.29	2.41	0.10	0.02	000
93543		A	Injection for heart x-rays	0.29	1.26	0.10	0.01	000
93544		A	Injection for aortography	0.25	1.05	0.08	0.01	000
93545		A	Inject for coronary x-rays	0.40	2.82	0.13	0.02	000
93555		A	Imaging, cardiac cath	0.81	0.39	NA	0.04	XXX
93555	TC	A	Imaging, cardiac cath	0.00	0.11	NA	0.00	XXX
93555	26	A	Imaging, cardiac cath	0.81	0.27	0.27	0.04	XXX
93556		A	Imaging, cardiac cath	0.83	0.57	NA	0.04	XXX
93556	TC	A	Imaging, cardiac cath	0.00	0.29	NA	0.00	XXX
93556	26	A	Imaging, cardiac cath	0.83	0.28	0.28	0.04	XXX
93561		C	Cardiac output measurement	0.00	NA	NA	0.00	000
93561	TC	C	Cardiac output measurement	0.00	NA	NA	0.00	000
93561	26	A	Cardiac output measurement	0.50	0.16	0.16	0.03	000

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93562		C	Cardiac output measurement	0.00	NA	NA	0.00	000
93562	TC	C	Cardiac output measurement	0.00	NA	NA	0.00	000
93562	26	A	Cardiac output measurement	0.16	0.04	0.04	0.01	000
93571		C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93571	TC	C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93571	26	A	Heart flow reserve measure	1.80	0.61	0.61	0.10	ZZZ
93572		C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93572	TC	C	Heart flow reserve measure	0.00	NA	NA	0.00	ZZZ
93572	26	A	Heart flow reserve measure	1.44	0.48	0.48	0.09	ZZZ
93580		A	Transcath closure of asd	17.97	NA	6.35	0.94	000
93581		A	Transcath closure of vsd	24.39	NA	8.47	1.24	000
93600		C	Bundle of His recording	0.00	NA	NA	0.00	000
93600	TC	C	Bundle of His recording	0.00	NA	NA	0.00	000
93600	26	A	Bundle of His recording	2.12	0.71	0.71	0.12	000
93602		C	Intra-atrial recording	0.00	NA	NA	0.00	000
93602	TC	C	Intra-atrial recording	0.00	NA	NA	0.00	000
93602	26	A	Intra-atrial recording	2.12	0.71	0.71	0.14	000
93603		C	Right ventricular recording	0.00	NA	NA	0.00	000
93603	TC	C	Right ventricular recording	0.00	NA	NA	0.00	000
93603	26	A	Right ventricular recording	2.12	0.70	0.70	0.15	000
93609		C	Map tachycardia, add-on	0.00	NA	NA	0.00	ZZZ
93609	TC	C	Map tachycardia, add-on	0.00	NA	NA	0.00	ZZZ
93609	26	A	Map tachycardia, add-on	4.99	1.68	1.68	0.26	ZZZ
93610		C	Intra-atrial pacing	0.00	NA	NA	0.00	000
93610	TC	C	Intra-atrial pacing	0.00	NA	NA	0.00	000
93610	26	A	Intra-atrial pacing	3.02	1.00	1.00	0.21	000
93612		C	Intraventricular pacing	0.00	NA	NA	0.00	000
93612	TC	C	Intraventricular pacing	0.00	NA	NA	0.00	000
93612	26	A	Intraventricular pacing	3.02	0.99	0.99	0.22	000
93613		A	Electrophys map 3d, add-on	6.99	NA	2.35	0.37	ZZZ
93615		C	Esophageal recording	0.00	NA	NA	0.00	000
93615	TC	C	Esophageal recording	0.00	NA	NA	0.00	000
93615	26	A	Esophageal recording	0.99	0.33	0.33	0.05	000
93616		C	Esophageal recording	0.00	NA	0.00	0.00	000
93616	TC	C	Esophageal recording	0.00	NA	0.00	0.00	000
93616	26	A	Esophageal recording	1.49	0.24	0.24	0.09	000
93618		C	Heart rhythm pacing	0.00	NA	NA	0.00	000
93618	TC	C	Heart rhythm pacing	0.00	NA	NA	0.00	000
93618	26	A	Heart rhythm pacing	4.25	1.42	1.42	0.23	000
93619		C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93619	TC	C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93619	26	A	Electrophysiology evaluation	7.31	2.45	2.45	0.38	000

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93620		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	000
93620	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	000
93620	26	A	Electrophysiology evaluation	11.57	3.90	3.90	0.61	000
93621		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93621	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93621	26	A	Electrophysiology evaluation	2.10	0.71	0.71	0.11	ZZZ
93622		C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93622	TC	C	Electrophysiology evaluation	0.00	NA	0.00	0.00	ZZZ
93622	26	A	Electrophysiology evaluation	3.10	1.04	1.04	0.17	ZZZ
93623		C	Stimulation, pacing heart	0.00	NA	0.00	0.00	ZZZ
93623	TC	C	Stimulation, pacing heart	0.00	NA	0.00	0.00	ZZZ
93623	26	A	Stimulation, pacing heart	2.85	0.96	0.96	0.15	ZZZ
93624		C	Electrophysiologic study	0.00	NA	0.00	0.00	000
93624	TC	C	Electrophysiologic study	0.00	NA	0.00	0.00	000
93624	26	A	Electrophysiologic study	4.80	1.60	1.60	0.26	000
93631		C	Heart pacing, mapping	0.00	NA	0.00	0.00	000
93631	TC	C	Heart pacing, mapping	0.00	NA	0.00	0.00	000
93631	26	A	Heart pacing, mapping	7.59	2.41	2.41	1.19	000
93640		C	Evaluation heart device	0.00	NA	NA	0.00	000
93640	TC	C	Evaluation heart device	0.00	NA	NA	0.00	000
93640	26	A	Evaluation heart device	3.51	1.18	1.18	0.22	000
93641		C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93641	TC	C	Electrophysiology evaluation	0.00	NA	NA	0.00	000
93641	26	A	Electrophysiology evaluation	5.92	1.99	1.99	0.32	000
93642		A	Electrophysiology evaluation	4.88	4.99	4.99	0.24	000
93642	TC	A	Electrophysiology evaluation	0.00	3.34	3.34	0.01	000
93642	26	A	Electrophysiology evaluation	4.88	1.65	1.65	0.23	000
93650		A	Ablate heart dysrhythm focus	10.49	NA	3.77	0.55	000
93651		A	Ablate heart dysrhythm focus	16.23	NA	5.46	0.86	000
93652		A	Ablate heart dysrhythm focus	17.65	NA	5.96	0.94	000
93660		A	Tilt table evaluation	1.89	2.07	2.07	0.10	000
93660	TC	A	Tilt table evaluation	0.00	1.42	1.42	0.01	000
93660	26	A	Tilt table evaluation	1.89	0.64	0.64	0.10	000
93662		C	Intracardiac ecg (ice)	0.00	NA	0.00	0.00	ZZZ
93662	TC	C	Intracardiac ecg (ice)	0.00	NA	0.00	0.00	ZZZ
93662	26	A	Intracardiac ecg (ice)	2.80	0.94	0.94	0.15	ZZZ
93668		N	Peripheral vascular rehab	0.00	0.44	NA	0.00	XXX
93701		A	Bioimpedance, thoracic	0.17	0.63	NA	0.01	XXX
93701	TC	A	Bioimpedance, thoracic	0.00	0.57	NA	0.00	XXX
93701	26	A	Bioimpedance, thoracic	0.17	0.06	0.06	0.01	XXX
93720		A	Total body plethysmography	0.17	1.11	1.11	0.01	XXX
93721		A	Plethysmography tracing	0.00	0.97	NA	0.00	XXX

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93722		A	Plethysmography report	0.17	0.05	0.05	0.01	XXX
93724		A	Analyze pacemaker system	4.88	2.30	2.30	0.25	000
93724	TC	A	Analyze pacemaker system	0.00	0.63	0.63	0.01	000
93724	26	A	Analyze pacemaker system	4.88	1.67	1.67	0.24	000
93740		B	Temperature gradient studies	0.16	NA	NA	0.01	XXX
93740	TC	B	Temperature gradient studies	0.00	NA	NA	0.00	XXX
93740	26	B	Temperature gradient studies	0.16	0.06	0.06	0.01	XXX
93745		C	Set-up cardiovert-defibrill	0.00	0.00	NA	0.00	XXX
93745	TC	C	Set-up cardiovert-defibrill	0.00	0.00	NA	0.00	XXX
93745	26	C	Set-up cardiovert-defibrill	0.00	0.00	0.00	0.00	XXX
93770		B	Measure venous pressure	0.16	NA	NA	0.01	XXX
93770	TC	B	Measure venous pressure	0.00	NA	NA	0.00	XXX
93770	26	B	Measure venous pressure	0.16	0.06	0.06	0.01	XXX
93784		A	Ambulatory BP monitoring	0.38	0.97	0.97	0.02	XXX
93786		A	Ambulatory BP recording	0.00	0.72	NA	0.00	XXX
93788		A	Ambulatory BP analysis	0.00	0.40	NA	0.00	XXX
93790		A	Review/report BP recording	0.38	0.14	0.14	0.02	XXX
93797		A	Cardiac rehab	0.18	0.27	0.07	0.01	000
93798		A	Cardiac rehab/monitor	0.28	0.35	0.10	0.01	000
93799		C	Cardiovascular procedure	0.00	0.00	NA	0.00	XXX
93799	TC	C	Cardiovascular procedure	0.00	0.00	NA	0.00	XXX
93799	26	C	Cardiovascular procedure	0.00	0.00	0.00	0.00	XXX
93875		A	Extracranial study	0.22	2.42	NA	0.01	XXX
93875	TC	A	Extracranial study	0.00	2.34	NA	0.00	XXX
93875	26	A	Extracranial study	0.22	0.08	0.08	0.01	XXX
93880		A	Extracranial study	0.60	5.49	NA	0.05	XXX
93880	TC	A	Extracranial study	0.00	5.30	NA	0.00	XXX
93880	26	A	Extracranial study	0.60	0.20	0.20	0.05	XXX
93882		A	Extracranial study	0.40	4.05	NA	0.05	XXX
93882	TC	A	Extracranial study	0.00	3.92	NA	0.00	XXX
93882	26	A	Extracranial study	0.40	0.13	0.13	0.05	XXX
93886		A	Intracranial study	0.94	8.06	NA	0.06	XXX
93886	TC	A	Intracranial study	0.00	7.71	NA	0.00	XXX
93886	26	A	Intracranial study	0.94	0.35	0.35	0.06	XXX
93888		A	Intracranial study	0.62	4.99	NA	0.05	XXX
93888	TC	A	Intracranial study	0.00	4.76	NA	0.00	XXX
93888	26	A	Intracranial study	0.62	0.22	0.22	0.05	XXX
93890		A	Tcd, vasoreactivity study	1.00	6.91	NA	0.06	XXX
93890	TC	A	Tcd, vasoreactivity study	0.00	6.54	NA	0.00	XXX
93890	26	A	Tcd, vasoreactivity study	1.00	0.37	0.37	0.05	XXX
93892		A	Tcd, emboli detect w/o inj	1.15	9.00	NA	0.07	XXX
93892	TC	A	Tcd, emboli detect w/o inj	0.00	8.56	NA	0.00	XXX

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[4] Global totals for malpractice RVUs may not sum due to rounding.

CPT[1,3] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
93892	26	A	Tcd, emboli detect w/o inj	1.15	0.44	0.44	0.06	XXX
93893		A	Tcd, emboli detect w/inj	1.15	8.31	NA	0.07	XXX
93893	TC	A	Tcd, emboli detect w/inj	0.00	7.87	NA	0.00	XXX
93893	26	A	Tcd, emboli detect w/inj	1.15	0.44	0.44	0.07	XXX
93922		A	Extremity study	0.25	2.91	NA	0.02	XXX
93922	TC	A	Extremity study	0.00	2.82	NA	0.00	XXX
93922	26	A	Extremity study	0.25	0.08	0.08	0.02	XXX
93923		A	Extremity study	0.45	4.36	NA	0.05	XXX
93923	TC	A	Extremity study	0.00	4.21	NA	0.00	XXX
93923	26	A	Extremity study	0.45	0.14	0.14	0.05	XXX
93924		A	Extremity study	0.50	5.35	NA	0.05	XXX
93924	TC	A	Extremity study	0.00	5.19	NA	0.00	XXX
93924	26	A	Extremity study	0.50	0.16	0.16	0.05	XXX
93925		A	Lower extremity study	0.58	7.18	NA	0.05	XXX
93925	TC	A	Lower extremity study	0.00	6.99	NA	0.00	XXX
93925	26	A	Lower extremity study	0.58	0.19	0.19	0.05	XXX
93926		A	Lower extremity study	0.39	4.75	NA	0.06	XXX
93926	TC	A	Lower extremity study	0.00	4.64	NA	0.00	XXX
93926	26	A	Lower extremity study	0.39	0.12	0.12	0.06	XXX
93930		A	Upper extremity study	0.46	5.75	NA	0.04	XXX
93930	TC	A	Upper extremity study	0.00	5.60	NA	0.00	XXX
93930	26	A	Upper extremity study	0.46	0.15	0.15	0.04	XXX
93931		A	Upper extremity study	0.31	3.80	NA	0.03	XXX
93931	TC	A	Upper extremity study	0.00	3.70	NA	0.00	XXX
93931	26	A	Upper extremity study	0.31	0.10	0.10	0.03	XXX
93965		A	Extremity study	0.35	2.73	NA	0.03	XXX
93965	TC	A	Extremity study	0.00	2.62	NA	0.00	XXX
93965	26	A	Extremity study	0.35	0.11	0.11	0.03	XXX
93970		A	Extremity study	0.68	5.69	NA	0.07	XXX
93970	TC	A	Extremity study	0.00	5.48	NA	0.00	XXX
93970	26	A	Extremity study	0.68	0.21	0.21	0.07	XXX
93971		A	Extremity study	0.45	3.68	NA	0.05	XXX
93971	TC	A	Extremity study	0.00	3.55	NA	0.00	XXX
93971	26	A	Extremity study	0.45	0.14	0.14	0.05	XXX
93975		A	Vascular study	1.80	7.49	NA	0.16	XXX
93975	TC	A	Vascular study	0.00	6.92	NA	0.01	XXX
93975	26	A	Vascular study	1.80	0.57	0.57	0.15	XXX
93976		A	Vascular study	1.21	4.08	NA	0.10	XXX
93976	TC	A	Vascular study	0.00	3.70	NA	0.00	XXX
93976	26	A	Vascular study	1.21	0.37	0.37	0.09	XXX
93978		A	Vascular study	0.65	5.38	NA	0.07	XXX
93978	TC	A	Vascular study	0.00	5.17	NA	0.00	XXX
94002		A	Vent mgmt inpat, init day	1.99	NA	0.46	0.12	XXX
94003		A	Vent mgmt inpat, subq day	1.37	NA	0.40	0.08	XXX
94004		A	Vent mgmt nf per day	1.00	NA	0.29	0.06	XXX
94005		B	Home vent mgmt supervision	1.50	0.93	NA	0.08	XXX
94010		A	Breathing capacity test	0.17	0.71	NA	0.01	XXX
94010	TC	A	Breathing capacity test	0.00	0.65	NA	0.00	XXX
94010	26	A	Breathing capacity test	0.17	0.06	0.06	0.01	XXX
94014		A	Patient recorded spirometry	0.52	0.74	0.74	0.03	XXX
94015		A	Patient recorded spirometry	0.00	0.58	NA	0.00	XXX
94016		A	Review patient spirometry	0.52	0.17	0.17	0.02	XXX
94060		A	Evaluation of wheezing	0.31	1.22	1.22	0.02	XXX
94060	TC	A	Evaluation of wheezing	0.00	1.12	1.12	0.00	XXX
94060	26	A	Evaluation of wheezing	0.31	0.10	0.10	0.02	XXX
94070		A	Evaluation of wheezing	0.60	0.95	NA	0.03	XXX
94070	TC	A	Evaluation of wheezing	0.00	0.76	NA	0.00	XXX
94070	26	A	Evaluation of wheezing	0.60	0.19	0.19	0.03	XXX
94150		B	Vital capacity test	0.07	0.53	NA	0.00	XXX
94150	TC	B	Vital capacity test	0.00	0.50	NA	0.00	XXX
94150	26	B	Vital capacity test	0.07	0.03	0.03	0.00	XXX
94200		A	Lung function test (MBC/MVV)	0.11	0.49	NA	0.01	XXX
94200	TC	A	Lung function test (MBC/MVV)	0.00	0.45	NA	0.00	XXX
94200	26	A	Lung function test (MBC/MVV)	0.11	0.03	0.03	0.01	XXX
94240		A	Residual lung capacity	0.26	0.73	NA	0.01	XXX
94240	TC	A	Residual lung capacity	0.00	0.66	NA	0.00	XXX
94240	26	A	Residual lung capacity	0.26	0.08	0.08	0.01	XXX
94250		A	Expired gas collection	0.11	0.48	NA	0.01	XXX
94250	TC	A	Expired gas collection	0.00	0.45	NA	0.00	XXX
94250	26	A	Expired gas collection	0.11	0.03	0.03	0.01	XXX

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CPT[1,2] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
94260		A	Thoracic gas volume	0.13	0.66	NA	0.01	XXX
94260	TC	A	Thoracic gas volume	0.00	0.63	NA	0.00	XXX
94260	26	A	Thoracic gas volume	0.13	0.04	0.04	0.01	XXX
94350		A	Lung nitrogen washout curve	0.26	0.59	NA	0.01	XXX
94350	TC	A	Lung nitrogen washout curve	0.00	0.51	NA	0.00	XXX
94350	26	A	Lung nitrogen washout curve	0.26	0.08	0.08	0.01	XXX
94360		A	Measure airflow resistance	0.26	0.85	NA	0.01	XXX
94360	TC	A	Measure airflow resistance	0.00	0.77	NA	0.00	XXX
94360	26	A	Measure airflow resistance	0.26	0.08	0.08	0.01	XXX
94370		A	Breath airway closing volume	0.26	0.59	NA	0.01	XXX
94370	TC	A	Breath airway closing volume	0.00	0.50	NA	0.00	XXX
94370	26	A	Breath airway closing volume	0.26	0.08	0.08	0.01	XXX
94375		A	Respiratory flow volume loop	0.31	0.66	NA	0.02	XXX
94375	TC	A	Respiratory flow volume loop	0.00	0.57	NA	0.00	XXX
94375	26	A	Respiratory flow volume loop	0.31	0.10	0.10	0.02	XXX
94400		A	CO2 breathing response curve	0.40	0.97	NA	0.02	XXX
94400	TC	A	CO2 breathing response curve	0.00	0.85	NA	0.00	XXX
94400	26	A	CO2 breathing response curve	0.40	0.12	0.12	0.02	XXX
94450		A	Hypoxia response curve	0.40	1.37	NA	0.02	XXX
94450	TC	A	Hypoxia response curve	0.00	1.22	NA	0.00	XXX
94450	26	A	Hypoxia response curve	0.40	0.15	0.15	0.02	XXX
94452		A	Hast w/report	0.31	1.09	NA	0.02	XXX
94452	TC	A	Hast w/report	0.00	1.00	NA	0.00	XXX
94452	26	A	Hast w/report	0.31	0.09	0.09	0.02	XXX
94453		A	Hast w/oxygen titrate	0.40	1.51	NA	0.02	XXX
94453	TC	A	Hast w/oxygen titrate	0.00	1.40	NA	0.00	XXX
94453	26	A	Hast w/oxygen titrate	0.40	0.11	0.11	0.02	XXX
94610		A	Surfactant admin thru tube	1.16	0.46	0.46	0.06	XXX
94620		A	Pulmonary stress test/simple	0.64	0.76	NA	0.04	XXX
94620	TC	A	Pulmonary stress test/simple	0.00	0.57	NA	0.00	XXX
94620	26	A	Pulmonary stress test/simple	0.64	0.20	0.20	0.03	XXX
94621		A	Pulm stress test/complex	1.42	2.69	NA	0.07	XXX
94621	TC	A	Pulm stress test/complex	0.00	2.25	NA	0.00	XXX
94621	26	A	Pulm stress test/complex	1.42	0.44	0.44	0.07	XXX
94640		A	Airway inhalation treatment	0.00	0.42	NA	0.00	XXX
94642		C	Aerosol inhalation treatment	0.00	0.00	0.00	0.00	XXX
94644		A	Cbt, 1st hour	0.00	1.03	NA	0.00	XXX
94645		A	Cbt, each addl hour	0.00	0.33	NA	0.00	XXX
94660		A	Pos airway pressure, CPAP	0.76	0.81	0.24	0.04	XXX
94662		A	Neg press ventilation, cnp	0.76	NA	0.21	0.04	XXX
94664		A	Evaluate pt use of inhaler	0.00	0.40	NA	0.00	XXX
94667		A	Chest wall manipulation	0.00	0.55	NA	0.00	XXX
94668		A	Chest wall manipulation	0.00	0.54	NA	0.00	XXX
94680		A	Exhaled air analysis, o2	0.26	1.12	1.12	0.01	XXX
94680	TC	A	Exhaled air analysis, o2	0.00	1.03	1.03	0.00	XXX
94680	26	A	Exhaled air analysis, o2	0.26	0.09	0.09	0.01	XXX
94681		A	Exhaled air analysis, o2/co2	0.20	1.05	NA	0.01	XXX
94681	TC	A	Exhaled air analysis, o2/co2	0.00	0.98	NA	0.00	XXX
94681	26	A	Exhaled air analysis, o2/co2	0.20	0.07	0.07	0.01	XXX
94690		A	Exhaled air analysis	0.07	1.12	NA	0.00	XXX
94690	TC	A	Exhaled air analysis	0.00	1.09	NA	0.00	XXX
94690	26	A	Exhaled air analysis	0.07	0.03	0.03	0.00	XXX
94720		A	Monoxide diffusing capacity	0.26	1.01	NA	0.01	XXX
94720	TC	A	Monoxide diffusing capacity	0.00	0.94	NA	0.00	XXX
94720	26	A	Monoxide diffusing capacity	0.26	0.08	0.08	0.01	XXX
94725		A	Membrane diffusion capacity	0.26	0.96	NA	0.01	XXX
94725	TC	A	Membrane diffusion capacity	0.00	0.88	NA	0.00	XXX
94725	26	A	Membrane diffusion capacity	0.26	0.08	0.08	0.01	XXX
94750		A	Pulmonary compliance study	0.23	1.76	NA	0.01	XXX
94750	TC	A	Pulmonary compliance study	0.00	1.68	NA	0.00	XXX
94750	26	A	Pulmonary compliance study	0.23	0.07	0.07	0.01	XXX
94760		T	Measure blood oxygen level	0.00	0.07	NA	0.00	XXX
94761		T	Measure blood oxygen level	0.00	0.10	NA	0.00	XXX
94762		A	Measure blood oxygen level	0.00	0.67	NA	0.00	XXX
94770		A	Exhaled carbon dioxide test	0.15	NA	0.82	0.01	XXX
94770	TC	A	Exhaled carbon dioxide test	0.00	NA	0.77	0.00	XXX
94770	26	A	Exhaled carbon dioxide test	0.15	0.05	0.05	0.01	XXX
94772		C	Breath recording, infant	0.00	NA	NA	0.00	XXX
94772	TC	C	Breath recording, infant	0.00	NA	NA	0.00	XXX
94772	26	C	Breath recording, infant	0.00	0.00	0.00	0.00	XXX
94774		C	Ped home apnea rec, compl	0.00	0.00	0.00	0.00	YYY
94775		C	Ped home apnea rec, bk-up	0.00	0.00	0.00	0.00	YYY
94776		C	Ped home apnea rec, downld	0.00	0.00	0.00	0.00	YYY
94777		C	Ped home apnea rec, report	0.00	0.00	0.00	0.00	YYY
94799		C	Pulmonary service/procedure	0.00	0.00	NA	0.00	XXX
94799	TC	C	Pulmonary service/procedure	0.00	0.00	NA	0.00	XXX
94799	26	C	Pulmonary service/procedure	0.00	0.00	0.00	0.00	XXX
95004		A	Percut allergy skin tests	0.01	0.14	NA	0.00	XXX
95010		A	Percut allergy titrate test	0.15	0.32	NA	0.01	XXX
95012		A	Exhaled nitric oxide meas	0.00	0.48	NA	0.00	XXX
95015		A	Id allergy titrate-drug/bug	0.15	0.20	NA	0.01	XXX
95024		A	Id allergy test, drug/bug	0.01	0.16	NA	0.00	XXX
95027		A	Id allergy titrate-airborne	0.01	0.10	NA	0.00	XXX
95028		A	Id allergy test-delayed type	0.00	0.32	NA	0.00	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95044		A	Allergy patch tests	0.00	0.13	NA	0.00	XXX
95052		A	Photo patch test	0.00	0.14	NA	0.00	XXX
95056		A	Photosensitivity tests	0.00	1.05	NA	0.00	XXX
95060		A	Eye allergy tests	0.00	0.80	0.80	0.00	XXX
95065		A	Nose allergy test	0.00	0.61	0.61	0.00	XXX
95070		A	Bronchial allergy tests	0.00	0.69	NA	0.00	XXX
95071		A	Bronchial allergy tests	0.00	0.85	NA	0.00	XXX
95075		A	Ingestion challenge test	0.95	0.75	0.35	0.03	XXX
95115		A	Immunotherapy, one injection	0.00	0.22	NA	0.00	XXX
95117		A	Immunotherapy injections	0.00	0.26	NA	0.00	XXX
95120		I	Immunotherapy, one injection	0.00	0.00	0.00	0.00	XXX
95125		I	Immunotherapy, many antigens	0.00	0.00	0.00	0.00	XXX
95130		I	Immunotherapy, insect venom	0.00	0.00	0.00	0.00	XXX
95131		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95132		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95133		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95134		I	Immunotherapy, insect venoms	0.00	0.00	0.00	0.00	XXX
95144		A	Antigen therapy services	0.06	0.25	0.02	0.00	XXX
95145		A	Antigen therapy services	0.06	0.32	0.02	0.00	XXX
95146		A	Antigen therapy services	0.06	0.60	0.02	0.00	XXX
95147		A	Antigen therapy services	0.06	0.59	0.02	0.00	XXX
95148		A	Antigen therapy services	0.06	0.87	0.02	0.00	XXX
95149		A	Antigen therapy services	0.06	1.16	0.02	0.00	XXX
95165		A	Antigen therapy services	0.06	0.26	0.02	0.00	XXX
95170		A	Antigen therapy services	0.06	0.18	0.02	0.00	XXX
95180		A	Rapid desensitization	2.01	1.62	0.83	0.06	XXX
95199		C	Allergy immunology services	0.00	0.00	0.00	0.00	XXX
95250		A	Glucose monitoring, cont	0.00	3.63	NA	0.00	XXX
95251		A	Gluc monitor, cont, phys i&r	0.85	0.35	0.35	0.04	XXX
95803		C	Actigraphy testing	0.00	0.00	NA	0.00	XXX
95803	TC	C	Actigraphy testing	0.00	0.00	NA	0.00	XXX
95803	26	C	Actigraphy testing	0.00	0.00	0.00	0.00	XXX
95805		A	Multiple sleep latency test	1.88	6.49	NA	0.10	XXX
95805	TC	A	Multiple sleep latency test	0.00	5.88	NA	0.01	XXX
95805	26	A	Multiple sleep latency test	1.88	0.61	0.61	0.10	XXX
95806		A	Sleep study, unattended	1.66	3.81	NA	0.09	XXX
95806	TC	A	Sleep study, unattended	0.00	3.25	NA	0.00	XXX
95806	26	A	Sleep study, unattended	1.66	0.56	0.56	0.08	XXX
95807		A	Sleep study, attended	1.66	9.76	NA	0.09	XXX
95807	TC	A	Sleep study, attended	0.00	9.23	NA	0.00	XXX
95807	26	A	Sleep study, attended	1.66	0.52	0.52	0.08	XXX
95808		A	Polysomnography, 1-3	2.65	16.69	NA	0.13	XXX

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CPT[1,2]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
95808	TC	A	Polysomnography, 1-3	0.00	15.78	NA	0.01	XXX
95808	26	A	Polysomnography, 1-3	2.65	0.91	0.91	0.12	XXX
95810		A	Polysomnography, 4 or more	3.52	16.27	NA	0.19	XXX
95810	TC	A	Polysomnography, 4 or more	0.00	15.13	NA	0.01	XXX
95810	26	A	Polysomnography, 4 or more	3.52	1.13	1.13	0.18	XXX
95811		A	Polysomnography w/cpap	3.79	18.01	NA	0.21	XXX
95811	TC	A	Polysomnography w/cpap	0.00	16.80	NA	0.01	XXX
95811	26	A	Polysomnography w/cpap	3.79	1.21	1.21	0.20	XXX
95812		A	Eeg, 41-60 minutes	1.08	8.58	NA	0.06	XXX
95812	TC	A	Eeg, 41-60 minutes	0.00	8.14	NA	0.00	XXX
95812	26	A	Eeg, 41-60 minutes	1.08	0.43	0.43	0.06	XXX
95813		A	Eeg, over 1 hour	1.73	9.22	NA	0.10	XXX
95813	TC	A	Eeg, over 1 hour	0.00	8.52	NA	0.00	XXX
95813	26	A	Eeg, over 1 hour	1.73	0.69	0.69	0.10	XXX
95816		A	Eeg, awake and drowsy	1.08	7.77	NA	0.07	XXX
95816	TC	A	Eeg, awake and drowsy	0.00	7.34	NA	0.00	XXX
95816	26	A	Eeg, awake and drowsy	1.08	0.43	0.43	0.06	XXX
95819		A	Eeg, awake and asleep	1.08	9.01	NA	0.06	XXX
95819	TC	A	Eeg, awake and asleep	0.00	8.57	NA	0.00	XXX
95819	26	A	Eeg, awake and asleep	1.08	0.43	0.43	0.06	XXX
95822		A	Eeg, coma or sleep only	1.08	8.10	NA	0.06	XXX
95822	TC	A	Eeg, coma or sleep only	0.00	7.66	NA	0.00	XXX
95822	26	A	Eeg, coma or sleep only	1.08	0.44	0.44	0.06	XXX
95824		C	Eeg, cerebral death only	0.00	NA	NA	0.00	XXX
95824	TC	C	Eeg, cerebral death only	0.00	NA	NA	0.00	XXX
95824	26	A	Eeg, cerebral death only	0.74	0.29	0.29	0.05	XXX
95827		A	Eeg, all night recording	1.08	17.56	NA	0.07	XXX
95827	TC	A	Eeg, all night recording	0.00	17.13	NA	0.00	XXX
95827	26	A	Eeg, all night recording	1.08	0.43	0.43	0.06	XXX
95829		A	Surgery electrocorticogram	6.20	36.81	NA	0.27	XXX
95829	TC	A	Surgery electrocorticogram	0.00	34.27	NA	0.02	XXX
95829	26	A	Surgery electrocorticogram	6.20	2.54	2.54	0.26	XXX
95830		A	Insert electrodes for EEG	1.70	3.87	0.65	0.11	XXX
95831		A	Limb muscle testing, manual	0.28	0.50	0.11	0.02	XXX
95832		A	Hand muscle testing, manual	0.29	0.48	0.13	0.03	XXX
95833		A	Body muscle testing, manual	0.47	0.51	0.13	0.01	XXX
95834		A	Body muscle testing, manual	0.60	0.67	0.20	0.02	XXX
95851		A	Range of motion measurements	0.16	0.31	0.05	0.01	XXX
95852		A	Range of motion measurements	0.11	0.29	0.04	0.01	XXX
95857		A	Tensilon test	0.53	0.80	0.24	0.03	XXX
95860		A	Muscle test, one limb	0.96	1.58	NA	0.05	XXX
95860	TC	A	Muscle test, one limb	0.00	1.16	NA	0.00	XXX

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95860	26	A	Muscle test, one limb	0.96	0.42	0.42	0.05	XXX
95861		A	Muscle test, 2 limbs	1.54	2.23	NA	0.08	XXX
95861	TC	A	Muscle test, 2 limbs	0.00	1.57	NA	0.00	XXX
95861	26	A	Muscle test, 2 limbs	1.54	0.66	0.66	0.08	XXX
95863		A	Muscle test, 3 limbs	1.87	2.71	NA	0.11	XXX
95863	TC	A	Muscle test, 3 limbs	0.00	1.93	NA	0.01	XXX
95863	26	A	Muscle test, 3 limbs	1.87	0.78	0.78	0.10	XXX
95864		A	Muscle test, 4 limbs	1.99	2.90	NA	0.11	XXX
95864	TC	A	Muscle test, 4 limbs	0.00	2.07	NA	0.01	XXX
95864	26	A	Muscle test, 4 limbs	1.99	0.83	0.83	0.10	XXX
95865		A	Muscle test, larynx	1.57	1.70	NA	0.07	XXX
95865	TC	A	Muscle test, larynx	0.00	1.00	NA	0.00	XXX
95865	26	A	Muscle test, larynx	1.57	0.70	0.70	0.07	XXX
95866		A	Muscle test, hemidiaphragm	1.25	1.76	NA	0.08	XXX
95866	TC	A	Muscle test, hemidiaphragm	0.00	1.26	NA	0.00	XXX
95866	26	A	Muscle test, hemidiaphragm	1.25	0.50	0.50	0.07	XXX
95867		A	Muscle test cran nerv unilat	0.79	1.50	NA	0.04	XXX
95867	TC	A	Muscle test cran nerv unilat	0.00	1.16	NA	0.00	XXX
95867	26	A	Muscle test cran nerv unilat	0.79	0.34	0.34	0.04	XXX
95868		A	Muscle test cran nerve bilat	1.18	1.91	NA	0.06	XXX
95868	TC	A	Muscle test cran nerve bilat	0.00	1.42	NA	0.00	XXX
95868	26	A	Muscle test cran nerve bilat	1.18	0.50	0.50	0.06	XXX
95869		A	Muscle test, thor paraspinal	0.37	1.45	NA	0.02	XXX
95869	TC	A	Muscle test, thor paraspinal	0.00	1.29	NA	0.00	XXX
95869	26	A	Muscle test, thor paraspinal	0.37	0.16	0.16	0.02	XXX
95870		A	Muscle test, nonparaspinal	0.37	1.39	NA	0.02	XXX
95870	TC	A	Muscle test, nonparaspinal	0.00	1.23	NA	0.00	XXX
95870	26	A	Muscle test, nonparaspinal	0.37	0.16	0.16	0.02	XXX
95872		A	Muscle test, one fiber	2.88	2.22	NA	0.16	XXX
95872	TC	A	Muscle test, one fiber	0.00	1.05	NA	0.01	XXX
95872	26	A	Muscle test, one fiber	2.88	1.17	1.17	0.16	XXX
95873		A	Guide nerv destr, elec stim	0.37	1.39	1.39	0.01	ZZZ
95873	TC	A	Guide nerv destr, elec stim	0.00	1.21	1.21	0.00	ZZZ
95873	26	A	Guide nerv destr, elec stim	0.37	0.18	0.18	0.01	ZZZ
95874		A	Guide nerv destr, needle emg	0.37	1.31	1.31	0.02	ZZZ
95874	TC	A	Guide nerv destr, needle emg	0.00	1.15	1.15	0.00	ZZZ
95874	26	A	Guide nerv destr, needle emg	0.37	0.16	0.16	0.02	ZZZ
95875		A	Limb exercise test	1.10	1.91	NA	0.07	XXX
95875	TC	A	Limb exercise test	0.00	1.47	NA	0.00	XXX
95875	26	A	Limb exercise test	1.10	0.44	0.44	0.06	XXX
95900		A	Motor nerve conduction test	0.42	1.24	NA	0.02	XXX
95900	TC	A	Motor nerve conduction test	0.00	1.06	NA	0.00	XXX

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95900	26	A	Motor nerve conduction test	0.42	0.18	0.18	0.02	XXX
95903		A	Motor nerve conduction test	0.60	1.33	NA	0.03	XXX
95903	TC	A	Motor nerve conduction test	0.00	1.08	NA	0.00	XXX
95903	26	A	Motor nerve conduction test	0.60	0.24	0.24	0.03	XXX
95904		A	Sense nerve conduction test	0.34	1.12	NA	0.02	XXX
95904	TC	A	Sense nerve conduction test	0.00	0.98	NA	0.00	XXX
95904	26	A	Sense nerve conduction test	0.34	0.14	0.14	0.02	XXX
95920		A	Intraop nerve test add-on	2.11	2.30	2.30	0.12	ZZZ
95920	TC	A	Intraop nerve test add-on	0.00	1.44	1.44	0.01	ZZZ
95920	26	A	Intraop nerve test add-on	2.11	0.86	0.86	0.11	ZZZ
95921		A	Autonomic nerv function test	0.90	1.29	NA	0.04	XXX
95921	TC	A	Autonomic nerv function test	0.00	0.96	NA	0.00	XXX
95921	26	A	Autonomic nerv function test	0.90	0.33	0.33	0.04	XXX
95922		A	Autonomic nerv function test	0.96	1.79	NA	0.05	XXX
95922	TC	A	Autonomic nerv function test	0.00	1.43	NA	0.00	XXX
95922	26	A	Autonomic nerv function test	0.96	0.36	0.36	0.04	XXX
95923		A	Autonomic nerv function test	0.90	3.30	NA	0.05	XXX
95923	TC	A	Autonomic nerv function test	0.00	2.95	NA	0.00	XXX
95923	26	A	Autonomic nerv function test	0.90	0.36	0.36	0.05	XXX
95925		A	Somatosensory testing	0.54	4.19	NA	0.03	XXX
95925	TC	A	Somatosensory testing	0.00	3.97	NA	0.00	XXX
95925	26	A	Somatosensory testing	0.54	0.22	0.22	0.03	XXX
95926		A	Somatosensory testing	0.54	4.04	NA	0.03	XXX
95926	TC	A	Somatosensory testing	0.00	3.83	NA	0.00	XXX
95926	26	A	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95927		A	Somatosensory testing	0.54	3.44	NA	0.03	XXX
95927	TC	A	Somatosensory testing	0.00	3.22	NA	0.00	XXX
95927	26	A	Somatosensory testing	0.54	0.21	0.21	0.03	XXX
95928		A	C motor evoked, uppr limbs	1.50	5.48	NA	0.09	XXX
95928	TC	A	C motor evoked, uppr limbs	0.00	4.87	NA	0.00	XXX
95928	26	A	C motor evoked, uppr limbs	1.50	0.61	0.61	0.09	XXX
95929		A	C motor evoked, lwr limbs	1.50	5.92	NA	0.09	XXX
95929	TC	A	C motor evoked, lwr limbs	0.00	5.31	NA	0.00	XXX
95929	26	A	C motor evoked, lwr limbs	1.50	0.61	0.61	0.09	XXX
95930		A	Visual evoked potential test	0.35	3.51	NA	0.02	XXX
95930	TC	A	Visual evoked potential test	0.00	3.36	NA	0.00	XXX
95930	26	A	Visual evoked potential test	0.35	0.15	0.15	0.02	XXX
95933		A	Blink reflex test	0.59	1.60	NA	0.03	XXX
95933	TC	A	Blink reflex test	0.00	1.36	NA	0.00	XXX
95933	26	A	Blink reflex test	0.59	0.24	0.24	0.03	XXX
95934		A	H-reflex test	0.51	1.15	NA	0.03	XXX
95934	TC	A	H-reflex test	0.00	0.93	NA	0.00	XXX

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95934	26	A	H-reflex test	0.51	0.21	0.21	0.03	XXX
95936		A	H-reflex test	0.55	0.77	NA	0.03	XXX
95936	TC	A	H-reflex test	0.00	0.55	NA	0.00	XXX
95936	26	A	H-reflex test	0.55	0.22	0.22	0.03	XXX
95937		A	Neuromuscular junction test	0.65	1.17	NA	0.05	XXX
95937	TC	A	Neuromuscular junction test	0.00	0.91	NA	0.00	XXX
95937	26	A	Neuromuscular junction test	0.65	0.26	0.26	0.05	XXX
95950		A	Ambulatory eeg monitoring	1.51	7.10	NA	0.09	XXX
95950	TC	A	Ambulatory eeg monitoring	0.00	6.50	NA	0.00	XXX
95950	26	A	Ambulatory eeg monitoring	1.51	0.60	0.60	0.08	XXX
95951		C	EEG monitoring/videorecord	0.00	NA	NA	0.00	XXX
95951	TC	C	EEG monitoring/videorecord	0.00	NA	NA	0.00	XXX
95951	26	A	EEG monitoring/videorecord	5.99	2.41	2.41	0.37	XXX
95953		A	EEG monitoring/computer	3.30	10.69	NA	0.20	XXX
95953	TC	A	EEG monitoring/computer	0.00	9.36	NA	0.01	XXX
95953	26	A	EEG monitoring/computer	3.30	1.33	1.33	0.19	XXX
95954		A	EEG monitoring/giving drugs	2.45	6.35	NA	0.15	XXX
95954	TC	A	EEG monitoring/giving drugs	0.00	5.67	NA	0.01	XXX
95954	26	A	EEG monitoring/giving drugs	2.45	0.67	0.67	0.14	XXX
95955		A	EEG during surgery	1.01	3.87	3.87	0.06	XXX
95955	TC	A	EEG during surgery	0.00	3.47	3.47	0.00	XXX
95955	26	A	EEG during surgery	1.01	0.40	0.40	0.06	XXX
95956		A	Eeg monitoring, cable/radio	3.08	18.79	NA	0.18	XXX
95956	TC	A	Eeg monitoring, cable/radio	0.00	17.61	NA	0.01	XXX
95956	26	A	Eeg monitoring, cable/radio	3.08	1.18	1.18	0.18	XXX
95957		A	EEG digital analysis	1.98	8.38	NA	0.12	XXX
95957	TC	A	EEG digital analysis	0.00	7.60	NA	0.01	XXX
95957	26	A	EEG digital analysis	1.98	0.79	0.79	0.12	XXX
95958		A	EEG monitoring/function test	4.24	9.18	NA	0.26	XXX
95958	TC	A	EEG monitoring/function test	0.00	7.57	NA	0.01	XXX
95958	26	A	EEG monitoring/function test	4.24	1.61	1.61	0.24	XXX
95961		A	Electrode stimulation, brain	2.97	4.28	NA	0.18	XXX
95961	TC	A	Electrode stimulation, brain	0.00	3.06	NA	0.01	XXX
95961	26	A	Electrode stimulation, brain	2.97	1.23	1.23	0.17	XXX
95962		A	Electrode stim, brain add-on	3.21	3.18	3.18	0.19	ZZZ
95962	TC	A	Electrode stim, brain add-on	0.00	1.88	1.88	0.01	ZZZ
95962	26	A	Electrode stim, brain add-on	3.21	1.30	1.30	0.18	ZZZ
95965		C	Meg, spontaneous	0.00	0.00	NA	0.00	XXX
95965	TC	C	Meg, spontaneous	0.00	0.00	NA	0.00	XXX
95965	26	A	Meg, spontaneous	7.99	3.23	3.23	0.48	XXX
95966		C	Meg, evoked, single	0.00	0.00	NA	0.00	XXX
95966	TC	C	Meg, evoked, single	0.00	0.00	NA	0.00	XXX
95967		C	Meg, evoked, each add'l	0.00	0.00	NA	0.00	ZZZ
95967	TC	C	Meg, evoked, each add'l	0.00	0.00	NA	0.00	ZZZ
95967	26	A	Meg, evoked, each add'l	3.49	1.41	1.41	0.21	ZZZ
95970		A	Analyze neurostim, no prog	0.45	1.23	0.18	0.03	XXX
95971		A	Analyze neurostim, simple	0.78	0.68	0.27	0.05	XXX
95972		A	Analyze neurostim, complex	1.50	1.32	0.57	0.12	XXX
95973		A	Analyze neurostim, complex	0.92	0.72	0.37	0.07	ZZZ
95974		A	Cranial neurostim, complex	3.00	2.08	1.15	0.19	XXX
95975		A	Cranial neurostim, complex	1.70	1.02	0.68	0.10	ZZZ
95978		A	Analyze neurostim brain/1h	3.50	2.65	1.45	0.29	XXX
95979		A	Analyz neurostim brain addon	1.64	1.07	0.68	0.11	ZZZ
95980		A	Io anal gast n-stim init	0.80	NA	0.34	0.13	XXX
95981		A	Io anal gast n-stim subsq	0.30	0.51	0.17	0.03	XXX
95982		A	Io ga n-stim subsq w/reprog	0.65	0.69	0.31	0.06	XXX
95990		A	Spin/brain pump refil & main	0.00	2.17	NA	0.00	XXX
95991		A	Spin/brain pump refil & main	0.77	2.24	0.29	0.05	XXX
95992		I	Canalith repositioning proc	0.75	0.39	0.27	0.04	XXX
95999		C	Neurological procedure	0.00	0.00	0.00	0.00	XXX
96000		A	Motion analysis, video/3d	1.80	NA	0.71	0.09	XXX
96001		A	Motion test w/ft press meas	2.15	NA	0.76	0.10	XXX
96002		A	Dynamic surface emg	0.41	NA	0.15	0.02	XXX
96003		A	Dynamic fine wire emg	0.37	NA	0.15	0.02	XXX
96004		A	Phys review of motion tests	2.14	0.88	0.88	0.11	XXX
96020		C	Functional brain mapping	0.00	NA	NA	0.00	XXX
96020	TC	C	Functional brain mapping	0.00	NA	NA	0.00	XXX
96020	26	A	Functional brain mapping	3.43	1.04	1.04	0.25	XXX
96040		B	Genetic counseling, 30 min	0.00	1.07	NA	0.00	XXX
96101		A	Psycho testing by psych/phys	1.86	0.24	0.23	0.06	XXX
96102		A	Psycho testing by technician	0.50	0.99	0.10	0.03	XXX
96103		A	Psycho testing admin by comp	0.51	1.12	0.16	0.02	XXX
96105		A	Assessment of aphasia	0.00	2.51	NA	0.00	XXX
96110		A	Developmental test, lim	0.00	0.20	NA	0.00	XXX
96111		A	Developmental test, extend	2.60	1.02	0.88	0.12	XXX
96116		A	Neurobehavioral status exam	1.86	0.59	0.46	0.07	XXX
96118		A	Neuropsych tst by psych/phys	1.86	0.58	0.21	0.05	XXX
96119		A	Neuropsych testing by tec	0.55	1.19	0.07	0.02	XXX
96120		A	Neuropsych tst admin w/comp	0.51	1.81	0.14	0.02	XXX
96125		A	Cognitive test by hc pro	1.70	1.04	0.62	0.05	XXX
96150		A	Assess hlth/behave, init	0.50	0.06	0.05	0.01	XXX
96151		A	Assess hlth/behave, subseq	0.48	0.06	0.05	0.01	XXX
96152		A	Intervene hlth/behave, indiv	0.46	0.06	0.05	0.01	XXX

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96153		A	Intervene hlth/behave, group	0.10	0.02	0.01	0.00	XXX
96154		A	Interv hlth/behav, fam w/pt	0.45	0.05	0.05	0.01	XXX
96155		N	Interv hlth/behav fam no pt	0.44	0.16	0.16	0.02	XXX
96360		A	Hydration iv infusion, init	0.17	1.12	NA	0.01	XXX
96361		A	Hydrate iv infusion, add-on	0.09	0.26	NA	0.00	ZZZ
96365		A	Ther/proph/diag iv inf, init	0.21	1.43	NA	0.01	XXX
96366		A	Ther/proph/diag iv inf addon	0.18	0.34	NA	0.01	ZZZ
96367		A	Tx/proph/dg addl seq iv inf	0.19	0.54	NA	0.01	ZZZ
96368		A	Ther/diag concurrent inf	0.17	0.28	NA	0.01	ZZZ
96369		A	Sc ther infusion, up to 1 hr	0.21	3.35	NA	0.01	XXX
96370		A	Sc ther infusion, addl hr	0.18	0.22	NA	0.01	ZZZ
96371		A	Sc ther infusion, reset pump	0.00	2.22	NA	0.00	ZZZ
96372		A	Ther/proph/diag inj, sc/im	0.17	0.42	NA	0.01	XXX
96373		A	Ther/proph/diag inj, ia	0.17	0.33	NA	0.01	XXX
96374		A	Ther/proph/diag inj, iv push	0.18	1.09	NA	0.01	XXX
96375		A	Tx/pro/dx inj new drug addon	0.10	0.40	NA	0.00	ZZZ
96379		C	Ther/prop/diag inj/inf proc	0.00	0.00	0.00	0.00	XXX
96401		A	Chemo, anti-neopl, sq/im	0.21	1.48	NA	0.01	XXX
96402		A	Chemo hormon antineopl sq/im	0.19	0.57	NA	0.01	XXX
96405		A	Chemo intralesional, up to 7	0.52	1.48	0.28	0.02	000
96406		A	Chemo intralesional over 7	0.80	1.97	0.38	0.03	000
96409		A	Chemo, iv push, sngl drug	0.24	2.18	NA	0.01	XXX
96411		A	Chemo, iv push, addl drug	0.20	1.17	NA	0.01	ZZZ
96413		A	Chemo, iv infusion, 1 hr	0.28	2.85	NA	0.01	XXX
96415		A	Chemo, iv infusion, addl hr	0.19	0.51	NA	0.01	ZZZ
96416		A	Chemo prolong infuse w/pump	0.21	3.19	NA	0.01	XXX
96417		A	Chemo iv infus each addl seq	0.21	1.35	NA	0.01	ZZZ
96420		A	Chemo, ia, push tecnique	0.17	2.22	NA	0.01	XXX
96422		A	Chemo ia infusion up to 1 hr	0.17	3.59	NA	0.01	XXX
96423		A	Chemo ia infuse each addl hr	0.17	1.59	NA	0.01	ZZZ
96425		A	Chemotherapy,infusion method	0.17	3.80	NA	0.01	XXX
96440		A	Chemotherapy, intracavitary	2.37	18.75	1.06	0.42	000
96445		A	Chemotherapy, intracavitary	2.20	4.35	0.93	0.13	000
96450		A	Chemotherapy, into CNS	1.53	2.86	0.61	0.09	000
96521		A	Refill/maint, portable pump	0.21	2.76	NA	0.01	XXX
96522		A	Refill/maint pump/resvr syst	0.21	2.28	NA	0.01	XXX
96523		T	Irrig drug delivery device	0.04	0.51	NA	0.00	XXX
96542		A	Chemotherapy injection	0.75	1.99	0.35	0.04	XXX
96549		C	Chemotherapy, unspecified	0.00	0.00	0.00	0.00	XXX
96567		A	Photodynamic tx, skin	0.00	3.24	NA	0.00	XXX
96570		A	Photodynamic tx, 30 min	1.10	0.38	0.38	0.14	ZZZ
96571		A	Photodynamic tx, addl 15 min	0.55	0.15	0.15	0.03	ZZZ

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CPT[1]/HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
96900		A	Ultraviolet light therapy	0.00	0.49	NA	0.00	XXX
96902		B	Trichogram	0.41	0.17	0.15	0.02	XXX
96904		R	Whole body photography	0.00	1.53	NA	0.00	XXX
96910		A	Photochemotherapy with UV-B	0.00	1.70	NA	0.00	XXX
96912		A	Photochemotherapy with UV-A	0.00	2.18	NA	0.00	XXX
96913		A	Photochemotherapy, UV-A or B	0.00	3.06	NA	0.00	XXX
96920		A	Laser tx, skin < 250 sq cm	1.15	3.24	0.69	0.04	000
96921		A	Laser tx, skin 250-500 sq cm	1.17	3.34	0.69	0.04	000
96922		A	Laser tx, skin > 500 sq cm	2.10	4.29	1.27	0.07	000
96999		C	Dermatological procedure	0.00	0.00	0.00	0.00	XXX
97001		A	Pt evaluation	1.20	0.78	NA	0.04	XXX
97002		A	Pt re-evaluation	0.60	0.49	NA	0.02	XXX
97003		A	Ot evaluation	1.20	1.01	NA	0.05	XXX
97004		A	Ot re-evaluation	0.60	0.74	NA	0.02	XXX
97005		I	Athletic train eval	0.00	0.00	0.00	0.00	XXX
97006		I	Athletic train reeval	0.00	0.00	0.00	0.00	XXX
97010		B	Hot or cold packs therapy	0.06	0.08	NA	0.00	XXX
97012		A	Mechanical traction therapy	0.25	0.17	NA	0.01	XXX
97014		I	Electric stimulation therapy	0.18	0.22	NA	0.01	XXX
97016		A	Vasopneumatic device therapy	0.18	0.30	NA	0.01	XXX
97018		A	Paraffin bath therapy	0.06	0.20	NA	0.00	XXX
97022		A	Whirlpool therapy	0.17	0.40	NA	0.01	XXX
97024		A	Diathermy eg, microwave	0.06	0.10	NA	0.00	XXX
97026		A	Infrared therapy	0.06	0.08	NA	0.00	XXX
97028		A	Ultraviolet therapy	0.08	0.10	NA	0.00	XXX
97032		A	Electrical stimulation	0.25	0.24	NA	0.01	XXX
97033		A	Electric current therapy	0.26	0.34	NA	0.01	XXX
97034		A	Contrast bath therapy	0.21	0.25	NA	0.01	XXX
97035		A	Ultrasound therapy	0.21	0.12	NA	0.01	XXX
97036		A	Hydrotherapy	0.28	0.54	NA	0.02	XXX
97039		C	Physical therapy treatment	0.00	0.00	NA	0.00	XXX
97110		A	Therapeutic exercises	0.45	0.38	NA	0.02	XXX
97112		A	Neuromuscular reeducation	0.45	0.41	NA	0.02	XXX
97113		A	Aquatic therapy/exercises	0.44	0.65	NA	0.01	XXX
97116		A	Gait training therapy	0.40	0.33	NA	0.01	XXX
97124		A	Massage therapy	0.35	0.32	NA	0.01	XXX
97139		C	Physical medicine procedure	0.00	0.00	NA	0.00	XXX
97140		A	Manual therapy	0.43	0.35	NA	0.01	XXX
97150		A	Group therapeutic procedures	0.27	0.26	NA	0.01	XXX
97530		A	Therapeutic activities	0.44	0.46	NA	0.01	XXX
97532		A	Cognitive skills development	0.44	0.26	NA	0.01	XXX
97533		A	Sensory integration	0.44	0.32	NA	0.01	XXX

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CPT[1,]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,]	Non-Facility PE RVUs[2,]	Facility PE RVUs[2,]	Mal-Practice RVUs[2,3,4]	Global
97535		A	Self care mngment training	0.45	0.45	NA	0.01	XXX
97537		A	Community/work reintegration	0.45	0.34	NA	0.01	XXX
97542		A	Wheelchair mngment training	0.45	0.35	NA	0.01	XXX
97545		R	Work hardening	0.00	0.00	NA	0.00	XXX
97546		R	Work hardening add-on	0.00	0.00	NA	0.00	ZZZ
97597		A	Active wound care/20 cm or <	0.58	1.35	0.14	0.04	XXX
97598		A	Active wound care > 20 cm	0.80	1.56	0.19	0.06	XXX
97602		B	Wound(s) care non-selective	0.00	0.49	NA	0.00	XXX
97605		A	Neg press wound tx, < 50 cm	0.55	0.49	0.13	0.06	XXX
97606		A	Neg press wound tx, > 50 cm	0.60	0.50	0.14	0.08	XXX
97750		A	Physical performance test	0.45	0.40	NA	0.02	XXX
97755		A	Assistive technology assess	0.62	0.32	NA	0.02	XXX
97760		A	Orthotic mgmt and training	0.45	0.51	NA	0.02	XXX
97761		A	Prosthetic training	0.45	0.39	NA	0.02	XXX
97762		A	C/o for orthotic/prosth use	0.25	0.90	NA	0.01	XXX
97799		C	Physical medicine procedure	0.00	0.00	0.00	0.00	XXX
97802		A	Medical nutrition, indiv, in	0.53	0.10	0.05	0.02	XXX
97803		A	Med nutrition, indiv, subseq	0.45	0.09	0.04	0.02	XXX
97804		A	Medical nutrition, group	0.25	0.03	0.02	0.01	XXX
97810		N	Acupunct w/o stimul 15 min	0.60	0.35	0.22	0.03	XXX
97811		N	Acupunct w/o stimul addl 15m	0.50	0.22	0.18	0.03	ZZZ
97813		N	Acupunct w/stimul 15 min	0.65	0.37	0.24	0.03	XXX
97814		N	Acupunct w/stimul addl 15m	0.55	0.27	0.20	0.03	ZZZ
98925		A	Osteopathic manipulation	0.45	0.37	0.17	0.02	000
98926		A	Osteopathic manipulation	0.65	0.47	0.23	0.03	000
98927		A	Osteopathic manipulation	0.87	0.59	0.29	0.04	000
98928		A	Osteopathic manipulation	1.03	0.66	0.34	0.04	000
98929		A	Osteopathic manipulation	1.19	0.77	0.41	0.05	000
98940		A	Chiropractic manipulation	0.45	0.25	0.13	0.01	000
98941		A	Chiropractic manipulation	0.65	0.32	0.19	0.02	000
98942		A	Chiropractic manipulation	0.87	0.38	0.25	0.02	000
98943		N	Chiropractic manipulation	0.40	0.23	0.15	0.02	XXX
98960		B	Self-mgmt educ & train, 1 pt	0.00	0.63	NA	0.00	XXX
98961		B	Self-mgmt educ/train, 2-4 pt	0.00	0.30	NA	0.00	XXX
98962		B	Self-mgmt educ/train, 5-8 pt	0.00	0.22	NA	0.00	XXX
98966		N	Hc pro phone call 5-10 min	0.25	0.12	0.09	0.01	XXX
98967		N	Hc pro phone call 11-20 min	0.50	0.21	0.18	0.03	XXX
98968		N	Hc pro phone call 21-30 min	0.75	0.31	0.27	0.04	XXX
99000		B	Specimen handling	0.00	0.00	0.00	0.00	XXX
99001		B	Specimen handling	0.00	0.00	0.00	0.00	XXX
99002		B	Device handling	0.00	0.00	0.00	0.00	XXX
99024		B	Postop follow-up visit	0.00	0.00	0.00	0.00	XXX
99050		B	Medical services after hrs	0.00	0.00	0.00	0.00	XXX
99051		B	Med serv, eve/wkend/holiday	0.00	0.00	0.00	0.00	XXX
99053		B	Med serv 10pm-8am, 24 hr fac	0.00	0.00	0.00	0.00	XXX
99056		B	Med service out of office	0.00	0.00	0.00	0.00	XXX
99058		B	Office emergency care	0.00	0.00	0.00	0.00	XXX
99060		B	Out of office emerg med serv	0.00	0.00	0.00	0.00	XXX
99070		B	Special supplies	0.00	0.00	0.00	0.00	XXX
99071		B	Patient education materials	0.00	0.00	0.00	0.00	XXX
99078		B	Group health education	0.00	0.00	0.00	0.00	XXX
99080		B	Special reports or forms	0.00	0.00	0.00	0.00	XXX
99082		C	Unusual physician travel	0.00	0.00	0.00	0.00	XXX
99090		B	Computer data analysis	0.00	0.00	0.00	0.00	XXX
99091		B	Collect/review data from pt	1.10	0.40	NA	0.06	XXX
99100		B	Special anesthesia service	0.00	NA	0.00	0.00	ZZZ
99116		B	Anesthesia with hypothermia	0.00	NA	0.00	0.00	ZZZ
99135		B	Special anesthesia procedure	0.00	NA	0.00	0.00	ZZZ
99140		B	Emergency anesthesia	0.00	NA	0.00	0.00	ZZZ
99143		C	Mod cs by same phys, < 5 yrs	0.00	0.00	NA	0.00	XXX
99144		C	Mod cs by same phys, 5 yrs +	0.00	0.00	NA	0.00	XXX
99145		C	Mod cs by same phys add-on	0.00	0.00	0.00	0.00	ZZZ
99148		C	Mod cs diff phys < 5 yrs	0.00	NA	NA	0.00	XXX
99149		C	Mod cs diff phys 5 yrs +	0.00	NA	NA	0.00	XXX
99150		C	Mod cs diff phys add-on	0.00	NA	0.00	0.00	ZZZ
99170		A	Anogenital exam, child	1.75	1.84	0.70	0.10	000
99173		N	Visual acuity screen	0.00	0.06	NA	0.00	XXX
99174		N	Ocular photoscreening	0.00	0.68	NA	0.00	XXX
99175		A	Induction of vomiting	0.00	0.57	NA	0.00	XXX
99183		A	Hyperbaric oxygen therapy	2.34	3.13	0.81	0.19	XXX
99185		A	Regional hypothermia	0.00	1.27	NA	0.00	XXX
99186		A	Total body hypothermia	0.00	1.36	NA	0.00	XXX
99195		A	Phlebotomy	0.00	2.07	NA	0.00	XXX
99199		C	Special service/proc/report	0.00	0.00	0.00	0.00	XXX
99201		A	Office/outpatient visit, new	0.48	0.62	0.21	0.04	XXX
99202		A	Office/outpatient visit, new	0.93	0.98	0.40	0.06	XXX
99203		A	Office/outpatient visit, new	1.42	1.33	0.59	0.11	XXX
99204		A	Office/outpatient visit, new	2.43	1.82	1.00	0.16	XXX
99205		A	Office/outpatient visit, new	3.17	2.11	1.23	0.21	XXX
99211		A	Office/outpatient visit, est	0.18	0.31	0.07	0.01	XXX
99212		A	Office/outpatient visit, est	0.48	0.62	0.20	0.03	XXX
99213		A	Office/outpatient visit, est	0.97	0.89	0.39	0.05	XXX
99214		A	Office/outpatient visit, est	1.50	1.25	0.58	0.08	XXX
99215		A	Office/outpatient visit, est	2.11	1.60	0.82	0.12	XXX

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99217		A	Observation care discharge	1.28	NA	0.61	0.06	XXX
99218		A	Observation care	1.28	NA	0.47	0.07	XXX
99219		A	Observation care	2.14	NA	0.80	0.11	XXX
99220		A	Observation care	2.99	NA	1.09	0.15	XXX
99221		A	Initial hospital care	1.92	NA	0.71	0.14	XXX
99222		A	Initial hospital care	2.61	NA	1.00	0.16	XXX
99223		A	Initial hospital care	3.85	NA	1.45	0.21	XXX
99231		A	Subsequent hospital care	0.76	NA	0.29	0.04	XXX
99232		A	Subsequent hospital care	1.39	NA	0.52	0.07	XXX
99233		A	Subsequent hospital care	2.00	NA	0.74	0.10	XXX
99234		A	Observ/hosp same date	2.56	NA	0.95	0.15	XXX
99235		A	Observ/hosp same date	3.41	NA	1.27	0.17	XXX
99236		A	Observ/hosp same date	4.26	NA	1.55	0.22	XXX
99238		A	Hospital discharge day	1.28	NA	0.61	0.06	XXX
99239		A	Hospital discharge day	1.90	NA	0.90	0.09	XXX
99241		N	Office consultation	0.64	0.61	0.23	0.05	XXX
99242		N	Office consultation	1.34	1.00	0.49	0.10	XXX
99243		N	Office consultation	1.88	1.36	0.69	0.13	XXX
99244		N	Office consultation	3.02	1.86	1.10	0.16	XXX
99245		N	Office consultation	3.77	2.24	1.38	0.21	XXX
99251		N	Inpatient consultation	1.00	NA	0.36	0.05	XXX
99252		N	Inpatient consultation	1.50	NA	0.55	0.09	XXX
99253		N	Inpatient consultation	2.27	NA	0.83	0.11	XXX
99254		N	Inpatient consultation	3.29	NA	1.20	0.13	XXX
99255		N	Inpatient consultation	4.00	NA	1.46	0.18	XXX
99281		A	Emergency dept visit	0.45	NA	0.12	0.03	XXX
99282		A	Emergency dept visit	0.88	NA	0.24	0.05	XXX
99283		A	Emergency dept visit	1.34	NA	0.34	0.08	XXX
99284		A	Emergency dept visit	2.56	NA	0.57	0.15	XXX
99285		A	Emergency dept visit	3.80	NA	0.76	0.23	XXX
99288		B	Direct advanced life support	0.00	NA	NA	0.00	XXX
99291		A	Critical care, first hour	4.50	2.54	1.38	0.26	XXX
99292		A	Critical care, addÆl 30 min	2.25	0.93	0.69	0.13	ZZZ
99304		A	Nursing facility care, init	1.64	0.78	0.78	0.11	XXX
99305		A	Nursing facility care, init	2.34	1.06	1.06	0.15	XXX
99306		A	Nursing facility care, init	3.06	1.31	1.31	0.17	XXX
99307		A	Nursing fac care, subseq	0.76	0.41	0.41	0.04	XXX
99308		A	Nursing fac care, subseq	1.16	0.64	0.64	0.05	XXX
99309		A	Nursing fac care, subseq	1.55	0.84	0.84	0.07	XXX
99310		A	Nursing fac care, subseq	2.35	1.18	1.18	0.11	XXX
99315		A	Nursing fac discharge day	1.13	0.58	0.58	0.05	XXX
99316		A	Nursing fac discharge day	1.50	0.73	0.73	0.07	XXX
99318		A	Annual nursing fac assessmnt	1.71	0.82	0.82	0.08	XXX
99324		A	Domicil/r-home visit new pat	1.01	0.45	NA	0.05	XXX
99325		A	Domicil/r-home visit new pat	1.52	0.61	NA	0.08	XXX
99326		A	Domicil/r-home visit new pat	2.63	1.11	NA	0.13	XXX
99327		A	Domicil/r-home visit new pat	3.46	1.47	NA	0.16	XXX
99328		A	Domicil/r-home visit new pat	4.09	1.64	NA	0.18	XXX
99334		A	Domicil/r-home visit est pat	1.07	0.52	NA	0.05	XXX
99335		A	Domicil/r-home visit est pat	1.72	0.79	NA	0.08	XXX
99336		A	Domicil/r-home visit est pat	2.46	1.10	NA	0.11	XXX
99337		A	Domicil/r-home visit est pat	3.58	1.55	NA	0.17	XXX
99339		B	Domicil/r-home care supervis	1.25	0.77	NA	0.07	XXX
99340		B	Domicil/r-home care supervis	1.80	1.04	NA	0.10	XXX
99341		A	Home visit, new patient	1.01	0.44	NA	0.05	XXX
99342		A	Home visit, new patient	1.52	0.57	NA	0.08	XXX
99343		A	Home visit, new patient	2.53	0.96	NA	0.13	XXX
99344		A	Home visit, new patient	3.38	1.44	NA	0.16	XXX
99345		A	Home visit, new patient	4.09	1.73	NA	0.19	XXX
99347		A	Home visit, est patient	1.00	0.46	NA	0.05	XXX
99348		A	Home visit, est patient	1.56	0.67	NA	0.08	XXX
99349		A	Home visit, est patient	2.33	1.06	NA	0.11	XXX
99350		A	Home visit, est patient	3.28	1.44	NA	0.15	XXX
99354		A	Prolonged service, office	1.77	0.83	0.67	0.09	ZZZ
99355		A	Prolonged service, office	1.77	0.80	0.64	0.09	ZZZ
99356		A	Prolonged service, inpatient	1.71	NA	0.69	0.09	ZZZ
99357		A	Prolonged service, inpatient	1.71	NA	0.69	0.09	ZZZ
99358		B	Prolonged serv, w/o contact	2.10	0.80	0.80	0.11	ZZZ
99359		B	Prolonged serv, w/o contact	1.00	0.40	0.40	0.05	ZZZ
99360		X	Physician standby services	1.20	NA	0.44	0.06	XXX
99363		B	Anticoag mgmt, init	1.65	1.60	0.60	0.09	XXX
99364		B	Anticoag mgmt, subseq	0.63	0.48	0.23	0.03	XXX
99366		B	Team conf w/pat by hc pro	0.82	0.32	0.30	0.04	XXX
99367		B	Team conf w/o pat by phys	1.10	NA	0.40	0.06	XXX
99368		B	Team conf w/o pat by hc pro	0.72	NA	0.26	0.04	XXX
99374		B	Home health care supervision	1.10	0.72	0.40	0.06	XXX
99375		I	Home health care supervision	1.73	1.01	0.63	0.09	XXX
99377		B	Hospice care supervision	1.10	0.72	0.40	0.06	XXX
99378		I	Hospice care supervision	1.73	1.01	0.63	0.09	XXX
99379		B	Nursing fac care supervision	1.10	0.72	0.40	0.06	XXX
99380		B	Nursing fac care supervision	1.73	1.01	0.63	0.09	XXX
99381		N	Init pm e/m, new pat, inf	1.19	1.22	0.43	0.06	XXX
99382		N	Init pm e/m, new pat 1-4 yrs	1.36	1.28	0.50	0.07	XXX
99383		N	Prev visit, new, age 5-11	1.36	1.27	0.50	0.07	XXX

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99384		N	Prev visit, new, age 12-17	1.53	1.33	0.56	0.08	XXX
99385		N	Prev visit, new, age 18-39	1.53	1.33	0.56	0.08	XXX
99386		N	Prev visit, new, age 40-64	1.88	1.46	0.69	0.10	XXX
99387		N	Init pm e/m, new pat 65+ yrs	2.06	1.62	0.75	0.11	XXX
99391		N	Per pm reeval, est pat, inf	1.02	1.05	0.37	0.05	XXX
99392		N	Prev visit, est, age 1-4	1.19	1.11	0.43	0.06	XXX
99393		N	Prev visit, est, age 5-11	1.19	1.10	0.43	0.06	XXX
99394		N	Prev visit, est, age 12-17	1.36	1.17	0.50	0.07	XXX
99395		N	Prev visit, est, age 18-39	1.36	1.17	0.50	0.07	XXX
99396		N	Prev visit, est, age 40-64	1.53	1.23	0.56	0.08	XXX
99397		N	Per pm reeval est pat 65+ yr	1.71	1.40	0.62	0.09	XXX
99401		N	Preventive counseling, indiv	0.48	0.45	0.18	0.03	XXX
99402		N	Preventive counseling, indiv	0.98	0.63	0.36	0.05	XXX
99403		N	Preventive counseling, indiv	1.46	0.80	0.53	0.08	XXX
99404		N	Preventive counseling, indiv	1.95	0.98	0.71	0.10	XXX
99406		A	Behav chng smoking 3-10 min	0.24	0.13	0.09	0.01	XXX
99407		A	Behav chng smoking > 10 min	0.50	0.23	0.18	0.03	XXX
99408		N	Audit/dast, 15-30 min	0.65	0.28	0.24	0.03	XXX
99409		N	Audit/dast, over 30 min	1.30	0.52	0.47	0.07	XXX
99411		N	Preventive counseling, group	0.15	0.26	0.05	0.01	XXX
99412		N	Preventive counseling, group	0.25	0.29	0.09	0.01	XXX
99420		N	Health risk assessment test	0.00	0.24	NA	0.00	XXX
99441		N	Phone e/m by phys 5-10 min	0.25	0.12	0.09	0.01	XXX
99442		N	Phone e/m by phys 11-20 min	0.50	0.21	0.18	0.03	XXX
99443		N	Phone e/m by phys 21-30 min	0.75	0.31	0.27	0.04	XXX
99450		N	Basic life disability exam	0.00	0.35	NA	0.00	XXX
99455		R	Work related disability exam	0.00	0.68	NA	0.00	XXX
99456		R	Disability examination	0.00	0.80	NA	0.00	XXX
99460		A	Init nb em per day, hosp	1.17	NA	0.44	0.05	XXX
99461		A	Init nb em per day, non-fac	1.26	1.24	0.46	0.07	XXX
99462		A	Sbsq nb em per day, hosp	0.62	NA	0.23	0.03	XXX
99463		A	Same day nb discharge	1.50	NA	0.70	0.06	XXX
99464		A	Attendance at delivery	1.50	NA	0.51	0.06	XXX
99465		A	Nb resuscitation	2.93	NA	1.07	0.16	XXX
99466		A	Ped crit care transport	4.79	NA	1.78	0.30	XXX
99467		A	Ped crit care transport addl	2.40	NA	0.94	0.11	ZZZ
99468		A	Neonate crit care, initial	18.46	NA	7.00	1.15	XXX
99469		A	Neonate crit care, subsq	7.99	NA	2.69	0.33	XXX
99471		A	Ped critical care, initial	15.98	NA	5.32	0.67	XXX
99472		A	Ped critical care, subsq	7.99	NA	2.76	0.37	XXX
99475		A	Ped crit care age 2-5, init	11.25	3.45	3.45	0.66	XXX
99476		A	Ped crit care age 2-5, subsq	6.75	2.07	2.07	0.39	XXX
99477		A	Init day hosp neonate care	7.00	NA	2.44	0.29	XXX
99478		A	Ic, lbw inf < 1500 gm subsq	2.75	NA	1.08	0.13	XXX
99479		A	Ic lbw inf 1500-2500 g subsq	2.50	NA	0.99	0.12	XXX
99480		A	Ic inf pbw 2501-5000 g subsq	2.40	NA	0.92	0.12	XXX
99499		C	Unlisted e&m service	0.00	0.00	0.00	0.00	XXX
99500		I	Home visit, prenatal	0.00	0.00	0.00	0.00	XXX
99501		I	Home visit, postnatal	0.00	0.00	0.00	0.00	XXX
99502		I	Home visit, nb care	0.00	0.00	0.00	0.00	XXX
99503		I	Home visit, resp therapy	0.00	0.00	0.00	0.00	XXX
99504		I	Home visit mech ventilator	0.00	0.00	0.00	0.00	XXX
99505		I	Home visit, stoma care	0.00	0.00	0.00	0.00	XXX
99506		I	Home visit, im injection	0.00	0.00	0.00	0.00	XXX
99507		I	Home visit, cath maintain	0.00	0.00	0.00	0.00	XXX
99509		I	Home visit day life activity	0.00	0.00	0.00	0.00	XXX
99510		I	Home visit, sting/m/fam couns	0.00	0.00	0.00	0.00	XXX
99511		I	Home visit, fecal/enema mgmt	0.00	0.00	0.00	0.00	XXX
99512		I	Home visit for hemodialysis	0.00	0.00	0.00	0.00	XXX
99600		I	Home visit nos	0.00	0.00	0.00	0.00	XXX
99601		I	Home infusion/visit, 2 hrs	0.00	0.00	0.00	0.00	XXX
99602		I	Home infusion, each addtl hr	0.00	0.00	0.00	0.00	XXX
A4262		B	Temporary tear duct plug	0.00	0.00	0.00	0.00	XXX
A4263		B	Permanent tear duct plug	0.00	0.00	0.00	0.00	XXX
A4270		B	Disposable endoscope sheath	0.00	0.00	0.00	0.00	XXX
A4300		B	Cath impl vasc access portal	0.00	0.00	0.00	0.00	XXX
A4550		B	Surgical trays	0.00	0.00	0.00	0.00	XXX
A4890		R	Repair/maint cont hemo equip	0.00	0.00	0.00	0.00	XXX
G0008		X	Admin influenza virus vac	0.00	0.00	0.00	0.00	XXX
G0009		X	Admin pneumococcal vaccine	0.00	0.00	0.00	0.00	XXX
G0010		X	Admin hepatitis b vaccine	0.00	0.00	0.00	0.00	XXX
G0101		A	CA screen;pelvic/breast exam	0.45	0.52	NA	0.02	XXX
G0102		A	Prostate ca screening; dre	0.17	0.31	0.07	0.01	XXX
G0104		A	CA screen;flexi sigmoidscope	0.96	2.48	0.66	0.07	000
G0105		A	Colorectal scrn; hi risk ind	3.69	6.00	1.84	0.26	000
G0105	53	A	Colorectal scrn: hi risk ind	0.96	2.48	0.66	0.05	000
G0106		A	Colon CA screen;barium enema	0.99	4.43	NA	0.05	XXX
G0106	TC	A	Colon CA screen;barium enema	0.00	4.13	NA	0.00	XXX
G0106	26	A	Colon CA screen;barium enema	0.99	0.30	0.30	0.05	XXX
G0108		A	Diab manage trn per indiv	0.00	0.58	NA	0.00	XXX
G0109		A	Diab manage trn ind/group	0.00	0.30	NA	0.00	XXX
G0117		T	Glaucoma scrn high risk direc	0.45	0.90	NA	0.01	XXX
G0118		T	Glaucoma scrn high risk direc	0.17	0.90	NA	0.00	XXX
G0120		A	Colon ca scrn; barium enema	0.99	4.43	NA	0.05	XXX

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
G0120	TC	A	Colon ca scrn; barium enema	0.00	4.13	NA	0.00	XXX
G0120	26	A	Colon ca scrn; barium enema	0.99	0.30	0.30	0.05	XXX
G0121		A	Colon ca scrn not hi rsk ind	3.69	6.00	1.84	0.26	000
G0121	53	A	Colon ca scrn not hi rsk ind	0.96	2.48	0.66	0.05	000
G0122		N	Colon ca scrn; barium enema	0.99	6.20	NA	0.05	XXX
G0122	TC	N	Colon ca scrn; barium enema	0.00	5.84	NA	0.00	XXX
G0122	26	N	Colon ca scrn; barium enema	0.99	0.36	0.36	0.05	XXX
G0124		A	Screen c/v thin layer by MD	0.42	0.35	0.35	0.02	XXX
G0127		R	Trim nail(s)	0.17	0.41	0.04	0.01	000
G0128		R	CORF skilled nursing service	0.08	0.17	NA	0.00	XXX
G0130		A	Single energy x-ray study	0.22	0.62	NA	0.01	XXX
G0130	TC	A	Single energy x-ray study	0.00	0.54	NA	0.00	XXX
G0130	26	A	Single energy x-ray study	0.22	0.09	0.09	0.01	XXX
G0141		A	Scr c/v cyto,autosys and md	0.42	0.35	0.35	0.02	XXX
G0166		A	Extrnl counterpulse, per tx	0.07	3.38	NA	0.00	XXX
G0168		A	Wound closure by adhesive	0.45	1.92	0.27	0.03	000
G0179		A	MD recertification HHA PT	0.45	0.58	NA	0.02	XXX
G0180		A	MD certification HHA patient	0.67	0.68	NA	0.04	XXX
G0181		A	Home health care supervision	1.73	1.06	NA	0.08	XXX
G0182		A	Hospice care supervision	1.73	1.07	NA	0.08	XXX
G0186		C	Dstry eye lesn,fdr vssl tech	0.00	0.00	0.00	0.00	YYY
G0202		A	Screeningmammographydigital	0.70	2.80	NA	0.05	XXX
G0202	TC	A	Screeningmammographydigital	0.00	2.57	NA	0.00	XXX
G0202	26	A	Screeningmammographydigital	0.70	0.24	0.24	0.05	XXX
G0204		A	Diagnosticmammographydigital	0.87	3.40	NA	0.06	XXX
G0204	TC	A	Diagnosticmammographydigital	0.00	3.10	NA	0.00	XXX
G0204	26	A	Diagnosticmammographydigital	0.87	0.30	0.30	0.06	XXX
G0206		A	Diagnosticmammographydigital	0.70	2.67	NA	0.05	XXX
G0206	TC	A	Diagnosticmammographydigital	0.00	2.43	NA	0.00	XXX
G0206	26	A	Diagnosticmammographydigital	0.70	0.24	0.24	0.05	XXX
G0237		A	Therapeutic procd strg endur	0.00	0.21	NA	0.00	XXX
G0238		A	Oth resp proc, indiv	0.00	0.22	NA	0.00	XXX
G0239		A	Oth resp proc, group	0.00	0.27	NA	0.00	XXX
G0245		R	Initial foot exam pt lops	0.88	0.98	0.40	0.05	XXX
G0246		R	Followup eval of foot pt lop	0.45	0.62	0.20	0.02	XXX
G0247		R	Routine footcare pt w lops	0.50	0.73	0.16	0.03	ZZZ
G0248		R	Demonstrate use home inr mon	0.00	2.83	NA	0.00	XXX
G0249		R	Provide INR test mater/equip	0.00	2.74	NA	0.00	XXX
G0250		R	MD INR test revie inter mgmt	0.18	0.06	NA	0.01	XXX
G0252	26	N	PET imaging initial dx	1.50	0.55	0.55	0.08	XXX
G0268		A	Removal of impacted wax md	0.61	0.76	0.29	0.02	000
G0269		B	Occlusive device in vein art	0.00	0.00	0.00	0.00	XXX

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CPT[1,7] HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
G0270		A	MNT subs tx for change dx	0.45	0.09	0.04	0.02	XXX
G0271		A	Group MNT 2 or more 30 mins	0.25	0.03	0.02	0.01	XXX
G0275		A	Renal angio, cardiac cath	0.25	NA	0.08	0.01	ZZZ
G0278		A	Iliac art angio,cardiac cath	0.25	NA	0.08	0.01	ZZZ
G0281		A	Elec stim unattend for press	0.18	0.17	NA	0.01	XXX
G0282		N	Elect stim wound care not pd	0.00	0.12	NA	0.00	XXX
G0283		A	Elec stim other than wound	0.18	0.17	NA	0.01	XXX
G0288		A	Recon, CTA for surg plan	0.00	0.85	NA	0.00	XXX
G0289		A	Arthro, loose body + chondro	1.48	NA	0.73	0.22	ZZZ
G0329		A	Electromagnetic tx for ulcers	0.06	0.19	NA	0.00	XXX
G0337		X	Hospice evaluation prelecti	1.42	0.00	0.00	0.11	XXX
G0339		C	Robot lin-radsurg com, first	0.00	0.00	0.00	0.00	XXX
G0340		C	Robt lin-radsurg fractx 2-5	0.00	0.00	0.00	0.00	XXX
G0341		A	Percutaneous islet celltrans	6.98	3.03	NA	0.37	000
G0342		A	Laparoscopy islet cell trans	11.92	NA	6.76	0.64	090
G0343		A	Laparotomy islet cell transp	19.85	NA	11.43	1.06	090
G0364		A	Bone marrow aspirate &biopsy	0.16	0.15	0.07	0.01	ZZZ
G0365		A	Vessel mapping hemo access	0.25	5.25	NA	0.03	XXX
G0365	TC	A	Vessel mapping hemo access	0.00	5.17	NA	0.00	XXX
G0365	26	A	Vessel mapping hemo access	0.25	0.08	0.08	0.03	XXX
G0372		A	MD service required for PMD	0.17	0.07	0.07	0.01	XXX
G0389		A	Ultrasound exam AAA screen	0.58	2.10	NA	0.04	XXX
G0389	TC	A	Ultrasound exam AAA screen	0.00	1.92	NA	0.00	XXX
G0389	26	A	Ultrasound exam AAA screen	0.58	0.18	0.18	0.04	XXX
G0392		A	AV fistula or graft arterial	9.48	39.25	3.20	0.66	000
G0393		A	AV fistula or graft venous	6.03	31.10	2.14	0.44	000
G0396		A	Alcohol/subs interv 15-30mn	0.65	0.26	0.21	0.03	XXX
G0397		A	Alcohol/subs interv >30 min	1.30	0.52	0.47	0.07	XXX
G0398		C	Home sleep test/type 2 Porta	0.00	0.00	NA	0.00	XXX
G0398	TC	C	Home sleep test/type 2 Porta	0.00	0.00	NA	0.00	XXX
G0398	26	C	Home sleep test/type 2 Porta	0.00	0.00	0.00	0.00	XXX
G0399		C	Home sleep test/type 3 Porta	0.00	0.00	NA	0.00	XXX
G0399	TC	C	Home sleep test/type 3 Porta	0.00	0.00	NA	0.00	XXX
G0399	26	C	Home sleep test/type 3 Porta	0.00	0.00	0.00	0.00	XXX
G0400		C	Home sleep test/type 4 Porta	0.00	0.00	NA	0.00	XXX
G0400	TC	C	Home sleep test/type 4 Porta	0.00	0.00	NA	0.00	XXX
G0400	26	C	Home sleep test/type 4 Porta	0.00	0.00	0.00	0.00	XXX
G0402		A	Initial preventive exam	2.30	1.84	NA	0.06	XXX
G0403		A	EKG for initial prevent exam	0.17	0.33	0.33	0.01	XXX
G0404		A	EKG tracing for initial prev	0.00	0.00	NA	0.00	XXX
G0405		A	EKG interpret & report preve	0.17	0.07	0.07	0.01	XXX
G0406		A	Telhealth inpt consult 15min	0.76	NA	0.29	0.04	XXX

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CPT[1,3]/ HCPCS	Mod	Status	Description	Physician Work RVUs[2,3]	Non-Facility PE RVUs[2,3]	Facility PE RVUs[2,3]	Mal-Practice RVUs[2,3,4]	Global
G0407		A	Telheath inpt consult 25min	1.39	NA	0.52	0.07	XXX
G0408		A	Telhealth inpt consult 35min	2.00	NA	0.74	0.11	XXX
G0409		A	CORF related serv 15 mins ea	0.00	0.23	NA	0.00	XXX
G0412		A	Open tx iliac spine uni/bil	10.45	NA	7.73	1.56	090
G0413		A	Pelvic ring fracture uni/bil	15.73	NA	10.83	2.31	090
G0414		A	Pelvic ring fx treat int fix	14.65	NA	10.50	2.16	090
G0415		A	Open tx post pelvic fxcture	20.93	NA	13.73	3.21	090
G0416		A	Sat biopsy prostate 1-20 spc	3.09	1.13	NA	0.17	XXX
G0416	TC	A	Sat biopsy prostate 1-20 spc	0.00	0.00	NA	0.01	XXX
G0416	26	A	Sat biopsy prostate 1-20 spc	3.09	1.13	1.13	0.16	XXX
G0417		A	Sat biopsy prostate 21-40	5.86	2.14	NA	0.31	XXX
G0417	TC	A	Sat biopsy prostate 21-40	0.00	0.00	NA	0.02	XXX
G0417	26	A	Sat biopsy prostate 21-40	5.86	2.14	2.14	0.30	XXX
G0418		A	Sat biopsy prostate 41-60	10.30	3.76	NA	0.55	XXX
G0418	TC	A	Sat biopsy prostate 41-60	0.00	0.00	NA	0.03	XXX
G0418	26	A	Sat biopsy prostate 41-60	10.30	3.76	3.76	0.52	XXX
G0419		A	Sat biopsy prostate: >60	11.61	4.24	NA	0.62	XXX
G0419	TC	A	Sat biopsy prostate: >60	0.00	0.00	NA	0.03	XXX
G0419	26	A	Sat biopsy prostate: >60	11.61	4.24	4.24	0.59	XXX
G9041		A	Low vision rehab occupationa	0.54	0.22	0.22	0.02	XXX
G9042		A	Low vision rehab orient/mobi	0.20	0.20	0.20	0.01	XXX
G9043		A	Low vision lowvision therapi	0.20	0.20	0.20	0.00	XXX
G9044		A	Low vision rehabilate teache	0.19	0.15	0.15	0.00	XXX
G9050		I	Oncology work-up evaluation	0.00	0.00	0.00	0.00	XXX
G9051		I	Oncology tx decision-mgmt	0.00	0.00	0.00	0.00	XXX
G9052		I	Onc surveillance for disease	0.00	0.00	0.00	0.00	XXX
G9053		I	Onc expectant management pt	0.00	0.00	0.00	0.00	XXX
G9054		I	Onc supervision palliative	0.00	0.00	0.00	0.00	XXX
G9055		I	Onc visit unspecified NOS	0.00	0.00	0.00	0.00	XXX
G9056		I	Onc prac mgmt adheres guide	0.00	0.00	0.00	0.00	XXX
G9057		I	Onc pract mgmt differs trial	0.00	0.00	0.00	0.00	XXX
G9058		I	Onc prac mgmt disagree w/gui	0.00	0.00	0.00	0.00	XXX
G9059		I	Onc prac mgmt pt opt alterna	0.00	0.00	0.00	0.00	XXX
G9060		I	Onc prac mgmt dif pt comorb	0.00	0.00	0.00	0.00	XXX
G9061		I	Onc prac cond noadd by guide	0.00	0.00	0.00	0.00	XXX
G9062		I	Onc prac guide differs nos	0.00	0.00	0.00	0.00	XXX
GXX26		A	Ed svc CKD ind per session	0.53	0.10	0.05	0.02	XXX
GXX27		A	Ed svc CKD grp per session	0.25	0.03	0.02	0.01	XXX
GXX28		A	Intens cardiac rehab w/exerc	See 2010 OPPS Rule	See 2010 OPPS Rule	See 2010 OPPS Rule	See 2010 OPPS Rule	XXX
GXX29		A	Intens cardiac rehab no exer	See 2010	See 2010	See 2010	See 2010	XXX

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GXX30		A	Pulmonary rehab w exer	OPPS Rule 0.18	OPPS Rule 0.40	OPPS Rule 0.40	OPPS Rule 0.01	XXX
M0064		A	Visit for drug monitoring	0.37	0.91	0.06	0.01	XXX
P3001		A	Screening pap smear by phys	0.42	0.35	0.35	0.02	XXX
P7001		I	Culture bacterial urine	0.00	0.00	0.00	0.00	XXX
Q0035		A	Cardiokymography	0.17	0.26	NA	0.01	XXX
Q0035	TC	A	Cardiokymography	0.00	0.21	NA	0.00	XXX
Q0035	26	A	Cardiokymography	0.17	0.05	0.05	0.01	XXX
Q0091		A	Obtaining screen pap smear	0.37	0.75	0.14	0.02	XXX
Q0092		A	Set up port xray equipment	0.00	0.38	0.38	0.00	XXX
Q3001		C	Brachytherapy Radioelements	0.00	0.00	0.00	0.00	XXX
Q3026		I	Subc inj interferon beta-1a	0.00	0.00	0.00	0.00	XXX
Q3031		B	Collagen skin test	0.00	0.00	0.00	0.00	XXX
R0070		C	Transport portable x-ray	0.00	0.00	NA	0.00	XXX
R0075		C	Transport port x-ray multipl	0.00	0.00	NA	0.00	XXX
R0076		B	Transport portable EKG	0.00	0.00	NA	0.00	XXX
V5299		R	Hearing service	0.00	0.00	0.00	0.00	XXX

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ADDENDUM C: [Reserved]

ADDENDUM D: Proposed 2010 Geographic Adjustment Factors (GAFs)

Contractor	Locality	Locality Name	2010** GAF
00831	01	Alaska	1.288***
01102	06	San Mateo, CA	1.204
01102	05	San Francisco, CA	1.201
13202	01	Manhattan, NY	1.164
13202	02	NYC Suburbs/Long I., NY	1.162
01102	09	Santa Clara, CA	1.148
12402	01	Northern NJ	1.134
31143	01	Metropolitan Boston	1.134
01102	07	Oakland/Berkley, CA	1.131
13292	04	Queens, NY	1.130
01192	26	Anaheim/Santa Ana, CA	1.128
12202	01	DC + MD/VA Suburbs	1.121
01192	17	Ventura, CA	1.121
00590	04	Miami, FL	1.114
01192	18	Los Angeles, CA	1.112
01102	03	Marin/Napa/Solano, CA	1.112
13102	00	Connecticut	1.100
00952	16	Chicago, IL	1.085
12402	99	Rest of New Jersey	1.082
12502	01	Metropolitan Philadelphia, PA	1.075
00953	01	Detroit, MI	1.072
00952	15	Suburban Chicago, IL	1.063
01202	01	Hawaii/Guam	1.056
00590	03	Fort Lauderdale, FL	1.050
00524	01	Rhode Island	1.045
31143	99	Rest of Massachusetts	1.041
12302	01	Baltimore/Surr. Cntys, MD	1.035
13202	03	Poughkpsie/N NYC Suburbs, NY	1.034
00836	02	Seattle (King Cnty), WA	1.033
01302	00	Nevada	1.016
04402	18	Houston, TX	1.016
12102	01	Delaware	1.014
01102	99	Rest of California*	1.012
01192	99	Rest of California*	1.012
00528	01	New Orleans, LA	1.010
04402	11	Dallas, TX	1.010
00511	01	Atlanta, GA	1.005
00952	12	East St. Louis, IL	0.989
00973	50	Virgin Islands	0.989
00835	01	Portland, OR	0.987
04402	31	Austin, TX	0.987

Contractor	Locality	Locality Name	2010** GAF
00590	99	Rest of Florida	0.987
31144	40	New Hampshire	0.986
04402	15	Galveston, TX	0.986
04402	09	Brazoria, TX	0.985
12302	99	Rest of Maryland	0.984
04402	28	Fort Worth, TX	0.982
31142	03	Southern Maine	0.980
05302	02	Metropolitan Kansas City, MO	0.978
04102	01	Colorado	0.975
00883	00	Ohio	0.973
00836	99	Rest of Washington	0.970
05392	01	Metropolitan St Louis, MO	0.969
00953	99	Rest of Michigan	0.968
03102	00	Arizona	0.968
12502	99	Rest of Pennsylvania	0.966
00954	00	Minnesota	0.959
31145	50	Vermont	0.956
00904	00	Virginia	0.952
04402	20	Beaumont, TX	0.950
03502	09	Utah	0.948
00952	99	Rest of Illinois	0.943
13282	99	Rest of New York	0.941
04202	05	New Mexico	0.941
00630	00	Indiana	0.941
05535	00	North Carolina	0.938
00951	00	Wisconsin	0.936
04402	99	Rest of Texas	0.933
00511	99	Rest of Georgia	0.931
00835	99	Rest of Oregon	0.930
00528	99	Rest of Louisiana	0.927
05440	35	Tennessee	0.924
00880	01	South Carolina	0.924
00884	16	West Virginia	0.924
05202	00	Kansas	0.915
05130	00	Idaho	0.914
31142	99	Rest of Maine	0.913
00660	00	Kentucky	0.909
00512	00	Mississippi	0.907
00510	00	Alabama	0.907
03602	21	Wyoming	0.904
05102	00	Iowa	0.903
04302	00	Oklahoma	0.901
05402	00	Nebraska	0.901
05392	99	Rest of Missouri*	0.895
05302	99	Rest of Missouri*	0.895
03202	01	Montana	0.894
00520	13	Arkansas	0.891
03402	02	South Dakota	0.888
03302	01	North Dakota	0.880
00973	20	Puerto Rico	0.787

GAF equation: (0.52466 * work GPCI) + (0.43669 * pe GPCI) + (0.03865 * mp GPCI).

*Indicates multiple contractors.

**GAF values do not reflect the 1.000 floor on physician work GPCI established by the MIPPA.

***GAF value for Alaska reflects 1.500 floor on physician work GPCI established by the MIPPA.

ADDENDUM E: Proposed CY 2010 Geographic Practice Cost Indices (GPCIs) by State and Medicare Locality

Contractor	Locality	Locality Name	Work** GPCI	PE GPCI	MP GPCI
00510	00	Alabama	0.982	0.853	0.496
00831	01	Alaska	1.500***	1.090	0.646
03102	00	Arizona	0.988	0.957	0.822
00520	13	Arkansas	0.961	0.846	0.446
01192	26	Anaheim/Santa Ana, CA	1.034	1.269	0.811
01192	18	Los Angeles, CA	1.041	1.225	0.804
01102	03	Marin/Napa/Solano, CA	1.034	1.265	0.432
01102	07	Oakland/Berkley, CA	1.053	1.286	0.425
01102	05	San Francisco, CA	1.059	1.441	0.414
01102	06	San Mateo, CA	1.072	1.433	0.394
01102	09	Santa Clara, CA	1.083	1.294	0.377
01192	17	Ventura, CA	1.027	1.265	0.766
01102	99	Rest of California*	1.007	1.058	0.549
01192	99	Rest of California*	1.007	1.058	0.549
04102	01	Colorado	0.986	0.992	0.641
13102	00	Connecticut	1.038	1.185	0.980
12202	01	DC + MD/VA Suburbs	1.047	1.218	1.032
12102	01	Delaware	1.011	1.046	0.678
00590	03	Fort Lauderdale, FL	0.989	1.018	2.250
00590	04	Miami, FL	1.000	1.069	3.167
00590	99	Rest of Florida	0.973	0.939	1.724
00511	01	Atlanta, GA	1.009	1.014	0.836
00511	99	Rest of Georgia	0.979	0.883	0.829
01202	01	Hawaii/Guam	0.998	1.161	0.665
05130	00	Idaho	0.967	0.883	0.546
00952	16	Chicago, IL	1.025	1.080	1.940
00952	12	East St. Louis, IL	0.989	0.919	1.793
00952	15	Suburban Chicago, IL	1.017	1.068	1.629
00952	99	Rest of Illinois	0.975	0.880	1.219
00630	00	Indiana	0.986	0.918	0.599
05102	00	Iowa	0.965	0.870	0.434
05202	00	Kansas	0.969	0.882	0.557
00660	00	Kentucky	0.969	0.860	0.652
00528	01	New Orleans, LA	0.986	1.044	0.956
00528	99	Rest of Louisiana	0.970	0.878	0.892
31142	03	Southern Maine	0.980	1.025	0.492
31142	99	Rest of Maine	0.962	0.893	0.492
12302	01	Baltimore/Surr. Cntys, MD	1.012	1.057	1.086
12302	99	Rest of Maryland	0.994	0.982	0.874
31143	01	Metropolitan Boston	1.029	1.291	0.764
31143	99	Rest of Massachusetts	1.007	1.106	0.764
00953	01	Detroit, MI	1.036	1.040	1.906
00953	99	Rest of Michigan	0.998	0.923	1.083
00954	00	Minnesota	0.992	0.983	0.245
00512	00	Mississippi	0.959	0.854	0.808
05302	02	Metropolitan Kansas City, MO	0.990	0.945	1.188
05392	01	Metropolitan St Louis, MO	0.993	0.931	1.075
05392	99	Rest of Missouri*	0.949	0.821	0.997
05302	99	Rest of Missouri*	0.949	0.821	0.997
03202	01	Montana	0.950	0.847	0.673
05402	00	Nebraska	0.959	0.890	0.245
01302	00	Nevada	1.002	1.026	1.083
31144	40	New Hampshire	0.982	1.039	0.462
12402	01	Northern NJ	1.057	1.228	1.116
12402	99	Rest of New Jersey	1.042	1.126	1.116
04202	05	New Mexico	0.973	0.890	1.096
13202	01	Manhattan, NY	1.064	1.298	1.010
13202	02	NYC Suburbs/Long I., NY	1.051	1.289	1.235
13202	03	Poughkpsie/N NYC Suburbs, NY	1.014	1.077	0.822
13292	04	Queens, NY	1.032	1.239	1.220
13282	99	Rest of New York	0.997	0.921	0.425
05535	00	North Carolina	0.972	0.925	0.634
03302	01	North Dakota	0.947	0.844	0.387
00883	00	Ohio	0.993	0.927	1.232
04302	00	Oklahoma	0.964	0.850	0.627
00835	01	Portland, OR	1.002	1.015	0.472
00835	99	Rest of Oregon	0.968	0.927	0.472
12502	01	Metropolitan Philadelphia, PA	1.016	1.097	1.617
12502	99	Rest of Pennsylvania	0.993	0.925	1.081
00973	20	Puerto Rico	0.904	0.694	0.250
00524	01	Rhode Island	1.013	1.088	0.996
00880	01	South Carolina	0.975	0.906	0.446
03402	02	South Dakota	0.942	0.864	0.420
05440	35	Tennessee	0.978	0.889	0.608
04402	31	Austin, TX	0.992	0.984	0.969
04402	20	Beaumont, TX	0.984	0.875	1.346
04402	09	Brazoria, TX	1.019	0.922	1.223
04402	11	Dallas, TX	1.009	1.001	1.110
04402	28	Fort Worth, TX	0.998	0.953	1.110
04402	15	Galveston, TX	0.991	0.959	1.223
04402	18	Houston, TX	1.016	0.986	1.345
04402	99	Rest of Texas	0.968	0.879	1.065
03502	09	Utah	0.977	0.907	1.026
31145	50	Vermont	0.968	0.983	0.489
00904	00	Virginia	0.982	0.942	0.657
00973	50	Virgin Islands	0.997	0.978	1.009

Contractor	Locality	Locality Name	Work** GPCI	PE GPCI	MP GPCI
00836	02	Seattle (King Cnty), WA	1.014	1.085	0.706
00836	99	Rest of Washington	0.987	0.974	0.693
00884	16	West Virginia	0.973	0.827	1.353
00951	00	Wisconsin	0.988	0.921	0.409
03602	21	Wyoming	0.956	0.842	0.889

* Indicates multiple contractors.
** CY 2010 work GPCI does not reflect the 1.000 floor established by the MIPPA which expires 01/01/2010.
*** CY 2010 work GPCI reflects 1.500 floor in Alaska established by the MIPPA.

ADDENDUM F: CY 2010 ESRD Wage Index for Urban Areas Based on CBSA Labor Market Areas

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10180	Abilene, TX Callahan County, TX Jones County, TX Taylor County, TX	0.8413
10380	Aguadilla-Isabela-San Sebastián, PR Aguada Municipio, PR Aguadilla Municipio, PR Añasco Municipio, PR Isabela Municipio, PR Lares Municipio, PR Moca Municipio, PR Rincón Municipio, PR San Sebastián Municipio, PR	0.6876
10420	Akron, OH Portage County, OH Summit County, OH	0.9371
10500	Albany, GA Baker County, GA Dougherty County, GA Lee County, GA Terrell County, GA Worth County, GA	0.9423
10580	Albany-Schenectady-Troy, NY Albany County, NY Rensselaer County, NY Saratoga County, NY Schenectady County, NY Schoharie County, NY	0.9299
10740	Albuquerque, NM Bernalillo County, NM Sandoval County, NM Torrance County, NM Valencia County, NM	0.9953
10780	Alexandria, LA Grant Parish, LA Rapides Parish, LA	0.8484

CBSA Code	Urban Area (Constituent Counties)	Wage Index
10900	Allentown-Bethlehem-Easton, PA-NJ	1.0199
	Warren County, NJ	
	Carbon County, PA	
	Lehigh County, PA	
	Northampton County, PA	
11020	Altoona, PA	0.9385
	Blair County, PA	
11100	Amarillo, TX	0.9200
	Armstrong County, TX	
	Carson County, TX	
	Potter County, TX	
	Randall County, TX	
11180	Ames, IA	1.0055
	Story County, IA	
11260	Anchorage, AK	1.2720
	Anchorage Municipality, AK	
	Matanuska-Susitna Borough, AK	
11300	Anderson, IN	0.9584
	Madison County, IN	
11340	Anderson, SC	0.9330
	Anderson County, SC	
11460	Ann Arbor, MI	1.0898
	Washtenaw County, MI	
11500	Anniston-Oxford, AL	0.8093
	Calhoun County, AL	
11540	Appleton, WI	0.9836
	Calumet County, WI	
	Outagamie County, WI	
11700	Asheville, NC	0.9605
	Buncombe County, NC	
	Haywood County, NC	
	Henderson County, NC	
	Madison County, NC	
12020	Athens-Clarke County, GA	1.0051
	Clarke County, GA	
	Madison County, GA	
	Oconee County, GA	
	Oglethorpe County, GA	
12060	Atlanta-Sandy Springs-Marietta, GA	1.0307
	Barrow County, GA	
	Bartow County, GA	
	Butts County, GA	
	Carroll County, GA	
	Cherokee County, GA	
	Clayton County, GA	
	Cobb County, GA	
	Coweta County, GA	
	Dawson County, GA	
	DeKalb County, GA	
	Douglas County, GA	
	Fayette County, GA	
	Forsyth County, GA	
	Fulton County, GA	
	Gwinnett County, GA	
	Haralson County, GA	
	Heard County, GA	
	Henry County, GA	
	Jasper County, GA	
	Lamar County, GA	
	Meriwether County, GA	
	Newton County, GA	
	Paulding County, GA	
	Pickens County, GA	
	Pike County, GA	
	Rockdale County, GA	
	Spalding County, GA	
	Walton County, GA	
12100	Atlantic City-Hammonton, NJ	1.2234
	Atlantic County, NJ	
12220	Auburn-Opelika, AL	0.8618
	Lee County, AL	
12260	Augusta-Richmond County, GA-SC	0.9653
	Burke County, GA	
	Columbia County, GA	
	McDuffie County, GA	
	Richmond County, GA	
	Aiken County, SC	
	Edgefield County, SC	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
12420	Austin-Round Rock, TX Bastrop County, TX Caldwell County, TX Hays County, TX Travis County, TX Williamson County, TX	1.0087
12540	Bakersfield, CA Kern County, CA	1.1864
12580	Baltimore-Towson, MD Anne Arundel County, MD Baltimore County, MD Carroll County, MD Harford County, MD Howard County, MD Queen Anne's County, MD Baltimore City, MD	1.0815
12620	Bangor, ME Penobscot County, ME	1.0751
12700	Barnstable Town, MA Barnstable County, MA	1.3360
12940	Baton Rouge, LA Ascension Parish, LA East Baton Rouge Parish, LA East Feliciana Parish, LA Iberville Parish, LA Livingston Parish, LA Pointe Coupee Parish, LA St. Helena Parish, LA West Baton Rouge Parish, LA West Feliciana Parish, LA	0.8661
12980	Battle Creek, MI Calhoun County, MI	1.0588
13020	Bay City, MI Bay County, MI	0.9813
13140	Beaumont-Port Arthur, TX Hardin County, TX Jefferson County, TX Orange County, TX	0.8877
13380	Bellingham, WA Whatcom County, WA	1.0266
13460	Bend, OR Deschutes County, OR	1.2120
13644	Bethesda-Frederick-Gaithersburg, MD Frederick County, MD Montgomery County, MD	1.0904
13740	Billings, MT Carbon County, MT Yellowstone County, MT	0.9299
13780	Binghamton, NY Broome County, NY Tioga County, NY	0.9294
13820	Birmingham-Hoover, AL Bibb County, AL Blount County, AL Chilton County, AL Jefferson County, AL St. Clair County, AL Shelby County, AL Walker County, AL	0.9024
13900	Bismarck, ND Burleigh County, ND Morton County, ND	0.8086
13980	Blacksburg-Christiansburg-Radford, VA Giles County, VA Montgomery County, VA Pulaski County, VA Radford City, VA	0.8866
14020	Bloomington, IN Greene County, IN Monroe County, IN Owen County, IN	0.9554
14060	Bloomington-Normal, IL McLean County, IL	0.9930
14260	Boise City-Nampa, ID Ada County, ID Boise County, ID Canyon County, ID Gem County, ID Owyhee County, ID	0.9835
14484	Boston-Quincy, MA Norfolk County, MA Plymouth County, MA Suffolk County, MA	1.2864

CBSA Code	Urban Area (Constituent Counties)	Wage Index
14500	Boulder, CO Boulder County, CO	1.0871
14540	Bowling Green, KY Edmonson County, KY Warren County, KY	0.8965
14600	Bradenton-Sarasota-Venice, FL Manatee County, FL Sarasota County, FL	1.0305
14740	Bremerton-Silverdale, WA Kitsap County, WA	1.1388
14860	Bridgeport-Stamford-Norwalk, CT Fairfield County, CT	1.3539
15180	Brownsville-Harlingen, TX Cameron County, TX	0.9552
15260	Brunswick, GA Brantley County, GA Glynn County, GA McIntosh County, GA	0.9913
15380	Buffalo-Niagara Falls, NY Erie County, NY Niagara County, NY	1.0303
15500	Burlington, NC Alamance County, NC	0.9264
15540	Burlington-South Burlington, VT Chittenden County, VT Franklin County, VT Grand Isle County, VT	1.0702
15764	Cambridge-Newton-Framingham, MA Middlesex County, MA	1.1941
15804	Camden, NJ Burlington County, NJ Camden County, NJ Gloucester County, NJ	1.0733
15940	Canton-Massillon, OH Carroll County, OH Stark County, OH	0.9313
15980	Cape Coral-Fort Myers, FL Lee County, FL	0.9610
16180	Carson City, NV Carson City, NV	1.1150
16020	Cape Girardeau-Jackson, MO-IL Alexander County, IL Bollinger County, MO Cape Girardeau County, MO	0.9579
16220	Casper, WY Natrona County, WY	1.0081
16300	Cedar Rapids, IA Benton County, IA Jones County, IA Linn County, IA	0.9513
16580	Champaign-Urbana, IL Champaign County, IL Ford County, IL Piatt County, IL	1.0703
16620	Charleston, WV Boone County, WV Clay County, WV Kanawha County, WV Lincoln County, WV Putnam County, WV	0.8621
16700	Charleston-North Charleston-Summerville, SC Berkeley County, SC Charleston County, SC Dorchester County, SC	0.9794
16740	Charlotte-Gastonia-Concord, NC-SC Anson County, NC Cabarrus County, NC Gaston County, NC Mecklenburg County, NC Union County, NC York County, SC	1.0032
16820	Charlottesville, VA Albemarle County, VA Fluvanna County, VA Greene County, VA Nelson County, VA Charlottesville City, VA	0.9923

CBSA Code	Urban Area (Constituent Counties)	Wage Index
16860	Chattanooga, TN-GA Catoosa County, GA Dade County, GA Walker County, GA Hamilton County, TN Marion County, TN Sequatchie County, TN	0.9351
16940	Cheyenne, WY Laramie County, WY	0.9894
16974	Chicago-Naperville-Joliet, IL Cook County, IL DeKalb County, IL DuPage County, IL Grundy County, IL Kane County, IL Kendall County, IL McHenry County, IL Will County, IL	1.1085
17020	Chico, CA Butte County, CA	1.1858
17140	Cincinnati-Middletown, OH-KY-IN Dearborn County, IN Franklin County, IN Ohio County, IN Boone County, KY Bracken County, KY Campbell County, KY Gallatin County, KY Grant County, KY Kenton County, KY Pendleton County, KY Brown County, OH Butler County, OH Clermont County, OH Hamilton County, OH Warren County, OH	1.0037
17300	Clarksville, TN-KY Christian County, KY Trigg County, KY Montgomery County, TN Stewart County, TN	0.8449
17420	Cleveland, TN Bradley County, TN Polk County, TN	0.8009
17460	Cleveland-Elyria-Mentor, OH Cuyahoga County, OH Geauga County, OH Lake County, OH Lorain County, OH Medina County, OH	0.9438
17660	Coeur d'Alene, ID Kootenai County, ID	0.9778
17780	College Station-Bryan, TX Brazos County, TX Burleson County, TX Robertson County, TX	1.0057
17820	Colorado Springs, CO El Paso County, CO Teller County, CO	1.0399
17860	Columbia, MO Boone County, MO Howard County, MO	0.9124
17900	Columbia, SC Calhoun County, SC Fairfield County, SC Kershaw County, SC Lexington County, SC Richland County, SC Saluda County, SC	0.9264
17980	Columbus, GA-AL Russell County, AL Chattahoochee County, GA Harris County, GA Marion County, GA Muscogee County, GA	0.9237
18020	Columbus, IN Bartholomew County, IN	1.0096

CBSA Code	Urban Area (Constituent Counties)	Wage Index
18140	Columbus, OH	1.0676
	Delaware County, OH	
	Fairfield County, OH	
	Franklin County, OH	
	Licking County, OH	
	Madison County, OH	
	Morrow County, OH	
	Pickaway County, OH	
	Union County, OH	
18580	Corpus Christi, TX	0.9205
	Aransas County, TX	
	Nueces County, TX	
	San Patricio County, TX	
18700	Corvallis, OR	1.1651
	Benton County, OR	
19060	Cumberland, MD-WV	0.8519
	Allegany County, MD	
	Mineral County, WV	
19124	Dallas-Plano-Irving, TX	1.0482
	Collin County, TX	
	Dallas County, TX	
	Delta County, TX	
	Denton County, TX	
	Ellis County, TX	
	Hunt County, TX	
	Kaufman County, TX	
	Rockwall County, TX	
19140	Dalton, GA	0.9176
	Murray County, GA	
	Whitfield County, GA	
19180	Danville, IL	0.9252
	Vermilion County, IL	
19260	Danville, VA	0.8813
	Pittsylvania County, VA	
	Danville City, VA	
19340	Davenport-Moline-Rock Island, IA-IL	0.8771
	Henry County, IL	
	Mercer County, IL	
	Rock Island County, IL	
	Scott County, IA	
19380	Dayton, OH	0.9754
	Greene County, OH	
	Miami County, OH	
	Montgomery County, OH	
	Preble County, OH	
19460	Decatur, AL	0.8258
	Lawrence County, AL	
	Morgan County, AL	
19500	Decatur, IL	0.8465
	Macon County, IL	
19660	Deltona-Daytona Beach-Ormond Beach, FL	0.9388
	Volusia County, FL	
19740	Denver-Aurora-Broomfield, CO	1.1354
	Adams County, CO	
	Arapahoe County, CO	
	Broomfield County, CO	
	Clear Creek County, CO	
	Denver County, CO	
	Douglas County, CO	
	Elbert County, CO	
	Gilpin County, CO	
	Jefferson County, CO	
	Park County, CO	
19780	Des Moines-West Des Moines, IA	1.0217
	Dallas County, IA	
	Guthrie County, IA	
	Madison County, IA	
	Polk County, IA	
	Warren County, IA	
19804	Detroit-Livonia-Dearborn, MI	1.0301
	Wayne County, MI	
20020	Dothan, AL	0.7842
	Geneva County, AL	
	Henry County, AL	
	Houston County, AL	
20100	Dover, DE	1.0515
	Kent County, DE	
20220	Dubuque, IA	0.9391
	Dubuque County, IA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
20260	Duluth, MN-WI Carlton County, MN St. Louis County, MN Douglas County, WI	1.1063
20500	Durham-Chapel Hill, NC Chatham County, NC Durham County, NC Orange County, NC Person County, NC	1.0101
20740	Eau Claire, WI Chippewa County, WI Eau Claire County, WI	1.0129
20764	Edison-New Brunswick, NJ Middlesex County, NJ Monmouth County, NJ Ocean County, NJ Somerset County, NJ	1.1713
20940	El Centro, CA Imperial County, CA	0.9282
21060	Elizabethtown, KY Hardin County, KY Larue County, KY	0.8882
21140	Elkhart-Goshen, IN Elkhart County, IN	1.0047
21300	Elmira, NY Chemung County, NY	0.8831
21340	El Paso, TX El Paso County, TX	0.9044
21500	Erie, PA Erie County, PA	0.8954
21660	Eugene-Springfield, OR Lane County, OR	1.1684
21780	Evansville, IN-KY Gibson County, IN Posey County, IN Vanderburgh County, IN Warrick County, IN Henderson County, KY Webster County, KY	0.9024
21820	Fairbanks, AK Fairbanks North Star Borough, AK	1.1768
21940	Fajardo, PR Ceiba Municipio, PR Fajardo Municipio, PR Luquillo Municipio, PR	0.6876
22020	Fargo, ND-MN Cass County, ND Clay County, MN	0.8654
22140	Farmington, NM San Juan County, NM	0.8353
22180	Fayetteville, NC Cumberland County, NC Hoke County, NC	0.9908
22220	Fayetteville-Springdale-Rogers, AR-MO Benton County, AR Madison County, AR Washington County, AR McDonald County, MO	0.9280
22380	Flagstaff, AZ Coconino County, AZ	1.3209
22420	Flint, MI Genesee County, MI	1.1779
22500	Florence, SC Darlington County, SC Florence County, SC	0.8612
22520	Florence-Muscle Shoals, AL Colbert County, AL Lauderdale County, AL	0.8443
22540	Fond du Lac, WI Fond du Lac County, WI	1.0229
22660	Fort Collins-Loveland, CO Larimer County, CO	1.0774
22744	Fort Lauderdale-Pompano Beach-Deerfield Beach, FL Broward County, FL	1.0995
22900	Fort Smith, AR-OK Crawford County, AR Franklin County, AR Sebastian County, AR Le Flore County, OK Sequoyah County, OK	0.8323
23020	Fort Walton Beach-Crestview-Destin, FL Okaloosa County, FL	0.9273

CBSA Code	Urban Area (Constituent Counties)	Wage Index
23060	Fort Wayne, IN Allen County, IN Wells County, IN Whitley County, IN	0.9542
23104	Fort Worth-Arlington, TX Johnson County, TX Parker County, TX Tarrant County, TX Wise County, TX	1.0058
23420	Fresno, CA Fresno County, CA	1.1903
23460	Gadsden, AL Etowah County, AL	0.8753
23540	Gainesville, FL Alachua County, FL Gilchrist County, FL	0.9507
23580	Gainesville, GA Hall County, GA	0.9660
23844	Gary, IN Jasper County, IN Lake County, IN Newton County, IN Porter County, IN	0.9848
24020	Glens Falls, NY Warren County, NY Washington County, NY	0.8954
24140	Goldsboro, NC Wayne County, NC	0.9589
24220	Grand Forks, ND-MN Polk County, MN Grand Forks County, ND	0.8232
24300	Grand Junction, CO Mesa County, CO	1.0293
24340	Grand Rapids-Wyoming, MI Barry County, MI Ionia County, MI Kent County, MI Newaygo County, MI	0.9719
24500	Great Falls, MT Cascade County, MT	0.8845
24540	Greeley, CO Weld County, CO	1.0142
24580	Green Bay, WI Brown County, WI Kewaunee County, WI Oconto County, WI	1.0187
24660	Greensboro-High Point, NC Guilford County, NC Randolph County, NC Rockingham County, NC	0.9596
24780	Greenville, NC Greene County, NC Pitt County, NC	0.9955
24860	Greenville-Mauldin-Easley, SC Greenville County, SC Laurens County, SC Pickens County, SC	1.0515
25020	Guayama, PR Arroyo Municipio, PR Guayama Municipio, PR Patillas Municipio, PR	0.6876
25060	Gulfport-Biloxi, MS Hancock County, MS Harrison County, MS Stone County, MS	0.9300
25180	Hagerstown-Martinsburg, MD-WV Washington County, MD Berkeley County, WV Morgan County, WV	0.9492
25260	Hanford-Corcoran, CA Kings County, CA	1.1658
25420	Harrisburg-Carlisle, PA Cumberland County, PA Dauphin County, PA Perry County, PA	0.9832
25500	Harrisonburg, VA Rockingham County, VA Harrisonburg City, VA	0.9556
25540	Hartford-West Hartford-East Hartford, CT Hartford County, CT Middlesex County, CT Tolland County, CT	1.1838

CBSA Code	Urban Area (Constituent Counties)	Wage Index
25620	Hattiesburg, MS Forrest County, MS Lamar County, MS Perry County, MS	0.8113
25860	Hickory-Lenoir-Morganton, NC Alexander County, NC Burke County, NC Caldwell County, NC Catawba County, NC	0.9526
25980	Hinesville-Fort Stewart, GA Liberty County, GA Long County, GA	0.9552
26100	Holland-Grand Haven, MI Ottawa County, MI	0.9208
26180	Honolulu, HI Honolulu County, HI	1.2339
26300	Hot Springs, AR Garland County, AR	0.9535
26380	Houma-Bayou Cane-Thibodaux, LA Lafourche Parish, LA Terrebonne Parish, LA	0.8338
26420	Houston-Sugar Land-Baytown, TX Austin County, TX Brazoria County, TX Chambers County, TX Fort Bend County, TX Galveston County, TX Harris County, TX Liberty County, TX Montgomery County, TX San Jacinto County, TX Waller County, TX	1.0412
26580	Huntington-Ashland, WV-KY-OH Boyd County, KY Greenup County, KY Lawrence County, OH Cabell County, WV Wayne County, WV	0.9632
26620	Huntsville, AL Limestone County, AL Madison County, AL	0.9598
26820	Idaho Falls, ID Bonneville County, ID Jefferson County, ID	0.9992
26900	Indianapolis-Carmel, IN Boone County, IN Brown County, IN Hamilton County, IN Hancock County, IN Hendricks County, IN Johnson County, IN Marion County, IN Morgan County, IN Putnam County, IN Shelby County, IN	1.0505
26980	Iowa City, IA Johnson County, IA Washington County, IA	1.0110
27060	Ithaca, NY Tompkins County, NY	1.0707
27100	Jackson, MI Jackson County, MI	0.9233
27140	Jackson, MS Copiah County, MS Hinds County, MS Madison County, MS Rankin County, MS Simpson County, MS	0.8667
27180	Jackson, TN Chester County, TN Madison County, TN	0.9086
27260	Jacksonville, FL Baker County, FL Clay County, FL Duval County, FL Nassau County, FL St. Johns County, FL	0.9642
27340	Jacksonville, NC Onslow County, NC	0.8498
27500	Janesville, WI Rock County, WI	0.9742

CBSA Code	Urban Area (Constituent Counties)	Wage Index
27620	Jefferson City, MO	0.9222
	Callaway County, MO	
	Cole County, MO	
	Moniteau County, MO	
	Osage County, MO	
27740	Johnson City, TN	0.7914
	Carter County, TN	
	Unicoi County, TN	
	Washington County, TN	
27780	Johnstown, PA	0.8718
	Cambria County, PA	
27860	Jonesboro, AR	0.8176
	Craighead County, AR	
	Poinsett County, AR	
27900	Joplin, MO	0.8772
	Jasper County, MO	
	Newton County, MO	
28020	Kalamazoo-Portage, MI	1.0868
	Kalamazoo County, MI	
	Van Buren County, MI	
28100	Kankakee-Bradley, IL	1.0772
	Kankakee County, IL	
28140	Kansas City, MO-KS	1.0263
	Franklin County, KS	
	Johnson County, KS	
	Leavenworth County, KS	
	Linn County, KS	
	Miami County, KS	
	Wyandotte County, KS	
	Bates County, MO	
	Caldwell County, MO	
	Cass County, MO	
	Clay County, MO	
	Clinton County, MO	
	Jackson County, MO	
	Lafayette County, MO	
	Platte County, MO	
	Ray County, MO	
28420	Kennewick-Pasco-Richland, WA	1.1063
	Benton County, WA	
	Franklin County, WA	
28660	Killeen-Temple-Fort Hood, TX	0.9214
	Bell County, TX	
	Coryell County, TX	
	Lampasas County, TX	
28700	Kingsport-Bristol-Bristol, TN-VA	0.8436
	Hawkins County, TN	
	Sullivan County, TN	
	Bristol City, VA	
	Scott County, VA	
	Washington County, VA	
28740	Kingston, NY	0.9918
	Ulster County, NY	
28940	Knoxville, TN	0.8345
	Anderson County, TN	
	Blount County, TN	
	Knox County, TN	
	Loudon County, TN	
	Union County, TN	
29020	Kokomo, IN	1.0394
	Howard County, IN	
	Tipton County, IN	
29100	La Crosse, WI-MN	1.0498
	Houston County, MN	
	La Crosse County, WI	
29140	Lafayette, IN	0.9721
	Benton County, IN	
	Carroll County, IN	
	Tippecanoe County, IN	
29180	Lafayette, LA	0.9017
	Lafayette Parish, LA	
	St. Martin Parish, LA	
29340	Lake Charles, LA	0.8456
	Calcasieu Parish, LA	
	Cameron Parish, LA	
29404	Lake County-Kenosha County, IL-WI	1.1092
	Lake County, IL	
	Kenosha County, WI	
29420	Lake Havasu City-Kingman, AZ	1.1189
	Mohave County, AZ	
29460	Lakeland-Winter Haven, FL	0.8884
	Polk County, FL	

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29540	Lancaster, PA Lancaster County, PA	0.9745
29620	Lansing-East Lansing, MI Clinton County, MI Eaton County, MI Ingham County, MI	1.0218
29700	Laredo, TX Webb County, TX	0.8550
29740	Las Cruces, NM Dona Ana County, NM	0.9465
29820	Las Vegas-Paradise, NV Clark County, NV	1.2835
29940	Lawrence, KS Douglas County, KS	0.9085
30020	Lawton, OK Comanche County, OK	0.8309
30140	Lebanon, PA Lebanon County, PA	0.8597
30300	Lewiston, ID-WA Nez Perce County, ID Asotin County, WA	1.0134
30340	Lewiston-Auburn, ME Androscoggin County, ME	0.9619
30460	Lexington-Fayette, KY Bourbon County, KY Clark County, KY Fayette County, KY Jessamine County, KY Scott County, KY Woodford County, KY	0.9412
30620	Lima, OH Allen County, OH	0.9913
30700	Lincoln, NE Lancaster County, NE Seward County, NE	1.0126
30780	Little Rock-North Little Rock-Conway, AR Faulkner County, AR Grant County, AR Lonoke County, AR Perry County, AR Pulaski County, AR Saline County, AR	0.9045
30860	Logan, UT-ID Franklin County, ID Cache County, UT	0.9522
30980	Longview, TX Gregg County, TX Rusk County, TX Upshur County, TX	0.8522
31020	Longview, WA Cowlitz County, WA	1.1336
31084	Los Angeles-Long Beach-Santa Ana, CA Los Angeles County, CA	1.2721
31140	Louisville-Jefferson County, KY-IN Clark County, IN Floyd County, IN Harrison County, IN Washington County, IN Bullitt County, KY Henry County, KY Meade County, KY Nelson County, KY Oldham County, KY Shelby County, KY Spencer County, KY Trimble County, KY	0.9491
31180	Lubbock, TX Crosby County, TX Lubbock County, TX	0.9266
31340	Lynchburg, VA Amherst County, VA Appomattox County, VA Bedford County, VA Campbell County, VA Bedford City, VA Lynchburg City, VA	0.9023
31420	Macon, GA Bibb County, GA Crawford County, GA Jones County, GA Monroe County, GA Twiggs County, GA	1.0404
31460	Madera-Chowchilla, CA Madera County, CA	0.8426

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31540	Madison, WI Columbia County, WI Dane County, WI Iowa County, WI	1.1896
31700	Manchester-Nashua, NH Hillsborough County, NH	1.0769
31740	Manhattan, KS Geary County, KS Pottawatomie County, KS Riley County, KS	0.9579
31860	Mankato-North Mankato, MN Blue Earth County, MN Nicollet County, MN	0.9717
31900	Mansfield, OH Richland County, OH	0.9635
32420	Mayagüez, PR Hormigueros Municipio, PR Mayagüez Municipio, PR	0.6876
32580	McAllen-Edinburg-Mission, TX Hidalgo County, TX	0.9339
32780	Medford, OR Jackson County, OR	1.0677
32820	Memphis, TN-MS-AR Crittenden County, AR DeSoto County, MS Marshall County, MS Tate County, MS Tunica County, MS Fayette County, TN Shelby County, TN Tipton County, TN	0.9814
32900	Merced, CA Merced County, CA	1.1057
33124	Miami-Miami Beach-Kendall, FL Miami-Dade County, FL	1.0541
33140	Michigan City-La Porte, IN LaPorte County, IN	0.9860
33260	Midland, TX Midland County, TX	1.0108
33340	Milwaukee-Waukesha-West Allis, WI Milwaukee County, WI Ozaukee County, WI Washington County, WI Waukesha County, WI	1.0748
33460	Minneapolis-St. Paul-Bloomington, MN-WI Anoka County, MN Carver County, MN Chisago County, MN Dakota County, MN Hennepin County, MN Isanti County, MN Ramsey County, MN Scott County, MN Sherburne County, MN Washington County, MN Wright County, MN Pierce County, WI St. Croix County, WI	1.1751
33540	Missoula, MT Missoula County, MT	0.9748
33660	Mobile, AL Mobile County, AL	0.8243
33700	Modesto, CA Stanislaus County, CA	1.3238
33740	Monroe, LA Ouachita Parish, LA Union Parish, LA	0.8208
33780	Monroe, MI Monroe County, MI	0.9408
33860	Montgomery, AL Autauga County, AL Elmore County, AL Lowndes County, AL Montgomery County, AL	0.8793
34060	Morgantown, WV Monongalia County, WV Preston County, WV	0.8957
34100	Morristown, TN Grainger County, TN Hamblen County, TN Jefferson County, TN	0.7625

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34580	Mount Vernon-Anacortes, WA Skagit County, WA	1.1068
34620	Muncie, IN Delaware County, IN	0.8724
34740	Muskegon-Norton Shores, MI Muskegon County, MI	1.0401
34820	Myrtle Beach-North Myrtle Beach-Conway, SC Horry County, SC	0.9242
34900	Napa, CA Napa County, CA	1.5285
34940	Naples-Marco Island, FL Collier County, FL	1.0231
34980	Nashville-Davidson–Murfreesboro--Franklin, TN Cannon County, TN Cheatham County, TN Davidson County, TN Dickson County, TN Hickman County, TN Macon County, TN Robertson County, TN Rutherford County, TN Smith County, TN Sumner County, TN Trousdale County, TN Williamson County, TN Wilson County, TN	1.0262
35004	Nassau-Suffolk, NY Nassau County, NY Suffolk County, NY	1.3193
35084	Newark-Union, NJ-PA Essex County, NJ Hunterdon County, NJ Morris County, NJ Sussex County, NJ Union County, NJ Pike County, PA	1.2081
35300	New Haven-Milford, CT New Haven County, CT	1.2161
35380	New Orleans-Metairie-Kenner, LA Jefferson Parish, LA Orleans Parish, LA Plaquemines Parish, LA St. Bernard Parish, LA St. Charles Parish, LA St. John the Baptist Parish, LA St. Tammany Parish, LA	0.9627
35644	New York-White Plains-Wayne, NY-NJ Bergen County, NJ Hudson County, NJ Passaic County, NJ Bronx County, NY Kings County, NY New York County, NY Putnam County, NY Queens County, NY Richmond County, NY Rockland County, NY Westchester County, NY	1.3734
35660	Niles-Benton Harbor, MI Berrien County, MI	0.9427
35980	Norwich-New London, CT New London County, CT	1.2069
36084	Oakland-Fremont-Hayward, CA Alameda County, CA Contra Costa County, CA	1.7276
36100	Ocala, FL Marion County, FL	0.9060
36140	Ocean City, NJ Cape May County, NJ	1.0758
36220	Odessa, TX Ector County, TX	1.0442
36260	Ogden-Clearfield, UT Davis County, UT Morgan County, UT Weber County, UT	0.9911

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36420	Oklahoma City, OK Canadian County, OK County, OK Grady County, OK Lincoln County, OK Logan County, OK McClain County, OK Oklahoma County, OK	0.9425
36500	Olympia, WA Thurston County, WA	1.2209
36540	Omaha-Council Bluffs, NE-IA Harrison County, IA Mills County, IA Pottawattamie County, IA Cass County, NE Douglas County, NE Sarpy County, NE Saunders County, NE Washington County, NE	1.0174
36740	Orlando-Kissimmee, FL Lake County, FL Orange County, FL Osceola County, FL Seminole County, FL	0.9483
36780	Oshkosh-Neenah, WI Winnebago County, WI	0.9690
36980	Owensboro, KY Daviess County, KY Hancock County, KY McLean County, KY	0.8849
37100	Oxnard-Thousand Oaks-Ventura, CA Ventura County, CA	1.3011
37340	Palm Bay-Melbourne-Titusville, FL Brevard County, FL	0.9594
37380	Palm Coast, FL Flagler County, FL	1.0168
37460	Panama City-Lynn Haven-Panama City, FL Bay County, FL	0.8814
37620	Parkersburg-Marietta-Vienna, WV-OH Washington County, OH Pleasants County, WV Wirt County, WV Wood County, WV	0.8170
37700	Pascagoula, MS George County, MS Jackson County, MS	0.8930
37764	Peabody, MA Essex County, MA	1.1511
37860	Pensacola-Ferry Pass-Brent, FL Escambia County, FL Santa Rosa County, FL	0.8792
37900	Peoria, IL Marshall County, IL Peoria County, IL Stark County, IL Tazewell County, IL Woodford County, IL	0.9650
37964	Philadelphia, PA Bucks County, PA Chester County, PA Delaware County, PA Montgomery County, PA Philadelphia County, PA	1.1356
38060	Phoenix-Mesa-Scottsdale, AZ Maricopa County, AZ Pinal County, AZ	1.1256
38220	Pine Bluff, AR Cleveland County, AR Jefferson County, AR Lincoln County, AR	0.7710
38300	Pittsburgh, PA Allegheny County, PA Armstrong County, PA Beaver County, PA Butler County, PA Fayette County, PA Washington County, PA Westmoreland County, PA	0.9102
38340	Pittsfield, MA Berkshire County, MA	1.1286

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38540	Pocatello, ID Bannock County, ID Power County, ID	0.9782
38660	Ponce, PR Juana Díaz Municipio, PR Ponce Municipio, PR Villalba Municipio, PR	0.6876
38860	Portland-South Portland-Biddeford, ME Cumberland County, ME Sagadahoc County, ME York County, ME	1.0786
38900	Portland-Vancouver-Beaverton, OR-WA Clackamas County, OR Columbia County, OR Multnomah County, OR Washington County, OR Yamhill County, OR Clark County, WA Skamania County, WA	1.2168
38940	Port St. Lucie, FL Martin County, FL St. Lucie County, FL	1.0479
39100	Poughkeepsie-Newburgh-Middletown, NY Dutchess County, NY Orange County, NY	1.1889
39140	Prescott, AZ Yavapai County, AZ	1.0716
39300	Providence-New Bedford-Fall River, RI-MA Bristol County, MA Bristol County, RI Kent County, RI Newport County, RI Providence County, RI Washington County, RI	1.1417
39340	Provo-Orem, UT Juab County, UT Utah County, UT	1.0109
39380	Pueblo, CO Pueblo County, CO	0.9075
39460	Punta Gorda, FL Charlotte County, FL	0.9290
39540	Racine, WI Racine County, WI	0.9924
39580	Raleigh-Cary, NC Franklin County, NC Johnston County, NC Wake County, NC	1.0215
39660	Rapid City, SD Meade County, SD Pennington County, SD	1.0637
39740	Reading, PA Berks County, PA	0.9808
39820	Redding, CA Shasta County, CA	1.4839
39900	Reno-Sparks, NV Storey County, NV Washoe County, NV	1.0891
40060	Richmond, VA Amelia County, VA Caroline County, VA Charles City County, VA Chesterfield County, VA Cumberland County, VA Dinwiddie County, VA Goochland County, VA Hanover County, VA Henrico County, VA King and Queen County, VA King William County, VA Louisa County, VA New Kent County, VA Powhatan County, VA Prince George County, VA Sussex County, VA Colonial Heights City, VA Hopewell City, VA Petersburg City, VA Richmond City, VA	1.0082
40140	Riverside-San Bernardino-Ontario, CA Riverside County, CA San Bernardino County, CA	1.1884

CBSA Code	Urban Area (Constituent Counties)	Wage Index
40220	Roanoke, VA Botetourt County, VA Craig County, VA Franklin County, VA Roanoke County, VA Roanoke City, VA Salem City, VA	0.9142
40340	Rochester, MN Dodge County, MN Olmsted County, MN Wabasha County, MN	1.1791
40380	Rochester, NY Livingston County, NY Monroe County, NY Ontario County, NY Orleans County, NY Wayne County, NY	0.9153
40420	Rockford, IL Boone County, IL Winnebago County, IL	1.0750
40484	Rockingham County, NH Rockingham County, NH Strafford County, NH	1.0721
40580	Rocky Mount, NC Edgecombe County, NC Nash County, NC	0.9365
40660	Rome, GA Floyd County, GA	0.9440
40900	Sacramento--Arden-Arcade--Roseville, CA El Dorado County, CA Placer County, CA Sacramento County, CA Yolo County, CA	1.4843
40980	Saginaw-Saginaw Township North, MI Saginaw County, MI	0.9655
41060	St. Cloud, MN Benton County, MN Stearns County, MN	1.1761
41100	St. George, UT Washington County, UT	0.9780
41140	St. Joseph, MO-KS Doniphan County, KS Andrew County, MO Buchanan County, MO DeKalb County, MO	1.0788
41180	St. Louis, MO-IL Bond County, IL Calhoun County, IL Clinton County, IL Jersey County, IL Macoupin County, IL Madison County, IL Monroe County, IL St. Clair County, IL Crawford County, MO Franklin County, MO Jefferson County, MO Lincoln County, MO St. Charles County, MO St. Louis County, MO Warren County, MO Washington County, MO St. Louis City, MO	0.9637
41420	Salem, OR Marion County, OR Polk County, OR	1.1621
41500	Salinas, CA Monterey County, CA	1.6102
41540	Salisbury, MD Somerset County, MD Wicomico County, MD	0.9647
41620	Salt Lake City, UT Salt Lake County, UT Summit County, UT Tooele County, UT	0.9930
41660	San Angelo, TX Irion County, TX Tom Green County, TX	0.8380

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41700	San Antonio, TX	0.9365
	Atascosa County, TX	
	Bandera County, TX	
	Bexar County, TX	
	Comal County, TX	
	Guadalupe County, TX	
	Kendall County, TX	
	Medina County, TX	
	Wilson County, TX	
41740	San Diego-Carlsbad-San Marcos, CA	1.2440
	San Diego County, CA	
41780	Sandusky, OH	0.9411
	Erie County, OH	
41884	San Francisco-San Mateo-Redwood City, CA	1.6887
	Marin County, CA	
	San Francisco County, CA	
	San Mateo County, CA	
41900	San Germán-Cabo Rojo, PR	0.6876
	Cabo Rojo Municipio, PR	
	Lajas Municipio, PR	
	Sabana Grande Municipio, PR	
	San Germán Municipio, PR	
41940	San Jose-Sunnyvale-Santa Clara, CA	1.7348
	San Benito County, CA	
	Santa Clara County, CA	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
41980	San Juan-Caguas-Guaynabo, PR	0.6876
	Aguas Buenas Municipio, PR	
	Aibonito Municipio, PR	
	Arecibo Municipio, PR	
	Barceloneta Municipio, PR	
	Barranquitas Municipio, PR	
	Bayamón Municipio, PR	
	Caguas Municipio, PR	
	Camuy Municipio, PR	
	Canóvanas Municipio, PR	
	Carolina Municipio, PR	
	Cataño Municipio, PR	
	Cayey Municipio, PR	
	Ciales Municipio, PR	
	Cidra Municipio, PR	
	Comerío Municipio, PR	
	Corozal Municipio, PR	
	Dorado Municipio, PR	
	Florida Municipio, PR	
	Guaynabo Municipio, PR	
	Gurabo Municipio, PR	
	Hatillo Municipio, PR	
	Humacao Municipio, PR	
	Juncos Municipio, PR	
	Las Piedras Municipio, PR	
	Loíza Municipio, PR	
	Manatí Municipio, PR	
	Maunabo Municipio, PR	
	Morovis Municipio, PR	
	Naguabo Municipio, PR	
	Naranjito Municipio, PR	
	Orocovis Municipio, PR	
	Quebradillas Municipio, PR	
	Río Grande Municipio, PR	
	San Juan Municipio, PR	
	San Lorenzo Municipio, PR	
	Toa Alta Municipio, PR	
	Toa Baja Municipio, PR	
	Trujillo Alto Municipio, PR	
	Vega Alta Municipio, PR	
	Vega Baja Municipio, PR	
	Yabucoa Municipio, PR	

CBSA Code	Urban Area (Constituent Counties)	Wage Index
42020	San Luis Obispo-Paso Robles, CA San Luis Obispo County, CA	1.3288
42044	Santa Ana-Anaheim-Irvine, CA Orange County, CA	1.2670
42060	Santa Barbara-Santa Maria-Goleta, CA Santa Barbara County, CA	1.3047
42100	Santa Cruz-Watsonville, CA Santa Cruz County, CA	1.7719
42140	Santa Fe, NM Santa Fe County, NM	1.1324
42220	Santa Rosa-Petaluma, CA Sonoma County, CA	1.6835
42340	Savannah, GA Bryan County, GA Chatham County, GA Effingham County, GA	0.9575
42540	Scranton--Wilkes-Barre, PA Lackawanna County, PA Luzerne County, PA Wyoming County, PA	0.8867
42644	Seattle-Bellevue-Everett, WA King County, WA Snohomish County, WA	1.2258
42680	Sebastian-Vero Beach, FL Indian River County, FL	0.9912
43100	Sheboygan, WI Sheboygan County, WI	0.9705
43300	Sherman-Denison, TX Grayson County, TX	0.8535
43340	Shreveport-Bossier City, LA Bossier Parish, LA Caddo Parish, LA De Soto Parish, LA	0.8877
43580	Sioux City, IA-NE-SD Woodbury County, IA Dakota County, NE Dixon County, NE Union County, SD	0.9630
43620	Sioux Falls, SD Lincoln County, SD McCook County, SD Minnehaha County, SD Turner County, SD	0.9511
43780	South Bend-Mishawaka, IN-MI St. Joseph County, IN Cass County, MI	1.0260
43900	Spartanburg, SC Spartanburg County, SC	0.9891
44060	Spokane, WA Spokane County, WA	1.1058
44100	Springfield, IL Menard County, IL Sangamon County, IL	1.0107
44140	Springfield, MA Franklin County, MA Hampden County, MA Hampshire County, MA	1.0985
44180	Springfield, MO Christian County, MO Dallas County, MO Greene County, MO Polk County, MO Webster County, MO	0.8524
44220	Springfield, OH Clark County, OH	0.9736
44300	State College, PA Centre County, PA	0.9631
44700	Stockton, CA San Joaquin County, CA	1.3018
44940	Sumter, SC Sumter County, SC	0.8631
45060	Syracuse, NY Madison County, NY Onondaga County, NY Oswego County, NY	1.0357
45104	Tacoma, WA Pierce County, WA	1.1855

CBSA Code	Urban Area (Constituent Counties)	Wage Index
45220	Tallahassee, FL Gadsden County, FL Jefferson County, FL Leon County, FL Wakulla County, FL	0.8901
45300	Tampa-St. Petersburg-Clearwater, FL Hernando County, FL Hillsborough County, FL Pasco County, FL Pinellas County, FL	0.9510
45460	Terre Haute, IN Clay County, IN Sullivan County, IN Vermillion County, IN Vigo County, IN	0.9486
45500	Texarkana, TX-Texarkana, AR Miller County, AR Bowie County, TX	0.8591
45780	Toledo, OH Fulton County, OH Lucas County, OH Ottawa County, OH Wood County, OH	1.0102
45820	Topeka, KS Jackson County, KS Jefferson County, KS Osage County, KS Shawnee County, KS Wabaunsee County, KS	0.9350
45940	Trenton-Ewing, NJ Mercer County, NJ	1.1172
46060	Tucson, AZ Pima County, AZ	1.0065
46140	Tulsa, OK Creek County, OK Okmulgee County, OK Osage County, OK Pawnee County, OK Rogers County, OK Tulsa County, OK Wagoner County, OK	0.9172
46220	Tuscaloosa, AL Greene County, AL Hale County, AL Tuscaloosa County, AL	0.9210
46340	Tyler, TX Smith County, TX	0.8802
46540	Utica-Rome, NY Herkimer County, NY Oneida County, NY	0.8984
46660	Valdosta, GA Brooks County, GA Echols County, GA Lanier County, GA Lowndes County, GA	0.8412
46700	Vallejo-Fairfield, CA Solano County, CA	1.5813
47020	Victoria, TX Calhoun County, TX Goliad County, TX Victoria County, TX	0.8529
47220	Vineland-Millville-Bridgeton, NJ Cumberland County, NJ	1.0807
47260	Virginia Beach-Norfolk-Newport News, VA-NC Currituck County, NC Gloucester County, VA Isle of Wight County, VA James City County, VA Mathews County, VA Surry County, VA York County, VA Chesapeake City, VA Hampton City, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk City, VA Virginia Beach City, VA Williamsburg City, VA	0.9844
47300	Visalia-Porterville, CA Tulare County, CA	1.0823

CBSA Code	Urban Area (Constituent Counties)	Wage Index
47380	Waco, TX McLennan County, TX	0.8869
47580	Warner Robins, GA Houston County, GA	0.9269
47644	Warren-Troy-Farmington Hills, MI Lapeer County, MI Livingston County, MI Macomb County, MI Oakland County, MI St. Clair County, MI	1.0394
47894	Washington-Arlington-Alexandria, DC-VA-MD-WV District of Columbia, DC Calvert County, MD Charles County, MD Prince George's County, MD Arlington County, VA Clarke County, VA Fairfax County, VA Fauquier County, VA Loudoun County, VA Prince William County, VA Spotsylvania County, VA Stafford County, VA Warren County, VA Alexandria City, VA Fairfax City, VA Falls Church City, VA Fredericksburg City, VA Manassas City, VA Manassas Park City, VA Jefferson County, WV	1.1521
47940	Waterloo-Cedar Falls, IA Black Hawk County, IA Bremer County, IA Grundy County, IA	0.9020
48140	Wausau, WI Marathon County, WI	0.9996
48260	Weirton-Steubenville, WV-OH Jefferson County, OH Brooke County, WV Hancock County, WV	0.7802
48300	Wenatchee, WA Chelan County, WA Douglas County, WA	1.0291
48424	West Palm Beach-Boca Raton-Boynton Beach, FL Palm Beach County, FL	1.0460
48540	Wheeling, WV-OH Belmont County, OH Marshall County, WV Ohio County, WV	0.7274
48620	Wichita, KS Butler County, KS Harvey County, KS Sedgwick County, KS Sumner County, KS	0.9498
48660	Wichita Falls, TX Archer County, TX Clay County, TX Wichita County, TX	0.9738
48700	Williamsport, PA Lycoming County, PA	0.8341
48864	Wilmington, DE-MD-NJ New Castle County, DE Cecil County, MD Salem County, NJ	1.1169
48900	Wilmington, NC Brunswick County, NC New Hanover County, NC Pender County, NC	0.9515
49020	Winchester, VA-WV Frederick County, VA Winchester City, VA Hampshire County, WV	1.0352
49180	Winston-Salem, NC Davie County, NC Forsyth County, NC Stokes County, NC Yadkin County, NC	0.9460
49340	Worcester, MA Worcester County, MA	1.1741
49420	Yakima, WA Yakima County, WA	1.0534

CBSA Code	Urban Area (Constituent Counties)	Wage Index
49500	Yauco, PR Guánica Municipio, PR Guayanilla Municipio, PR Peñuelas Municipio, PR Yauco Municipio, PR	0.6876
49620	York-Hanover, PA York County, PA	0.9847
49660	Youngstown-Warren-Boardman, OH-PA Mahoning County, OH Trumbull County, OH Mercer County, PA	0.9114
49700	Yuba City, CA	1.1743
49740	Yuma, AZ Yuma County, AZ	0.9682

ADDENDUM G: CY 2009 ESRD Wage Index Based on CBSA Labor Market Areas for Rural Areas

CBSA Code	Nonurban Area	Wage Index
1	Alabama	0.7760
2	Alaska	1.2356
3	Arizona	0.9310
4	Arkansas	0.7769
5	California	1.2551
6	Colorado	1.0513
7	Connecticut	1.1849
8	Delaware	1.0493
10	Florida	0.9070
11	Georgia	0.8077
12	Hawaii	1.1767
13	Idaho	0.8188
14	Illinois	0.8784
15	Indiana	0.9010
16	Iowa	0.9230
17	Kansas	0.8651
18	Kentucky	0.8262
19	Louisiana	0.8058
20	Maine	0.9084
21	Maryland	0.9668
22	Massachusetts	1.2389
23	Michigan	0.9290
24	Minnesota	0.9714
25	Mississippi	0.8088
26	Missouri	0.8144
27	Montana	0.8912
28	Nebraska	0.9104
29	Nevada	1.0244
30	New Hampshire	1.0537
31	New Jersey	------
32	New Mexico	0.9464
33	New York	0.8739
34	North Carolina	0.9029

CBSA Code	Nonurban Area	Wage Index
35	North Dakota	0.8243
36	Ohio	0.8996
37	Oklahoma	0.8104
38	Oregon	1.0842
39	Pennsylvania	0.8765
40	Puerto Rico	0.6876
41	Rhode Island[1]	------
42	South Carolina	0.8863
43	South Dakota	0.8900
44	Tennessee	0.8270
45	Texas	0.8223
46	Utah	0.8856
47	Vermont	1.0338
48	Virgin Islands	0.7853
49	Virginia	0.8332
50	Washington	1.0825
51	West Virginia	0.7832
52	Wisconsin	0.9744
53	Wyoming	1.0096

[1] All counties within the State are classified as urban.

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