DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Care Financing Administration

42 CFR Parts 409, 410, 411, 412, 413, 419, 424, 489, 498, and 1003

[HCFA–1005–FC]

RIN 0938–AI56

Office of Inspector General; Medicare Program; Prospective Payment System for Hospital Outpatient Services

AGENCY: Health Care Financing Administration (HCFA), HHS, and Office of Inspector General (OIG), HHS.

ACTION: Final rule with comment period.

SUMMARY: This final rule with comment period implements a prospective payment system for hospital outpatient services furnished to Medicare beneficiaries, as set forth in section 1833(t) of the Social Security Act. It also establishes requirements for provider departments and provider-based entities, and it implements section 9343(c) of the Omnibus Budget Reconciliation Act of 1986, which prohibits Medicare payment for nonphysician services furnished to a hospital outpatient by a provider or supplier other than a hospital, unless the services are furnished under an arrangement with the hospital. In addition, this rule establishes in regulations the extension of reductions in payment for costs of hospital outpatient services required by section 4522 of the Balanced Budget Act of 1997, as amended by section 201(k) of the Balanced Budget Refinement Act of 1999.

DATES: *Effective date:* July 1, 2000, except that the changes to § 412.24(d)(6), new § 413.65, and the changes to § 489.24(h), § 498.2, and § 498.3 are effective October 10, 2000.

Applicability date: For Medicare services furnished by all hospitals, including hospitals excluded from the inpatient prospective payment system, and by community mental health centers, the applicability date for implementation of the hospital outpatient prospective payment system is July 1, 2000.

Comment date: Comments on the provisions of this rule resulting from the Balanced Budget Refinement Act of 1999 will be considered if we receive them at the appropriate address, as provided below, no later than 5 p.m. on June 6, 2000. We will not consider comments concerning provisions that remain unchanged from the September 8, 1998 proposed rule or that were revised based on public comment.

See section VIII for a more detailed discussion of the provisions subject to comment.

ADDRESSES: Mail written comments (one original and three copies) to the following address ONLY: Health Care Financing Administration, Department of Health and Human Services, Attention: HCFA–1005–FC, P.O. Box 8013, Baltimore, MD 21244–8013.

If you prefer, you may deliver, by courier, your written comments (one original and three copies) to one of the following addresses:

Room 443–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, or

C5–14–03, Central Building, 7500 Security Boulevard, Baltimore, MD 21244–1850.

Comments mailed to those addresses may be delayed and could be considered late.

Because of staffing and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code HCFA–1005–FC.

Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, in Room 443–G of the Department's offices at 200 Independence Avenue, SW., Washington, DC, on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (Phone (202) 690–7890).

For comments that relate to information collection requirements, mail a copy of comments to:

Health Care Financing Administration, Office of Information Services, Security and Standards Group, Division of HCFA Enterprise Standards, Room N2–14–26, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: John Burke, HCFA–1005–FC; and

Lauren Oliven, HCFA Desk Officer, Office of Information and Regulatory Affairs, Room 3001, New Executive Office Building, Washington, DC 20503.

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FOR FURTHER INFORMATION CONTACT:

Janet Wellham, (410) 786–4510 or Chuck Braver, (410) 786–6719 (for general information)

Joel Schaer (OIG), (202) 619–0089 (for information concerning civil money penalties)

Kitty Ahern, (410) 786–4515 (for information related to the classification of services into ambulatory payment classification (APC) groups)

George Morey (410) 786–4653 (for information related to the determination of provider-based status)

Janet Samen (410) 786–9161 (for information on the application of APCs to community mental health centers)

SUPPLEMENTARY INFORMATION: To assist readers in referencing sections contained in this document, we are providing the following table of contents. Within each section, we summarize pertinent material from our proposed rule of September 8, 1998 (63 FR 47552) followed by public comments and our responses.

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Addenda

Alphabetical List of Acronyms Appearing in the Final Rule

APC Ambulatory payment classification
APG Ambulatory patient group
ASC Ambulatory surgical center
AWP Average wholesale price
BBA 1997 Balanced Budget Act of 1997
BBRA 1999 Balanced Budget Refinement Act of 1999
CAH Critical access hospital
CAT Computerized axial tomography
CCI [HCFA's] Correct Coding Initiative
CCR Cost center specific cost-to-charge ratio
CCU Coronary care unit
CMHC Community mental health center
CMP Civil money penalty
CORF Comprehensive outpatient rehabilitation facility
CPI Consumer Price Index
CPT [Physicians'] Current Procedural Terminology, 4th Edition, 2000,

copyrighted by the American Medical Association
DME Durable medical equipment
DMEPOS DME, orthotics, prosthetics, prosthetic devices, prosthetic implants and supplies
DRG Diagnosis-related group
DSH Disproportionate share hospital
EACH Essential access community hospital
EBAA Eye Bank Association of America
ED Emergency department
EMS Emergency medical services
EMTALA Emergency Medical Treatment and Active Labor Act
ENT Ear/Nose/Throat
ESRD End-stage renal disease
FDA Food and Drug Administration
FDO Formula-driven overpayment
FQHC Federally qualified health center
HCPCS HCFA Common Procedure Coding System
HHA Home health agency
HRSA Health Resources and Services Administration
ICD–9–CM International Classification of Diseases, Ninth Edition, Clinical Modification
ICU Intensive care unit
IHS Indian Health Service
IME Indirect medical education
IOL Intraocular lens
JCAHO Joint Commission on Accreditation of Healthcare Organizations
LTH Long-term hospital
MDH Medicare-dependent hospital
MedPAC Medicare Payment Advisory Commission
MRI Magnetic resonance imaging
MSA Metropolitan statistical area
NECMA New England County Metropolitan Area
OBRA Omnibus Budget Reconciliation Act
OT Occupational therapy
PPO Preferred provider organization
PPS Prospective payment system
RFA Regulatory Flexibility Act
RHC Rural health clinic
RPCH Rural primary care hospital
RRC Rural referral center
SCH Sole community hospital
SGR Sustainable growth rate
SNF Skilled nursing facility
TEFRA Tax Equity and Fiscal Responsibility Act of 1982
TPA Tissue Plasminogen Activator
Y2K Year 2000

I. Background

A. General and Legislative History

When the Medicare program was first implemented, it paid for hospital services (inpatient and outpatient) based on hospital-specific reasonable costs attributable to serving Medicare beneficiaries. Later, the law was amended to limit payment to the lesser of a hospital's reasonable costs or its customary charges. In 1983, section 601 of the Social Security Amendments of 1983 (Pub. L. 98–21) completely revised the cost-based payment system for most hospital inpatient services by enacting section 1886(d) of the Social Security Act (the Act). This section provided for a prospective payment system (PPS) for acute hospital inpatient stays, effective with hospital cost reporting periods beginning on or after October 1, 1983.

Although payment for most inpatient services became subject to the PPS, Medicare hospital outpatient services continued to be paid based on hospital-specific costs, which provided little incentive for hospitals to furnish outpatient services efficiently. At the same time, advances in medical technology and changes in practice patterns were bringing about a shift in the site of medical care from the inpatient to the outpatient setting. During the 1980s, the Congress took steps to control the escalating costs of providing outpatient care. The Congress amended the statute to implement across-the-board reductions of 5.8 percent and 10 percent to the amounts otherwise payable by Medicare for hospital operating costs and capital costs, respectively, and enacted a number of different payment methods for specific types of hospital outpatient services. These methods included fee schedules for clinical diagnostic laboratory tests, orthotics, prosthetics, and durable medical equipment (DME); composite rate payment for dialysis for persons with end-stage renal disease (ESRD); and payments based on blends of hospital costs and the rates paid in other ambulatory settings such as separately certified ambulatory surgical centers (ASCs) or physician offices for certain surgery, radiology, and other diagnostic procedures. However, Medicare payment for services performed in the hospital outpatient setting remains largely cost-based.

In the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) (Pub. L. 99–509), the Congress paved the way for development of a PPS for hospital outpatient services. Section 9343(g) of OBRA 1986 mandated that fiscal intermediaries require hospitals to report claims for services under the HCFA Common Procedure Coding System (HCPCS). Section 9343(c) of OBRA 1986 extended the prohibition against unbundling of hospital services under section 1862(a)(14) of the Act to include outpatient services as well as inpatient services. The HCPCS coding enabled us to determine which specific procedures and services were being billed, while the extension of the prohibition against unbundling ensured that all nonphysician services provided to hospital outpatients would be billed only by the hospital, not by an outside supplier, and, therefore, would be reported on hospital bills and captured in the hospital outpatient data that could be used to develop an outpatient PPS.

A proposed rule to implement section 9343(c) was published in the **Federal Register** on August 5, 1988. However, those regulations were never published as a final rule, so we included them in the hospital outpatient PPS proposed rule published in the **Federal Register** on September 8, 1998 (63 FR 47552) and will implement them as part of this final rule.

Section 1866(g) of the Act, as added by section 9343(c) of OBRA 1986, and amended by section 4085(i)(17) of the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) (Pub. L. 100–203), authorizes the Department of Health and Human Services' Office of Inspector General to impose a civil money penalty (CMP), not to exceed $2,000, against any individual or entity who knowingly and willfully presents a bill in violation of an arrangement (as defined in section 1861(w)(1) of the Act).

In section 9343(f) of the OBRA 1986 and section 4151(b)(2) of the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101–508), the Congress required that we develop a proposal to replace the current hospital outpatient payment system with a PPS and submit a report to the Congress on the proposed system.

The Secretary submitted a report to the Congress on March 17, 1995, summarizing the research we conducted searching for a way to classify outpatient services for purposes of developing an outpatient PPS. The report cited ambulatory patient groups (APGs), developed by 3M-Health Information Systems (3M–HIS) under a cooperative grant with HCFA, as the most promising classification system for grouping outpatient services and recommended that APG-like groups be used in designing a hospital outpatient PPS.

The report also presented a number of options that could be used, once a PPS was in place, for addressing the issue of rapidly growing beneficiary coinsurance. As a separate issue, we recommended that the Congress amend the provisions of the law pertaining to the blended payment methods for ASC surgery, radiology, and other diagnostic services to correct an anomaly that resulted in a less than full recognition of the amount paid by the beneficiary in calculating program payment (referred to as the formula-driven overpayment).

Three sections of the Balanced Budget Act of 1997 (the BBA 1997) (Pub. L. 105–33), enacted on August 5, 1997, affect Medicare payment for hospital outpatient services. Section 4521 of the BBA 1997 eliminates the formula-driven overpayment for ambulatory surgical

center procedures, radiology services, and diagnostic procedures furnished on or after October 1, 1997. In November 1998, we issued cost report instructions (Provider Reimbursement Manual, Part II, Chapter 36, Transmittal 4) that implemented this provision for services furnished on or after October 1, 1997. Section 4522 of the BBA 1997 amends section 1861(v)(1)(S)(ii) of the Act by extending cost reductions in payment for hospital outpatient operating costs and hospital capital costs, 5.8 percent and 10 percent respectively, before January 1, 2000. Section 4523 of the BBA 1997 amends section 1833 of the Act by adding subsection (t), which provides for implementation of a PPS for outpatient services. (Under Section 4523 of the BBA 1997 the outpatient PPS does not apply to cancer hospitals before January 1, 2000.) Set forth below in section I.B is a detailed description of the changes made by the BBA 1997.

On November 29, 1999, the Balanced Budget Refinement Act of 1999 (the BBRA 1999), Pub. L. 106–113, was enacted. This Act made major changes that affect the proposed hospital outpatient PPS. The legislative changes are summarized in section I.E, below. More specific details on individual provisions that we are implementing in this final rule with comment period are included under the various sections of this preamble.

B. Summary of Provisions in the Balanced Budget Act of 1997 (the BBA 1997)

1. Prospective Payment System (PPS)

Section 4523 of the BBA 1997 amended section 1833 of the Act by adding subsection (t), which provides for a PPS for hospital outpatient department services. (The following citations reflect the statute as enacted by the BBA 1997.) Section 1833(t)(1)(B) of the Act authorizes the Secretary to designate the hospital outpatient services that would be paid under the PPS. That section also requires that the hospital outpatient PPS include hospital inpatient services designated by the Secretary that are covered under Part B for beneficiaries who are entitled to Part A benefits but who have exhausted them or otherwise are not entitled to them. Section 1833(t)(1)(B)(iii) of the Act specifically excludes ambulance, physical and occupational therapy, and speech-language pathology services, for which payment is made under a fee schedule.

Section 1833(t)(2) of the Act sets forth certain requirements for the hospital outpatient PPS. The Secretary is required to develop a classification system for covered outpatient services that may consist of groups arranged so that the services within each group are comparable clinically and with respect to the use of resources.

Section 1833(t)(2)(C) of the Act specifies data requirements for establishing relative payment weights. The weights are to be based on the median hospital costs determined by 1996 claims data and data from the most recent available cost reports. Section 1833(t)(2)(D) of the Act requires that the portion of the Medicare payment and the beneficiary coinsurance that are attributable to labor and labor-related costs be adjusted for geographic wage differences in a budget neutral manner.

The Secretary is authorized under section 1833(t)(2)(E) of the Act to establish, in a budget neutral manner, other adjustments, such as outlier adjustments or adjustments for certain classes of hospitals, that are necessary to ensure equitable payments. Section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered outpatient services.

Section 1833(t)(3) of the Act specifies how beneficiary deductibles are to be treated in calculating the Medicare payment and beneficiary coinsurance amounts and requires that rules be established regarding determination of coinsurance amounts for covered services that were not furnished in 1996. The statute freezes beneficiary coinsurance at 20 percent of the national median charges for covered services (or group of covered services) furnished during 1996 and updated to 1999 using the Secretary's estimated charge growth from 1996 to 1999.

Section 1833(t)(3) of the Act also prescribes the formula for calculating the initial conversion factor used to determine Medicare payment amounts for 1999 and the method for updating the conversion factor in subsequent years.

Sections 1833(t)(4) and (t)(5) of the Act describe the method for determining the Medicare payment amount and the beneficiary coinsurance amount for services covered under the outpatient PPS. Section 1833(t)(5)(B) of the Act requires the Secretary to establish a procedure whereby hospitals may voluntarily elect to reduce beneficiary coinsurance for some or all covered services to an amount not less than 20 percent of the Medicare payment amount. Hospitals are further allowed to disseminate information on any such reductions of coinsurance amounts. Section 4451 of the BBA 1997 added section 1861(v)(1)(T) to the Act, which provides that any reduction in coinsurance must not be treated as a bad debt.

Section 1833(t)(6) authorizes periodic review and revision of the payment groups, relative payment weights, wage index, and conversion factor.

Section 1833(t)(7) of the Act describes how payment is to be made for ambulance services, which are specifically excluded from the outpatient PPS under section 1833(t)(1)(B) of the Act.

Section 1833(t)(8) of the Act provides that the Secretary may establish a separate conversion factor for services furnished by cancer hospitals that are excluded from hospital inpatient PPS.

Section 1833(t)(9) of the Act prohibits administrative or judicial review of the hospital outpatient PPS classification system, the groups, relative payment weights, wage adjustment factors, other adjustments, calculation of base amounts, periodic adjustments, and the establishment of a separate conversion factor for those cancer hospitals excluded from hospital inpatient PPS.

Section 4523(d) of the BBA 1997 made a conforming

amendment to section 1833(a)(2)(B) of the Act to provide for payment under the hospital outpatient PPS for some services described in section 1832(a)(2) that are currently paid on a cost basis and furnished by providers of services, such as comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHAs), hospices, and community mental health centers (CMHCs). This amendment provides that partial hospitalization services furnished by CMHCs be paid under the PPS.

2. Elimination of Formula-Driven Overpayment

Before enactment of section 4521(b) of the BBA 1997, using the blended payment formulas for ASC procedures, radiology, and other diagnostic services, the ASC or physician fee schedule portion was calculated as if the beneficiary paid 20 percent of the ASC rate or physician fee schedule amount instead of the actual amount paid, which was 20 percent of the hospital's billed charges. Section 4521(b), which amended sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act, corrects this anomaly by changing the blended calculations so that all amounts paid by the beneficiary are subtracted from the total payment in the calculation to determine the amount due from the program. Effective for services furnished on or after October 1, 1997, payment for surgery, radiology, and other diagnostic services calculated by blended payment methods is now calculated by

subtracting the full amount of coinsurance due from the beneficiary (based on 20 percent of the hospital's billed charges).

3. Extension of Cost Reductions

Section 1861(v)(1)(S)(ii) of the Act was amended by section 4522 of the BBA 1997 to require that the amounts otherwise payable for hospital outpatient operating costs and capital costs be reduced by 5.8 percent and 10 percent, respectively, through December 31, 1999.

C. The September 8, 1998 Proposed Rule

We published a proposed rule in the **Federal Register** on September 8, 1998 (63 FR 47552) setting forth the proposed PPS for hospital outpatient services. In that proposed rule, we explained that, due to Year 2000 (Y2K) systems concerns, implementation of the new payment system would be delayed until after January 1, 1999. (The statement in the rule that the statute requires implementation ''effective January 1, 1999,'' and other similar statements in other rules, were not intended to mean that the statute requires retroactive implementation of the hospital outpatient PPS. As noted elsewhere in this rule, the statute does not impose such a requirement.) As noted in that document, the scope of systems changes required to implement the hospital outpatient PPS is so enormous as to be impossible to accomplish concurrently with the critical work that we, our contractors, and our provider-partners had to perform to ensure that all of our respective systems were Y2K compliant. Section XI of the proposed rule (63 FR 47605) explains in greater detail the reasons for delaying implementation.

The proposed rule originally provided for a 60-day comment period. However, the comment period was extended four times, ultimately ending on July 30, 1999. (See 63 FR 63429, November 13, 1998; 64 FR 1784, January 12, 1999; 64 FR 12277, March 12, 1999; and 64 FR 36320; July 6, 1999.)

On June 30, 1999, we published a correction notice (64 FR 35258) to correct a number of technical and typographical errors contained in the September 8, 1998 proposed rule. The numerical values in the proposed rule reflected incorrect data and data programming. Among other corrections, the notice set forth revised numerical values for the current payment, total services (total units), relative weights, proposed payment rates, national unadjusted coinsurance, minimum unadjusted coinsurance, and service-mix index.

D. Overview of Public Comments

We received approximately 10,500 comments in response to our September 8, 1998 proposed rule. That count includes the numerous requests from hospital and other interested groups and organizations that we extend the public comment period to allow additional time for analysis of the impact of our proposals. As we explain above, we extended the comment period four times, to end finally on July 30, 1999.

In addition to receiving comments from a number of organizations representing the full spectrum of the hospital industry, we received comments from beneficiaries and their families, physicians, health care workers, individual hospitals, professional associations and societies, legal and nonlegal representatives and spokespersons for beneficiaries and hospitals, members of the Congress, and other interested citizens. The majority of comments addressed our proposals regarding payment for: Corneal tissue; payment for high-cost technologies, both existing and future; payment for blood and blood products; and payment for high cost drugs, including chemotherapy agents. We also received numerous comments addressing: Our approach to ratesetting using the ambulatory payment classification (APC) system; our method of calculating the payment conversion factor; and the potentially negative impact of the proposed hospital outpatient PPS on hospital revenues. In addition, we received many comments concerning the proposed regulations for provider-based entities.

We carefully reviewed and considered all comments received timely. The many modifications that we made to our proposed regulations in response to commenters' suggestions and recommendations are reflected in the provisions of this final rule. Comments and our responses are addressed by topic in the sections that follow.

E. Summary of Relevant Provisions in the Balanced Budget Refinement Act of 1999 (the BBRA 1999)

As noted above, subsequent to publication of the proposed rule, the BBRA 1999 was enacted on November 29, 1999. The BBRA 1999 made major changes that affect the proposed hospital outpatient PPS. Because these changes are effective with the implementation of the PPS, we have had to make some revisions from the September 8, 1998 proposed rule. The provisions of the BBRA 1999 that we are implementing in this final rule with comment period follow.

1. Outlier Adjustment

Section 201(a) of the BBRA 1999 amends section 1833(t) by redesignating paragraphs (5) through (9) as paragraphs (7) through (11) and adding a new paragraph (5). New section 1833(t)(5) of the Act provides that the Secretary will make payment adjustments for covered services whose costs exceed a given threshold (that is, an outlier payment). This section describes how the additional payments are to be calculated and caps the projected outlier payments at no more than 2.5 percent of the total projected payments (sum of both Medicare and beneficiary payments to the hospital) made under hospital outpatient PPS for years before 2004 and 3.0 percent of the total projected payments for 2004 and subsequent years.

2. Transitional Pass-Through for Additional Costs of Innovative Medical Devices, Drugs, and Biologicals

Section 201(b) of the BBRA 1999 adds new section 1833(t)(6) to the Act, establishing transitional pass-through payments for certain medical devices, drugs, and biologicals. This provision does the following: Specifies the types of items for which additional payments must be made; describes the amount of the additional payment; limits these payments to at least 2 years but not more than 3 years; and caps the projected payment adjustments annually at 2.5 percent of the total projected payments for hospital outpatient services each year before 2004 and no more than 2.0 percent in subsequent years. Under this provision, the Secretary has the authority to reduce pro rata the amount of the additional payments if, before the beginning of a year, she estimates that these payments would otherwise exceed the caps.

3. Budget Neutrality Applied to New Adjustments

Section 201(c) of the BBRA 1999 amends section 1833(t)(2)(E) of the Act to require that the establishment of outlier and transitional pass-through payment adjustments is to be made in a budget neutral manner.

4. Limitation on Judicial Review

Section 201(d) of the BBRA 1999 amends redesignated section 1833(t)(11) of the Act by extending the prohibition of administrative or judicial review to include the factors for determining outlier payments (that is, the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable total payment percentage), and the determination of additional payments for certain medical devices,

drugs, and biologicals, the insignificant cost determination for these items, the duration of the additional payment or portion of the PPS payment amount associated with particular devices, drugs, or biologicals, and any pro rata reduction.

5. Inclusion in the Hospital Outpatient PPS of Certain Implantable Items

Section 201(e) of the BBRA 1999 amends section 1833(t)(1)(B) of the Act to include as covered outpatient services implantable prosthetics and DME and diagnostic x-ray, laboratory, and other tests associated with those implantable items.

6. Payment Weights Based on Mean Hospital Costs

Section 201(f) of the BBRA 1999 amends section 1833(t)(2)(C) of the Act, which specifies data requirements for establishing relative payment weights, to allow the Secretary the discretion to base the weights on either the median or mean hospital costs determined by data from the most recent available cost reports.

7. Limitation on Variation of Costs of Services Classified Within a Group

Section 201(g) of the BBRA 1999 amends section 1833(t)(2) of the Act to limit the variation of costs of services within each payment classification group by providing that the highest median (or mean cost, if elected by the Secretary) for an item or service within the group cannot be more than 2 times greater than the lowest median (or mean) cost for an item or service within the group. The provision allows the Secretary to make exceptions in unusual cases, such as for low volume items and services.

8. Annual Review of the Hospital Outpatient PPS Components

Section 201(h) of the BBRA 1999 amends redesignated section 1833(t)(8) of the Act to require at least annual review of the groups, relative payment weights, and the wage and other adjustments made by the Secretary to take into account changes in medical practice, the addition of new services, new cost data, and other relevant information and factors. That section of the Act is further amended to require the Secretary to consult with an expert outside advisory panel composed of an appropriate selection of provider representatives who will review the clinical integrity of the groups and weights and advise the Secretary accordingly. The panel may use data other than those collected or developed by the Department of HHS for the review and advisory purposes.

9. Coinsurance Not Affected by Pass-Throughs

Section 201(i) of the BBRA 1999 amends redesignated section 1833(t)(7) of the Act to provide that the beneficiary coinsurance amount will be calculated as if the outlier and transitional pass-throughs had not occurred; that is, there will be no coinsurance collected from beneficiaries for the additional payments made to hospitals by Medicare for these adjustments.

10. Extension of Cost Reductions

Section 201(k) of the BBRA 1999 amends section 1861(v)(1)(S)(ii) of the Act to extend until the first date that the hospital outpatient PPS is implemented, the 5.8 and 10 percent reductions for hospital operating and capital costs, respectively.

11. Clarification of Congressional Intent Regarding Base Amounts Used in Determining the Hospital Outpatient PPS

Section 201(l) of the BBRA 1999 provides that, ''With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of the BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.'' Pursuant to this provision, we are calculating the aggregate PPS payment to hospitals in a budget neutral manner.

12. Transitional Corridors for Application of Outpatient PPS

Section 202 of the BBRA 1999 amends section 1833(t) of the Act by redesignating paragraphs (7) through (11) as paragraphs (8) through (12), and adding a new paragraph (7), which provides for a transitional adjustment to limit payment reductions under the hospital outpatient PPS. More specifically, for the years 2000 through 2003, a provider, including a CMHC, will receive an adjustment if its payment-to-cost ratio for outpatient services furnished during the year is less than a set percentage of its payment-to-cost ratio for those services in its cost reporting period ending in 1996 (the base year). Two categories of hospitals, rural hospitals with 100 or fewer beds and cancer hospitals, will be held harmless under this provision. Small rural hospitals, for services furnished before January 1, 2004, will be maintained at the same payment-to-cost ratio as their base year cost report if their PPS payment-to-cost ratio is less. The hold-harmless provision applies permanently to cancer centers. Section 202 also requires the Secretary to make interim payments to affected hospitals subject to retrospective adjustments and requires that the provisions of this section do not affect beneficiary coinsurance. Finally, this provision is not subject to budget neutrality.

13. Limitation on Coinsurance for a Procedure

Section 204 of the BBRA 1999 amends redesignated section 1833(t)(8) of the Act to provide that the coinsurance amount for a procedure performed in a year cannot exceed the hospital inpatient deductible for that year.

14. Reclassification of Certain Hospitals

Section 401 of the BBRA 1999 adds section 1886(d)(8)(E) to the Act to permit reclassification of certain urban hospitals as rural hospitals. Section 401 adds section 1833(t)(13) to the Act to provide that a hospital being treated as a rural hospital under section 1886(d)(8)(E) also be treated as a rural hospital under the hospital outpatient PPS.

II. Prohibition Against Unbundling of Hospital Outpatient Services

A. Background

Sections 9343(c)(1) and (c)(2) of OBRA 1986 amended sections 1862(a)(14) and 1866(a)(1)(H) of the Act, respectively. As revised, section 1862(a)(14) of the Act prohibits payment for nonphysician services furnished to hospital patients (inpatients and outpatients), unless the services are furnished by the hospital, either directly or under an arrangement (as defined in section 1861(w)(1) of the Act). As revised, section 1866(a)(1)(H) of the Act requires each Medicare-participating hospital to agree to furnish directly all covered nonphysician services required by its patients (inpatients and outpatients) or to have the services furnished under an arrangement (as defined in section 1861(w)(1) of the Act). Section 9338(a)(3) of OBRA 1986 affected implementation of the bundling mandate by amending section 1861(s)(2)(K) of the Act to permit services of physician assistants to be covered and billed separately. Sections 4511(a)(2)(C) and (D) of the BBA 1997 further revised sections 1862(a)(14) and 1866(a)(1)(H) of the Act, respectively, to exclude services of nurse practitioners

and clinical nurse specialists, described in section 1861(s)(2)(K)(ii) of the Act, from the bundling requirement.

B. Office of Inspector General (OIG) Civil Money Penalty Authority and Civil Money Penalties for Unbundling Hospital Outpatient Services

In order to deter the unbundling of nonphysician hospital services, section 9343(c)(3) of OBRA 1986 added section 1866(g) to the Act to provide for the imposition of civil money penalties (CMPs), not to exceed $2,000, against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the requirement for billing under arrangements specified in section 1866(a)(1)(H) of the Act. In addition, section 1866(g) includes authorization to impose a CMP, in the same manner as other CMPs are imposed under section 1128A of the Act when arrangements should have been made but were not. Section 4085(i)(17) of OBRA 1987 amended section 1866(g) of the Act by deleting all references to hospital outpatient services under Part B of Medicare. The result of this amendment is that the CMP is now applicable for services furnished to hospital patients, whether paid for under Medicare Part A or B.

In order to implement section 1866(g) of the Act, we proposed in our August 5, 1988 proposed rule that the OIG would impose a CMP against any person who knowingly and willfully presents, or causes to be presented, a bill or request for payment for a hospital outpatient service under Part B of Medicare that violates the billing arrangement under section 1866(a)(1)(H) of the Act or the requirement for an arrangement. The amount of the CMP is to be limited to $2,000 for each improper bill or request, even if the bill or request included more than one item or service.

C. Summary of Final Regulations on Bundling of Hospital Outpatient Services

In our September 8, 1998 proposed rule, we proposed to make final most of the provisions of the August 5, 1988 proposed rule but with a number of revisions that we describe in detail in the proposed rule (63 FR 47558 through 47559). We are adopting as final regulations what we proposed in the September 8, 1998 rule with the following additional changes:

- We are adding a new paragraph (b)(7) to § 410.42 (Limitations on coverage of certain services furnished to hospital outpatients) to provide an exception to the hospital bundling requirements for services hospitals furnish to SNF residents as defined in § 411.15(p). (Section 410.42 has been redesignated from § 410.39 in the proposed rule.)
- We are making a minor change to newly redesignated paragraph (m)(2) (this language was formerly included in paragraph (m)(1)) in § 411.15 (Particular services excluded from coverage) to make it clearer that the exclusion discussed in this section is referring to excluding certain services from coverage.
- Except for minor wording changes in introductory paragraph (b) of § 1003.102 (Basis for civil money penalties and assessments), that section remains as it appeared in the August 5, 1988 proposed rule. Paragraph (b)(15) is redesignated from proposed paragraph (b)(4) in the August 5, 1988 proposed rule and (b)(14) in the September 8, 1998 proposed rule. Paragraphs (b)(12) through (b)(14) of § 1003.102 are reserved.
- We are adding a new paragraph (k) to § 1003.103 (Amount of penalty) to indicate that the OIG may impose a penalty of not more than $2,000 for each bill or request for items and services furnished to hospital patients in violation of the bundling requirements.
- We are also amending § 1003.105 (Exclusion from participation in Medicare, Medicaid and other Federal health care programs) by revising paragraph (a)(1)(i) to reflect that the basis for imposition of a CMP is also a basis for exclusion from participation in Medicare, Medicaid and other Federal health care programs.

D. Comments and Responses

Comment: One association requested that we clarify whether lab tests are subject to the bundling requirement or whether those services are included in the definition of diagnostic tests that are not required to be bundled. If lab tests are bundled, the association asked that we seek a legislative change to permit a provider, other than the lab that performs the test, to bill for the test.

Response: Laboratory tests, like all other services furnished to hospital patients, must be provided directly or under arrangements by the hospital and only the hospital may bill the program. Section 1833(h)(5)(A)(iii) of the Act provides an exception to the requirement that payment for a clinical diagnostic lab may be made only to the person or entity that performed or supervised the performance of the test. This section provides that in the case of a clinical diagnostic laboratory test provided under arrangement made by a hospital or CAH, payment is made to the hospital.

All diagnostic tests that are furnished by a hospital, directly or under arrangements, to a registered hospital outpatient during an encounter at a hospital are subject to the bundling requirements. The hospital is not responsible for billing for the diagnostic test if a hospital patient leaves the hospital and goes elsewhere to obtain the diagnostic test.

Comment: The same association asked us to clarify that services billed to skilled nursing facilities (SNFs) under the consolidated billing requirement would be exempt from the bundling requirement for hospital outpatient services.

Response: We agree that in situations where a beneficiary receives outpatient services from a Medicare participating hospital or CAH while temporarily absent from the SNF, the beneficiary continues to be considered a SNF resident specifically with regard to the comprehensive care plan required under § 483.20(b). Such services are, therefore, subject to the SNF consolidated billing provision and should be exempt from the hospital outpatient bundling requirements. The final regulations at § 410.42(b)(7) reflect this exception.

We note that the SNF consolidated billing requirements, under § 411.15(p)(3)(iii), do not apply to a limited number of exceptionally intensive hospital outpatient services that lie well beyond the scope of care that SNFs would ordinarily furnish, and thus beyond the ordinary scope of SNF care plans. The hospital outpatient services that are currently included in this policy are: Cardiac catheterization; computerized axial tomography (CAT) scans; MRIs; ambulatory surgery involving the use of an operating room; emergency room services; radiation therapy; angiography; and lymphatic and venous procedures. When a hospital or CAH provides these services to a beneficiary, the beneficiary's status as a SNF resident ends, but only with respect to these services. The beneficiary is now considered to be a hospital outpatient and the services are subject to hospital outpatient bundling requirements. In November 1998, we issued Program Memorandum transmittal number A–98–37, which provides additional clarification on this exclusion as well as a list of specific HCPCS codes that identify the services that are excluded from SNF consolidated billing but subject to hospital outpatient bundling.

Comment: One commenter understood that the proposed rule

would permit payment for all diagnostic tests that are furnished by a hospital or other entity if the patient leaves the hospital and obtains the service elsewhere; however, the commenter requested clarification as to the treatment of ''outsourced'' hospital departments. The commenter stated that hospitals are increasingly outsourcing departments to providers that can furnish services efficiently. Often these providers do not operate as ''under arrangements'' providers to the hospital, but as free-standing providers offering outpatient services on hospital grounds. The commenter specifically asked whether a free-standing entity providing outpatient services on hospital grounds, but operated independently of the hospital is able to bill separately for services furnished or is the entity considered to be part of the hospital and required to furnish services ''under arrangement.''

Response: A free-standing entity, that is, one that is not provider-based, may bill for services furnished to beneficiaries who do not meet the definition of a hospital outpatient at the time the service is furnished. Our bundling requirements apply to services furnished to a ''hospital outpatient,'' as defined in § 410.2, during an ''encounter,'' also defined in § 410.2.

Comment: One commenter indicated that while the proposed revision to § 1003.102(b) accurately reflected the statutory directive that the basis for imposing a CMP is a ''bill or request for payment,'' the proposed amendment to § 1003.103(a) regarding the appropriate penalty amount to be imposed for bundling violations was in error. The commenter indicated that the OIG lacks the authority to impose a CMP in the amount of $10,000 for these violations, and that such a penalty should be not more than $2,000 for each violation.

Response: The commenter is correct. While section 231(c) of the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104–191, increased the CMP maximum amount from $2,000 to $10,000, the statute sets forth ''items or services'' as the basis upon which a higher CMP amount may be assessed. However, with regard to bundling violations, the Secretary may impose a CMP only on the basis of a ''bill or request for payment'' rather than ''for each item and service'' as stated in the proposed revision to § 1003.103. We are correcting this error by adding a new § 1003.103(k) to indicate that the OIG may impose a penalty of not more than $2,000 for each bill or request for items and services furnished to hospital patients in violation of the bundling requirements.

III. Hospital Outpatient Prospective Payment System (PPS)

In this section, we designate the services for which Medicare will make payment under the hospital outpatient PPS, the payment rates set for those services, and the method by which we determined the outpatient PPS payment and coinsurance amounts.

We explain the structure of the hospital outpatient PPS, respond to comments that we received about the proposed PPS, and describe modifications that we made to the proposed PPS in response to comments, such as provisions we are making to expedite appropriate payment for new technologies and provisions to pay for blood and blood products.

In this section, we also discuss how we will implement requirements enacted by the BBRA 1999, including transitional payment corridors and other payment adjustments such as outliers and transitional pass-throughs.

A. Hospitals Included In or Excluded From the Outpatient PPS

This PPS applies to covered hospital outpatient services furnished by all hospitals participating in the Medicare program, except as noted below. Partial hospitalization services in community mental health centers (CMHCs) are also paid under this PPS. Exclusions from outpatient PPS are different and more limited than exclusions from inpatient PPS. Thus, hospitals or distinct parts of hospitals that are excluded from the inpatient PPS are included in the outpatient PPS, to the extent that the hospital or distinct part furnishes outpatient services. For example, we will make payment under the outpatient PPS for outpatient psychiatric services. The outpatient services provided by hospitals of the Indian Health Service (IHS) will continue to be paid under separately established rates which are published annually in the **Federal Register**. We intend to develop a plan that will help these facilities transition to the PPS and will consult with the IHS to develop this plan.

The following hospitals are excluded from the outpatient PPS:

- Certain hospitals in Maryland qualify under section 1814(b)(3) of the Act for payment under the State's payment system. The excluded services are limited to those paid under the State's payment system as described in section 1814(b)(3) of the Act. Any other outpatient services furnished by the hospital are paid under the outpatient PPS.
- Critical access hospitals that are paid under a reasonable cost based system, as required under section 1834(g) of the Act.

Comment: National and State associations representing children's hospitals and a number of individual children's hospitals located across the country strongly recommended that their hospitals be excluded from the hospital outpatient PPS just as they have been excluded from the hospital inpatient PPS. These commenters argued that the exclusion should apply to outpatient services furnished by children's hospitals because these hospitals treat a unique patient group whose health needs are different from those of adult beneficiaries entitled to Medicare benefits. The commenters further argued that services to Medicare patients are, on average, only 1 percent of the total inpatient and outpatient services that children's hospitals furnish and that these services are largely ESRD services that are already excluded from the hospital outpatient PPS. The commenters were concerned that the resources required to implement and comply with the new system would be disproportionately high relative to the small number of patients who would be affected by the new system. In addition, the impact analysis that accompanied the proposed rule estimated that children's hospitals would lose more than 20 percent of their Medicare revenues under the new system. Commenters expressed great concern about this loss of revenue.

Response: Our most recent analysis of the impact on hospitals of the PPS shows a negative effect for children's hospitals of 11.9 percent, which is significantly less than what we estimated in the proposed rule. However, the transitional corridor payments provided by the BBRA 1999 will protect these hospitals from even this level of loss through 2004. The estimated loss for CY 2000–2001 for children's hospitals is only 3.2 percent. (See Table 2 in section IX of this preamble.) As we discuss in section III.H.2 below, we will conduct extensive analyses during the first years of implementation of the PPS to determine whether we should propose adjustments for certain types of hospitals, including children's hospitals, when the transitional corridor provision expires. In the meantime, we are not excluding any special class of hospital from the PPS.

B. Scope of Facility Services

Section 1833(t)(1)(B)(i) of the Act gives us the authority to designate the services to be covered under the hospital outpatient PPS. In this section of the final rule, we designate the types

of services included or excluded under the hospital outpatient PPS.

1. Services Excluded From the Scope of Services Paid Under the Hospital Outpatient PPS

a. Background

In developing a hospital outpatient PPS, we want to ensure that all services furnished in a hospital outpatient setting will be paid on a prospective basis. We have already been paying, in part, for some hospital outpatient services such as clinical diagnostic laboratory services, orthotics, and end-stage renal disease (ESRD) dialysis services based on fee schedules or other prospectively determined rates that also apply across other sites of ambulatory care. Rather than duplicate existing payment systems that are effectively achieving consistency of payments across different service delivery sites, we proposed to exclude from the outpatient PPS those services furnished in a hospital outpatient setting that were already subject to an existing fee schedule or other prospectively determined payment rate. The similar payments across various settings create a more level playing field in which Medicare makes virtually the same payment for the same service, without regard to where the service is furnished.

We therefore proposed to exclude from the scope of services paid under the hospital outpatient PPS the following:

• Services already paid under fee schedules or other payment systems including, but not limited to: screening mammographies, services for patients with ESRD that are paid for under the ESRD composite rate; the professional services of physicians and non-physician practitioners paid under the Medicare physician fee schedule; laboratory services paid under the clinical diagnostic laboratory fee schedule; and DME, orthotics, prosthetics, and prosthetics devices, prosthetic implants, and supplies (DMEPOS) paid under the DMEPOS fee schedule when the hospital is acting as a supplier of these items. An item such as crutches or a walker that is given to the patient to take home, but that may also be used while the patient is at the hospital, would be billed to the DME regional carrier rather than paid for under the hospital outpatient PPS.

• Hospital outpatient services furnished to SNF inpatients as part of his or her resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital ''under arrangements'' but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

• Services and procedures that require inpatient care.

The statute excludes from the definition of ''covered OPD services'' ambulance services, physical and occupational therapy, and speech-language pathology services, specified in section 1833(t)(1)(B)(iii) of the Act (redesignated as section 1833(t)(1)(B)(iv) by section 201(e) of the BBRA 1999). These services are to be paid under fee schedules in all settings.

b. Comments and Responses

Comment: One commenter urged that we exclude services furnished to ESRD patients from the scope of the hospital outpatient PPS.

Response: Services furnished to ESRD patients include dialysis, Epoietin (EPO), drugs, and supplies provided outside the composite rate, surgery specific to access grafts, and many other medical services related to renal disease or to other coexisting conditions. We will continue to base payment for dialysis services on the composite rate, and we will continue to pay for EPO based on the current rate established for that service. The drugs and supplies that are used within a dialysis session, but for which payment is not included in the composite rate, are paid outside that rate. We have to conduct further analyses in order to develop appropriate APC groups upon which to base payment. In the meantime, we will continue to pay on a reasonable cost basis for dialysis related drugs and supplies that are paid outside the composite rate.

Comment: A hospital industry association took exception to the requirement that hospitals obtain a separate supplier number, post a bond, and bill separately to the DME regional carrier for DME supplies such as crutches. They believe that this is an unnecessary requirement that results in additional costs for small rural hospitals. The commenter recommended that we include within the PPS rate supplies such as crutches that are directly related to the provison of the hospital outpatient services or that we permit hospitals to bill under the DME fee schedule without having to obtain a DME supplier number or post a bond.

Response: Section 1834(j)(1)(A) of the Act provides that no payment may be made for items furnished by a supplier of medical equipment and supplies unless the supplier obtains a supplier number. Section 1834(a)(1)(C) of the Act provides that payment for DME can be made only under the DME fee schedule. Therefore, to receive payment for DME under Medicare, a hospital must obtain a supplier number and must meet the other requirements set by applicable Medicare rules and regulations.

Comment: Several major hospital associations and a number of other commenters opposed our proposal to exclude from payment certain procedures that we designate as ''inpatient only.'' Other commenters, including a physician professional society, agree that many of the procedures that we designated in the proposed rule as ''inpatient only'' are currently performed appropriately and safely only in the inpatient setting. However, these commenters believe that our explicit exclusion of individual procedures, besides being unnecessary, could have an adverse effect on advances in surgical care. Some commenters alleged that we provided no concrete support for designating procedures as ''inpatient only.'' A number of commenters argued that medicine is not practiced uniformly across the nation and that some services listed among the exclusions are currently being performed on an outpatient basis in various parts of the country with positive outcomes.

An industry association stated that we failed to consider surgical judgment and patient choice in determining the appropriate treatment setting for certain services that we proposed to exclude from coverage. Other commenters believe that the appropriate site for performing a medical service is best determined by physicians and their patients. One professional society stated that case law including medical malpractice case law is sufficient to ensure that medical services are delivered in the appropriate treatment setting and in conformance with prevailing medical standards.

Response: We recognize and acknowledge that our assigning ''inpatient only'' status to certain services and procedures raises numerous questions and concerns, and that some individual determinations can be reasonably debated. However, section 1833(t)(1)(B) of the Act explicitly authorizes the Secretary to designate which hospital outpatient services are to be ''covered OPD services'' subject to payment under the hospital outpatient PPS. Therefore, we have had to select from the universe of possible services those that we determine are reasonable, necessary, and appropriate for Medicare payment under the hospital outpatient PPS. We note that our designation of a service as ''inpatient only'' does not necessarily preclude the service from being furnished in a hospital outpatient

setting, but means only that Medicare will not make payment for the service were it to be furnished to a Medicare beneficiary in that setting. This unfortunately leaves the beneficiary liable for payment if the procedure is in fact performed in the outpatient setting. We hope that hospitals will advise beneficiaries of the consequences if procedures on the inpatient list are provided as outpatient services (that is, denial of Medicare payment with concomitant beneficiary liability). In section III.C.5 of this preamble, we discuss in greater detail our rationale for designating specific procedures as ''inpatient only.'' In response to comments, we have removed the ''inpatient only'' status from a number of services, which will allow them to be paid under the hospital outpatient PPS. We emphasize our intention to review annually, in consultation with hospital and professional societies and associations and the expert outside advisory panel mandated by the BBRA 1999, those procedures classified as ''inpatient only'' to ensure that the designation remains consistent with current standards of practice.

Comment: One industry association contends that the statutory and regulatory authorities that we cite in the proposed rule (section 1862(a)(1)(A) of the Act and 42 CFR 411.15(k)(1), respectively) do not support the proposed medical services exclusions. The commenter argues that those provisions are the basis for prohibiting coverage for services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. The commenter states that these provisions are not the basis upon which we identified services for the ''inpatient only'' list. The commenter further states that use of these provisions as a basis for denying coverage of the services would be confusing to beneficiaries.

Response: The commenter is correct that the proper citations are not section 1862(a)(1) of the Act and 42 CFR 411.15(k)(1). In fact, the basis for our designating certain procedures as ''inpatient only'' is dependent on medical judgment regarding the proper site of service, and the proper citation for such designation is section 1833(t)(1)(B) of the Act. In some instances, the identification of services to be included or excluded from this PPS was perfectly clear. For example, emergency departments (EDs) are outpatient departments of hospitals. Thus emergency services rendered in EDs qualify as outpatient services. On the other hand, coronary artery bypass graft surgery (CABG) requires many hours in surgery, part of the time with the patient's life being sustained by artificial means; a period of hours, if not days, in the surgical intensive care unit (ICU); and further care in an inpatient unit with frequent nursing attention. It clearly cannot be an outpatient procedure, and it would not be reasonable to consider it for inclusion in this PPS. There are many procedures which require similar intensity of care, including periods in specialty ICUs and several days of intense nursing attention.

Some procedures formerly performed only in the inpatient setting, however, have moved to the outpatient site of service. This movement has taken place due to new, less-invasive surgical techniques, such as laparoscopy, or new anesthesia agents that clear from the body more rapidly, allowing some patients to have general anesthesia in the morning and return home that afternoon. Thus we have had to decide which procedures may reasonably be performed in the outpatient setting, and which cannot. We have been guided in this decision by our medical advisors' clinical judgment regarding what is reasonable in various settings, comments we received in response to the proposed rule, and bill data which shows movement from one site to another. In section III.C.5, we discuss the criteria we considered in defining ''inpatient only'' procedures.

Comment: One hospital asked how we would pay a hospital that routinely performs on an outpatient basis a procedure that we proposed to designate as ''inpatient only.'' The commenter recommended that a specific billing mechanism be used to guarantee payment in these situations.

Response: Services designated as ''inpatient only'' will be excluded from Medicare payment under the hospital outpatient PPS. If the service is performed on an outpatient basis and a claim is submitted, the claim will be denied, and the beneficiary may be billed for the service. We would consider this a very poor policy on the hospital's part, and would hope that hospitals decide to abide by the constraints of the inpatient list.

Comment: One commenter noted that hospital outpatient departments have never been limited to a list of approved procedures as are Medicare participating ASCs. The commenter stated that the ''inpatient only'' policy would exclude payment for a significant number of procedures that have traditionally been performed in the hospital outpatient setting. The commenter stated that some of the excluded procedures incorporate an observation stay in a recovery care center. The commenter contended that many of the excluded procedures could be safely performed in the outpatient setting particularly if a 24 to 72 hour recovery care center is part of the outpatient surgical care provided.

Response: Routinely billing an observation stay for patients recovering from outpatient surgery is not allowed under current Medicare rules nor will it be allowed under the hospital outpatient PPS. As we state in section III.C.5 of this preamble, one of the primary factors we considered as an indicator for the ''inpatient only'' designation is the need for at least 24 hours of postoperative care.

Comment: One commenter asked what option a hospital has if a beneficiary's secondary insurer requires that a procedure included on the Medicare inpatient only list be performed on an outpatient basis.

Response: Upon implementation, the provisions of this final rule will govern payment for Medicare covered outpatient services furnished by hospitals to Medicare beneficiaries. Medicare payment policy and rules are not binding on employer-provided retiree coverage that may supplement Medicare coverage. Medigap insurers, however, must follow Medicare's coverage determinations.

c. Payment for Certain Implantable Items Under the BBRA 1999

In the course of identifying items and services whose costs we proposed to designate for payment under the hospital outpatient PPS, we gave considerable thought to including implantable items and services because these items and services are such an integral part of the procedure by which they are inserted or implanted. However, a number of the more common implants such as aqueous shunts, hallux valgus implants, infusion pumps, and neurostimulators, are classified as implantable prosthetics or DME. The statutory language governing payment for DMEPOS provides that, notwithstanding any other provision of the Medicare statute, DMEPOS must be paid for using the DMEPOS fee schedule. Therefore, under the proposed rule, the scope of services paid under the hospital outpatient PPS did not include implantable prosthetics and DME paid under the DMEPOS fee schedule. However, we did propose to package payment for implanted items such as stents, vascular catheters, and venous ports within the APC payment rate for the procedure related to the insertion of these items because we

define these items as supplies rather than as prosthetic implants or implantable DME.

Section 201(e) of the BBRA 1999 amends section 1833(t)(1)(B) of the Act to provide that ''covered OPD services'' include implantable items described in paragraph (3), (6), or (8) of section 1861(s) of the Act. The conference report accompanying the BBRA 1999, H. R. Rep. No. 436 (Part I), 106th Cong., 1st Sess. (1999), expresses the belief of the conferees that the current DMEPOS fee schedule is not appropriate for certain implantable medical items such as pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants as well as items that come into contact with internal human tissue during invasive medical procedures, but are not permanently implanted. In the conference report agreement, the conferees state their intention that payment for these items be made through the outpatient PPS, regardless of how these products might be classified on current HCFA fee schedules. The implantable items affected by this BBRA 1999 requirement include prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care and including replacement of these devices); implantable DME; and implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

Comment: A number of commenters disagreed with our proposal to pay under the DMEPOS fee schedule for implantable items and devices that require surgical insertion. We received comments on specific implantable items, including Vitrasert (a drug delivery system that is implanted in the eye); cochlear devices, which allow the profoundly deaf to hear sound and in some cases recognize speech; nerve stimulators that treat intractable epilepsy and other diseases; new technology intraocular lenses implanted following cataract surgery; and access devices for dialysis treatment. Commenters were also concerned that the costs of some implantable devices not paid under the DMEPOS fee schedule, which we packaged in our proposed rule, were not properly recognized in the APC payment.

Response: As we explain above, the amendments made to the statute by section 201(e) of the BBRA 1999 provide for payment to be made under the hospital outpatient PPS for implantable items that are part of diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests; implantable durable medical equipment; and implantable prosthetic devices (other than dental). This BBRA 1999 provision requires that an implantable item be classified to the group that includes the service to which the item relates. Thus, under this final rule with comment period, we are including within the scope of the hospital outpatient PPS items such as aqueous shunts that would, absent the BBRA 1999 provision, have been paid under the DMEPOS fee schedule. Because implantable items are now packaged into the APC payment rate for the service or procedure with which they are associated, certain items may be candidates for the transitional pass-through payment, which is discussed in detail in section III.D of this preamble. The APC rates may not in every case perfectly recognize the cost of implantable items. We will continue to review the impact of packaging implantables in future updates.

d. Summary of Final Action

We are modifying proposed § 419.22 to remove prosthetic implants from the list of services excluded from payment under the hospital outpatient PPS. We are adding subparagraphs (9), (10), and (11) to proposed § 419.2(b), to include the following in the list of items and services whose costs are included in hospital outpatient PPS payment rates: prosthetic implants (other than dental) that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), and including replacement of these devices; implantable DME; and implantable items used in performing diagnostic x-rays, diagnostic laboratory tests, and other diagnostic tests.

2. Services Included Within the Scope of the Hospital Outpatient PPS

We proposed to include three categories of services within the scope of the outpatient PPS, as follows:

a. Services for Patients Who Have Exhausted Their Part A Benefits

Section 1833(t)(1)(B)(ii) of the Act provides for Medicare payment under the hospital outpatient PPS for certain services designated by the Secretary that are furnished to inpatients who have exhausted their Part A benefits or who are otherwise not in a covered Part A stay. Examples of services covered under this provision include diagnostic x-rays and certain other diagnostic services and radiation therapy covered under section 1832 of the Act.

b. Partial Hospitalization Services

Section 1833(a)(2)(B) of the Act provides that partial hospitalization services furnished in CMHCs be paid under the hospital outpatient PPS. Partial hospitalization is a distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients who have profound and disabling mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment program.

c. Services Designated by the Secretary

We proposed to designate the following services to be paid under the hospital outpatient PPS:

- All hospital outpatient services, except those that are identified as excluded, above, in section III.B.1 of this final rule. The types of services subject to payment under the hospital outpatient PPS include the following: surgical procedures; radiology, including radiation therapy; clinic visits; emergency department visits; diagnostic services and other diagnostic tests; partial hospitalization for the mentally ill; surgical pathology; and cancer chemotherapy.
- Specific hospital outpatient services furnished to a beneficiary who is admitted to a Medicare-participating SNF but who is not considered to be a SNF resident, for purposes of SNF consolidated billing, with respect to those services that are beyond the scope of SNF comprehensive care plans. The specific hospital outpatient services that are excluded from SNF consolidated billing are cardiac catheterization, computerized axial tomography (CAT) scans, MRIs, ambulatory surgery involving the use of an operating room, emergency room services, radiation therapy, angiography, and lymphatic and venous procedures.
- Supplies such as surgical dressings used during surgery or other treatments in the hospital outpatient setting that are also paid under the DMEPOS fee schedule. Payment for these supplies, when they are furnished in a hospital outpatient setting, is packaged into the APC payment rate for the procedure or service with which the items are associated.
- Certain preventive services furnished to healthy persons, such as colorectal cancer screening.

Section 4523(d)(3) of the BBA 1997 amended section 1833(a)(2)(B) of the Act to provide that we discontinue reasonable cost based payment and instead make Part B payment under the hospital outpatient PPS for certain medical and other health services when

they are furnished by other providers such as hospices, SNFs, and HHAs. Specifically, we proposed to pay under the hospital outpatient PPS for the following medical and other health services when they are furnished by a provider of services:

- Antigens (as defined in 1861(s)(2)(G) of the Act);
- Splints and casts (1861(s)(5) of the Act);
- Pneumococcal vaccine, influenza vaccine, hepatitis B vaccine (1861(s)(10) of the Act).

Upon implementation of the hospital outpatient PPS, we would make Part B payment for the above services under the outpatient PPS when they are furnished by an HHA or hospice program. We would also make payment for antigens and the vaccines under the PPS when they are furnished by CORFs. (Splints and casts furnished by CORFs are paid under the rehabilitation fee schedule.) However, this provision would not apply to services furnished by a CORF that fall within the definition of CORF services at section 1861(cc)(1) of the Act. It also would not apply to services furnished by a hospice within the scope of the hospice benefit. Nor would it apply to services furnished by HHAs to individuals under an HHA plan of treatment within the scope of the home health benefit.

d. Summary of Final Action

We received no comments about the services we proposed to include within the scope of the hospital outpatient PPS. As noted in the preceding section III.B.1, we added certain implantable items to § 419.2(b) to implement section 201(e) of the BBRA 1999.

3. Hospital Outpatient PPS Payment Indicators

In the September 8, 1998 proposed rule in the **Federal Register,** we proposed a payment status indicator for every code in the HCPCS to identify how the service or procedure described by the code would be paid under the hospital outpatient PPS. We received no comments on our proposal to assign a payment status indicator to every HCPCS code. (In section III.C.6, below, we respond to commenters who disagreed with the payment status indicator that we proposed for individual codes.) Therefore, we are implementing payment status indicators as part of the hospital outpatient PPS. Addendum B displays the final payment status indicator for each HCPCS code, including codes for incidental services that are packaged into APC payment rates. Addendum E identifies the HCPCS codes to which we have assigned payment status indicator ''C'' to identify inpatient services that are not payable under outpatient PPS as implemented by this final rule. We respond below, in section III.C.5, to public comments about the specific codes we classified as inpatient services in the proposed rule and our final determination regarding the payment status of those codes.

The following are the payment status indicators and description of the particular services each indicator identifies:

- We use ''A'' to indicate services that are paid under some other method such as the DMEPOS fee schedule or the physician fee schedule.
- We use ''C'' to indicate inpatient services that are not paid under the outpatient PPS.
- We use ''E'' to indicate services for which payment is not allowed under the hospital outpatient PPS. In some instances, the service is not covered by Medicare. In other instances, Medicare does not use the code in question, but does use another code to describe the service.
- We use ''F'' to indicate corneal tissue acquisition costs, which are paid separately.
- We use ''G'' to indicate a current drug or biological for which payment is made under the transitional pass-through.
- We use ''H'' to indicate a device for which payment is made under the transitional pass-through.
- We use ''J'' to indicate a new drug or biological for which payment is made under the transitional pass-through.
- We use ''N'' to indicate services that are incidental, with payment packaged into another service or APC group.
- We use ''P'' to indicate services that are paid only in partial hospitalization programs.
- We use ''S'' to indicate significant procedures for which payment is allowed under the hospital outpatient PPS but to which the multiple procedure reduction does not apply.
- We use ''T'' to indicate surgical services for which payment is allowed under the hospital outpatient PPS. Services with this payment indicator are the only services to which the multiple procedure payment reduction applies.
- We use ''V'' to indicate medical visits for which payment is allowed under the hospital outpatient PPS.
- We use ''X'' to indicate ancillary services for which payment is allowed under the hospital outpatient PPS.

The table below lists types of services, the hospital outpatient PPS payment status indicator assigned to each type of service, and the basis for Medicare payment for the service.

MEDICARE HOSPITAL OUTPATIENT PPS PAYMENT STATUS INDICATORS: HOW MEDICARE PAYS FOR VARIOUS SERVICES WHEN THEY ARE BILLED FOR HOSPITAL OUTPATIENTS

Indicator	Service	Status
A	Pulmonary Rehabilitation; Clinical Trial	Not paid.
C	Inpatient Procedures	Not paid.
A	Orthotics, and Non-implantable Durable Medical Equipment and Prosthetics.	DMEPOS Fee Schedule.
E	Nonallowed Items and Services	Not paid.
A	Physical, Occupational and Speech Therapy	Rehab Fee Schedule.
A	Ambulance	Reasonable cost or charge or, when implemented, Ambulance Fee Schedule.
A	EPO for ESRD Patients	National Rate.
A	Clinical Diagnostic Laboratory Services	Lab Fee Schedule.
A	Physician Services for ESRD Patients	Bill to Carrier.
A	Screening Mammography	Lower of Charge or National Rate.
N	Incidental Services, Packaged into APC Rate	Packaged; No Additional Payment Allowed.
P	Partial Hospitalization Services	Paid Per Diem.
S	Significant Procedure, Not Reduced When Multiple Procedures Performed.	Paid Under Hospital Outpatient PPS (APC Rate).
T	Significant Procedure, Multiple Procedure Reduction Applies	Hospital Paid Under Outpatient PPS (APC Rate).

MEDICARE HOSPITAL OUTPATIENT PPS PAYMENT STATUS INDICATORS: HOW MEDICARE PAYS FOR VARIOUS SERVICES WHEN THEY ARE BILLED FOR HOSPITAL OUTPATIENTS—Continued

Indicator	Service	Status
V	Visit to Clinic or Emergency Department	Paid Under Hospital Outpatient PPS (APC Rate).
X	Ancillary Service	Paid Under Hospital Outpatient PPS (APC Rate).
F	Acquisition of Corneal Tissue	Paid at reasonable cost.
G	Current Drug/Biological Pass-Through	Additional payment.
H	Device Pass-Through	Additional payment.
J	New Drug/Biological Pass-Through	Additional payment.

C. Description of the Ambulatory Payment Classification (APC) Groups

1. Setting Payment Rates Based on Groups of Services Rather Than on Individual Services

In our March 17, 1995 report to Congress, we recommended that groups similar to the ambulatory patient groups (APGs) developed by 3M Health Information Systems (3M) be used as the basis for the hospital outpatient PPS. We made this recommendation after examining a number of other payment systems that were already in place or under development, including DRGs that are the basis for Medicare payment for hospital inpatient services, the Medicare physician fee schedule that was implemented in 1992, and the payment groups that have been the basis for Medicare payments for ambulatory surgical center (ASC) facility services since 1982.

As provided by the BBA 1997, section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered outpatient services. Section 1833(t)(2)(B) provides that this classification system may be composed of groups, so that services within each group are comparable clinically and with respect to the use of resources. The statute refers to ''each such service (or group of services),'' confirming that the Secretary may choose or not choose to group services.

We explain in our proposed rule that we revised the APGs, based on more recent Medicare data than that used by 3M, to create the ambulatory payment classification (APC) system. We proposed to group services identified by HCPCS codes and descriptors within APC groups as the basis for setting payment rates under the hospital outpatient PPS. We indicated that we organized the APC groups so that the services within each group would be homogeneous both clinically and in terms of resource utilization. We invited comments on our proposal to set rates on the basis of groups of services rather than on individual codes.

Comments: Some commenters claimed that basing payment on APC groups rather than on individual services would result in underpayment for services that are more resource intensive, causing hospitals with a more resource intensive case mix to lose money. An organization representing physicians strongly opposed the use of APCs, because it believes that it is not possible to achieve an incentive-neutral, ''level playing field'' payment system using groups of codes or services. This organization favored replacing the APC system with a fee schedule based on individual services, similar to the Medicare physician fee schedule, as MedPAC recommends in its 1999 report to Congress. (We address the MedPAC recommendation later in this section.) The same physician organization is concerned that the broad range of services included in each APC will create an incentive for hospitals to provide lower cost services, even though a patient might require higher cost services. This organization expressed concern about the negative impact on physicians if a payment methodology similar to the APC system were applied to payment for physician services. To facilitate pricing new codes using individual services rather than APC groups, the same organization suggested that we establish a ''relative value relationship in direct costs'' between the new code and a comparable code, or that we consult AMA's Specialty Society RVS Updating Committee (RUC) for advice on relative cost relationships.

One major hospital association expressed its preference for a service-specific fee schedule because of the wide variation in costs represented by groups of codes. Another hospital association advocated using individual services rather than groups of services as the basis for ratesetting, but recommended, if we were to use some form of grouping, that we apply tight limits on the variations of costs for services within a group.

Response: We understand the concerns of commenters that setting payment weights using groups of services rather than individual services could result in payment for particular services that might not fully offset the costs that hospitals incur when they furnish expensive, resource-intensive services. However, we believe these concerns are in large measure addressed by the provisions of this final rule. As we explain in section III.C.6, we significantly restructured the proposed APC groups, first in response to comments and, second, to comply with section 1833(t)(2) of the Act, as amended by the BBRA 1999, which limits the variation of costs of services classified within a group. The result is more APC groups with fewer codes and a narrower range of costs in each group. In addition, other provisions of the BBRA 1999, such as the transitional pass-throughs (see section III.D, below), and outlier payments and transitional corridors (see section III.H, below) protect hospital revenues while hospitals gain experience with the PPS.

Medicare Payment Advisory Commission (MedPAC) Recommendation

In both its March 1998 and March 1999 reports to the Congress on Medicare payment policy, MedPAC recommends that payment rates under the hospital outpatient PPS be based upon costs of individual services rather than groups of similar services to help ensure consistent payments across ambulatory settings. In its March 1999 report, MedPAC asserts its belief that the burden imposed by our proposed APC system outweighs its benefits in ambulatory settings. MedPAC gives several reasons to support its position.

- The use of groups to calculate weights masks questionable cost data for low volume and new procedures.
- Different classes of hospitals face disproportionate impacts, suggesting APC groups may not be as homogeneous as we believe.
- Grouping services will likely create additional administrative burdens for hospitals, because hospitals may have to purchase or develop new software and will experience additional education and training costs.

Response: We carefully reviewed the concerns about using groups of services

expressed by MedPAC in its March 1998 report, and we responded to those concerns in our proposed rule (63 FR 47562). Even though MedPAC concedes in its March 1999 report that using groups to set rates has certain potential advantages, MedPAC continues to oppose using groups because, according to MedPAC, they entail considerable costs and drawbacks and necessitate ''a much more complicated design logic'' than would be required using a service-level fee schedule.

We do not share MedPAC's concerns. We have a high level of confidence in the ratesetting method using APC groups that we implement in this final rule with comment period. As we explain below, in section III.C.6, we have extensively restructured the APC groups to respond to comments on the proposed rule, to incorporate specific provisions of the BBRA 1999, and to correct some errors that had come to our attention. We believe that by using median costs in the calculation of group weights, we limit the extent to which infrequently performed services with suspect costs can affect the payment rate of an APC group.

As discussed below in the impact analysis (section IX of this preamble), the provisions of this final rule with comment period, which include setting rates using APC groups, alleviate to a large extent the disproportionate impacts on different classes of hospitals estimated in our proposed rule. In addition, as we explain in section III.C.6, when we restructured the APC groups, we were particularly attentive to the degree of provider concentration associated with the individual services within a group in order to avoid biasing the payment system against any subset of hospitals.

Finally, none of the commenters cited increased administrative burden as an argument against using groups. Even though we are using APC groups to set rates under the hospital outpatient PPS, hospitals will bill for services using HCPCS codes (not APCs) using the same claims forms that they use currently. Although to receive payment under the new system, hospitals will have to more fully code the services they furnish, they will not have to know to which APC the service is assigned in order to determine the payment amount. We are publishing the payment rate applicable to each HCPCS code in Addendum B of this final rule. Any burdens on hospitals necessitating additional technical assistance, training, or systems changes are more a function of implementing an entirely new payment system than of our setting rates on the basis of groups of services.

Final Action: The payment rates implemented by this final rule with comment period are determined based on APC groups that use HCPCS codes to describe individual services. The codes assigned to an APC group are comparable clinically and in terms of resource use.

2. Packaging Under the APC System

a. Summary of Proposal

In our proposed rule, we described packaged services as those items or services that we recognized as contributing to the cost of the procedures or services in an APC group, and for which we would not make separate payment. We proposed to include as packaged services use of the operating room and recovery room, anesthesia, medical/surgical supplies, pharmaceuticals, observation, blood, intraocular lenses, casts and splints, the costs of acquiring tissue such as corneal tissue for surgical insertion and various incidental services such as venipuncture. We packaged the services (and their costs) within the APC group of procedures with which they were delivered in the base year. For a list of proposed packaged services grouped by hospital revenue centers, refer to the June 30, 1999 correction notice (64 FR 35258).

b. General Comments and Responses (Supporting or Objecting to Packaging)

Comment: Few commenters disagreed with our proposal to aggregate into one payment the costs for a ''package'' of services variously related to a procedure or to the principal service being furnished. However, many commenters did object to our packaging costs for certain specific items such as expensive drugs and pharmaceuticals, observation services in the emergency department, blood and blood products, corneal tissue acquisition costs, and chemotherapy and supportive drugs. Commenters, fearful that packaging items and services will result in lower payments that do not offset the high costs of particularly expensive items, raised the prospect of dire consequences such as forcing hospitals to use only the cheapest drugs, being unable to employ oncology nurses, eliminating otherwise clinically necessary ancillary services, or not being able to hold emergency room patients for observation.

Response: We are persuaded by commenters' arguments that packaging payment for certain expensive items and services into an APC group rate could have such a potentially negative impact as to jeopardize beneficiary access to these items and services in the hospital outpatient setting. Therefore, in response to comments, we are not packaging within an APC payment rate the costs associated with certain specified items and services. Instead, we will make a separate APC payment for these particular items and services under the outpatient PPS. However, as we explain in section III.C.2.d, we do not concur with commenters who urge separate payment for observation services; rather, we are packaging the costs in the APC for each service with which observation services were billed in our 1996 database. We discuss in further detail below, in section III.C.2.d through section III.C.2.g, and in section III.C.6, the changes that we are making to the packaging we originally proposed. We address in section III.B.1, above, the BBRA 1999 provision that requires us to package into APC group rates payment for certain implantable items and devices. In section III.D, below, we describe additional payments for certain packaged medical devices, drugs, and biologicals that are provided as transitional pass-throughs under section 201(b) of the BBRA 1999.

As we gain experience with and collect additional cost data under the hospital outpatient PPS, we will review our policy to pay separately for certain items and services that would otherwise be packaged into the APC payment. Should we decide to modify this policy, we will do so through the rulemaking process as part of our annual hospital outpatient PPS update.

MedPAC Recommendation: In its March 1999 report to the Congress, MedPAC cites two models that Medicare uses to define a unit of payment: the DRG-based payment model for hospital inpatient services, and the Medicare physician fee schedule. MedPAC contends that services provided in the hospital outpatient setting more closely parallel those furnished in an office-based setting than those furnished as part of a hospital inpatient admission. Therefore, MedPAC recommends that, in establishing ambulatory care prospective payment systems in general, we define the unit of payment for ambulatory care facilities as an individually coded service, consisting of the primary service that is the reason for the encounter, and the necessary and essential ancillary services and supplies integral to it, including limited follow-up care if it is integral to the primary service, but not including physicians' services. MedPAC further recommends that the unit of payment be defined consistently across all ambulatory care settings.

Response: The packaging that we proposed as the basis for determining APC payment rates and that we will implement under the hospital outpatient PPS is generally consistent with MedPAC's recommendation. However, we did not propose to include ''limited follow-up services'' in our packaged groups under the hospital outpatient PPS because of the difficulty of matching in our database the costs of these services with their associated primary encounter. For now, hospitals are to bill follow-up care, such as suture removal, using an appropriate medical visit code. We did not propose, nor have we included in this final rule with comment period, provision for a global period for hospital outpatient services analogous to the global period affecting payments for professional services made under the Medicare physician fee schedule.

c. Packaging of Casts and Splints

Comment: One commenter stated that we should not package costs for casts and splints with other procedures.

Response: We proposed to assign payment status indicator ''N'' to CPT codes for strapping and casting services (CPT codes 29000–29750) to designate that these are incidental services for which payment is packaged into the APC rate for another service or procedure, in this case, the repair or reduction of a fracture or dislocation. After further review, we determined that strapping and casting services can be performed independently, for example, when a cast placed as a part of a procedure must later be replaced with another cast. Therefore, we have decided that strapping and casting services will not be packaged and we are creating two APCs (0058 and 0059) to pay for these services. The BBA 1997 required that we pay under the outpatient PPS for casting and strapping services furnished in HHAs and hospices, to the extent that these services are provided and are not within the patient's plan of care.

d. Packaging of Observation Services

We received many comments urging us to pay separately for observation services, particularly when patients are seen in the emergency department. Observation service is placing a patient in an inpatient area, adjacent to the emergency department, or, according to some comments, in the intensive care unit (ICU) or coronary care unit (CCU), in order to monitor the patient while determining whether he or she needs to be admitted, have further outpatient treatment, or be discharged. After 1983, many hospitals began to rely heavily on the use of observation services when peer review organizations questioned admissions under the hospital inpatient prospective payment system. However, in some cases, patients were kept in ''outpatient'' observation for days or even weeks at a time. This resulted in excess payments both from the Medicare program and from beneficiaries who generally paid a higher coinsurance. In response to this practice, in November 1996, we issued instructions limiting covered observation services to no more than 48 hours except in the most extreme circumstances. However, the cost data upon which the APC system is based contain all costs for observation in 1996, including those that exceeded the 48-hour limit imposed at the end of that year. We have packaged those costs into the service with which they were furnished in the base year. Thus, APC payments for emergency room visits include the costs of observation within the payment.

Comment: Some commenters acknowledged that being paid separately for observation following a surgical procedure was not necessary; the packaged recovery room and observation services were sufficient. However, a major concern of commenters was observation of patients with chest pain who had equivocal results on initial diagnostic testing. Commenters were concerned that the APC payment for these cases would not be adequate.

Response: We assume that chest pain patients, such as those described by the commenters, are sent to the CCU or ICU for observation. We believe that, in general, if a patient needs to be monitored in the ICU or CCU for any length of time, then that patient should be admitted as an inpatient. Furthermore, we have never considered care furnished in an ICU or CCU to be outpatient services. Existing cost reporting instructions allow for the use of these specialty beds during a shortage of regular inpatient beds, but charges are to reflect routine care, not intensive care.

Although, as noted above, we received many comments urging that observation services be covered as a separate APC, we continue to believe that these services have been used so inappropriately in the past that we will have to gather data under the PPS before considering constructing a separate APC. We have packaged observation wherever it was billed. Roughly $139 million was identified by revenue code 762 as representing observation services. An additional $253 million was identified in revenue codes 760, 761, and 769, which could be used for either observation or treatment room use. That $253 million is also packaged. (Both figures are in 1996 dollars.)

Further analyses will be necessary on the use of observation as an adjunct to emergency treatment, as in the case of chest pain. In order to ensure that we will have sufficient data for our future analyses, hospitals must continue to bill for observation using revenue center 762 and showing hours in the units field. Observation that is billed must represent some level of active monitoring by medical personnel. It must not be billed as a way to capture room and board for outpatients. During our first review of the APC groups, we will assess whether patients with certain conditions use observation services that should be separately recognized. Thus, correct diagnosis coding is required.

e. Packaging Costs of Procuring Corneal Tissue

Comment: We received about 2,000 comments from physicians, eye banks, and health care associations opposing our proposal to package corneal tissue acquisition costs into the APC payment for corneal transplant procedures. Most commenters argued that the payment for the procedures in proposed APC group 670, Corneal transplant, is grossly inadequate and that we have failed to recognize the high costs associated with tissue screening and testing procedures required by the Food and Drug Administration that are reflected in the fees charged by eye banks. In addition, commenters contended that we failed to recognize the wide variation in tissue acquisition costs resulting from the level of philanthropic contributions in different areas of the country and in different years. Commenters asserted that by packaging corneal tissue acquisition costs with the payment for corneal transplant surgery, we would limit beneficiary access to quality care, force eye banks that are nonprofit, low-cost operations to close, provide disincentives for philanthropic contributions, and impede our goal to increase tissue availability.

As part of their comments, the Eye Bank Association of America (EBAA) submitted a report of a study the EBAA commissioned on corneal tissue acquisition costs. The study was conducted by the Lewin Group which collected and analyzed data on corneal tissue acquisition costs incurred by 74 of EBAA's 100 members that are charitable nonprofit organizations. The report states that these 74 eye banks supplied approximately 82 percent of the corneal tissue distributed

throughout the United States in 1997. Based on the data that they collected, the Lewin Group found that the median gross acquisition cost per transplant is $1,689 in 1999 dollars. Of this amount, approximately $233 represents the national median value of donated in-kind services such as volunteer staff. The Lewin Group concluded that the proposed hospital outpatient PPS payment of $1,583 did not adequately reflect the cost of procuring corneal tissue.

Additionally, the report states that ''fund raising and in-kind service values are not as well centered on their median values as the underlying cost data. Variability in fund raising and in-kind contributions not only exists between eye banks, but from year to year, within the same eye bank.'' According to the study, charitable contributions in the form of cash and in-kind services represented 28 percent of the eye banks' total gross cost for tissues furnished in 1997. The Lewin Group finds that ''If HCFA were to move to fee schedule or other fixed-payment rate, and pays the adjusted median Gross cost Per Transplant * * * payment of $1689, HCFA would overpay some banks and underpay others, depending on philanthropy and in-kind services which varies from community to community and from year to year. The variation is too extreme to determine a fair rate-based system, without destroying the philanthropy the community is built upon.''

Response: Based on the concerns raised by the commenters and the data presented in the Lewin Group study, we have decided not to package payment for corneal tissue acquisition costs with the APC payment for corneal transplant surgical procedures at this time. Instead, we will make separate payment, based on the hospital's reasonable costs incurred to acquire corneal tissue. Final payment will be subject to cost report settlement. To receive payment for corneal acquisition costs, hospitals must submit a bill using HCPCS code V2785, Processing, preserving and transporting corneal tissue, and indicate the acquisition cost rather than the hospital's charge on the bill. We intend to review this policy after we have acquired updated data on corneal procedures.

f. Packaging Costs of Blood and Blood Products

Comment: Many commenters, including the American Red Cross, a major medical association, teaching hospitals, and community oncology centers, believe that the payments we proposed for blood and blood-related products and for APCs that required the use of blood and blood-related products, were too low. Commenters claimed that the proposed payments are so much lower than actual costs that hospitals might be forced to stop providing a range of blood services, especially those more complex than a simple transfusion. The commenters were concerned that our proposed payment would not allow hospitals to furnish the most clinically appropriate blood products and services. The commenters also stated that blood and blood product exchange were not assigned to appropriate APCs, thus skewing payment rates and not recognizing the true costs of services with which blood and blood product exchange are associated. Commenters attributed this deficiency to the fact that certain blood-related products were incorrectly billed in the 1996 data we used as the basis for pricing APCs. Commenters were also concerned that we excluded procedures whose costs fell outside 3 standard deviations of the mean cost. One major organization recommended that we separate payment for blood and blood products from the service with which it is associated. This commenter also recommended separate payment for infusible blood-derived drugs, and that we base payment for transfusable blood products on costs. Some commenters recommended a transition period prior to full implementation of the proposed PPS.

Response: Based on the recommendations of commenters, we have created separate APC groups to pay for blood and blood products. We agree with the commenters that blood use varies enough that packaging blood units with their administration could lead to inequities. Because we were not able to capture enough claims data in the base year to accurately price the blood and blood-product APCs, we have based payment rates for these APCs on data provided by commenters, including suppliers of blood and blood products. We have based payment on current costs rather than 1996 costs so that we recognize the costs of recently developed blood safety tests. The safety of the nation's blood supply is a major concern of the Department of Health and Human Services, and we want to encourage appropriate testing and follow-up care.

g. Packaging Costs for Drugs, Pharmaceuticals, and Biologicals

We proposed to package the cost of drugs, pharmaceuticals, and biologicals with APC groups because we believe drugs are usually provided in connection with some other treatment or procedure. We collected aggregate cost data on all drugs that were billed with HCPCS codes and those billed with revenue center codes, whether or not a HCPCS was entered. By so doing, we captured historical patterns of drug use within the APC groups with which the drugs were billed during the base year. However, because we did not require HCPCS coding of drugs, we could not isolate costs associated with individual drugs, some of which are very expensive even though they are rarely used and may be used by only a few hospitals. As a result, we acknowledge that our proposed APC payment rates may not fully reflect costs of very expensive drugs or biologicals.

We also proposed to create separate drug groups for chemotherapeutic agents because those were separately identified in the APG system designed by 3M. However, because we did not have bills that were coded to identify drugs individually, we were concerned that the APC groups for chemotherapeutic groups may not have completely reflected the costs of these drugs.

Comment: Many commenters criticized the proposed APC payment rates because they were developed using cost data from 1996 that do not reflect the cost of many new drugs, pharmaceuticals, and biologicals. Some commenters expressed particular concern about oncology drugs such as paclitaxil (Taxol) and topotecan. Some advised that Taxol and carboplatin chemotherapy have become the standard treatment for ovarian carcinoma. A number of commenters believe that our proposal did not provide sufficient financial incentives to dissuade hospitals from using the older less effective chemotherapy regimens even though there is significantly greater toxicity and reduced chances of favorable outcomes associated with their use. Many commenters strongly suggested that we carve out new drugs and biologicals and those introduced after 1996 from the PPS and pay for them on a reasonable cost basis. Several commenters asserted that packaging drugs and pharmaceuticals within the APC groups understates their cost to hospitals and their value to patients.

Response: We believe the commenters' concerns have, to a great extent, been addressed by implementation of the BBRA 1999 pass-through provisions for drugs and biologicals. Addendum K includes a complete list of all drugs, biologicals, and medical devices that are eligible for pass-through payments. We encourage interested parties to follow the process outlined below in section III.I.4 of this

preamble to submit requests for consideration of drugs, biologicals, and medical devices that may be eligible for additional payment under the transitional pass-through provision but that are not listed in Addendum K.

h. Summary of Final Action

After consideration of comments received about packaging of services and of the requirements set forth in the amendments made to section 1833(t) of the Act by section 201(b) and section 201(e) of the BBRA 1999, we have revised the package of services directly related and integral to performing a procedure or furnishing a service on an outpatient basis whose costs will determine the national payment rate for that procedure or service under the hospital outpatient PPS.

- We will package into the APC payment rate for a given procedure or service any costs incurred to furnish the following items and services: Use of an operating suite, procedure room or treatment room; use of the recovery room or area; use of an observation bed; anesthesia; medical and surgical supplies and equipment; surgical dressings; supplies and equipment for administering and monitoring anesthesia or sedation; intraocular lenses; capital-related costs; costs incurred to procure donor tissue other than corneal tissue; and, various incidental services such as venipuncture.
- In general, we will package the cost of drugs, pharmaceuticals and biologicals into the APC payment rate for the primary procedure or treatment with which they are used. Additional payment for some drugs, pharmaceuticals, and biologics may be allowed under the transitional pass-through provisions, which we explain below, in section III.D.
- We will *not* package payment for corneal tissue acquisition costs into the payment rate for corneal transplant surgical procedures at this time. We will make separate payment for these acquisition costs based on the hospital's reasonable costs incurred to acquire corneal tissue.
- We will *not* package into the APC payment rate for another procedure or service costs incurred to furnish the following items and services: blood and blood products, including anti-hemophilic agents; casting, splinting, and strapping services; immunosuppressive drugs for patients following organ transplant; and certain other high cost drugs that are infrequently administered. We have created new APC groups for these items and services, which allows separate payment to be made for them.

3. Treatment of Clinic and Emergency Department Visits

a. Provisions of the Proposed Rule

As we discussed in our proposed rule, determining payment for hospital clinic and emergency department (ED) visits requires a variety of considerations such as the following:

- The impact of packaging on setting payment rates.
- How to code visits in a manner that recognizes variations in service intensity and levels of resource consumption.
- How to keep the system administratively manageable.
- How to define critical care in terms of facility as opposed to physician input.
- Data problems associated with identifying costs from claims that list multiple services.
- How to move toward greater uniformity of payments across ambulatory settings so as to remove payment as an incentive for determining site of service.

The major issue we faced in determining payment for hospital clinic and ED visits is whether to include diagnosis as well as *Physicians' Current Procedural Terminology* (CPT) codes in setting payment rates.

In our proposed rule, we considered several approaches to setting prospective payment rates for hospital clinic and ED visits. Potential options included: (1) Using diagnosis codes only; (2) using CPT codes only; and (3) using a CPT-diagnosis code hybrid. We solicited comments on these approaches to setting payment rates for clinic and ED visits as well as comments on alternative approaches that we did not set forth in the proposed rule. In the proposed rule, we discussed in detail our assessment of the advantages and disadvantages of each approach.

In addition, we proposed to create a HCPCS code that would be used to bill when a patient presents to an ED, requests a screening, and is screened in accordance with section 1867(a) of the Act. Payment for this new code would be minimal because we included no treatment costs in the screening service. Payment for the screening APC would be made only when no additional services were furnished by the emergency department. If nonemergency treatment was furnished, the appropriate emergency department visit would be billed, and not the screening. Similarly, if the screening reveals that an emergency does exist and treatment is instituted immediately, the screening would not be billed because we would consider payment to be subsumed into the payment for further treatment.

We proposed paying for critical care as the highest level of ''visit.'' In our proposed rule, we stated that hospitals would use CPT code 99291 to bill for outpatient encounters in which critical care services are furnished.

We used the CPT definition of ''critical care'' which is the evaluation and management of the critically ill or injured patient. Under the outpatient PPS, we would allow the hospital to use CPT code 99291 in place of, but not in addition to, a code for a medical visit or for an emergency department service. Although the CPT system allows the physician to bill in 30-minute increments following the first 74-minute period of providing critical care, we proposed to pay separately for only the initial period (CPT code 99291), packaging the few instances in which the 30-minute increments (CPT code 99292) were billed. If other services, such as surgery, x-rays, or cardiopulmonary resuscitation, were furnished on the same day as the critical care services, we would allow the hospital to bill for them separately.

b. Comments and Responses

Comment: The major hospital associations argued that none of our three proposed approaches fully explains facility resource use in connection with clinic and emergency visits. Hospitals did not see a clear benefit in the payment ranges created by using the CPT and diagnosis hybrid approach. A major medical association adamantly opposed the use of diagnosis codes. One major HMO that does not currently use CPT codes was opposed to the use of CPT codes to describe clinic and emergency visits.

Response: In this final rule, we are not using patient diagnosis codes to compute payment rates for medical visits to clinics and emergency departments under the outpatient PPS because a number of concerns were raised about basing payment for medical visits on both HCPCS codes and ICD–9 diagnosis codes. The final payment groups for medical visits are constructed using CPT procedure codes only, which is consistent with our overall PPS grouping strategy and with the approach we have followed to establish payment groups for surgical and diagnostic services. However, we will continue to require hospitals to provide accurate diagnosis coding on claims for payment. We will continue to assess the value of using patient diagnosis for application

to our payment system for possible use in the future.

In developing medical visit APCs based on CPT procedure codes only (a change from the proposed rule), we are collapsing 31 CPT codes that define clinic and emergency visits into six groups, three each for the clinics and the emergency department. The final APC groups for clinic and emergency visits are as follows: APC 0600, Low Level Clinic Visits; APC 0601, Mid-Level Clinic Visits; APC 0602, High Level Clinic Visits; APC 0603, Interdisciplinary Team Conference; APC 0610, Low Level Emergency Visits; APC 0611, Mid-Level Emergency Visits; APC 0612, High Level Emergency Visits; and APC 0620, Critical Care.

When basing payment on CPT codes alone, the range of costs reflects hospitals' billing patterns in increasing level of intensity. However, those increasing increments are due largely to hospitals' use of ''chargemaster'' systems, which generate bills using predetermined charges for codes. Thus, billing patterns reflect standard bills, not the resources used in any particular case.

We had been concerned that certain hospitals' use of the lowest level code, CPT code 99201, to bill for all clinic visits would distort the data, causing inflation in both the volume and cost of low-level clinic visits, and a corresponding underreporting of mid- and high-level visits. (Costs for mid- and high-level visits would presumably have been correct, because individual hospitals would have reported appropriate charges with these codes; there simply would have been fewer reported visits at those levels.)

We have developed the weights for clinic visits by using claims data only from a subset of hospitals that billed a wider range of visits rather than relying solely on claims with CPT code 99201. We chose to use this subset of hospitals (for this purpose only) because we do not know what CPT code 99201 indicates when hospitals use it exclusively to bill all visits.

We emphasize the importance of hospitals assessing from the outset the intensity of their clinic visits and reporting codes properly based on internal assessment of the charges for those codes, rather than failing to distinguish between low-and mid-level visits ''because the payment is the same.'' The billing information that hospitals report during the first years of implementation of the hospital outpatient PPS will be vitally important to our revision of weights and other adjustments that affect payment in future years. We realize that while these HCPCS codes appropriately represent different levels of physician effort, they do not adequately describe nonphysician resources. However, in the same way that each HCPCS code represents a different degree of physician effort, the same concept can be applied to each code in terms of the differences in resource utilization. Therefore, each facility should develop a system for mapping the provided services or combination of services furnished to the different levels of effort represented by the codes. (The meaning of ''new'' and ''established'' pertain to whether or not the patient already has a hospital medical record number.)

We will hold each facility accountable for following its own system for assigning the different levels of HCPCS codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, we will assume that it is in compliance with these reporting requirements as they relate to the clinic/emergency department visit code reported on the bill. Therefore, we would not expect to see a high degree of correlation between the code reported by the physician and that reported by the facility.

Hospitals are required to use HCPCS code 99291 to report outpatient encounters in which critical care services are furnished. (See the American Medical Association's CPT 2000 coding manual for the definition of this code.) The hospital is required to use HCPCS code 99291 in place of, but not in addition to, a code for a medical visit or for an emergency department service.

We will work with the American Hospital Association and the American Medical Association to propose the establishment of appropriate facility-based patient visit codes in time for the next proposed rule.

Comment: Several commenters expressed concern that resources expended in the emergency department are not fully explained by the codes at their disposal. One commenter pointed out that some hospitals use internal coding systems to capture differing charges based on whether or not a case requires one-on-one nursing care.

Response: While we share commenters' concerns on this point, we remind hospitals that they can receive additional payment under the outpatient PPS for services such as diagnostic testing and administration of infused drugs, and for therapeutic procedures including resuscitation that are furnished during the course of an emergency visit. We will also pay separately for certain high cost drugs, such as the expensive ''clotbuster'' drugs that must be given within a short period of time following a heart attack or stroke, if these drugs are furnished during an emergency visit. Even though some ED patients will be transferred to another hospital for inpatient treatment, the hospital that administers the drugs will be paid for them. Cases that fall far outside the normal range of costs will be eligible for an outlier adjustment established by section 201(a) of the BBRA 1999. (See section III.H, below.) In addition, one of the first topics of review to be addressed by the expert outside advisory panel, required by section 201(h)(1)(B) of the BBRA 1999, will be to determine if emergency department visits can be categorized in a way that better recognizes the underlying resources, especially nursing resources, involved in the visit.

Comment: Several commenters expressed concern about the appropriate level of payment for patients who die in the ED. One commenter believes that services furnished to these patients are resource-intensive and recommends that we continue to pay for the services on a reasonable cost basis.

Response: We are directing fiscal intermediaries to use the following guidelines in determining how to make payment when a patient dies in the ED or is sent directly to surgery and dies there.

- If the patient dies in the ED, make payment under the outpatient PPS for services furnished.
- If the ED or other physician orders the patient to the operating room for a surgical procedure, and the patient dies in surgery, payment will be made based on the status of the patient. If the patient had been admitted as an inpatient, pay under the hospital inpatient PPS (a DRG-based payment). If the patient was not admitted as an inpatient, pay under the outpatient PPS (an APC-based payment). If the patient was not admitted as an inpatient and the procedure is designated as an inpatient-only procedure (payment status indicator ''C''), no Medicare payment will be made for the procedure, but payment will be made for ED services.

Comment: Some commenters objected to our proposal to restrict payment for critical care services to CPT code 99291 and not allow payment for CPT code 99292. One commenter recommended that we create an APC group for the additional increments of time a physician spends in critical care for which the physician may bill.

Response: We do not believe that paying hospitals for incremental time as critical care would better reflect facility resources. The most resource-intensive period for the hospital is generally the first hour of critical care. In addition, we believe it would be burdensome for hospitals to keep track of minutes for billing purposes. Therefore, we will pay for critical care as the most resource-intensive visit possible as defined by CPT code 99291. Critical care services will be assigned to APC 0620.

Comment: Several commenters advised that a screening code was not necessary because an emergency visit code could be billed for ED screening services.

Response: We agree with the commenters, and we will instead use the appropriate emergency department codes for screening services (as defined in section 1867(a) of the Act). If no treatment is furnished, we would expect screening to be billed with a low-level emergency department code.

Comment: Some commenters expressed concern about our proposal to allow hospitals to create a separate claim for each visit when two or more medical visits occur on the same day for different diagnoses. Commenters feared that this would result in our paying under the outpatient PPS for clinic care furnished at sites other than hospital outpatient departments, and that we are promoting fragmented care. One commenter was concerned that, to the extent that patients see multiple specialists, tests will be repeated unnecessarily, hospitalizations will rise, and beneficiaries and the Medicare program will be burdened with additional, unnecessary costs.

Response: Our decision not to use diagnosis codes as a factor in determining payment for clinic visits largely negates these concerns because the need to prepare different claims for visits for different diagnoses has been eliminated. When patients are seen in different clinics on the same day, hospitals should bill using the proper codes for the level of the visits, using the units field if appropriate to reflect more than one visit at the same level.

However, we note that the comment did prompt us to develop a code for billing those visits during which numerous physicians see a patient concurrently, for example, a surgeon, medical oncologist, and radiation oncologist for a cancer patient, to discuss treatment options and to ensure that the patient is fully informed. In this instance, each physician is addressing the patient's care from a unique perspective. If several physicians see a patient concurrently in the same clinic for the same reason, the hospital would bill for one clinic visit using an appropriate visit code even though each physician would bill individually for his or her professional services. We have established a code for hospitals to use in reporting a scheduled medical conference with the patient involving a combination of at least three health care professionals, at least one of whom is a physician. That code is G0175, Scheduled interdisciplinary team conference (minimum of three, exclusive of patient care nursing staff) with patient present.

4. Treatment of Partial Hospitalization Services

As we explained in the proposed rule, partial hospitalization is an intensive outpatient program of psychiatric services provided to patients in lieu of inpatient psychiatric care. Partial hospitalization may be provided by a hospital to its outpatients or by a Medicare-certified community mental health center (CMHC). It is important to note that the services of physicians, clinical psychologists, clinical nurse specialists (CNSs), nurse practitioners (NPs), and physician assistants (PAs) furnished to partial hospitalization patients would continue to be billed separately to the carrier as professional services and are not considered to be partial hospitalization services. Thus, payment for partial hospitalization services represents the provider's overhead costs, support staff, and the services of clinical social workers (CSWs) and occupational therapists (OTs), whose professional services are considered to be partial hospitalization services for which payment is made to the provider. Including CSW and OT services reflects historical patterns of treatment billed during the base year.

Because a day of care is the unit that defines the structure and scheduling of partial hospitalization services, we proposed a per diem payment methodology for the partial hospitalization APC. We analyzed the service components billed by hospitals over the course of a billing period and determined the median hospital cost of furnishing a day of partial hospitalization. As noted in the June 30, 1999 correction notice, this analysis resulted in a proposed APC payment rate of $206.71 per day, of which $46.78 is the beneficiary's coinsurance.

We also solicited comments on a number of issues related to partial hospitalization. We asked for information on the mix of services that constitute a typical partial hospitalization day and average duration of a partial hospitalization episode, whether we should impose a minimum number of services for each covered partial hospitalization day, and whether we should establish a limit on routine outpatient mental health services furnished on a given day to equal the partial hospitalization per diem amount. Finally, we indicated that we are considering specifying a timeframe for physician recertification of need for partial hospitalization services as a method of ensuring that a patient's condition continues to require the intensity of a partial hospitalization program.

We did not receive a significant number of public comments on this issue. A summary of the comments we received and our responses follow.

Comment: We received many similar comments from rural hospitals that operate partial hospitalization programs. The hospitals indicated that the proposed per diem amount does not cover their direct cost of providing services. Each commenter included an estimate of their partial hospitalization program cost (without depreciation or allocation of overhead costs). The estimates range from $270 to $325 per patient per day. The commenters indicated that approximately 65 to 70 percent of the costs are personnel-related.

Response: The commenters did not indicate why their costs were higher than the per diem amount, but only that a significant proportion of their costs are related to personnel. In the future, we are committed to assessing the extent to which the per diem reflects special needs of rural hospitals. In the meantime, the BBRA 1999 includes provisions that offer relief to rural hospitals during the early years of the outpatient PPS. (See section III.H of this preamble.)

Comment: We received several other comments regarding the proposed per diem amount. One commenter stated that the proposed per diem rate is equivalent to 3.3 psychotherapy units. The commenter believed this is an inadequate level of therapy for partial hospitalization patients and suggested that a per diem rate equal to 4 psychotherapy units would provide payment for a more appropriate level of service intensity. Several other commenters suggested that we set a single rate using a therapeutic hour of treatment (for example, the group psychotherapy APC rate) as the unit of service coupled with an overall aggregate limit for a course of treatment. These commenters estimated that a typical partial hospitalization day costs $275. Another commenter, a national association, conducted a survey of its

member hospitals which showed that the median cost per day of treatment was approximately $210. Other commenters urged us to establish separate per diem amounts for partial hospitalization programs serving geriatric beneficiaries and those serving disabled beneficiaries under age 65. They indicated that programs designed to serve geriatric beneficiaries consist of different treatment modalities that are costlier than programs that serve younger beneficiaries. One commenter stated that programs serving younger beneficiaries typically average high patient volume and therefore have much lower costs per patient day than do the programs that serve geriatric patients. Other commenters urged us to establish a half day rate, although some stated that a half-day benefit does not reduce administrative costs appreciably.

Response: In accordance with section 1833(t)(2)(C) of the Act, the proposed per diem amount represents the national median cost of providing partial hospitalization services. We used all the data from hospital bills that included the condition code 41, which identifies the claim as partial hospitalization. Because providers do not report on the claim the specific services provided each day, we do not currently have data that would permit us to establish an aggregate limit for a course of treatment or to analyze differences in the mix of services provided to various populations. As discussed in the preamble to the proposed rule and in Transmittal 7 of the CMHC Manual (issued November 1999) and Transmittal 747 of the Hospital Manual (issued December 1999), beginning April 1, 2000, hospitals and CMHCs will be required to indicate line item dates of service on claims. Once we have accumulated these data, we will be better able to determine if refinements to the per diem methodology are warranted, including the extent to which half-days are utilized.

Comment: Several commenters expressed concern that no CMHC data were used to establish the partial hospitalization per diem payment rate. The commenters stated that CMHC costs are significantly different from hospital-based programs and urged us to collect CMHC cost data and base payments to CMHCs on CMHC-specific information. Another commenter stated that implementing PPS for partial hospitalization services provided by CMHCs is intended to contain costs and urged us to track the impact of the PPS on CMHCs. Still another commenter expressed concern that the per diem amount is insufficient for CMHCs to provide quality services. The commenter admitted, however, that historically their service area has had limited resources to provide minimum support for the persistent and chronically mentally ill. Two commenters expressed concern about certification requirements for CMHCs. One urged us to require accreditation by a national accrediting body and another commenter noted that reliance on the statutory definition established for CMHCs under the Public Health Service Act in 1963 is no longer appropriate and urged us to redefine a CMHC for Medicare certification purposes.

Response: Partial hospitalization services are covered services under the hospital outpatient PPS. Section 1833(a)(2)(B) of the Act provides that partial hospitalization services furnished by CMHCs are to be paid under the hospital outpatient PPS. And, section 1833(t)(2)(C) of the Act requires that we establish relative payment weights based on median (or mean, at the election of the Secretary) hospital costs determined by 1996 claims data and data from the most recent available cost reports. As stated above, we are committed to analyzing future data from hospitals and CMHCs to determine if refinements to the per diem are warranted. As we noted in the proposed rule, the Medicare partial hospitalization benefit is designed to furnish services to patients who have been discharged from inpatient psychiatric care, and partial hospitalization services are provided in lieu of continued inpatient treatment, and for patients who exhibit disabling psychiatric/psychological symptoms or experience an acute exacerbation of a severe and persistent mental disorder. Because the statute requires a physician to certify that the patient would otherwise require inpatient psychiatric care in the absence of the partial hospitalization services, we do not believe the Medicare partial hospitalization benefit was intended to provide support for the persistent and chronically mentally ill except when they are in an acute phase of their mental illness. With regard to accreditation requirements for CMHCs and substantively revising the definition of a CMHC, this final rule is not the appropriate vehicle in which to address these issues. We are, however, amending § 410.2 to remove an obsolete provision from the definition of a CMHC.

Comment: Several commenters questioned whether the proposed per diem approach meets the definition of an APC, that is, a group of services that are comparable clinically and in resource use. They believed that partial hospitalizations vary widely in their treatment approach and cost. Therefore, creating one payment amount for all partial hospitalization days is not consistent with our proposed classification system.

Response: We continue to believe that the structure of the average partial hospitalization day is more similar than the commenters believe. We followed the basic analytical methodology used to establish all the APC payment amounts, except that we determined that, for partial hospitalization services, the unit of service is a day. Nonetheless, requiring providers to submit claims by date of service and by service provided will allow for future analysis to determine if the APC grouping for partial hospitalization can be improved.

Comment: One commenter expressed concern about the use of 1996 data as the basis for the per diem amount. They referenced testimony by the Inspector General that indicated a significant improvement in the accuracy of provider billing in 1998 audits. They urged us to use 1997 or 1998 cost reports by region to develop the APC rate.

Response: Section 1833(t)(2)(C) of the Act requires that we use 1996 claims data and the most recent cost reports as the basis for ratesetting under the hospital outpatient PPS. For purposes of the final rule, we primarily used cost reports for periods beginning in FY 1997.

Comment: Several commenters, including national industry associations, expressed concern that partial hospitalization programs are required by their individual fiscal intermediaries to meet different medical necessity and programmatic requirements. For this reason, programs vary widely in program content and resultant cost. The commenters urged us to establish national coverage criteria before implementing a PPS for partial hospitalization services. Another commenter urged us to rely on more recent claims data that identify all services provided on each date of service in order to determine the relative resource cost of various outpatient mental health treatment programs.

Response: Section 1833(a)(2)(B) of the Act provides that partial hospitalization services are paid under section 1833(t). We will refine the system, as needed, based on our review of more specific bill data. Movement to a per diem payment methodology will necessitate changes in the medical review approach used by fiscal intermediaries. It will become necessary to ensure that all patients receive the level of service their

individual condition requires. Some patients will require days of service that cost the provider more than the per diem payment amount. Other patients may require less intensive days of service during an acute episode of partial hospitalization care or as they transition out of the partial hospitalization program. We will be developing medical review guidance for fiscal intermediaries, which we believe will lead to more consistency in medical review.

Comment: One commenter noted that, in the past, a daily or partial-day payment approach was commonly used and was abandoned in favor of component billing for each partial hospitalization service. The commenter now believes that component billing provides a more accurate indication of the services provided to individual patients.

Response: We believe that a per diem payment approach is a more appropriate methodology than billing for each program component. This approach is supported by the major industry groups involved with partial hospitalization and is used by other governmental and private insurers to pay for partial hospitalization program services. A per diem approach also incorporates and recognizes the cost of services that are not separately billable as outpatient psychiatric services, such as nursing services, training and education services, activity therapy, and support staff costs.

Comment: Several commenters requested additional information on the HCPCS codes to which the partial hospitalization indicator applies and questioned how codes will group to APC 20 rather than grouping to psychotherapy APCs 91 through 94. They also asked whether substance abuse day programs will group to APC 20.

Response: We issued revised billing instructions for partial hospitalization services provided by CMHCs in November 1999 and for hospital programs in December 1999. We instructed CMHCs to use HCPCS codes to bill for their partial hospitalization services; we required hospitals and CMHCs to report line item dates of service; and we established new HCPCS codes for occupational therapy and training and educational services furnished as a component of a partial hospitalization treatment program. We included in the instructions a complete listing of the revenue codes and HCPCS codes that may be billed as partial hospitalization services as follows:

Revenue codes	Description	HCPCS code
43X	Occupational Therapy (Partial Hospitalization)	G0129.
904	Activity Therapy (Partial Hospitalization)	Q0082.
910	Psychiatric General Services	90801, 90802, 90875, 90876, 90899, or 97770.
914	Individual Psychotherapy	90816, 90818, 90821, 90823, 90826, or 90828.
915	Group Psychotherapy	90849, 90853, or 90857.
916	Family Psychotherapy	90846, 90847, or 90849.
918	Psychiatric Testing	96100, 96115, or 96117.
942	Education Training (Partial Hospitalization)	G0172.

To bill for partial hospitalization services under the hospital outpatient PPS, hospitals are to use these HCPCS and revenue codes and are to specify condition code 41 on the HCFA–1450 claim form. Before assigning a claim for payment to APC 0033 (the final APC for partial hospitalization services), the outpatient code editor (OCE) will check for errors; for example, the OCE will verify that the claim includes a mental health diagnosis, and at least three partial hospitalization HCPCS codes for each day of service, one of which must be a psychotherapy HCPCS code (other than brief). Claims that do not pass the OCE edits will undergo further prepayment review.

With regard to the comments regarding substance abuse day programs, the Medicare benefit category is partial hospitalization services. Because there is no separate benefit category for substance abuse programs, any such program would have to meet requirements established for partial hospitalization programs in order for claims to group to APC 0033, including the requirements that a physician certify that the patient would otherwise require inpatient psychiatric care in the absence of the partial hospitalization services and that the program provides active treatment.

Comment: In regard to physician recertification, we received several comments expressing support for establishing a specific timeframe and recommending a range from 7 to 31 days.

Response: We agree that physicians should initially certify a patient's need for partial hospitalization services and recertify continued need for this intensive level of treatment. Because partial hospitalization is the outpatient substitute for inpatient psychiatric care, we believe it is appropriate to adopt the standard currently used for inpatient psychiatric care. Therefore, in this final rule, we are amending § 424.24(e) to establish physician recertification requirements for partial hospitalization services. The initial physician certification establishing the need for partial hospitalization must be received by the partial hospitalization program upon admission. Thus, services provided to establish a patient's need for partial hospitalization services would continue to be billed to the carrier as professional services. The first recertification is required as of the 18th day of services and subsequent recertifications are required no less frequently than every 30 days. Each recertification must address the patient's response to the intensive, therapeutic interventions provided by the active treatment program which make up partial hospitalization services, changes in functioning and status of the serious psychiatric symptoms that place the patient at risk of hospitalization, and treatment plan and goals for coordination of services such as community supports and less intensive treatment options to facilitate discharge from the partial hospitalization program.

Comment: We received several comments regarding our proposal to limit payment for less intensive outpatient mental health treatment at the partial hospitalization per diem rate. One commenter did not believe the law supports establishment of a payment ceiling and that any such action is arbitrary. Other commenters believe that treatment should be determined by the clinical needs of each patient. However, the commenters conceded that additional requirements may have to be added to the final rule to prevent duplication or overlap of partial

hospitalization and routine outpatient mental health services.

Response: Our rationale for this proposal was that the costs associated with administering a partial hospitalization program represent the most resource intensive of all outpatient mental health treatment and, therefore, we should not pay more for a day of individual services. We are also concerned that a provider may disregard a patient's need for the intensive active treatment offered by a partial hospitalization program and opt to bill for individual services. In addition, the per diem amount represents the cost of an average day of partial hospitalization because the data used to calculate the per diem were derived from all the partial hospitalization data and include the most and the least intensive days. It would not be appropriate for a provider to obtain more payment through component billing.

Comment: Several commenters expressed concern about staffing services that are bundled in the per diem payment and other staffing issues. One commenter stated that due to increased medical review by the fiscal intermediary, no partial hospitalization services may be furnished by unlicensed personnel. The commenter urged that the necessity for upgrades in staffing be taken into consideration in establishing a per diem rate. One commenter believes that all services, except for physician services, should be bundled into the per diem rate.

Response: The list of covered partial hospitalization services is located in section 1861(ff) of the Act. The list includes several services such as patient education and training and activity therapy that may be provided by unlicensed but qualified staff who are specifically trained to work with the mentally ill. We note that the billing instructions issued in November 1999 (for CMHCs) and in December 1999 (for hospitals) announced a new HCPCS code for patient training and education services as a component of a partial hospitalization program. (A HCPCS code for activity therapy as part of a partial hospitalization program has been in place for several years.) Although the list also specifically references the services of social workers, trained psychiatric nurses, and other staff trained to work with psychiatric patients, there are no specific HCPCS codes for these services. Certain other partial hospitalization services, for example, individual and group psychotherapy, family counseling, occupational therapy (OT), and diagnostic services, must be provided by licensed staff, authorized by the State to provide these services.

With regard to the content and staffing of partial hospitalization programs, we believe that all the covered services listed in section 1861(ff) of the Act and the disciplines of the staff who provide the services, that is, the multidisciplinary team, are an important element in creating the therapeutic milieu that distinguishes partial hospitalization programs from other outpatient mental health treatment. We believe it would be inappropriate if providers no longer offered the full range of partial hospitalization services, especially services such as OT that continue to be bundled in the per diem amount. We plan to monitor the extent to which providers change their programming in response to implementation of the PPS. Because the data on which the per diem was based included the full range of services and the use of certain bundled professionals, we will monitor changes in services or increased use of unbundled practitioners to evaluate and update the per diem rate. In response to the comment recommending that we bundle more professional services into the per diem rate, we captured historical patterns of treatment and staffing during the base year. Thus, the partial hospitalization per diem amount is limited to the provider's overhead costs, support staff, and the services of clinical social workers and occupational therapists, whose professional services are defined as partial hospitalization services. We have amended § 410.43(b) to update the list of services that are not paid as partial hospitalization services.

Comment: One commenter took issue with our characterizing partial hospitalization to be the result of an acute exacerbation of a beneficiary's severe and persistent mental illness for which partial hospitalization services are provided in lieu of an inpatient psychiatric admission. They urged us to clarify that admission to a partial hospitalization is based on a physician certification that the patient would otherwise require inpatient psychiatric care, but continued stay in a partial hospitalization program would serve as a maintenance program for the chronically mentally ill. The commenter raised many other concerns about how we described partial hospitalization in the proposed rule, noting specific concern with regard to active treatment, community-based support, and frequency and duration of services.

Response: It was not our intention in the proposed rule to generate public comment on the nature and coverage of partial hospitalization under the Medicare program. Rather, the information presented has appeared in various program memoranda and was included to describe the benefit and explain the per diem payment methodology. We continue to believe that partial hospitalization is a covered Medicare benefit category only when provided as an alternative to inpatient psychiatric care for acutely mentally ill beneficiaries.

Result of Evaluation of Comments

We are adopting as final our proposal to—

- Establish a per diem payment of $202.19 for the partial hospitalization APC (APC 0033); and
- Limit the payment for outpatient mental health treatment furnished on a day of services to the partial hospitalization APC payment amount.

In addition, we are amending § 424.24(e) to establish requirements for physician recertification for partial hospitalization services.

5. Inpatient Only Procedures

In our proposed rule, we assigned payment status indicator ''C'' to 1,803 codes that represent procedures that our medical advisors and staff determined require inpatient care because of the invasive nature of the procedure, the need for postoperative care, or the underlying physical condition of the patient who would require the surgery. We did not assign these procedures to an APC group, and we proposed to make no payment for these services under the hospital outpatient PPS. Above, in section III.B.1.b of this preamble, we respond to the numerous general comments we received challenging both our classification of various procedures as inpatient procedures and our exclusion of these procedures from the scope of services paid under the hospital outpatient PPS.

Comment: Commenters objected on the grounds that medical practice and new technology have allowed many procedures that formerly were performed only in the inpatient setting to be safely and effectively performed on an outpatient basis. In addition, they believe we are making decisions that should be left to the discretion of surgeons and their patients. Finally, the commenters believe that it is better for the patient if procedures are performed on an outpatient basis whenever possible. Commenters requested that we remove the payment status indicator of ''inpatient only'' from 195 codes and include them in an appropriate APC.

Response: Under section 1833(t)(1)(B)(i) of the Act, the Secretary has broad authority to designate which

services fall within the definition of ''covered OPD [outpatient department] services'' that will be subject to payment under the prospective payment system. We believe that certain surgically invasive procedures on the brain, heart, and abdomen, such as craniotomies, coronary-artery bypass grafting, and laparotomies, indisputably require inpatient care, and therefore are outside the scope of outpatient services. Certain other procedures that we proposed as ''inpatient only'' may not be so clearly classified as such, but they are performed virtually always on an inpatient basis for the Medicare population. We acknowledge that emerging new technologies and innovative medical practice are blurring the difference between the need for inpatient care and the sufficiency of outpatient care for many procedures, although we are concerned that some of the procedures that commenters claim to be performing on an outpatient basis may actually have been performed with overnight postoperative care furnished in observation units. And, regardless of how a procedure is classified for purposes of payment, we expect, as we stated in our proposed rule, that in every case the surgeon and the hospital will assess the risk of a procedure or service to the individual patient, taking site of service into account, and will act in that patient's best interests.

After a careful review of comments by our medical advisors and staff, we have assigned to APC groups certain procedures that we had proposed as inpatient only. We made some changes because we were convinced by commenters' arguments that certain procedures are often performed safely in the outpatient setting; others because we believe that the simplest procedure described by the code may be performed safely in the outpatient setting; and yet others because they were related to codes we moved (for example, the radiologic part of an interventional cardiology procedure). The procedures we moved to the outpatient APCs include codes from within the following families: Explorations of penetrating wounds; repairs of some cranial and facial fractures; planned tracheostomies; diagnostic thoracoscopies; some insertion/removal/replacement of pacemakers, pulse generators, electrodes and cardioverter-defibrillators; embolectomies and thrombectomies; transluminal balloon angioplasty and peripheral atherectomy; transcatheter therapies; bone marrow transplantation; gastrostomies; percutaneous nephrostolithotomy; surgical laparoscopies, including cholecystectomies; ovarian biopsies; and surgeries on the orbit. Although we are moving these procedures into APC groups and they can receive outpatient payment, we emphasize that we expect only the simplest and least resource intensive procedures of each type to be performed in the outpatient setting. For example, several codes could be used to describe initial insertion of a pacemaker or replacement of the pacemaker or its electrodes. We believe most initial pacemaker insertions are performed on an inpatient basis, so codes billed in this range are most likely to be for replacement of a pacemaker, which requires fewer facility resources.

Because of the risk involved with invasive cardiovascular procedures, including angioplasty and atherectomy, we are placing an additional requirement on their performance that we do not think is necessary with other procedures. That is, Medicare will pay for these procedures only in those settings in which the patient can immediately be placed on cardiopulmonary bypass in the event of a complication such as perforation of a coronary artery, which would require an immediate thoracotomy.

When our medical advisors and staff disagreed with the recommendation of commenters to reclassify a particular procedure, they based their decision to retain a procedure as ''inpatient only'' on several considerations. In general terms, as stated above, we define inpatient procedures as those that require inpatient care because of the invasive nature of the procedure, the need for at least 24 hours of postoperative recovery time or monitoring before the patient can be safely discharged, or the underlying physical condition of the patient who would require the surgery. In other words, inpatient procedures are those that, in the judgment of our medical advisors and staff, would not be safe, appropriate, or considered to fall within the boundaries of acceptable medical practice if they were performed on other than a hospital inpatient basis.

Among the procedures cited by commenters that we believe should remain as ''inpatient only'' are: Breast reconstruction using myocutaneous flaps; radical resections of tumors of the mandible; open treatment of certain craniofacial fractures; osteotomies of the femur and tibia; sinus endoscopy with repair of cerebrospinal fluid leaks; carinal reconstruction; surgical thoracoscopies; pacemaker procedures by thoracotomy; certain thromboendarterectomies; excision of mediastinal cysts and tumors; excisions of stomach tumors; enterostomies; hepatotomies; ureterotomies and ureteral endoscopies through ureterotomies; transcranial approaches to the orbit; and laminectomies. Our medical advisors and staff, as well as consulting physicians, believe these procedures are too invasive (for example, thoracotomies), too extensive (for example, breast reconstruction with myocutaneous flaps), or too risky by virtue of proximity to major organs (for example, repairs of spinal fluid leaks and carinal reconstruction) to be performed on an outpatient basis. The procedures that we exclude from outpatient payment because we believe they should be performed on an inpatient basis are listed in Addendum E. This list represents national Medicare policy and is binding on fiscal intermediaries and peer review organizations as well as on hospitals and Medicare participating ASCs. Note, however, that services included in outpatient PPS and assigned to an APC may be performed on an inpatient basis when the patient's condition warrants inpatient admission.

In the future, as part of our annual update process, we will be working with professional societies and hospital associations, as well as with the expert outside advisory panel that we will be convening as required by new section 1833(t)(9)(A) of the Act, to reevaluate procedures on the ''inpatient only'' list and we will propose to move procedures to the outpatient setting whenever we determine it to be appropriate. For example, a decreasing length of inpatient stay for a procedure may signal that it is appropriate for consideration for payment under the outpatient PPS. If hospitals find that surgeons are discharging patients successfully on the day of surgery, they should bring this to our attention as well, because hospitals may become aware of this trend before our payment data disclose it. Thus, assignment of a ''C'' payment status indicator in this final rule should not be considered as a permanent or irrevocable designation.

Comment: One professional society recommended that we assign payment status indicator ''C'' to CPT codes 21343, open treatment of depressed frontal sinus fracture, 42842, radical resection of tonsil, tonsillar pillars, and/or retromolar trigone—without closure, and 69150, radical excision external auditory canal lesion—without neck dissection, because these procedures require inpatient care.

Response: We accepted the commenters' recommendation that these CPT codes should not be performed in an outpatient setting. We also reclassified as an inpatient procedure

CPT code 94762, noninvasive ear or pulse oximetry for oxygen saturation; by continuous overnight monitoring (separate procedure), because it requires an overnight stay.

Comment: One commenter noted that, to the extent that we require that certain surgical procedures be performed in an inpatient setting in order to receive Medicare payment, the beneficiary will incur the higher deductible associated with a hospital inpatient service.

Response: The commenter is correct that the Part A hospital inpatient deductible amount that a beneficiary will have to pay may be higher than coinsurance and deductibles the beneficiary would have paid as an outpatient for a surgical procedure. However, our decisions concerning whether to pay for certain surgical procedures under the PPS are based on patient safety concerns and the medical appropriateness of performing the procedures in the hospital inpatient versus outpatient setting.

Final Action

Under the hospital outpatient PPS, we will not make payment for procedures that are designated as ''inpatient only.'' We have, however, revised the list of procedures that are designated as ''inpatient only'' based on comments. (See Addendum E.)

6. Modification of APC Groups

a. How the Groups Were Constructed

Section 1833(t)(2)(A) of the Act requires the Secretary to develop a classification system for covered outpatient services. Within that classification system, the Secretary is given the authority under section 1833(t)(2)(B) of the Act to establish groups of covered services so that the services within each group are comparable clinically and with respect to the use of resources. In the proposed rule, we explain how we constructed the APC groups that are the basis for ratesetting under the hospital outpatient PPS.

Our medical advisors and staff used the ambulatory patient groups (APGs) developed by 3M-Health Information Systems as a starting point for the APC groups, but we modified the APGs to take into account 1996 outpatient claims data, data collected in a 1994 survey of ambulatory surgical center (ASC) costs and charges, data collected in 1995 and 1996 to establish resource-based practice expense relative values under the Medicare physician fee schedule, and comments offered by a broad range of professional and trade societies and associations. For a more detailed discussion of this process, see section V.B of the proposed rule (63 FR 47561).

b. Comments on Classification of Procedures and Services Within APC Groups

In the proposed rule, we invited comments on the composition of the APC groups, and we requested that commenters support their recommendations for changes with resource cost data and clinical arguments. We received a large number of comments on our proposed grouping of individual procedures and services. The most common comment was that the APC groups generally lacked consistency in terms of clinical characteristics and resource utilization. Below, in section III.C.6.d of this preamble, we address recommendations from commenters that specific HCPCS codes be assigned to a group other than the one we proposed. In addition to reviewing the APC groups that were the subject of comments, our medical advisors and staff reviewed every APC group to take into account the effect across all related groups of commenters' recommended changes.

Criteria for Evaluating Changes Recommended by Commenters

In determining whether or not to accept a recommended change, we focused on five criteria that are fundamental to the definition of a group within the APC system. The decision to accept or decline a modification to an APC group was measured by whether the change enhanced, detracted from, or had no effect on the integrity of an APC group within the context of these five criteria. The five criteria are as follows:

• Resource Homogeneity

The amount and type of facility resources, for example, operating room time, medical surgical supplies, and equipment, that are used to furnish or perform the individual procedures or services within each APC should be homogeneous. That is, the resources used are relatively constant across all procedures or services even though resource use may vary somewhat among individual patients. If the procedures within an APC require widely varying resources, it would be difficult to develop equitable payment rates. Aggregated payments to a facility that performed a disproportionate share of either the expensive or inexpensive procedures within an APC would be distorted. Further, the facility might be encouraged to furnish only the less costly procedures within the APC, resulting in a potential access problem for the more costly services.

It is important to note that procedures within an individual HCPCS code can vary widely in resource use. The coefficient of variation of cost for the procedures within one HCPCS code can be as high as the overall coefficient of variation across all the HCPCS codes that comprise an APC group. Thus, a significant amount of the variability in resource use within some APC groups can be attributed to the variability of resources within individual HCPCS codes. Nevertheless, if resource use is reasonably homogeneous among the HCPCS codes within an APC group, the average pattern of resource use among a group of cases in an APC can be accurately predicted. In section III.C.6.c, below, we discuss the BBRA 1999 provision that sets limits on the variation in resource cost within an APC.

• Clinical Homogeneity

The definition of each APC group should be ''clinically meaningful,'' that is, the procedures or services included within the APC group relate generally to a common organ system or etiology, have the same degree of extensiveness, and utilize the same method of treatment, for example, surgical, endoscopic, etc. The definition of clinical meaningfulness is, of course, dependent on the goal of the classification system. For APCs, the definition of clinical meaningfulness relates to the medical rationale for differences in resource use. If, on the other hand, classifying patient prognosis were the goal, the definition of patient characteristics that were clinically meaningful might be different.

• Provider Concentration

We considered the degree of provider concentration associated with the individual services that comprise the APC. If a particular service is offered only in a limited number of hospitals, then the impact of payment for the service is concentrated in a subset of hospitals. Therefore, it is particularly important to have an accurate payment level for services with a high degree of provider concentration. Conversely, the accuracy of payment levels for services that are routinely offered by most hospitals does not bias the payment system against any subset of hospitals. Thus, differences in the resource requirements for individual services within an APC are of less significance if all the services within the APC are routinely offered by most hospitals because the impact of the difference should average out at the hospital level.

• Frequency of Service

Unless we found a high degree of provider concentration, we avoided creating separate APC groups for

services that are infrequently performed. It is difficult to establish reliable payment rates for low volume APC groups. Therefore, we assigned the HCPCS codes to the APC that was the most similar in terms of resource use and clinical coherence.

Some procedures, such as craniotomies, are clearly inpatient procedures, and are rarely performed in an outpatient setting. However, there are some procedures that, while they are normally performed on an inpatient basis, can also be safely performed on an outpatient basis. The performance of those procedures on an outpatient basis is infrequent and is limited to the simplest cases. Therefore, when we included these procedures in APC groups, we assumed a level of resource use that would apply only to the simplest cases rather than that typical of more complex cases that would be performed on an inpatient basis.

• Minimal Opportunities for Upcoding and Code Fragmentation

The APC system is intended to discourage using a code in a higher paying group to define a case. That is, putting two related codes, such as the codes for excising a lesion of 1.1 cm and one of 1.0 cm, in different APC groups may create an incentive to exaggerate the size of the lesions in order to justify the incrementally higher payment. APC groups based on subtle distinctions would be susceptible to this kind of upcoding. Therefore, we kept the APC groups as broad and inclusive as possible without sacrificing resource or clinical homogeneity.

In general, HCPCS codes that are nonspecific (such as 20999, ''unlisted procedure, musculoskeletal system, general'') were assigned to the lowest paying APC that was consistent with the clinical characteristics of the service. In the case of 20999, the codes to which it is related are in the range 20000–20979. The APCs to which they group range from 0004, with a payment rate of $89.22, to 0050, with a payment rate of $1,024.53. We placed 20999 in the lowest paying, related group, 0004.

c. Effect of the BBRA 1999 on Final APC Groups

Section 201(g) of the BBRA 1999 amends section 1833(t)(2) of the Act to limit the variation in resource use among the procedures or services within an APC group. Specifically, section 1833(t)(2) of the Act now provides that the items and services within a group cannot be considered comparable with respect to the use of resources if the highest cost item or service within a group is more than 2 times greater than the lowest cost item or service within the same group. The Secretary is to use either the mean or median cost of the item or service. We are using the median cost because we have continued to set the relative payment weights for each APC based on median hospital costs in this final rule. (See the discussion in section III.E of this preamble.)

Section 1833(t)(2) of the Act as amended also allows the Secretary to make exceptions to this limit on the variation of costs within each group in unusual cases such as low volume items and services, although we may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act. See the discussion of the classification of orphan drugs in section II.D of this preamble and the discussion of APC groups that we excepted from the ''2 times'' limit in section III.C.6.e.

We applied the limit on variation on median costs required by section 201(g) to the revised APC groups. (See section C.6.d, below.) As a result of our analysis of the array of median costs within the revised APC groups, we had to split some otherwise clinically homogeneous APC groups into smaller groups. We are concerned that this further subdivision of groups may create vulnerabilities for upcoding, which conflicts with one of the five criteria described above that we used to evaluate the construction of the APC groups. We will be examining the extent to which the APC reorganization due to the ''2 times'' rule results in upcoding.

d. Summary of APC Modifications

In this section, we summarize and explain our response to comments on individual or serial APCs. We use the APC number that appeared in the proposed rule to identify a group that was changed. In most instances, we moved a HCPCS code from its proposed APC group to a different APC group either in response to comments or to comply with section 1833(t)(2)(C) of the Act. In some cases, we moved codes when a change in response to a comment or the cost variation limit resulted in a grouping that seriously compromised one of the criteria we used to evaluate changes recommended by commenters. Because we made so many changes in the APC groups, we renumbered all the groups and, in many cases, renamed groups. In our response to comments in connection with an APC, the final designation for a HCPCS code corresponds to the renumbered APC group found in the addenda.

APC 121: Level I Needle Biopsy/ Aspiration

Comment: One specialty society commented that there was significant variation in resource consumption for the procedures performed in this APC and that the proposed payment rate of $33.95 for APC 121 does not accurately reflect the preparation, examination, and consultation expenses for a pathologist to thoroughly perform these procedures. The commenter recommended including CPT codes 85095, 85102, 88170, and 88171 in proposed APC 122.

Response: The procedures we proposed to classify in APC 121 were considered sufficiently similar from a clinical perspective. We found no provider concentration associated with the procedures proposed for this APC. Therefore, any variation in cost across the procedures in this APC should average out at the hospital level. However, to be consistent with the BBRA 1999 ''two times'' provision concerning comparable resources, we have moved CPT codes 85095 and 85102 to final APC 0003, and CPT codes 88170 and 88171 remain in final APC 0002.

APC 122: Level II Needle Biopsy/ Aspiration

Comment: A number of commenters indicated that there was significant variation in resource consumption for the procedures proposed in this APC group. For example, one commenter stated that although all the codes within this group are needle biopsies, they range dramatically in complexity, they are quite dissimilar in terms of resource use, they are not clinically similar, and the proposed grouping results in inappropriate payment for the more complex procedures.

Response: We decided that CPT code 67415, Fine needle aspiration of orbital contents, was more appropriately grouped from a clinical perspective with ophthalmic procedures in final APC 0239. We further divided the codes in proposed APC groups 121 and 122 for needle biopsy/aspiration into final APC groups 0002, 0003, 0004, and 0005 to be consistent with the BBRA 1999 ''two times'' requirement.

APC 131: Level I incision & drainage

Although we received no comments on proposed APC group 131, based on internal review of this APC, we moved CPT code 11976, Removal, implantable contraceptive capsules, to final APC 019 because this procedure represents an excision rather than an incision. We divided proposed APC 131 into final

APC groups 0006, 0007, and 0008 to be consistent with the BBRA 1999 ''two times'' requirement.

APC 141: Level I Destruction of lesion

APC 142: Level II Destruction of lesion

Comment: One commenter questioned our proposed assignment of CPT codes 17106 through 17108, which describe destruction of cutaneous vascular proliferative lesions, to APC groups 141 and 142.

Response: We moved CPT code 17106 to final APC 0011 because its median cost is significantly higher than the other codes in 0010. However, the median cost for that code is greater than we would have expected it to be. We will review the appropriateness of this placement in the course of future updates of the APC groups.

APC 151: Level I debridement/ destruction

APC 152: Level II debridement/ destruction

Comment: We received general comments questioning the resource homogeneity of the proposed skin APC groups. One commenter recommended including removal of skin lesion with laser on other body parts in proposed APC 152 rather than restricting the APC to vulva, anus, and penis procedures. The commenter believes that removal of these benign lesions, including papillomas, should include other areas of the body.

Response: We agree with commenters' general concerns about resource homogeneity. We reclassified the codes in proposed APCs 151 and 152 into final APC groups 00012 through 00017 to better differentiate resource use and clinical characteristics and to be consistent with the ''two times'' BBRA 1999 requirement. We also moved CPT code 42809, Removal of foreign body from pharynx, to final APC 251 because it is an otorhinolaryngology (Ear/Nose/ Throat (ENT)) procedure.

APC 161: Level I excision/biopsy

APC 162: Level II excision/biopsy

APC 163: Level III excision/biopsy

Comment: Numerous commenters were concerned about the variation of resource use among the procedures in proposed APC groups 161, 162, and 163. Commenters requested that we consider classifying procedures in these groups based on anatomic location where functionality is of high importance in combination with the size of excision.

Response: We made a number of modifications to the excision APC groups to satisfy the BBRA 1999 ''two times'' requirement, resulting in final APC groups 0018 through 0022. We reclassified CPT codes 11043 and 11044 to APC groups 0016 and 0017 because these codes describe debridement of skin, subcutaneous tissue, muscle, and bone.

In the final excision/biopsy APC groups, we endeavored to make distinctions based on the location and size of the excision. For example, excisions of malignant lesions from the face, ears, eyelids, nose, lips greater than 4 cm were placed in an APC requiring more resource use than excisions of malignant lesions from the trunk, arms or legs greater than 4 cm because ''functionality'' is of greater importance when the site is the face, ears, eyelids, nose, or lips. We moved excisions involving the eye to ophthalmic procedure APCs. We did not make grouping distinctions between benign and malignant lesions of the same size and location because resource use for both types is similar.

We moved benign and malignant excisions larger than 2 cm to final APC group 0020 because these excisions require more resources than, for example, excisions smaller than 1 cm.

We moved CPT code 20220, superficial biopsy of bone (*e.g.,* ilium, sternum, spinous process, ribs) with trocar or needle, to final APC 0019, because the resources used in connection with this procedure are similar to those required for excisions of small benign or malignant lesions.

As noted above, we classified two debridement procedures (CPT codes 11043 and 11044) to final APC groups 0016 and 0017, respectively.

We also moved seven codes from proposed APC 162 to the ophthalmic APC groups.

APC 181: Level I skin repair

APC 182: Level II skin repair

APC 183: Level III skin repair

APC 184: Level IV skin repair

Comment: We received numerous comments expressing concern about the consistency of resource use and clinical homogeneity of the procedures in the four proposed skin repair APC groups. Many commenters recommended moving more complex procedures, such as large layer closures, to an APC with a higher payment rate because the procedures require more operating room and recovery time. Some commenters recommended moving some of the skin repair codes to other body systems.

Response: Our review of proposed APC groups 181, 182, 183, and 184 resulted in our regrouping the skin repair codes based more on cost than on clinical considerations. The volume of claims in most of the codes, however, is quite low. In addition, we moved CPT code 33222, Revision or relocation of skin pocket for pacemaker, from proposed APC 360 to final APC 0026, because this procedure is so similar to the other skin repair procedures in terms of clinical content and resource consumption. We will review these groups carefully as data become available.

APC 197: Incision/excision breast

APC 198: Breast reconstruction/ mastectomy

Comment: One commenter observed that the procedures in proposed APC group 198 are related both to the definitive treatment of breast cancer and to plastic and reconstructive operations of the breast. The commenter recommended moving CPT code 19162, Mastectomy, partial with axillary lymphadenectomy, and CPT code 19182, Mastectomy, subcutaneous, into an APC group with a higher payment rate because both procedures are more complex and involve more time and resources than the other procedures in proposed APC group 198. Another commenter stated that CPT code 19162, and CPT code 19318, Reduction mammoplasty, require significantly longer operating times than the other procedures in proposed APC group 198. The same commenter further observed that CPT code 19162 essentially involves performing two procedures.

Response: Our medical advisors and staff carefully reviewed the comments submitted in connection with the procedures in proposed APC group 198 within the context of the criteria that we discuss at the beginning of this section. They concluded that, although reduction mammoplasty (CPT code 19318) could require slightly more resources, a reduction mammoplasty is still fundamentally similar to other procedures in proposed APC 198 such as CPT code 19162, Partial mastectomy with axillary lymphadenectomy. Our medical advisors and staff concluded that the procedures in proposed APC groups 197 and 198 were sufficiently similar clinically and in terms of resource use to retain the proposed groupings. Therefore, we are retaining our proposed grouping in final APC groups 0029 and 0030.

APC 207: Closed treatment fracture finger/toe/trunk

Although we did not receive comments about this APC group, our medical advisors and staff determined that treatment of closed fractures

pertaining to the larynx should be moved to the ENT APC groups because they are more similar from a clinical and resource use perspective to ENT procedures. The larynx procedures do not involve casts and, more importantly, they require completely different resources and ancillary personnel than, for example, the setting of a finger fracture. Proposed APC 207 is renumbered final APC 0043.

APC 209: Closed treatment fracture/dislocation except finger/toe/trunk

Comment: One commenter objected to including multiple procedures for dislocation and fractures in proposed APC group 209, when the cost of drugs and supplies alone for these procedures probably exceeds $100. The commenter believed that the proposed payment rate for APC 209 was $71.00.

Response: We note that the proposed payment for APC 209 was $98.75, rather than $71.00, as the commenter quoted. Although we included in proposed APC 209 some procedures that could involve considerable time and resources, only the simplest cases of these potentially more complex procedures would be performed on an outpatient basis, with proportionally lower costs than would be incurred when the procedures are performed in an inpatient setting. Therefore, we retained in final APC 0044 the codes in proposed APC 209, except we moved CPT code 31586, Treatment of closed laryngeal fracture, to final APC 0256, because this is primarily an ENT procedure.

APC 216: Open/percutaneous treatment fracture or dislocation

Comment: Numerous commenters took issue with the variation in resource use among the procedures that include the open treatment of almost all bone fractures, ranging from relatively simple finger and toe fractures to major long bone fractures.

Response: We expect that only the simplest of the procedures proposed in APC group 216 would be performed on an outpatient basis. Therefore, we kept open/percutaneous treatment of fractures in one APC rather than splitting these procedures into multiple APCs. We find it unlikely that one provider would specialize in, for example, only open fractures of fingers or only open fractures of long bones. Because the CPT code descriptors for so many procedures in this APC group indicate ''with and/or without internal fixation,'' it is impossible to make distinctions based on whether or not internal fixation is applied. Proposed APC 216 is renumbered final APC 0046.

APC 226: Maxillofacial prostheses

APC 231: Level I skull and facial bone procedures

APC 232: Level II skull and facial bone procedures

Although we did not receive specific recommendations for these APCs, our medical advisors and staff determined that the procedures in these groups are more similar to ENT procedures from a clinical and resource use perspective. Therefore, we moved all of the procedures in these proposed APC groups to the final APCs 0251 through 0256, the ENT APCs.

APC 251: Level I Musculoskeletal Procedures

APC 252: Level II Musculoskeletal Procedures

Comment: One commenter expressed concerns about the clinical homogeneity of the codes in these two groups. The commenter stated that proposed APC 251 contains 77 widely disparate procedures, including CPT code 23100 and CPT code 24100, which describe arthrotomies with biopsies, CPT code 25248, Exploration with removal of deep foreign body, forearm or wrist, and CPT code 27704, Removal of ankle implant. The commenter further stated that proposed APC 252 contains equally diverse procedures ranging from: CPT code 20900, Bone graft, any donor area; minor or small, to CPT code 25251, Removal of wrist prosthesis; complicated, including ''total wrist,'' to CPT codes 27396, 27580, and 27665, which are different types of tendon procedures. The commenter recommended that procedures that require specialized equipment and more operating room time be moved into a group with a higher payment rate.

Response: Our medical advisors and staff, after careful consideration of the commenter's concerns and after reviewing alternative groupings of the numerous codes in these two proposed musculoskeletal APC groups, concluded that splitting these groups to address the disparities cited by the commenter would result in too many small, low-volume groups for which we would be unable to establish reliable payment rates. The broad inclusiveness of these two APC groups is in part a reflection of the magnitude of the musculoskeletal system. Given the homogeneity of resource use across the many procedures within each group, we concluded that the factors supporting retention of the two groups outweighed the concerns raised by the commenter. We did, however, move CPT code 27086, Removal of foreign body, pelvis or hip; subcutaneous tissue, to final APC 0019.

APC 280: Diagnostic Arthroscopy

APC 281: Level I Surgical Arthroscopy

APC 282: Level II Surgical Arthroscopy

Comment: A number of commenters expressed concerns about the homogeneity of codes in the proposed surgical arthroscopy APC groups. In particular, commenters stated that while an arthroscope is needed for all the procedures assigned to proposed APC group 281, the nature of the repair may mandate different additional equipment and differing times to complete. Commenters did not find the procedures in proposed APC 281 to be homogeneous with respect to the time required to perform the procedures nor their associated costs. Commenters specifically recommended transferring complex elbow and wrist procedures represented by CPT codes 29826, 29838, 29839, 29846, 29847, 29848, 29861, 29862, and 29863 into an APC group with a higher payment rate.

Response: Upon revisiting the assignment of codes to proposed APC groups 280, 281, and 282, and considering the concerns expressed by commenters, our medical advisors and staff concluded that collapsing the three proposed APC groups into a single group would result in a more homogeneous grouping in terms of resource use. Hence, final APC 0041 contains the codes proposed as APC groups 280, 281, and 282. The relatively low volume of many of the procedures in the proposed APCs supports combining them into a single group. Further, we found that, from a facility perspective, the resource use for all the codes in final APC 0041 is similar. For example, we had proposed to place CPT code 29881, Arthroscopy, knee, surgical; with meniscectomy (medial or lateral, including any meniscal shaving), and CPT code 29882, Arthroscopy, knee, surgical; with meniscus repair (medial or lateral), in two different APC groups. However, the resources required for these two procedures is sufficiently comparable to warrant placing both into the same APC.

APC 286: Arthroscopically-Aided Procedures

We considered including the procedures in proposed APC group 286 with the other arthroscopic procedures in final APC 0041 because they are so infrequently performed in an outpatient setting for Medicare beneficiaries. However, the resources required to perform the procedures in proposed

APC 286 are so strikingly distinct from those used in connection with the procedures in final APC group 0041 as to warrant being retained in a separate group. Further, it is unlikely that an individual provider specializes in the particular type of arthroscopic procedure contained in this APC, so separating all of the codes in final APC 042 from those in APC 041 should not disadvantage any one hospital.

APC 311: Level I ENT Procedures

APC 312: Level II ENT Procedures

APC 313: Level III ENT Procedures

APC 314: Level IV ENT Procedures

We received numerous comments about the composition of the four proposed ENT APC groups. After careful review of the comments, our medical advisors and staff recognized the need for a major reorganization of the groups we proposed for ENT procedures. The outcome of our review was the creation of five final APC groups for ENT procedures: APC groups 0251, 0252, 0253, 0254, and 0256. We moved a large number of bone procedures involving the facial and ENT areas from musculoskeletal groups to ENT groups. We transferred some codes out of the ENT groups altogether, and we shifted codes among the five final ENT groups to comply with the BBRA 1999 ''two times'' requirement. We respond to recommendations regarding specific codes below.

Comment: One commenter observed that CPT codes 31603 and 31605, emergency tracheostomy procedures, are risky and life-threatening no matter how quickly they are performed, and, as such, they should not be grouped with procedures for removing a foreign body from the ear canal or removing cerumen (proposed APC 311).

Response: We agree. We created new APC group 0340 to which we assigned CPT code 69200, removal of foreign body from external auditory canal; without general anesthesia, and CPT code 69210, Removal impacted cerumen (separate procedure), one or both ears. We shifted these two procedures to the Minor Ancillary Procedures APC group because of their relative high frequency, their low cost in terms of resource use with low disposable equipment cost, and because these procedures generally do not require scheduling. Removing CPT code 69210 from the final ENT groups also corrects any pricing distortions that may have resulted from the disproportionately high volume of that procedure.

We also moved the tracheostomy emergency procedures to final APC 0254.

We moved several other procedures such as CPT code 41870, Periodontal mucosal grafting, to final APC 0253, a group with higher cost procedures.

We moved several abscess drainage procedures such as CPT code 41800, Drainage of abscess, cyst, hematoma from dentoalveolar structures, to final APC group 0251 because of their relatively low cost.

Comment: One commenter stated that all the procedures in proposed APC 312 appear to be reasonably priced with the exception of CPT code 69436, Tympanostomy (requiring insertion of ventilating tube), general anesthesia. In the view of the commenter, the extra supplies and time required for this procedure necessitate a higher payment.

Response: We moved CPT code 69433, Tympanostomy (requiring insertion of ventilating tube, local or topical anesthesia), to final APC 0252 because of its lower resource use relative to CPT code 69436. CPT code 69436 is assigned to final APC 0253.

We moved a large number of procedures such as CPT code 42335, Sialolithotomy; submandibular (submaxillary), complicated, intraoral from original APC 313 to final APC 0253 to reflect a similarity of resource use. In terms of resource use, CPT code 30115, Excision, nasal polyp(s), extensive, is more similar to CPT code 42300, Drainage of abscess, parotid, simple, than it is to CPT 42410, Excision of parotid tumor or parotid gland; lateral lobe without nerve dissection.

We shifted CPT code 21040, Excision of benign cyst or tumor of mandible, from the musculoskeletal group to final APC 0253 with other ENT procedures.

Comment: One commenter stated that procedures directed towards cancer treatment were inappropriately assigned to proposed APC 313. As examples, the commenter cited CPT codes 30150 and 30160, rhinectomy procedures; CPT code 41120, Glossectomy; less than one-half tongue; and CPT code 69210, Excision external ear, complete amputation. The commenter also indicated concern that proposed APC group 313 includes a disproportionately large percentage of resource-consuming ENT procedures and commonly performed sinus procedures. Other commenters recommended that more complex otorhinolaryngology procedures in the group that have longer operating and recovery room times be moved to a group with a higher payment rate.

Response: We moved CPT code 69210 to final APC group 0340, and we assigned CPT codes 30150, 30160, and 41120 to final APC group 0256. We also moved CPT code 42215, Palatoplasty for cleft palate; major revision to final APC group 0256.

Comment: One commenter suggested placing certain thyroid procedures in the ENT groups.

Response: While we agree that CPT code 60280, Thyroglossal cyst excisions, is somewhat similar to CPT code 42440, Excision of submandibular, submaxillary gland, we nonetheless believe that the former type of excision is more appropriately placed from a clinical perspective with other thyroid procedures.

APC 318: Nasal Cauterization/Packing

Comment: A number of commenters addressed generally the range of resource use among the procedures within this proposed APC. One commenter observed that CPT code 30901 is almost always a simple office procedure within the context of an otolaryngology practice. The same commenter indicated that CPT codes 30903, 30905, and 30906 frequently require several hours of direct physician contact and monitoring and recommended that we consider reclassifying CPT codes 30903, 30905, and 30906 to proposed APC group 332, Level II Endoscopy Upper Airway. Another commenter was concerned that CPT codes 30905 and 30906 stand out as inappropriate for this APC level because they require much more time and expertise and are used in more life-threatening situations than the other codes in the group.

Response: While there is a range of procedures in this APC pertaining to control of nasal hemorrhage, hospitals normally treat the entire range of these procedures, and there is no concentration of certain of these procedures in a subset of hospitals. Our medical advisors and staff also found that there can be a range of resource consumption within many of the procedures themselves as well as across procedures in this APC. We therefore are not reassigning the codes.

We did, however, move CPT codes 30999 and 42999 for unlisted procedures to final APC 0251 and 0252, respectively, to be consistent with our policy of placing unlisted codes in the lowest paid related group.

APC 331: Level I Endoscopy Upper Airway

Comment: One commenter noted that the relative weight and payment rate proposed for APC group 331 approximated the relative weight and payment rate proposed for APC groups 997 or 987. The commenter stated that CPT codes 31575 and 31579 should have a higher relative weight and

payment rate than that proposed for APC 331 because both procedures require more time, higher skill levels, and more equipment than the procedures in APC 997 or 987. A professional association, echoing the first commenter, noted that CPT codes 31575 and 31579 are the most complex of all noninvasive laryngeal diagnostic procedures performed by otolaryngologists and speech language pathologists, further justifying a higher relative weight and payment rate for these procedures.

Response: Proposed APC groups 997 and 987, Manipulation therapy and Subcutaneous chemotherapy, respectively, are clinically very different from proposed APC group 331. The professional skill and expertise of the physician performing the laryngoscopy are recognized separately and are not costs that are packaged with the payment rate for services furnished by the hospital in connection with the procedure. Further, it is very unlikely that there will be systematic differences among facilities with some only doing the most difficult of the basic laryngoscopies that are contained in this group and others only specializing in the simplest variety. However, we have reorganized the proposed endoscopy, upper airway groups into final APC groups 0071 through 0075 to be consistent with the BBRA 1999 ''two times'' requirement.

APC 341: Level I Needle and Catheter Placement

APC 342: Level II Needle and Catheter Placement

APC 343: Level III Needle and Catheter Placement

APC 347: Injection Procedures for Interventional Radiology

Based on our cost data, our medical advisors and staff determined that the codes in these proposed APC groups should be assigned status indicator ''N,'' which designates incidental services whose costs are packaged into the APC payment rate. Injection procedures themselves are low cost but, more importantly, they are an integral portion of another procedure. The needle and catheter placement are typically an integral portion of interventional radiology procedures. An exception was made for CPT code 36420, cutdown on a child under age one, which was placed in final APC 0032, to recognize its infrequent use but high median cost.

APC 360: Removal/Revision, Pacemaker/Vascular Device

Comment: Most commenters recommended changing a number of pacemaker codes from ''inpatient only'' payment status to allow payment under the hospital outpatient PPS. One commenter noted that whereas we proposed to exclude most pacemaker and implantable cardioverter defibrillator (ICD) replacement procedures from the outpatient PPS, we did include pacemaker revision/removal procedures in proposed APC 360 even though both types of procedures require very similar steps to perform. The commenter is concerned that by not paying for pacemaker replacement procedures under the outpatient PPS, we are forcing physicians to perform these replacement procedures on an inpatient basis. By so doing, the commenter suggested that we are adding costs to the entire system that could be saved, because the pacemaker replacement procedures can be safely performed in the outpatient setting, with less inconvenience to the patient.

Response: After careful consideration of commenters' recommendations, our medical advisors and staff agreed that paying for pacemaker insertion or replacement codes under the outpatient PPS is appropriate if the outpatient setting is determined to be reasonable and medically necessary for the individual beneficiary. We assigned procedures for revising or removing implanted infusion pumps and venous access ports in proposed APC 360 and pacemaker insertion or replacement codes payable under the outpatient PPS to final APCs 0089 and 0090. Also, we moved CPT code 33222, Revision or relocation of skin pocket for pacemaker, and CPT code 33223, Revision or relocation of skin pocket for implantable cardioverter-defibrillator, to final APC 0026 because the resource use for these two procedures is similar to that of the skin repair procedures in APC 0027.

APC 367: Vascular Ligation

Comment: One commenter wrote that the procedures in proposed APC 367 include ligation of major arteries and veins, which are usually performed as emergencies in the inpatient setting, and elective ligation and stripping of lower extremity varicose veins of variable complexity. The commenter contended that costs for these procedures vary dramatically, with simple ligation and division of the saphenous vein at the low end of the cost scale, and the stripping of long and saphenous veins at the high end.

Response: We split proposed APC 367 into two groups, final APCs 0091 and 0092, to conform with the BBRA 1999 ''two times'' requirement. Although we are not sure to which codes the comment refers, codes 37780 and 37730 are now in different groups. These represent ligation and division of the short saphenous vein, and ligation, division and stripping of long and short saphenous veins, respectively.

APC 368: Vascular Repair/Fistula Construction

Comment: Commenters disagreed with the codes assigned to proposed APC 368, especially services related to insertion of implantable hemodialysis access ports. Commenters did not find the services in APC 368 to be comparable clinically. In particular, they recommended moving cannula insertion and declotting procedures to proposed APC groups 341, 342, and 343, which consist of needle and catheter placement procedures.

Response: We split the codes in proposed APC 368 into APC groups 0088, 0090, 0092, and 0093. The resulting classifications are more clinically homogeneous, and they meet the BBRA 1999 ''two times'' requirement. We also moved CPT code 35875, Thrombectomy of arterial or venous graft (other than hemodialysis graft or fistula), into final APC 0088.

APC 369: Blood and Blood Product Exchange

Comments: As we noted in section III.C.2.f, above, many commenters disagreed with both our proposed payment rates and our proposed classification for blood and blood-related products. Most commenters disagreed with our classifying in one APC group therapeutic apheresis, stem cell procedures, and blood transfusion services. The commenters stated that therapeutic apheresis and stem cell procedures are very costly and resource intensive procedures which cost more than 3 times the proposed payment rate for APC 369, yet we are proposing to pay a median amount for these services that is appropriate for blood transfusions only. Commenters questioned whether we had taken into account the costs associated with the specialized equipment, supplies and personnel that are required to perform therapeutic apheresis and stem cell procedures. Commenters stated that the payment rate proposed for APC 369 would not offset the costs hospitals incur to furnish therapeutic apheresis services because outpatient apheresis procedures often combine dissimilar kinds and combinations of plasma replacement products, causing widely differing costs per service.

A major association representing community cancer centers stated that our data for stem cell harvesting claims (CPT 38231) include a range of costs so

large as to suggest that there are errors in the data. The commenter believes that the very small sample of claims (reduced by HCFA's exclusion of multiple procedure claims and claims without codes) further renders the data unreliable. The same commenter cited bone marrow harvesting (CPT 38230) as an example to argue that our data, which indicates a median cost of $18.00 for what is normally a lengthy procedure performed under general anesthesia, are problematic.

Some commenters stated that the proposed payment rate was not sufficient for transfusion services if the rate was supposed to pay for both the blood product and the transfusion procedure, because even though outpatient transfusion services are relatively simple and low-cost, they are associated with a costly blood product that is far more variable.

Commenters expressed concern that the proposed payment rate for APC 369 was insufficient to pay for extracorporeal photopheresis (CPT 36522), whose actual cost is approximately $1,000, and would have an especially negative impact for patients with cutaneous T-cell lymphoma.

A major organization recommended that we separate payment for a service from payment for the blood product associated with that service. The same commenter also recommends separate payment for infusible blood-derived drugs, and that payment for transfusable blood products be based on costs. This organization recommends that APC 369 be split into several APCs because payment for services such as transfusion services, therapeutic apheresis, stem cell collection, Staph column pheresis, and others are distinct, and deserve separate APC payments. The same commenter also recommended that we accelerate the HCPCS coding process for blood-related products.

Response: In response to commenters' recommendations, we are creating different APC groups for blood-related procedures and transfusions, and we are paying for blood and blood products separately, instead of packaging them with the procedures or services with which they are associated. We were convinced by commenters' illustrations of the variability in the use of blood and blood products in various procedures, and by our desire to recognize the costs of tests now being performed on donated blood that were not captured in our 1996 data. The procedures we proposed in APC 369 are split among final APC groups 0109, 0110, 0111, and 0112. We have also created individual APC groups for blood and blood related products. The final APC 0109 that we created to capture bone marrow harvesting and bone marrow/stem cell transplant had a median cost of only $15.00. This is due to the few, highly variable claims in our database. Based on the information available to us at this time, we have assigned a rate of $200.00, and will adjust the rate to reflect actual claims as we collect data under PPS.

APC 407: Esophagoscopy

APC 417: Diagnostic Upper GI Endoscopy

APC 418: Therapeutic Upper GI Endoscopy

Comment: Commenters were concerned about low payment rates set for these three proposed APC groups.

Response: Our medical advisors reviewed the proposed groups and determined that combining the codes into a single APC group for upper gastrointestinal endoscopic procedures conformed with the criteria we used to define APC coherence and resulted in a reasonable payment rate supported by cost data. Resource use for all procedures in final APC 0141 is similar because each procedure involves an endoscopic examination. In addition, most of the procedures involve diagnostic and therapeutic tests such as brushings or fulgurations.

APC 426: Diagnostic Lower GI Endoscopy

APC 427: Therapeutic Lower GI Endoscopy

Comment: Commenters were concerned that the payment rates proposed for APC groups 426 and 427 were too low to offset costs incurred to perform these procedures. One commenter indicated that a diagnostic colonoscopy (CPT code 45379), without any mark up or consideration of room time and equipment use, costs $350, with additional costs if a polyp has to be removed ($155 just for a bicap). The commenter indicated that the current cost of a hot biopsy forceps is $45. Given these costs, the provider would necessarily incur a loss when performing these procedures.

Response: Our medical advisors and staff, after reviewing the cost data for these two proposed groups, combined the diagnostic and therapeutic APCs into a single group, final APC 0143. Resource use for the procedures in this APC is similar because they all involve an endoscopic examination. More importantly, even though resource use may vary relative to the clinical requirements of individual cases, facilities are not likely to specialize in just therapeutic or diagnostic endoscopic services. Therefore, costs should even out across all cases.

Comment: One commenter found the low rate proposed for CPT code 45378, Diagnostic colonoscopy, to be inconsistent with our major policy initiative to screen persons at high risk for colorectal cancer.

Response: We moved HCPCS code G0105, Colorectal Cancer Screening: Colonoscopy,to its own group, final APC 0158, because it is preventive rather than diagnostic or therapeutic in nature.

APC 446: Diagnostic Sigmoidoscopy

APC 447: Therapeutic Proctosigmoidoscopy

APC 448: Therapeutic Flexible Sigmoidoscopy

We reassigned the different types of sigmoidoscopy procedures into two groups, final APC 0146 and final APC 0147. The procedures within each group are similar both clinically and in terms of resource use. We moved HCPCS code G0104, CA screening; flexible sigmoidoscopy, to its own group, final APC 0159, because it is preventive rather than diagnostic or therapeutic in nature.

APC 451: Level I Anal/Rectal Procedures

APC 452: Level II Anal/Rectal Procedures

To conform with the BBRA 1999 ''two times'' requirement, our medical advisors and staff reclassified procedures in the proposed APC groups resulting in final APC groups 0148 and 0149. We believe the final APC groups are more consistent both clinically and in terms of resource use.

APC 470: Tube Procedures

Comments: We split the codes in proposed APC group 470 into final APC groups 0121, 0122, and 0123 to conform with the BBRA 1999 ''two times'' requirement. Also, we moved CPT code 50398, Change of nephrostomy or pyelostomy tube, from proposed APC 521 to final APC 0122.

APC 523: Level III Cystourethroscopy and Other Genitourinary Procedures

Comment: A number of commenters recommended moving CPT code 52240, Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; large bladder tumor(s), to the APC for Level IV Cystourethroscopy and other Genitourinary Procedures because the magnitude of the procedure most

closely resembles that of the codes in the higher payment group.

Response: We agree with commenters' recommendations; we moved CPT code 52240 to final APC group 0163 because of the extensive time and equipment required to perform the procedure.

Comment: One commenter recommended placing CPT codes 52335 through 52338 in their own group, given the complexity and technical demands of these ureteroscopic procedures. The same commenter suggested as an acceptable alternative placing these codes in the APC group for Level IV Cystourethroscopy and other Genitourinary Procedures, to reflect more accurately their cost, complexity, and need for expensive single use items such as dilation balloons, baskets and stents. Other commenters recommended moving CPT codes 51020 through 51880 (cystotomy procedures) to the APC group for Level IV Cystourethroscopy and other Genitourinary Procedures.

Response: After a careful review of comments and our cost data, our medical advisors and staff concluded that the cystotomy codes are similar enough in terms of equipment and the time required to perform the procedures to justify keeping them together in final APC 162. Our medical advisors and staff also concluded that the facility equipment and time duration for CPT code 52335, Cystourethroscopy, with ureteroscopy and/or pyeloscopy (includes dilation of the ureter and/or pyeloureteral junction by any method), was sufficiently similar to be retained with the other procedures in final APC 0162.

APC 524: Level IV Cystourethroscopy and other Genitourinary Procedures

Comment: Numerous commenters were concerned that the payment rate proposed for APC 524 was insufficient to offset the costs associated with CPT code 53850, Transurethral destruction of prostate tissue, by microwave thermotherapy (TUMT). The commenters argue that TUMT is a very expensive procedure due to its high capital equipment costs and the need to construct a special microwave area, the high cost of disposable probes and other disposable supplies required for the procedure, and the need for specially trained nursing staff. The commenters urged us to establish a unique APC group for this procedure and to provide a payment rate that is consistent with its anticipated costs, which they predict would total approximately $2,200.

Response: After careful consideration of comments and available cost data, our medical advisors and staff determined that CPT code 53850 satisfies the criteria discussed below, in section III.C.8, as a new technology service. Payment for this procedure will be made under new technology APC 0980.

APC 529: Simple Urinary Studies and Procedures

Comment: A number of commenters proposed that we classify CPT code 51726, Complex cystometrogram, to its own unique APC and keep the other urinary study procedures together in proposed APC 529.

Response: After a careful review of comments and our data, our medical advisors and staff agreed with commenters' concerns and subdivided proposed APC group 529. The resulting final APC groups 0164 and 0165 are more homogeneous both in terms of clinical coherence and resource use. We also added simple anal procedures such as CPT code 91122, Anorectal manometry, to final APC 0165 because of the similarity of resource use.

APC 546: Testes/Epididymis Procedures

Comment: A number of commenters disagreed with our classification of scrotal procedures with inguinal procedures in proposed APC group 546. The commenters observed that the scrotal procedures vary considerably from the inguinal procedures in terms of resource usage. The commenters recommended that we move CPT codes 54530, 54550, 54640, 55520, 55530, 55535 and 55540 to proposed APC 466, Hernia/Hydrocele Procedures, because they all involve operating on vessels at the internal ring, and are therefore similar to a hernia repair.

Response: We agree with comments that these procedures are similar to hernia repairs. We moved CPT codes 54530, 54550, 54640, 55535, and 55540 to final APC group 0154.

APC 551: Level I Laparoscopy

APC 552: Level II Laparoscopy

Comment: We received two categories of comments pertaining to laparoscopic procedures: Numerous commenters disagreed with our proposal to define certain laparoscopic procedures as inpatient only, and numerous commenters claimed that the resource costs among the procedures within proposed APC groups 551 and 552 varied too greatly for the groups to be considered homogeneous. Most commenters stated that the costs associated with the procedures in proposed APC groups 551 and 552 exceed their respective proposed payment rates because of the expensive equipment and disposable supplies and the length of time required to perform laparoscopic procedures.

Response: Our medical advisors and staff, after a thorough review and consideration of comments, agreed with commenters who claimed that most laparoscopic procedures can and are being safely and appropriately performed in an outpatient setting. We therefore moved most of the laparoscopic codes to which we proposed to assign a payment status indicator ''C,'' indicating that the procedures would not be covered under the hospital outpatient PPS, into an APC group with a payment status indicator ''T'' (significant procedure, multiple procedure reduction applies, payable under the outpatient PPS). In order to absorb these additional procedures within the APC system, we created a third laparoscopic APC group in order to accommodate the wide range of resource use and time that is required to perform the expanded list of laparoscopic procedures.

Although the AMA revised the coding of laparoscopic procedures in CPT 2000, in order to set rates for the laparoscopy APC groups, we used the codes that were in our database of 1996 claims. That is, we moved CPT codes 56362 and 56363 to the Level I laparoscopic group, final APC group 0130, because the resources used in connection with these procedures are less compared to the Level II procedures generally. For example, CPT code 56362, Laparoscopy with guided transhepatic cholangiography, primarily involves the laparoscopy without any associated removal of tissue. Conversely, we shifted CPT codes 56303 and 56304 from Level I to Level II (final APC 0131). CPT code 56303, Laparoscopy, surgical, with fulguration or excision of lesions of the ovary, pelvic viscera, or peritoneal surface, requires more resources than, for example, CPT code 56300, Diagnostic laparoscopy, the most common laparoscopic procedure within Level I, final APC group 0130.

The new Level III laparoscopy group, final APC group 0132, consists largely of laparoscopic procedures that we had proposed to classify as inpatient. In addition, we moved CPT code 56312, Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy, and CPT code 56313, Laparoscopy, surgical; with bilateral total pelvic lymphadenectomy and peri-aortic lymph node sampling (biopsy), single or multiple, to final APC group 0132 because of the extensive resources and time involved in performing these procedures. Refer to Current Procedural Terminology 2000, published by the American Medical Association, for a summary of coding

changes and crosswalks for laparoscopic procedures.

APC 561: Level I Female Reproductive Procedures

APC 562: Level II Female Reproductive Procedures

APC 563: Level III Female Reproductive Procedures

Comment: One commenter expressed concern that the payment rate for proposed APC group 563 would have a negative effect on certain treatment options for women suffering with incontinence. The commenter contrasted the proposed payment of $848 with a current median cost calculated at $1,931 for CPT code 57288, Sling operation for stress incontinence (*e.g.,* fascia or synthetic).

Response: After reviewing the procedures in proposed APCs 561, 562, and 563, and to be consistent with the BBRA 1999 ''two times'' requirement, we split the proposed groups into final APCs 0191 through 0195. The cost of CPT code 57288, to which the commenter refers, is still at the high end of the highest weighted group, but the volume of claims for that service is so low that splitting the group again would be problematic. If these more intense surgeries move to the outpatient setting in greater numbers, we will be able to price them more precisely.

APC 601: Level I Nervous System Injections

APC 602: Level II Nervous System Injections

Comment: Commenters contended that there are no similarities among the procedures in the proposed APC groups for nervous system injections.

Response: We disagree. We find the range of services included within each APC group to be generally consistent from a clinical perspective. And, even though an injection into the subarachnoid space may be a more complex injection than some of the others in the group, no institution is likely to specialize solely in one kind of injection. Because all the services within the APC group are offered by most hospitals, the impact of the variation in resource consumption among the different codes should average out at the hospital level. Therefore, we are keeping intact in final APC groups 0211 and 0212 the two levels of nervous system injections that we proposed, with the exception of CPT codes 62194 and 62225, which we moved to final APC group 0121 because they are catheter replacement procedures.

APC 616: Implantation of Neurostimulator Electrodes

APC 617: Revision/Removal Neurological Device

APC 618: Implantation of Neurological Device

Comment: One commenter was concerned that the payment rate proposed for APC group 616 falls far short of the costs incurred to implant a neurostimulator system that embodies a vagus nerve stimulator for the treatment of patients with refractory epilepsy. The commenter estimated that hospitals incur costs between $2,000 and $5,000 to surgically insert the Neurocybernetic Prosthesis system (NCP), which includes an implantable neurostimulator, pulse generator, and implantable electrodes. The commenter stated that the NCP costs $9,100. The commenter recommended that we create a separate APC group for the procedure to ensure appropriate payment. The commenter also expressed concern that the broad range of procedures in proposed APC 618 results in inappropriate payment rates. The commenter noted that the median cost of the procedures in proposed APC group 618 varies from a low of $269.44 to a high of $3,890.70, with a proposed payment rate of $1,274.

Another commenter stated that vagus nerve stimulation, approved by the FDA in 1997, which can sometimes be performed as an outpatient procedure, would be inappropriately paid under our PPS. The commenter stated that the reported cost for the device is $6,900 for the implantable neurostimulator pulse generator and $2,030 for the implantable vagus nerve stimulator leads. A manufacturer of this new system, which is used in treating intractable epilepsy, also expressed concern that the proposed PPS will underpay hospitals for new technologies such as its system and deny beneficiaries access to them.

Response: In response to these and other comments, we made several changes in proposed APC groups 616, 617, and 618. We moved CPT code 63650, Percutaneous implantation of neurostimulator electrodes, peripheral, to final APC 0224 because the procedure is less time intensive and uses fewer facility resources than the implant procedures in final APC 0225. We also shifted CPT codes 64585 and 64595 to final APC 0225. We will re-evaluate APCs 0223, 0224, and 0225 as we accumulate data and will incorporate our findings in a subsequent hospital outpatient PPS rule. Additionally, we will determine whether the implantable neurostimulator system is eligible for treatment as a ''pass-through'' device under section 201(b) of the BBRA 1999. The criteria for assessing a medical device's eligibility for additional payment under this provision are discussed in section III.D.4, below.

Ophthalmic Procedures: We received numerous comments concerning the APC groups proposed for eye procedures. Based on their analysis of these comments and recommended changes, a review of our data, and consideration of the limit on variation within a group required by section 201(g) of the BBRA 1999, our medical advisors and staff have significantly restructured the ophthalmic APC groups. Eye procedures and services are assigned to final APC groups 0230 through 0248.

APC 930: Minor Eye Examinations

APC 931: Level I Eye Tests

APC 932: Level II Eye Tests

We assigned to final APC groups 0230 and 0231 the procedures in proposed APC groups 930, 931, and 932 in addition to codes from proposed APC groups 681, 682, and 683 that are either tests or minor ophthalmologic procedures requiring relatively low resource use.

APC 651: Level I Anterior Segment Eye Procedure

APC 652: Level II Anterior Segment Procedure

Comment: We received a number of comments about these proposed APC groups. Commenters were primarily concerned that the payment rates proposed for the two levels of anterior segment eye procedures are significantly less than the costs incurred to perform the procedures assigned to these groups, especially those for glaucoma surgery (CPT codes 66150 through 66170). One commenter indicated that the rate proposed for CPT 66180 is acceptable only if separate payment is made for the aqueous shunt and patch graft.

Response: Based on their review of comments and to be consistent with the BBRA 1999 ''two times'' requirement, our medical advisors and staff added a third APC group for anterior segment eye procedures. The anterior segment eye procedures are assigned to final APC groups 0232, 0233, and 0234. We made a number of code changes among the three groups. We moved CPT codes 66155, 66160, 66165, and 66170 for glaucoma surgery to final APC group 0234. We shifted CPT code 65800, Paracentesis of anterior chamber of eye (separate procedure) with diagnostic aspiration of aqueous, from proposed APC 683 to final APC 0232 because the

instruments used in connection with CPT code 65800 are similar to those used in all procedures that are primarily paracentesis and because operating room time is likewise similar.

APC 667: Cataract Procedures

APC 668: Cataract Procedures With IOL Insert

Based on our data, the median cost for final APC group 0245 (cataract extraction without lens insert) was slightly higher than that for final APC group 0246 (cataract extraction with lens insertion). We attribute the discrepancy to poor coding, and we have increased the payment rate for APC group 0246 to equal the payment rate for APC group 0245. Proper coding in the future should result in better differentiated costs between these two groups.

Comment: One commenter objected to assigning payment status indicator ''T,'' Significant procedure, multiple procedure reduction applies, to the procedures in proposed APC group 668. The commenter contended that CPT code 66984, Cataract removal with lens insertion, is often performed in conjunction with other procedures such as CPT code 67010, partial removal of eye fluid, CPT code 65875, incise inner eye adhesions, and 66170, Glaucoma surgery, which also have a ''T'' payment status indicator. The commenter believes that the multiple procedure reduction would undercompensate for these services and that all these procedures should be given an ''S'' payment status indicator, which would not subject them to the multiple procedure discount.

Response: We disagree. When more than one surgical procedure is performed during a single operative session, full Medicare payment and the full beneficiary coinsurance payment are made for the procedure that has the highest payment rate. The costs associated with anesthesia, operating and recovery room use, and other services for any additional procedures are incremental and are accounted for within the discounted additional payment.

APC 670: Corneal Transplant

Comment: The numerous comments that we received about this proposed APC focused on our proposal to package the cost of procuring corneal tissue as part of the costs associated with corneal transplant surgery. Commenters feared that this fixed payment method would underpay some hospitals while overpaying others because hospitals acquire corneal tissue from eye banks whose charges are dependent upon the amount of philanthropic contributions the bank receives during the course of a year. A national association representing eye banks reported that fee data from different member facilities show that the corneal tissue acquisition fee alone nearly consumes or, in some cases, exceeds, the entire payment rate proposed for APC group 670. Commenters expressed great concern that we would significantly reduce the supply of corneas available for transplant if we were to package corneal tissue acquisition costs within the APC rate.

Response: Given the current basis for pricing corneal tissue, we are accepting commenters' recommendations that corneal tissue acquisition costs be paid separately and in addition to the payment rate for corneal transplant procedures. At least until we gather data regarding costs associated with the acquisition of corneal tissue, this will ensure that individual hospital's reasonable corneal tissue procurement costs are covered under the PPS. Corneal transplant procedures are in final APC group 0244.

APC 676: Posterior Segment Eye Procedures

Comment: Commenters were concerned that the payment rate for proposed APC group 676 was too low given the costs incurred to perform a number of procedures in the group. For example, one commenter noted that CPT code 67005 requires the same draping as a cataract extraction.

Response: In response to commenters' concerns and to be consistent with the BBRA 1999 ''two times'' requirement, we split the procedures in proposed APC group 676 into final APC groups 0235 through 0237. We also moved procedures such as CPT code 67025, Replace eye fluid, and CPT code 67027, Implant eye drug system, to final APC 0237 because of the similarity of resource use. CPT code 67025 involves injection of a vitreous substitute, usually gas, silicone, or a similar substance, and the procedure may also involve an aspiration.

APC 681: Level I Eye Procedure

APC 682: Level II Eye Procedure

APC 683: Level III Eye Procedure

APC 684: Level IV Eye Procedure

Comment: Commenters were concerned about the wide variation of resource use and clinical characteristics among the procedures within proposed APC groups 681, 682, 683, and 684. Commenters noted that the surgical complexity of individual procedures in proposed APC group 684 ranges from simple suturing (CPT code 67914, Repair of ectropion; suture) to complex eyelid reconstructions with full thickness tarsoconjunctival flap transfer (CPT code 67971). Commenters recommended that these proposed APC groups be revised and that the more complex procedures that require longer operating room time be paid a higher rate.

Response: We agree. Guided by commenters' recommendations as well as the ''two times'' limit on cost variation required by the BBRA 1999, we created several new groups and we completely reorganized the procedures in proposed APC groups 681, 682, 683, and 684 into the final APC groups 0230 through 0234 and 0238 through 0242.

APC 690: Vitrectomy

Comment: Several commenters were concerned that the cost of an intravitreal implant ($4,000, according to one commenter) would not be adequately recognized if payment for the device were to be packaged with payment for the insertion procedure (CPT code 67027, Implant eye drug system). Commenters were concerned that beneficiary access to this implant would be restricted if we did not make adequate payment. Commenters supported our proposal to make separate payment for the intravitreal implant.

Response: We assigned all of the procedures in proposed APC 690 to final APC group 0237. As we explain in section III.B.1.c, above, section 201(e) of the BBRA 1999 requires us to classify implantable items to the group that includes the service to which the item relates. However, the intravitreal implant that dispenses ganciclovir is an orphan drug that qualifies for a transitional pass-through payment under the BBRA 1999, which is explained in section III.D, below. Thus, we have assigned the entire drug delivery system to its own APC, 0913. We believe that the payment rate set for CPT code 67027 combined with the additional payment for ganciclovir results in an appropriate payment for this service.

APC 700: Plain Film

Comment: We received numerous comments about the structure of proposed APC group 700. Commenters recommended breaking down the proposed APC group into a number of smaller, more congruous groups. For example, one commenter found no justification for the assumption that resource costs are the same for all plain films listed in APC 700, noting that

there is a significant difference in capital costs, room costs, and maintenance costs between an x-ray room that is designed to take chest x-rays compared to an x-ray room with a table used to take abdominal x-rays. The commenter pointed out that there is a substantial increase in cost when cineradiography capabilities are added. The same commenter questioned our assumption that therapeutic radiology port films are clinically similar to diagnostic radiology films or that bone density studies are clinically similar to and have the same resource costs as plain film radiography.

Response: We agree with commenters' concerns about the composition of proposed APC group 700. In response to commenters' recommendations and applying the ''two times'' limit on cost variation required by the BBRA 1999, we split proposed APC group 700 into final APC groups 0260 through 0262. We assigned CPT code 70300, Radiologic examination, teeth; single view; CPT code 70310, Radiologic examination, teeth; partial examination, less than full mouth; and, CPT code 70320, Radiologic examination, teeth; complete, full mouth, to their own group, final APC group 0262, because these procedures require minimal time and relatively little radiographic film and technical equipment. We classified the remaining codes to final APC groups 0260 and 0261. We believe that these two groups are sufficient to distinguish clinical consistency and similar resource use. Facilities perform, relatively, a similar proportion of the different plain film procedures, and hospitals do not systematically use one type of plain film over another type, with the exception of dental films, which we moved to a separate group. The absolute magnitude of the difference in resource use among different plain films is not as significant as the difference between dental and other types of plain film. Additionally, our data indicate minimal differences in the amount of resource use between bone density measurement tests and plain films.

APC 706: Miscellaneous Radiological Procedures

Comment: A number of commenters found the tests grouped in proposed APC group 706 to vary significantly in the amount of time, effort, and costs required to provide the service.

Response: As a result of applying the ''two times'' limit on cost variation required by the BBRA 1999, we divided proposed APC 706 into two levels: final APC 0263 and final APC 0264. We also moved CPT code 76075, Bone Density Study, one or more sites, to final APC 0261. We explain below, in section III.C.6.e, why we are making an exception to the BBRA 1999 ''two times'' limit on cost variation in the case of final APC group 264.

APC 710: Computerized Axial Tomography

APC 720: Magnetic Resonance Angiography

APC 726: Magnetic Resonance Imaging

Comment: A number of commenters believe that assigning all computerized axial tomography (CAT) to a single group and all magnetic resonance imaging (MRI) to a single group results in a lack of homogeneity among the procedures within each group. These commenters were concerned that we ignored the cost of contrast materials, labor, and equipment within proposed APC group 710 and proposed APC group 726 and that combining contrast and non-contrast studies represents an inconsistency in resource use because an examination that uses contrast will be more costly than one without contrast. One commenter observed that an MRI examination with the use of contrast material requires approximately 30 percent more time and effort than an examination performed without contrast material and that a bilateral examination requires 50 percent more staff time and effort to complete. The same commenter expressed concern that proposed APC 720 consists of only one procedure, CPT code 70541, Magnetic image, head (MRA). The commenter recommended that we place this code and the other MRA codes that we now cover into two APC groups, one with and the other without contrast. A number of commenters recommended that we pay separately for contrast material, as a cost pass-through. One commenter believes that including diagnostic studies with placement of radiation therapy fields in proposed APC 710 violates the ''clinically similar'' criterion.

Response: Our medical advisors and staff carefully reviewed our data for the procedures in proposed APC group 710, proposed APC group 720, and proposed APC group 726 in light of commenters' concerns about the extent to which these groups take into account the costs associated with the use of contrast material. We concluded that costs associated with the use of contrast material are reflected in the payment rate in proportion to its frequency of use. We believe it is reasonable to have the CAT scans and MRIs with and without contrast together in their respective APC groups because facilities do not specialize based on whether or not they use contrast material. Further, the cost of contrast material relative to the overall inherent cost of CAT scans and MRI procedures alone is small. Moreover, the use of contrast material with CAT scans and MRI procedures differs significantly when compared to the use of contrast with plain films. Contrast comprises a significant portion of the cost of plain film services, and not all facilities perform plain films with contrast. A plain film can be ordered without being scheduled, but any plain film with contrast has to be scheduled. This scheduling distinction does not apply to a CAT or MRI scan with or without contrast. We did find that applying the ''two times'' limit on cost variation required by the BBRA 1999 resulted in the creation of two CAT groups, final APC groups 0282, to which we assigned CPT codes 70486, 76370, 76375, and 76380, and final APC 0283, to which the remaining codes in proposed APC group 710 are assigned. We further eliminated proposed APC group 720 and combined CPT code 70541, Magnetic image, head (MRA), with the other MRI procedures in final APC group 0284 because the base procedure, magnetic resonance imaging, is the same.

APC 716: Fluoroscopy

Comment: A number of commenters recommended that we pay separately for the fluoroscopy portion of procedures that include this radiologic service.

Response: We have assigned payment status indicator ''X'' to the procedures in final APC groups 0272 and 0273 to indicate that these are ancillary services that are paid separately under the hospital outpatient PPS.

Comment: A professional society commented that CPT code 74340, X-ray guide for GI tube, requires approximately 10 times the amount of radiologic technologist and room time, approximately 15 times the amount of film and many more supplies than does CPT code 71023, Chest x-ray and fluoroscopy. The commenter recommended that we divide proposed APC 716 into three separate and distinct levels based on the extent of the procedures and that we recalculate the relative weight and associated payment rate for the resulting groups.

Response: We disagree with the commenter. Our medical advisors and staff, after reviewing the procedures in proposed APC group 716, concluded that the fluoroscopic portion of these procedures is sufficiently similar in terms of clinical characteristics and resource requirements to be grouped together. However, applying the ''two times'' limit on cost variation required

by the BBRA 1999 results in the formation of two groups, final APC groups 0272 and 0273.

APC 728: Myelography

Comment: Commenters objected to assigning the same payment amount to procedures regardless of whether or not a contrast agent is used. One commenter was concerned that this payment policy will dissuade hospitals from utilizing contrast agents even in cases where the use of contrast is medically appropriate.

Response: We agree that median costs vary more among the procedures in proposed APC 728 than their clinical similarities would suggest. However, although we found that final APC group 0274 did not satisfy the ''two times'' limit on cost variation required by the BBRA 1999, we are making an exception in this case as we explain below, in section III.C.6.e., and we are retaining all myelographic procedures in final APC 0274.

APC 730: Arthrography

Comment: Some commenters suggested reassigning various arthrographic procedures that were assigned to proposed APC 730.

Response: We find the procedures in this group to be sufficiently homogeneous in terms of clinical definition and resource use. The procedures are comparable with respect to the use of resources in that the highest median cost procedure is less than twice the lowest median cost procedure, consistent with the standard set by the BBRA 1999. Therefore, we are retaining the proposed grouping of arthrographic procedures in final APC 0275.

APC 736: Digestive Radiology

To be consistent with the limit on cost variation required by section 201(g) of the BBRA 1999, we divided the procedures in proposed APC 736 into final APC groups 0276 and 0277.

APC 738: Therapeutic Radiologic Procedures

To be consistent with the limit on cost variation required by section 201(g) of the BBRA 1999, we split the procedures in proposed APC 738 into final APC groups 0296 and 0297.

APC 739: Diagnostic Angiography and Venography

Comment: Numerous commenters expressed concern about the lack of homogeneity among procedures in proposed APC 739. One commenter recommended that we divide proposed APC 739 into three groups: one for CPT code 75790, Angiography, arteriovenous shunt; one for all other angiography procedures; and one for venography procedures.

Response: In response to these comments, we created final APC group 0281, Venography of Extremity, to reflect the significant clinical and resource consumption differences between venographic procedures performed on extremities and diagnostic angiography and venography performed on other parts of the body. Venographic procedures on the extremities consume less time and fewer resources than other angiography and venography procedures. To be consistent with the limit on cost variation required by the BBRA 1999, we split the other procedures in proposed APC 739 into final APC groups 0279 and 0280. With respect to final APC group 0279, we explain in section III.C.6.e why we are making an exception to the BBRA 1999 limit on cost variation.

APC 747: Diagnostic Ultrasound Except Vascular

Comment: A number of commenters suggested that we restructure proposed APC group 747 according to body site because the APC criterion of clinical homogeneity is violated by including within one group body sites that range from the eye to the pregnant uterus to the scrotum and contents.

Response: Our medical advisors and staff carefully weighed the suggestion of commenters that clinical homogeneity would be better served if the procedures in proposed APC group 747 were divided into groups according to body site. We concluded that resource costs based on the type of technology used are what primarily dictates the definition of groups for various diagnostic services. Thus, we did not assign plain film of the chest in the same APC group with MRI of the chest. Because ultrasound is the type of technology common to all procedures in proposed APC group 747 and because resource use for the various procedures is similar irrespective of body site, we did not break this group up according to body site. However, to be consistent with the limit on cost variation required by the BBRA 1999, we split the procedures in proposed APC 747 into final APC groups 0265 and 0266.

APC 749: Guidance Under Ultrasound

Although there is a range of sites for the procedures in proposed APC group 749, as we explain above in our response to the comments submitted in connection with proposed APC 747, we are keeping this group intact in final APC group 0268 because the base procedure, ultrasonography, is the same for all procedures. Also, the procedures in final APC group 0268 are comparable with respect to the use of resources in accordance with the ''two times'' limit on cost variation.

APC 750: Therapeutic Radiation Treatment Planning

Comment: Commenters were concerned that radiation physics services are not appropriately recognized in proposed APC group 750. One commenter observed that proposed APC 750 lacks clinical homogeneity by including HCPCS codes for calculations and computer-based treatment planning with codes for the construction of treatment devices. Another commenter objected to including CPT codes 77261, 77262, 77263, 77431, and 77432 in proposed APC 750 because these codes are for professional services only and do not include a technical or facility component. As such, there are no facility costs associated with the codes. The commenter noted that if these codes were removed from proposed APC group 750, three medical physics consultation codes, CPT codes 77336, 77370, and 77399 would remain in the group. The commenter suggested that the resource requirements for two of the three remaining codes are dramatically different.

Response: We agree with commenters' concerns about proposed APC group 750, and we modified this group accordingly. First, we assigned payment status indicator ''E,'' which designates certain items and services that are not paid under the hospital outpatient PPS, to five codes that describe professional services, which would not be billed by hospitals: CPT code 77261, Therapeutic radiology treatment planning; simple; CPT code 77262, Therapeutic radiology treatment planning; intermediate; CPT code 77263, Therapeutic radiology treatment planning; complex; CPT code 77431, Radiation therapy management with complete course of therapy consisting of one or two factions only; and CPT code 77432, Stereotactic radiation treatment management of cerebral lesion(s) (complete course of treatment consisting of one session).

We renamed the remaining group of codes as final APC 0311, Radiation Physics Services. The codes specific to radiation physics that we classified in this APC are CPT code 77336, Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy; CPT code 77370, Special medical radiation physics

consultation; and CPT code 77399, Unlisted procedure, medical radiation physics, dosimetry and treatment devices, and special services.

APC 751: Level I Therapeutic Radiation Treatment Preparation

APC 752: Level II Therapeutic Radiation Treatment Preparation

Comment: One commenter objected to including CPT code 77295, Therapeutic radiology simulation-aided field setting; three-dimensional, in proposed APC 752 because this service has dramatically different resource requirements than the other CPT codes in group. Another commenter believes that the resources used in connection with simple intracavitatory applications, which are normally performed with re-usable Cs-137 sources, are totally dissimilar from the resources required for remote afterloading high intensity brachytherapy in proposed APC 751. This commenter noted that the equipment and room costs associated with remote afterloading high intensity brachytherapy may well exceed $500,000.

Response: We agree. In response to commenters' concerns, we made a number of modifications to proposed APC group 751 and proposed APC group 752. First, we assigned payment status indicator ''E,'' which designates certain items and services that are not paid under the hospital outpatient PPS, to CPT code 77299, Unlisted procedure, therapeutic radiology clinical treatment planning, thereby removing it from an APC group.

We created final APC group 0303, which consists of the following three codes: CPT code 77332, Unlisted procedure, therapeutic radiology clinical treatment planning; CPT code 77333, Treatment devices, design and construction; intermediate (multiple blocks, stents, bite blocks, special bolus); and, CPT code 77334, Treatment devices, design and construction; complex (irregular blocks, special shields, compensators, wedges, molds or casts). We created final APC 0303 because the resources needed for device construction are unique. We decided to put these three codes together in one group rather than assigning each to its own individual group because we could make no clear cost distinctions among the three codes and because we expect that facilities do not specialize in one type of device over another, but rather construct all of the types of devices encompassed within the three codes.

We created final APC group 0310, to which we assigned CPT code 77295, Therapeutic radiology simulation-aided field setting, three-dimensional. We assigned CPT code 77295 to its own individual APC group because it requires significantly greater resource consumption than the procedures in either final APC group 0304 or final APC group 0305.

We assigned the codes remaining in proposed APC groups 751 and 752 to final APC groups 0304 and 0305. Both APC groups 0304 and 0305 are comparable with respect to the use of resources in accordance with the ''two times'' requirement set by the BBRA 1999.

APC 757: Radiation Therapy

Comment: We received a number of comments about the assignment to proposed APC 757 of CPT code 61793, Stereotactic radiosurgery, particle beam, gamma ray or linear accelerator, one or more sessions. Commenters indicated that CPT code 61793 is clinically distinct from other forms of radiation treatment delivery and that this service generally involves significantly greater treatment time and costs. One commenter stated that if we were to keep CPT code 61793 in proposed APC 757, we would be prejudicing use of this new, proven technology. Another commenter contended that radiation therapy is not the same as a surgical procedure. The commenter urged us to separate stereotactic radiation therapy (SRT) and intensity-modulated radiation therapy (IMRT) services from the conventional radiation therapy procedures in APC 757 and to assign them a higher payment rate due to their higher cost.

Response: We created final APC group 0302, to which we assigned stereotactic radiosurgery, which requires significantly more costly resources than the procedures assigned to final APC groups 0300 and 0301. Note that we have created two codes, G0173 and G0174, to use in place of CPT code 61793. They represent stereotactic radiosurgery completed in one session, and that which requires multiple sessions, respectively. We also assigned CPT code 77470 to APC 0302, since we believe it requires resources similar to those required for radiosurgery. We will continue to track the data for these codes to ensure their proper placement. The procedures in final APC group 300 and in final APC group 301 are comparable with respect to the use of resources in accordance with the ''two times'' limit on cost variation.

APC 759: Brachytherapy and Complex Radioelement Applications

Comment: One commenter expressed concern because we did not identify a payment amount for the radioactive seeds used in brachytherapy. Another commenter referred to low dose rate interstitial brachytherapy that is used to treat complex gynecologic tumors, prostate cancers, and head and neck cancers, noting that this type of radiation therapy employs single-use radioactive sources (iodine, gold, iridium, and palladium seeds) and various disposable applicators. The commenter pointed out that only a limited number of vendors produce these radioactive sources and that the seeds cost as much as $200 each with the number of implants varying depending on the size, stage, and location of the cancer. The commenter stated that some patients with prostate cancer may require as many as 100 to 150 seeds. The commenter asserted that we have not captured the costs of these radiopharmaceuticals in the APC payment.

Response: We have changed how we pay for brachytherapy and the other services we proposed to classify to APC 759 in response both to comments and to the provisions of section 201(b) of the BBRA 1999, which provide for an additional payment to be made for innovative medical devices, including ''a (current) device of brachytherapy.'' (See section III.D., below.) Within this framework, we recognize the seeds provided during brachytherapy. For bill processing purposes, we have assigned brachytherapy seeds to APC 0918. We will make payment for brachytherapy seeds under the transitional pass-through rules explained in section III.D., below.

Based on commenters' suggestions, a review of our data, and the BBRA 1999 ''two times'' requirement, we have classified the procedures in proposed APC 759 in final APC 0312, Radioelement Applications, and final APC 0313, Brachytherapy. APC 0313 consists of CPT code 77781, Remote afterloading high intensity brachytherapy; 1–4 source positions or catheters; CPT code 77782, Remote afterloading high intensity brachytherapy; 5–8 source positions or catheters; CPT code 77783, Remote afterloading high intensity brachytherapy; 9–12 source positions or catheters; CPT code 77784, Remote afterloading high intensity brachytherapy; over 12 source positions or catheters; and, CPT code 77799, Unlisted procedure, clinical brachytherapy. Because these

procedures are all different types of brachytherapy, final APC 313 is more coherent clinically than was proposed APC 759.

We moved CPT code 77750, Infusion or instillation of radioelement solution, to final APC 301, Level II Radiation Therapy, and CPT code 77789, Surface application of radioelement, were moved to final APC 300, Level I Radiation Therapy. The remaining procedures from proposed APC 759 constitute final APC 312, Radioelement Applications. The procedures in final APC group 312 and in final APC group 313 are comparable with respect to the use of resources in accordance with the ''two times'' limit on cost variation.

APC 761: Standard Non-Imaging Nuclear Medicine

APC 762: Complex Non-Imaging Nuclear Medicine

APC 771: Standard Planar Nuclear Medicine

APC 772: Complex Planar Nuclear Medicine

APC 781: Standard SPECT Nuclear Medicine

APC 782: Complex SPECT Nuclear Medicine

APC 791: Standard Therapeutic Nuclear Medicine

APC 792: Complex Therapeutic Nuclear Medicine

Comment: We received numerous comments about the proposed nuclear medicine APC groups. Commenters addressed what they believe to be discrepancies in the payment weights among the proposed groups. Commenters also asserted that the proposed payment levels are inadequate to offset the cost of radiopharmaceuticals. They believe, in part, that our use of single-procedure claims in constructing our database failed to capture the costs associated with the various radiopharmaceuticals that may be used in combination during multiple procedures performed during a single session on various patients. One commenter disagrees with our decision to consider therapeutic radiopharmaceuticals and radionuclides as incidental services, bundling their costs into nuclear medicine and radiation therapy procedures. The commenter recommended that we develop unique APC groups for radiopharmaceuticals and radionuclides. One manufacturer expressed particular concern about our proposed payment for a radiopharmaceutical used to relieve the pain of bone metastasis (CPT code 79400) that we proposed to package into APC 791 for which the proposed payment was $758. The commenter stated that this new radiopharmaceutical, which has generated a very high clinical response rate, costs more than $2,000 per dose.

Response: In response to these and other comments, as well as the changes made by the BBRA 1999 to the outpatient PPS, our medical advisors and staff have reconstructed the nuclear medicine APC groups. First, we have placed radiopharmaceuticals into a separate set of APC groups that are listed in Addendum K. As we state above, new section 1833(t)(6) of the Act provides for additional payment for current and new radiopharmaceuticals. We list in Addendum K those radiopharmaceuticals that are eligible for additional payment effective with services furnished on or after July 1, 2000. In accordance with the process outlined below, in section III.D.4, we invite requests to consider other radiopharmaceuticals as potential candidates for additional pass-through payments.

Next, we reconfigured the nuclear medicine APC groups based on the resources required for the procedures themselves, exclusive of costly radiopharmaceuticals. We took into account the fact that SPECT equipment, which costs significantly more than the non-SPECT equipment that was initially used most frequently for planar medicine, is now commonly used to conduct planar studies. As a final step, we further reorganized the groups to satisfy the requirement set by the BBRA 1999 ''two times'' requirement, resulting in final APC groups 0286, 0290, 0291, 0292, 0294, and 0295.

Comment: We received a number of comments concerning the clinical efficacy of iodine 131 tositumomab in the treatment of cancer. One commenter stated that iodine 131 tositumomab, which was reported to be pending final FDA approval, has the potential to be the first radioimmunotherapeutic agent to be approved for the treatment of cancer. The commenter expected this pharmaceutical to be the first in its class, and characterized it as neither a chemotherapeutic agent nor a radiopharmaceutical. The commenter stated that the cost of this pharmaceutical will be significantly higher than the payment amount proposed for any of the APC groups containing drugs used for cancer therapies. The commenter believes that we should have proposed an outlier policy to ensure equitable payment for pharmaceuticals such as iodine 131 tositumomab.

Response: If iodine 131 tositumomab receives final FDA approval, we strongly encourage interested parties to submit the appropriate materials to us for determination of this product's eligibility for additional payment under the pass-through provision as described below in section II.D.6.

Comment: One commenter finds our method of paying for new products to be flawed. The commenter sees it as highly probable that a new product will be inserted into an APC procedure category where the payment rate is significantly lower than the actual cost of the newly developed product. The commenter cites our proposed payment for a new product, In–111 Octreo Scan, which is used for tumor imaging. The product costs four times the payment rate for proposed APC 772, Complex Planar Nuclear Medicine. The commenter believes that this enormous discrepancy will discourage hospital outpatient departments from utilizing procedures that require this product and that Medicare beneficiaries may be denied access to the most appropriate care available as a result.

Response: We are firmly committed to ensuring that the provisions of the hospital outpatient PPS do not in any way obstruct or limit Medicare beneficiaries' access to reasonable medically necessary and appropriate care. We further recognize that the development of new technology and products is a highly dynamic enterprise that is constantly evolving and changing the character and cost of current diagnostic and treatment modalities. New section 1833(t)(6) of the Act provides for an additional transitional pass-through payment for certain innovative medical devices, drugs, and biologicals. We are also creating a series of transitional APCs for the express purpose of providing appropriate payment for new technology services when they emerge into the marketplace while we collect data to enable us ultimately to incorporate the new technology service within an APC group, making payment adjustments as needed. We expect to continue working closely with hospitals and their representatives throughout this process to ensure that payment does not inhibit beneficiary access to appropriate care. We discuss the transitional pass-through payment groups in greater detail in section III.D and provisions for payment for new technology in section III.C.8.

APC 881: Level I Pathology

APC 882: Level II Pathology

APC 883: Level III Pathology

Comment: We received numerous comments on the proposed pathology APC groups. One commenter expressed concern that our proposed assignment of tests among the three groups may create an incentive for physicians to order complex and unnecessary tests when simpler, less comprehensive tests may be adequate, because we have grouped together and are paying the same amount for tests that are clinically similar but that are comprehensively more difficult than one another.

Response: Our medical advisors and staff reviewed and completely reorganized the grouping of pathology tests in light of commenters' concerns and the BBRA 1999 ''two times'' requirement. Pathology tests are in final APC groups 0342, 0343, and 0344.

APC 906: Infusion Therapy Except Chemotherapy

APC 907: Intramuscular Injections

Comment: We received many comments about proposed APC groups 906 and 907. The commenters were generally concerned that packaging payment for nonchemotherapeutic infused and injected drugs in the payment rates for the administration of nonchemotherapy drugs does not take into account the great variation among these products with regard to their indication/application and cost nor the cost of new drugs that have been introduced since 1996. Commenters fear that we will underpay hospitals and inhibit the introduction of new drugs into the system.

Response: In response to the concerns expressed by commenters, we have created additional groups for certain expensive pharmaceuticals. These high-cost, nonchemotherapy, nonorphan drugs are captured in the following APCs: 0886–0891, 0907, 0908, 0911, 0914, 0915, 0917, 7007, 7036, and 7042. We have set the rates for these high-cost drug APCs based on data we obtained from a contracted study of drug costs. In section III.D, below, we discuss the process for pricing new high cost drugs as they are introduced into the marketplace to assure adequate payment until these new drugs can be assigned to an appropriate APC. Final APC 120, Infusion Therapy Except Chemotherapy, and final APC 359, Intramuscular injections, are priced based on the resources used to perform the procedures, including many less expensive drugs that are packaged into the two APCs.

APC 957: Echocardiography

Comment: Numerous commenters remarked on the lack of homogeneity in resource consumption in this APC. One commenter objected to our not distinguishing between procedures performed with or without contrast agents. Another commenter contends that proposed APC 957 does not account for the diversity of services in costs based on type of equipment, use of conscious sedation medication, and use of contrast agents.

Response: Conscious sedation and contrast media were packaged where they were used in the base year. We believe that packaging of items into the payment amount is appropriate because hospitals do not specialize in providing only services with or only services without sedation or contrast. To the extent that different equipment is used for different procedures, and has different costs, those differing costs are captured and recognized in our payment algorithm.

Comment: Several commenters referred to the fact that some of the echocardiograms are part of more comprehensive codes pertaining to echocardiograms that are in the same APC. For example, one commenter noted that CPT code 93880, the basic vascular ultrasound service, is defined as a ''duplex scan.'' The commenter stated that all duplex vascular ultrasound codes involve three components and that, to the extent all three components are incorporated into this single vascular code, a provider is paid for only one procedure. On the other hand, CPT code 93307, the basic echocardiography service, incorporates only one of the three types of services included in the basic vascular service, CPT code 93880. Other codes, CPT 93320 and 93325 are used to bill for the other services that are a standard part of all vascular ultrasound procedures like CPT code 93880. This approach results in a provider receiving three separate payments for an echocardiogram with Doppler and color flow mapping as compared to a single payment for an equivalent vascular study.

Response: We agree that duplex vascular ultrasound scanning procedures include two dimensional and doppler signal display. However, for the example cited by the commenter, there is no separate code that includes both the two dimensional and the doppler ultrasound spectral analysis. To report a duplex vascular ultrasound of the heart, the only codes available are CPT codes 93307, 93320 and 93325, unlike the duplex vascular ultrasound scan of the extracranial arteries, which is coded with CPT code 93880. We agree that this limitation of the coding system affects the payment system, since the APC system is based on charges associated with each of the codes. We will bring this issue to the attention of the American Medical Association's CPT Editorial Panel.

However, in those instances where there is a code for the comprehensive service and separate codes for services that are inherent components of the comprehensive service, the Correct Coding Initiative (CCI) edits, which we are incorporating into the hospital outpatient PPS claims processing system, will address this concern. The CCI edits have been in place in the Part B claims processing system since January 1996. These edits detect when codes representing component services are reported with the code for the more comprehensive service. For example, there is an edit that prohibits the payment of CPT code 93875, a doppler study of the extracranial arteries when reported with CPT code 93880, the duplex scan of the extracranial arteries.

APC 960: Cardiac Electrophysiologic Tests/Procedures APC

Comment: Many commenters cited extreme variations in resource use among the procedures in proposed APC 960. One commenter noted that the procedures involve the use of one or more catheters, and argued that the proposed payment does not cover the cost of even one catheter. Another commenter claims that, at a minimum, the total cost of the four diagnostic catheters and one ablation catheter used in performing these procedures is $1,955.

Response: In response to these concerns, we moved CPT code 93660, Evaluation of cardiovascular function with tilt table evaluation, with continuous ECG monitoring and intermittent blood pressure monitoring, with or without pharmacological intervention, to final APC 0101, and CPT code 93724, Electronic analysis of antitachycardia pacemaker system, to final APC 0100. We reclassified the remaining procedures in proposed CPT 960 into final APC groups 0084, 0085, 0086, and 0087 to be consistent with the BBRA 1999 ''two times'' requirement.

APC 966: Electronic Analysis of Pacemakers/Other Devices

Comment: A number of commenters stated that the procedures in proposed APC 966 are not related clinically or in terms of resource cost. One commenter indicated that analyzing a spine infusion pump or neuroreceiver is a very different process from analyzing a

pacemaker or cardio/defibrillator and hence uses very different resources.

Response: Although the devices that are the subject of electronic analysis in proposed APC group 966 differ, we believe that the resource use among the services in the group is, on average, relatively similar. We determined that the procedures in proposed APC 966 meet the ''two times'' test for comparability with respect to the use of resources set by the BBRA 1999. In addition, we find it unlikely that facilities will specialize in one particular type of electronic analysis of pacemakers/other devices to the exclusion of others. Therefore, we did not change the procedures in final APC group 102 from what we had proposed.

APC 968: Vascular Ultrasound

Comment: One commenter recommended removing CPT code 93875, Non-invasive physiologic studies of extracranial arteries, complete bilateral study (for example, periorbital flow direction with arterial compression, ocular pneumoplethysmography, Doppler ultrasound spectral analysis), from proposed APC 968 because this study is a physiologic procedure and should be in the same group with other noninvasive physiologic vascular studies.

Response: We agree. We moved CPT code 93875 to final APC 0096.

Comment: One commenter recommended creating additional APC groups for CAT, MRI, and general ultrasound procedures to distinguish between diagnostic procedures that utilize contrast media and those that do not. The commenter believes that additional APC groups that properly recognize the resources required for contrast agents will encourage hospitals to use the procedures most suitable for the clinical needs of different patients.

Response: As we explained above, in our response to comments about proposed APC groups 710, 720, and 726, our medical advisors and staff carefully reviewed our data and concluded that costs associated with the use of contrast material are reflected in the payment rate for vascular ultrasound procedures in proportion to its frequency of use. We believe it is reasonable to have vascular ultrasound procedures with and without contrast together in one group because facilities do not specialize based on whether or not they use contrast material. Further, the cost of contrast material is small relative to the overall cost of the ultrasound. Moreover, facilities are not likely to schedule ultrasound according to whether or not contrast is used. Therefore, with the exception of moving CPT code 93875, we did not further change the procedures in final APC group 0267. Final APC group 0267 is within the limit on cost variation required by the BBRA 1999.

APC 969: Hyperbaric Oxygen

Comment: Many commenters were concerned that our cost data for hyperbaric oxygen therapy are flawed because of poor coding, and that the proposed payment rate is, as a consequence, inadequate. One commenter suggested that we did not use a common definition of hyperbaric oxygen therapy across all hospitals and that, due to ambiguity in codes, there is wide variation in how hyperbaric oxygen therapy services are defined for billing purposes.

Response: We cannot subdivide final APC 0031 because we have no mechanism for creating clinically distinct groups related to differences in resource consumption among facilities within a single CPT code. However, we explain below, in section III.H, that we intend to make adjustments in future years to APC group weights, once the hospital outpatient PPS is implemented. If commenters believe that current codes are inadequate to describe these services, they should seek new CPT codes from the American Medical Association.

Comment: One commenter was concerned about not only the low payment rate proposed for hyperbaric oxygen therapy, but also the fact that the proposed national unadjusted coinsurance amount exceeds the proposed total payment rate for the service.

Response: We calculated the payment rate and coinsurance amount for APC 0031 using the same method that we followed for the other APC groups. Charges for hyperbaric oxygen are much higher than their costs, which accounts for the unusually high national unadjusted coinsurance rate relative to the total payment rate for CPT code 99183. Note, however, that hospitals may elect to offer a reduced coinsurance rate for the service as described below in section III.F.4.

APC 971: Level 1 Pulmonary Tests

APC 972: Level II Pulmonary Tests

APC 973: Level III Pulmonary Tests

Comment: Commenters generally questioned the clinical consistency of procedures in the proposed pulmonary test APC groups and expressed concern about the variability of resources required to perform the procedures within each group. One commenter disagreed with our combining procedures before and after medication with procedures before rest and after exercise.

Response: After carefully reviewing the assignment of codes among the three proposed pulmonary test groups, our medical advisors and staff made a number of changes. To better recognize their median costs, we moved CPT code 94060, Bronchospasm evaluation before and after bronchodilator, and CPT code 94260, Thoracic gas volume, to final APC group 0368, and classified CPT code 94720, Carbon monoxide diffusing capacity, to final APC group 0367. We made additional changes among the three groups to ensure comparability of resources within each pulmonary test APC group in accordance with the ''two times'' standard set by the BBRA 1999.

APC 976: Pulmonary Therapy

Comment: Commenters generally questioned the clinical consistency of procedures in the proposed pulmonary therapy APC group and expressed concern about the variability of resources required to perform the procedures within the group. One professional association wrote that the respiratory therapy procedures in proposed APC group 976 are significantly different in complexity and require significantly different equipment and expertise to perform. The same commenter noted that CPT code 94657, Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, subsequent days; CPT code 94660, Continuous positive airway pressure ventilation (CPAP), initiation and management; and, CPT code 94662, Continuous negative pressure ventilation (CNP), initiation and management, all require close monitoring, more costly equipment, and, often, more expertise than do other therapies in proposed APC group 976.

Response: We agree with the commenter. We moved the CPT codes describing ventilation initiation and management (CPT codes 94657, 94660, 94662) into their own APC, final APC 0079, Ventilation Initiation and Management, to recognize that these procedures represent a completely different type of clinical service and because they utilize resources that are materially different from those used in connection with other pulmonary therapy procedures. We further divided the procedures in proposed APC 976 to meet the definition of comparable resources required by the BBRA 1999, resulting in final APC groups 0077 and 0078.

APC 979: Extended EEG Studies and Sleep Studies

APC 980: Electroencephalogram

APC 981: Level I Nerve and Muscle Tests

APC 982: Level II Nerve and Muscle Tests

Comment: One commenter expressed concern about our grouping sleep medicine services in proposed APC 979 with EEG and Epilepsy diagnostic services. Another commenter is concerned about the clinical homogeneity of our proposed groups for the numerous different neurologic and neuromuscular diagnostic codes that are encompassed within the range of services described by CPT code 95805 through CPT code 95958. The commenter believes that our proposed groups do not make appropriate distinctions among the many different tests relating to different parts of the body, taking different amounts of time, using different equipment, and measuring different outcomes. One commenter asked that we add two codes created in 1998 for sleep services to the list of procedures in the APC system. The commenter recommended assigning CPT 95811, Polysomnography with CPAPP, to proposed APC group 979. The commenter also recommended that CPT code 95806, Sleep study, unattended by a technologist, *not* be assigned to proposed APC group 979 to avoid creating an incentive for hospitals to use that procedure, which the commenter asserts is both less costly and less conclusive than other studies in proposed APC 979, in place of more comprehensive tests. One commenter claimed that the variety of neurological and neuromuscular diagnostic tests warrants an expansion of the number of APCs for these procedures to six, because the resources used vary widely. The commenter prefers that payments be made on a per service rather than on a per group basis. However, if we retain groups, the commenter recommended, on the basis of cost-based practice expenses, separate APCs for sleep and polysomnography services, for EEG studies, for EEG monitoring codes, for EMG codes, for nerve conduction and H reflex tests, and for sensory evoked potential and autonomic nerve function tests.

Response: Our medical advisors and staff decided that CPT codes 95806 and 95811 are both most appropriately assigned to final APC 0213. While sleep studies unattended by a technologist may consume less resources than those studies which involve the presence of a technologist, we believe that physicians are likely to order a mix of sleep studies, and that institutions are unlikely to specialize in sleep studies with or without the presence of a technologist. We added CPT code 95951 to APC group 0213. We believe the codes we proposed in APC groups 979 and 980 are sufficiently comparable clinically and in terms of resource use not to require further subdivision into smaller groups. Therefore, we retained our proposed classification in final APC groups 213 and 214.

We created a third APC group for the nerve and muscle test codes, and we split the codes in proposed APCs 981 and 982 among final APC groups 0215, 0216, and 0217 to ensure comparability of resources within each of the three nerve and muscle test APC groups in accordance with the ''two times'' requirement set by section 201(g) of the BBRA 1999.

APC 987: Subcutaneous or Intramuscular Chemotherapy

APC 988: Chemotherapy except by Extended Infusion

APC 989: Chemotherapy by Extended Infusion

APC 990: Photochemotherapy

Comments: We received numerous comments that criticized our proposed payments for chemotherapy services. The commenters argued that the proposed payment for chemotherapy and radiation therapy would severely reduce payments to hospitals and create perverse incentives for hospitals to substitute the older, less effective therapies for the newer ones. The commenters asserted that the proposed payment would not cover the costs of supportive care such as drugs to control nausea and vomiting. They expected that low payment rates to hospitals would force them to discontinue chemotherapy services, and that patients would be faced with trips to distant facilities to obtain services.

Response: We believe that the concerns raised by the commenters have been addressed through the transitional pass-through provision set forth in section 1833(t)(6) of the Act, as added by section 201(b) of the BBRA 1999. In accordance with that provision, we have separately identified current drugs and biologicals used in the treatment of cancer. These are listed in Addendum K of this final rule, and are eligible for additional payment under this provision. We have obtained codes for any anticancer, supportive, or adjunctive drugs we could identify. Thus, we will pay for chemotherapy by recognizing the mode(s) of administration and each of the covered drugs given, whether they are to treat the cancer, to protect the patient against the toxic effects of the treatment, or to relieve the side effects of treatment. In section III.D.4, below, we discuss how to request codes for new drugs.

Note that we moved CPT-based chemotherapy infusion codes into the ''E'' (noncovered) category because HCPCS ''Q'' codes for these services will be used to identify chemotherapy infusions. Hospitals had been instructed in the past not to bill using the CPT codes.

APC 999: Therapeutic Phlebotomy

Comment: One commenter is concerned that facilities will lose money because the proposed payment rate does not cover the cost incurred to provide the nursing care, phlebotomy bag and other supplies, overhead, scheduling time and disposal of hazardous waste that are all required to furnish this service.

Response: We have carefully reviewed the costs associated with APC 999 and believe that the CPT code 99195 was mistakenly used to report simple venipuncture in some cases, thus lowering the cost of proposed APC 999. However, we believe it is appropriate to base payment for this APC on the median amount billed, since CPT code 99195 was billed more than 20,000 times. Hospitals must use this code only when *therapeutic* phlebotomy is furnished, and charge an appropriate rate for the resources involved. Appropriate reporting will enable us to determine a more precise weight for this APC in future years.

Final APC 081: Non-Coronary Angioplasty or Atherectomy

Final APC 082: Coronary Atherectomy

Final APC 083: Coronary Angioplasty

We created these three new APC groups to accommodate atherectomy and angioplasty procedures that we originally proposed to classify as inpatient only. We discuss in section III.C.5 our response to commenters' concerns about our proposing to designate certain procedures as ''inpatient only'' and our final decision to change the status of these atherectomy and angioplasty procedures.

Final APC 058: Strapping

Final APC 059: Casting

We proposed to assign the procedures in these new APC groups a payment status indicator ''N'' as incidental services for which payment is packaged into the APC rate for another service or procedure. However, we determined

that the procedures in the final APC groups 0058 and 0059 could be performed independently, that is, the procedures for which a strapping has been previously applied and/or a new cast has previously been placed. We explain in more detail in section III.C.2.c our rationale for not packaging the costs associated with these services. We therefore created APC groups 0058 and 0059 for these codes to which we assigned payment status indicator ''S'' to indicate that these are significant procedures paid under the hospital outpatient PPS to which the multiple procedure discount does not apply.

e. Exceptions to BBRA 1999 Limit on Variation of Costs Within APC Groups

As we note above, section 201(g) of BBRA 1999 amends section 1833(t)(2) of the Act to define what constitutes comparable use of resources among the procedures or services within an ambulatory payment classification group under the hospital outpatient PPS. The standard set by section 1833(t)(2) of the Act is that the items and services within a group cannot be considered comparable with respect to the use of resources if the highest median (elected by the Secretary, as opposed to the mean) cost item or service within a group is more than 2 times greater than the lowest median cost item or service within the same group (the ''two-times'' requirement).

Section 1833(t)(2) of the Act allows the Secretary to make exceptions to the ''two-times'' requirement in unusual cases, such as low volume items and services, although the Secretary may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug, and Cosmetic Act. As we explain in the preceding section of this preamble, after we had modified the composition of the APC groups based on the recommendations of commenters, we made numerous additional changes to the APC groups to conform with the BBRA 1999 ''two times'' requirement. In the resulting groups, we found certain anomalies that were irreconcilable with the principles underlying formation of the APC groups. After carefully evaluating the various combinations resulting from further subdividing groups or reassigning codes to other groups to resolve the anomalies, and after reviewing our data, we decided to maintain the composition of certain APC groups, as exceptions to the ''two times'' requirement. We based exceptions on factors such as low procedure volume, suspect or incomplete cost data, concerns about inaccurate or incorrect coding, or compelling clinical arguments. We believe that as hospitals gain experience under the hospital outpatient PPS, and as they refine their coding of services, a number of the apparent anomalies within the groups that we are treating as exceptions to the ''two times'' will be resolved.

Below we list the APC groups that are exceptions to the ''two times'' requirement, and our reasons for the exception. We use the final APC number to identify the group.

APC 0016: Level IV Debridement and Destruction

We are retaining CPT code 56501 in final APC group 0016, even though its median cost exceeds the ''two times limit.'' We believe the higher costs that are reflected in the data are the result of incorrect coding. The descriptor for CPT code 56501 defines the procedure as the simple destruction of skin and superficial subcutaneous tissues. In the judgment of our medical advisors, costs associated with simple destruction of skin and superficial subcutaneous tissues are typically within the range of costs associated with the other procedures in final APC group 0016, and the median cost that our data attribute to CPT code 56501 is higher than the code description warrants.

APC 0030: Breast Reconstruction/ Mastectomy

Although the range of costs for procedures in final APC group 0030 exceeds the ''two times limit,'' we believe that only the simplest breast procedures will be done in the outpatient setting. Most of the procedures with median costs over $1000 used observation services in order to provide an overnight stay. We expect these cases to revert to the more appropriate inpatient setting.

APC 0058: Level I Strapping/Casting

The codes in final APC group 0058 are the simpler casting, splinting, and strapping procedures. Costs associated with the more resource-intensive procedures in final APC group 0059 are fairly uniform, but the median costs of procedures in final APC group 0058 vary widely. We are excepting final APC group 0058 from the ''two times limit'' until we can review the data for the first year of the outpatient PPS.

APC 0060: Manipulation Therapy

Taken collectively, the codes in final APC group 0060 are low in volume and erratically priced. For example, although the number of areas treated increases within the range of CPT codes 98925 through 98929, suggesting progressively increasing resource utilization, our data show median costs associated with the codes in the range 98925–98929 as $38, $11, $16, $17, and $19, respectively. Although costs associated with treating 9 to 10 body regions might not be 5 to 10 times greater than treating one or two regions, we would still expect costs for the more extensive procedures to be higher than those for the less extensive procedures, and certainly not lower as suggested by our data. Nor do we expect a hospital to specialize in treating more or fewer body areas. Therefore, the median payment set for final APC 0060 should average out, providing adequate payment for any number of body areas treated.

APC 0079: Ventilation Initiation and Management

These codes all represent respiratory treatment and support within the outpatient setting. Their costs should be roughly the same, even though our data suggest otherwise. We are excepting final APC group 0079 from the ''two times limit'' at this time, pending the collection of more conclusive cost data.

APC 0080: Diagnostic Cardiac Catheterization

The data for CPT code 93524 reflect costs that are lower than we would expect. We can find no apparent explanation for the wide variation in costs among the cardiac catheterization codes, although we suspect that the accuracy of the chargemaster system, when assigning charges in other than the surgical suite, may be problematic. We expect costs to even out once hospitals decide which cases may be handled on an outpatient basis without requiring an overnight stay.

APC 0081: Non-Coronary Angioplasty

We are excepting final APC group 0081 from the ''two times limit'' because of the low volume of cases for the codes in the group. For some of the codes in this group, the data reflect lower than expected median costs, which we attribute to low volume and to miscoding, which would account for the erratic sequences of costs found in our data.

APC 0093: Vascular Repair/Fistula Construction

We believe the median costs for CPT codes 36530 and 36810 are aberrant. These codes are very similar clinically to the other codes in APC 0093, and we would expect their costs to be similar. We believe low volume may account for the variability in cost.

APC 0094: Resuscitation and Cardioversion

We believe the median costs for CPT codes 92953 and 31500 are aberrant, perhaps due to misuse of the codes. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect and analyze more accurate data once the hospital outpatient PPS is implemented.

APC 210: Spinal Tap

The two CPT codes that comprise this group are essentially the same procedure, one performed for diagnostic reasons and the other therapeutic. We suspect the disparity in median costs is attributable to the much higher volume of diagnostic spinal taps. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect and analyze more accurate data once the hospital outpatient PPS is implemented.

APC 0233: Level II Anterior Segment Eye

We are excepting final APC group 233 from the ''two times limit'' because many of the codes in this APC are low volume and the coding seems erratic. For example, CPT designates a number of codes that are in final APC group 0233 as ''relatively small'' surgical procedures, which suggests that miscoding may have resulted in inflated cost data.

APC 0251: Level I ENT Procedures

A combination of low volume and unlisted codes obscures the fact that this APC represents the least intense ENT procedures. Because there are so many ENT codes, consistent agreement on what the codes represent may be difficult to achieve. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate data under outpatient PPS.

APC 0264: Level II Miscellaneous Radiology Procedures

In the judgment of our medical advisors, the median costs for CPT codes 74740 and 76102 are aberrant. These procedures would be underpaid if they were paid separately and on the basis of what our data show to be their median cost. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

APC 0274: Myelography

In the judgment of our medical advisors, the median costs for CPT codes 70010 and 70015 are aberrant. These codes would be underpaid if they were moved to their own APC and paid on the basis of their median cost. All codes in this APC should cluster around the same cost. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

APC 0279: Level I Diagnostic Angiography

We believe the median costs for the codes at the low end of this APC may be inaccurate, because, clinically, these codes are homogeneous. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

APC 0302: Level III Radiation Therapy

We are retaining CPT code 77470 in final APC group 302, because the median cost seems low for the code description, possibly because this code may have been billed improperly in the past. We are also uncertain of the appropriate median cost of CPT code 61793, because we have been told that CPT code 61793 was used for both single-session gamma knife procedures and for each of multiple sessions of treatment with linear accelerators. Therefore, we have created two codes to be used in place of CPT code 61793, in order to collect more reliable data: G0173 (Stereotactic radiosurgery, complete course of therapy in one session), and G0174 (Stereotactic radiosurgery, requiring more than one session).

We will initially pay both codes at the same rate; however, we expect differences in cost would become apparent during the first year or 18 months of the outpatient PPS.

APC 0311: Radiation Physics Services

We are retaining CPT code 77370 in final APC group 0311, because we believe a special medical radiation physics consultation (outside the weekly management of a patient) is probably more costly than our data indicate.

APC 0341: Immunology Tests

We think the variation in costs among the procedures within final APC group 0341 may be the result of erratic coding. Because these services are so similar clinically, we would expect their individual costs to cluster around the median. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

APC 0371: Allergy Injections

We attribute the variation in median costs among the procedures within final APC group 0371 to erratic coding. Because these services are so similar clinically, we would expect their individual costs to cluster around the median. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

APC 0373: Neuropsychological Testing

With one exception, the codes in final APC group 0373 are billed per hour, so facility costs should all cluster around the median. Therefore, we are excepting this APC group from the ''two times limit,'' until we collect more accurate cost data under outpatient PPS.

7. Discounting of Surgical Procedures

To be consistent with Medicare policy and regulations governing payment for ambulatory surgical services furnished in a physician's office and in an ASC, we proposed under the hospital outpatient PPS to discount payment amounts when more than one procedure is performed during a single operative session or when a surgical procedure is terminated prior to completion. Specifically, we proposed that when more than one surgical procedure with payment status indicator ''T'' is performed during a single operative session, we would pay the full Medicare payment and the beneficiary would pay the coinsurance for the procedure having the highest payment rate. Fifty percent of the usual Medicare PPS payment amount and beneficiary coinsurance amount would be paid for all other procedures performed during the same operative session to reflect the savings associated with having to prepare the patient only once and the incremental costs associated with anesthesia, operating and recovery room use, and other services required for the second and subsequent procedures.

We also proposed to require hospitals to use modifiers on bills to indicate procedures that are terminated before completion. Modifier -73 (Discontinued Outpatient Procedure Prior to Anesthesia Administration) would identify a procedure that is terminated after the patient has been prepared for surgery, including sedation when provided, and taken to the room where the procedure is to be performed, but before anesthesia is induced (for example, local, regional block(s), or general anesthesia). Modifier-52 (Reduced Services) would be used to indicate a procedure that did not require anesthesia, but was terminated after the patient has been prepared for the procedure, including sedation when provided and taken to the room where the procedure is to be performed. We proposed to pay 50 percent of the usual Medicare PPS payment amount and

beneficiary coinsurance amount for a procedure terminated before anesthesia is induced. Modifier-74 (Discontinued Procedure) would be used to indicate that a surgical procedure was started but discontinued *after* the induction of anesthesia (for example, local, regional block, or general anesthesia), or *after* the procedure was started (incision made, intubation begun, scope inserted) due to extenuating circumstances or circumstances that threatened the well-being of the patient. To recognize the costs incurred by the hospital to prepare the patient for surgery and the resources expended in the operating room and recovery room, the hospital will receive full payment for a procedure that was started but discontinued after the induction of anesthesia or after the procedure was started, as indicated by a modifier-74. The elective cancellation of procedures would not be reported. If multiple procedures were planned, only the procedure actually initiated would be billed.

Comment: Some commenters asked us to clarify how the policy would be applied. For example, one commenter asked whether the surgical discounting methodology would apply in the following situation: Contrast x-ray of lower spine (CPT code 72265) is followed by contrast CAT of the spine (CPT code 72132). Both procedures have related surgical codes (CPT codes 62270 and 62284). Other commenters provided examples that were similar in nature but involved other codes.

Response: We proposed to apply the reduced payment for multiple procedures to surgical procedures only, that is, those CPT codes that have a payment status indicator ''T.'' Therefore, services such as CPT codes 72265 and 72132 that have a payment status indicator of ''S'' would not be subject to the multiple procedure discount, whereas CPT codes 62270 and 62284, which are surgical procedures and have a payment status indicator of ''T,'' would be subject to the multiple procedure discount. Hypothetically, if all four codes were provided in a single operative session, as suggested by this commenter, then the reduced payment would apply only to the surgical procedure with the lower payment rate. (For the record, we have responded to the commenter's example in order to clarify how the multiple procedure discount would apply in a hypothetical situation. However, we question whether the suggested combination of codes would be covered if actually performed during the course of a single patient encounter.)

Comment: Commenters asked what factors guided our assignment of payment status indicator ''T'' to a code.

Response: We generally assigned the payment status indicator ''T'' to surgical services. Our medical advisors and staff will continue to review the designation of status indicators and we may propose revisions in the future.

Comment: A variety of commenters stated that the reduced payments for multiple procedures would inappropriately reduce payments for a second procedure. Some were concerned that application of the multiple procedure discount could result in hospitals being less likely to offer procedures assigned the payment status indicator ''T.'' These commenters recommended that we change all ''T'' payment indicators to a different indicator such as ''S,'' which we define as a significant procedure not reduced when multiple, until we have had an opportunity to collect reliable cost data upon which to base payment decisions about discounting.

Response: We continue to believe that the proposed reduced payment for multiple surgical procedures is reasonable. We disagree that hospitals would be less likely to provide these services. We believe there clearly are savings achieved when more than one surgical procedure is performed during a single operative session. The patient has to be prepared for surgery only once, and the costs associated with anesthesia, operating and recovery room use, and other services required for the second procedure are incremental.

Comment: Some commenters questioned whether the reduced payment for multiple procedures applied to the beneficiary coinsurance as well as to the Medicare program payment. Others did not understand how this reduced payment was accounted for in determining the conversion factor.

Response: The reduced payment for multiple procedures would apply to both the beneficiary coinsurance and the Medicare payment. In order to do this in a ''budget neutral'' manner, we increased the conversion factor to account for the reduced payments for multiple procedures. In this way, total payments in the aggregate are not affected.

Comment: One commenter believes we should exclude from the multiple-procedure discount those procedures that were subject to a 50 percent reduction under the previous cost-based system because those procedures were recognized as being an adjunct to a primary procedure. The commenter believes that we had already factored these discounts into our cost determinations and would therefore be inappropriately reducing payment even further for these procedures.

Response: We disagree with the commenter. In determining the weights for the APC groups, we included only single procedure claims. Multiple procedure reductions existing under the previous cost-based system would not have been reflected in these single procedure claims, and, therefore, do not affect the APC payment weights.

Final Action

Under the hospital outpatient PPS, we will discount payment amounts for surgical procedures when more than one procedure is performed during a single operative session or when a surgical procedure is terminated prior to completion. Parallel discounts will apply to beneficiary coinsurance amounts.

8. Payment for New Technology Services

a. Background

We proposed to price a new item or service that was assigned a new HCPCS code by classifying the new code to whichever existing APC group most closely resembled the item or service in terms of its clinical characteristics and estimated resource use. We proposed to use the group weight, payment rate, and coinsurance amount established for the existing APC to price the new code for at least 2 years to give us an opportunity to collect cost data for the new item or service.

After we published our proposed rule, the Congress expressed concern in the conference report accompanying the BBRA 1999, that our proposed PPS does not adequately address ''issues pertaining to the treatment of * * * new technology.'' (See H. R. Rep. No. 436 (Part I), 106th Cong., 1st Sess. 868 (1999).) Therefore, the Congress enacted ''transitional pass-throughs'' in section 201(b) of the BBRA 1999 that provide an additional payment for ''new medical devices, drugs, and biologicals'' that do not otherwise meet the definition of current orphan drugs, or current cancer therapy drugs and biologicals and brachytherapy, or current radiopharmaceutical drugs and biological products. (See section III.D of this preamble for a discussion of how we are implementing the transitional pass-throughs.)

b. Comments and Responses

Comment: The most frequent commenters regarding our treatment of new technology under the proposed

hospital outpatient PPS were device manufacturers and pharmaceutical companies and their trade associations. Commenters were concerned because the proposed APC payment rates were developed using 1996 cost data that do not reflect the cost of many new technologies introduced subsequent to 1996. Commenters believe that the proposed method of ratesetting under the APC system lacks the flexibility needed to recognize emergent technologies in a timely manner. In the view of the commenters, assigning new technologies to existing APC groups pending the collection of cost data would result in underpayment, thereby discouraging the adoption of new technologies.

Commenters further stated that the proposed payment rates for current yet relatively new devices were too low and would favor continued use of older, less effective regimens on the basis of financial pressures rather than on the improved clinical outcomes of newer technology. Some commenters, concerned that we will not update codes or payment rates quickly enough to allow hospitals to pay for new technologies, recommended that we assign HCPCS codes as soon as products become available and alter APC group weights to account for a new technology. These commenters believe that the time lapse between coding updates is a barrier to innovation because it can take several years for a code to be issued for a new surgical technique, and until a new code is issued, facilities must bill for new surgical techniques as ''unlisted procedures'' resulting in the lowest payment rate for the category of surgery.

One commenter urged that we implement a payment carve-out for certain drug and biological therapies and pay for these items on a reasonable cost basis in order to provide timely patient access to many new pharmaceutical and biotechnology products. The same commenter recommended that if we reject a complete carve-out, then, at a minimum, we should pay for new products introduced after 1996 on a reasonable cost basis for 1 year to adequately compensate companies for developing new and more effective products. Another commenter recommended that we increase the number of APC groups to better reflect services with similar cost structures.

One professional association recommended abandoning the APC group system altogether and pricing services individually because assigning new technology and most costly procedures to APC groups with established lower cost procedures creates a strong disincentive for hospitals to provide new or improved items or services and, in the case of newer, higher cost drugs, encourages hospitals to develop formularies and practice patterns based on financial considerations rather than on the medical value of drugs.

Technologies that commenters cited as being inadequately addressed by the proposed outpatient PPS include new technologies based on molecular genetics; gamma knife procedures used in radiation surgery; and prostatic microwave thermotherapy (transurethral microwave thermotherapy (TUMT)) which a commenter said has a direct cost of $1,918 and, factoring in indirect costs, a total cost of $2,623.

Response: The concerns expressed by commenters regarding new technology items and services highlight two issues. The first is specific to the data used to construct APC groups and calculate their prices at the start of the PPS. As required by section 1833(t)(2)(C) of the Act, we are using claims data from 1996 as the basis for determining APC group weights and payment rates under the new system. The 1996 data do not capture items and services that have emerged since that time and that are now in use. The second issue relates to new items and services that will be introduced in the future, after the outpatient PPS is implemented. Postponing the adjustment of APC groups and weights for several years to allow for the collection of cost data would potentially inhibit the dissemination of medically desirable innovations.

We recognize the concerns raised by commenters about our proposed treatment of new codes under the hospital outpatient PPS. We therefore have developed a process that we believe will allow us to recognize new technologies on an ongoing basis as expeditiously as our systems permit. We expect that this process, which we explain below, combined with the transitional pass-throughs established by section 201(b) of the BBRA 1999 (which we describe in section III.D of this preamble), will provide additional payment for a significant share of new technologies.

In this final rule, we have created special APC groups to accommodate payment for new technology services. In contrast to the other APC groups, the new technology APC groups do not take into account clinical aspects of the services they are to contain, but only their costs. We will assign new items and services that we determine cannot appropriately be placed in existing APC groups for established procedures and services to the new technology APC groups.

The new technology APC groups, which are now largely unpopulated, are already defined in our claims processing system for the outpatient PPS, and we have established payment rates for the APC groups based on the midpoint of ranges of possible costs, for example, the payment amount for a new technology APC group reflecting a range of costs from $300 to $500 would be set at $400. The cost range for the groups reflects current cost distributions, and we reserve the right to modify the ranges as we gain experience under the outpatient PPS. The final APC groups for new technology are groups 0970 through 0984 and cover a range of costs from less than $50 to $6,000. Upon implementation of the outpatient PPS, we will make payment for the following new technology services under the new technology APCs:

53850 Transurethral destruction of prostate tissue; by microwave thermotherapy
53852 Transurethral destruction of prostate tissue; by radiofrequency thermotherapy
96570 Photodynamic therapy, first 30 minutes
96751 Photodynamic therapy, each additional 15 minutes
G0125 PET lung imaging of solitary pulmonary nodules, using 2-(Fluorine-18)-Fluoro-2-Deoxy-D-Glucose (FDG), following CT (71250/71260 or 71270)
G0126 PET lung imaging of solitary pulmonary nodules, using 2-(Fluorine-18)-Fluoro-2-Deoxy-D-Glucose (FDG), following CT (71250/71260 or 71270); initial staging of pathologically diagnosed non-small cell lung cancer
G0163 Positron emission tomography (PET), whole body, for recurrence of colorectal metastatic cancer
G0164 Positron emission tomography (PET), whole body, for staging and characterization of lymphoma
G0165 Positron emission tomography (PET), whole body, for recurrence of melanoma or melanoma metastatic cancer
G0166 External counterpulsation, per treatment session
G0168 Wound closure by adhesive

The new technology APC groups give us a mechanism for initiating payment at an appropriate level within a relatively short timeframe, and certainly less than the 2 or 3 years that we contemplated in our proposed rule. As in the case of items qualifying for the transitional pass-through payment, placement in a new technology APC will be temporary. After we gain information about actual hospital costs incurred to furnish a new technology service, we will move it to a clinically-related APC group with comparable resource costs. If we cannot move the new technology service to an existing

APC because it is dissimilar clinically and with respect to resource costs from all other APCs, we will create a separate APC for such service. We will retain a service within a new technology APC group for at least 2 years, but no more than 3 years, consistent with the time duration allowed for the transitional pass-through payments. Movement from a new technology APC to a clinically-related APC would occur as part of the annual update of APC groups. Beneficiary coinsurance amounts for items and services in the new technology APC groups are 20 percent of the payment rate set for the new technology APCs.

We ask that interested parties take the following steps to bring to our attention services that they believe merit consideration for pricing using the new technology APC groups. Mail requests for consideration of possible new technology services that have established HCPCS codes to the following address ONLY: PPS New Tech/Pass-Throughs, Division of Practitioner and Ambulatory Care, Mailstop C4–03–06, Health Care Financing Administration, 7500 Security Boulevard, Baltimore, MD 21244–1850.

To be considered, requests MUST include the following information:

- Trade/brand name of item.
- A detailed description of the clinical application of the item, including HCPCS code(s) to identify the procedure(s) with which the item is used.
- Current cost of the item to hospitals (*i.e.,* actual cost paid by hospitals net of all discounts, rebates, and incentives in cash or in-kind). In other words, submit the best and latest information available that provides evidence of the hospital's actual cost for a specific item.
- If the item is a service, itemize the costs required to perform the procedure, *e.g.,* labor, equipment, supplies, overhead, etc.
- If the item requires FDA approval/clearance, submit information that confirms receipt of FDA approval/clearance and the date obtained.
- If the item already has an assigned HCPCS code, include the code and its descriptor in your submission plus a dated copy of the HCPCS code ''recommendation application'' previously submitted for this item.
- If the item does not have an assigned HCPCS code, follow the procedure discussed, below, for obtaining HCPCS codes and submit a copy of the application with our payment request.
- Name, address, and telephone number of the party making the request.
- Other information as HCFA may require to evaluate specific requests.

We believe some items not yet known to us do not yet have assigned HCPCS codes. We expect to use national HCPCS codes in the hospital outpatient PPS to the greatest extent possible. These codes are established by a well-ordered process that operates on an annual cycle, starting with submission of information by interested parties due by April 1 and leading to announcement of new codes in October of each year. This process is described, and relevant application forms are available, on the following HCFA website: http://www.hcfa.gov/medicare/hcpcs.htm.

Considering the exigencies of implementing a new system, we intend to establish temporary codes in 2000 to permit implementation of additional payments for other eligible items effective beginning October 1, 2000. The process for submitting information will be the same as for national codes.

For new technology services that DO NOT have established HCPCS codes, submit the regular application for a national HCPCS code in accordance with the instructions found on the internet at *http://www.hcfa.gov/medicare/hcpcs.htm.* Send applications for national HCPCS codes to: C. Kaye Riley, HCPCS Coordinator, Health Care Financing Administration, Mailstop C5–08–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850. A fuller discussion of the HCPCS process and schedule is in section III.D.6 of this preamble.

Because of staffing and resource limitations, we cannot accept requests by facsimile (FAX) transmission. Because of claims processing systems constraints, a new technology payment rate can only be initiated at the start of a calendar quarter. Since we will update our outpatient PPS quarterly to include new technology additional services, October 1, 2000 is the earliest date that we will implement payment for additional new technology services other than for those items beginning on July 1, 2000. In general, we expect to be able to complete action on requests to assign an item or service to a new technology APC group in about 6 months from the date we receive the request.

In order to be considered for assignment to a new technology APC group, an item or service must meet the following criteria:

- The item or service is one that could not have been billed to the Medicare program in 1996 or, if it was available in 1996, the costs of the item or service could not have been adequately represented in 1996 data.
- The item or service does not qualify for an additional payment under the transitional pass-through provided for by section 1833(t)(6) of the Act, as amended by section 201(b) of the BBRA 1999, and 42 CFR 419.43(e) as a current orphan drug, as a current cancer therapy drug or biological or brachytherapy, as a current radiopharmaceutical drug or biological product, or as a new medical device, drug, or biological.
- The item or service has a HCPCS code. (See section III.D for additional information about obtaining HCPCS codes.)
- The item or service falls within the scope of Medicare benefits under section 1832(a) of the Act.
- The item or service has been determined to be reasonable and necessary in accordance with section 1862(a)(1)(A) of the Act.

Final Action

We are initiating a method to pay for new technology services that are not addressed by the transitional pass-through provisions of the BBRA 1999.

D. Transitional Pass-Through for Innovative Medical Devices, Drugs, and Biologicals

1. Statutory Basis

Section 201(b) of the BBRA 1999 amended section 1833(t) of the Act by adding a new section 1833(t)(6). This provision requires the Secretary to make additional payments to hospitals for a period of 2 to 3 years for specific items. The items designated by the law are the following: current orphan drugs, as designated under section 526 of the Federal Food, Drug, and Cosmetic Act; current drugs, biologic agents, and brachytherapy devices used for treatment of cancer; current radiopharmaceutical drugs and biological products; and new medical devices, drugs, and biologic agents, in instances where the item was not being paid for as a hospital outpatient service as of December 31, 1996, and where the cost of the item is ''not insignificant'' in relation to the hospital outpatient PPS payment amount. In this context, ''current'' refers to those items for which hospital outpatient payment is being made on the first date the new PPS is implemented.

Section 1833(t)(6)(C)(i) of the Act sets the additional payment amounts for the drugs and biologicals as the amount by which the amount determined under section 1842(o) of the Act (95 percent of the average wholesale price (AWP)) exceeds the portion of the otherwise applicable hospital outpatient department fee schedule amount that

the Secretary determines to be associated with the drug or biological. Section 1833(t)(6)(C)(ii) provides that the additional payment for medical devices be the amount by which the hospital's charges for the device, adjusted to cost, exceed the portion of the otherwise applicable hospital outpatient department fee schedule amount determined by the Secretary to be associated with the device. Under section 1833(t)(6)(D), the total amount of pass-through payments for a given year cannot be projected to exceed an ''applicable percentage'' of total payments. For a year (or a portion of a year) before 2004, the applicable percentage is 2.5 percent; for 2004 and subsequent years, the applicable percentage is 2.0 percent. If the Secretary estimates that total pass-through payments would exceed the caps, the statute requires the Secretary to reduce the additional payments uniformly to ensure the ceiling is not exceeded.

Section 201(c) of the BBRA amended section 1833(t)(2)(E) of the Act to require that these pass-through payments be made in a budget neutral manner. In accordance with section 1833(t)(7) of the Act, as amended by section 201(i) of the BBRA 1999, these additional payments do not affect the computation of the beneficiary coinsurance amount.

Implementation of this pass-through provision requires us to—

- Identify eligible pass-through items;
- Designate a Billing Code for each;
- Determine the term ''not insignificant'' in the context of determining whether an additional payment is appropriate;
- Determine an appropriate cost-to-charge ratio to use to adjust the hospital's charges for a new medical device to cost;
- Determine the portion of the applicable APC that would be associated with the drug, biological or device; and
- Determine the additional payment amount.

As with other provisions of this final rule that reflect implementation of the BBRA 1999, we are soliciting comments on our implementation of the transitional pass-through payments, as set forth below.

2. Identifying Eligible Pass-Through Items

a. Drugs and Biologicals

Section 1833(t)(6)(A) of the Act establishes definitions and examples of the drugs and biologicals that are candidates for pass-through payments. As indicated above, these drugs and biologicals are characterized as both current and new. Current refers to those drugs and biologicals for which payment is made on the first date the hospital outpatient PPS is implemented, that is, on July 1, 2000. They include the following:

1. Orphan drugs. These are drugs or biologicals that have been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

2. Cancer therapy drugs, biologicals, and brachytherapy. These items are those drugs or biologicals that are used in cancer therapy, including (but not limited to) chemotherapeutic agents, antiemetics, hematopoietic growth factors, colony stimulating factors, biological response modifiers, bisphosphonates, and a device of brachytherapy.

3. Radiopharmaceutical drugs and biological products. These are radiopharmaceutical drug or biological products used in nuclear medicine for diagnostic, monitoring, or therapeutic purposes.

A new drug or biological is defined as a product that was not paid as a hospital outpatient service prior to January 1, 1997 and for which the cost is not insignificant in relation to the payment for the APC to which it is assigned. These items are not reflected in the 1996 claims data we are required to use in developing the outpatient PPS. Before payment can be made for these new drugs and biologicals, a determination must be made that these items are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member as required by section 1862(a)(1)(A) of the Act. Drugs that can be self-administered are not covered under Part B of Medicare (with specific exemptions for certain oral chemotherapeutic agents and antiemetics, blood-clotting factors, immunosuppressives, and erythropoietin for dialysis patients).

b. Medical Devices

Under section 201(b) of the BBRA 1999, for purposes of making pass-through payments, a new or innovative medical device is one for which payment as a hospital outpatient service was not being made as of December 31, 1996 and for which the cost of the device ''is not insignificant'' in relation to the hospital outpatient department fee schedule amount payable for the service involved. For the purpose of identifying ''new medical devices'' that may be eligible for pass-through payments, we are excluding equipment, instruments, apparatuses, implements or items that are generally used for diagnostic or therapeutic purposes, that are not implanted or incorporated into a body part, and that are used on more than one patient (that is, are reusable). This material is generally considered to be hospital overhead costs and the depreciation expenses associated with them are reflected in the APC payments. The unit of payment for the outpatient PPS is a service or procedure. Equipment or instrumentation is a method or means of delivering that service. We are not establishing separate APC payments for equipment, instruments, apparatuses, implements, or items because payment for these types of devices is packaged in the APC payment for the service or item with which they are used. However, as we discuss above in section III.C.8, we have created new technology APCs to accommodate new technology services that may be performed using equipment or instrumentation that is capitalized and depreciated and used on more than one patient. An example of a new technology service is CPT code 53850, Transurethral destruction of prostate tissue; by microwave thermotherapy. We have assigned this procedure to new technology APC 0980. (See section III.C.8 of this preamble for further discussion of payment for new technology under the hospital outpatient PPS.)

Section 201(e) of the BBRA 1999 amends section 1833(t)(1)(B) of the Act to include as ''covered OPD services'' implantable items described in paragraphs (3), (6), or (8) of section 1861(s) of the Act. Paragraph (3) refers to diagnostic tests including diagnostic x-rays, mammographies, laboratory tests, and other diagnostic tests. Paragraph (6) refers to implantable durable medical equipment (DME), and paragraph (8) refers to prosthetic devices that replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care). Implantables are not mentioned specifically in these paragraphs, but we consider a prosthetic device that replaces all or part of an internal body organ that is mentioned in section 1861(s)(8) to be an implantable. The BBRA 1999 Conference Report lists pacemakers, defibrillators, cardiac sensors, venous grafts, drug pumps, stents, neurostimulators, and orthopedic implants, as well as items that come in contact with human tissue during invasive procedures as examples of implantable items.

Implantable items covered under section 201(e) of the BBRA 1999 may be considered eligible for the transitional pass-through payments allowed under

section 201(b) of the BBRA 1999 to the extent that these implantables meet the statutory requirements set forth in section 201(b) and the criteria established in this final rule for payment of these devices.

Although we are recognizing the implantable items identified in section 201(e) of the BBRA 1999 for possible pass-through payments, we are not applying the pass-through provision to any DME, orthotics, and prosthetic devices that are not covered under section 201(e) of the BBRA 1999. Rather, we will pay for these items under the DMEPOS fee schedule when the hospital is acting as a supplier.

3. Criteria To Define New or Innovative Medical Devices Eligible for Pass-Through Payments

In summary, we will make pass-through payment for new or innovative medical devices that meet the following criteria:

a. They were not recognized for payment as a hospital outpatient service prior to 1997.

b. They have been approved/cleared for use by the FDA.

c. They are determined to be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body part, as required by section 1862(a)(1)(A) of the Act. We recognize that some investigational devices are refinements of existing technologies or replications of existing technologies and may be considered reasonable and necessary. We will consider devices for coverage under the outpatient PPS if they have received an FDA investigational device exemption (IDE) and are classified by the FDA as Category B devices. (See §§ 405.203 to 405.215.) However, in accordance with § 405.209, payment for a nonexperimental investigational device ''is based on, and may not exceed, the amount that would have been paid for a currently used device serving the same medical purpose that has been approved or cleared for marketing by the FDA.''

d. They are an integral and subordinate part of the procedure performed, are used for one patient only, are surgically implanted or inserted, and remain with that patient after the patient is released from the hospital outpatient department.

e. The associated cost is not insignificant in relation to the APC payment for the service in which the innovative medical equipment is packaged. (See section III.D.4 below for the definition of ''not insignificant.'')

f. They are not equipment, instruments, apparatuses, implements, or such items for which depreciation and financing expenses are recovered as depreciable assets as defined in Chapter 1 of the Medicare Provider Reimbursement Manual (HCFA Pub. 15–1). (As indicated above, these costs are considered overhead expenses that have been factored into the APC payment.)

g. They are not materials and supplies such as sutures, clips, or customized surgical kits furnished incident to a service or procedure.

h. They are not materials such as biologicals or synthetics that may be used to replace human skin.

Comment: Some commenters asked how we would pay for new technology intraocular lenses (IOLs) under the hospital outpatient PPS.

Response: We will use the same criteria established in the June 16, 1999 final rule (64 FR 32198) titled ''Medicare Program; Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers'' to identify IOLs that may be considered new technology and eligible for pass-through payments. In accordance with that rule, IOLs must first be approved by the FDA before they can be considered as a new technology IOL. The rule establishes only one criterion for distinguishing new technology IOLs from other IOLs. Specifically, all claims of the IOL's clinical advantages and superiority over existing IOLs must have been approved by the FDA for labeling and advertising purposes. For further discussion on the reasons for relying on the FDA's determination, we refer the reader to the IOL proposed rule published on September 4, 1997 (62 FR 46700 through 46701). We recognize that this criterion has been developed to define the characteristics that distinguish a new technology IOL from other IOLs in order to comply with section 141(b) of the Social Security Act Amendments of 1994 (Pub. L. 103–432) that is specific to IOLs furnished in ASCs and not hospital outpatient departments. However, we believe that it is appropriate to rely on an established approach to assist us in distinguishing this new technology since more than 1 million IOLs are inserted annually during or subsequent to cataract surgery performed in the outpatient setting. Moreover, we believe that consistent application of the criterion in both the ASC and hospital outpatient prospective payment systems is less burdensome to those requesting recognition of new technology IOLs. Therefore, when IOLs that are recognized as ''new technology IOLs'' in accordance with the provisions of the June 16, 1999 final rule are furnished in a hospital outpatient setting, we will pay for such new technology IOLs in accordance with the hospital outpatient PPS method for determining additional payments under the pass-through provision set forth in this final rule.

Comment: We received many comments urging that we establish appropriate payments for brachytherapy seeds used in the treatment of prostate cancer.

Response: In accordance with section 1833(t)(6)(A)(ii), as added by section 201(b) of the BBRA 1999, we will provide additional payments for brachytherapy seeds as an implanted device. The brachytherapy device is assigned to APC 0918.

4. Determination of ''Not Insignificant'' Cost of New Items

Section 1833(t)(6)(A)(iv)(II) of the Act, as added by section 201(b) of the BBRA 1999 provides that the transitional pass-throughs apply to new drugs, biologicals, and devices whose cost is not insignificant in relation to the hospital outpatient PPS payment amount. Section 1833(t)(6)(C) defines the additional payment as the difference between an amount specified by the law and the portion of the applicable fee schedule amount determined to be associated with the item. The objective of this section is to prevent the hospital outpatient PPS from creating disincentives for the diffusion of valuable new technology by initially paying a rate significantly below the costs of these items. We believe that the ''not insignificant'' criterion was included in recognition that: (1) The costs of some new technologies would not be large enough relative to the fee schedule amount to provide disincentives for their use in the short run; and (2) that an excessive number of pass-through items could place a substantial burden on the claims processing systems of both HCFA and individual hospitals in a way that could hamper the rapid processing of pass-through payments for those items that would be significantly more costly than the applicable fee schedule amount. Therefore, in order to be consistent with the objectives of this section, we are establishing the following criteria for determining whether the costs of drugs, biologicals, and devices are ''not insignificant'' relative to the hospital outpatient department fee schedule amount:

(1) Its expected reasonable cost exceeds 25 percent of the applicable fee schedule amount for the associated service.

(2) The expected reasonable cost of the new drug, biological, or device must exceed the portion of the fee schedule amount determined to be associated with the drug, biological, or device by 25 percent.

(3) The difference between the expected, reasonable cost of the item and the portion of the hospital outpatient department fee schedule amount determined to be associated with the item exceed 10 percent of the applicable hospital outpatient department fee schedule amount.

The following illustrates the application of these three criteria.

Example: Let us assume that the reasonable cost of the new device ZZ is $32.00. ZZ is associated with HCPCS code 00000 assigned to APC 0001. The fee schedule amount for APC 0001 is $100.00. The portion of the fee schedule amount included in APC 0001 that represents the cost associated with the former device is $25.00.

1. (a) Multiply the fee schedule amount for APC 0001 by 25 percent

$100.00 × .25 = $25.00

(b) Compare the reasonable cost for ZZ to the product derived in Step 1

$32.00 > $25.00

Finding: The first criterion is met.

2. (a) Multiply the portion of the fee schedule amount for APC 0001 that is associated with a device by 25 percent

$25.00 × .25 = $6.25

(b) Subtract the portion of the fee schedule amount for APC 0001 attributable to a device from the reasonable cost for ZZ

$32.00 − $25.00 = $7.00

(c) Compare the remainder in Step 4 to the product in Step 2(a)

$7.00 > $6.25

Finding: The second criterion is met.

3. (a) Multiply the fee schedule amount for APC 0001 by 10 percent

$100.00 × .10 = $10.00

(b) Compare the remainder in Step 3 to the product derived in Step 3(a)

$7.00 < $10.00

Finding: The third criterion is not met. Therefore, new device ZZ is not eligible for transitional pass-through payment.

5. Calculating the Additional Payment

Section 1833(t)(6)(C)(i) of the Act requires that for drugs, biologicals, and radiopharmaceuticals, the additional payment be determined as the difference between the amount determined under section 1842(o) of the Act (95 percent of AWP) and the portion of the hospital outpatient department fee schedule amount determined by the Secretary to be associated with those items. For devices, the additional payment is the difference between the hospital's charges adjusted to costs and the portion of the applicable hospital outpatient department fee schedule amount associated with the device. Under section 1833(t)(7) of the Act, as added by section 201(i) of the BBRA 1999, the coinsurance amounts for beneficiaries are not affected by pass-through payments.

We will determine, on an item-by-item basis, the amount of the applicable fee schedule amount associated with the relevant drug, biological, or device. To the extent possible, hospital outpatient department claims data will be used to make these estimates. When necessary, external data pertaining to the costs of the drugs, biologicals and devices already included in the fee schedule amounts will be used to make these determinations.

Before January 1, 2002, charges for devices eligible for pass-throughs will be adjusted to cost on each claim by applying the individual hospital's average cost-to-charge ratio across all outpatient departments. The 1996 data do not allow for determination of which revenue center-specific ratios might be used for this purpose. We will examine claims for the latter half of 2000 and for 2001 in order to determine if a revenue center-specific set of cost-to-charge ratios should be used for 2002 and beyond.

A one-time exception to the general methodology described above pertains to current drugs and biologicals that will be eligible for transitional pass-throughs when the PPS is implemented. For this final rule, we revised many APC groups by removing, to the extent possible, many of these drugs and radiopharmaceuticals. Therefore, the payment rates for the APC groups with which these drugs are associated exclude the costs of these drugs and the total amount paid to hospitals for the drugs will be 95 percent of the applicable AWP. In order to be able to determine a coinsurance amount for these drugs, we needed to estimate what portion of this payment would have been included as part of the APC payment amount associated with these drugs and what portion would be the pass-through amount. Using an external survey of hospitals' drug acquisition costs, we determined the APC payment amount for many of these drugs as their average acquisition cost adjusted to year 2000 dollars. Where valid cost data were not available for individual drugs, we applied the following average ratios of acquisition cost to AWP calculated from the survey to determine the fee schedule amount: .68 for drugs with one manufacturer, .61 for multi-source drugs, and .43 multi-source drugs with generic competitors. In either case, the coinsurance amounts were determined as 20 percent of these fee schedule amounts. It is important to note that these estimates do not affect the total payment to hospitals for these drugs (95 percent of AWP).

Because claims data are not available for most items that will be eligible for transitional pass-through payments for 2000 and 2001, it is extremely difficult to project expenditures under this provision. For this reason, and because many eligible items will be added after the system's implementation, we cannot estimate if, and to what extent, these payments would exceed 2.5 percent of total payments in 2000 and 2001. Therefore, there will be no uniform reduction factor applied to these payments during this period.

6. Process To Identify Items and To Obtain Codes for Items Subject to Transitional Pass-Throughs

We have identified a large number of items subject to the transitional pass-through payment through our own data-gathering activities or through comments on the proposed rule. Many of them already have HCPCS codes, and we are taking steps to establish temporary codes for the remaining items. We will make additional payments for these items when the hospital outpatient PPS system is implemented on July 1. A list of the items already known to us is set forth in Addendum K.

Other items potentially eligible for additional pass-through payments may not be known to us at this time. Because of systems limitations, if we do not know about an item, we will not be able to make additional payments for those items beginning on July 1, 2000. However, we will update our outpatient PPS on a quarterly basis beginning October 1, 2000 to add other items that are eligible for pass-through payments. Therefore, implementation of additional payment for any such item must wait until a later release of systems instructions, that is, in October 2000, January 2001 (annual update), or later.

A manufacturer or other interested party who wishes to bring items that may be eligible for additional transitional pass-through payments to our attention should mail requests for consideration of items to the following address ONLY: PPS New Tech/Pass-Throughs, Division of Practitioner and Ambulatory Care, Mailstop C4–03–06, Health Care Financing Administration,

7500 Security Boulevard, Baltimore, MD 21244–1850.

To be considered, requests MUST include the following information:

- Trade/brand name of item.
- A detailed description of the clinical application of the item, including HCPCS code(s) to identify the procedure(s) with which the item is used. If the item replaces or improves upon an existing item, identify the predecessor item by trade/brand name and HCPCS code.
- Current cost of the item to hospitals (*i.e.,* actual cost paid by hospitals net of all discounts, rebates, and incentives in cash or in-kind). In other words, submit the best and latest information available that provides evidence of the hospital's actual cost for a specific item.
- Date of sale of first unit.
- For drugs, submit the most recent average wholesale price (AWP) of the drug and the date associated with the AWP quote.
- If the item requires FDA approval/clearance, submit information that confirms receipt of FDA approval/clearance and the date obtained.
- If the item already has an assigned HCPCS code, include the code and its descriptor in your submission plus a dated copy of the HCPCS code ''recommendation application'' previously submitted for this item.
- If the item does not have an assigned HCPCS code, follow the procedure discussed, below, for obtaining HCPCS codes and submit a copy of the application with your payment request.
- Name, address, and telephone number of the party making the request.
- Other information as HCFA may require to evaluate specific requests.

We believe some items not yet known to us do not yet have assigned HCPCS codes. We expect to use national HCPCS codes in the hospital outpatient PPS to the greatest extent possible. These codes are established by a well-ordered process that operates on an annual cycle, starting with submission of information by interested parties due by April 1 and leading to announcement of new codes in October of each year. This process is described, and relevant application forms are available, on the following HCFA website: http://www.hcfa.gov/medicare/hcpcs. htm.

Considering the exigencies of implementing a new system, we intend to establish temporary codes in 2000 to permit implementation of additional payments for other eligible items effective beginning October 1, 2000. The process for submitting information will be the same as for national codes.

For items that might be candidates for additional transitional pass-through payments but that DO NOT have established HCPCS codes, submit the regular application for a national HCPCS code in accordance with the instructions found on the internet at http://www.hcfa.gov/medicare/hcpcs.htm. Send applications for national HCPCS codes to: C. Kaye Riley, HCPCS Coordinator, Health Care Financing Administration, Mailstop C5–08–27, 7500 Security Boulevard, Baltimore, Maryland 21244–1850.

Because of staffing and resource limitations, we cannot accept requests by facsimile (FAX) transmission.

As indicated in the instructions posted at our website address cited above, the deadline for submission of applications for a national HCPCS code for the CY 2001 cycle is April 1, 2000. The HCPCS process will proceed to assign national codes as warranted, and we expect these codes will be used in the hospital outpatient PPS starting January 1, 2001. Because the coding application will contain information vital to determining a specific item or product's eligibility for pass-through payments, we are requesting that a copy of the application be sent concurrently to ATTN: PPS New Tech/Pass-Throughs at the address shown above.

This year, we plan to implement additional payment for appropriate items on October 1, 2000. Requests submitted to us with appropriate information will be evaluated for payment effective October 1. We will use the same submissions made for national HCPCS codes as the basis for making temporary code assignments. However, a very large volume of requests or systems constraints could affect our ability to achieve this goal.

Any applications for HCPCS codes that are received after April 1 will be retained for the next cycle of the national HCPCS code assignment process starting the following April 1. We will also consider these items for assignment of temporary codes that might take effect in January or later in the next year.

How quickly additional payment for a new item can be implemented will depend on processing and systems constraints; it will in general require at least 6 months and may require as many as 9 or more months. Thus, a submission that we receive in May (which is too late for October implementation) might be assigned a temporary code to be used for implementing additional payments starting the following January.

As previously stated, pass-through payment for each item is temporary. After we obtain information about actual hospital costs incurred to furnish a pass-through item, we will package it into the service with which it is clinically associated.

Comment: A number of commenters expressed concern about the extensive amount of time required to obtain HCPCS codes for new items or services. They argued that the lag-time in coding updates creates a barrier to innovation, claiming that it can be several years before a code is issued for a new surgical technique or product. Some commenters noted that when facilities are forced to code new surgical techniques as ''unlisted procedures,'' pending issuance of a specific code for the procedure, it would result in the facility receiving payment for the lowest related APC group. Some commenters recommended that we assign HCPCS codes as soon as products become available.

Response: We recognize the urgency expressed by commenters. We believe the process we have outlined above will assist interested parties in obtaining HCPCS codes for new items and services in the most expeditious manner possible within the constraints imposed by our system requirements.

E. Calculation of Group Weights and Conversion Factor

1. Group Weights (Includes Table 1, Packaged Services by Revenue Center)

Section 1833(t)(2)(C) of the Act requires the Secretary to establish relative payment weights for covered hospital outpatient services. That section requires that the weights be developed using data on claims from 1996 and data from the most recent available hospital cost reports. Before enactment of the BBRA 1999, we were required to base the relative payment weights on median hospital costs. Section 201(f) of the BBRA 1999 amended section 1833(t)(2)(ii) of the Act to authorize the Secretary to base the relative payment weights on either the median or mean hospital costs. In constructing the database for the outpatient PPS proposed rule group weights and conversion factor, we used a universe of approximately 98 million calendar year 1996 final action claims for hospital outpatient department services received through June 1997 to match to the most recent hospital cost reports available. We have decided to continue to base the relative payments weights in this final rule on median (as opposed to mean) costs because, among other things, reconstructing our database to evaluate the impact of using mean costs after the BBRA 1999 was

enacted would have delayed implementation of the hospital outpatient PPS.

To derive weights based on median hospital costs for services in the hospital outpatient APC groups, we converted billed charges to costs and aggregated them to the procedure or visit level. To accomplish this, we first identified the cost-to-charge ratio that was specific to each hospital's cost centers (''cost center specific cost-to-charge ratios'' or CCRs). We then developed a crosswalk to match the hospital's CCRs to revenue centers used on the hospital's 1996 outpatient bills. The CCRs included operating and capital costs but excluded costs associated with direct graduate medical education and allied health education.

To determine the hospital CCRs, the most recent available cost report from each hospital was identified. For the proposed rule, we used cost reports from cost reporting periods beginning on or after October 1, 1994 and before October 1, 1995 (referred to as PPS–12) or earlier. For this final rule, more recent cost reports were available for hospitals. We used cost reports from cost reporting periods beginning on or after October 1, 1996 and before October 1, 1997 (PPS–14) for approximately 94 percent of the hospitals in our database.

If the most recent available cost report for a hospital was one that had been submitted but not settled, we calculated a factor to adjust for the differences that generally exist between settled and ''as submitted'' cost reports. The adjustment factor was determined by dividing the outpatient department cost-to-charge ratio from the hospital's most recent settled cost report by the outpatient department cost-to-charge ratio from the hospital's ''as submitted'' cost report for the same period. The resulting ratio was used to adjust each of the CCRs in the hospital's most recent ''as submitted'' cost report. We repeated this process for every hospital for which the most recent available cost report was a cost report that had not been settled.

The Office of Inspector General (OIG) for DHHS is concerned that the cost reports we are using may reflect some unallowable costs. Therefore, the OIG, in conjunction with HCFA, is proposing to examine the extent to which the cost reports used reflect costs that were inappropriately allowed. If this examination reveals excessive inappropriate costs, we will address this issue in a future proposed rule, or perhaps seek legislation to adjust future payment rates downward.

We next eliminated from the hospital CCR database 258 hospitals that we have identified as having reported charges on their cost reports that were not actual charges (for example, they make uniform charges for all services). These excluded hospitals were Kaiser, New York Health and Hospital Corporation, and all-inclusive rate hospitals. After removing these hospitals, we calculated the geometric mean of the total operating CCRs of hospitals remaining in our CCR database. We identified 58 hospitals whose total operating CCR exceeded the geometric mean by more than 3 standard deviations. These hospitals were also removed from our CCR database.

After assembling and editing our new CCR database, we matched revenue centers from approximately 80 million claims to CCRs of approximately 5,700 hospitals. We excluded from the crosswalk approximately 15 million claims in which the bill type denoted services that would not be covered under the PPS (for example, bill type 72X for dialysis services for patients with ESRD). We also excluded almost 3 million claims from the hospitals that we had removed or trimmed from the hospital CCR database. The table below shows the five cost reporting periods used and the percentage of the cost reports within each PPS period for which we were able to match 1996 claims.

Reporting period	Percentage of cost reports matched
PPS–15 (cost reporting period beginning on or after 10/1/97 and before 10/1/98)	0.1
PPS–14 (cost reporting period beginning on or after 10/1/96 and before 10/1/97)	94.2
PPS–13 (cost reporting period beginning on or after 10/1/95 and before 10/1/96)	3.7
PPS–12 (cost reporting period beginning on or after 10/1/94 and before 10/1/95)	1.7
PPS–11 (cost reporting period beginning on or after 10/1/93 and before 10/1/94)	0.3
Total	100.0

Next, we took the estimated 80 million claims that we had matched with a cost report and separated them into two distinct groups: Single-procedure claims and multiple-procedure claims. Single-procedure claims were those that included only one HCPCS code (other than laboratory and incidentals such as packaged drugs and venipuncture) that could be grouped to an APC. Multiple-procedure claims included more than one HCPCS code that could be mapped to an APC. There were approximately 45.4 million single-procedure claims and 34.6 million multiple-procedure claims.

To calculate median costs for services within an APC, we used only the single-procedure bills. (Of the roughly 45.4 million single-procedure claims, about 24 million were excluded from the conversion process largely because the only HCPCS codes reported on the claims were for laboratory procedures or other outpatient services not paid under the outpatient PPS.) This approach was taken because the information on claims does not enable us to specifically allocate charges or costs for packaged items and services such as anesthesia, recovery room, drugs, or supplies to a particular procedure when more than one significant procedure or medical visit was billed on a claim. Use of the single-procedure bills minimizes the risk of improperly assigning costs to the wrong procedure or visit. Although we used only single-procedure/visit bills to determine APC relative payment weights, we used multiple-procedure bills in the conversion factor and service mix calculations, regressions, and impact analyses.

For each single-procedure claim, we calculated a cost for every billed line item charge by multiplying each revenue center charge by the appropriate hospital-specific CCR. If the appropriate cost center did not exist for a given hospital, we crosswalked the revenue center to a secondary cost center when possible, or to the hospital's overall cost-to-charge ratio for outpatient department services. We excluded from this calculation all charges associated with HCPCS codes previously defined as not paid under this PPS (for example, laboratory, ambulance, and therapy services).

To calculate the per-procedure or per-visit costs, we used the charges shown in the revenue centers that contained items integral to performing the procedure or visit. These included those items that we previously discussed as being subject to our proposed packaging provision. For instance, in calculating the surgical procedure cost, we included charges for the operating room, treatment rooms, recovery, observation, medical and surgical supplies, pharmacy, anesthesia, casts and splints, and donor tissue, bone, and organ. For medical visit cost estimates, we included charges for items such as medical and surgical supplies, drugs, and observation. A complete listing of the revenue centers that we used is shown below in Table 1, Packaged Services by Revenue Center.

TABLE 1.—PACKAGED SERVICES BY REVENUE CENTER

ASC AND OTHER SURGERY

250 PHARMACY
251 GENERIC
252 NONGENERIC
257 NONPRESCRIPTION DRUGS
258 IV SOLUTIONS
259 OTHER PHARMACY
260 IV THERAPY, GENERAL CLASS
262 IV THERAPY/PHARMACY SERVICES
263 IV THERAPY/DRUG/SUPPLY/DELIVERY
264 IV THERAPY/SUPPLIES
269 OTHER IV THERAPY
270 M&S SUPPLIES
271 NONSTERILE SUPPLIES
272 STERILE SUPPLIES
276 INTRAOCULAR LENS
279 OTHER M&S SUPPLIES
370 ANESTHESIA
379 OTHER ANESTHESIA
390 BLOOD STORAGE AND PROCESSING
399 OTHER BLOOD STORAGE AND PROCESSING
630 DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631 SINGLE SOURCE DRUG
632 MULTIPLE SOURCE DRUG
633 RESTRICTIVE PRESCRIPTION
700 CAST ROOM
709 OTHER CAST ROOM
710 RECOVERY ROOM
719 OTHER RECOVERY ROOM
720 LABOR ROOM
721 LABOR
723 CIRCUMCISION
762 OBSERVATION ROOM
810 ORGAN ACQUISITION
819 OTHER ORGAN ACQUISITION
890 OTHER DONOR BANK
891 BONE
892 ORGAN
893 SKIN
899 OTHER DONOR BANK

MEDICAL VISIT

250 PHARMACY
251 GENERIC
252 NONGENERIC
257 NONPRESCRIPTION DRUGS
258 IV SOLUTIONS
259 OTHER PHARMACY
270 M&S SUPPLIES
271 NONSTERILE SUPPLIES
272 STERILE SUPPLIES
279 OTHER M&S SUPPLIES
630 DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631 SINGLE SOURCE DRUG
632 MULTIPLE SOURCE DRUG
633 RESTRICTIVE PRESCRIPTION
700 CAST ROOM
709 OTHER CAST ROOM
762 OBSERVATION ROOM

OTHER DIAGNOSTIC (BLENDED SERVICES)

254 PHARMACY INCIDENT TO OTHER DIAGNOSTIC
372 ANESTHESIA INCIDENT TO OTHER DIAGNOSTIC
622 SUPPLIES INCIDENT TO OTHER DIAGNOSTIC

TABLE 1.—PACKAGED SERVICES BY REVENUE CENTER—Continued

710 RECOVERY ROOM
719 OTHER RECOVERY ROOM
762 OBSERVATION ROOM

RADIOLOGY SUBJECT TO THE FEE SCHEDULE AND OTHER RADIOLOGY

255 PHARMACY INCIDENT TO RADIOLOGY
371 ANESTHESIA INCIDENT TO RADIOLOGY
621 SUPPLIES INCIDENT TO RADIOLOGY
710 RECOVERY ROOM
719 OTHER RECOVERY ROOM
762 OBSERVATION ROOM

ALL OTHER APC GROUPS

250 PHARMACY
251 GENERIC
252 NONGENERIC
257 NONPRESCRIPTION DRUGS
258 IV SOLUTIONS
259 OTHER PHARMACY
260 IV THERAPY, GENERAL CLASS
262 IV THERAPY PHARMACY SERVICES
263 IV THERAPY DRUG/SUPPLY/DELIVERY
264 IV THERAPY SUPPLIES
269 OTHER IV THERAPY
270 M&S SUPPLIES
271 NONSTERILE SUPPLIES
272 STERILE SUPPLIES
279 OTHER M&S SUPPLIES
630 DRUGS REQUIRING SPECIFIC IDENTIFICATION, GENERAL CLASS
631 SINGLE SOURCE DRUG
632 MULTIPLE SOURCE DRUG
633 RESTRICTIVE PRESCRIPTION
762 OBSERVATION ROOM

We then applied to these cost estimates an adjustment to calibrate the costs to calendar year 1996 for those services in hospitals whose CCRs were calculated using FY 1997 or later cost reports. On average, hospital charges were rising faster than costs in FY 1997. We therefore made this adjustment for the calculation of the weights, as well as for the hospital costs used in the conversion factor and impact model, to ensure that we did not underestimate costs and payments. We based this hospital specific CCR adjustment on the observed change in each hospital's overall CCR (total operating + total capital) from the proposed rule cost report database to the new final rule database. If applicable, we then calculated a monthly rate of change and applied it based on the number of months past 1996 encompassed in a hospital's cost reporting period; if a hospital's period coincided completely within calendar year 1996, no adjustment was made.

After calibrating the costs to calendar year 1996, we standardized costs for geographic wage variation by dividing the labor-related portion of the operating and capital costs for each billed item by the FY 2000 hospital inpatient prospective payment system wage index published in the **Federal Register** on July 30, 1999 (64 FR 41585). As in the proposed rule and correction notice, we used 60 percent to represent our estimate of that portion of costs attributable, on average, to labor. A more detailed discussion of wage index adjustments is found below in section III.G of this document.

The standardized labor-related cost and the nonlabor-related cost component were summed for each billed item to derive the total standardized cost for each procedure or medical visit. Extremely unusual costs that appeared to be errors in the data were trimmed from standardized procedure and visit costs. This trimming methodology is analogous to that used in calculating the DRG weights for the inpatient PPS: eliminate any bills with costs outside of 3 standard deviations from the geometric mean. We used the geometric mean and the associated standard deviation because the distribution of costs more closely resembles a lognormal distribution than a normal distribution: There are no negative costs, and the average cost is greater than the median cost. Use of the geometric mean minimizes the impact of the most unusual bills in the determination of the mean. The geometric mean is calculated by taking the mean of the natural logarithm cost. Because the distribution of the natural logarithms of a set of numbers is more compact than the distribution of the numbers themselves, bills with extreme costs do not appear as extreme as they would if non-logged costs were examined. This ensures that only the most aberrant data will be removed from the calculation.

After trimming the procedure and visit level costs, we mapped each procedure or visit cost to its assigned APC and calculated the median cost for each APC weighted by procedure volume. Using the median APC costs, we calculated the relative payment weights for each APC. We scaled all the relative payment weights to APC 601, a mid-level clinic visit, because it is one of the most frequently performed services. This approach is consistent with that used in developing relative value units for the Medicare physician fee schedule. By assigning APC 601 a relative payment weight of 1.0, hospitals can easily compare the relative relationship of one APC to another. Next, we divided the median cost for each APC by the median cost for a mid-level clinic visit, APC 601, to derive the relative payment weight for each APC.

The median cost for APC 601 is $47.00. In the proposed rule, we also used a mid-level clinic visit, APC 91336, which had a median cost of $54.00, as the scaler of APC weights. On average, due to the reduced value of the scaler used for this notice, the final weights will be higher than those published in the proposed rule.

Comment: Some commenters believe that the ratesetting methodology does not reflect complex cases because we eliminate statistical ''outlier'' claims from the calculation of the median costs and the weights.

Response: As noted above, we trimmed claims with estimated costs that were outside of three standard deviations from the geometric mean. Because we removed claims above or below the mean, we corrected for data errors that would have skewed the estimates of median costs and group weights upward or downward. We believe this trim is a valid method of removing extremely unusual costs that are most likely associated with data submission errors and do not represent actual costs. In addition, it is consistent with the method we use to set inpatient hospital diagnosis-related group (DRG) weights.

Comment: Numerous commenters disagreed with our use of single-procedure claims only in the calculation of the relative payment weights. One commenter was concerned that we could be masking differences in resource use attributable to patient characteristics by using only single-procedure claims to calculate relative weights.

Response: We used single-procedure claims to calculate the relative weight for each APC because we could not accurately allocate costs to a particular procedure when the costs were part of a bill for multiple procedures. Bills with a single major procedure provided are, in most cases, the best estimate of relative procedure costs. It is important to note that for all other calculations, including calculation of the conversion factor, we used both single-procedure and multiple-procedure bills.

We do not believe that using single-procedure bills biases the relative cost of any particular procedure. Although patients with more complex healthcare needs might have several procedures performed, hospital charges for an individual procedure would not be greater. Our most significant concern was that distribution of single bill procedures within an APC would not reflect the correct distribution of those procedure on all bills. However, careful statistical analyses demonstrated that the distribution of procedures within an APC group did not differ when single bill procedure frequencies were compared with all bills. It is also important to note that when items or services were to be packaged with a major procedure, we added their costs to that procedure prior to making the single bill determination. Therefore, the costs of contrast media, for example, are included in the relative weights. In some cases, we agreed with the commenters that this approach needed to be modified. For example, for chemotherapy, we are not grouping drugs, but rather paying for each one separately. Moreover, as a result of the transitional pass-through provisions of the BBRA 1999, radiopharmaceuticals will be paid separately from the nuclear medicine APCs.

Comment: Several commenters expressed concern that the 1996 claims data are insufficient or inadequate to develop the PPS model. For example, some commenters asserted that the 1996 data are not recent enough to reflect the current mix of outpatient services. Some commenters also argued that undercoding in the data would lead to underestimates of median costs. Other commenters recommended that we address alleged inadequacies in the data by gathering cost data on new procedures and by basing payment on these data until we can determine whether to place a new procedure in an existing APC or create a new APC.

Response: While we acknowledge limitations of setting payment rates with historical claims data, section 1833(t)(2)(C) of the Act requires us to use 1996 claims in developing the PPS. We discuss how we will price new procedures that are not reflected in our database in section III.C.8 of this preamble.

Comment: Commenters were concerned about the cost-to-charge ratios used to estimate median APC costs and pre-BBA payments. For example, one medical organization recommended that we account for the capital-intensive nature of radiology services by adjusting the cost-to-charge ratios applicable to these services for the step-down methodology that allocates capital expenses by square footage. The belief is that these allocation methods underestimate radiological equipment costs and certain cost-to-charge ratios, leading to underestimates of the median costs for relevant APC groups.

Response: Although capital-related costs may be allocated to routine and ancillary service cost centers using the step-down methodology based on square footage, as an alternative, the ''dollar value'' method may be used by hospitals. This method is made available to hospitals in Worksheet B–1 of the hospital cost report (HCFA 2552–96). The dollar value method more accurately distributes the capital costs associated with equipment to the revenue-producing cost center to which the equipment is assigned. We are not able to adjust the cost-to-charge ratios of those hospitals that allocate equipment based on square footage because we have no way of knowing which specific equipment costs should be allocated to revenue-producing cost centers in each hospital.

2. Conversion Factor

Section 1833(t)(3)(C)(i) of the Act requires that we establish a conversion factor for 1999 to determine the Medicare payment amounts for each covered group of services. For the proposed rule as corrected, we derived the conversion factor from a base amount of payments described in section 1833(t)(3)(A) of the Act, as enacted in the BBA 1997. Such base amount was calculated for the services included in the outpatient PPS as an estimate of the sum of (1) total payments that would be payable from the Trust Fund under the current (non-PPS) payment system in 1999, plus (2) the beneficiary coinsurance that would have been paid under the new (PPS) system in 1999. For the final rule, however, we derived the conversion factor from a base amount that includes beneficiary coinsurance that would have been made under the current (non-PPS) system rather than the proposed (PPS) system. Section 201(l) of the BBRA 1999 states: ''With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of the BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and that the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.''

Section 1833(t)(2)(C) of the Act requires us to project utilization for hospital outpatient services. We were unable to make precise projections of increases in the volume and intensity of services because we were not able to quantify some of the factors that affect utilization. For instance, we would anticipate that Medicare beneficiaries who choose to migrate to managed care plans may be healthier than those who choose to stay in fee-for-service plans. Thus, we could assume a decrease in the volume of services coupled with an increase in the intensity of services

furnished for Medicare beneficiaries in the fee-for-service program. Another factor that we believe will affect future utilization is the incentive to code billed services more accurately. Currently, hospitals are paid for the majority of the outpatient services they furnish on a cost basis, and inaccurate or improper coding does not necessarily affect the amount of payment. In contrast, under the PPS, hospitals are required to use HCPCS codes in order to receive payment. We expect that the frequency of some services may increase as a result of the coding requirements. We believe each of these assumptions will affect the reporting of volume and intensity of services, although we are not able to quantify them individually to project 1999 utilization. Therefore, we used what we believe to be a more reliable and valid approach to computing the conversion factor under the methodology described below.

Comment: A large national trade association commented that the exclusion of claims for unclassified services (for example, those claims for which we cannot identify the service to be paid) from the PPS model could bias the conversion factor downward if the excluded claims have a disproportionate number of services with high payment to cost ratios, such as clinic and emergency room visits.

Response: In order to set the conversion factor as accurately as possible, we used only claims for which the costs and volume of services could be identified on the bill. As noted by the commenter, this decision resulted in the exclusion of claims with unclassifiable services. Upon examination of these claims, we have determined that services with high payment to cost ratios (those that would gain under the PPS system) were not disproportionately represented. Therefore, we believe the exclusion of unclassifiable services does not bias the conversion factor.

Setting the Rates

In order to convert the relative weights determined for each APC (see section III.E.1) into payment rates, we calculated a conversion factor that would result in total estimated payments to hospitals under the PPS in 1999 equal to the total estimated payments that would have been payable from the Trust Fund in 1999 if PPS had not been enacted plus estimated beneficiary coinsurance for the same services during the same period. The prospective payment rate for each APC is calculated by multiplying the APC's relative weight by the conversion factor. For the calculation of the conversion factor, we have excluded all data from the 58 Maryland providers that qualify under section 1814(b)(3) of the Act for payment under the State's payment system. We computed the conversion factor by first adding together the aggregate Medicare hospital outpatient payments made under the cost-based payment system (referred to in this section as pre-PPS payments) for calendar year 1996, plus the estimated beneficiary coinsurance amounts made under pre-PPS law for the same services. We then divided that amount by a wage-adjusted sum of the relative weights for all APCs under the hospital outpatient PPS. The methodology we used to determine current law Medicare hospital outpatient payments and beneficiary coinsurance is discussed below in section III.E.2.a. A discussion of the sum of the relative weights follows in section III.E.2.b.

a. Calculating Aggregate Calendar Year 1996 Medicare and Beneficiary Payments for Hospital Outpatient Services (Pre-PPS)

To calculate Medicare hospital outpatient payment amounts before implementation of the PPS, we first identified calendar year 1996 single and multiple procedure bills for all the services that we will recognize under the outpatient PPS. As we identified services that will be paid under the outpatient PPS, we eliminated invalid or noncovered HCPCS codes.

Hospital payments include both operating and capital costs for the HCPCS coded services for which payment is to be made under the outpatient PPS. We summed these two types of costs by HCPCS code at the provider level. Consolidating the data in this manner allowed us to simulate provider payment on an aggregate basis. Then (as required by section 1861(v)(1)(S)(ii) of the Act as amended by section 201(k) of the BBRA 1999), we applied the capital cost reductions of 10 percent and operating cost reductions of 5.8 percent.

We determined for each HCPCS code the applicable payment methodology under the current system. Payment before implementation of PPS for procedures in the baseline was calculated using one of the following equations, as appropriate:

- For radiology procedures paid for under the radiology fee schedule, we determined payment in the aggregate for each provider as the lower of the cost, charge, or blended amount. We use the following equation to determine the radiology blended amount: (0.42 × lower of cost or charge minus beneficiary coinsurance) + (0.58 × ((0.62 × global physician fee schedule amount) − beneficiary coinsurance)).
- For surgical procedures for which Medicare pays an ASC facility fee, we determined payment in the aggregate for each provider as the lower of the cost, charge, or blended amount. We used the following equation to determine the ASC blended amount: (0.42 × lower of cost or charge minus beneficiary coinsurance) + (0.58 × (ASC payment rate − beneficiary coinsurance)).
- For diagnostic procedures paid for under the diagnostic fee schedule, we determined payment in the aggregate for each provider as the lower of the cost, charge, or blended amount. We used the following equation to determine the blended amount for diagnostic procedures: (0.50 × lower of cost or charge minus beneficiary coinsurance) + (0.50 × ((0.42 × global physician fee schedule amount) − beneficiary coinsurance)).

For all other covered services not subject to one of the blended payment method categories, we determined payment as the lower of costs or charges less beneficiary coinsurance. Because the formula-driven overpayment (FDO) was corrected beginning October 1, 1997, the blended equations eliminate FDO.

We then determined the Medicare payment amount for each provider by summing the aggregate amounts computed for each of the four types of payment methodologies discussed above. In addition, we determined the amount of the beneficiary coinsurance for each provider using the beneficiary coinsurance amounts that would have been paid before implementation of PPS. The total amount (Medicare and beneficiary payments) reflects the amount hospitals would be paid under the PPS and is the numerator in the equation for calculating the unadjusted conversion factor.

b. Sum of the Relative Weights

Next we summed the discounted relative weights for services that are within the scope of the outpatient PPS. (See discussion of discounting for surgical procedures in section III.C.7.) Specifically, we multiplied (using single and multiple procedure claims in a hospital) the discounted volume of procedures or visits in each APC group by the relative weights for each APC group; we wage-adjusted 60 percent of this total by each hospital's wage index, and we then summed the wage-adjusted and nonadjusted weights across all hospitals. (The wage indices used are included in Addenda H, I, and J.) The resulting sum equals the denominator in the calculation of the conversion factor.

We calculated the conversion factor by dividing the sum of the discounted relative weights into the total payment explained in section III.E.2.a, above, including both Medicare payment and beneficiary coinsurance. We then adjusted the conversion factor so that the outlier and pass-through payments are implemented in a budget neutral manner, as described in sections III.H.1 and III.D. The adjusted calendar year 1996 conversion factor is $43.023. To inflate the 1996 conversion factor to 1999, our Office of the Actuary estimated an update factor of 1.106. Therefore, the adjusted 1999 conversion factor is $47.583.

For calendar year 2000, we updated the conversion factor as specified in section 1833(t)(3)(C)(iii) of the Act. The update is the market basket percentage increase applied to hospital discharges occurring during the fiscal year ending in calendar year 2000 minus 1 percentage point. For 2000, the updated conversion factor is $48.487.

Comment: A number of commenters suggested that we remove the behavioral offset that we proposed to apply to the conversion factor. As proposed, the intent of the offset was to adjust for hospital coding changes that take place in response to reductions in beneficiary coinsurance.

Response: We have decided not to include a behavioral offset to the conversion factor in this final rule. Hospital coding changes are expected to occur under the outpatient PPS; however, we believe changes that occur during the first PPS years will result from hospitals billing more accurately under the new system. A behavioral offset implemented in the initial PPS years may distort the incentives to bill accurately. We may reconsider implementation of a behavioral offset in future years as we gather data and gain experience under the new system.

Comment: A large national trade association expressed concern that application of the 5.8 percent and 10.0 percent reduction to costs for all hospital outpatient services included in the PPS model underestimates the conversion factor. They recommended that we exclude the Part B services provided to inpatients who exhaust their Part A benefits from the reductions.

Response: Our analysis shows that fewer than 5,000 of the more than 80 million claims used to set the conversion factor were associated with these types of services. Total costs associated with these claims were less than $1.4 million, which is too small to have a measurable effect on the conversion factor.

Comment: Many commenters strongly argued that we misinterpreted the provisions of section 1833(t)(3) of the Act in calculating beneficiary coinsurance for purposes of setting the base amount of the conversion factor. The commenters noted that this methodology contributed significantly to the estimated 5.7 percent reduction in Medicare outpatient payments to hospitals reflected in the proposed rule. Most commenters further argued that the Congress did not intend for this loss to occur and that we had the authority to interpret the methodology described in the statute so that no net change in payments would result from the conversion factor.

Response: Section 1833(t)(3)(A) of the Act, as added by the BBA 1997, states that, for purposes of calculating the base amount used to determine the conversion factor, the Secretary shall calculate ''the total amount of copayments estimated to be paid *under this subsection.* * * *'' (Emphasis added.) For the proposed rule, we estimated the coinsurance that would be paid under PPS. In section 201(l) of the BBRA 1999, the Congress addressed the calculation of the base amount, stating, ''With respect to determining the amount of copayments described in paragraph (3)(A)(ii) of section 1833(t) of the Social Security Act, as added by section 4523(a) of the BBA, Congress finds that such amount should be determined without regard to such section, in a budget neutral manner with respect to aggregate payments to hospitals, and the Secretary of Health and Human Services has the authority to determine such amount without regard to such section.'' Therefore, for this final rule, we estimated the coinsurance that would have been paid if PPS had not been enacted.

F. Calculation of Coinsurance Payments and Medicare Program Payments Under the PPS

1. Background

In section III.E, above, we explained how we determined APC group weights, calculated an outpatient PPS conversion factor, and determined national prospective payment rates, standardized for area wage variations, for the APC groups. We will now explain how we calculated beneficiary coinsurance amounts for each APC group.

The outpatient PPS established by section 1833(t) of the Act includes a mechanism designed to eventually achieve a beneficiary coinsurance level equal to 20 percent of the prospectively determined payment rate established for the service. As discussed in the proposed rule, for each APC we calculate an amount referred to in section 1833(t)(3)(B) of the Act as the ''unadjusted copayment amount.'' The unadjusted coinsurance amount is calculated by taking 20 percent of the national median charges billed in 1996 for the services that are in the APC, trended forward to 1999; however, the coinsurance amount cannot be less than 20 percent of the APC payment rate. The unadjusted coinsurance amount for an APC remains frozen, while the payment rate for the APC is increased by adjustments based on the Medicare market basket. As the APC rate increases and the coinsurance amount remains frozen, the unadjusted coinsurance amount will eventually become 20 percent of the payment rate for all APC groups. Once the unadjusted coinsurance amount is 20 percent of the payment amount, both the APC payment rate and the unadjusted coinsurance amount will be updated by the annual market basket adjustment.

In the proposed rule, we proposed to not adopt new APCs for new procedures or services for at least 2 years, but instead assign them to existing groups while accumulating data on their costs. In the final rule we do provide for APCs for new procedures that do not fit well into another APC. When an APC is added that consists of HCPCS codes for which we do not have 1996 charge data upon which to calculate the unadjusted coinsurance amount, coinsurance will be calculated as 20 percent of the APC payment amount.

There is an exception to the coinsurance provisions for screening colonoscopies and screening sigmoidoscopies. Section 4104 of the BBA 1997 provided coverage for colorectal screening. This section, in part, added new sections 1834(d)(2) and (3) to the Act, which provide that for covered screening sigmoidoscopies and colonoscopies performed in hospital outpatient departments and ambulatory surgical centers (ASCs), payment is to be based on the *lesser* of the hospital or the ASC payment rates and coinsurance for both screening colonoscopies and screening sigmoidoscopies is to be 25 percent of the rate used for payment.

Section 4104 of the BBA 1997 also allows, at the Secretary's discretion, coverage of screening barium enemas as a colorectal cancer screening tool. We are including screening barium enemas as a covered service under the hospital outpatient PPS. The payment rate for screening barium enemas is the same as for diagnostic barium enemas. Coinsurance for a screening barium enema is based on 20 percent of the APC payment rate.

Sections 201(a) and (b) of the BBRA 1999 amend section 1833(t) of the Act to provide for additional payments to hospitals for outlier cases and for certain medical devices, drugs, and biologicals. These additional payments to hospitals will not affect coinsurance amounts. Redesignated section 1833(t)(8)(D) of the Act, as amended by section 201(i) of the BBRA 1999, provides that the coinsurance amount is to be computed as if outlier adjustments, adjustments for certain medical devices, drugs, and biologicals, as well as any other adjustments we may establish under section 1833(t)(2)(E) of the Act, had not occurred. Section 202 of the BBRA 1999 adds a new section 1833(t)(7) to the Act to provide transitional corridor payments to certain hospitals through calendar year 2003 and indefinitely for certain cancer centers.

Section 1833(t)(7)(H) of the Act provides that the transitional corridor payment provisions will have no effect on determining copayment amounts.

Section 204(a) of the BBRA 1999 amended redesignated section 1833(t)(8)(C) of the Act to provide that the coinsurance amount for a hospital outpatient procedure cannot exceed the amount of the inpatient hospital deductible for that year. The inpatient hospital deductible for calendar year 2000 is $776.00. We will apply the limitation to the wage adjusted coinsurance amount (not the unadjusted coinsurance amount) after any Part B deductible amounts are taken into account. Therefore, although the published unadjusted coinsurance amount for any APC may be higher or lower than $776.00 in 2000, the actual coinsurance amount for an APC, determined after any deductible amounts and adjustments for variations in geographic areas are taken into account, will be limited to the Medicare inpatient hospital deductible. Any reductions in copayments that occur in applying the limitation will be paid to hospitals as additional program payments. (See section III.F.3.a, below, for discussion of calculating the Medicare payment amount.)

MedPAC Comment: In its March 1999 report to the Congress, MedPAC expressed concern that the statute's approach to addressing the reduction in coinsurance could mean that it will be decades before coinsurance is 20 percent of all APC payment rates. MedPAC recommended that the Secretary seek and the Congress legislate a more rapid phase-in and that the cost be financed by increases in program spending, rather than through additional reductions in payments to hospitals. MedPAC agrees that the approach to calculating the coinsurance delineated in section 1833(t) of the Act is methodologically sound, but they recommend a shorter period to complete the coinsurance reduction.

Response: The coinsurance reductions enacted by the BBA 1997 already provide significantly higher levels of financial protection for beneficiaries than have existed in the past. While an acceleration of this protection might be desirable, the costs of such a policy must be balanced against other needs for increased Medicare spending and protection of the trust funds. The President's budget for FY 2001 does not contain such a proposal.

Comment: Three commenters discussed the delay in implementing the outpatient PPS until after January 1, 2000. A hospital association stated that it strongly believes that the outpatient PPS should not be implemented until all systems are ready, and suggested that implementation occur at the start of a calendar year so that Medigap insurers did not receive an unearned windfall by reason of a midyear decrease in beneficiary coinsurance amounts. Stating that the delay in implementation was of serious concern to it, an insurance group strongly urged us to implement the outpatient PPS as soon as possible. Finally, a beneficiary advocacy group stated that it is deeply concerned about the delay in implementation. While stating that it understood the magnitude of the Y2K problem, this group urged us to find a way to proceed with the phase-down of beneficiary coinsurance or, failing that, to offer our assurance that the phase-down will not be delayed beyond January 1, 2000.

Response: As noted elsewhere in this final rule, we intend to implement the outpatient PPS effective for services furnished on or after July 1, 2000. As noted in the proposed rule, we concluded that attempting to make the massive computer changes required to implement PPS at the same time we were trying to ensure that Medicare's computers were Y2K compliant would have jeopardized the compliance effort, which was HCFA's highest priority. Now that HCFA's efforts to make its computer systems, and those of its contractors, Y2K compliant are complete, we believe that July 1, 2000 is the earliest date on which we can feasibly implement the PPS. Pursuant to HCFA's contracts with the contractors responsible for maintaining its computer systems, HCFA makes programming changes such as those required to implement the outpatient PPS at the beginning of fiscal quarters. Thus, pursuant to this practice, after January 1, 2000, there are only three dates in 2000 on which the programming changes necessary to implement outpatient PPS can be put into effect—April 1, 2000, July 1, 2000 and October 1, 2000.

The first step in changing HCFA's computer systems to allow for implementation of the outpatient PPS is to expand the claim record of several HCFA and contractor systems to accept and retain specific information related to how a service is being paid or why it is denied. The claim record expansion is an indispensable prerequisite to implementation of outpatient PPS. Once expansion of the claim form is completed, we can then make the remaining programming changes necessary to implement the outpatient PPS. As we noted in the proposed rule, 63 FR 47605, these are massive changes that will require extensive testing. We anticipate that these software coding changes cannot be completed before the end of the second quarter of 2000. Therefore, the earliest possible date on which they can be installed and made operational is July 1, 2000.

We do not believe that it is technically feasible to complete installation of both the claims-form line item expansion and the coding changes needed to implement PPS any sooner than July 1, 2000. Each of these two stages of preparing HCFA's computer system for PPS constitutes major systems changes in and of itself. To attempt to make both changes simultaneously would be to run the risk that the system would not function properly at all, potentially requiring implementation to be delayed beyond July 1, 2000. We believe that the two-stage approach discussed above is the only feasible way to make the systems changes necessary to implement PPS and to be certain that they will work. The soonest date on which PPS can be implemented after the millennium is therefore July 1, 2000.

Despite one commenter's request that we implement the outpatient PPS at the start of a calendar year, we do not believe it would be appropriate to delay implementation beyond July 1, 2000. We see no reason to delay implementation beyond the time necessary for HCFA to have completed its Y2K efforts and make all the systems changes necessary for PPS. As with all of the other aspects of PPS, we believe that the beneficiary coinsurance reform contained in the outpatient PPS should be put into effect as soon as possible, so that beneficiaries can be subject to the lower coinsurance amounts under the new payment methodology at the

earliest date. We believe that this consideration outweighs any concern that Medigap insurers might receive a windfall because they set premiums for a given year assuming coinsurance amounts would be at one level only to see those amounts decrease in the middle of the year. In addition, we note that, if insurers received a large enough windfall for the reasons described by the commenter, the insurers might be required to refund premiums to beneficiaries or offer them a credit on premiums pursuant to section 1882(r) of the Act.

While none of the commenters specifically requested that we do so, we have considered the possibility of applying the outpatient PPS payment methodology retroactively to services furnished on or after January 1, 1999. We have decided not to make these retroactive payments for the reasons described below.

The first reason is the practical problem that the information needed to implement PPS retroactively does not exist in a usable form. Under current payment methodologies for many outpatient services, hospitals submit bills for furnished services based on their charges for the services. For these services, HCFA does not require hospitals to submit bills containing the HCPCS code for the furnished service and other data (such as the dates of service of multiple services submitted on the same bill) necessary to process bills under the new prospective payment methodology. Without the HCPCS code for a given service, we would be unable to determine retroactively into which APC group the service should be placed for payment under PPS. In turn, that would mean that we could not determine the appropriate payment amount for the service. Thus, given the information currently available to us, we could not now simply reprocess bills for outpatient services that had been furnished between January 1, 1999 and July 1, 2000 and recompute payment and coinsurance amounts for these services. As a result, the data needed to implement PPS retroactively do not exist in a form that would allow for such implementation.

Nor would it have been feasible to attempt to capture the information necessary for retroactive application during 1999. As noted above, we concluded that it would not have been prudent to make the computer programming changes necessary to implement PPS until our Y2K efforts were complete. Those same changes would have been necessary to allow us to capture the more detailed claims data needed to perform a retroactive application of PPS back to January 1, 1999 once the system was implemented prospectively. Because we delayed those changes out of concern that they would interfere with our Y2K efforts, no automated process existed for the period January 1, 1999 through July 1, 2000 by which we could have captured the more detailed claims data necessary to effect an eventual retroactive implementation of PPS. Publication of a final rule before January 1, 1999 would not have altered this situation. Even if we had published such a rule, it could not have become effective until we could make the computer changes necessary to implement PPS—the functional equivalent of what we have done through publication of the proposed rule and this final rule—and until we could make those changes, we could not compile by computer the data needed to later reprocess claims under PPS.

In theory, we might have been able to implement PPS retroactively despite the lack of an automated method of compiling the data necessary to do so. But it simply would not have been practicable to maintain and later process by hand such data for the period between January 1, 1999 and July 1, 2000, given the millions of claims for outpatient services submitted during that period. (Based on the latest data available, we process approximately 160 million claims for outpatient services over an 18-month period.) Neither HCFA nor its contractors have the staff needed to accomplish such a task.

We might also have conceivably required hospitals to maintain the data required for a later retroactive implementation of PPS, but this approach has practical difficulties. First, during the interim period between January 1, 1999 and implementation of PPS, hospitals themselves were exerting significant efforts to ensure the Y2K compliance of their own automated Medicare billing systems, and it is doubtful that those systems could have accommodated the necessary programming changes any more than Medicare's systems could have. Even if hospitals could have maintained the information (or if HCFA could have maintained it by hand or could obtain it from any source now), the burden associated with attempting to implement the new prospective payment methodology both retroactively and prospectively at the same time would have been prohibitive. As noted in the proposed rule and in this final rule, effecting the transition between the old payment methodologies and the new prospective payment methodology constitutes a massive programmatic undertaking. Any effort to reprocess the huge number of bills for outpatient services that would be involved in any attempt to retroactively implement PPS would compete for the same resources needed to implement PPS prospectively, and would compromise our ability to ensure the smoothest prospective implementation.

This is especially so if paper records of claims from the interim period would have to be manually input into Medicare's automated payment systems in order to make retroactive payments for services furnished on or after January 1, 1999. Undertaking an effort, once PPS is implemented, to review hospital records of every outpatient service furnished between January 1, 1999 and July 1, 2000; translate those records into the data needed to process a Medicare claim for the service under PPS; and issue a retroactive payment reflecting the PPS rate for the service would cause a huge backlog of current bills to be processed (and of other carrier tasks), and thus would not be practicable. Therefore, there was no feasible way to have captured the information necessary to make PPS apply retroactively.

In addition to the practical problems described above, the statute does not require retroactive application of PPS. The statutory requirement to implement the PPS for services furnished on or after January 1, 1999 is ambiguous. While section 1833(t)(1)(A)'s reference to outpatient services ''furnished during a year beginning with 1999'' might be read as imposing such a requirement, it is also true that section 1833(t)(1)(B)(i) does not expressly set a time limit for HCFA to designate which services are ''covered'' outpatient services for purposes of payment under PPS. Nor does it set a deadline for HCFA to issue regulations implementing the outpatient PPS. As a result, the statute can also be read to require implementation of PPS for services furnished in a year beginning in 1999 *if* HCFA has designated in its implementing regulations those services as covered services for purposes of PPS. The better reading is that the system applies prospectively only.

We recognize that, under section 1833(a)(2)(B), Congress arguably made the old payment methodologies for outpatient services inapplicable to services furnished on or after January 1, 1999. Again, though, Congress imposed no corresponding limit on the time within which HCFA must designate the services that would be ''covered'' services for purposes of PPS. While it is therefore possible to read the statute in such a way that an outpatient service

furnished after January 1, 1999 but not yet designated as a covered outpatient service by HCFA for purposes of PPS would have no payment methodology applicable to it, we do not believe that Congress intended such a result. We believe that where HCFA, because of significant Y2K concerns, has not yet designated a given outpatient service as a covered service for purposes of PPS, the most appropriate reading of section 1833(t)(1)(A) is that it authorizes the Secretary to continue to pay for the service under the existing methodology until PPS can be implemented. If the Congress had known about the Y2K problem at the time it enacted the PPS statute, this is the only rational approach it could have adopted.

We believe that a clear expression of Congressional intent not to require retroactive application of PPS can be found in the legislative history of amendments to section 1833(t) of the Act, enacted as sections 201, 202, and 204 of the BBRA 1999. In each instance, the legislation provides that the ''amendments made by this section shall be effective as if included in the enactment of the BBA,'' that is, the original enactment of PPS in section 1833(t) (sections 201(m), 202(b), and 204(c) of the BBRA 1999). This language was taken from the House version of the bill (H.R. Rep. No. 436 (Part I), 106th Cong., 1st Sess. 14, 16 (1999)). The House Report stated that the outpatient payment reforms contained in the BBRA 1999 (and hence in the BBA 1997) were intended to take effect ''upon implementation of the hospital prospective payment system'' by HCFA, *id.* at 52, 55, 56, not on January 1, 1999. The House Conference Committee Report reiterated the understanding that the payment and coinsurance provisions of the BBA and BBRA do not take effect until after implementation by HCFA. H. Conf. Rep. No. 479, 106th Cong., 1st Sess. 866 (1999) (''[c]urrently, beneficiaries pay 20% of charges for outpatient services,'' but ''[u]nder the outpatient PPS, beneficiary coinsurance will be limited to frozen dollar amounts based on 20% of national median charges for services in 1996, updated to the year of implementation of the PPS''); *id.* at 867 (''[t]he conferees fully expect that the beneficiary coinsurance phase-down will commence, as scheduled, on July 1, 2000''); 870 (''[h]ospital outpatient PPS is to be implemented simultaneously and in full for all services and hospitals (estimated for July 2000)'').

Both the House Report and the Conference Report expressly acknowledge, without disapproval, HCFA's decision to delay implementation of the outpatient PPS until after January 1, 2000. H.R. Rep. No. 436 (Part I) at 51 (stating that Secretary ''delayed implementation of the new system until after the start of CY 2000 in order to ensure that 'year 2000' data processing problems are fully resolved before the new system is implemented'' and that ''HCFA currently estimates that the outpatient department prospective payment system will be implemented in July 2000''); 145 Cong. Rec. at H12529 (daily ed. Nov. 17, 1999) (H. Conf. Rep. No. 479) (acknowledging ''[t]here has already been a one-year delay in implementation of the BBA 97 provision'' and stating that conferees ''fully expect'' that the outpatient prospective payment system ''will commence, as scheduled, on July 1, 2000''). These statements indicate Congressional intent that payments and coinsurance for covered hospital outpatient services would be governed prospectively by PPS only after HCFA promulgated and made effective final implementing regulations.

Finally, there is a serious question as to whether retroactive implementation of PPS might constitute prohibited retroactive rulemaking. In *Bowen* v. *Georgetown University Hospital*, 488 U.S. 204, 208 (1988), the Supreme Court stated that a statutory grant of legislative rulemaking authority does not encompass the power to promulgate retroactive rules unless that power is conveyed by Congress in express terms, even where some substantial justification for retroactive rulemaking might exist. The Court then declined to find this express authorization for retroactive rulemaking in the Medicare statute's general grant of rulemaking authority.

We do not find this express authorization in section 1833(t) or any other statutory provision concerning the outpatient PPS. Section 1833(t)(1) requires that payment for outpatient services that are furnished during any calendar year beginning after January 1, 1999 and that are designated by HCFA as ''covered'' outpatient services shall be made under a prospective payment system. While Congress may have presumed, when it enacted section 1833(t) as part of the BBA, that HCFA would be able to designate covered outpatient services and implement the outpatient PPS by January 1, 1999, Congress did not foresee at that time that Y2K concerns would prevent the agency from doing so. As a result, the statute is silent as to what was to occur if HCFA was unable to designate covered outpatient services and implement PPS by January 1, 1999. We do not believe that this silence constitutes the express authorization of retroactive rulemaking required by the Supreme Court's *Georgetown* decision.

Comment: Several commenters contended that the proposed rules for beneficiary coinsurance are overly complex and that the phase-in period is too long. One commenter asked HCFA to consider a less involved method and a more aggressive time period for implementation. Another commenter suggested using a 5-year phase-in period. One commenter requested that we recommend a legislative change to the Congress to reduce beneficiary coinsurance to 20 percent by January 1, 2003. Still another commenter expressed concern that calculations of coinsurance amounts for each hospital will be particularly burdensome to Medicare fiscal intermediaries and, as a result of the increased workload, errors may occur. The commenter also recommended a more rapid reduction of coinsurance to 20 percent of the payment amount.

Response: We agree that the rules governing how coinsurance is to be calculated under the PPS are complex, and the phase-in to 20 percent coinsurance is a lengthy one. However, the methods for calculating coinsurance are dictated by the statute. The legislative changes were made in order to put some control on rapidly increasing beneficiary coinsurance payments, to begin to decrease the proportion of beneficiary liability for hospital outpatient services, and to continue to reduce beneficiary liability over time. As we have stated, the impetus to accelerate the reduction of beneficiary coinsurance has to be viewed within the context of other needs for increased Medicare expenditures and long-term protection of the trust funds. The delay in implementing the hospital outpatient PPS past the statutory effective date was unavoidable due to systems constraints imposed by Y2K compliance requirements.

Comment: One commenter noted that the proposed rule set beneficiary coinsurance at 20 percent of *median* charges, but the commenter believes that coinsurance amounts should be recalculated to equal 20 percent of the *average* charge for the applicable APC group. The commenter indicates that such a change would provide some financial relief to hospitals.

Response: Section 1833(t)(3)(B)(i) of the Act requires that unadjusted coinsurance amounts be calculated as 20 percent of the national *median* of the charges for services within the APC group.

Comment: One commenter stated that because coinsurance is based on the median charges of the APC, some beneficiaries would pay a higher coinsurance than they would under the current system. The commenter believes that beneficiaries who require less intensive services in an APC group will essentially subsidize other beneficiaries who receive more intensive services within the group. The commenter asserted that fairness would dictate beneficiaries be charged coinsurance amounts that more appropriately reflect the services received, not an amount based on a median of multiple services they did not receive.

Response: Section 1833(t)(3)(B)(ii) of the Act provides that the unadjusted coinsurance amounts are based on the national median of the charges for the ''services within'' an APC. Because an APC group consists of services that are both clinically similar and similar with respect to the resources required to perform the service, we would expect that charges for the services should also be fairly homogeneous. We believe that services within a group are homogeneous enough to warrant a single payment amount and a single coinsurance amount.

In the following sections, we describe how we determined the beneficiary coinsurance amount and the Medicare program payment amount for services paid for under the hospital outpatient PPS.

2. Determining the Unadjusted Coinsurance Amount and Program Payment Percentage

To calculate Medicare program payment amounts and beneficiary coinsurance amounts, we first determined for each APC group two base amounts, in accordance with statutory provisions:

- An unadjusted copayment amount, described in section 1833(t)(3)(B) of the Act; and
- The predeductible payment percentage, which we call the program payment percentage, described in section 1833(t)(3)(E) of the Act.

a. Calculating the Unadjusted Coinsurance Amount for Each APC Group

In the proposed rule, we described the specific steps used to calculate the unadjusted coinsurance amounts for each APC group as follows:

(i) We determined the national median of the charges billed in 1996 for the services that constitute an APC group after standardizing charges for geographic variations attributable to labor costs. (To determine the labor adjustment, we divided the portion of each charge that we estimated was attributable to labor costs (60 percent) by the hospital's inpatient wage index value and added the result to the nonlabor portion of the charge (40 percent)).

(ii) We updated charge values to projected 1999 levels by multiplying the 1996 median charge for the APC group by 13.0 percent (increased to 14.7 percent in this final rule), which the HCFA Office of the Actuary estimates to be the rate of growth of charges between 1996 and 1999.

(iii) To obtain the unadjusted coinsurance amount for the APC group, we multiplied the estimated 1999 national median charge for the APC group by 20 percent. The unadjusted coinsurance amount is frozen at the 1999 level until such time as the program payment percentage (as determined below) equals or exceeds 80 percent (section 1833(t)(3)(B)(ii) of the Act).

b. Calculating the Program Payment Percentage (Predeductible Payment Percentage)

In the proposed rule and in this final rule, we use the term ''program payment percentage'' to replace the term ''predeductible payment percentage,'' which is referred to in section 1833(t)(3)(E) of the Act. The program payment percentage is calculated annually for each APC group, until the value of the program payment percentage equals 80 percent. To determine the program payment percentage for each APC group, we—

(i) Subtract the APC group's unadjusted coinsurance amount from the payment rate set for the APC group; and

(ii) Divide the difference (APC payment rate minus unadjusted coinsurance amount) by the APC payment rate, and multiply by 100.

The program payment percentage will be recalculated each year because APC payment rates will change when APC rates are increased by annual market basket updates and whenever we revise an APC.

Comment: One commenter expressed concern about how the coinsurance amounts are determined. The commenter stated that the calculation is flawed and penalizes beneficiaries in those States where charges for services tend to be lower than in other States. The commenter alleged that if the hospitals in those States where charges for services tend to be lower accept a reduced coinsurance in order to hold beneficiaries harmless, the hospitals will be penalized. The commenter also asserted that Medigap policies and Medicaid programs will also be affected. The commenter further stated that coinsurance should be based on regional, not national, charges. The commenter contended that the provision does not achieve the intended outcome of equalizing payment across the nation.

Response: Sections 1833(t)(3) and (t)(8) of the Act prescribe how coinsurance amounts are to be calculated under the PPS. Our method of calculating unadjusted coinsurance amounts for each APC group based on 20 percent of national median charges follows the requirements of section 1833(t)(3)(B) of the Act.

Comment: A number of commenters believe that the payment system as proposed would create gross anomalies in coinsurance for particular chemotherapy drugs. For example, the proposed $36.61 coinsurance for fluorouracil is 10 times the hospital's cost to purchase that drug. The commenters asserted that this excessive coinsurance represents an abuse of patients and would undermine beneficiary confidence in the new system. They recommended that coinsurance be limited to 20 percent of the payment amount for each drug.

Several other commenters noted that classifying drugs with widely varying costs in the same APC will have a significant negative effect on beneficiary coinsurance, and in some cases beneficiaries could be required to pay a greater percentage of coinsurance for less effective therapies. For example, one commenter alleged that the coinsurance for the drug 5–FU, which the commenter believes has a current coinsurance of approximately $1, would increase to $40 under the proposed system.

Response: The coinsurance anomalies for chemotherapy drugs that appeared in the proposed rule are not an issue under this final rule. Unlike the proposed chemotherapy drug APCs, which grouped all chemotherapy drugs under four APCs, in this final rule, each chemotherapy drug is assigned to a separate APC. As discussed in section III.D.5 of this preamble, the unadjusted coinsurance amounts for these APCs is calculated as 20 percent of the APC payment rate.

Comment: One commenter noted that the proposed national unadjusted coinsurance amounts for cardiovascular stress testing and perfusion imaging result in beneficiaries bearing 85 percent of the total payment for stress testing and 60 percent for perfusion imaging, which many beneficiaries will be unable to afford. Another commenter

requested that we either exclude cataract procedures and angioplasty from the hospital outpatient PPS or create an outlier policy that affords special treatment for these procedures in order to protect beneficiaries from excessive coinsurance amounts.

Response: Coinsurance amounts, by law, are based on 20 percent of the median of the charges actually billed in 1996 (updated to 1999) for the services within an APC. The fact that coinsurance is a larger proportion of the total payment for some APCs than for others reflects the differences in hospital charging practices for different services. For example, in examining departmental cost-to-charge ratios reflected on hospital cost reports, we have found that most hospitals have higher mark-ups in charges for radiology and diagnostic services than they do for clinic visits.

3. Calculating the Medicare Payment Amount and Beneficiary Coinsurance Amount

a. Calculating the Medicare Payment Amount

The national APC payment rate that we calculate for each APC group is the basis for determining the total payment (subject to wage-index adjustment) the hospital will receive from the beneficiary and the Medicare program. (A hospital that elects to reduce coinsurance, as described below in section III.F.4, may receive a total payment that is less than the APC payment rate.) The Medicare payment amount takes into account the wage index adjustment and the beneficiary deductible and coinsurance amounts. In addition, the amount calculated for an APC group applies to all the services that are classified within that APC group. The Medicare payment amount for a specific service classified within an APC group under the outpatient PPS is calculated as follows:

(i) Apply the appropriate wage index adjustment to the national payment rate that is set annually for each APC group.

(ii) Subtract from the adjusted APC payment rate the amount of any applicable deductible as provided under § 410.160.

(iii) Multiply the adjusted APC payment rate, from which the applicable deductible has been subtracted, by the program payment percentage determined for the APC group or 80 percent, whichever is lower. This amount is the *preliminary Medicare payment amount.*

(iv) If the wage-index adjusted coinsurance amount for the APC is reduced because it exceeds the inpatient deductible amount for the calendar year, add the amount of this reduction to the amount determined in (iii) above. The resulting amount is the *final Medicare payment amount.*

b. Calculating the Coinsurance Amount

A coinsurance amount is calculated annually for each APC group. The coinsurance amount calculated for an APC group applies to all the services that are classified within the APC group. The beneficiary coinsurance amount for an APC is calculated as follows:

Subtract the APC group's Medicare payment amount from the adjusted APC group payment rate less deductible; for example, coinsurance amount = (adjusted APC group payment rate less deductible)—APC group *preliminary Medicare payment amount.* If the resulting amount does not exceed the annual hospital inpatient deductible amount for the calendar year, the resulting amount is the beneficiary coinsurance amount. If the resulting amount exceeds the annual inpatient hospital deductible amount, the beneficiary coinsurance amount is limited to the inpatient hospital deductible. For example, assume that the wage-adjusted payment rate for an APC is $300; the program payment percentage for the APC group is 70 percent; the wage-adjusted coinsurance amount for the APC group is $90; and the beneficiary has not yet satisfied any portion of his or her $100 annual Part B deductible.

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible:

$300–$100 = $200

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

$0.7 \times \$200 = \$140$

(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount, which cannot exceed the inpatient hospital deductible for the calendar year:

$200 − $140 = $60

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$140 + $0 = $140

In this case, the beneficiary pays a deductible of $100 and a $60 coinsurance, and the program pays $140, for a total payment to the hospital of $300. Applying the program payment percentage ensures that the program and the beneficiary pay the same proportion of payment that they would have paid if no deductible were taken.

If the annual Part B deductible has already been satisfied, the calculation is:

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible:

$300 − 0 = $300

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

$0.7 \times \$300 = \$210$

(D) Subtract the Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the amount of the inpatient hospital deductible for the calendar year:

$300 − $210= $90

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$210 + $0 = $210

In this case, the beneficiary makes a $90 coinsurance payment, and the program pays $210, for a total payment to the hospital of $300.

The following example illustrates a case in which the inpatient hospital deductible limit on coinsurance amounts applies. Assume that the wage-adjusted payment rate for an APC is $2,000; the wage-adjusted coinsurance amount for the APC is $900; the program payment percentage is 55 percent; the inpatient hospital deductible amount for the calendar year is $776 and the beneficiary has not yet satisfied any portion of his or her $100 Part B deductible.

(A) Adjusted APC payment rate: $2,000.

(B) Subtract the applicable deductible:

$2000 − $100 = $1,900

(C) Multiply the remainder by the program payment percentage to determine the preliminary Medicare payment amount:

$0.55 \times \$1,900 = \$1,045$

(D) Subtract the preliminary Medicare payment amount from the adjusted APC payment rate less deductible to determine the coinsurance amount. The coinsurance amount cannot exceed the inpatient hospital deductible amount of $776:

$1,900 − $1,045 = $855, but coinsurance limited to $776

(E) Calculate the final Medicare payment amount by adding the

preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation ($855 − $776 = $79).

$1,045 + $79 = $1,124

In this case, the beneficiary pays a deductible of $100 and coinsurance that is limited to $776. The program pays $1,124 (which includes the amount of the reduction in beneficiary coinsurance due to the inpatient hospital deductible limitation) for a total payment to the hospital of $2,000.

4. Hospital Election To Offer Reduced Coinsurance

For most APCs, the transition to the standard Medicare coinsurance rate (20 percent of the APC payment rate) will be gradual. For those APC groups for which coinsurance is currently a relatively high proportion of the total payment, the process will be correspondingly lengthy. The law offers hospitals, but not CMHCs, the option of electing to reduce coinsurance amounts and permits hospitals to disseminate information on their reduced rates. In this section, we discuss the procedure by which hospitals can elect to offer a reduced coinsurance amount, and the effect of the election on calculation of the program payment and beneficiary coinsurance.

Section 1833(t)(5)(B) of the Act, as added by section 4523 of the BBA 1997, requires the Secretary to establish a procedure under which a hospital, before the beginning of a year, may elect to reduce the coinsurance amount otherwise established for some or all hospital outpatient services to an amount that is not less than 20 percent of the hospital outpatient prospective payment amount. The statute further provides that the election of a reduced coinsurance amount will apply without change for the entire year, and that the hospital may disseminate information on its reduced copayments. Section 1833(t)(5)(C) of the Act, as added by the BBA 1997, provides that deductibles cannot be waived. Finally, section 1861(v)(1)(T) of the Act (as added by section 4451 of the BBA 1997) provides that no reduction in coinsurance elected by the hospital under section 1833(t)(5)(B) of the Act may be treated as a bad debt. We note that section 1833(t)(5) of the Act has been redesignated as section 1833(t)(8) of the Act by sections 201(a) and 202(a) of the BBRA 1999.

Elections to reduce coinsurance will not be taken into account in calculating transitional corridor payments to hospitals (discussed in section III.H.2 of this preamble). That is, a hospital's transitional corridor payment will be determined as if the hospital received unreduced coinsurance amounts from beneficiaries.

In the proposed rule, we stated that we would require that hospitals make the election to reduce coinsurance on a calendar year basis. The proposed rule required that the hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than 90 days prior to the date the PPS is implemented or 90 days prior to the start of any subsequent calendar year and that the hospital's notification must be in writing. It must specifically identify the APC groups to which the hospital's election will apply and the coinsurance amount (within the limits identified below) that the hospital has elected for each group. The election of reduced coinsurance must remain in effect and unchanged during the year for which the election is made. Because the law states that hospitals may disseminate information on any reduced coinsurance amounts, we provided in the proposed rule that hospitals would be allowed to publicly advertise this information.

The proposed regulations provided that a hospital may elect to reduce the coinsurance amount for any or all APC groups. A hospital may *not* elect to reduce the coinsurance amount for some, but not all, services within the same APC group.

As proposed, a hospital may not elect a coinsurance amount for an APC group that is less than 20 percent of the adjusted APC payment rate for that hospital. In determining whether to make such an election, hospitals should note that the national coinsurance amount under this system, based on 20 percent of national median charges for each APC, may yield coinsurance amounts that are significantly higher or lower than the coinsurance that the hospital previously has collected. This is because the median of the national charges for an APC group, from which the coinsurance amount is ultimately derived, may be higher or lower than the hospital's historic charges. Therefore, in determining whether to elect lower coinsurance and the level at which to make the election, we advise that hospitals carefully study the wage-adjusted coinsurance amounts for each APC group in relation to the coinsurance amount that the hospital has previously collected.

As discussed in section III.F.1, under sections 1834(d)(2)(C)(ii) and 1834(d)(3)(C)(ii) of the Act the coinsurance for screening sigmoidoscopies furnished by hospitals and screening colonoscopies furnished by hospital outpatient departments and ASCs is 25 percent of the applicable payment rate. The payment rate for these colorectal cancer screening tests is the lower of the hospital outpatient rate or the ASC payment rate. The payment rate for screening barium enemas is the same as that for diagnostic barium enemas. However, the coinsurance amount for screening barium enemas is 20 percent of the APC payment rate. Hospitals may *not* elect to reduce coinsurance for screening sigmoidoscopies, screening colonoscopies, or screening barium enemas.

Calculation of coinsurance amounts on the basis of a hospital's election of reduced coinsurance is similar to the formula described in section III.F.3. For example, assume that the adjusted APC payment rate is $300; the program payment percentage for the APC group is 60 percent; the hospital has elected a $60 *reduced* coinsurance amount for the APC group; and the beneficiary has not satisfied the annual Part B deductible.

(A) Adjusted APC payment rate: $300.

(B) Subtract the applicable deductible:

$300 − $100 = $200

(C) Multiply the remainder by the program payment percentage to determine the Medicare payment amount:

$0.6 \times \$200 = \$120$

(D) Beneficiary's coinsurance is the difference between the APC payment rate reduced by any deductible amount and the Medicare payment amount, but not to exceed the lesser of the reduced coinsurance amount or the inpatient hospital deductible amount:

$200 − $120 = $80 (limited to $60 because of the hospital-elected reduced coinsurance amount)

(E) Calculate the final Medicare payment amount by adding the preliminary Medicare payment amount determined in step (C) to the amount that the coinsurance was reduced as a result of the inpatient hospital deductible limitation.

$120 + $0 = $120

In this case, Medicare makes its regular payment of $120, and the beneficiary pays a $100 deductible and a reduced coinsurance amount of $60. The hospital receives a total payment of $280 instead of the $300 that it would have received if it had not made its election to reduce coinsurance.

Comment: One commenter stated that it is currently illegal to accept lower coinsurance amounts from beneficiaries and asked for an explanation as to how

we could propose to encourage hospitals to lower coinsurance.

Response: Although Medicare, in general, has prohibitions against reducing beneficiary coinsurance, redesignated section 1833(t)(8)(B) of the Act specifically provides the legal authority for hospitals to make elections to reduce coinsurance amounts for purposes of the outpatient PPS. However, those coinsurance amounts cannot be reduced below 20 percent of the adjusted APC payment rate for the hospital.

Comment: One commenter asked whether, in view of our proposal to allow hospitals to elect lower coinsurance, Medigap insurance plans will be permitted to offer a waiver of a participating hospital's coinsurance. That is, can a Medigap plan act as a preferred provider organization (PPO) with a financial incentive to select those hospitals that elect to reduce coinsurance?

Response: There are two kinds of Medigap policies—regular Medigap and Medicare SELECT. While regular Medigap policies must pay full supplemental benefits on all claims that are submitted by all Medicare providers and are approved by Medicare carriers and intermediaries, Medicare SELECT plans, which are a managed care form of Medigap, may restrict payment of supplemental benefits to network providers. Thus, by design, Medicare SELECT plans are permitted to negotiate selectively with hospitals. Ordinarily, Medicare SELECT plans contract with certain hospitals to waive the hospital deductible for inpatient services.

Since the Congress has expressly permitted hospitals to reduce outpatient coinsurance to no less than 20 percent of the PPS payment amount, a Medicare SELECT plan is free to contract selectively with these hospitals. We note that a hospital's election to reduce coinsurance under redesignated section 1833(t)(8)(B) of the Act requires that the reduction be across-the-board for some or all APC groups. Thus, an agreement between a Medicare SELECT plan and a hospital to reduce coinsurance would result in coinsurance reductions for all beneficiaries who receive those APC group services at the hospital, whether or not they are enrolled in the Medicare SELECT plan.

Comment: One commenter requested that we seek a legislative change to offer hospitals more flexibility under the coinsurance reduction provision by permitting them to review and revise coinsurance amounts every 3 months.

Response: We believe that there would be a significant impact on contractors if hospitals were allowed to revise their reduced coinsurance more often than annually. More frequent coinsurance changes may also be confusing to beneficiaries. Because we do not have a good estimate of how many hospitals will make the elections and we do not yet know whether those hospitals that do make elections will elect to reduce coinsurance for just a few or for a significant number of APCs, we do not support allowing hospitals to make or change elections more often than annually. However, we may reconsider our position after we gain more experience under the PPS and can better assess what the impact of more frequent elections would be on hospitals, beneficiaries, and HCFA and its contractors.

Comment: One commenter noted that if we intend to publish a final rule no more than 90 days before implementation of the PPS, hospitals would not have sufficient time to make coinsurance election decisions. The commenter recommended that hospitals be permitted to make the election 60 days before implementation of the system.

Response: This final rule will not be published more than 90 days before the date of implementation of the PPS. Therefore, the final regulations require that hospitals inform their fiscal intermediaries (FIs) of their elections to reduce coinsurance not later than June 1, 2000. Beginning with elections for calendar year 2001, elections are required to be made by December 1 preceding the calendar year. At this time, we do not know how many hospitals will choose to reduce coinsurance or for how many APCs these hospitals will elect reductions. While we want to provide hospitals sufficient time to make their elections, we also must provide fiscal intermediaries with enough time to incorporate the elections into their systems.

Comment: Several commenters disagreed with our proposal to allow hospitals to advertise reduced coinsurance amounts. They noted that, although the BBA 1997 provision with respect to hospitals' election to reduce coinsurance amounts provides that hospitals may ''disseminate information'' on their reductions, we have interpreted that to mean that hospitals may ''advertise'' their reductions. Two commenters stated that disseminating information is not synonymous with granting one category of hospitals the unique opportunity to advertise to attract customers. They believe that this interpretation is antithetical to the spirit underlying provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that prohibit beneficiary inducements and may conflict with State anti-kickback laws. Some commenters were also concerned that under our proposal to allow hospitals to advertise, hospitals may issue a general advertisement of reduced coinsurance when the reduction may apply only to certain services. Other commenters were concerned that hospital advertising may lead Medicare beneficiaries to believe that hospital outpatient care is more economical than other ambulatory settings, even when that is not the case, or beneficiaries may become confused and believe that all ambulatory providers have the ability to reduce coinsurance. These commenters asked us to reconsider our proposal to allow hospitals to advertise rather than to disseminate information. In addition, they asked us to establish additional requirements for hospitals' dissemination of information concerning coinsurance reductions so that beneficiaries are made aware that reduced coinsurance applies only to certain specified services, that it applies only to coinsurance billed by hospitals for those services, and that the law does not permit reduced coinsurance for other Part B services such as physician services.

Several other commenters stated that for the election to reduce coinsurance to be effective, hospitals must have the right to advertise and, therefore, the commenters supported our proposal to permit hospitals to advertise coinsurance reductions.

Response: We believe that hospitals must be able to advertise their coinsurance reductions in order to achieve what we believe to be the intent of the BBA provision, that is, to provide hospitals with some ability to compete with other ambulatory settings (where coinsurance is already 20 percent of the applicable Medicare payment rate) and to reduce beneficiary coinsurance liability.

Hospitals would have less incentive to reduce coinsurance if they could not advertise. In addition, beneficiaries need to be fully informed so that they can make informed decisions. We believe that advertising as a way of disseminating information has merit.

We were persuaded by some commenters' concerns that beneficiaries may not understand that reduced coinsurance applies to specific hospital outpatient services furnished by specific hospitals that choose to elect reductions and that similar reductions cannot be made by other providers of ambulatory services. We, therefore, are amending the regulations to require that all

advertisements or other information furnished to beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that these coinsurance reductions are available only where a hospital elects to reduce coinsurance for hospital outpatient services and reductions are not allowed in other ambulatory settings or physician offices.

Comment: One commenter, noting the complexity of the PPS coinsurance requirements, requested that we provide a phase-in period in the final rule to allow hospitals sufficient time to implement the changes necessary to meet the requirements.

Response: The method required to be used in calculating coinsurance under the PPS results in an overall decrease in the total coinsurance amounts beneficiaries pay for hospital outpatient services. Total coinsurance is somewhat reduced in the first year of implementation and will be reduced even more in future years, until coinsurance for all PPS services equal 20 percent of the applicable APC payment rate. It is only by fully implementing the coinsurance provisions under section 1833(t)(3)(B) of the Act that beneficiaries will realize these reductions. We, therefore, do not support a phase-in period.

Comment: One commenter recommended that we include, as part of the public record, year by year estimates of the total economic burden placed on beneficiaries by the prolonged coinsurance phase-in period, assuming hospitals charge the maximum and minimum coinsurance amounts. The commenter believes these estimates would be useful as a basis for future discussions of how to remedy the coinsurance problem.

Response: As a rule, we develop estimates of impacts for legislative proposals that are under consideration by the Congress and for final legislation as we are developing regulations to implement the law. Although we do not have the resources available to model any number of other data analyses that may have merit, our data are made available to the public, so the commenter and any other interested party may perform the coinsurance analysis.

Comment: One commenter stated that the proposed PPS creates new complexities for Medicare beneficiaries in that they will have to wait for hospitals to do the calculations necessary to determine coinsurance. The beneficiaries will also receive multiple bills and explanations of benefits for multiple hospital visits occurring on the same day. The commenter stated that we will need to have an extensive process in place to explain why, in most cases, beneficiaries are paying 50 to 70 percent of their outpatient services and why they are receiving separate statements when they have multiple visits on the same day.

Response: In the proposed rule, we assigned medical visits, that is, clinic and emergency room visits, to APCs based on both the level of visit as defined by a HCPCS code and the diagnosis of the patient. In order to implement that type of APC assignment, we would have to require hospitals to submit a separate bill for each medical visit that occurred on the same day; however, under the final rule, medical visits are assigned to APCs based solely on the HCPCS code, and it will be possible for hospitals to bill for multiple medical visits on the same bill. We agree that the way coinsurance is determined under the PPS is a significant change. We are developing a brochure for beneficiaries that will explain the new system and the policies under the outpatient PPS that will affect them.

Comment: One commenter recommended that we make information available to beneficiaries that compares the average coinsurance for high volume procedures performed at hospitals in a particular geographic area so that beneficiaries can make informed health care decisions about their care.

Response: We believe that beneficiaries will be informed about the coinsurance reductions elected by hospitals in their area through advertisements and other information made available by hospitals.

Comment: One commenter asked whether the EOMB (Explanation of Medicare Benefits) notice to the beneficiary will clearly explain that a hospital's decision to reduce coinsurance applies to a specific service furnished at that specific hospital.

Response: We are reviewing the EOMB in light of the changes in Medicare payments and coinsurance amounts under the PPS, but we have not yet finalized our work. We will take the commenter's suggestion into consideration as we investigate changes we will make to the EOMB.

G. Adjustment for Area Wage Differences

1. Proposed Wage Index

Under section 1833(t)(2)(D) of the Act, the Secretary is required to determine a wage adjustment factor to adjust, in a budget-neutral manner, the portion of the payment rate and the coinsurance amount that is attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions. As stated in the proposed rule, we considered several options and we proposed using the hospital inpatient PPS wage index as the source of an adjustment factor for geographic wage differences for the hospital outpatient department PPS. We believe that using the hospital inpatient PPS wage index is both reasonable and logical, given the inseparable, subordinate status of the outpatient department within the hospital overall. Use of a hospital outpatient-specific wage index was not required by the Congress and we did not have either the time or resources necessary to construct one. We explained in our proposed rule that there are several possible versions of the hospital inpatient wage index that can be developed by extracting the basic wage and salary data from hospital cost reports, depending on the methodology that is applied to the data. For the hospital outpatient PPS, we proposed to adopt the same version that is used to determine payments to hospitals under the hospital inpatient PPS to adjust for relative differences in labor and labor-related costs across geographic areas. This version reflects the effect of hospital redesignation under 1886(d)(8)(B) of the Act and hospital reclassification under 1886(d)(10) of the Act.

By statute, we implement the annual updates of the hospital inpatient PPS on a fiscal year basis. However, we proposed to update the hospital outpatient department PPS on a calendar year basis. Therefore, the hospital inpatient PPS wage index values that are updated annually on October 1 would be implemented for the hospital outpatient department PPS on the January 1 immediately following. We proposed this schedule so that wage index changes will be implemented on a calendar year basis concurrently with other revisions and updates, such as the conversion factor update or changes in the APC groups resulting from new or deleted CPT codes. Subsequent to our proposal, section 201(h) of the BBRA 1999 amended section 1833(t)(8)(A) of the Act (as redesignated by section 201(a) of the BBRA 1999) to require the Secretary to review and revise the outpatient PPS wage index adjustment factor at least annually rather than on a periodic basis. (This section of the Act was further redesignated as section 1833(t)(9)(A) by section 202(a) of the BBRA 1999.)

2. Labor-Related Portion of Hospital Outpatient Department PPS Payment Rates

We proposed to recognize 60 percent of the hospital's outpatient department costs as labor-related costs that would be standardized for geographic wage differences. We initially estimated this percentage by comparing the percentage of costs attributed to labor by other systems (that is, hospital inpatient PPS and ASC) and by considering health care market factors such as the shift in more complex services from the inpatient to the outpatient setting, which could influence labor intensity and costs. We stated that 60 percent represented a reasonable estimate of outpatient costs attributable to labor, as it fell between the hospital inpatient PPS operating cost labor factor of 71.1 percent and the ASC labor factor of 34.45 percent, and is close to the labor-related costs under the hospital inpatient operating cost PPS attributed directly to wages, salaries, and employee benefits (61.4 percent) under the rebased 1992 hospital market basket that was used to develop the fiscal year 1997 update factor for inpatient PPS rates (published August 30, 1996 at 61 FR 46187).

We confirmed our estimate through regression analysis. Using this approach, we analyzed the percentage change in hospital costs attributable to a 1 percent increase in the wage index as expressed by the hospital wage index coefficient. The coefficient from a fully specified payment regression of the hospital cost per unit, standardized for the service mix on the wage index, disproportionate share patient percentage, modified teaching, rural, and urban variables, is approximately 0.60, suggesting a labor share of 60 percent. Even though we decided not to propose additional adjustments, we believed that the coefficient from this specification provided the best estimate of the labor share for the proposed PPS. This judgment was based on a policy to use a labor share that reflects the relationship between the wage index and costs, rather than the effects of correlated factors.

After calculating 60 percent of each hospital's total operating and capital costs, we divided that amount by the hospital's FY 1998 hospital inpatient PPS wage index value to standardize costs to remove the differences that are attributable to geographic wage differences. Therefore, as we explained in the proposed rule, the total cost of performing a procedure or visit would include standardized operating and capital costs, as well as related costs (for example, operating room time, medical/surgical supplies, anesthesia, recovery room, observation) and minor ancillary procedures such as venipuncture that we packaged.

Comment: Some commenters urged that we annually update the wage index applied to the outpatient PPS as we do under the hospital inpatient PPS.

Response: We proposed to update the wage index annually, on a calendar year basis. In addition, section 1833(t)(9)(A) of the Act, redesignated and amended by the BBRA 1999, requires us to review and revise the wage adjustment at least annually.

Comment: A professional society recommended eliminating the ''regional variation for radiologic technologists working in small and rural practices'' and applying the ''same wage scale'' used for their urban counterparts. The commenter asserted that our wage index methodology is biased against rural hospital radiology departments that must compete with the urban areas to attract and retain radiologic technologists. The commenter stated that hospitals are operating in a very competitive labor market in which rural facilities are forced to match or exceed wages paid in the urban areas for reduced workloads. The commenter further stated that the impact of higher hourly technologist wages does not result in a corresponding increase in a higher wage index for radiologic technologists in rural hospitals because these wages are averaged with those for all other hospital inpatient personnel working in the same area.

Response: The commenter is correct that the wage index is calculated based upon all of the wages paid and hours worked of hospital personnel within areas of the hospital that are paid under the inpatient PPS. The wages and hours are then totaled for a particular labor market area (defined as a Metropolitan Statistical Area [MSA] or all of the counties of a State that are not part of an MSA). We believe the inpatient wage index is an appropriate measure of the relative costs of labor across geographic areas for purposes of outpatient PPS.

Currently, we do not have data available that would allow us to calculate the wage index for the costs of employing staff in particular occupational categories. Collecting these data would require significant recordkeeping and reporting efforts for hospitals, and the impacts of adjusting the wage index using the data are uncertain. Although some analyses have indicated that the wage indices of rural areas could rise as a result of such an adjustment, these findings are limited by the lack of a national database through which to fully assess the impacts.

Comment: Several commenters viewed our proposal to establish a 60 percent labor share as an arbitrary decision for which we provided no rational support. One commenter stated that ''Congress did not expect HCFA to invent a number.''

Response: As we explained in the proposed rule (63 FR 47581), we used a statistical tool, that is, regression analysis, to validate the percentage of costs that we had initially estimated could be attributed to labor and, therefore, subject to the wage adjustment. We adopted this approach because we did not have adequate and appropriate data readily available through a reputable source from which we could derive a hospital outpatient labor share within the time allotted to develop our new system. While hospital outpatient costs, including labor costs, are reported annually on the hospital cost report, they are not reported in a manner and format that allow us to capture the statistical and cost data necessary to calculate a precise hospital outpatient labor share. Therefore, we decided to use regression analysis to test our estimate of that labor share. Within the constraints imposed by a lack of accessible, reliable data and the compressed timeframe under which we were working to develop the outpatient PPS, we believe our approach was appropriate and the best available option.

Comment: Several commenters urged us to use more current hospital cost report data to determine the appropriate hospital outpatient labor share.

Response: As stated above, at this time the Medicare hospital cost report is not a feasible data source for determining a hospital outpatient labor share.

Comment: One commenter asserted that setting the labor-related share at 60 percent fails to recognize all labor costs associated with the delivery of hospital outpatient services. The commenter stated that the labor-related percentage for the outpatient PPS should be the same as that used for the hospital inpatient PPS, that is, 71.1 percent. Another commenter supported 60 percent as a ''maximum'' labor percentage on an interim basis and suggested that we reconsider our decision to use the inpatient PPS hospital wage index to adjust the outpatient PPS payments because of the commenter's concerns about flaws inherent in the system used to derive the inpatient PPS wage index values. A third commenter proposed that the

labor-related portion should be closer to the 34.45 percent currently applied to adjust ASC payment for wage variation. The latter commenter contended that apportioning 60 percent of the outpatient PPS payment rate for wage adjustment would adversely affect rural hospitals because the wage index values for these areas are generally below 1.0.

Response: We note that commenters' opinions regarding an appropriate labor percentage are mixed. However, beyond expressing a preference for a percentage other than 60 percent, none of the commenters provided data to assist us in re-evaluating our proposal. We realize that rural hospitals would benefit from using a labor share that is less than 60 percent and that some other hospitals would derive advantages from a labor share greater than 60 percent. However, we believe the approach that we used to determine the labor share that will be applied to all hospitals paid under our new system is reasonable and the best option available at this time. We will re-evaluate our decision as we gain more experience with the new system and as new data become available.

3. Adjustment of Hospital Outpatient Department PPS Payment and Coinsurance Amounts for Geographic Wage Variations

In the proposed rule, we noted our intent to use fiscal year 1999 hospital inpatient PPS wage index values to compute the initial outpatient PPS rates. However, we have decided to use fiscal year 2000 inpatient PPS wage index values in determining the payment rates set forth in this final rule. The rationale for using the fiscal year 2000 wage index includes availability of the more recent wage index, that it is more current than the 1999 wage index would have been, and that it is being used to calculate FY 2000 payments under the hospital inpatient PPS.

We proposed to use the annually updated hospital inpatient PPS wage index values to adjust both program payment and coinsurance amounts under the outpatient PPS for area wage variations. Under our proposal, when intermediaries calculate actual payment amounts, they would multiply the prospectively determined APC payment rate and coinsurance amount by that labor-related percentage to determine the labor-related portion of the base payment rate and coinsurance amount that is to be adjusted using the applicable wage index factor. We proposed that the labor-related portion would then be multiplied by the hospital's inpatient PPS wage index factor, and the resulting wage-adjusted labor-related portion would be added to the nonlabor-related portion, resulting in wage-adjusted payment and coinsurance rates. The wage-adjusted coinsurance amount would then be subtracted from the wage-adjusted APC payment rate, and the remainder would be the Medicare payment amount for the service or procedure. Note that even if a hospital elects to reduce the coinsurance or if the coinsurance is capped at the inpatient deductible, the full coinsurance is assumed for purposes of determining the Medicare payment percentage. (See section III.F.3 for a discussion on how Medicare program payments are calculated when the Part B deductible applies.)

The following is an example of how an intermediary would calculate the Medicare payment for a surgical procedure with a hypothetical APC payment rate of $300 that is performed in the outpatient department of a hospital located in Heartland, USA. The coinsurance amount for the procedure is $120. The hospital inpatient PPS wage index value for hospitals located in Heartland, USA is 1.0234. The labor-related portion of the payment rate is $180 ($300 × 60 percent), and the nonlabor-related portion of the payment rate is $120 ($300 × 40 percent). The labor-related portion of the unadjusted coinsurance amount is $72 ($120 × 60 percent), and the nonlabor-related portion of the unadjusted coinsurance amount is $48 ($120 × 40 percent). It is assumed that the beneficiary deductible has been met.

Wage-Adjusted Payment Rate (rounded to nearest dollar):
= ($180 × 1.0234) + $120
= $184 + $120
= $304

Wage-Adjusted Coinsurance Amount (rounded to nearest dollar):
= ($72 × 1.0234) + $48
= $74 + $48
= $122

Calculate Medicare Program Payment Amount:
$304 − $122 = $182

4. Special Rules Under the BBRA 1999

We issued the federal fiscal year (FY) 2000 hospital inpatient PPS wage index values in the **Federal Register** on July 30, 1999, in a final rule titled ''Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2000 Rates'' (64 FR 41490). Subsequent to that publication, section 152 of the BBRA 1999 reclassified certain counties and labor market areas for purposes of payment under the Medicare hospital inpatient PPS; section 153 of the BBRA 1999 enacted a ''wage index correction''; and section 154 of the BBRA 1999 provided for the calculation and application of a wage index floor for a specified area. These changes are effective for FY 2000 and will be explained in detail in an interim final rule with comment that we expect to issue in the **Federal Register** shortly. The wage index values in Addendum H, Addendum I, and Addendum J reflect the changes made by the BBRA 1999.

H. Other Adjustments

1. Outlier Payments

Section 1833(t)(2)(E) of the Act, as enacted by the BBA 1997, authorized, but did not require, an outlier adjustment. In the proposed rule, we discussed our reasons for not implementing an outlier adjustment policy. We explained that we had reached that decision after carefully evaluating several factors. For the following reasons, we believed an outlier policy was not necessary: (a) in the proposed PPS, unlike the hospital inpatient PPS, we would use limited packaging of services and allow payment for multiple services delivered to a given patient on a given day; (b) payment for critical care services would reflect the intensity and higher costs associated with providing this type of medical care; and (c) we would make higher payment for serious medical cases even if critical care were not provided and additional payments would be made for any other laboratory work, x-rays, or surgical interventions resulting from medical visits to the emergency room.

Section 201(a) of the BBRA 1999 amended section 1833(t) of the Act by adding an outlier adjustment provision, section 1833(t)(5). Under this new provision, the statute now requires that we make an additional payment (that is, an outlier adjustment) for outpatient services for which a hospital's charges, adjusted to cost, exceed a fixed multiple of the outpatient PPS payment as adjusted by pass-through payments. The Secretary determines this fixed multiple and the percent of costs above the threshold that is to be paid under this outlier provision. The statute sets a limit on projected aggregate outlier payments. Under the statute, projected outlier payments may not exceed an ''applicable percentage'' of projected total payments. The applicable percentage means a percentage specified by the Secretary (projected percentage of outlier payments relative to total payments), subject to the following limits: for years before 2004, the projected percentage that we specify cannot exceed 2.5 percent; for 2004 and later, the projected percentage cannot

exceed 3.0 percent. Section 201(c) of the BBRA 1999 amended section 1833(t)(2)(E) of the Act to require that these payments be budget neutral.

Section 1833(t)(5)(D) of the Act grants the Secretary authority until 2002 to identify outliers on a bill basis rather than on a specific service basis and to use an overall hospital cost-to-charge ratio (CCR) to calculate costs on the bill rather than using department-specific CCRs for each hospital.

To set the threshold or fixed multiple and the payment percent of costs above that multiple for which an outlier payment would be made, we first had to determine what specified percentage of total program payment, up to 2.5 percent, we should select. We decided to set the outlier target at 2.0 percent. In order to set the fixed multiple outlier threshold and payment percentage, we simulated PPS payments, as described below in section G of the preamble. As explained further below, we calibrated the threshold and the payment percentage applying an iterative process so that the simulated outlier payments were 2.5 percent of simulated total payments. *For purposes of the simulation,* we set a ''target'' of 2.5 percent (rather than 2.0 percent), because we believe that *a given set of numerical criteria* would result in a higher percentage of outlier payments under the simulation using 1996 data than under the PPS. This is because we believe that the 1996 data reflects undercoding of services, which means simulated total payments would likely be understated and it in turn means the percentage of outlier payments would be overstated. In addition, we are unable to fully estimate the amount and distribution of pass-through payments using the 1996 data. Our inability to make these estimates further understates the total payments under the simulation. We believe that a set of numerical criteria that results in simulated outlier payments of 2.5 percent using the 1996 data would result in outlier payments of 2.0 percent under PPS. The difference arises from the effect of undercoding in the historical data and the payment of pass-throughs under PPS. Under the budget neutrality requirement in section 1833(t)(2)(E) of the Act, as amended by section 201(c) of the BBRA 1999, we make a corresponding 2.0 percent reduction to the otherwise applicable conversion factor. We will monitor outlier payment and make any necessary refinements to the outlier methodology when we set outlier policies for CY 2002.

After setting the outlier target percentage and reducing the unadjusted conversion factor to reflect the 2 percent outlier reduction and the 2.5 percent pass-through adjustment (see discussion in section III.D), we identified those claims in our 1996 database with at least one payable service under the PPS system. For these bills, we first calculated the total PPS payment for the bill using the reduced conversion factor. Next, we calculated for each claim the total charges attributed to services being paid under the PPS system. These charges were then adjusted to cost, using a hospital-specific CCR. We used the sum of the hospital's total operating CCR and total capital CCR as the hospital specific CCR. These CCRs were calculated from the most current cost report data available and were adjusted to calendar year 1996.

We also identified all bills for the 1,800-plus hospitals that we had previously identified as having coded only the lowest level clinic visit code (CPT code 99201) for all visits. For these hospitals, we isolated those claims with at least one service with the CPT code 99201 and one or more additional PPS covered service. Due to the undercoding on these bills and the inherent problem in determining a possible outlier condition, we excluded these bills from the calculation process but set aside a proportional amount of outlier payments based on the proportional cost of these bills to the total cost of all bills used in the outlier calculation.

After determining the PPS payment and the cost for all 42 million claims for which there was at least one billable service under the PPS system, we experimented with several combinations of thresholds or fixed multiples and payment percent of costs over these multiples. We found that the combination of using a multiple of 2.5 for the threshold and the use of a payment percent of 75 percent of cost over this threshold achieved our target of a 2.5 percent outlier payment. Approximately 1.6 million claims in our 1996 claims database had calculated bill costs that exceeded the PPS payments on the claim by more than 2.5 times and thus qualified for an outlier payment in our model.

Comment: We received several comments that supported our proposal not to create outlier payments. However, most commenters opposed it and supported including an outlier policy. Several commenters disagreed that multiple payment for multiple services furnished during a given visit would absolve the need for outliers. One commenter stated that outlier payments are necessary because of the limited number of APC groups. Several commenters believe that outlier payments are necessary to recognize variability in APC groups stemming from treatment options and patient complexity. Some argued that our own data demonstrate that an outlier policy is necessary to ensure equitable payments. Several commenters stated that the data trimming algorithm that we used, excluding from our PPS database claims that were greater than three standard deviations from the geometric mean, probably eliminated claims that included high cost items and services that should have been reflected in our data and that may have been associated with the later technologies. A professional association noted that an examination of our PPS data indicated that ''20 percent of outpatient services subject to the PPS (excluding clinic and emergency room visits) include maximum costs that are at least 10 times higher than the corresponding rate; 100 services have maximum costs that are at least 40 times higher than the corresponding payment rate.''

One commenter believes that an outlier policy is necessary for a payment system based on averaging to provide additional payments for potentially variable and expensive items such as pharmaceuticals and supplies. Several commenters suggested that outlier payments would be necessary if we did implement their option to carve out all pharmaceuticals and certain supplies from the hospital outpatient PPS and pay them separately based on reasonable costs or average wholesale price (AWP). Most commenters who urged establishing outlier payments advocated them for high cost drugs, supplies, and new technologies. Some commenters advised that a drug such as Activase administered to a cardiac patient in the emergency room prior to inpatient admission or transfer to another hospital for inpatient admission would be costly. One commenter estimated that the cost for two doses of the drug would exceed $4,000. One commenter urged an outlier policy that would adequately pay for iodine I 131 tositomomab. Another commenter recommended that we make an outlier payment for Hemophilia Factor Concentrate that could be packaged in APC 906 (Infusion Therapy, except Chemotherapy) or APC 907 (Intramuscular Injections) and Tissue Plasminogen Activator (TPA) and IV therapy drugs as outliers.

A professional association expressed the need for an outlier policy for tests whose costs exceed a reasonable range of costs for similar procedures. They identified CPT codes 95951 and 95956 as examples of those tests. Another association recommended adoption of

an outlier policy to recognize higher costs associated with new technologies. The commenter suggested that the policy remain in effect a full year after the hospital outpatient PPS is implemented to allow us adequate time to collect the appropriate data for use in updating the payment rates. Several other commenters believe that we may need to adopt an outlier policy on an interim basis while data are collected to determine the appropriate assignment of certain services and items to an APC. One commenter advocated outlier payments for hospitals whose aggregate costs exceed total payments under the hospital outpatient PPS in a given year. A number of other commenters stated that the hospital outpatient PPS outlier policy should be similar to that currently used for the inpatient PPS.

Response: As we discussed above, section 201(a) of the BBRA 1999 amended the Act by adding a new section 1833(t)(5). This provision now requires the Secretary to make an additional outlier payment for outpatient services for which a hospital's or a CMHC's charges, adjusted to cost, exceed a fixed multiple of the new PPS payment as adjusted by pass-through payments. The Secretary is required to determine the fixed multiple and the percent of costs above the threshold that is to be paid under the outlier provision. As we explain above, to implement the outlier adjustment, we have determined that an outlier payment will be made when calculated bill costs exceed the PPS payments on a claim by more than 2.5 times. In addition, the provision of transitional pass-throughs under section 201(b) of the BBRA 1999, which requires the Secretary to make an additional payment for certain high cost medical devices, drugs, and biologicals, constitutes a kind of outlier adjustment (see section III.D of this preamble), and our decision to create special transitional payments for new technology items and services (see section III.C.8) will also provide additional payments to hospitals that incur higher costs under the outpatient PPS.

2. Transitional Corridors/Interim Payments

As we developed the proposed rule, we conducted extensive regression analysis of the relationship between outpatient hospital costs and several factors that affect costs, such as teaching intensity and disproportionate share percentage, as part of the analysis to determine whether payment adjustments should be proposed for the outpatient PPS. Ultimately, we did not propose any adjustments other than the wage index used to adjust for local variation in labor costs. One of the main reasons we did not propose any special adjustments was that the estimated effects of measured factors on costs were small and, in most cases, not statistically significant. In addition, we believe that the negative impacts estimated in the proposed rule for certain classes of hospitals were partially attributable to undercoding and coding variations in the data because coding did not affect the payment of many services under the current payment system, especially medical visits.

Since publication of our proposed policy, section 202(a)(3) of the BBRA 1999 added new paragraph (7) to section 1833(t) of the Act to require the Secretary to make payment adjustments during a transition period to limit the decline in payments under PPS for hospitals. These additional payments are to be implemented without regard to budget neutrality and are in effect through 2003.

Under paragraphs (A), (B), and (C) of section 1833(t)(7) of the Act, the amount of the payment adjustment for an individual hospital depends on the difference between the hospital's ''PPS amount'' and the hospital's ''pre-BBA amount.'' Section 1833(t)(7)(E) of the Act defines the ''PPS amount'' as the amount payable under PPS for the hospital's covered outpatient department services, excluding the effects of the transitional corridor and including coinsurance and deductibles. For purposes of calculating the PPS amount, we include the full copayment amounts; if a hospital chooses to reduce the copayment for some or all of the services that it furnishes, we will count the full copayment amounts rather than the reduced copayment amounts. Section 1833(t)(7)(F) of the Act defines the ''pre-BBA amount'' for a period as the amount equal to the product of (1) the hospital's reasonable cost for covered outpatient department services, and (2) the base outpatient department payment-to-cost ratio for the hospital. The statute defines ''base payment-to-cost ratio'' as the ratio of (1) the hospital's reimbursement for covered outpatient department services during the cost reporting period ending in 1996, to (2) the reasonable cost of the services for the period. The base payment-to-cost ratio will be calculated as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA 1997, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996.

For calendar years 2000 and 2001, payment to hospitals whose PPS payment is less than 100 percent, but is at least 90 percent, of the pre-BBA payment, is increased by 80 percent of the difference. Hospitals whose PPS payment is less than 90 percent, but is at least 80 percent, of the pre-BBA payment, will receive additional payment equal to the amount by which 71 percent of the estimated pre-BBA payment exceeds 70 percent of the PPS payment. Hospitals whose PPS payment is less than 80 percent, but is at least 70 percent, of the pre-BBA payment will receive additional payment equal to the amount by which 63 percent of the pre-BBA payment exceeds 60 percent of the PPS payment. Payments to hospitals whose PPS payment is less than 70 percent of the pre-BBA payment will be increased by 21 percent of the pre-BBA payment. For calendar years 2001 through 2003, the number of corridors and the associated percentage increases decline over time. As required by statute, interim payments will be made subject to retrospective adjustments. Section 1833(t)(7) of the Act provides special transition payments for cancer centers and small rural hospitals, which are discussed below in section III.H.3.

Comment: Hundreds of commenters, including associations, hospitals, and entities providing goods and services to hospitals, expressed grave concerns about the estimated impact of our proposed system on certain classes of hospitals. Many commenters noted that the case mix and service mix for specific classes of hospitals such as rehabilitation, cancer, children's, rural, and teaching hospitals are different than for other hospitals. They argued that a number of these hospitals deal with patients who typically require more resources. The commenters noted that we have authority under the statute to make adjustments for specific classes of hospitals. Some reasoned that given our estimates of substantial losses for certain classes of hospitals under the proposed hospital outpatient PPS, we should use our authority to exclude these classes of hospitals from the outpatient PPS for 2 years, require proper coding of bills from those hospitals, and have an opportunity to analyze the results of the improved coding. These commenters urged that we examine reasons other than coding that may contribute to the disparity. Many commenters recommended that a separate conversion factor be developed

for the hospitals whose payments are adversely affected by the new system.

Response: As discussed above, section 1833(t)(7) of the Act, as added by section 202(a) of the BBRA 1999, provides that, for several years, additional payments be made to any facility for which the PPS payment is less than an estimate of the hospital's pre-PPS payment and that these payments are in addition to the total payments under the PPS. Our estimate of the impacts of this change in policy along with other payment-related provisions of the BBRA 1999 (discussed in further detail in section IX) show improved payments under PPS relative to pre-BBRA law for nearly all classes of hospitals. Our simulations show that hospitals overall receive an additional 4.6 percent in payments under PPS compared to pre-PPS law. Long-term care and children's hospitals show losses (1.7 percent and 3.2 percent, respectively). Moreover, urban hospitals with no indirect teaching or disproportionate share inpatient adjustments show a loss of 0.3 percent. In addition, we reexamined and reestimated the multivariate regression specifications described in the proposed rule to reflect the changes described in this rule. Based on the results of regression analysis, we believe further adjustments are not warranted at this time. We found, for example, the disproportionate share percentage did not have a statistically significant effect on unit costs standardized by service mix. In addition, positive and significant results did not occur for most teaching variables that we specified. For instance, positive and significant results did not occur for hospitals whose ratio of residents to inpatient and outpatient days was less than .28. Hospitals with a large number of residents to inpatient and outpatient days did demonstrate slightly higher standardized costs, but only when the regression model included independent variables for urban/rural location. Moreover, the parameter estimate was small and payment was not greatly improved when a corresponding adjustment was made to these teaching hospitals. Therefore, we are not making such adjustments for these hospital groups. We do not believe that this action will restrict beneficiary access to care because the projected losses are relatively small and could reflect undercoding on the part of these hospitals before PPS.

We will begin comprehensive analyses of cost and payment differentials between different classes of hospitals as soon as there is a sufficient amount of claims data submitted under the PPS. We will use data from the initial years of the PPS to conduct regression and simulation analyses. In addition, we will carefully track and analyze the additional payment made to hospitals under section 1833(t)(7) of the Act. These analyses will be used to consider and possibly propose adjustments in the system, particularly beginning in 2004 when the BBRA 1999 transition provisions expire.

Comment: Commenters from organizations representing teaching hospitals recommended that we include a budget-neutral payment adjustment for certain classes of hospitals such as teaching hospitals. For example, the concern is that PPS payments are not adequate for academic medical centers because they provide more resource-intensive outpatient services than other hospital types.

Response: As noted above, we are not making adjustments for specific classes of hospitals in this final rule. The primary reason for this decision is that section 1833(t)(7) of the Act requires additional payments through 2003 to all hospitals whose PPS payment falls below estimates of pre-PPS payment. We will conduct analyses and studies of cost and payment differential among different classes of hospitals, including teaching facilities, when sufficient data under the PPS have been submitted. We will carefully consider whether permanent adjustments should be made in the system once the BBRA 1999 transition provisions expire.

3. Cancer Centers and Small Rural Hospitals

Cancer Centers

In the BBA 1997, the Congress did not exclude from the hospital outpatient PPS the 10 cancer centers that are currently excluded from the inpatient PPS, but section 1833(t)(8) of the Act (as enacted in the BBA 1997) provides special consideration for these hospitals under the outpatient PPS. More specifically, that section provides that the outpatient PPS would not apply to the 10 cancer centers before January 1, 2000, and that the Secretary may establish a separate conversion factor for cancer centers to take into account the unique costs they incur due to their patient population and the intensity of their services.

In the proposed rule, we stated that, because we had no choice but to delay implementation of the PPS for all hospitals until sometime after January 1, 2000 due to Y2K concerns, we would begin paying cancer centers under hospital outpatient PPS at the same time. Also, we did not propose a separate conversion factor for cancer centers. Although our proposed impact analysis indicated that, under the PPS, the cancer centers could lose 32 percent of their current outpatient Medicare payments, we proposed to do additional work to try to explain the impact before we provided for a separate conversion factor or other payment adjustment.

Section 1833(t)(7)(D)(ii) of the Act, as added by the BBRA 1999, provides that the 10 cancer centers excluded from the inpatient PPS are permanently held harmless with respect to their pre-BBA 1997 amount.

Comment: The cancer centers commented that they are unlike other hospitals in that they treat the most difficult cases (patients often referred by community hospitals) and they are usually the first hospitals to use the latest technology related to cancer treatments. They also pointed out that their clinic visits often involve consultations with a number of physicians and therefore are longer and require more hospital resources than clinic visits in other hospitals. They believe that our proposed payments for clinic visits would seriously underpay them for their more comprehensive visits. The cancer centers also stated that any delay in recognizing and paying appropriately for new technology would affect them more adversely than it would other hospitals.

During the comment period for the proposed rule, the cancer centers submitted for our consideration an alternative payment methodology. Under their methodology, we would calculate a separate conversion factor for each of the 10 centers based on their individual base year Medicare payments and service mix. Subsequently, the conversion factors would be updated using the Congressionally determined update factor applicable to all hospitals. Hospitals would be paid interim payment amounts during the year, but payment would ultimately be based on the lesser of—

- The PPS payments they would receive using their individual conversion factor; or
- The payments they would receive based on their cost reports by applying the current (that is, pre-PPS) outpatient services payment methodology.

Capital costs would be excluded from this comparison and be paid on a reasonable cost pass-through basis. The proposal also envisioned some payment penalties and incentives similar to the penalties and incentives provided under the reasonable payment cost limit methodology applicable to hospitals excluded from the inpatient PPS.

Response: As noted above, new section 1833(t)(7)(D)(ii) of the Act holds cancer centers harmless on a permanent basis by providing that, in instances where Medicare payment to a cancer center under the hospital outpatient PPS would be lower than a specified pre-BBA Medicare payment for the same services, we are to pay the full pre-BBA amount. Therefore, an alternative approach to paying cancer centers under the hospital outpatient PPS is no longer needed.

Small Rural Hospitals

We noted in the proposed rule that rural hospitals generally receive a relatively high percentage of their Medicare income from outpatient services (greater than the national average), which compounds the impact of the reduction in Medicare payments to rural hospitals that we projected would result upon implementation of the hospital outpatient PPS. We attributed these reduced revenues to undercoding, lack of economies of scale, and reliance on the median instead of the geometric mean in the calculation of APC weights. Because our impact analysis revealed that low-volume rural hospitals that are sole community hospitals or Medicare-dependent hospitals could experience a considerable reduction in revenues under the outpatient PPS, we solicited comments in the proposed rule on two possible approaches to phasing in the outpatient PPS for these types of hospitals.

Section 1833(t)(7)(D)(i) of the Act provides that hospitals located in a rural area with 100 or fewer beds are held harmless with respect to their pre-BBA 1997 amount for outpatient services furnished before January 1, 2004. For purposes of implementing this provision, bed size will be determined in the same way it is for inpatient PPS for the indirect medical education adjustment as defined in § 412.105(b), Determination of number of beds. A hospital's location in a rural area will also be determined as it is in the inpatient PPS; see § 412.63(b), Geographic classifications.

Comment: Many commenters were concerned that the projected negative impact of the proposed outpatient PPS on rural hospitals would be magnified because outpatient revenues make up such a large part of rural hospitals' total revenues. Some commenters believe that our proposed PPS ratesetting method favors high volume, urban hospitals. Some commenters supported phasing in the outpatient PPS for rural disproportionate share hospitals because those facilities may not have the resources to improve their coding in the near future. One association opposed phasing in the PPS because doing so would postpone but not resolve the financial jeopardy imposed on rural hospitals by the hospital outpatient PPS. Some commenters recommended that we provide an ''add-on'' to the prospective rate for emergency services in low-volume sole community and rural disproportionate share hospitals. One commenter expressed concern about the numerous factors contributing to rural hospitals' negative margins that limit their ability to absorb losses, including a disproportionately high share of Medicare, Medicaid, and indigent patients, significant problems recruiting practitioners, low population density, and limited patient volume. Numerous commenters recommended that we establish a payment floor for low-volume rural hospitals. One association requested that we either revise the payment methodology or put in place a payment floor that guarantees health care services will continue to be available to Medicare beneficiaries served by rural hospitals.

Response: As we discuss above, in order to limit potential reductions in payment to hospitals under the outpatient PPS, section 1833(t)(7) of the Act, as added by section 202(a)(3) of the BBRA 1999, requires us to establish payment adjustments for hospitals whose PPS payments are less than our estimate of the hospital's pre-BBA payments. These additional payments are to be implemented in a non-budget neutral manner and are to be paid through 2003. Section 1833(t)(7)(D)(i) of the Act includes a special ''hold harmless'' provision, which is to be paid through 2003, for hospitals that are located in a rural area and that have no more than 100 beds. Under section 1833(t)(7)(D)(i) of the Act, as added by the BBRA 1999, small rural hospitals will be paid a predetermined pre-BBA amount for services covered under the outpatient PPS if payment under the PPS would be less than the pre-BBA amount. This hold harmless provision establishes a payment floor until January 1, 2004 for small rural hospitals. During this period, we will collect and analyze data under the PPS in order to assess whether any special adjustments will need to be made for rural hospitals once the hold harmless provision expires.

I. Annual Updates

1. Revisions to APC Groups, Weights and the Wage and Other Adjustments

Prior to enactment of the BBRA 1999, section 1833(t)(6)(A) of the Act required the Secretary to periodically review and revise the APC groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

In the proposed rule, we described our plan to update the various components of the outpatient PPS. We proposed to keep the composition of all the APC groups essentially intact from one year to the next, with the exception of the few changes that may be necessary as a consequence of annual revisions to HCPCS and ICD–9–CM (International Classification of Diseases, Ninth Edition, Clinical Modification) codes. We stated that we did not plan to routinely reclassify services and procedures from one APC to another. We proposed to make these changes based on evidence that a reassignment would improve the group(s) either clinically or with respect to resource consumption. However, we specifically solicited comments on how frequently to recalibrate the APC weights and on the method and data that should be used. We defined recalibration as the updating of all the APC group weights based on more recent information.

We proposed to update the wage index values used to calculate program payment and coinsurance amounts on a calendar year basis, adopting, effective for services furnished each January 1, the wage index value established for a hospital under the inpatient PPS the previous October 1. The first update to the wage index values will be effective for calendar year 2001 beginning January 1, 2001.

Section 201(h)(1)(A) of the BBRA 1999 amended section 1833(t)(8)(A) of the Act (as redesignated by section 201(a) of the BBRA 1999) to require the Secretary to review the components of the outpatient PPS not less often than annually and revise the groups, the relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, and the addition of new services, new cost data, and other relevant information and factors. (Section 202(a) of the BBRA 1999 further redesignated section 1833(t)(8) as section 1833(t)(9).)

Section 201(h)(1)(B) of the BBRA 1999 further amended this section of the Act to require that the Secretary consult

with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise the Secretary concerning) the clinical integrity of the groups and weights. This provision allows these experts to use data other than those collected or developed by us during our review of the APC groups and weights. Section 201(h)(2) of the BBRA 1999 requires the Secretary to initiate the annual review process beginning in 2001 for the PPS payments that would take effect January 1, 2002.

Comment: A number of commenters urged that we adopt an annual update cycle for APC recalibration. Some commented that the APC update frequency should not be less often than the annual cycles that we have instituted for both the hospital inpatient PPS and physician fee schedule payment system. Many commenters maintained that annual updating is necessary to ensure that the APCs appropriately reflect changes in new technologies, standards of care, and other marketplace patterns. Several commenters stated that an annual update cycle is needed to take into account changes in drug prices and appropriately reflect advancements in nuclear medicine. Some commenters believe that updating the APCs less frequently than annually would adversely impact hospitals that would incur financial losses attributable to inappropriate payment for new technologies. Some commenters contended that infrequent updating would be a disincentive for manufacturers to develop new outpatient therapies.

Response: In accordance with the amendments enacted by the BBRA 1999, we will review and update annually, for implementation effective January 1 of each year, the APC groups, the relative payment weights, and the wage and other adjustments that are components of the outpatient PPS, beginning with the update to be effective January 1, 2002.

2. Annual Update to the Conversion Factor

We stated in the proposed rule that section 1833(t)(3)(C)(ii) of the Act requires us to update annually the conversion factor used to determine APC payment rates. Section 1833(t)(3)(C)(iii) of the Act provides that the update be equal to the hospital inpatient market basket percentage increase applicable to hospital discharges under section 1886(b)(3)(B)(iii) of the Act, reduced by one percentage point for the years 2000, 2001, and 2002. The Secretary also has the option (under section 1833(t)(3)(C)(iii) of the Act) of developing a market basket that is specific to hospital outpatient services. We advised in our proposed rule that we are considering this option, and specifically invited comments on possible sources of data that are suitable for constructing a market basket specific to hospital outpatient services. We did not receive any comments regarding potential data sources for constructing a hospital outpatient-specific market basket. Therefore, we will update the conversion factor annually by the hospital inpatient market basket increase (as specified in section 1886(b)(3)(B) of the Act), reduced by one percentage point for the years 2000, 2001, and 2002.

3. Advisory Panel for APC Updates

As stated above, section 1833(t)(9)(A) of the Act (as redesignated by section 201(a) of the BBRA 1999 and further redesignated by section 202(a) of the BBRA 1999) requires the Secretary, beginning in 2001, to consult with an expert outside advisory panel of appropriately selected provider representatives when annually reviewing and updating the APC groups and the relative group weights. The statute specifies that the expert panel will act in an advisory capacity on matters pertaining to the clinical integrity of the groups and weights and that it may use data other than those developed or collected by us in executing this function. We will initiate this review process in 2001 for the hospital outpatient PPS payments that will take effect for services furnished on or after January 1, 2002. We will adopt a process for identifying and appropriately selecting provider representatives to serve as members of an expert advisory panel. We anticipate informing the hospital community of the formation of an expert advisory panel through timely notice in the **Federal Register**.

J. Volume Control Measures

Section 1833(t)(2)(F) of the Act requires the Secretary to develop a method for controlling unnecessary increases in the volume of covered outpatient department services. Section 1833(t)(6)(C) of the Act, as added by the BBA 1997, authorizes the Secretary to adjust the update of the conversion factor if we determine that the volume of services paid for under the outpatient PPS increases beyond amounts we establish under section 1833(t)(2)(F) of the Act.

In the proposed rule, we proposed a volume control measure for services furnished in CY 2000 only. We discussed several long-term alternatives to control volume for services furnished in subsequent years, and we solicited comments on those options. We stated that we would propose an appropriate volume control mechanism for services furnished in CY 2001 and beyond after we completed further analysis. Given the complexities of developing an appropriate volume control mechanism for hospital outpatient services, we believed additional study was necessary.

For CY 2000, we proposed to use a modified version of the physician sustainable growth rate system (SGR), which is required under section 1848(d)(3) of the Act, for purposes of the hospital outpatient PPS. As we stated in the proposed rule, this appeared to be the most feasible initial approach. Using this approach, we proposed to update the target amount specified under section 1833(t)(3)(A) for CY 1999 as an expenditure target for services furnished in CY 2000. We stated that we would update the CY 1999 target for inflation (based on the projected change in the hospital market basket minus one percentage point), estimate changes in the volume and intensity of hospital outpatient services, and estimate Part B fee-for-service changes in enrollment. If volume exceeded the target for CY 2000, we proposed to adjust the update to the conversion factor for CY 2002. We further stated that we would compare the CY 2000 target to an estimate of CY 2000 actual payments to hospitals as determined by our Office of the Actuary using the best available data. We proposed that if unnecessary volume increases, as reflected by expenditure levels, caused payment to exceed the target, we would determine the percentage by which the target is exceeded, and adjust the CY 2002 update to the conversion factor by the same percentage.

We indicated that we would respond in the final rule to comments on our proposed volume control measure for services furnished in CY 2000, but not to comments about volume control options for services furnished after CY 2000, which will be addressed in a later proposed rule.

Comment: We received many comments opposing our proposed use of an SGR-like system to control unnecessary volume increases under the hospital outpatient PPS. Most commenters strongly urged us to exercise the discretionary authority allowed under section 1833(t)(9)(C) of the Act (as redesignated) not to adjust the update to the conversion factor. A few commenters endorsed the provision

of the ''President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (issued July 2, 1999) to delay adoption of a volume control measure in order to give hospitals additional time to adjust to the new system. Several commenters, including one national physicians' association, contended that we did not have the statutory authority to establish and use an expenditure target in the manner that we had proposed. The physicians' association stated that the law limits use of the SGR system to physician services. Some commenters believe that we lack the expertise needed to set an accurate target amount. Others argued that an expenditure target is not a reliable way to distinguish the growth of necessary versus unnecessary services and that our proposal would therefore have consequences not intended by the statute (that is, affecting all services rather than only those that would be considered unnecessary). Some commenters stated that expenditure caps only work when they directly affect those who control the volume. These commenters contended that a volume control measure is unfair to hospitals because it is physicians, not hospitals, who order services and therefore control volume. Some commenters were concerned that adopting a volume control measure would penalize hospitals for increases in outpatient volume attributable to technological changes that appropriately shift service delivery from the inpatient to outpatient setting. In addition, numerous organizations recommended that we not implement the volume expenditure targets and control measures because payments would be reduced to inadequate levels and affect beneficiary access to care.

Response: We are delaying implementation of a volume control mechanism as suggested by the ''President's Plan to Modernize and Strengthen Medicare for the 21st Century'' (the statute does not specify an implementation date). This delay gives hospitals time to adjust to the PPS, and it gives us additional time to study appropriate methods of controlling outpatient volume over the long term. We are currently working with a contractor to study options for volume control measures for outpatient services. In the future, before we make any final decision, we will publish a notice in which we will discuss our proposal and will provide a public comment period.

K. Claims Submission and Processing and Medical Review

Comment: Numerous commenters expressed a variety of concerns related to information exchange processes required by the new PPS. Several commenters stated that the remittance advice documents will need to reflect all of the components used in calculating payment for each claim, as well as possible coinsurance reductions. The commenters also were concerned that, with the complexity of the APC system, hospitals will need the ability to verify payment. One health system that had experience with 3M's APGs offered the experience of their member hospitals to assist us by providing input on the data needed by hospitals to manage APCs. This same commenter stated that hospitals must be given detailed instructions on claims submission, changes to the UB–92, and changes to the Correct Coding Initiative (CCI) in advance to ensure that systems and personnel can comply with Medicare requirements.

Response: We released specific hospital billing instructions that address line item reporting and reporting of service units on December 23, 1999 (Transmittals 1787 and 747). We will be issuing final instructions for implementation of this PPS in a program memorandum to fiscal intermediaries. The program memorandum addresses a range of issues such as appropriate use of revenue center/HCPCS codes for compliance with Medicare requirements and changes to Remittance Advice messages and Medicare Summary Notices/EOMBs.

All current correct coding initiative (CCI) edits with the exception of laboratory and anesthesiology edits have been incorporated in the outpatient code editor (OCE) that fiscal intermediaries use to process claims for hospital outpatient services for payment. We will address OCE changes in a program memorandum to fiscal intermediaries. The effective date of these edits is July 1, 2000.

We have decided not to pursue changes to the UB–92 claim form to allow line item diagnosis because, as we discuss in section III.C.3, we will not be using diagnosis to determine payments for clinic and emergency visits when the PPS is first implemented. Diagnosis codes, however, are still required to be reported on hospital outpatient bills.

Medical Review Under the Hospital Outpatient PPS

We have received inquiries regarding the anticipated medical review process for hospital outpatient PPS claims. The methodology of review for outpatient claims does not change under the PPS. The goal of medical review is to identify inappropriate billing and to ensure that payment is not made for noncovered services. Contractors may review any claim at any time, including requesting medical records, to ensure that payment is appropriate. In accordance with this final rule, Medicare will make payment under the PPS for hospital outpatient services including partial hospitalization services; certain Part B services furnished to inpatients who have no Part A coverage; partial hospitalization services furnished by CMHCs; vaccines, splints, casts and antigens provided by HHAs and CORFs that provide medical and other health services; and splints, casts and antigens provided to hospice patients for the treatment of a nonterminal illness. In addition, we expect focused reviews will include the adjustments we have made to the hospital outpatient PPS as a result of the enactment of the BBRA 1999, especially the transitional pass-through payments for innovative drugs, biologicals, and medical devices that are discussed in section III.D. Fiscal intermediaries will continue focused and random review of services such as ambulance, clinical diagnostic laboratory, orthotics, prosthetics, take home surgical dressings, chronic dialysis, screening mammographies, and outpatient rehabilitation (physical therapy including speech language pathology and occupational therapy) even though these services are excluded from the scope of services paid under the hospital outpatient PPS.

L. Prohibition Against Administrative or Judicial Review

Section 1833(t)(9) of the Act, as added by the BBA 1997, prohibits administrative or judicial review of the development of the PPS classification system, the groups, relative payment weights, wage adjustment factors, other adjustments, volume control methods, calculation of base amounts, periodic control methods, periodic adjustments, and the establishment of a separate conversion factor for cancer hospitals. Section 201(a) of the BBRA 1999 redesignates this section as section 1833(t)(11) of the Act, and section 201(d) of the BBRA 1999 amends the section by adding the following to the list of adjustments subject to the limitation on judicial review: the factors used to determine outlier payments, that is, the fixed multiple, or a fixed dollar cutoff amount; the marginal cost of care, or applicable total payment percentage; and the factors used to determine additional payments for certain medical devices, drugs, and biologicals such as the determination of insignificant cost, the duration of the additional payments, the portion of the outpatient PPS

payment amount associated with particular devices, drugs, or biologicals, and any pro rata reduction. Section 202(a) of the BBRA 1999 further redesignates section 1833(t)(11) as section 1833(t)(12).

IV. Provider-Based Status

A. Background

The Medicare law (section 1861(u) of the Act) lists the types of facilities that are regarded as providers of services, but does not use or define the term ''provider-based.'' However, from the beginning of the Medicare program, some providers, which we refer to in this section as ''main providers,'' have owned and operated other facilities, such as SNFs or HHAs, that were administered financially and clinically by the main provider. The subordinate facilities may have been located on the main provider campus or may have been located away from the main provider. In order to accommodate the financial integration of the two facilities without creating an administrative burden, we have permitted the subordinate facility to be considered provider-based. The determination of provider-based status allowed the main provider to achieve certain economies of scale. To the extent that overhead costs of the main provider, such as administrative, general, housekeeping, etc., were shared by the subsidiary facility, these costs were allowed to flow to the subordinate facility through the cost allocation process in the cost report. This was considered appropriate because these facilities were also operationally integrated, and the provider-based facility was sharing the overhead costs and revenue producing services controlled by the main provider.

Before implementation of the hospital inpatient PPS in 1983, there was little incentive for providers to affiliate with one another merely to increase Medicare revenues or to misrepresent themselves as being provider-based, because at that time each provider was paid primarily on a retrospective, cost-based system. At that time, it was in the best interest of both the Medicare program and the providers to allow the subordinate facilities to claim provider-based status, because the main providers achieved certain economies, primarily on overhead costs, due to the low incremental nature of the additional costs incurred.

In the proposed rule, we pointed out the increase of provider-based facilities and the financial and organizational incentives for that increase since 1983. A variety of factors such as the emergence of integrated delivery systems and the pressure to enhance revenues have combined to create incentives for providers to affiliate with one another and to acquire control of nonprovider treatment settings, such as physician offices.

We noted in the proposed rule that it is essential that we make decisions regarding provider-based status appropriately, and that we have clear rules for identifying provider-based entities. By failing to distinguish properly between provider-based and free-standing facilities or organizations, we risk increasing program payments and beneficiary coinsurance with no commensurate benefit to the Medicare program or its beneficiaries and we jeopardize the delivery of safe and appropriate health care services to our beneficiaries.

Although there is no direct statutory requirement to maintain explicit criteria for determination of provider-based status, there are statutory references acknowledging the existence of this payment outcome. For example, section 1881(b) of the Act provides for separate payment rates for hospital-based ESRD facilities. There is currently no general definition of ''provider-based facility'' in the CFR. However, in the proposed rule, we cited issuances that do contain provisions for recognition of specific types of entities as provider-based, including Program Memorandum A–96–7, published on August 27, 1996, which pulled together instructions for specific entity types from previously published documents and consolidated them into a general instruction for the designation of provider-based status for all facilities or organizations. That Program Memorandum was subsequently reissued, without substantive change, as Program Memoranda A–98–15 and A–99–24 and, in October 1999, was manualized by the Provider Reimbursement Manual, Part I, Transmittal 411 (adding new section 2446), and the State Operations Manual, Transmittal 11 (replacing previous section 2003 and adding new section 2004). Our policy will continue to follow the principles we articulated in Program Memorandum A–96–7 and the Provider Reimbursement Manual and State Operations Manual sections cited above until October 10, 2000. After that date, we shall apply the policies set forth in these final regulations.

B. Provisions of the Proposed Rule

We announced our intention to implement §§ 413.24(d)(6)(i) and (ii), 413.65, 489.24(b), and 498.3, as revised based on our consideration of public comments, with respect to services furnished on or after 30 days following publication of a final rule. We describe these sections below and explain that we have now provided a 6-month delay in the effective date of the regulations on provider-based status.

We proposed to add a new § 413.65 on the determination of provider-based status. In paragraph (a), we proposed to define the following terms: department of a provider, free-standing facility, main provider, provider-based entity, and provider-based status. In paragraph (b), we proposed that a facility or organization would not be entitled to be treated as provider-based simply because it or the provider believe it to be provider-based. The facility or organization, or the provider, would have to contact HCFA and obtain an affirmative provider-based determination before billing of the facility's or organization's costs through the main provider, or inclusion of those costs on the main provider's cost report, is initiated. Further, we proposed to presume a facility not located on the campus of a hospital and used as a site of physician services of the kind ordinarily furnished in physician offices to be a free-standing facility unless we determined it to have provider-based status.

We proposed to require, in paragraph (c), that a main provider that acquires a facility or organization for which it wishes to claim provider-based status must report its acquisition of the facility or organization to us if the facility or organization is off the campus of the main provider, or is located on the campus of the main provider and, if acquired, would increase the main provider's costs by 5 percent or more. The main provider must also furnish all information needed for a determination as to whether the facility or organization meets the criteria in this section for provider-based status. A main provider that has had one or more facilities or organizations determined to have provider-based status also must report to us any material change in the relationship between it and any department or provider-based entity, such as a change in ownership of the entity or entry into a new or different management contract, that could affect the provider-based status of the department or entity.

In paragraph (d), we proposed the requirements for a determination of provider-based status. In paragraph (d)(1), we proposed to set forth licensure requirements for facilities or organizations seeking provider-based status.

In paragraph (d)(2), we proposed to require that a facility or organization be

under the ownership and control of the main provider.

In paragraph (d)(3), with respect to administration and direct supervision of the main provider, we proposed to require that a facility or organization seeking provider-based status have a reporting relationship to the main provider that is characterized by the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments.

In paragraph (d)(4), we proposed that a facility or organization seeking provider-based status and the main provider share integrated clinical services, as evidenced by privileging of the professional staff of the department or entity at the main provider, and the main provider's maintenance of the same monitoring and oversight of the department or entity as of other departments. Also, the medical director of the department or entity would be required to maintain a day-to-day reporting relationship with the chief medical officer (or equivalent) of the main provider, and be under the same supervision as any other director of the main provider.

In paragraph (d)(5), we proposed to require that the department or entity and the main provider be fully financially integrated within the main provider's financial system, as evidenced by the sharing of income and expenses. The department's or entity's costs should be reported in a cost center of the provider, and the department's or entity's financial status should be incorporated into, and readily identifiable in, the main provider's trial balance.

In paragraph (d)(6), we proposed to require that the main provider and the facility seeking status as a department of the provider be held out to the public as a single entity, so that when patients enter the department they are aware that they are entering the provider and will be billed accordingly. (This requirement would not apply to a provider-based entity that is itself a provider, such as a SNF.)

In paragraph (d)(7), we proposed to require that the department of a provider or provider-based entity and the main provider be located on the same campus, except where requirements relating to service to the same patient population are met.

Paragraph (e) would specifically prohibit the approval of provider-based status for any proposed department or entity that is owned by two or more providers engaged in a joint venture.

In proposed paragraph (f), we proposed to state that facilities or organizations operated under management contracts would be considered provider-based only if specific requirements are met related to: Staff employment, administrative functions, day-to-day control of operations, and holding of the management contract by the provider itself rather than by a parent organization.

In proposed paragraph (g), we proposed to specify nine obligations of hospital outpatient departments and hospital-based entities. We explained that these obligations ensure that facilities seeking recognition as hospital outpatient departments or hospital-based entities are in fact what they represent themselves to be, and are not simply the private offices of individual physicians or of physicians in group practices.

We also proposed to preclude any facility or organization that furnishes all services under arrangements from qualifying as provider-based. We believe the provision of services under arrangement was intended to be allowed only to a limited extent, in situations where cost-effectiveness or clinical considerations, or both, necessitate the provision of services by someone other than the provider's own staff. The ''under arrangement'' provision in section 1861(w)(1) of the Act and § 409.3 is not intended to allow a facility merely to act as a billing agent for another.

Proposed paragraph (h) states that, if we learn of a provider that has inappropriately treated a facility or organization as provider-based, before obtaining our determination of provider-based status, we would reconsider all payments to that main provider for those periods subject to reopening, and we would investigate to determine whether the designation was appropriate.

In proposed paragraph (i), we would apply the principles in paragraph (h) to situations involving inappropriate billing for services furnished in a physician's office or other facility or organization as if they had been furnished in a hospital outpatient or other department of a provider or in a provider-based entity.

We also proposed to add a new paragraph (j) that would allow us to review past determinations. If we find that a designation was in error, and the facility or organization in question does not meet the requirements of this section, we will notify the main provider that the provider-based status will cease as of the first day of the next cost report period following notification of the redetermination.

In addition, we proposed to add to § 413.24(d) new paragraphs (6)(i) and (6)(ii) to clarify that main providers, in completing their Medicare cost reports, may not allocate overhead costs to the provider-based or other cost centers that incur similar costs directly through management contracts or other arrangements. These changes are needed to prevent misallocation of management costs, which would result in excessive payment to those types of providers paid on a reasonable cost basis.

To provide an administrative appeals process for entities that have been denied provider-based status, we proposed to revise the regulations on provider appeals at § 498.3. As revised, these rules would specify that a provider seeking a determination that a facility or an organization is a department of the provider or a provider-based entity under proposed § 413.65 would be included in the definition of ''prospective provider'' for purposes of part 498, and would be afforded the same appeal rights as a prospective provider, such as a hospital or SNF, that we have found not to qualify for participation as a provider.

C. Comments and Responses

In response to our proposals, we received approximately 120 letters of comment, most of which raised a number of issues. Included among the commenters were hospitals and hospital and other provider associations, physicians, attorneys, and other individuals. Here we respond to comments submitted on the proposed rule.

General Comments

Many comments were not directed to a specific provision or criterion, but concerned the implementation of the regulations or the application of provider-based criteria to specific types of facilities. These are summarized below.

Effective Date

Comment: A commenter requested clarification as to when the parts of the final rule setting forth criteria for provider-based status would be effective, and a number of commenters requested an extended grace period or a delay in effective date of the final rules, with some commenters requesting delays as long as 12 to 18 months. Various reasons were cited, including the pressures on providers to prepare their systems and staff for the outpatient PPS, the need to bring operations into compliance with the provider-based criteria, and the anticipated workloads of HCFA regional offices that may

receive a large number of requests for provider-based determinations. Commenters argued that it is unrealistic to expect that a hospital would engage in a full-blown analysis of its provider-based arrangements and modify each arrangement until it knows against which exact criteria it is measuring those arrangements. Any changes in status will require hospitals to implement billing and other operational changes. Thus, commenters argued that it is not reasonable to expect hospitals to complete such steps within a 30-day period.

Response: We agree, and are providing a delay in the effective date until October 10, 2000. Moreover, as stated in our response to comments on proposed § 413.65(j) below, any redetermination of provider-based status that finds the facility or organization not to be provider-based will not take effect for at least 6 months after the date the provider is notified of the redetermination.

Application to Specific Facilities

Comment: One commenter stated that under the Balanced Budget Act of 1997 (the BBA 1997) long-term hospitals established on or before September 30, 1995 are entitled to retain their long-term hospital classification notwithstanding their location in the same building or campus of another hospital. In the commenter's view, these hospitals should not now have this classification revoked by this proposed regulation.

Response: The provision referred to by the commenter, section 4417(a) of the BBA 1997, is codified in section 1886(d)(1)(B) of the Act and is implemented under regulations at § 412.22(f). That provision authorizes certain hospitals to continue being excluded from the Medicare hospital inpatient prospective payment system (PPS) based on their exclusion status and configuration on or before September 30, 1995, even though they would not otherwise qualify for this exclusion. The criteria for provider-based status do not conflict with or even directly relate to the section 4417(a) provision, and we have therefore not made any change in the regulations based on this comment.

Comment: The commenter believes that rural health clinics (RHCs) should be exempted from provider-based designation requirements if they meet the intent of the enabling regulation. The commenter requested that an RHC be granted provider-based status if it meets one of the following criteria: Is the sole source of primary care for the community; has traditionally served the community with an open door policy; or treats a disproportionate share of the community's Medicare and Medicaid population.

Response: We share the commenter's concern, but believe the criteria suggested are overly inclusive and could lead to a proliferation of RHCs in areas where there are no true shortages of care. While we do not believe a blanket exemption from the criteria is warranted, we have developed a special provision for RHCs affiliated with small rural hospitals, as described below in our responses to comments on § *415.65(d)(7), Location in immediate vicinity.*

Comment: A commenter stated that there may be instances where the Medicare regulations related to provider-based definitions conflict with the Medicaid provider-based regulations, and asked whether Medicaid will be required to comply with the new Medicare provider-based regulations.

Response: Because hospitals under Medicaid are required to meet the same standards as Medicare facilities, these final rules would affect the Medicaid definition of these facilities as well as the Medicare definitions.

Comment: Commenters stated that the reasons cited for establishing provider-based requirements that are found in the preamble do not apply to clinical laboratories and thus these requirements should not apply. The commenters asked that we explicitly state in the final regulations that the provider-based requirements are not applicable to clinical laboratories. They believe the regulations have little bearing where, as with clinical laboratory services, reimbursement is under a fee schedule amount, and neither the Medicare program nor the beneficiary will pay anyone differently as a result of the treatment of the laboratory in the manner proposed.

Response: As explained more fully in the preamble to the proposed rule, our objective in issuing specific criteria for provider-based status is to ensure that higher levels of Medicare payment and increases in beneficiary liability for deductibles or coinsurance (which can all be associated with provider-based status) are limited to situations where the facility or organization is clearly and unequivocally an integral and subordinate part of a provider. Under this principle, we agree with the commenter's view that it would not be either necessary or appropriate to make provider-based determinations with respect to facilities or organizations if by law their status (that is, provider-based or free-standing) would not affect either Medicare payment levels or beneficiary liability. However, we believe that it is not necessary to specify in the regulations that specific facility types are excluded, since these facilities or organizations are unlikely to seek a provider-based determination. We will be careful to clarify this policy in program operating instructions.

Comment: A commenter stated that the proposed provider-based requirements seem to preclude the possibility of a Comprehensive Outpatient Rehabilitation Facility (CORF) meeting these new requirements. The commenter believes that in the past, CORFs have been permitted to be either provider-based or free-standing and asked whether the final rules will give CORFs the option of being either free-standing or provider-based.

Response: As explained more fully in the preamble to the proposed rule, our objective in issuing specific criteria for provider-based status is to ensure that higher levels of Medicare payment and increases in beneficiary liability for deductibles or coinsurance (which can all be associated with provider-based status) are limited to situations where the facility or organization is clearly and unequivocally an integral and subordinate part of a provider. We are aware that, under the cost-based payment system that applied to CORFs prior to January 1, 1999, approximately 17 percent of participating CORFs claimed provider-based status. However, effective January 1, 1999, in accordance with the BBA 1997, payment for all CORF services is made no longer on the basis of cost reimbursement but on the basis of the physician fee schedule. Beneficiary liability is also determined under the fee schedule, regardless of the organizational structure or affiliations of the CORF. The switch to fee schedule payment from a cost-based system eliminates or removes any payment incentives to be a provider-based rather than a free-standing CORF. Thus, as in the case of the preceding comment, we agree with the commenter's view that it would not be either necessary or appropriate to make provider-based determinations with respect to facilities or organizations if by law their status (that is, provider-based or free-standing) would not affect either Medicare payment levels or beneficiary liability. We also note that existing regulations at § 413.174 specify rules for determining whether ESRD facilities are independent or hospital-based, and we have revised § 413.65(a) to state that determinations with respect to ESRD facilities will continue to be made under § 413.174,

not § 413.65. However, we believe that it is not necessary to specify in the regulations that most specific facility types are excluded, since these facilities or organizations are unlikely to seek a provider-based determination. We will be careful to clarify this policy in program operating instructions.

Application to Specific Facilities—Indian Health Service (IHS)

Comment: Several commenters requested an exception or exemption from the rules for IHS and tribal facilities. One commenter was concerned that the implementation of these proposed regulations will have the effect of denying Medicare participation as provider-based entities to a number of IHS facilities that are currently operated by Indian tribes under the auspices of Public Law 93–638. They will also cause a disruption of the coordinated health care delivery system(s) that exist between IHS and numerous tribes, and jeopardize statutorily authorized contracting and compacting relationships between the IHS and these tribes due to the conflict between these proposed regulations and the statutory opportunities for self-determination by the Indian tribes. The IHS strongly recommended that these proposed regulations not apply to IHS and tribal health systems as written. Recommendations were also made to deem satellite facilities within a discrete Indian reservation as meeting the definition of a provider-based entity as well as satellite facilities within a historical service unit. Finally, the IHS recommended that the current system be ''grandfathered'' to meet the definition of provider-based entity.

Response: We share many of these concerns and have provided special treatment for IHS and tribal facilities as described below.

Comment: A commenter was concerned that the proposed regulations would severely restrict a number of IHS satellite clinics from receiving reimbursement for the provision of Medicare Part B services. The commenter believes that a number of the requirements that must be met before an entity can be designated as provider-based for Medicare payment purposes are unrealistic for IHS satellite clinics, which are often the only Medicare providers on remote tribal lands. The commenter recommended that HCFA provide for an exemption for IHS satellite facilities that are generally located on a main hospital campus or within a short distance of a hospital. Also, the commenter recommended that the final rule clarify that IHS and tribal outpatient departments or satellite clinics are eligible to receive designation as a department of a provider or a provider-based entity and are eligible for Part B reimbursement.

Response: We share many of these concerns and have provided special treatment for IHS and tribal facilities as described below.

Comment: Many tribes have acquired operations of outpatient facilities and are in the process of acquiring the affiliated hospitals. The commenter stated that this trend, coupled with the complexities of the Indian Self-Determination Act (Pub. L. 93–638), the Indian Health Care Improvement Act (Pub. L. 94–437), and a moratorium on tribal compacting and contracting, requires special consideration by HCFA. The commenter requested that facilities be recognized as provider-based if—

(1) The outpatient facility is owned and operated by the tribe that owns the majority of the tribal shares utilized in funding the main hospital;

(2) The tribe has previously compacted programs that were historically administered by the hospital and are now administered through a committee or board comprised of medical staff of both facilities;

(3) The outpatient facility is in the same State as the hospital;

(4) There is coordination and integration of services, to the extent practicable, between the outpatient facility seeking provider-based status and the main provider.

Response: We recognize that the provision of health services to members of Federally recognized Tribes is based on a special and legally recognized relationship between Indian tribes and the United States Government. To address this relationship, the IHS has developed an integrated system to provide care that has its foundation in IHS hospitals. Because of these special circumstances, not present in the case of private, non-Federal facilities and organizations that serve patients generally, we agree that it would not be appropriate to apply the provider-based criteria to IHS facilities or organizations or to most tribal facilities or organizations. Therefore, we have revised the final rule to state that facilities and organizations operated by the IHS or Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are: (1) owned and operated by the IHS; (2) owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes: or (3) owned by the IHS but leased and operated by the Tribe under the Indian Self-Determination Act in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes. Facilities or organizations that are neither leased nor owned by the IHS would not be eligible for this special treatment, even if operated on Tribal land by members of the Tribe. These facilities would, of course, be eligible to participate in Medicare as FQHCs if applicable requirements in our regulations at 42 CFR part 405, subpart X are met. We did not adopt the conditions recommended by one commenter because we believe they may not apply to all Tribes.

Application to Specific Facilities—Federally Qualified Health Centers (FQHCs)

Comment: A commenter stated that despite specific acknowledgment of the eligibility of FQHCs to qualify as provider-based entities, certain proposed ownership, governance, and supervision criteria in connection with the determination of provider-based status would effectively prohibit entities from maintaining concurrent provider-based and FQHC designations. The commenter believe the criteria should be modified, or some other special provision created, to allow FQHCs to be departments of a provider.

Response: We understand the commenter's concerns and have provided special treatment for FQHCs as described below.

Comment: The commenter, a hospital that is affiliated with a number of off-site community health centers, believes the criteria in the proposed rule would deny provider-based status to community controlled, urban tax-exempt health centers operated under the license of a ''main provider.'' Several of the commenter's health centers are FQHCs that must fulfill certain criteria to maintain this status. In the commenter's view, it is not feasible to require the ''main provider'' to own and control these health centers or to require that the health centers and the ''main provider'' strictly meet all of the requirements set forth in the proposed rule. The commenter asked that the final rule be revised to take into account these historical relationships and ''grandfather'' the provider-based status of health centers that have been on the license of a disproportionate share hospital for at least 10 years. The recommended ''grandfathering''

provisions also could, in the commenter's view, require common Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation, integration of clinical care committees, main provider approval of clinical guidelines and protocols, and financial oversight and review by the main provider.

Response: We share many of these concerns and have provided special treatment for FQHCs as described below.

Comment: A commenter requested that we provide a transition period of at least five years for health centers that have been treated as provider-based entities for a significant period of time (for example, 10 years or more), so that the centers will have adequate time to achieve compliance with the provider-based criteria. In the commenter's view, an extended time period for compliance would permit continuity of care to the populations served by the health centers while granting the affected health centers an opportunity to find alternative funding streams.

Response: We recognize that FQHC qualification criteria effectively require these facilities to be governed by community-based boards independent of hospitals and other providers, while our provider-based criteria require facilities seeking provider-based status to be operated under the ownership and control of the main provider, and to be under the direct supervision of that provider. This does not preclude an FQHC from participating in Medicare as a free-standing entity; on the contrary, this participation is entirely appropriate. However, it does preclude the facility from qualifying as a department of a hospital or other provider under our criteria.

Despite the difference between HRSA and HCFA requirements, we are aware that some FQHCs may have been treated by hospitals as departments for purposes of Medicare and Medicaid billing, and we are concerned that an abrupt change in status for them could force some or all to close, leading to shortages of care in some areas. Therefore, we plan to establish special provisions for FQHCs and FQHC ''look-alikes'' (facilities that are structured like FQHCs and meet all requirements for grant funding, but have not actually received these grants). Specifically, we have revised the regulations to state that if a facility has since April 7, 1995 furnished only services that were billed as if they had been furnished by a department of a provider and either (1) received a grant before 1995 under section 330 of the Public Health Service Act or, before 1995, received funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the Public Health Service Act; or (2) based on the recommendation of the PHS, was determined by HCFA before 1995 to meet the requirements for receiving such a grant, the facility will continue to be treated, for purposes of this section, as a department of the provider without regard to whether it complies with the criteria for provider-based status in § 413.65. We note that both types of facilities would be obligated, for as long as they are treated as a department of a provider, to comply with the applicable requirements for departments of providers as stated in § 413.65(g).

Application of Standards

Comment: One commenter believes that the proposed rule did not make clear how it would apply to existing entities, because some language in the rule could be read to require that existing entities would not receive provider-based status until we have issued a determination letter. Another commenter requested that we clarify whether we expect to review all clinics prospectively or just new clinics. The commenter stated that requirements that only new clinics seek designation does not preclude us from auditing currently designated clinics. Another commenter asked if there will be a set time frame during which current providers with provider-based departments or entities under Program Memorandum A–96–7 must contact us and receive an official designation in order to continue billing as they currently do. More specifically, the commenter asked whether, if there is such a time frame, compliance with the criteria in the Program Memorandum would constitute a good faith effort as referred to in § 413.65(i)(2). Additional guidance was also requested as to what providers should do now to demonstrate that they have made a good faith effort.

Response: We plan to review all new requests for provider-based status. At present, we have no plans to systematically review all providers to determine whether they may be claiming provider-based status for some facilities or organizations inappropriately. However, we will review the status of specific facilities or organizations in response to complaints or any other credible information that indicates that provider-based status requirements are not being met. If the regional office determines that this is the case, it will take action in accordance with the rules in new § 413.65(h) and (i). In response to the comment about possible retroactive application of the new regulations, we note that they will apply only on or after their effective date of October 10, 2000. We will not apply the provider-based criteria in the new regulations to periods prior to that date; on the contrary, decisions for such periods will be reviewed only under the criteria in effect at the time, as stated in Program Memoranda and the Provider Reimbursement Manual and State Operations Manual.

Comment: Two commenters pointed out the proposed rules do not state whether the required approval status is retroactive to when the provider applied or to when we granted approval. These commenters believe it should be retroactive to the date of the provider's application for the determination.

Response: We plan to make provider-based status applicable as of the earliest date on which a request for provider-based status has been made and all requirements for provider-based status are shown to have been met, not on the date of our determination. Thus, if a provider requests provider-based status for a facility on May 1 and demonstrates that applicable criteria were met on that date, but the regional office did not make a formal determination until June 1, the determination would be effective on May 1.

Comment: The commenter stated that we should not have published important provider-based policies in a **Federal Register** document that some providers, such as skilled nursing facilities and home health agencies, may not have read. The commenter recommended that we re-issue these proposed rules separately from the proposed hospital outpatient prospective payment rules.

Response: We do not agree that the proposed rules were published in an obscure location. On the contrary, the number of written comments received, many of them from providers other than hospitals, indicates that our proposals were widely known among providers that could be affected. Therefore, we do not intend to republish the proposed rules.

Comment: A commenter expressed concern that these provider-based provisions are unnecessarily restrictive and will unreasonably limit practice arrangements. The commenter went on to state that in the current health care environment, physicians and hospitals need flexibility to adapt to local market conditions and participate in a variety of practice arrangements to provide cost effective, high quality care. An unnecessary strict definition of

''provider-based entity'' could have a chilling effect on the evolution of new care delivery structures that would expand access to care, especially in rural areas.

Response: We share the commenter's concern with preserving Medicare beneficiaries' access to care, but do not agree that the provider-based rules will limit access. We note that the rules do not prohibit hospitals from purchasing physician practices or taking other actions to enhance access to care in remote rural areas; they only set minimum standards for the type of affiliations that will be recognized for provider-based designation.

For example, an institutional provider such as a hospital or SNF may elect to use part of its institutional complex to house physician offices or other facilities that provide services complementing those of the provider. Those facilities'costs will have to be included in the trial balance of the institutional complex, in order to allow costs to be allocated accurately to all parts of the complex, and permit the costs of the provider to be determined. However, inclusion of such facilities' costs on the institutional complex trial balance does not make the facilities provider-based. On the contrary such facilities would have to meet the criteria in § 413.65 to qualify for provider-based status.

Comment: Different views were expressed on how much

discretion regional offices should have in applying the provider-based criteria. One commenter asked that we make the rules as clear and concise as possible. The commenter argued that rules allowing for great latitude in interpretation could be dangerous for the provider community. On the other hand, another commenter stated that we should allow Medicare regional offices greater latitude for determining when sufficient integration exists for a facility to qualify as provider-based, and should avoid adopting regulations that ''micro-manage'' a hospital's operations. Another commenter suggested that rather than requiring that *all* criteria must be met to achieve provider-based status, we change the test to *substantially all.* There may be circumstances where criteria are not fully met, but an overall assessment supports a provider-based determination. This same commenter recommended that a ''pending'' status be incorporated into the evaluation process, whereby hospitals not meeting the criteria for provider-based status would be afforded an opportunity to make the modifications necessary. Another commenter asked that instead of meeting all criteria, we permit the regional offices to evaluate a facility's status with respect to the main provider with input from local government and the fiscal intermediary. Another commenter also suggested that the standards only be enforced to the extent that they are applicable and relevant, consistent with state laws, and relate to practices that are subject to the control of the particular provider.

Response: We have tried to balance the need to apply standards that can be adapted to fit particular circumstances, and agree that the standards should not be overly prescriptive, but rely on regional judgment to ensure appropriate decision making. Because provider-based status is a matter of extreme importance to many facilities, published standards provide a basis for advance assessment and planning of particular organizational and financial arrangements. Therefore, we have decided that a facility or organization will be found to be provider-based only when it is in compliance with *all* standards set forth in these final rules.

With respect to the comment regarding situations in which all but a few criteria for provider-based status are met, we note that nothing prohibits the main provider from re-applying for approval of provider-based status for a facility or organization after having made the changes necessary to come into compliance. Regional offices would in such cases only need to verify compliance with whatever criteria had not been previously met, unless the amount of time that elapses between requests, or other factors, make a full re-evaluation necessary. Because facilities have this flexibility under the rules as proposed, we did not make any changes based on this comment.

Comment: One commenter believes that we had not fully addressed the impact of these rules on service delivery. The commenter suggested that changes would affect deemed status, survey and certification requirements, state licensure requirements, physician referral requirements, and a host of related issues. Another commenter stated that the new requirement regarding administration and supervision found in § 413.65(d)(3) could impact more than our estimated 105 providers. The commenter believes that if providers are required to convert management firm employees to hospital employees and then revert back when outpatient PPS becomes effective, this could impact 5,000 inpatient PPS hospitals.

Response: We again reviewed our requirements, but do not believe they will have the far-reaching effects envisioned by these commenters. In particular, to the extent a facility or organization that claims to be a department of a provider must be accredited, surveyed, or licensed as a part of that provider, or must adapt to the physician referral requirements of the main provider, that result does not flow from the existence of criteria for provider-based status, but instead is a direct result of the provider's decision to claim the facility or entity as a department. We also do not think it is reasonable to assume that any significant number of hospitals will restructure themselves repeatedly because of the final rules set forth below. As noted earlier, both the proposed and final rules closely parallel policies that have been stated explicitly on program instructions since 1996, and we are providing a 6-month delay in effective date for the final rule. Thus, hospitals and other providers have had ample time to assess the impact of any changes and to make necessary adjustments in an orderly way.

Comment: A commenter requested clarification as to how the proposed rules would apply to two hospitals seeking consolidation into a single provider. The commenter also asked whether two small PPS hospitals located approximately 15 to 25 miles apart in separate towns within a metropolitan statistical area (MSA) who wish to consolidate would be prohibited from doing so because of patient population or licensure requirements. Furthermore, if these two hospitals are already certified as a single provider, would the proposed rules require them to separate and create separate providers? Another commenter requested that the final regulatory text state that the provider-based requirements do not apply to any facility where there are inpatient beds since such a facility would be viewed as a ''main provider.'' The provider-based requirements should apply only to facilities or organizations other than main providers.

Response: Although the Program Memorandum and proposed rules were issued in response to situations primarily involving outpatient facilities, we believe the policies set forth in these documents are equally applicable to inpatient facilities, and should be applied in the many cases in which a determination about inpatient facilities must be made. The rules would not prohibit two previously separate hospitals from merging to become a single provider. However, for either facility to be considered provider-based with respect to the main provider, the facility would have to meet the criteria

in this final rule. To clarify the scope of application of these regulations, we have added a definition of ''remote location of a hospital'' and a reference to hospital satellite facilities to § 413.65(a) Definitions, and have clarified the wording of several later sections by including references to remote locations and satellites. We have defined a ''remote location of a hospital'' as a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital may not be licensed to provide inpatient hospital services in its own right, and Medicare conditions of participation do not apply to a department as an independent entity. The term ''remote location of a hospital'' does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1). Hospitals may acquire remote locations by various means, but often do so by mergers or acquisitions, in which a single hospital purchases other, previously separate hospitals, and operates them as remote locations that are not separately organized as departments, but instead furnish the same types of services as the original hospital. For example, a long-term care or other specialty hospital might acquire one or more other hospitals, terminate their separate participation in Medicare, but continue to use them as sites of the same type of care as the original hospital. Satellite facilities are currently defined in our regulations at § 412.22(h)(1) (for hospitals) and § 412.25(e)(1) (for units). In general, a satellite facility is a part of a hospital (or of a hospital unit) that provides services in a building also used by another hospital, or in one or more buildings on the same campus as buildings also used by another hospital. Satellite status always involves co-location with another hospital, while remote locations are not co-located with other hospitals' facilities.

Comment: A commenter requested clarification that the provider-based requirements apply only to providers who are paid under the reasonable cost methodology. The preamble language in section VI implies that these requirements would also apply to providers under the outpatient PPS. The commenter believe that if this were the case, the requirements found in §§ 413.24(d)(6) and 413.65 would be appropriately placed in Subchapter E (for example, Part 482, Conditions of Participation for Hospitals).

Response: The rules set forth below are not limited in their scope to providers paid on a reasonable cost basis but, except where specifically stated in the text of the rules, apply to all providers and facilities seeking Medicare payment. While many of the problems associated with inappropriate accordance of provider-based status relate to cost reimbursement, the different payment systems used for various providers may produce some unintended incentives for one type of facility to gain an unfair payment advantage by misrepresenting itself. The specific requirements cited do not, like the Medicare conditions of participation, implement section 1861(e) of the Act, nor do they primarily concern patient health and safety. Therefore, we did not adopt the suggestion that the section be relocated to part 482.

Comment: A commenter would support a provision that prohibits hospitals from acquiring free-standing physician practices and converting them to hospital-based entities.

Response: We understand the commenter's concern, but do not have authority under the Medicare law to prohibit this practice. We do believe that the rules set forth below will keep hospitals from misrepresenting physicians' practices as hospital outpatient departments.

Section 413.24(d)(6) Adequate cost data and cost finding: Management contracts

Comment: The proposed cost reporting requirements state that if an overhead administrative cost center does not perform services for the off-site clinic or department, no costs should be allocated to that function. The commenter pointed out that this contradicts generally established Medicare cost reporting principles that have always required that the administrative costs be allocated to allowed and nonallowed cost centers.

Response: Our position, as expressed in the Provider Reimbursement Manual, Part II, Chapter 36 for hospitals, is to allow the provider to bypass the allocation of overhead through the cost report to avoid inappropriate allocations. An example of this would be lab services under arrangement, where there is obviously no administrative activity by the main provider. Our electronic cost report systems are set up to ''skip'' that particular cost center and to re-allocate the costs to the remaining cost centers. Likewise, where administrative costs such as billing are performed by the subordinate provider, no billing cost from the main provider should be allocated to that cost center from the main provider.

Comment: Several commenters suggested clarification of ''like'' costs by adding a definition or providing examples. Also, a commenter stated that since the main concern is costs, this provision should be applied when management costs exceed the hospital's operating costs of the department by 10 percent on a comparable basis. Another commenter stated that: (1) Management services benefit only the specific department to which they are expensed, and provide no direct services to other hospital departments; (2) A department under the management contract receives necessary services from other hospital overhead departments; (3) such overhead departments do not represent duplicate services provided under the management contract. Since management agreements can be drastically diverse, the commenter believes this clarification would assist in avoiding any confusion, as well as allow for consistency with generally accepted cost finding principles. Another commenter stated that most entities that contract to manage an area of a hospital manage just that area. Therefore, if they offer assistance with a particular function, it is only for that area and not for the whole hospital. The commenter believes the same principles of reimbursement should be applied whether the hospital provides the service directly or contracts for the service to be provided.

Response: Examples of similar costs when management contracts provide services also available through the main provider are the following: billing services, computer services, accounting services, and, possibly, general administrative staff. When the same services are included in the administrative and general costs of the main provider, and allocated down to subordinate cost centers or providers incurring and reporting these same costs in the trial balance, the result is a duplication of costs to the subordinate cost center or provider. As long as the main provider has the ability to identify these ''like'' service costs, these costs should be re-allocated to the remaining reimbursable and non-reimbursable cost centers in proportion to each cost center's total costs as prescribed in the Provider Reimbursement Manual, Part II, Chapter 36. However, if the main provider is not able to identify the costs of these same services to permit the exclusion of allocation to the subordinate providers or cost centers,

the cost of the management contract of the subordinate provider or cost center must be reclassified to the main provider's administrative and general cost center, and allocated down to *all* reimbursable and non-reimbursable cost centers in proportion to each cost center's total cost.

Comment: With regard to the language in paragraph (d)(6)(ii), Medicare principles of reimbursement require that, when two entities are related, and one contracts from the other, reimbursement for these services is at cost due to the ''related party principle.'' The commenter stated that the cost of a service is both direct and indirect; Medicare reimbursement has a longstanding methodology concerning nonrevenue producing costs and their allocation on a provider's cost report. A separate work paper should not be required. The appropriate methodology for stepping down administrative costs should be based on the cost of the entity utilizing the service. The cost of the free-standing entity must be placed on the main provider's cost report to step down cost appropriately. Additional work papers would allow room for error and would delay any necessary adjustments.

Response: The intent of § 413.24(d)(6)(ii) was to require the main provider to report costs of related party entities that would not be reported through their accounting system on the main provider's books and records, for example, trial balance. Consequently, when there is a sharing of administrative services, for example, managerial staff, the related entity escapes any administrative overhead allocation when that same related entity is not reported on the main provider's trial balance of the cost report. While the commenter is correct regarding the proper reporting of related transactions at cost of the related entity, this regulation section goes further to require the main provider to develop the total cost of the related entity, utilizing and maintaining workpapers to justify the amount to be reported, and to report those costs by the main provider on the cost report trial balance.

Section 413.65(a) Definitions (retitled in this final rule as Section 413.65(a) Scope and definitions)

Comment: Two commenters requested that a definition be provided for ''a provider's campus.'' A definition would be important since the proposed regulation specifies additional requirements for off-campus locations.

Response: We agree that location on or off a hospital's campus is important. To provide a clear standard, we have revised the final rule to define ''campus'' as ''the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by our regional office, to be part of the provider's campus.'' This definition would encompass not only institutions that are located in self-contained, well-defined settings, but other locations, such as in central city areas, where there may be a group of buildings that function as a campus but are not strictly contiguous and may even be crossed by public streets. This would also allow the regional offices to determine, on a case-by-case basis, what comprises a hospital's campus. We believe allowing regional office discretion to make these determinations will allow us to take a flexible and realistic approach to the many physical configurations that hospitals and other providers can adopt.

Comment: The commenter expressed concern regarding the definition of provider-based facilities as many hospital-owned outpatient services are often provided with leased employees with ambulatory care experience. It is not clear that such an arrangement would satisfy the intent of the regulation.

Response: The regulations do not explicitly prohibit the use of leased employees, and each situation will be evaluated relative to the criteria in the regulations set forth below.

Comment: One commenter stated that the difference between ''department of a provider'' and ''provider-based entity'' is not clear from the definitions given of those terms. The commenter requested that we clarify in the regulations text whether a provider-based entity must be certified in its own right, and what type of certification this encompasses. The commenter also requested clarification in the regulations text concerning whether the term ''provider'' in the definition is intended to mean only entities that satisfy the Medicare definition of ''provider'' contained in § 400.202.

Response: We have clarified § 413.65(a) to state that a ''department of a provider'' is a facility or organization that could not by itself be qualified to participate in Medicare as a provider under § 489.2, while a ''provider-based entity'' could be so qualified. For example, a skilled nursing facility (SNF) could be a ''provider-based entity,'' whereas an entity that furnishes ambulatory surgical services could not be a provider-based entity, and could participate in Medicare (for example, receive Medicare payment for services furnished to beneficiaries), only as a department of a provider, as a physician office, or as an ambulatory surgical center approved by Medicare under part 416, if at all. We have further revised the final rule to clarify that a department of a provider furnishes services of the same type as the main provider (for example, a department of a hospital furnishes hospital services), while a provider-based entity furnishes services of a different type from those of the main provider (for example, a hospital-based RHC furnishes RHC services, not hospital services).

Comment: A commenter believes the proposed rule should be revised for medically underserved populations and health manpower shortage areas to allow the referral of beneficiaries back to their community for treatment of community-based therapy providers. Therapy services provided under such a referral would be included under the provider-based designation.

Response: We do not oppose use of such referrals where they are medically appropriate, but believe that referral arrangements should not be equated to provider-based status.

Comment: A commenter questioned the requirement that services be furnished ''under the name'' of the main provider entity. The commenter argued that the requirement is inconsistent with the commenter's view that health care in the late 1990s is, and in many markets must be, ''marketed'' in a highly competitive environment. The commenter's view is that having provider-based status turn on the names used will inevitably invite micro-management of the way the main provider's name is used by the department or other hospital-based entity.

Response: We disagree with any suggestion that health care is merely a generic commodity that can be repackaged under another name for marketing purposes. On the contrary, we believe that operating under the name of the main provider, and holding oneself forward to patients under that name, is an important indicator of status as an integral and subordinate part of that provider. Therefore, we did not make any changes in the regulation based on this comment.

Section 413.65(b) Responsibility for obtaining provider-based determinations

Comment: A commenter stated that the proposed rule does not state clearly enough whether our approval is required in order to permit billing each

time a provider sets up a new service, regardless of whether the service is acquired, managed, new, located on the main campus, or off the main campus. Some commenters stated that if approval is required in all instances, it will cause a significant paperwork backlog and will be quite costly to administer.

Response: Section 413.65(b) states explicitly that a determination by us that a facility or organization is provider-based is required before the main provider may treat the facility or organization as provider-based for billing or cost reporting purposes. We recognize that this may generate some administrative cost, but believe the cost will be much less than the amounts that would be spent improperly if payment were made to a free-standing facility as if it were provider-based.

Comment: A commenter urged that the new determination process be applied to all current as well as new hospital-based services.

Response: We have no plans at present to review all hospitals and other providers with respect to provider-based criteria, but will look into any situations that come to our attention in which it appears that a facility does not meet the requirements of the new regulations but is being treated as provider-based. If the facility or organization does not qualify as provider-based, action will be taken as described later in this preamble and in § 413.65(i).

Comment: A commenter stated that there should be some mechanism in place for a long-term hospital (LTH) to seek an advance determination or advisory ruling that a proposed LTH satellite will be granted provider-based status. Because establishing an LTH requires a huge expenditure of time and human resources, an LTH main provider needs to know in advance whether or not its proposed satellite will receive a favorable provider-based determination. It is suggested that we institute a system by which advance rulings or determinations are available before the satellite is established.

Response: We understand the commenter's concern, but do not have the staff or facilities to provide advance approvals of restructuring proposals. We suggest that providers review the new criteria carefully and avoid forms of organization that are not clearly in compliance with them.

Comment: Two commenters suggested that we provide guidance on the application process providers must complete in order to receive a provider-based determination. In addition, time limits for approval of these determinations should be established. Furthermore, existing provider-based entities should not be required to change their billing and accounting procedures. A commenter also asked for clarification as to whether the intermediary and regional office is to be the contact, and who will make the actual determination of provider-based status.

Response: We are developing an application process and intend to have it in place and ready for use before the effective date of the regulation. We expect that determinations of provider-based status will be made by our regional offices. Involvement by other entities, such as fiscal intermediaries or State survey agencies, will be for information-gathering purposes and under the direction of the regional office.

Comment: A commenter suggested that if a determination goes against the provider, the provider should be given the option to come into compliance with the requirements or file an appeal.

Response: As noted earlier, the regulations do not prohibit a provider that meets most but not all criteria from taking action to fully meet the criteria, thus qualifying a facility or organization for provider-based status. In the case of a provider that believes that the determination of the regional office is incorrect, an appeals process is provided under part 498.

Comment: A commenter stated that the requirement in paragraph (b)(3) establishes an adverse presumption against provider status for ''off-campus'' physician practice sites, and that the focus on ''campus'' boundaries will prove elusive, and serve no real policy purpose.

Response: As explained later, we believe location in the immediate vicinity is an important indicator of provider-based status, and that location can be a good basis for identifying facilities for further scrutiny.

Section 413.65(c) Reporting

Comment: Several commenters pointed out that the regulatory language does not reflect the preamble language regarding off-campus entities and the five percent increase in a provider's costs.

Response: We have revised the final rule to correct this oversight.

Comment: One commenter asked whether this language applies only to entities that are applying for provider-based status, or also applies to entities that have already achieved provider-based status.

Response: The requirement applies to both types of providers, but providers that have entities with provider-based status are required to report only newly created or acquired facilities or organizations.

Comment: Two commenters stated that the five percent and off-campus criteria with regard to provider-based status do not take into account the characteristics of rural and frontier areas, and could lead to lower payments to some facilities, thus reducing the flow of Federal money into rural areas and possibly creating a shortage of care. In addition, considering the small budget of RHCs and other rural facilities, 5 percent is an inappropriately low and unreasonable growth limit.

Response: We understand the commenter's concern but do not agree that a 5 percent threshold for reporting is too low. Therefore, we made no change based on this comment.

Comment: A commenter asked whether this reporting requirement also applies to all newly developed services (that is, department on the campus of the hospital).

Response: The requirement applies to all newly developed on-campus services that could increase the costs of the provider by 5 percent or more.

Comment: A commenter requested clarification that a main provider that ''creates'' as well as ''acquires'' a facility or organization is responsible for reporting to us. The commenter also suggested specific items to be included in the reporting and approval process. These include specific data elements to be reported by the main provider, specifying our component with primary responsibility; specifying our approval process; adding a preliminary conditional approval process; adding a specific time period for our approval; and adding requirements for the effective date that the costs of the provider-based entity can be included on the main provider's cost report.

Response: We have revised the regulation to clarify that it applies to facilities or organizations created by the main provider, as well as those ongoing operations acquired by purchase or other means. We have not included the procedural detail requested by the commenter in regulations, but will consider including it in program instructions.

Comment: A commenter stated that the use of the phrase ''any material change'' in paragraph (c)(2) of this section is too vague and open to interpretation. It is suggested that the section be revised to clearly designate changes of ownership and new management agreements as the only two material changes that require reporting by provider-based entities.

Response: We do not agree that the range of reportable events should be limited in this way. On the contrary, we intend to require reporting of any change that could have a significant (''material'') effect on compliance with the provider-based criteria.

Comment: A commenter asked if the reporting requirements are coordinated with the notification of change of ownership requirements at § 489.18(b), where notice is to be given in advance, and whether there should be a cross reference or clarification with respect to the change in ownership regulation and this proposed regulation.

Response: We believe this suggestion has merit, and will consider revising our program instructions to specify that a report under § 489.18(b) should be reviewed for its applicability to provider-based determinations.

Section 413.65(d) Requirements

Comment: A commenter suggested that we clarify whether all requirements, or only a majority of the requirements, must be met to obtain provider-based status.

Response: We have revised the first sentence of paragraph (d) to state that all of the stated requirements must be met by a facility or organization that wishes to be classified as provider-based.

Section 413.65(d)(1) Licensure

Comment: Many commenters objected to the requirement that provider-based facilities share a common license with the main provider unless the State requires separate licensure for the subordinate facility. One commenter listed several reasons for this concern. First, in the commenter's opinion, licensure determinations may be made based on factors that are different from those that would be important for provider-based determinations. Another reason cited by the commenter is that State licensure laws may vary from State to State. Some State hospital licensure definitions are building specific, and do not include off-site outpatient facilities, thus giving what the commenter argues is undue weight to physical location in evaluating provider-based status. Finally, the commenter believes that requiring common licensure will create a situation where some States may have a large number of provider-based entities and others will have few or none, thus leading to inconsistent application of our rules. One commenter recommended that the same licensure requirement be waived for States with idiosyncratic licensure requirements. An alternative would be accreditation with the provider as a deemed status for meeting a common license requirement. The commenter suggested that the proposed language could be reworded to clarify that offsite clinics would not have to be licensed or operated under the same license as the provider in those States that do not license them.

Response: We recognize that licensure may not be an appropriate indicator of provider-based status in all States, and have therefore revised the regulations to require common licensure only in States with laws that permit common licensure of the provider and the prospective provider-based department under a single license. This means that in States that do not allow licensure of certain types of facilities, such as those providing ambulatory care or those located off the provider's main campus, the licensure criterion would not be applied. We do not agree that JCAHO or other accreditation should be accepted in lieu of licensure, since such accreditation may not necessarily reflect an on-site evaluation of the prospective provider-based department. In recognition of the fact that some hospitals are not licensed by the State because they are Indian Health Service (Federal) hospitals or are located on Tribal lands, we also will not apply the licensure requirement to departments of those hospitals.

Comment: Under paragraph (d)(1) as proposed, clinics in another State from the main provider could not be under the hospital's license. Several commenters argued that this requirement would arbitrarily affect rural and urban health care delivery, where the main provider is close to a State line. A commenter recommended that close proximity be used instead, where a hospital-based clinic is in another State from the main provider. For urban hospitals in large metropolitan statistical areas that cross State boundaries, the commenter believes that the market area of the main provider should be the primary determinant of the potential for integration with the main provider.

Response: Under the regulations as revised based on the comments summarized above, common licensure would not be required of facilities located across State lines if the law of the State in which the main provider is located does not allow such licensing. However, see the discussion, later in this preamble, of § 413.65(d)(7)(ii).

Comment: A commenter pointed out that the proposed rule appears to limit the licensure requirement to ''departments'' of the main provider. The commenter asked whether this requirement only applied to ''provider-based entities.'' The commenter also suggested that where a State has two licensure schemes for the same type of facility, we should not prefer one licensure scheme over the other for purposes of determining the provider-based status of the facility.

Response: The commenter is correct in noting that the common licensure requirement in the proposed rule would have applied only to provider-based departments. We did not propose to apply a common licensure requirement to provider-based entities such as SNFs and HHAs, because they are providers of services in their own right, and typically would be separately licensed without regard to their affiliation with the provider. We disagree with the commenter's view that licensure should not be viewed as an indicator of integration. On the contrary, our view is that if a facility could be licensed as part of a main provider but chooses not to be, the facility cannot reasonably be seen as an integral and subordinate part of that provider.

Comment: With regard to the proposed requirement that states that our determination regarding provider-based status will be based on a State health facilities' review commission, one commenter argued that relying on the commission's criteria for purposes of making provider-based determinations is arbitrary and inappropriate. The commenter believes imposing this criterion could disadvantage providers and discourage expansion to off-site locations, thus indirectly leading to shortages of care. Another commenter requested that there be a delay in implementation during which time changes can be made to the commission's definition of what rates it can regulate.

Response: We continue to believe it would be inappropriate for a facility to claim to be separate from the provider for State rate-setting purposes while also claiming to be an integral and subordinate part of the provider for Medicare purposes. To allow this practice would authorize providers to misrepresent their structures and affiliations in whatever way will yield the highest payment. Thus, we did not make changes to reflect the comment.

Section 413.65(d)(2) Operation under the ownership and control of the main provider

Comment: Regarding § 413.65(d)(2), the commenter suggested that the regulations provide a separate set of criteria that would allow a provider that is operated within one legal entity to be provider-based to a provider that is operated within another legal entity, as long as the two entities are under common control. Another commenter

stated that this ownership and control requirement is unnecessarily rigid, since a hospital-based clinic, which was strictly an administrative division of the hospital, might qualify while another similar clinic, wholly owned by the hospital with slightly different governing bodies and documents, would not be eligible.

Response: We do not agree that common control of two separate entities by the same parent organization should be sufficient to meet a requirement for ownership and control by the main provider. While this arrangement may be an appropriate way to manage two separate entities, it does not establish provider-based status for either. With respect to the second comment, we agree that the form of administration of an entity can determine whether or not the entity is found to be provider-based. We believe this would be an appropriate result, since it would help ensure that only facilities that are organized as provider-based entities or departments of a provider are given this status.

Comment: One commenter believes it is unrealistic to require a potential provider-based facility or organization to be owned by the main provider and share bylaws and an identical governing body. The commenter stated that in the present business climate an entity can operate as a provider-based entity without meeting these criteria. It is recommended that we replace the proposed 100 percent ownership standard with a majority standard, require only overlapping governing bodies, and eliminate the requirement for organization under the same organizational documents. Another commenter believes that the key consideration should be whether the provider is in control of the day-to-day operations of that portion of the facility in which the provider seeks provider-based status, and not necessarily whether the building is 100 percent owned by the provider. The commenter believes we should rephrase this provision to require that the operations of that portion of the facility or organization in which the provider is seeking provider-based status be controlled by the provider.

Response: In response to the first comment, we recognize that many organizations enter into business relationships that involve overlapping of ownership, governance, and applicability of bylaws. However, this degree of collaboration does not mean that one facility is an integral and subordinate part of another. Therefore, we made no change based on this comment. Regarding the second comment, we wish to clarify that it is ownership of the business enterprise, not of the buildings or other physical assets of the enterprise, that is required under paragraph (b)(1). We have therefore revised the regulation text to refer to ownership of the business enterprise.

Comment: A commenter stated that the requirements contained in paragraph (d)(2) would preclude entities that are jointly owned through legitimate joint ventures or those separately organized subordinate facilities from qualifying for provider-based status. Additionally, to require the level of integration suggested by our proposed rule would prevent providers from establishing efficient systems of delegation and management, solely to qualify for provider-based status.

Response: We agree that this criterion would have the stated effect. As explained further in our discussion of comments on proposed § 413.65(e), facilities operated jointly by two or more providers cannot appropriately be considered integral and subordinate parts of either provider. With respect to the second comment, we do not oppose systems of operation that stress separate, decentralized operation where this leads to greater efficiency. However, we believe such facilities or organizations should be recognized as the separate enterprises that they are, not considered integral and subordinate parts of another institution.

Comment: A commenter suggested that the requirement under paragraph (d)(2) be modified for medically underserved populations and health manpower shortage areas.

Response: We are also concerned that our criteria not limit access to care for any vulnerable populations and have, to avoid this potential problem, created special provisions for FQHCs and IHS and tribal facilities. As described later in this preamble, we have also created an exception to the location requirements in paragraph (d)(7), which is designed to help avoid restricting access to primary care furnished by RHCs in remote, underserved areas. In view of these provisions, we do not believe it is necessary to also modify our requirement relating to ownership of the facility or organization.

Comment: A commenter stated that the proposed requirements in paragraph (d)(2) are inherently inconsistent with section 330 of the Public Health Service Act statutory and regulatory requirements and the Bureau of Primary Health Care expectations necessary to obtain and maintain section 330 funding (and FQHC status). The commenter believes HCFA should not require FQHCs to be 100 percent owned by the main provider or share a common governing body and common bylaws with the main provider. The commenter also suggested that we accept appropriate reporting relationships and satisfaction of other criteria (for example, licensure, quality assurance, integration of certain administrative and clinical functions, such as billing, purchasing, retention of medical records, quality assurance and utilization review procedures; and public awareness of the relationship between the health center and the main provider) as a sufficient basis for provider-based status.

Response: As described earlier, we have provided a special transition period for FQHCs. We believe this period will be adequate to avoid the problems envisioned in this comment.

Section 413.65(d)(3) Administration and supervision

Comment: A commenter recommended that the daily reporting relationship stated in § 413.65(d)(3) should be replaced with the standard of having the reporting relationships have the same intensity as on-site departments. The commenter stated that in practice at the hospital, there may be very little day-to-day contact between medical directors of various hospital services. Also, the commenter believes it is unlikely that departmental directors report directly to the chief executive officer, but rather to a chief operating officer or other designee. Finally, the commenter argued that under the common governance requirement, while all hospital employees are theoretically accountable to the governing body, the accountability may be directed through the CEO, and multiple executives may not have an independent reporting with the board. Another commenter also believes that the standards for the provider-based entity should mirror those of the main facility; personnel reporting structure needs to be respected within the regulations. Still another commenter found ''intensity'' to be a subjective standard and asked how it will be measured.

Response: We agree that reporting need not be daily in all cases, and have revised the final rule to state that the reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments. We agree with the commenter that the intensity of supervision will have to be assessed on a case-by-case basis, but do not believe

this will lead to imprecise or poorly reasoned decisions.

Comment: Several commenters believe that this requirement limits the flexibility of the entity to operate efficiently and effectively in the current environment, since hospitals frequently turn to many specialized management companies to operate more efficiently and effectively than with hospital resources. Another commenter stated that whether the administrative department utilizes employees at one location and contracts at another location should be irrelevant as long as the function is integrated with the main provider, follows the policies and procedures of the main provider, and is accountable to the governing body of the main provider as is any other department. Still another disagreed, and believes that it may be appropriate to require that the main provider manage such contracts.

Response: We do not agree that the provision unreasonably limits hospital flexibility. Paragraph (3)(iii)(B) explicitly allows different management contracts to be used for the facility or organization and the main provider, as long as the provider manages the contracts. Thus, we did not make any changes in the proposal based on these comments.

Comment: A commenter asked whether the administrative functions listed in paragraph (d)(3)(iii) are the only services that must be integrated between the main provider and the subordinate facility.

Response: The commenter was correct in understanding that the functions listed are the only administrative functions that must be integrated. There are also requirements for integration of certain financial functions, as described below.

Comment: One commenter posed several questions concerning this proposed requirement. First, in a certain situation, the facility fee is billed to the intermediary by the hospital billing department using the provider number, while the professional fee is billed to the Part B carrier by the faculty practice billing organization under its physician group number. The commenter asked if the different provider number and tax identification impact on the provider-based status, and if there is a more appropriate way to obtain billing numbers for hospital-based clinics. Also, the commenter asked if clinic space can be shared by two clinics, when one is provider-based and one is free-standing, without impacting the provider-based status of the first clinic.

Response: In the circumstances described, the use of separate billing and tax identification numbers for provider and physician services would not adversely affect a facility's request for provider-based status, since such billings are required under Medicare to be separate in the case of services in hospitals. The question regarding sharing of space, however, can be answered only in the context of a specific case, and we expect that such decisions will be made by our regional offices.

Comment: With respect to the oversight of contracts under paragraph (3)(B)(iii)(B), several commenters stated that it is common for hospitals to subcontract out the billing for different departments, especially the hospital outpatient department, due to the complexity and number of claims. These commenters stated that while it may be appropriate to require the main provider to manage such contracts, departments other than the billing department should be permitted to perform this management function. One commenter suggested revising the criterion on billing under the integration of administrative functions to state, ''common billing or the contract for billing services is held by the provider where it is based.''

Response: We agree that departments other than the main provider's billing department may appropriately manage billing contracts, and have revised the criterion to state that the contract for a provider-based facility or organization must be managed by the main provider.

Section 413.65(d)(4) Clinical services

Comment: A commenter asked for clarification of paragraph (4)(iv) of this section, specifically concerning whether this language would require a Medicare certified HHA's improvement activities to be overseen by hospital medical staff, rather than the advisory committee as is now being done. The commenter believes that having the hospital medical staff overseeing the quality assurance activities of a HHA may not be appropriate or cost effective and may even slow the process of performance changes.

Response: The commenter is correct in understanding that compliance with this criterion would require oversight of a hospital-based HHA's quality improvement activities by the hospital's medical staff. We do not agree with the commenter that the outcome would be to substitute the judgment of the hospital for the HHA's own committee or that it would be inappropriate. The hospital conditions of participation contain a number of separate requirements that must be read together to make complete sense of this provision. Conditions spelled out at § 482.12 (Governing body), § 482.21 (Quality assurance), and § 482.22 (Medical staff) establish a chain of accountability in a hospital for the quality of care it provides. The requirements are clearly applicable to any activity (for example, provider-based entity) that is an integral part of the hospital. Thus, a quality improvement activity of the HHA is likely to be firmly grounded in the hospital's operating and governance fabric even when the group is ''established'' by the HHA, and staffed by employees and physicians who work primarily in home health. We would expect the linkages to be formal (that is, known to the governing bodies and medical staffs of both providers), and the quality assurance mechanisms interrelated to the extent that shared patients are the subject of the effort.

Comment: Regarding paragraph (d)(4)(v) of this provision, some commenters requested clarification of what is meant by a ''unified retrieval system,'' or for guidance as to what types of cross referencing are acceptable. Another commenter asked for an explanation of the practical expectations regarding the maintenance of medical records. Finally, a commenter expressed support for the requirement for a unified retrieval system (or cross references), saying the latter system would be used in States that mandate a unified system.

Response: We would like to clarify that what is intended is that a system be maintained under which both the potential provider-based entity or department of a provider and the main provider have access to the beneficiary's record, so that practitioners in either location can obtain relevant medical information about care in the other setting. We did not, however, make any changes in the requirement based on these comments.

Comment: A commenter believes that functions of operations should not be regulated to dissuade cost efficiency, and that laundry and housekeeping would be examples where shared services may not be the most effective manner of operation.

Response: We agree that in some cases it may be less expensive for a facility to obtain services independently, but continue to believe such separateness is an indicator that the facility is not an integral and subordinate part of a provider.

Comment: With regard to paragraph (d)(4)(vi) requiring integration of services of the main and provider-based entity, the commenter expressed concern about the potential impact of

this section on a patient's freedom of choice. The commenter believes that the entity's efforts to meet this standard would limit a patient's freedom of choice. The commenter suggested that we clarify our position so that providers acting in good faith will not be sanctioned for attempting to comply with this requirement.

Response: Paragraph (d)(4)(vi) requires only that patients have access to the services of the main provider and that they be referred to it where the referral is appropriate. We wish to clarify that these criteria are not intended to restrict patient freedom of choice or the practitioner's freedom to refer patients to other locations, where doing so will result in better care for the patient.

Section 413.65(d)(5) Financial integration

Comment: A commenter believes that § 413.65(d)(5), which requires full integration of financial operations, is too rigid. An alternative approach is suggested that would allow managers of provider-based entities to retain some control over both the resources and information required to administer these units.

Response: Section 413.65(d)(5) requires that there be financial integration of the potential provider-based facility or organization and the main provider, but does not preclude normal management control of resources. Thus, we made no change in the regulation based on this comment.

Comment: A commenter stated that the criteria for common resource usage of building, equipment, and service personnel is not even relevant for multi-campus systems or even buildings that are across the street from each other, much less off-site hospital outpatient departments.

Response: Although the provider-based program memoranda required that there be significant common resource usage of buildings, equipment, and service personnel on a daily basis, this requirement does not appear in the proposed rule. Thus, we made no change in the regulation based on this comment.

Comment: One commenter stated that the requirement for financial integration seems unnecessary in light of the requirement for 100 percent ownership by the main provider. The commenter stated that some providers may wish to segregate the operations of certain departments in their financial systems, and expressed the view that as long as the costs of a department can be adequately identified on the cost report, the practice should be acceptable.

Response: We do not believe that these two requirements are duplicative. On the contrary, in some cases a provider may own 100 percent of another facility or organization, but not be financially integrated with it, either because the other facility or organization is engaged in a different, non-health care activity, or because it is organized and operated separately from the main provider. In these circumstances, we believe the criteria on financial integration apply appropriately to deny provider-based status to separate facilities or organizations.

Section 413.65(d)(6) Public awareness

Comment: Section 413.65(d)(6) requires that provider-based entities be identified as part of the main provider organization. The commenter did not understand the importance of this criterion, particularly when the provider-based organization is licensed and Medicare certified separately from the main provider.

Response: The proposed rule would not apply this criterion to provider-based entities (which may participate separately as providers), but only to provider-based departments. In the latter case, we think it is not unreasonable for such a department to be expected to identify itself with the provider of which it claims to be a part.

Section 413.65(d)(7) Location in immediate vicinity

Comment: A commenter stated that if off-site RHCs cannot be considered provider-based, it will be much harder to deliver care in rural areas. The commenter asked that RHCs be allowed to continue as provider-based RHCs even though they are off campus.

Response: We continue to believe close physical proximity is an important indicator of provider-based status. We note, however, that paragraph (d)(7) does allow off-campus facilities to be treated as provider-based if they meet the criterion relating to service to the same patient population.

Comment: Many commenters believe that more specific tests of service to the same patient population are needed. One commenter suggested that an appropriate criterion would be that the proposed provider-based facility or organization be located within the same geographic area that accounts for a high percentage of patients in the main provider. The commenter believes this test is consistent with Program Memorandum No. 96–7 and with the qualification requirements for sole community hospitals. Other commenters suggested that the main provider's geographical service area be considered the area from which the main provider drew 80 percent of its Medicare inpatients for the previous three years.

Response: We agree that more precise criteria are needed. Therefore, we have revised the regulations to provide that a prospective provider-based facility or organization will be considered to serve the same patient population as the main provider if, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with us, at least 75 percent of the patients served by the facility or organization seeking provider-based status reside in the same zip code areas as at least 75 percent of the patients served by the main provider. As an alternative, we would consider a facility or organization to serve the same patient population if, during the same 12-month period described above, at least 75 percent of the patients served by the prospective provider-based facility or organization who required the type of care furnished by the main provider received that care from the main provider. We require this ''same patient population'' test to be met for the 12-month period used to support an initial determination of provider-based status, and it must continue to be met for each subsequent 12-month period to justify a continuation of provider-based status. Application of population/geographic standards to newly established facilities or organizations is discussed below.

Comment: Commenters suggested we show some flexibility with regard to the definition of patient population for teaching hospitals. The commenter stated that it will not always be the case that the patient populations for the teaching program will be the same as the overall mix or patient population for the main provider.

Response: We recognize that patient populations will not be identical in all cases, and thus have adopted a patient population criterion under which there may be a divergence of up to 25 percent between the main provider and the facility or organization seeking provider-based status. We believe this provides a reasonable allowance for differences in patient population. Moreover, we note that under section 1886 of the Act, Medicare provides much flexibility for teaching hospitals in other ways, for example, under section 1886(h)(4)(E), permitting the counting of residents for purposes of payment to teaching hospitals for the time the residents spend in nonhospital settings.

Comment: Two commenters suggested that the criterion on service to the same patient population be dropped. One commenter believes the criterion is overly vague, could limit access to care as facilities seek to control their service patterns, and, in general, represents a geographically based approach that is out of keeping with modern technology and communications. Another commenter stated that the criterion is unclear, and providers could find it burdensome to assemble the data to show compliance. Other commenters shared the second commenter's concern, but instead of recommending elimination of the criterion, they suggested that a more administrable solution would be to use regional or state standards to define ''same geographic area,'' such as, health systems area, a specified mileage amount, or our wage area.

Response: As described above, we have developed a more precisely stated test of service to the same patient population. We believe that test will be clear and understandable, not impose unrealistic burdens on providers, and allow provider-based designations that parallel service patterns.

Comment: With respect to paragraph (d)(7)(i), a commenter asserted that many currently operating facilities that are treated as provider-based by us provide types of service that are the same as those of the main provider, but serve patient populations from different geographic areas. The commenter believes these entities provide care under the direction of, and utilize substantial services from, the main provider. An example would be the geographically separate campuses of a single parent hospital that are located at various sites throughout a region. The commenter suggested that such campuses be presumed to be provider-based if they provide substantially the same services as the main provider, do not exceed the size of the main provider, and comply with all other provider-based requirements. Another commenter stated that the ''same patient population'' requirement should not apply to multi-campus long term care hospital locations. These locations are fundamentally different from other provider-based entities that the regulation addresses, since a long-term care hospital main provider and its remote campus furnish the same services, and offer the same programs of care, but operate in slightly different geographic areas. The commenter suggested that so long as all of the strict financial and administrative integration requirements of the proposed provider-based regulation are satisfied, the ''same patient population'' requirements should not apply to long-term care hospitals. The result of this criterion would be that satellites will not be established in many underserved areas where long term services are needed. Another commenter believes a specialty facility, such as a long-term care hospital, should be exempt from the geographic proximity requirement if it can demonstrate that it will improve the quality of patient care, and offer services that are not otherwise provided in that area.

Response: We recognize that there may be some cases in which a hospital and another facility seeking provider-based status as a remote location of that hospital may meet most or all other criteria in § 413.65, yet not qualify because the two facilities serve different patient populations. However, we do not agree that this result should lead us to abandon the ''same patient population'' test. On the contrary, we continue to believe that criterion is a valid indicator of provider-based status. Thus, we did not revise the regulation based on this comment. In this context, we note that there is no Medicare rule that would prohibit a hospital from setting up another hospital in another area. We do not agree with the commenter's assumption that because the program memorandum and proposed rule were issued in response to situations primarily involving outpatient facilities, they can apply only to such facilities. On the contrary, we believe the policies set forth in these documents are equally applicable to inpatient facilities, and should be applied in the many cases in which a determination about inpatient facilities must be made. In particular, the rules apply to remote locations of long-term care and other hospitals that are main providers, as well as to satellite facilities of hospitals and hospital units that are excluded from the hospital inpatient prospective payment system. Remote locations and satellite facilities are discussed more fully earlier in this preamble, and ''satellite facilities'' are specifically described in our regulations in §§ 412.22(h) and 412.25(e). (As explained in that document, we are concerned that establishment of satellites by hospitals and units excluded from the inpatient PPS could lead to payment abuses, such as circumvention of certain payment caps mandated by section 4414 of the Balanced Budget Act of 1997, and we have therefore established special payment rules for those facilities. Facilities seeking to qualify as ''satellites'' under the inpatient payment criteria in §§ 412.22(h) and 412.25(e) would first need to comply with the provider-based requirements before being eligible for satellite status.) We have revised the final rule to clarify its application to remote locations of hospitals and satellite facilities.

Comment: The commenter believes that flexibility in the definition of ''located in the immediate vicinity'' needs to be met with additional considerations when viewing rural and underserved areas; for example, it should not be our intention to eliminate the provider-based designation of a rural health clinic (RHC), when the purpose of the RHC is to be an outreach to geographically isolated areas.

Response: We share the commenter's concern and have developed a special provision for RHCs, as described below.

Comment: A commenter believes that the requirement that provider-based entities serve the same population as the main provider could cause significant problems for RHCs. The unique situations addressed by hospital-based RHCs attempting to satisfy the health care needs of medically underserved areas should be considered as exceptions to the proposed rule.

Response: We continue to believe close physical proximity is an important indicator of provider-based status; however, we recognize that small rural hospitals and their RHCs may not be able to demonstrate that a substantial number of clinic patients receive services from the main provider. Small rural hospitals typically provide limited inpatient care compared to their urban counterparts, which may cause the RHC patients to seek inpatient service from other providers. In light of this, we believe small rural hospitals (less than 50 beds) that own and operate RHCs should not be expected to demonstrate that they serve the same patient population as the main provider. Therefore, we are revising the regulation to allow off-campus RHCs affiliated with small rural hospitals (less than 50 beds) to retain their provider-based status without satisfying that requirement.

Comment: Several commenters opposed the inclusion of paragraph (d)(7)(ii), since they view a State border as an arbitrary boundary inhibiting a hospital's ability to serve patients, which seems counterproductive. They also argued that a regulation that fails to recognize the operation of health care systems that function across State lines is unrealistic. Another commenter suggested that we rely on the proposal concerning serving the same patient population. It was also stated that in one case a provider can be located in a city

split by the State border with its related facility located one mile away, but in another state, while in another case, the provider and its subordinate facility can be a mile apart and in the same State. Another commenter believes that, since Medicare beneficiaries often cross borders for health care services, disallowing hospitals in these areas from establishing provider-based entities eliminates choices and prohibits the development of new services. The commenter recommended that we revise or eliminate this criterion. Another commenter suggested that LTHs and their satellites not be subject to this requirement if the main provider and its satellite are located in two contiguous States. Alternatively, the commenter suggested that we consider using the wage index areas as guidelines for the areas to be served by provider-based entities even if that area crosses State lines.

Response: After reviewing these comments, we have decided to revise the regulations to allow providers in one State to have provider-based facilities in an adjacent State, if doing so is not inconsistent with the law of either State, and other criteria are met, including those related to service to the same patient population.

Comment: With regard to paragraph (d)(7)(i), while the proposed rule permits a provider to show that a ''high percentage'' of patients of the main provider and the facility come from the same geographic region, new facilities would not have any historical data upon which to base this assertion, and therefore would fail to be able to demonstrate the criteria prior to operation. Another commenter believes the requirement may pose an impediment to new facilities being located in underserved or outlying areas. Thus, the commenters believe the same patient population requirement should not apply to new facilities, including new long-term care hospital satellites.

Response: We agree that it would be appropriate to establish a criterion that could be met by new facilities or organizations, and therefore have revised the final rule to include a special provision for new facilities or organizations. Under this revision, a new facility or organization, (one that has not been in operation for all of the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with us), may be considered to meet the criterion on service to the same patient population, if it is located in a zip code area included among those that (during the 12-month period described above) accounted for at least 75 percent of the patients served by the main provider. We note that this provision would not be limited to long-term care hospitals' satellites or their remote locations, but would be available to all new facilities or organizations.

Section 413.65(e) Provider-based status not applicable to joint ventures

Comment: Several commenters expressed concern that this criterion would prohibit the use of joint ventures for entities that want to participate as provider-based entities, and argued that such a prohibition would unnecessarily restrict hospital flexibility. One believes this provision should be eliminated. Another commenter suggested modification of paragraph (d)(2) of the rule to establish majority ownership as the standard rather than 100 percent ownership. Still other commenters suggested that provider-based status for facilities or organizations run as joint ventures should be permitted, as long as the hospital at which the facility is located has the equipment or service under its control.

Response: We reviewed these comments carefully, but did not make any changes in the regulations based on them. When a facility or organization is run as a joint venture of two or more providers, it is by definition under their joint control, and therefore cannot be an integral and subordinate part of any individual provider. We have no interest in discouraging such ventures, but continue to believe they do not qualify as provider-based.

Section 413.65(f) Management contracts

Comment: Several commenters expressed the view that the criterion under which the staff of the facility or organization must be employed by the provider or another organization other than a management company is too restrictive, and should be deleted. One commenter argued that, if the written contract maintains the responsibility and control for services in the hands of the main provider, the employer of the staff working at the site is not relevant. Another believes the criterion will discourage economic efficiencies. If a provider is able to demonstrate integration and subordination of the off-site facility based upon other provider-based criteria, the fact that a hospital chooses to provide certain services either directly through its own employees or indirectly through an independent contractor/management arrangements is irrelevant. Another commenter argued that the proposed criterion is inconsistent with: the provision of the Medicare statute that expressly permits coverage of ''services under arrangement''; with the hospital conditions of participation that recognize that contractors may be used to furnish patient care services; and with the Provider Reimbursement Manual, which recognizes that providers commonly contract for management services and the costs of the contract services may be allowed under Medicare principles of reimbursement. Still another commenter believes the proposed criterion would negatively impact the therapy profession, and could impact the health and safety of Medicare beneficiaries.

Response: We do not believe the criterion is overly restrictive, nor do we agree that employment of the staff of a facility or organization is irrelevant to the question of whether that facility or organization is an integral and subordinate part of a provider. On the contrary, employment of the staff of such a facility or organization will normally give the provider significant control over it, thus promoting integration. Conversely, if a facility or organization is staffed by personnel who are employed by another entity that has only a contractual relationship with the provider, the facility or organization may well be an integral and subordinate part of the management company, not of the provider.

We also do not agree that the criterion is inconsistent with section 1861(w)(1) of the Act, which permits providers to make arrangements for the provision of specific health services, nor do we believe adopting this criterion will undercut the ability of providers to have selective services provided under arrangements. In this regard, we point out that existing Medicare policy, stated in section 207 of the Medicare Hospital Manual (HCFA Publication 10), emphasizes the need for the hospital to exercise professional responsibility for the arranged-for services, not merely to serve as a billing mechanism for the other party. This is consistent with our view that section 1861(w)(1) was intended to allow specific health care services to be furnished under arrangements, but was never meant to be a vehicle by which a provider could nominally operate a facility or organization, but, in fact, contract out its operation to another entity. Finally, we note that while there are various sections of the hospital conditions of participation and the Provider Reimbursement Manual that recognize the possibility that specialized health care services or management services may be provided under contract, this does not indicate that providers may

contract out entire departments or services while claiming them as provider-based. To clarify the scope of the requirement on contracted services, we have revised it to state that management staff of the facility or organization (rather than health care or support staff) need not be employed directly by the provider. We have also revised the rule to clarify that if staff of the facility or organization (other than management staff) are employed by an organization other than the management company or the provider, it must be the same organization that also employs the staff of the main provider.

Section 413.65(g) Obligations of hospital outpatient departments and hospital-based entities

Section 413.65(g)(1)

Because of the direct relationship between the proposed changes in this section and those in § 489.24(b), comments on both proposals are discussed later, under § 489.24(b), ''Special responsibilities of Medicare hospitals in emergency cases.''

Comment: A commenter requested clarification as to the application of the anti-dumping requirement in the home health setting.

Response: Section 413.65(g)(1) states that the EMTALA requirements apply to hospital outpatient departments. EMTALA requirements would not apply to off-campus provider-based entities that are not hospital departments, such as home health agencies.

Section 413.65(g)(2)

Comment: While one commenter agreed with the requirement under § 413.65(g)(2) for billing of physician services with the appropriate site-of-service indicator, another commenter also believes there should be clarification that correct billing is the responsibility of the entity performing the billing function. Both commenters suggested that the hospital notify physicians who do their own billing that they must use the correct indicator; they agree that it should not be the responsibility of the hospital.

Response: We agree that physicians (or those to whom they assign their billing privileges) are responsible for appropriate billing, but note that physicians who practice in hospitals, including off-site hospital departments, do so under privileges granted by the hospital. Thus, we believe the hospital has a role in ensuring proper billing.

Section 413.65(g)(5)

Comment: Presently, provider-based clinics bill Medicare for the facility charge on a UB–92 form, and the physician fee is billed separately on a HCFA–1500 form, while other payers may accept a single bill for both charges. A commenter believes it is inappropriate to mandate that two bills be submitted for all patients, as long as charges for similar services are uniform regardless of payer.

Response: As explained further below, we have revised the final rule to eliminate the part of this criterion relating to billing of services to non-Medicare patients. We believe this responds to this commenter's concern.

Comment: Many commenters stated that Medicare should treat a facility that claims a facility fee as being provider-based even when other payers do not do so, reasoning that as long as the hospital claims that the patient is an outpatient for Medicare purposes, the practices of other payers, with respect to similar patients, are not significant, and should be ignored. Another commenter believes this requirement should be eliminated, because, in the commenter's view, it has no bearing on the outpatient services delivered to Medicare beneficiaries, and therefore does not affect Medicare reimbursement. To illustrate, a large commercial insurer does not have the capability to accept certain types of outpatient claims from hospitals; therefore, it requires claims for those services to be billed on a physician claim form, so hospitals will receive the proper reimbursement. If this criteria is retained as proposed, many hospital-based departments would not meet our criteria due to the nuances of other payers' policies, that are often contractual issues with providers. Still another commenter believes that we should reexamine the proposal made in paragraph (g)(5), and at a minimum, clarify what it means by its proposal mandating uniform ''treatment of all patients, for billing purposes, as hospital outpatients.'' If we are proposing to mandate that all outpatients be billed on the same basis, this would effectively extend Medicare direct billing or rebundling rules to all payers. In addition, this proposed requirement would not only be contrary to past policy and practice, but would affect departments that have differentiated billing practices. Another commenter stated that payers typically determine payments based upon how they define a particular service or their individual market power; Medicare certification of outpatient departments should not be influenced by how unrelated third parties pay for services to the patients they cover at these sites. Moreover, this criterion would be very difficult to implement, because hospitals can have hundreds of contracts with insurance companies and the providers that subcontract for part of the risk for plans.

Response: After review of the comments on this section, we have decided to revise it to restrict the requirement for uniform billing to Medicare patients only, thus allowing hospitals to bill other payers in whatever manner is appropriate under those payers' rules. As revised, § 413.65(g)(6) states that hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

Comment: A commenter stated that there appears to be some confusion as to whether this requirement applies to ''departments'' or all facilities and organizations seeking provider-based status. Also, the commenter asked if there is a provision of the proposed rule that mandates that a facility fee be charged to patients of facilities and organizations receiving provider-based status.

Response: As noted earlier, the proposed rule would not apply this criterion to provider-based entities (which may participate separately as providers) but only to provider-based departments. Regarding the second issue, we have, as described in response to the preceding comment, revised the final rule to eliminate the criterion regarding billing of payers other than Medicare.

Section 413.65(g)(7)

Comment: A commenter stated that requiring written notice for each patient (presumably signed by the patient), would be an overly burdensome requirement, and requested that the requirement allow for a clear, prominently displayed sign in lieu of individual notice. Another commenter believes that the proposed requirement would apply a standard to hospital outpatient departments that is not applied to any other site of service.

Response: First, we emphasize that notice is required only for Medicare beneficiaries, not for all patients. We recognize that providing notice will generate some burden for the provider, but believe that the protection it affords to patients warrants the requirement. We considered allowing the notice requirement to be satisfied through the posting of signs, as recommended by one commenter, but concluded that use of individual written notices would more effectively ensure that each

beneficiary receives the necessary information. In response to the comment concerning settings other than hospital outpatient departments, we note that in other settings, a patient is unlikely to be misled as to what type of facility is the site of treatment, so provision of notice is not required. To avoid confusion as to when the requirement applies, we have revised the final rule to state that notice is required only if the hospital outpatient department or provider-based entity is not located on the campus of the hospital that is the main provider. We have revised this final rule to specify that the notice must be in writing, must be one the beneficiary can read and understand, and must be given to the beneficiary's authorized representative if the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights.

Section 413.65(g)(9) (redesignated in this final rule as Section 413.65(h), Furnishing all services under arrangement)

Comment: A commenter observed that § 413.65(g)(9) does not preclude an outpatient facility from obtaining a certain type of service from an off-site supplier. If this is correct, if the service is provided on-site in the hospital's outpatient facility, it is not clear how the proposed regulations are intended to be applied. It would appear that if the facility is looked at as a whole, all services are not provided ''under arrangements''; therefore, paragraph (g)(9) of this section would not preclude the facility from being recognized as provider-based. However, in this case, the commenter stated that both licensure and ownership requirements would be difficult to satisfy. In most cases, that portion of the facility that is operated ''under arrangements'' with the hospital will not be on the hospital's license, nor will that portion necessarily be owned by the hospital. Thus, the commenter urged that the ''under arrangements'' portion of an outpatient facility be excluded from the licensure and ownership analyses.

Response: We agree that where a facility offers a variety of services, provision of a single type of service under arrangement would not prevent the facility from meeting this criterion. The criterion could not, of course, be met by a facility that furnished only a specific type of service (such as physical therapy), and provided that service only under arrangement. In the case envisioned by the second commenter, the facility would be out of compliance with licensure and ownership requirements, as well as the requirement involving services under arrangement, and we would agree that it could not be provider-based.

Comment: A commenter asked for clarification of ''under arrangements'', in reference to our other regulations that contain these terms. Also, the commenter requested clarification on the types of services to which this standard applies, that is, direct patient care as opposed to facility related services.

Response: The term ''arrangements'' is defined in section 1861(w)(1) of the Act and the Medicare regulations § 409.3, in that ''arrangements'' refers to arrangements that provide that Medicare payment made to the provider that arranged for the services discharges the liability of the beneficiary or any other person to pay for the services. We wish to emphasize that the provision will apply to patient care services, not housekeeping, security, billing, or other services that are not patient care services but are needed to support their provision.

Section 413.65(h) Inappropriate treatment of a facility or organization as provider-based (redesignated in this final rule as paragraph (i))

Comment: This section establishes sanctions that may be used to address a main provider that has treated an entity as provider-based without our review and approval. A commenter believes that the investigation phase should precede the review of payments to the main provider. A commenter was also concerned that the individuals involved in these reviews and investigations are properly trained to make the required determinations.

Response: We believe review of payments will encompass two activities—investigation to determine whether applicable provider-based requirements were met, and a calculation of the amount of overpayment if they were not. Thus, investigation necessarily precedes recovery, but is a part of the overall effort, which is to reconsider payment amounts. To respond more effectively to concerns about how the review and recovery activities will occur, and to clarify the specific actions we will take in cases of inappropriate billing, we have reorganized paragraph (i) to deal separately with the processes of determination and review, recovery of overpayments, and the good faith effort exception. With respect to determination and review, we state that if we learn that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, we will review current payments and, if necessary, take action in accordance with the rules on inappropriate billing in paragraph (j), investigate and determine whether the requirements for provider-based status in paragraph (d) of § 413.65 (or, for periods prior to October 10, 2000, the requirements in applicable program instructions) were met, and review all previous payments to that provider for all cost reporting periods subject to re-opening in accordance with § 405.1885 and § 405.1889 of this chapter. With respect to recovery of overpayments and the good faith exception, we have clarified that we will recover only the difference between the amount of payments that actually were made and the amount of payments that we estimate should have been made in the absence of a determination of provider-based status, and that recovery will not be made for any period prior to the effective date of these final rules if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of § 413.65. In response to the comment about the competence of individuals involved in these activities, we wish to emphasize that we will ensure that staff involved in these activities have the necessary expertise.

Comment: A commenter believes that it would be unfair to apply the proposed regulations retroactively, that is, to periods before the effective date of the final rule. Even though paragraphs (h) and (i) provide for a good faith exception, it is still unfair to provide that the conditions for this exception will apply prior to the effective date of the final regulation. The commenter requested that these sections be revised to provide that the period of recovery will not extend to any period prior to the effective date of the final regulations. Another commenter also believes that any payment changes be prospective (unless the hospital did not make a good faith effort to operate the site as provider-based).

Response: We agree that it would be inappropriate to apply the rules in paragraph (h) to any period prior to their effective date, and have revised the final rule to clarify that for such periods, we will make determinations based on the program memoranda or other instructions in effect at the time. However, the criteria in paragraph (i) that form the basis for a good faith exception were in effect prior to the issuance of these regulations. Regarding

the last comment, we cannot agree to ignore possible overpayments resulting from noncompliance with published criteria in effect at that time.

Comment: A commenter believes that the term ''good faith effort'' should be defined to provide more direction and opportunity to comply. Also, entities making ''good faith efforts'' should be given an opportunity to correct those factors or criteria that render it out of compliance with the provider-based requirements.

Response: The conditions under which a provider will be found to have made a good faith effort were clarified in § 413.65(i)(2), and have been restated in the final rule.

Section 413.65(i) Inappropriate billing (redesignated in this final rule as paragraph (j))

Comment: A commenter believes that suspending all payments for outpatient services to facilities that have billed inappropriately as provider-based entities until the provider can demonstrate that payments are proper is too onerous. Instead, the commenter suggested that we consider suspending the reimbursement differential between a provider-based entity and a nonprovider-based entity until a determination is made or the facility has had a reasonable opportunity to comply.

Response: We understand the commenter's concern and have revised the final rule to authorize partial suspension of payment (that is, a reduction in payment) to the extent needed to prevent creation of an overpayment to the provider. This rule will allow payment to continue at a reduced rate, thus avoiding creation of financial hardship for the provider. To describe more clearly how we will deal with instances of inappropriate billing, we have reorganized paragraph (j) of § 413.65 to spell out more clearly the actions we will take, and the extent to which payment will be adjusted. Specifically, we state that if we find that a facility or organization is being treated as provider-based without having obtained a determination of provider-based status under this section, we will notify the provider, adjust future payments, review previous payments, determine whether the facility or organization qualifies for provider-based status under this paragraph, and continue payments only under specific conditions. The notice to the provider will explain that payments for past cost reporting periods may be reviewed and recovered, that future payments for services in or of the facility or organization will be adjusted, and that a determination of provider-based status will be made.

We further state that we will not stop all payment in such cases, but instead, will adjust future payments to approximate as closely as possible the amounts that would be paid in the absence of a provider-based determination, if all other requirements for billing were met. We also explain that we will review previous payments and, if necessary, take action in accordance with the rules on inappropriate treatment of a facility or organization described above. The regulation states that we will determine whether the facility or organization qualifies for provider-based status under the criteria in this section. If we determine that the facility or organization qualifies for provider-based status, future payment for services at or by the facility or organization will be adjusted to reflect that determination. Even if the facility or organization does not qualify for provider-based status, however, we will continue paying, at an appropriately adjusted level, for a limited time period in order to avoid disruption of services to program beneficiaries at that site and to allow an orderly transition to freestanding status.

The notice of denial of provider-based status sent to the provider will ask the provider to notify us in writing, within 30 days of the date the notice is issued, as to whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. If the provider indicates that the facility, organization, or practitioners will not be seeking to enroll, or if we do not receive a response within 30 days of the date the notice was issued, all payment will end as of the 30th day after the date of notice. If the provider indicates that the facility or organization, or its practitioners, will be seeking to enroll and meet other requirements for billing for services in a free-standing facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(2) of this section for as long as is required for all billing requirements to be met (but not longer than 6 months) if—

- The facility or organization, or its practitioners, submit a complete enrollment application and provide all other required information within 90 days after the date of notice, and
- The facility or organization, or its practitioners, furnish all other information we need to process the enrollment application and verify that other billing requirements are met.

If the necessary applications or information are not provided, we will terminate all payment to the provider, facility, or organization as of the date we issue notice that necessary applications or information have not been submitted. We have clarified the final rule to state that these reductions will occur where inappropriate billing is or has been taking place.

Comment: A commenter believes that there are already existing mechanisms for overpayment and recoupment that may be used in the situations described in this section. At the very least, administrative actions of this type should be subject to time frames in order to protect providers from the impact of extended investigations.

Response: We plan to conduct any recovery efforts in accordance with applicable law and regulations on overpayment recovery. However, investigations may be complex and require examination of many records, and we do not agree that they should be limited by additional, self-imposed restrictions.

Comment: A commenter stated that a facility or organization that requests a provider-based determination prior to the effective date of the final rule, and meets the good faith requirements, should not be subject to recovery of overpayment for periods either before or after the effective date of the final rule. This will prevent disruptions to existing arrangements that meet the good faith exception during the time that the request is being processed.

Response: If we were to adopt this proposal, we would be guaranteeing an overpayment to providers who, for a specific time period, knowingly billed for services as those of provider-based entities, even though they met only a few of the provider-based criteria. Thus, we did not adopt this comment.

Comment: A commenter requested that the requirement found at paragraph (i)(2)(iii) be clarified to state that management is only responsible for professional services billed by the hospital.

Response: As explained earlier, we believe hospitals' privileging mechanisms give them adequate leverage to prevent inappropriate billing by practitioners using their facilities. Therefore, we did not adopt this comment.

Comment: As to the good faith criteria found in paragraph (i)(2), a commenter questioned why requirements related to public awareness were chosen for inclusion. An organization can represent itself to the public in any number of inaccurate ways in order to mislead our officials and others. The

commenter believes that we should focus our attention on more tangible expressions of good faith efforts to operate a provider based entity.

Response: We believe inclusion of this requirement is needed to help ensure that beneficiaries are protected from unexpected deductible and coinsurance liability. While we agree with the commenter that some providers may misrepresent the status of off-site facilities, we believe such providers cannot reasonably be said to have acted in good faith, and should not receive favorable treatment with respect to past overpayments.

Section 413.65(j) Correction of errors (redesignated in this final rule as paragraph (k))

Comment: A commenter disagreed with the language in this subsection that would allow us to review and rescind, if appropriate, any past determinations. The commenter believes that this subsection should be removed and any previous determinations should be grandfathered in under the new regulations. Other commenters recommended that we grandfather facilities or organizations that had previously been determined by the regional office to be provider-based, or that have not received such a determination but have been billing as provider-based without a determination for a period of at least ten years, so that those facilities or organizations could retain provider-based status even though they do not meet the criteria in the regulations.

Response: We do not agree that it would be appropriate to grandfather existing facilities or organizations, since this would in effect create an ongoing double standard, under which some facilities or organizations are held to higher standards than others. Moreover, the fact that improper billing may have continued undetected for a long period is not a reason to continue to permit such billing. As explained in the response to the following comment, however, any adverse determination regarding provider-based status of facilities or organizations which we previously determined were provider-based will not be effective until the start of the cost reporting period after the period in which the provider is notified of the redetermination, or for at least 6 months, whichever date is later.

Comment: A commenter believes that our proposal that we may review past provider-based determinations inserts needless uncertainty into the process for making provider-based designations. The commenter is concerned that providers may file before the final rule is published in order to avoid a crush of applications and subsequent disruption in payment, if they do not have a determination within 30 days of the rule becoming final. The commenter stated that providers need to be able to receive prompt determinations on which they can rely.

Response: We understand the concern about avoiding the need to process a large number of applications in a short time, and agree that it would not be appropriate to make abrupt changes in provider-based status. To avoid a possible crush of applications within a 30-day period, as envisioned by the commenter, we are providing the delayed effective date described earlier in this document. In addition, under § 413.65(j) of these regulations, when a facility or organization that previously was determined to be provider-based is found to no longer qualify for provider-based status, treatment of the facility or organization as provider-based will not cease until the first day of the first cost reporting period following notification of the redetermination, but not less than 6 months after the date the provider is notified of the redetermination. If there has been no prior determination of provider-based status, and a facility or organization is later found not to meet the criteria, that determination may be effective up to 6 months after the date the provider is notified of the determination, if within 30 days of the determination, the provider indicates that the facility or organization, or its practitioners, will enroll separately and, within 90 days, the facility or organization, or its practitioners, take other necessary action to enroll.

Section 489.24(b) Special responsibilities of Medicare hospitals in emergency cases

Comment: One commenter disagreed strongly with the proposed revisions to the regulation defining ''comes to the emergency department,'' and in particular expressed the view that patients arriving on the campus, sidewalk, driveway, or parking lot of hospital facilities should not be considered to have come to the emergency department. The commenter stated the view that an obligation under section 1867 of the Act (sometimes referred to as the Emergency Medical Treatment and Active Labor Act (EMTALA), after the original title of the legislation adding section 1867) and our regulations at §§ 489.20(l), (m), (q), and (r), and § 489.24 should be triggered only by a presentation to the emergency department, and that only in exceptional situations should EMTALA apply to someone not technically in the emergency department. The commenter recommended that the regulations be revised to state that in these cases, the hospital may rely on a variety of transport options, consistent with the individual's condition and established policies that are applied in a nondiscriminatory manner. The commenter also recommended that the statute be interpreted as requiring only that hospitals with emergency departments have policies and procedures to assure that a person who presents to the hospital requesting emergency services is provided a medical screening examination and, if needed, stabilization or an appropriate transfer.

Another commenter raised several arguments against the proposed change. The commenter stated that there is a legal and ethical conflict in requiring hospital personnel to leave an area of patient care and furnish assistance to another patient in a remote area of the hospital. The commenter also believes that ED personnel are not well-trained or practiced in immobilization or scene safety, and patients and staff may be put at risk if staff are asked to go into the field and render aid to a victim who needs the expert care and experience for which field emergency medical services (EMS) personnel are trained. Finally, the commenter expressed concern about possible increases in the liability insurance cost to hospitals as a result of the proposed change.

Response: We do not agree that the proposed language inappropriately extends the scope of hospitals' EMTALA responsibilities. On the contrary, existing regulations at § 489.24 make it clear that EMTALA applies to hospitals that offer services for emergency medical conditions, and we believe it would defeat the purpose of EMTALA if we were to allow hospitals to rely on narrow, legalistic definitions of ''comes to the emergency department'' or of ''emergency department'' to escape their EMTALA obligations. We would also note, as discussed further below, that there is no requirement that all areas of the hospital be equipped to provide emergency care or that treatment always be provided outside the emergency area or department. Similarly, there is no prohibition of appropriate transfers to other facilities where such a transfer is conducted in accordance with § 489.24. On the contrary, the intent of the revised regulation is to ensure that patients who come to the hospital and request examination or treatment for what may be an emergency medical condition are not denied EMTALA protection simply because they enter the

wrong part of the hospital or fail to make their way to the emergency room.

Comment: Two commenters recommended clarification of the applicability of section 1867 of the Act regarding transfer requirements to scheduled patients at an ''off-campus'' hospital site, to ensure that the movement of scheduled patients unexpectedly requiring a higher level of care to another site of the same hospital is not construed as a ''transfer'' under the emergency access law, and that only those patients taken from one hospital's off-campus facility to another hospital's emergency department or inpatient unit be considered ''transfers'' that must be in accordance with the requirements of section 1867.

Response: We agree that movement of a patient from one part of a hospital to another, including movement from a remote location to a main hospital campus, does not constitute a ''transfer'' for EMTALA purposes, nor does it require compliance with the appropriate transfer requirements in § 489.24(d). The final regulations at § 489.24(i)(3)(i) clarify this policy.

Comment: A commenter expressed the view that the proposed revision to § 489.24 does not recognize the role that EMS personnel play in emergency situations and the true medical benefit provided by EMS personnel to patients in emergency situations. The commenter recommended that language be included in the regulation to authorize hospitals' use of EMS in responding to emergency situations on hospital grounds.

Response: We agree that EMS personnel can play a valuable role in transporting patients to appropriate sources of emergency care. A hospital may not, however, meet its EMTALA obligations merely by summoning EMS personnel. EMS may be used appropriately in conjunction with an appropriate hospital response to treat and move an individual who is already on hospital property. We therefore did not make any change to these regulations to authorize exclusive use of EMS to respond to emergency situations on hospital property.

Comment: A number of commenters stated that the anti-dumping rules implemented under section 1867 of the Act (EMTALA requirements) and our regulations at §§ 489.20(l), (m), (q), and (r), and § 489.24 should apply to the hospital's main campus and to all emergency departments. However, they argued that it is not reasonable to apply these rules to outpatient departments located off-campus that would not be set up to provide emergency services. In the commenters' view, it should suffice that patients in an emergency situation be directed to the hospital's emergency room. Another commenter stated that EMTALA obligations should be limited to those hospital entities that hold themselves out as providing emergency services, and should not be enforceable anywhere outside the emergency department or anywhere on hospital property, including an outpatient department or provider-based entity. Another commenter stated that the enforcement of this requirement would lead to the elimination of service-specific outpatient departments located off a main campus, and asked that we reconsider our policy. One commenter expressed concern that patients identifying a facility as a hospital-based department could mistakenly assume it is equipped to handle emergency cases. Another commenter believes that hospitals should be required to have policies and procedures in place to assure that all parts of the hospital are prepared to deal with getting an individual the appropriate medical screening.

Response: Existing regulations at § 489.24(b) define ''hospital with an emergency department'' to include all hospitals that offer services for emergency medical conditions, not just those that have organized emergency rooms or departments. To the extent a hospital acquires or creates an off-campus location, identifies it to us and to the public as a part of that hospital, and claims payment for services at that location as hospital services, we believe it is not unreasonable to expect that hospital also to assume the obligations, including compliance with EMTALA requirements, which flow from hospital status. This principle does not mean, of course, that a hospital must have a fully equipped and staffed emergency department at each location. It also does not mean that every appearance by an individual at an off-campus hospital department that does not offer services for emergency medical conditions will necessarily trigger an EMTALA obligation on the part of the hospital. Individuals come to these departments for many medical purposes which may not involve potential emergency medical conditions. Under these circumstances, the hospital would not have an EMTALA obligation with respect to that individual. This principle does mean, however, that if an individual comes to an off-campus department of a hospital and a request is made for examination or treatment for a potential emergency medical condition, the hospital incurs an obligation to provide, *within its capability,* an appropriate medical screening examination and necessary stabilizing treatment. In some cases, the patient may need to be taken back to the main hospital campus for a full screening and/or stabilizing treatment. Under these circumstances, the hospital is responsible for moving the patient or arranging his or her safe transport, but this movement would not be considered a ''transfer'' under § 489.24(b), since the patient is merely going from one part of the hospital to another. If it is necessary to transfer the patient to another medical facility, the hospital must provide an appropriate transfer in accordance with § 489.24(d).

After review of the comments on this issue, we have decided to revise the regulations to state more clearly the extent of a hospital's EMTALA obligations with respect to patients who come to a hospital department located off the hospital's main campus. Provider-based entities, such as SNFs or HHAs, located off the hospital campus would not, of course, be subject to EMTALA since a patient coming to such an entity would not have come to the hospital. We will require that each off-campus hospital department, during its regular hours of operation, have in effect procedures for: (1) assessing the possibility that an emergency medical condition exists, and providing such screening (as defined in § 489.24(a) and (b)) and necessary stabilization (as defined in § 489.24(c)) at the off-campus site); (2) transporting the patient to the hospital's emergency room or department for screening and necessary stabilization meeting the requirements of § 489.24; or (3) providing an appropriate transfer to another facility in accordance with the requirements in § 489.24(c). To meet these requirements, the hospital will need to develop procedures that permit staff of the off-campus department to contact emergency physicians or other qualified emergency practitioners at the main hospital campus, to obtain advice and direction regarding the handling of any potential emergencies, and to obtain prompt medical transport, by hospital-owned or other ambulance or other appropriate vehicle, either to the main hospital campus or, where an appropriate transfer is being provided, to another medical facility.

Specifically, we are adding new paragraph (i) to § 489.24 to describe a hospital's obligations. The paragraph states that, if an individual comes to a facility or organization that is located off the main hospital campus as defined in § 413.65(b), but has been determined under § 413.65 of this chapter to be a department of the hospital, and a

request is made on the individual's behalf for examination or treatment of a potential emergency medical condition as otherwise described in paragraph (a) of § 489.24, the hospital is obligated to provide the individual with an appropriate medical screening examination and any necessary stabilizing treatment.

The capability of the hospital includes that of the hospital as a whole, not just the capability of the off-campus facility or organization. Except for cases described in paragraph (i)(3)(iii) (those in which the main hospital campus does not have the specialized capability or facilities needed to treat the individual, or the individual's condition is deteriorating so rapidly that transport to the main campus would significantly jeopardize the life or health of the individual), the obligation of a hospital under this section must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-site locations to be on standby for possible emergencies.

In § 489.24(i)(2), Protocols for off-campus departments, we further state that the hospital must establish protocols for the handling of potential emergency cases at off-campus departments. These protocols must include provision for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus, and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services. The intent of these requirements is to ensure timely exchange of information between the two sites, and to allow the hospital the flexibility to bring emergency personnel to the patient, rather than the opposite, where doing so is the best medical approach to meeting the patient's needs.

Under the final rule, if the off-campus department is an urgent care center, primary care center, or other facility that is routinely staffed by physicians, RNs, or LPNs, these personnel must be trained, and given appropriate protocols, for the handling of emergency cases. At least one individual on duty at the off-campus department during its regular hours of operation must be designated as a qualified medical person as described in paragraph (d). The qualified medical person must initiate screening of individuals who come to the off-campus department with a potential emergency medical condition, and may be able to complete the screening and provide any necessary stabilizing treatment at the off-campus department, or to arrange an appropriate transfer.

The final rule further states that if the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and reported symptoms and, if appropriate, arrange transportation of the individual to the main hospital campus (if the main hospital campus has the capability required by the individual, and movement to the main campus would not significantly jeopardize the individual's life or health), or assist in an appropriate transfer. Movement of the individual to the main campus of the hospital is not considered a transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

Finally, specific rules apply if the individual's condition warrants movement to a facility other than the main hospital campus, either because the main hospital campus does not have the specialized capability or facilities required by the individual, or because the individual's condition is deteriorating so quickly that taking the time required to move the individual to the main hospital campus could place the life or health of the individual in significant jeopardy. Under these circumstances, personnel at the off-campus department must, in accordance with protocols established in advance by the hospital, assist in arranging an appropriate transfer of the individual to a medical facility other than the main hospital. The hospital must have protocols to ensure that the movement is an appropriate transfer in accordance with paragraph (d)(2) of this section. The protocol must include procedures and agreements established in advance with other hospitals or medical facilities in the area of the off-campus department to facilitate these anticipated transfers. We note that the interpretive guidelines for enforcement of EMTALA requirements will be revised to conform to these new rules.

Section 498.3 Scope and applicability

Comment: A commenter asked for clarification as to whether appeal rights would be available in the event of revocation by us of provider-based status.

Response: We have revised § 489.3(b)(2) to specify that a determination that a facility or organization no longer qualifies for provider-based status is an initial determination, thus providing an administrative appeals mechanism for these decisions.

D. Requirements for Payment

We proposed to revise § 410.27, Outpatient Hospital Services and Supplies Incident to a Physician Service: Conditions, to require that services furnished at a location other than an RHC or an FQHC that we designate as having provider-based status under § 413.65 must be under the direct supervision of a physician as defined in § 410.32(b)(3)(ii).

Comment: Several commenters requested clarification of what we mean by ''direct supervision.'' One commenter asked that we further define the nature and extent of the supervision needed to comply with our proposal. One commenter asked whether the supervision requirement would be met if a physician is in the hospital or whether the physician must be in the department while the procedure is being performed. The same commenter asked whether the physician billing for the incident to services must be of the same specialty as the procedure being performed. A large trade association stated that we appear to be replacing our current policy in section 3112.4(A) of the Intermediary Manual, which states that we assume the physician supervision requirement to be met when incident to services are furnished on hospital premises, with a policy requiring direct physician supervision at all times, in all outpatient departments, regardless of whether or not they are located on the hospital campus. The commenter recommended that if we retain a direct supervision requirement, it should be limited to outpatient departments located off-site of the main provider. One commenter stated that facilities and organizations accorded provider-based status that are located on the main provider's campus should be subject to the same physician supervision requirements that apply to ''incident to'' services provided elsewhere on the campus.

Response: We regret that our proposal to define ''direct supervision'' by referring to the definition of ''direct supervision of a physician'' given at § 410.32(b)(3)(ii) may have been confusing to some commenters. Section 410.32(b)(3)(ii) defines ''direct supervision'' within (a physician) office

setting as meaning that the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. The definition at § 410.32(b)(3)(ii) goes on to state that ''direct supervision'' does not mean that the physician must be present in the room when the procedure is performed.

Our intention in the proposed rule was to define ''direct supervision'' of hospital outpatient services incident to physician services when they are furnished at a department of a hospital to mean that a physician must be present on the premises of the entity accorded status as a department of the hospital and, therefore, immediately available to furnish assistance and direction for as long as patients are being treated at the site. By ''direct supervision'' we do not mean that the physician must physically be in the room where a procedure or service is furnished. Nor does the supervising physician necessarily have to be of the same specialty as the procedure or service that is being performed. We emphasize that our proposed amendment of § 410.27 to require direct supervision of hospital services furnished incident to a physician service to outpatients applies to services furnished at an entity that is located off the campus of a hospital that we designate as having provider-based status as a department of a hospital in accordance with the provisions of § 413.65. Our proposed amendment of § 410.27 to require direct supervision of hospital services furnished incident to a physician service to outpatients does not apply to services furnished in a department of a hospital that is located on the campus of that hospital. For hospital services furnished incident to a physician service to outpatients in a department of a hospital that is located on the campus of the hospital, we assume the direct supervision requirement to be met as we explain in section 3112.4(A) of the Intermediary Manual. The requirement at § 410.27 does not affect the definition of physician supervision in section 3112.4(A) of the Intermediary Manual. In response to these comments, we have revised our definition of ''direct supervision by a physician'' in the final regulation.

Comment: A major trade association asserted that requiring a physician to be on-site at a provider-based entity throughout the performance of all ''incident to'' services would be burdensome and costly for hospitals where there are a limited number of physicians available to provide coverage, particularly in rural settings. Another commenter believes that entities with provider-based status should not be subject to physician supervision requirements that are more stringent than those applicable to free-standing facilities. A third commenter believes that this requirement is unnecessary because the requirements for integration with the hospital and other requirements for provider-based status include adequate checks and balances to ensure quality care. The commenter recommended that this proposal be omitted from the final rule with the potential for a separate, better defined, proposal at a later date.

Response: We disagree with commenters who believe the proposed supervision requirement is not necessary or that it would be burdensome to the hospital. First, the supervision requirement is separate from and independent of the provider-based requirements, and hospitals and physicians already have to meet a direct supervision of ''incident to'' services requirement that is unrelated to provider-based issues. That is, we require that hospital services and supplies furnished to outpatients that are incident to physician services be furnished on a physician's order by hospital personnel and under a physician's supervision (Intermediary Manual, section 3112.4(A)). We assume the physician supervision requirement is met on hospital premises because staff physicians would always be nearby within the hospital. The effect of the regulations in this final rule is to extend this assumption to a department of a provider that is located on the campus of a hospital. However, the regulation *does not* extend the assumption of supervision to a department of a hospital that is located off the campus of the hospital. We would not extend this assumption to a provider-based entity, regardless of its location, because the ''incident to'' requirement in § 410.27(a)(1)(iii) applies only to hospitals. Also, as we state above, satisfying the requirements to be designated provider-based is unrelated to our requirement that hospital services furnished incident to a physician service to outpatients at an entity that has provider-based status be under the direct supervision of a physician. Finally, this supervision requirement is entirely consistent with the direct supervision requirements currently set forth in the Medicare Carriers Manual, Part 3, section 2050.1(B).

Comment: One commenter suggested that partial hospitalization services furnished by a hospital to its outpatients be exempt from the outpatient department ''incident to'' requirements, or that other requirements be drafted that would, in the commenter's opinion, be more appropriate to the nature of this care.

Response: Section 1861(s)(2)(B) restricts coverage of partial hospitalization services furnished by a hospital to its outpatients to services that meet ''incident to'' requirements. We do not have the discretion to ignore this statutory restriction.

Comment: One commenter asked that we provide an exception to the direct supervision requirement in the case of physical therapy services. The commenter questioned why therapists who furnish the same services in a provider-based entity that they would furnish in an independent practice should be subject to direct physician supervision in one setting and not the other.

Response: The provision on coverage for outpatient physical therapy and occupational therapy services does not require that they be ''incident to'' physician services (see section 1861(s)(2)(D) of the Act). Therefore, there is no need to exempt them from the supervision requirement for outpatient hospital services incident to a physician service that is furnished at a provider-based entity. We therefore made no change in the final regulation based on this comment.

Comment: One commenter suggested that we modify our proposed regulation to waive the direct supervision requirement in entities with provider-based status for certain procedures for which we already waive the direct supervision requirement when the procedures are performed on homebound patients, as set forth in section 2051 of the Medicare Carriers Manual. The commenter believes that general supervision is sufficient for these waived services, for example, the physician need not be present, but the services must be performed under a physician's overall supervision and control, and ordered by a physician.

Response: Under section 2050.2 of the Medicare Carriers Manual, subject to certain requirements, we waive the direct supervision requirement when the following services are furnished to homebound patients: injections; venipuncture; EKGs; therapeutic exercises; insertion and sterile irrigation of a catheter; changing of catheters and collection of catheterized specimen for urinalysis and culture; dressing changes, for example, the most common chronic conditions that may need dressing changes are decubitus care and gangrene; replacement and/or insertion of nasogastric tubes; removal of fecal

impaction, including enemas; sputum collection for gram stain and culture, and possible acid-fast and/or fungal stain and culture; paraffin bath therapy for hands and/or feet in rheumatoid arthritis or osteoarthritis; and, teaching and training the patient for the care of colostomy and ileostomy, the care of permanent tracheostomy, testing urine and care of the feet (diabetic patients only), and blood pressure monitoring. While we believe the commenter's suggestion has merit, we do not believe it would be appropriate to adopt it before we have had time to analyze the issue further. Therefore, we did not revise the final rule based on this comment.

In our proposed rule, we proposed to require that the same supervision levels established for diagnostic x-ray and other diagnostic tests in accordance with § 410.32(b)(3) be required when these tests are furnished at an entity that has been accorded provider-based status by us.

Comment: A large industry federation generally favored our requiring that diagnostic tests be furnished at provider-based entities under levels of physician supervision that we specify, consistent with the definitions of general, direct, and personal supervision established at § 410.32(b)(3). The commenter suggested that we modify the definition of general supervision to make it clear that the training of nonphysician personnel and the maintenance of necessary equipment and supplies are the responsibility of the hospital, not the physicians.

Response: We agree and we will modify our regulation accordingly.

Comment: Numerous commenters, including radiology and imaging specialty groups, neurologists, vascular technologists, and sonographers, questioned the level of supervision required for various specific diagnostic tests and services.

Response: Our model for this proposed requirement was the requirement for physician supervision for diagnostic tests payable under the Medicare physician fee schedule that was issued in the October 31, 1997 physician fee schedule final rule (for CY 1998) (62 FR 59048). There have been issues raised about the appropriate level of supervision for some specific diagnostic services, similar to the comments we received about our proposed regulation. We have not yet resolved these issues, and this final rule is not the place to convey decisions about appropriate supervision levels for specific diagnostic tests and services by individual HCPCS code. In January 1998, we sent a memorandum to all Associate Regional Administrators advising them to instruct carriers to follow their existing policies on physician supervision of diagnostic tests until we provide further instruction. We intend to instruct hospitals and intermediaries to use the October 31, 1997 physician supervision requirements as a guide, pending issuance of updated requirements. In the meantime, fiscal intermediaries, in consultation with their medical directors, will define appropriate supervision levels for services not listed in the October 31, 1997 final rule when those services are furnished at an entity with provider-based status in order to determine whether claims for these services are reasonable and necessary.

V. Summary of and Response to MedPAC Recommendations

The following are additional recommendations contained in the report on Medicare payment policy that the Medicare Payment Advisory Commission submitted to the Congress in March 1999. (MedPAC, *Report to the Congress: Medicare Payment Policy,* March 1999.) We respond to recommendations that are specifically related to a particular component of the hospital outpatient PPS in the appropriate section of this preamble.

MedPAC Recommendation: MedPAC recommends that the Secretary evaluate payment amounts under the hospital outpatient PPS and the ambulatory surgical center (ASC) PPS along with the practice expense payments under the Medicare physician fee schedule for services furnished in physicians' offices to ensure that the differing payments made under the three payment systems do not create unwarranted financial incentives regarding site of care.

Response: We agree that the three payment systems should avoid creating unnecessary financial incentives to deliver care in particular settings. We will consider this matter further and evaluate differences in payments.

MedPAC Recommendation: MedPAC recommends that the Secretary study means of adjusting base prospective payment rates across ambulatory settings for patient characteristics such as age, frailty, comorbidities and coexisting conditions, and other measurable traits. Under this approach, payment would be less dependent on the type of facility and more dependent on the relative costliness of furnishing specific services to individual patients. MedPAC notes that no viable patient-level adjuster currently exists that could be used in this fashion.

As an interim measure, MedPAC recommends, with reservations, that HCFA evaluate facility-level adjustments in order to preserve access to care for particularly vulnerable segments of the Medicare population.

Response: The underlying premise in this recommendation, as MedPAC states, is that HCFA should move toward development of a more unified and rational payment system for ambulatory care. Many powerful arguments favor such a system, but the challenges of creating and implementing it are substantial. We will give further consideration to the recommendation to study possible adjustments that could be used in various settings.

We agree that we should evaluate the need for facility-level adjustments. We believe the best course is to evaluate the need for these adjustments during the next several years as we gain actual experience with the operation of the hospital outpatient PPS and are able to observe the effects on particular provider groups. In consideration of the transitional protections provided by the BBRA 1999, we have not adopted facility-level adjustments, other than an adjustment for local labor costs, at this time.

MedPAC Recommendation: MedPAC recommends that the Secretary seek legislation to develop and implement a single update mechanism that would link conversion factor updates to volume growth across all ambulatory care settings. These settings include hospital outpatient departments, physicians' offices, and ASCs, as well as other specific settings mentioned.

Response: We believe that this proposal requires further study to determine its feasibility and possible impact. Therefore, we are not prepared to seek legislation at this time.

MedPAC Recommendation: MedPAC recommends that we not use patient diagnosis to calculate relative weights or make payments for medical visits, ''given the current state of the available data and the lack of definitive rules for reporting patients' diagnoses under the proposed system.''

Response: As discussed in section III.C.3, we have dropped diagnosis from our characterization of medical visit APCs. We hope to develop procedure codes for medical visits that are more descriptive of hospital outpatient resource use, rather than physician services. Once we revise procedure coding to better reflect hospital services, we will assess whether accurate diagnosis coding further improves recognition of resources.

MedPAC Recommendation: MedPAC recommends that the Secretary closely

monitor the use of hospital outpatient services to ensure that beneficiary access to care is not compromised.

Response: We plan to evaluate the operation of the new PPS to address a variety of issues, including beneficiary access to care. We note that the provisions of the BBRA 1999 should mitigate substantially any payment reductions and hence the possibility of reduced access.

MedPAC Recommendation: MedPAC recommends that the Secretary consider making payment adjustments in addition to the proposed adjustment for local area wages under the new system. These adjustments should be tied to patient characteristics. The facility-level adjustments that are made until the time that a patient-level adjuster is available should reflect the population of Medicare patients treated by facilities identified to receive the adjustments.

MedPAC points out that HCFA, in setting Medicare payment rates for hospital inpatient services, adjusts payments based on the costs or provider characteristics of hospitals (for example, sole community hospitals). Rather than continuing this practice in the outpatient setting, MedPAC recommends that HCFA move toward making adjustments based on patient characteristics and the relative costliness of resources required in furnishing care to differing patients. Any differences in the payment of the same ambulatory care service should be based on patient characteristics, rather than on the setting. MedPAC recommends that HCFA evaluate any relationships between immutable patient characteristics and the cost of furnishing care.

Response: Other than those adjustments specified in sections 201 and 202 of the BBRA 1999, we have made no additional adjustments in this final rule. We will consider the possibility of adjustments in the future once we have actual experience with operation of the hospital outpatient PPS and can examine its effects. The extent to which adjustments at the level of patient characteristics will be feasible is unclear and would require further study.

VI. Provisions of the Final Rule

The provisions of this final rule reflect the provisions of the September 8, 1998 proposed rule, except as noted elsewhere in this preamble. Following is a synopsis of the major changes we have made, either in response to comments or in order to implement provisions of the BBRA 1999 that apply to the hospital outpatient prospective payment system.

For our proposal to adjust the CY 2002 update of the conversion factor by the percentage that actual CY 2000 payments exceed the estimated CY 2000 expenditure target, we are delaying implementation of the volume control mechanism for 2 years.

For our proposal to package costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis, we are making the following changes:

- We are creating separate APC groups to pay for blood, blood products, and anti-hemophilic factors, for splints and casts, and for certain very costly drugs that are not included in the transitional pass-through payment provision.
- We are paying separately, at cost, for the acquisition of corneal tissue.
- As required by section 201(e) of the BBRA 1999, we are *not* paying for certain implantable items under the DMEPOS fee schedule, but are including them as covered outpatient services. We are packaging the costs of these items into the APC payment rate for the procedures or services with which they are associated. These include implantable items used in connection with diagnostic tests, implantable DME, and implantable prosthetic devices.

For our proposal to base payment for medical visits to clinics and emergency departments on diagnosis codes as well as HCPCS codes, we are not using diagnosis codes at this time.

For our proposal to classify a new technology procedure or service within the APC group that it most closely resembles in terms of clinical characteristics and resource utilization, pending collection of additional pricing data, we are creating separate APC groups to which we can temporarily classify new technology services while we gather additional data and gain pricing experience. We are also creating a process under which interested parties may submit requests for consideration of services that may be eligible for payment as new technology.

For our proposal to pay for drugs, pharmaceuticals, and biologicals (except for cancer therapy drugs and certain infrequently used but very expensive drugs) as part of the APC payment for the service or procedure with which they are used, we are establishing transitional pass-through payments, as directed by section 201(b) of the BBRA 1999. Under this provision, an additional payment will be made for current orphan drugs, current cancer therapy drugs, biologicals, and brachytherapy, and current radiopharmaceutical drugs and biological products.

For our proposal to classify a new or innovative medical device, drug or biological (for which we were not making payment as of December 31, 1996) within the APC group that it most closely resembles in terms of clinical characteristics and resource utilization, pending collection of additional pricing data, we are establishing transitional pass-through payments. Under this provision, as directed by section 201(b) of the BBRA 1999, an additional payment will be made for new or innovative devices, drugs, and biologicals whose cost is not insignificant in relation to the APC payment for the group of services with which they are used.

For our proposal not to establish an outlier adjustment, as directed by section 201(a) of the BBRA 1999, we will make an outlier payment when calculated bill costs exceed 2.5 times the PPS payment for a service.

For our proposal to determine comparability of resources and clinical characteristics among the codes within an APC group based on our claims data and the analyses and judgment of our medical advisors, supported by comments from medical specialty societies and trade associations, as provided in section 201(g) of the BBRA 1999, we are limiting the variation so that the highest median cost of an item or service in an APC group is no more than two times the lowest median cost of an item or service within that group. We will also consult with an expert outside advisory panel regarding the clinical integrity of the APC groups and weights as part of our update of the PPS.

For our proposal to periodically review and update payment weights, APC groups, and other elements of the hospital outpatient PPS, as required by section 201(h) of the BBRA 1999, we will annually review the groups, relative payment weights, and the wage and other adjustments that are a part of the PPS.

For our proposal to implement the hospital outpatient PPS fully and in its entirety for all hospitals beginning as early as possible in CY 2000, with no phase-in period, as required by section 202(a) of the BBRA 1999, we are establishing transitional corridors for services furnished before January 1, 2004 to limit losses facilities might otherwise face.

For our proposal not to make any adjustments for any specific classes of hospitals, we are holding small rural hospitals harmless through CY 2003 in accordance with the requirements set by section 202(a)(3) of the BBRA 1999,

which added section 1833(t)(7)(D)(i) to the Act. Also, we are holding cancer centers permanently harmless in accordance with the requirements set by section 202(a)(3) of the BBRA 1999.

For our proposal on beneficiary coinsurance payment amounts, we are limiting the coinsurance amount for a procedure to be no more than the hospital inpatient deductible, as specified in section 204(a)(3) of the BBRA 1999.

The following is a synopsis of the principal changes that we are making in the provider-based requirements:

For our proposal to require main providers and provider-based entities to share a common license, we will require common licensure only where State law permits it. Where State law prohibits it or is silent, we will not apply the licensure requirement. We will also exempt IHS facilities and facilities located on Tribal lands from this requirement.

For our proposal requiring a main provider and a provider-based entity to serve a common service area indicated largely by overlapping patient populations, we have redefined ''common service area'' to mean a 75 percent threshold of patients who reside in a zip code area that is common to the main provider and the provider-based entity.

For our proposal to require provider-based entities to be in the same State as the main provider, we will allow providers in one State to have provider-based facilities in an adjacent State, if doing so is consistent both with the law of the affected States and with other criteria, including those related to a common service area.

For our proposal to require that a provider-based outpatient department bill all payers as an outpatient department, we have rescinded this requirement.

For our proposal to require FQHCs that have been billing Medicare as hospital outpatient departments to comply with the provider-based requirements, we are grandfathering both FQHCs and FQHC ''look-alikes'' (facilities that are organized as FQHCs but do not receive grants) so that these facilities will be considered departments of providers without having to meet § 413.65 requirements.

For our proposal to apply the provider-based requirements to Indian Health Service (including tribally operated) entities, we are creating a permanent exception for those entities that were billing as departments of IHS or Tribal hospitals on or before October 10, 2000.

For our proposal to consider provider-based entities to be part of the hospital for Emergency Medical Treatment and Active Labor Act (EMTALA) (''anti-dumping'' purposes), we are maintaining the principle that off-site hospital facilities are subject to EMTALA. We have clarified the obligations of hospitals with respect to these locations to ensure they are consistent with staffing patterns and resources.

For our proposal to apply provider-based criteria to inpatient facilities such as multi-campus hospitals created by mergers and satellites of PPS-excluded hospitals that are created by hospitals leasing space in other hospitals, we have clarified the applicability of provider-based criteria to remote locations of hospitals and hospital satellite facilities.

VII. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 30-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 PRA requires that we solicit comment on the following issues:

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

We are soliciting public comment on each of these issues for the provisions summarized below that contain information collection requirements:

Section 413.24 Adequate cost data and cost finding

Section 413.24(d)(6)(ii) states that a provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as nonreimbursable cost centers in the provider's trial balance. While these information collection requirements are subject to the PRA, the burden associated with these requirements is captured under §§ 413.65(c)(1) and (c)(2) below.

Section 413.65 Requirements for a determination that a facility or an organization is a department of a provider or a provider-based entity

Section 413.65(b)(2) states that a provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider begins billing for services of the facility or organization as if they were furnished by a department of the provider-based entity, or before it includes costs of those services on its cost report. While these information collection requirements are subject to the PRA, the burden associated with these requirements is captured under §§ 413.65(c)(1) and (c)(2) below.

Sections 413.65(c)(1) and (c)(2) state that a main provider that acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status, if the facility or organization is located off the campus of the provider or would increase the provider's total costs by at least 5 percent. Furthermore, a main provider that has had one or more entities considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

The burden associated with this requirement is the time for the main provider to report its acquisition to HCFA, furnish all information needed for a determination, report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization. It is estimated that 105 main providers will take 10 hours for a total of 1,050 hours.

Section 413.65(d)(4)(v) states that medical records for patients treated in a facility or organization must be integrated and maintained into a unified retrieval system (or cross reference) of the main provider. The burden

associated with this requirement is the time required for the main provider to maintain medical records in a unified retrieval system. While this requirement is subject to the PRA, we believe this requirement is a usual and customary business activity and the burden associated with this requirement is exempt from the PRA, as stipulated under 5 CFR 1320.3(b)(2) and (b)(3).

Section 413.65(d)(7)(i) requires that for a facility or organization and the main provider that is not located on the same campus, the facility or organization must demonstrate a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with HCFA, and for each subsequent 12-month period meet the requirements of paragraphs (d)(7)(i)(A), (B), or (C) of this section. While the information collection requirements listed below are subject to the PRA, the burden associated with these requirements is captured under §§ 413.65(c)(1) and (c)(2).

Section 413.65(g)(7) states that when a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity, the hospital has a duty to notify the beneficiary, prior to the delivery of services, of the beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service).

The burden associated with this requirement is the time for the provider to disseminate information to each beneficiary of the beneficiary's potential financial liability (that is, a coinsurance liability for a facility visit as well as for the physician service). It is estimated that 750 providers will make on average 667 disclosures on an annual basis, at 3 minutes per disclosure, for a total annual burden of 25,013 hours.

Section 413.65(j)(5) requires that upon notice of denial of provider-based status sent to the provider by HCFA, the notice will ask the provider to notify HCFA in writing, within 30 days of the date the notice is issued, of whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. This requirement is exempt from the PRA as stipulated under 5 CFR 1320.4(a)(2).

Further, if the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, the facility or organization must submit a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization, or its practitioners, furnish all other information needed by HCFA to process the enrollment application and verify that other billing requirements are met. The requirements and burden associated with the provider enrollment process are currently approved under OMB control number 0938–0685, with a current expiration date of September 30, 2001.

Section 424.24 Requirements for Medical and Other Health Services Furnished by Providers Under Medicare Part B

Section 424.24(e)(3)(i) requires that when a partial hospitalization service occurs the physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment. While this signature requirement is subject to the PRA, the overall requirements associated with physician recertification, as currently referenced in HCFA regulation number HCFA–1006, published in the **Federal Register** on June 5, 1998, have not yet been approved by OMB under the PRA. Therefore, we continue to solicit comment on all of the requirements and associated burden referenced in § 424.24.

Section 419.42 Hospital Election To Reduce Copayment

Sections 419.42(b) and (c) state that a hospital must notify its fiscal intermediary of its election to reduce copayments no later than June 1, 2000 prior to the date the PPS is implemented or for subsequent calendar years, beginning with elections for calendar year 2001, no later than December 1 of the preceding calendar year. The hospital's election must be properly documented. It must specifically identify the ambulatory payment classification to which it applies and the coinsurance amounts (within the limits identified within this regulation) that the hospital has elected for each group.

The burden associated with these requirements is the time it takes a hospital to compile, review, and analyze data for both revenues and coinsurance; prepare and present the data to the hospital board; make a business decision as to whether the hospital would elect to reduce coinsurance; and then notify its fiscal intermediary of its election. A hospital would notify its fiscal intermediary of its election to reduce coinsurance only if there were other providers, in close proximity, that would attract a majority of the hospital's business if they did not reduce their coinsurance. Since hospitals do not want to lose money by absorbing coinsurance, we anticipate that this requirement will affect 750 hospitals and take them 10 hours each for a total of 7,500 hours.

Section 419.42(e) states that the hospital may advertise and otherwise disseminate information concerning the reduced level(s) of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that these coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not applicable in any other ambulatory settings or physician offices.

The burden associated with this requirement is the time for the hospital to disseminate information concerning its coinsurance election. It is estimated that 750 hospitals will each take 10 hours annually to disseminate this information via newsletters and information sessions at senior citizen centers for a total of 7,500 hours.

We have submitted a copy of this final rule to OMB for its review of the information collection requirements. These requirements are not effective until they have been approved by OMB. A notice will be published in the **Federal Register** when approval is obtained.

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

Health Care Financing Administration, Office of Information Services, Information Technology Investment Management Group, Division of HCFA Enterprise Standards, Room C2–26–17, 7500 Security Boulevard, Baltimore, MD 21244–1850, Attn: John Burke HCFA–1005–FC/R–240,

and

Office of Information and Regulatory Affairs, Office of Management and Budget, Room 10235, New Executive Office Building, Washington, DC 20503, Attn.: Allison Herron Eydt, HCFA–1005–FC.

VIII. Response to Comments

Because of the large number of items of correspondence we normally receive on **Federal Register** documents published for comment, we are not able to acknowledge or respond to them individually. Comments on the provision of this final rule that implement provisions of the BBRA 1999 will be considered if we receive them by the date and time specified in the DATES section of this preamble. We will not consider comments concerning provisions that remain unchanged from the September 8, 1998 proposed rule or that were changed based on public comments.

IX. Regulatory Impact Analysis

A. Introduction

Section 804(2) of title 5, United States Code (as added by section 251 of Pub. L. 104–121), specifies that a ''major rule'' is any rule that the Office of Management and Budget finds is likely to result in—

- An annual effect on the economy of $100 million or more;
- A major increase in costs or prices for consumers, individual industries, Federal, State, or local government agencies, or geographic regions; or
- Significant adverse effects on competition, employment, investment productivity, innovation, or on the ability of United States based enterprises to compete with foreign-based enterprises in domestic and export markets.

We estimate, based on a simulation model, that the effect on hospitals participating in the Medicare program associated with this final rule would be to increase Medicare payments by $600 million in calendar year 2000. This figure includes beneficiary copayments. We estimate that the additional expenditures to hospitals from the Part B Trust Fund associated with this final rule will be $490 million in fiscal year 2000. Therefore, this rule is a major rule as defined in Title 5, United States Code, section 804(2).

We have examined the impacts of this final rule as required by Executive Order 12866, the Unfunded Mandates Reform Act of 1995, and the Regulatory Flexibility Act (RFA) (Public Law 96–354). Executive Order 12866 directs agencies to assess all costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more annually). Because the projected spending resulting from this final rule is expected to exceed $100 million, it is considered a major rule for purposes of the RFA.

The Unfunded Mandates Reform Act of 1995 also requires (in section 202) that agencies prepare an assessment of anticipated costs and benefits for any rule that may result in an expenditure in any 1 year by State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million. This final rule does not mandate any requirements for State, local, or tribal governments.

We generally prepare a regulatory flexibility analysis that is consistent with the RFA (5 U.S.C. 601 through 612), unless we certify that a final rule will not have a significant economic impact on a substantial number of small entities. For purposes of the RFA, we consider all hospitals to be small entities.

Also, section 1102(b) of the Social Security Act requires us to prepare a regulatory impact analysis for any final rule that may have a significant impact on the operations of a substantial number of small rural hospitals. Such an analysis must conform to the provisions of section 604 of the RFA. With the exception of hospitals located in certain New England counties, for purposes of section 1102(b) of the Act, we define a small rural hospital as a hospital with fewer than 100 beds that is located outside of a Metropolitan Statistical Area (MSA) or New England County Metropolitan Area (NECMA). Section 601(g) of the Social Security Amendments of 1983 (Pub. L. 98–21) designated hospitals in certain New England counties as belonging to the adjacent NECMA. Thus, for purposes of the proposed prospective payment system, we classify these hospitals as urban hospitals.

B. Estimated Impact on the Medicare Program

Our Office of the Actuary projects that the additional benefit expenditures from the Part B Trust Fund resulting from implementation of the hospital outpatient PPS for hospital outpatient services furnished on or after July 1, 2000, and the hospital outpatient provisions enacted by the BBRA 1999, are as follows:

Fiscal year	Impact (In millions of dollars)
2000	490
2001	3,030
2002	3,520
2003	4,230
2004	4,670

C. Objectives

The primary objective of the hospital outpatient prospective payment system is to simplify the payment system and encourage hospital efficiency in providing outpatient services, while at the same time ensuring that payments are sufficient to compensate hospitals adequately for their legitimate costs. Another important goal of the new system is to reduce beneficiaries' share of outpatient payment to hospitals by freezing coinsurance amounts at an absolute level until they equal 20 percent of the total payment amounts.

We believe that implementation of the final PPS will ultimately further each of these goals while maintaining the financial viability of the hospital industry and ensuring access to high quality health care for Medicare beneficiaries. We expect that the provisions of this final rule with comment period will ensure that the outcomes of the PPS are reasonable and equitable while avoiding or minimizing unintended adverse consequences.

D. Limitations of Our Analysis

The following quantitative analysis presents the projected effects of our policy changes resulting from comments, as well as statutory changes enacted by the BBRA 1999, on various hospital groups. We use the best data available. In addition, we do not make adjustments for future changes in such variables as volume and intensity. For this final rule with comment period, we are soliciting comments and information about the anticipated effects of the changes on hospitals resulting from implementation of the hospital outpatient provisions of the BBRA 1999, and our methodology for estimating them.

E. Hospitals Included In and Excluded From the Prospective Payment System

The outpatient prospective payment system encompasses nearly all hospitals that participate in the Medicare program. However, Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the PPS. Critical access hospitals (CAHs) are also excluded and are paid at cost under section 1834(g) of the Act.

F. Quantitative Analysis of the Impact of Policy Changes on Payment Under the Hospital Outpatient PPS: Basis and Methodology of Estimates

We have analyzed the impact on hospital payment under the outpatient PPS. Our analysis compares the payment impact of PPS compared to current law. The definition and calculation of current law used in the impact analysis is the same used in estimating the conversion factor. That is, current law reflects pre-PPS payment methodologies in effect on January 1, 2000, and prior to July 1, 2000, which include the elimination of the formula-driven overpayment and application of the capital and operating cost reductions. A detailed explanation of the current law calculation can be found in section III.E.2.a.

The data used in developing the quantitative analyses presented below are taken from the CY 1996 cost and charge data and the most current provider-specific file that is used for payment purposes. Our analysis has several qualifications. First, we draw upon various sources for the data used to categorize hospitals in Table 2, below. In some cases, there is a degree of variation in the data from the different sources. We have attempted to construct these variables with the best available source overall. For individual hospitals, however, some miscategorizations are possible.

Using CY 1996 cost and charge data, we simulated payments using the pre-PPS and PPS payment methodologies. Although we used only single-procedure/visit bills to determine APC relative payment weights, we used both single and multiple-procedure bills in the conversion factor and service mix calculations, regressions, and impact analyses. Both pre-PPS and PPS payment estimates include operating and capital costs, adjusted to the calendar year 1996 cost reporting period. We excluded Kaiser, New York Health and Hospital Corporation, and all-inclusive providers because reported charges on their cost reports are not actual charges. Cost-to-charge ratios for these hospitals are not comparable to all other hospitals. The excluded Maryland hospitals were not included in the calculation of the conversion factor and the simulations; however, we did include the 10 cancer hospitals that will be paid under the PPS.

We also trimmed outlier hospitals from the impact analysis because inclusion of hospitals with extremely high and low unit costs would not allow us to assess the impacts among the various classes of hospitals accurately. First, we identified all of the outlier hospitals by using an edit of 3 standard deviations from the mean of the logged unit costs. Trimming the data in this manner ensures that only the hospitals with aberrantly high and low costs are eliminated from the impact analysis. In doing this, we removed 97 hospitals of which 41 hospitals had extremely low unit costs and 56 hospitals had extremely high unit costs. We conducted a thorough analysis of these hospitals to ensure that we did not remove any particular type of hospital (for example, teaching hospitals) that would further harm the integrity of the data. We speculate that many of these hospitals are not coding accurately, and we will continue to perform further analysis in this area following implementation of the PPS.

After we removed the 58 excluded Maryland hospitals, the all-inclusive rate hospitals, the statistical outlier hospitals, and hospitals for which we could not identify payment variables, we used the remaining 5,362 hospitals as the basis for our analysis. Table 2, Annual Impact of Outpatient Prospective Payment System in CY2000–CY2001, below, demonstrates the results of our analysis. The table categorizes hospitals by various geographic and special payment consideration groups to illustrate the varying impacts on different types of hospitals. The first column represents the number of hospitals in each category. The second column shows the hospitals' Medicare outpatient payments under the current (non-PPS) payment system as a percentage of the hospitals' total Medicare payment. The third and fourth columns show the impact of the PPS *excluding* the transitional corridor payments enacted by the BBRA 1999. Column three shows the percentage change in total Medicare outpatient payments comparing pre-PPS payments with payments under the PPS. The fourth column shows the change in *total* (outpatient and inpatient) Medicare payments resulting from implementation of the PPS for outpatient services. The fifth and sixth columns show the impact of the PPS *including* the transitional corridor payments enacted by the BBRA 1999. Column five shows the percentage change in Medicare outpatient payments comparing pre-PPS payments with payments under the PPS. Column six shows the change in total (outpatient and inpatient) Medicare payments resulting from implementation of the PPS for outpatient services.

The first row of Table 2 shows the overall impact on the 5,362 hospitals included in the analysis. We included as much data as possible to the extent that we were able to capture all the provider information necessary to determine payment. Our estimates include the same set of services for both pre-PPS and PPS payments so that we could determine the impact of the PPS as accurately as possible. Because payment under the hospital outpatient PPS can only be determined if bills are accurately coded, the data upon which the impacts were developed do not reflect all CY 1996 hospital outpatient services, but only those that were coded using valid HCPCS codes.

The second row of Table 2 shows the overall impact of the PPS on the 4,828 hospitals that remain when we exclude psychiatric, long-term care, children's, and rehabilitation hospitals.

The next four rows of the table contain hospitals categorized according to their geographic location (all urban, which is subdivided into large urban and other urban, and rural). We include 2,665 hospitals located in urban areas (MSAs or NECMAs) in our analysis. Among these, 1,505 hospitals are located in large urban areas (populations over 1 million), and 1,160 hospitals are located in other urban areas (populations of 1 million or less). In addition, we include 2,160 hospitals located in rural areas in our analysis. The next two groupings are by bed-size categories, shown separately for urban and rural hospitals. The next category groups urban and rural hospitals by volume of outpatient services. We then show the distribution of urban and rural hospitals by regional census divisions.

The next three categories group hospitals according to whether or not they have residency programs (teaching hospitals that receive an indirect medical education (IME) adjustment), receive disproportionate share hospital (DSH) payments, or some combination of these two adjustments. In our analysis we show the impact of the PPS on the 3,738 nonteaching hospitals, the 821 teaching hospitals with fewer than 100 residents, and the 269 teaching hospitals with 100 or more residents.

In the DSH categories, hospitals are grouped according to their DSH payment status. The next category groups hospitals considered urban after geographic reclassification, in terms of whether they receive the IME adjustment, the DSH adjustment, both, or neither. The next five rows examine the impacts of the changes on rural hospitals by special payment groups (rural referral centers (RRCs), sole community hospitals/essential access community hospitals (SCHs/EACHs), Medicare dependent hospitals (MDHs), and hospitals that are both SCHs and

RRCs), as well as rural hospitals not receiving a special payment designation. The RRCs (164), SCH/EACHs (634), MDHs (358), and SCH and RRCs (56) shown here were not reclassified for purposes of the standardized amount.

The next grouping is based on type of ownership. These data are taken primarily from the FY 1996 Medicare cost report files, if available; otherwise, earlier cost report data are used.

The final two groups are specialty hospitals. The first set includes eye and ear hospitals, trauma hospitals (hospitals having a level one trauma center), and cancer hospitals, which are TEFRA hospitals. The last group lists all other TEFRA hospitals, specifically, rehabilitation, psychiatric, long-term care, and children's hospitals.

G. Estimated Impact of the New APC System (Includes Table 2, Annual Impact of Hospital Outpatient Prospective Payment System in CY2000–CY2001)

Column 3 compares our estimate of PPS payments without application of the BBRA 1999 transitional corridors, but incorporating policy changes and all other BBRA 1999 provisions contained in this final rule, to our estimate of payments under the current system. The percent differences shown in columns 3 and 4 between current and PPS payment (without the BBRA 1999 transitional corridors) reflect the impact of the BBRA 1999 outlier and pass-through payment adjustments and nonbudget-neutral hold-harmless provisions for cancer hospitals, as well as distributional differences attributable to variation in cost and charge structures among hospitals.

The percent changes in columns 5 and 6 are the result of comparing our estimate of PPS payments with application of the BBRA 1999 transitional corridors, as well as the statutory and policy changes contained in this final rule, to our estimate of payments under the pre-PPS system. Percent differences between the pre-PPS and the PPS payment (with the BBRA 1999 transition) reflect the combined impact of the transitional corridor adjustments, outlier and pass-through payment adjustments and the hold-harmless provision for cancer hospitals, in addition to distributional differences attributable to variation in cost and charge structures among hospitals.

Basing the conversion factor on pre-PPS program and pre-PPS beneficiary payments and on budget-neutral outlier and pass-through adjustments results in no net change in payments to hospitals overall relative to pre-PPS payments. (As noted above, in section III.E.2 of this preamble, pursuant to section 201(l) of the BBRA 1999, we set the conversion factor by estimating pre-PPS rather than PPS copayments.) However, the BBRA hold-harmless provision for cancer hospitals results in a 0.2 percent increase in payments to hospitals overall because this provision is not budget neutral. Including the BBRA 1999 transitional corridor adjustments further increases payment to hospitals overall. We estimate that in calendar year 2000, payment will increase by an annual rate of 4.6 percent under the PPS compared to the pre-PPS payments.

Without the BBRA 1999 transitional corridor payments, the impact on short-term acute care hospitals is negative for a substantial number of hospital classifications. That is, for certain groups of hospitals, payments under the PPS without the transitional corridor payments would be several percentage points below pre-PPS payments. For nearly all of these hospital groups, the BBRA 1999 transitional corridor payments mitigate this negative impact. In addition, hospital groups that experience net gains without the BBRA 1999 transitional corridor payments experience even greater gains with them. The reason is that even though the average impact for hospitals in these groups is positive, some individual hospitals experience net losses in payments and, thus, benefit from the transitional corridor payments. The hospital groups that gain without the transitional corridor payments receive even greater increases in payments with the transitional corridor payments. The following discussion highlights some of the changes in payments among hospital classifications.

Comparing the pre-PPS and PPS payment estimates, payment to low-volume hospitals would decrease substantially without the BBRA 1999 transitional corridor payments (12.2 percent annually for rural and 7.7 percent annually for urban hospitals with fewer than 5,000 units of service). These hospitals experience a net gain with the BBRA 1999 transitional corridor payments (2.5 percent annually and 0.2 percent annually for low-volume rural and urban hospitals, respectively), although these payment increases are relatively small compared to the 4.6 percent annual increase for hospitals overall. We believe several factors contribute to this outcome, including undercoding, lack of economies of scale, and the reliance on the median instead of the geometric mean in the calculation of APC weights. The majority of these hospitals (about 75 percent) are rural. For these small hospitals, some of the higher standardized unit costs could be attributed to economies of scale. These low-volume rural hospitals also receive a greater percentage of their Medicare income (18.5 percent) from outpatient services than the national average (9.9 percent).

Major teaching hospitals, whose payments would decrease annually by 3.7 percentage points without the BBRA 1999 transitional corridor payments, gain 2.6 percent annually with the BBRA 1999 transitional corridor payments relative to pre-PPS payments. Major teaching hospitals receive less of their total Medicare income (9.1 percent) from outpatient services than the national average. This results in a 0.2 percent annual gain in their total Medicare payments. Minor teaching and nonteaching hospitals would experience marginal gains in outpatient payment without the BBRA 1999 transitional corridor payments. Payment to both hospital groups increases by 5.0 percent annually relative to the pre-PPS payment system.

Without the BBRA 1999 transitional corridor payments, hospitals with a high percentage of low-income patients (disproportionate share patient percentage greater than or equal to 0.35) would have a 2.5 percent annual decrease in payment relative to pre-PPS payments. But payments to these hospitals increase annually by 3.5 percent relative to pre-PPS payments with the BBRA 1999 transitional corridor payments. These hospitals have lower than average volume, and, like major teaching hospitals, receive a smaller than average percentage of their Medicare income from outpatient services. Thus, their total Medicare payments increase marginally, by 0.3 percent, with the BBRA 1999 transitional corridor payments.

Without the BBRA 1999 adjustments, payment to rural hospitals would decrease 1.8 percent annually and payment to large urban hospitals would decrease 0.3 percent annually, while payment to other urban hospitals would increase 1.8 percent annually relative to pre-PPS payments. These hospitals all experience net gains in PPS payment with the BBRA 1999 transitional corridor payments, at an annual rate of 4.4 percent, 4.3 percent, and 5.1 percent, respectively. Even though rural hospitals receive a greater percentage of their Medicare income (14.7 percent) from outpatient services compared to the national average, their total Medicare payments increase by only a fraction, 0.6 percent.

Negative impacts for urban hospitals in the Mid-Atlantic and the West North Central regions are also reversed under

the BBRA 1999 transitional corridor payments, changing from −3.4 percent to 2.4 percent on an annual basis, and from −3.5 percent to 2.5 percent on an annual basis, respectively. Similarly, rural hospitals in nearly all census regions experience net increases in payment relative to pre-PPS payments with the BBRA 1999 transitional corridor payments.

The impact on TEFRA hospitals is shown separately at the end of the table. The TEFRA hospitals were not included in determining the impact on any of the other categories discussed above (for example, geographic location, bed size, volume, etc.). These hospitals demonstrated a very low service mix, but an average unit cost that approximates the national average. We believe that undercoding or billing an all-inclusive rate could account for their low-volume, low-service mix, and average cost per unit. We expect that once these hospitals begin to code services accurately under the PPS, payments will more closely approximate pre-PPS payments.

If the effect of the BBRA 1999 transition payments were removed, differences between pre-PPS payments and PPS payments among hospitals would still exist. These distributional differences are the result of many factors. First, cost variations among hospitals result in differences between pre-PPS payments and PPS payments, and charge structure variations result in differences between pre-PPS payments and PPS beneficiary copayment amounts. Hospitals whose costs are low relative to payment would gain under the PPS even without the BBRA 1999 transitional corridor payments. Because the transitional corridor payments are not budget neutral, these hospitals continue to gain relative to pre-PPS payments.

Redistributions may also occur as a result of current payment methods. Total Medicare outpatient payments are less than reported total costs because (in addition to the 5.8 and 10 percent reductions for operating and capital costs) the blended payment methods applicable to many surgical and diagnostic services often result in payments that are less than reported costs. Other services such as medical visits, chemotherapy services, and non-ASC approved surgeries are paid based on hospital costs. The new system redistributes the current total Medicare payments, based in part on cost-based payments and in part on blended payment amounts, across all services. Hospitals, in the aggregate, will receive proportionately less for services that are currently paid based on costs, and more for services that had been paid under blended payment methods.

TABLE 2. ANNUAL IMPACT OF HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM IN CY2000–CY2001

	Number of hospitals	Outpatient percent	Excluding BBRA transitional corridors [1]		Including BBRA transitional corridors	
			Percent change in Medicare outpatient payments [3]	Percent change in total Medicare payments	Percent change in Medicare outpatient payments [3]	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)	(5)	(6)
ALL HOSPITALS	5,362	9.9	0.2	0.0	4.6	0.5
NON-TEFRA HOSPITALS	4,828	10	0.1	0.0	4.6	0.5
URBAN HOSPS [2]	2,665	9.3	0.6	0.1	4.6	0.4
LARGE URBAN [2] (GT 1 MILL.)	1,505	9.1	−0.3	0.0	4.3	0.4
OTHER URBAN [2] (LE 1 MILL.)	1,160	9.7	1.8	0.2	5.1	0.5
RURAL HOSPS	2,160	14.7	−1.8	−0.3	4.4	0.6
BEDS (URBAN): [2]						
0—99 BEDS	672	14.9	0.6	0.1	4.6	0.7
100–199 BEDS	924	10.5	1.3	0.1	5.2	0.5
200–299 BEDS	533	9.2	0.8	0.1	4.4	0.4
300–499 BEDS	399	8.5	1.8	0.2	5.2	0.4
500 + BEDS	137	8.4	−2.9	−0.2	2.8	0.2
BEDS (RURAL):						
0—49 BEDS	1,170	19.5	−8.5	−1.7	3.3	0.6
50–99 BEDS	615	15.5	−2.7	−0.4	4.4	0.7
100–149 BEDS	223	13.3	−0.2	0.0	3.8	0.5
150–199 BEDS	81	13	2.5	0.3	5.5	0.7
200 + BEDS	71	11.6	2.7	0.3	6.1	0.7
VOLUME (URBAN):						
LT 5,000	349	12	−7.7	−0.9	0.2	0.0
5,000–10,999	504	9.8	0.0	0.0	4.2	0.4
11,000–20,999	596	9.1	0.1	0.0	4.4	0.4
21,000–42,999	773	8.8	1.3	0.1	4.9	0.4
GT 42,999	443	9.7	0.4	0.0	4.6	0.4
VOLUME (RURAL):						
LT 5,000	1,049	18.5	−12.2	−2.3	2.5	0.5
5,000–10,999	595	15.2	−5.2	−0.8	2.9	0.4
11,000–20,999	322	13.8	0.1	0.0	4.7	0.6
21,000–42,999	173	13.6	2.4	0.3	5.7	0.8
GT 42,999	21	13.2	3.0	0.4	6.8	0.9
REGION (URBAN): [3]						
NEW ENGLAND	146	10.7	3.8	0.4	6.7	0.7
MIDDLE ATLANTIC	393	8.4	−3.4	−0.3	2.4	0.2
SOUTH ATLANTIC	401	8.6	0.3	0.0	4.2	0.4
EAST NORTH CENT.	465	10.7	1.0	0.1	4.5	0.5

TABLE 2. ANNUAL IMPACT OF HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM IN CY2000–CY2001—Continued

	Number of hospitals	Outpatient percent	Excluding BBRA transitional corridors [1]		Including BBRA transitional corridors	
			Percent change in Medicare outpatient payments [3]	Percent change in total Medicare payments	Percent change in Medicare outpatient payments [3]	Percent change in total Medicare payments
	(1)	(2)	(3)	(4)	(5)	(6)
EAST SOUTH CENT.	161	7.9	1.8	0.1	4.6	0.4
WEST NORTH CENT.	183	9.5	0.9	0.1	4.9	0.5
WEST SOUTH CENT.	335	9.7	−2.7	−0.3	2.5	0.2
MOUNTAIN	123	10.2	3.1	0.3	6.1	0.6
PACIFIC	423	9.4	5.6	0.5	8.6	0.8
PUERTO RICO	35	6.6	10.8	0.7	13.2	0.9
REGION (RURAL):						
NEW ENGLAND	53	17.2	−3.2	−0.6	3.3	0.6
MIDDLE ATLANTIC	80	13.6	7.1	1.0	10.1	1.4
SOUTH ATLANTIC	285	11.8	−1.8	−0.2	3.6	0.4
EAST NORTH CENT.	282	15.7	−1.2	−0.2	4.3	0.7
EAST SOUTH CENT.	260	11.1	0.1	0.0	4.9	0.5
WEST NORTH CENT.	508	19.8	−5.2	−1.0	3.0	0.6
WEST SOUTH CENT.	337	14.2	−5.7	−0.8	3.0	0.4
MOUNTAIN	213	16.9	−3.4	−0.6	4.7	0.8
PACIFIC	140	15.9	0.7	0.1	6.3	1.0
PUERTO RICO	2	6.6	32.1	2.1	32.1	2.1
TEACHING STATUS:						
NON-TEACHING	3,738	11.3	0.5	0.1	5.0	0.6
MINOR	821	9.1	1.6	0.1	5.0	0.5
MAJOR	269	9.1	−3.7	−0.3	2.6	0.2
DSH PATIENT PERCENT:						
0	101	10.9	−5.8	−0.6	0.7	0.1
GT 0—0.10	1,139	10.5	0.8	0.1	4.6	0.5
0.10–0.16	986	11	2.0	0.2	5.6	0.6
0.16–0.23	880	10.1	0.8	0.1	4.9	0.5
0.23–0.35	855	9.5	−1.5	−0.1	3.7	0.4
GE 0.35	867	9.2	−2.5	−0.2	3.5	0.3
URBAN IME/DSH: [2]						
IME & DSH	994	9	−0.4	0.0	4.1	0.4
IME/NO DSH	17	9.2	−3.6	−0.3	1.1	0.1
NO IME/DSH	1,611	9.9	1.9	0.2	5.4	0.5
NO IME/NO DSH	43	14.7	−8.2	−1.2	−0.3	0.0
RURAL HOSP. TYPES:						
NO SPECIAL STATUS	864	15	−2.2	−0.3	4.4	0.7
RRC	164	12.3	5.0	0.6	7.3	0.9
SCH/EACH	634	16.5	−7.7	−1.3	2.2	0.4
MDH	358	18.3	−5.4	−1.0	3.5	0.6
SCH AND RRC	56	13.9	−1.4	−0.2	3.1	0.4
TYPE OF OWNERSHIP:						
VOLUNTARY	2,816	9.9	0.6	0.1	4.7	0.5
PROPRIETARY	752	8.3	−0.1	0.0	4.7	0.4
GOVERNMENT	1,260	12.2	−2.3	−0.3	3.6	0.4
SPECIALTY HOSPITALS:						
EYE AND EAR	10	31.1	20.1	6.3	20.2	6.3
TRAUMA	159	9.1	−1.2	−0.1	4.0	0.4
CANCER	10	22	0.8	0.2	0.8	0.2
TEFRA HOSPITALS (NOT INCLUDED ON OTHER LINES):						
REHAB	147	3.7	−9.4	−0.3	1.7	0.1
PSYCH	281	9	21.3	1.9	27.9	2.5
LTC	65	3.7	−15.3	−0.6	−1.7	−0.1
CHILDREN	41	16.5	−11.9	−2.0	−3.2	−0.5

Notes:

[1] Includes all BBRA provisions except the transitional corridor provisions that expire 01/01/04.

[2] Does not include impact of reclassifications as allowed under section 401 of the BBRA 1999.

[3] Estimate of change compared to pre-PPS payments, which reflect the payment methodologies in effect as of January 1, 2000, and prior to July 1, 2000.

X. Federalism

We have examined this rule in accordance with Executive Order 13132, Federalism, and have determined that this final rule will not have any negative impact on the rights, roles, and responsibilities of State, local or Tribal governments.

XI. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and its reasons in the rule. We find that the circumstances surrounding this rule make it impracticable to pursue a process of notice-and-comment rulemaking before the provisions of this rule take effect.

The BBRA 1999 was enacted on November 29, 1999. This final rule incorporates the following hospital outpatient PPS provisions in the BBRA 1999: outlier adjustment for high cost cases; transitional pass-through payment adjustments for additional costs (over the payments for APCs otherwise made) for new medical devices, drugs, and biologicals; definition of APCs so that the variation of costs of items within an APC is subject to certain limits; establishment of ''transitional corridors'' for the first 3½ years of the new system that limit losses hospitals might otherwise face; payment for implantable devices under the hospital outpatient PPS, rather than under the Durable Medical Equipment Fee Schedule; limitation of the copayment on an outpatient procedure to the amount of the inpatient hospital deductible; requirement to review annually the APC groups, relative weights, and wage and other adjustments; and calculation of the conversion factor in a budget-neutral manner, eliminating the 5.7 percent reduction indicated in the proposed rule.

As discussed earlier in this rule, July 1, 2000 is the earliest date on which we can feasibly implement the PPS. The provisions of the BBRA 1999, enacted on November 29, 1999, made numerous refinements to the PPS. With respect to the BBRA 1999 provisions, it would have been impracticable to complete notice and comment procedures by July 1, 2000. Given the limited timeframe, given the nature and scope of the BBRA 1999 refinements, and given the time required to complete notice and comment rulemaking (to develop proposed policies, draft the proposed rule, provide a 60-day public comment period, consider public comments, develop final policies, draft a final rule), it would not have been possible to issue this document as a proposed rule and issue a final rule by July 1.

In addition, it would not be feasible to implement the hospital outpatient PPS *without* the BBRA 1999 provisions, not only because of the nature of the BBRA 1999 provisions, but also because section 201(m) of the BBRA 1999 states: ''Except as provided in this section, the amendments made by this section shall be effective as if included in the enactment of BBA.'' Therefore, if we undertook prior notice and comment procedures with respect to the BBRA 1999 provisions, then (because such procedures could not be completed by July 1, 2000) the PPS would not be implemented by July 1, 2000.

Accordingly, we find good cause to waive the procedures for *prior* notice and comment with respect to the provisions of this document that implement the BBRA 1999 refinements to hospital outpatient PPS. We are providing a 60-day period for public comment with respect to the provisions of this final rule with comment period that implement the BBRA refinements. We are not accepting comments with respect to the other aspects of this document (for which the public has already had an extensive opportunity to comment).

List of Subjects

42 CFR Part 409

Health facilities, Medicare.

42 CFR Part 410

Health facilities, Health professions, Kidney diseases, Laboratories, Medicare, Rural areas, X-rays.

42 CFR Part 411

Kidney diseases, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 419

Health facilities, Hospitals, Medicare.

42 CFR Part 424

Emergency medical services, Health facilities, Health professions, Medicare.

42 CFR Part 489

Health facilities, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 498

Administrative practice and procedure, Health facilities, Health professions, Medicare, Reporting and recordkeeping requirements.

42 CFR Part 1003

Administrative practice and procedure, Archives and records, Grant program—social programs, Maternal and Child Health, Medicaid, Medicare, Penalties.

For the reasons set forth in the preamble, 42 CFR chapter IV is amended as follows:

PART 409—HOSPITAL INSURANCE BENEFITS

A. Part 409 is amended as set forth below:

1. The authority citation for part 409 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services

2. In § 409.10, paragraph (b) is revised to read as follows:

§ 409.10 Included services.

* * * * *

(b) *Inpatient hospital services* does not include the following types of services:

(1) Posthospital SNF care, as described in § 409.20, furnished by a hospital or a critical access hospital that has a swing-bed approval.

(2) Nursing facility services, described in § 440.155 of this chapter, that may be furnished as a Medicaid service under title XIX of the Act in a swing-bed hospital that has an approval to furnish nursing facility services.

(3) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(4) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(5) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(6) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(7) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(8) Services of an anesthetist, as defined in § 410.69 of this chapter.

PART 410—SUPPLEMENTARY MEDICAL INSURANCE (SMI) BENEFITS

B. Part 410 is amended as set forth below:

1. The authority citation for part 410 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Provisions

2. In § 410.2, the introductory text is republished, the definition of ''Community mental health center (CMHC)'' is revised, and the definitions of ''Encounter'' and ''Outpatient'' are added in alphabetical order to read as follows:

§ 410.2 Definitions.

As used in this part—

Community mental health center (CMHC) means an entity that—

(1) Provides outpatient services, including specialized outpatient services for children, the elderly, individuals who are chronically mentally ill, and residents of its mental health service area who have been discharged from inpatient treatment at a mental health facility;

(2) Provides 24-hour-a-day emergency care services;

(3) Provides day treatment or other partial hospitalization services, or psychosocial rehabilitation services;

(4) Provides screening for patients being considered for admission to State mental health facilities to determine the appropriateness of this admission; and

(5) Meets applicable licensing or certification requirements for CMHCs in the State in which it is located.

Encounter means a direct personal contact between a patient and a physician, or other person who is authorized by State licensure law and, if applicable, by hospital or CAH staff bylaws, to order or furnish hospital services for diagnosis or treatment of the patient.

* * * * *

Outpatient means a person who has not been admitted as an inpatient but who is registered on the hospital or CAH records as an outpatient and receives services (rather than supplies alone) directly from the hospital or CAH.

* * * * *

Subpart B—Medical and Other Health Services

3. In § 410.27:

A. The section heading is revised;

B. The introductory text to paragraph (a) is revised;

C. The introductory text to paragraph (a)(1) is republished;

D. The word ''and'' at the end of paragraph (a)(1)(i) is removed; and

E. New paragraphs (a)(1)(iii), (e), and (f) are added to read as follows:

§ 410.27 Outpatient hospital services and supplies incident to a physician service: Conditions.

(a) Medicare Part B pays for hospital services and supplies furnished incident to a physician service to outpatients, including drugs and biologicals that cannot be self-administered, if—

(1) They are furnished—

* * * * *

(iii) In the hospital or at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter; and

* * * * *

(e) Services furnished by an entity other than the hospital are subject to the limitations specified in § 410.42(a).

(f) Services furnished at a location (other than an RHC or an FQHC) that HCFA designates as a department of a provider under § 413.65 of this chapter must be under the direct supervision of a physician. ''Direct supervision'' means the physician must be present and on the premises of the location and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

4. In § 410.28, paragraph (a)(4) is removed, paragraph (c) is redesignated as paragraph (d), and new paragraphs (c) and (e) are added to read as follows:

§ 410.28 Hospital or CAH diagnostic services furnished to outpatients: Conditions.

* * * * *

(c) Diagnostic services furnished by an entity other than the hospital or CAH are subject to the limitations specified in § 410.42(a).

* * * * *

(e) Medicare Part B makes payment under section 1833(t) of the Act for diagnostic services furnished at a facility (other than an RHC or an FQHC) that HCFA designates as having provider-based status only when the diagnostic services are furnished under the appropriate level of physician supervision specified by HCFA in accordance with the definitions in § 410.32(b)(3)(i), (b)(3)(ii), and (b)(3)(iii). Under general supervision at a facility accorded provider-based status, the training of the nonphysician personnel who actually perform the diagnostic procedure and the maintenance of the necessary equipment and supplies are the continuing responsibility of the facility.

5. A new § 410.42 is added to read as follows:

§ 410.42 Limitations on coverage of certain services furnished to hospital outpatients.

(a) *General rule.* Except as provided in paragraph (b) of this section, Medicare Part B does not pay for any item or service that is furnished to a hospital outpatient (as defined in § 410.2) during an encounter (as defined in § 410.2) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to its patients. As used in this paragraph, the term ''hospital'' includes a CAH.

(b) *Exception.* The limitations stated in paragraph (a) of this section do not apply to the following services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69.

(7) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

6. In § 410.43, paragraph (b) is revised to read as follows:

§ 410.43 Partial hospitalization services: Conditions and exclusions.

* * * * *

(b) The following services are separately covered and not paid as partial hospitalization services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(5) Services furnished to SNF residents as defined in § 411.15(p) of this chapter.

PART 411—EXCLUSIONS FROM MEDICARE AND LIMITATIONS ON MEDICARE PAYMENT

C. Part 411 is amended as set forth below:

1. The authority citation for part 411 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A—General Exclusions and Exclusion of Particular Services

2. In § 411.15:

A. The introductory text is republished;

B. The section heading to paragraph (m) is revised;

C. Paragraph (m)(1) is revised;

D. Paragraph (m)(2) is redesignated as paragraph (m)(3);

E. The introductory text to newly redesignated paragraph (m)(3) is republished;

F. Newly redesignated paragraphs (m)(3)(iii), (m)(3)(iv), and (m)(3)(v) are redesignated as paragraphs (m)(3)(iv), (m)(3)(v), and (m)(3)(vi), respectively; and

G. New paragraphs (m)(2) and (m)(3)(iii) are added to read as follows:

§ 411.15 Particular services excluded from coverage.

The following services are excluded from coverage:

* * * * *

(m) *Services to hospital patients*—(1) *Basic rule.* Except as provided in paragraph (m)(3) of this section, any service furnished to an inpatient of a hospital or to a hospital outpatient (as defined in § 410.2 of this chapter) during an encounter (as defined in § 410.2 of this chapter) by an entity other than the hospital unless the hospital has an arrangement (as defined in § 409.3 of this chapter) with that entity to furnish that particular service to the hospital's patients. As used in this paragraph (m)(1), the term ''hospital'' includes a CAH.

(2) *Scope of exclusion.* Services subject to exclusion from coverage under the provisions of this paragraph (m) include, but are not limited to, clinical laboratory services; pacemakers and other prostheses and prosthetic devices (other than dental) that replace all or part of an internal body organ (for example, intraocular lenses); artificial limbs, knees, and hips; equipment and supplies covered under the prosthetic device benefits; and services incident to a physician service.

(3) *Exceptions.* The following services are not excluded from coverage:

* * * * *

(iii) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

PART 412—PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

D. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart C—Conditions for Payment Under the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

2. In § 412.50, paragraphs (a) and (b) are revised to read as follows:

§ 412.50 Furnishing of inpatient hospital services directly or under arrangements.

(a) The applicable payments made under the prospective payment systems, as described in subparts H and M of this part, are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter. Inpatient hospital services do not include the following types of services:

(1) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(2) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(4) Certified nurse mid-wife services, as defined in section 1861(gg) of the Act.

(5) Qualified psychologist services, as defined in section 1861(ii) of the Act.

(6) Services of an anesthetist, as defined in § 410.69 of this chapter.

(b) HCFA does not pay any provider or supplier other than the hospital for services furnished to a beneficiary who is an inpatient, except for the services described in paragraphs (a)(1) through (a)(6) of this section.

* * * * *

PART 413—PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT RATES FOR SKILLED NURSING FACILITIES

E. Part 413 is amended as set forth below:

1. The authority citation for part 413 continues to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a), (i), and (n), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a), (i), and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A—Introduction and General Rules

§ 413.1 [Amended]

2. In § 413.1, paragraph (a)(2)(viii) is removed.

Subpart B—Accounting Records and Reports

3. In § 413.24, the heading to paragraph (d) is republished, and a new paragraph (d)(6) is added to read as follows:

§ 413.24 Adequate cost data and cost finding.

* * * * *

(d) *Cost finding methods.* * * *

(6) *Management contracts.* (i) If the main provider purchases services for a department of the provider or a provider-based entity through a management contract or otherwise directly assigns costs to the department or entity, the like costs of the main provider must be carved out to ensure that they are not allocated to the department of the provider or provider-based entity. However, if the like costs of the main provider cannot be separately identified, the costs of the services purchased through a management contract must be included in the main provider's administrative and general costs and allocated among the provider's overall statistics.

(ii) Costs of free-standing entities may not be shown in the provider's trial balance for purposes of stepping down overhead costs to these entities. The provider must develop detailed work papers showing the exact cost of the services (including overhead) provided to or by the free-standing entity and show those carved out costs as

nonreimbursable cost centers in the provider's trial balance.

* * * * *

Subpart E—Payments to Providers

4. A new § 413.65 is added to read as follows:

§ 413.65 Requirements for a determination that a facility or an organization has provider-based status.

(a) *Scope and definitions.* (1) *Scope.* This section applies to all facilities or organizations for which provider-based status is sought, including remote locations of hospitals, as defined in paragraph (a)(2) of this section and satellite facilities as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter, other than ESRD facilities. Determinations for ESRD facilities are made under § 413.174 of this chapter.

(2) *Definitions.* In this subpart E, unless the context indicates otherwise—

Campus means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the HCFA regional office, to be part of the provider's campus.

Department of a provider means a facility or organization or a physician office that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of the same type as those furnished by the main provider under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A department of a provider may not be licensed to provide health care services in its own right, may not by itself be qualified to participate in Medicare as a provider under § 489.2 of this chapter, and Medicare conditions of participation do not apply to a department as an independent entity. For purposes of this part, the term ''department of a provider'' does not include an RHC or, except as specified in paragraph (m)(1) of this section, an FQHC.

Free-standing facility means an entity that furnishes health care services to Medicare beneficiaries and that is not integrated with any other entity as a main provider, a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity.

Main provider means a provider that either creates, or acquires ownership of, another entity to deliver additional health care services under its name, ownership, and financial and administrative control.

Provider-based entity means a provider of health care services, or an RHC or an FQHC as defined in § 405.2401(b) of this chapter, that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the name, ownership, and administrative and financial control of the main provider, in accordance with the provisions of this section.

Provider-based status means the relationship between a main provider and a provider-based entity or a department of a provider, remote location of a hospital, or satellite facility, that complies with the provisions of this section.

Remote location of a hospital means a facility or an organization that is either created by, or acquired by, a hospital that is a main provider for the purpose of furnishing inpatient hospital services under the name, ownership, and financial and administrative control of the main provider, in accordance with the provisions of this section. A remote location of a hospital may not be licensed to provide inpatient hospital services in its own right, and Medicare conditions of participation do not apply to a remote location of a hospital as an independent entity. For purposes of this part, the term ''remote location of a hospital'' does not include a satellite facility as defined in § 412.22(h)(1) and § 412.25(e)(1) of this chapter.

(b) *Responsibility for obtaining provider-based determinations.* (1) A facility or organization is not entitled to be treated as provider-based simply because it or the main provider believe it is provider-based.

(2) A main provider or a facility or organization must contact HCFA and the facility or organization must be determined by HCFA to be provider-based before the main provider bills for services of the facility or organization as if the facility or organization were provider-based, or before it includes costs of those services on its cost report.

(3) A facility that is not located on the campus of a hospital and is used as a site of physician services of the kind ordinarily furnished in physician offices will be presumed to be a free-standing facility, unless it is determined by HCFA to have provider-based status.

(c) *Reporting.* (1) A main provider that creates or acquires a facility or organization for which it wishes to claim provider-based status, including any physician offices that a hospital wishes to operate as a hospital outpatient department or clinic, must report its acquisition of the facility or organization to HCFA if the facility or organization is located off the campus of the provider, or inclusion of the costs of the facility or organization in the provider's cost report would increase the total costs on the provider's cost report by at least 5 percent, and must furnish all information needed for a determination as to whether the facility or organization meets the requirements in paragraph (d) of this section for provider-based status.

(2) A main provider that has had one or more facilities or organizations considered provider-based also must report to HCFA any material change in the relationship between it and any provider-based facility or organization, such as a change in ownership of the facility or organization or entry into a new or different management contract that could affect the provider-based status of the facility or organization.

(d) *Requirements.* An entity must meet all of the following requirements to be determined by HCFA to have provider-based status.

(1) *Licensure.* The department of the provider, remote location of a hospital, or satellite facility and the main provider are operated under the same license, except in areas where the State requires a separate license for the department of the provider, remote location of a hospital, or satellite facility, or in States where State law does not permit licensure of the provider and the prospective department of the provider, remote location of a hospital, or satellite facility under a single license. If a State health facilities' cost review commission or other agency that has authority to regulate the rates charged by hospitals or other providers in a State finds that a particular facility or organization is not part of a provider, HCFA will determine that the facility or organization does not have provider-based status.

(2) *Operation under the ownership and control of the main provider.* The facility or organization seeking provider-based status is operated under the ownership and control of the main provider, as evidenced by the following:

(i) The business enterprise that constitutes the facility or organization is 100 percent owned by the provider.

(ii) The main provider and the facility or organization seeking status as a department of the provider, remote location of a hospital, or satellite facility have the same governing body.

(iii) The facility or organization is operated under the same organizational documents as the main provider. For

example, the facility or organization seeking provider-based status must be subject to common bylaws and operating decisions of the governing body of the provider where it is based.

(iv) The main provider has final responsibility for administrative decisions, final approval for contracts with outside parties, final approval for personnel actions, final responsibility for personnel policies (such as fringe benefits/code of conduct), and final approval for medical staff appointments in the facility or organization.

(3) *Administration and supervision.* The reporting relationship between the facility or organization seeking provider-based status and the main provider must have the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and one of its departments, as evidenced by compliance with all of the following requirements:

(i) The facility or organization is under the direct supervision of the main provider.

(ii) The facility or organization is operated under the same monitoring and oversight by the provider as any other department of the provider, and is operated just as any other department of the provider with regard to supervision and accountability. The facility or organization director or individual responsible for daily operations at the entity—

(A) Maintains a reporting relationship with a manager at the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the main provider and its departments; and

(B) Is accountable to the governing body of the main provider, in the same manner as any department head of the provider.

(iii) The following administrative functions of the facility or organization are integrated with those of the provider where the facility or organization is based: billing services, records, human resources, payroll, employee benefit package, salary structure, and purchasing services. Either the same employees or group of employees handle these administrative functions for the facility or organization and the main provider, or the administrative functions for both the facility or organization and the entity are—

(A) Contracted out under the same contract agreement; or

(B) Handled under different contract agreements, with the contract of the facility or organization being managed by the main provider.

(4) *Clinical services.* The clinical services of the facility or organization seeking provider-based status and the main provider are integrated as evidenced by the following:

(i) Professional staff of the facility or organization have clinical privileges at the main provider.

(ii) The main provider maintains the same monitoring and oversight of the facility or organization as it does for any other department of the provider.

(iii) The medical director of the facility or organization seeking provider-based status maintains a reporting relationship with the Chief Medical Officer or other similar official of the main provider that has the same frequency, intensity, and level of accountability that exists in the relationship between the medical director of a department of the main provider and the Chief Medical Officer or other similar official of the main provider, and is under the same type of supervision and accountability as any other director, medical or otherwise, of the main provider.

(iv) Medical staff committees or other professional committees at the main provider are responsible for medical activities in the facility or organization including quality assurance, utilization review, and the coordination and integration of services, to the extent practicable, between the facility or organization seeking provider-based status and the main provider.

(v) Medical records for patients treated in the facility or organization are integrated into a unified retrieval system (or cross reference) of the main provider.

(vi) Inpatient and outpatient services of the facility or organization and the main provider are integrated, and patients treated at the facility or organization who require further care have full access to all services of the main provider and are referred where appropriate to the corresponding inpatient or outpatient department or service of the main provider.

(5) *Financial integration.* The financial operations of the facility or organization are fully integrated within the financial system of the main provider, as evidenced by shared income and expenses between the main provider and the facility or organization. The costs of the facility or organization are reported in a cost center of the provider, and the financial status of the facility or organization is incorporated and readily identified in the main provider's trial balance.

(6) *Public awareness.* The facility or organization seeking status as a department of a provider, remote location of a hospital, or satellite facility is held out to the public and other payers as part of the main provider. When patients enter the provider-based facility or organization, they are aware that they are entering the main provider and are billed accordingly.

(7) *Location in immediate vicinity.* The facility or organization and the main provider are located on the same campus, except where the following requirements are met:

(i) The facility or organization demonstrates a high level of integration with the main provider by showing that it meets all of the other provider-based criteria, and demonstrates that it serves the same patient population as the main provider, by submitting records showing that, during the 12-month period immediately preceding the first day of the month in which the application for provider-based status is filed with HCFA, and for each subsequent 12-month period—

(A) At least 75 percent of the patients served by the facility or organization reside in the same zip code areas as at least 75 percent of the patients served by the main provider;

(B) At least 75 percent of the patients served by the facility or organization who required the type of care furnished by the main provider received that care from that provider (for example, at least 75 percent of the patients of an RHC seeking provider-based status received inpatient hospital services from the hospital that is the main provider); or

(C) If the facility or organization is unable to meet the criteria in paragraph (d)(7)(i)(A) or (d)(7)(i)(B) of this section because it was not in operation during all of the 12-month period described in the previous sentence, the facility or organization is located in a zip code area included among those that, during all of the 12-month period described in the previous sentence, accounted for at least 75 percent of the patients served by the main provider.

(ii) A facility or organization is not considered to be in the ''immediate vicinity'' of the main provider unless the facility or organization and the main provider are located in the same State or, where consistent with the laws of both States, adjacent States.

(iii) A rural health clinic that is otherwise qualified as a provider-based entity of a hospital that is located in a rural area, as defined in § 412.62(f)(1)(iii) of this chapter, and has fewer than 50 beds, as determined under § 412.105(b) of this chapter, is not subject to the criterion in this paragraph (d)(7).

(e) *Provider-based status not applicable to joint ventures.* A facility or

organization cannot be considered provider-based if the entity is owned by two or more providers engaged in a joint venture. For example, where a hospital has jointly purchased or jointly created free-standing facilities under joint venture arrangements, neither party to the joint venture arrangement can claim the free-standing facility as a provider-based entity.

(f) *Management contracts.* Facilities and organizations that otherwise meet the requirements of paragraph (d) of this section, but are operated under management contracts, must also meet all of the following criteria:

(1) The staff of the facility or organization, other than management staff, are employed by the provider or by another organization, other than the management company, which also employs the staff of the main provider.

(2) The administrative functions of the facility or organization are integrated with those of the main provider, as determined under criteria in paragraph (d)(3)(iii) of this section.

(3) The main provider has significant control over the operations of the facility or organization as determined under criteria in paragraph (b)(3)(ii) of this section.

(4) The management contract is held by the main provider itself, not by a parent organization that has control over both the main provider and the facility or organization.

(g) *Obligations of hospital outpatient departments and hospital-based entities.* (1) Hospital outpatient departments located either on or off the campus of the hospital that is the main provider must comply with the anti-dumping rules in §§ 489.20(l), (m), (q), and (r) and § 489.24 of this chapter. If any individual comes to any hospital-based entity (including an RHC) located on the main hospital campus, and a request is made on the individual's behalf for examination or treatment of a medical condition, as described in § 489.24 of this chapter, the hospital must comply with the anti-dumping rules in § 489.24 of this chapter.

(2) Physician services furnished in hospital outpatient departments or hospital-based entities (other than RHCs) must be billed with the correct site-of-service indicator, so that applicable site-of-service reductions to physician and practitioner payment amounts can be applied.

(3) Hospital outpatient departments must comply with all the terms of the hospital's provider agreement.

(4) Physicians who work in hospital outpatient departments or hospital-based entities are obligated to comply with the non-discrimination provisions in § 489.10(b) of this chapter.

(5) Hospital outpatient departments (other than RHCs) must treat all Medicare patients, for billing purposes, as hospital outpatients. The department must not treat some Medicare patients as hospital outpatients and others as physician office patients.

(6) In the case of a patient admitted to the hospital as an inpatient after receiving treatment in the hospital outpatient department or hospital-based entity, payments for services in the hospital outpatient department or hospital-based entity are subject to the payment window provisions applicable to PPS hospitals and to hospitals and units excluded from PPS set forth at § 412.2(c)(5) of this chapter and at § 413.40(c)(2), respectively.

(7) When a Medicare beneficiary is treated in a hospital outpatient department or hospital-based entity (other than an RHC) that is not located on the main provider's campus, the hospital has a duty to provide written notice to the beneficiary, prior to the delivery of services, of the amount of the beneficiary's potential financial liability (that is, of the fact that the beneficiary will incur a coinsurance liability for an outpatient visit to the hospital as well as for the physician service, and of the amount of that liability). The notice must be one that the beneficiary can read and understand. If the beneficiary is unconscious, under great duress, or for any other reason unable to read a written notice and understand and act on his or her own rights, the notice must be provided, prior to the delivery of services, to the beneficiary's authorized representative.

(8) Hospital outpatient departments must meet applicable hospital health and safety rules for Medicare-participating hospitals in part 482 of this chapter.

(h) *Furnishing all services under arrangement.* A facility or organization may not qualify for provider-based status if all patient care services furnished at the facility are furnished under arrangement.

(i) *Inappropriate treatment of a facility or organization as provider-based.* (1) *Determination and review.* If HCFA learns that a provider has treated a facility or organization as provider-based and the provider had not obtained a determination of provider-based status under this section, HCFA will—

(i) Review current payments and, if necessary, take action in accordance with the rules on inappropriate billing in paragraph (j) of this section;

(ii) Investigate and determine whether the requirements in paragraph (d) of this section (or, for periods prior to October 10, 2000, the requirements in applicable program instructions) were met; and

(iii) Review all previous payments to that provider for all cost reporting periods subject to re-opening in accordance with § 405.1885 and § 405.1889 of this chapter.

(2) *Recovery of overpayments.* If HCFA finds that payments for services at the facility or organization have been made as if the facility or organization were provider-based, even though HCFA had not previously determined that the facility or organization qualified for provider-based status, HCFA will recover the difference between the amount of payments that actually were made and the amount of payments that HCFA estimates should have been made in the absence of a determination of provider-based status, except that recovery will not be made for any period prior to October 10, 2000 if during all of that period the management of the entity made a good faith effort to operate it as a provider-based facility or organization, as described in paragraph (h)(3) of this section.

(3) *Exception for good faith effort.* HCFA determines that the management of a facility or organization has made a good faith effort to operate it as a provider-based entity if—

(i) The requirements regarding licensure and public awareness in paragraphs (d)(1) and (d)(6) of this section are met;

(ii) All facility services were billed as if they had been furnished by a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity of the main provider; and

(iii) All professional services of physicians and other practitioners were billed with the correct site-of-service indicator, as described in paragraph (g)(2) of this section.

(j) *Inappropriate billing.* If HCFA finds that a facility or organization is being treated as provider-based without having obtained a determination of provider-based status under this section, HCFA will notify the provider, adjust future payments, review previous payments, determine whether the facility or organization qualifies for provider-based status under this paragraph, and continue payments only under specific conditions, as described in paragraphs (j)(1), (j)(2), (j)(3), and (j)(4) of this section.

(1) *Notice to provider.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based

determination has been made by HCFA, HCFA will issue written notice to the provider that payments for past cost reporting periods may be reviewed and recovered as described in paragraph (i) of this section, that future payments for services in or of the facility or organization will be adjusted as described in paragraph (j)(2) of this section, and that a determination of provider-based status will be made.

(2) *Adjustment of payments.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will adjust future payments to the provider, the facility or organization, or both, to approximate as closely as possible the amounts that would be paid, in the absence of a provider-based determination, if all other requirements for billing were met.

(3) *Review of previous payments.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will review previous payments and, if necessary, take action in accordance with the rules on inappropriate treatment of a facility or organization as provider-based in paragraph (h) of this section.

(4) *Determination regarding provider-based status.* If HCFA finds that inappropriate billing has occurred or is occurring since no provider-based determination has been made by HCFA, HCFA will determine whether the facility or organization qualifies for provider-based status under the criteria in this section. If HCFA determines that the facility or organization qualifies for provider-based status, future payment for services at or by the facility or organization will be adjusted to reflect that determination. If HCFA determines that the facility or organization does not qualify for provider-based status, future payment for services at or by the facility or organization will be made only in accordance with the rules in paragraph (i)(5) of this section.

(5) *Continuation of payment.* The notice of denial of provider-based status sent to the provider will ask the provider to notify HCFA in writing, within 30 days of the date the notice is issued, of whether the facility or organization (or, where applicable, the practitioners who staff the facility or organization) will be seeking to enroll and meet other requirements to bill for services in a free-standing facility. If the provider indicates that the facility, organization, or practitioners will not be seeking to enroll, or if HCFA does not receive a response within 30 days of the date the notice was issued, all payment under this paragraph (i)(5) will end as of the 30th day after the date of notice. If the provider indicates that the facility or organization, or its practitioners, will be seeking to meet enrollment and other requirements for billing for services in a free-standing facility, payment for services of the facility or organization will continue, at the adjusted amounts described in paragraph (j)(2) of this section for as long as is required for all billing requirements to be met (but not longer than 6 months) if the facility or organization, or its practitioners, submit a complete enrollment application and provide all other required information within 90 days after the date of notice; and the facility or organization, or its practitioners, furnish all other information needed by HCFA to process the enrollment application and verify that other billing requirements are met. If the necessary applications or information are not provided, HCFA will terminate all payment to the provider, facility, or organization as of the date HCFA issues notice that necessary applications or information have not been submitted.

(k) *Correction of errors.* HCFA may review a past determination of provider-based status for a facility or organization or may review the status of a facility or organization (that is, whether the facility or organization is provider-based) if no determination regarding provider-based status has previously been made, if HCFA believes that status may be inappropriate, based on the provisions of this section. If HCFA determines that a previous determination was in error, and the entity should not be considered provider-based, HCFA notifies the main provider. Treatment of the facility or organization as provider-based ceases with the first day of the next cost report period following notification of the redetermination, but not less than 6 months after the date of notification.

(l) *Status of Indian Health Service and Tribal facilities and organizations.* Facilities and organizations operated by the Indian Health Service or Tribes will be considered to be departments of hospitals operated by the Indian Health Service or Tribes if, on or before April 7, 2000, they furnished only services that were billed as if they had been furnished by a department of a hospital operated by the Indian Health Service or a Tribe and they are:

(1) Owned and operated by the Indian Health Service;

(2) Owned by the Tribe but leased from the Tribe by the IHS under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes: or

(3) Owned by the Indian Health Service but leased and operated by the Tribe under the Indian Self-Determination Act (Pub. L. 93–638) in accordance with applicable regulations and policies of the Indian Health Service in consultation with Tribes.

(m) *FQHCs and ''look-alikes''.* A facility that has, since April 7, 1995, furnished only services that were billed as if they had been furnished by a department of a provider will continue to be treated, for purposes of this section, as a department of the provider without regard to whether it complies with the criteria for provider-based status in this section, if the facility—

(1) Received a grant before 1995 under section 330 of the Public Health Service Act, or is receiving funding from such a grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the Public Health Service Act; or

(2) Based on the recommendation of the Public Health Service, was determined by HCFA before 1995 to meet the requirements for receiving such a grant.

(n) *Effective date of provider-based status.* Provider-based status for a facility or organization is effective on the earliest date on which a request for provider-based status has been made, and all requirements of this part have been met.

Subpart F—Specific Categories of Costs

5. In § 413.118, the heading to paragraph (d) is republished, and a new paragraph (d)(5) is added to read as follows:

§ 413.118 Payment for facility services related to covered ASC surgical procedures performed in hospitals on an outpatient basis.

* * * * *

(d) *Blended payment amount.* * * *

(5) For portions of cost reporting periods beginning on or after October 1, 1997, for purposes of calculating the blended payment amount under paragraph (d)(4) of this section, the ASC payment amount is the sum of the standard overhead amounts reduced by deductibles and coinsurance as defined in section 1866(a)(2)(ii) of the Act.

* * * * *

6. In § 413.122:

A. The heading to paragraph (b) is republished

B. A new paragraph (b)(5) is added

C. The heading to paragraph (c) is republished; and

D. A new paragraph (c)(4) is added to read as follows:

§ 413.122 Payment for hospital outpatient radiology services and other diagnostic procedures.

* * * * *

(b) *Payment for hospital outpatient radiology services.* * * *

(5) For hospital outpatient radiology services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 42 percent of the hospital-specific amount; and

(ii) 58 percent of the fee schedule amount calculated as 62 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality, less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

(c) *Payment for other diagnostic procedures.* * * *

(4) For other diagnostic services furnished on or after October 1, 1997, the blended payment amount is equal to the sum of—

(i) 50 percent of the hospital-specific amount; and

(ii) 50 percent of the fee schedule amount calculated as 42 percent of the sum of the fee schedule amounts payable for the same services when furnished by participating physicians in their offices in the same locality less deductible and coinsurance as defined in section 1866(a)(2)(A)(ii) of the Act.

7. In § 413.124, paragraph (a) is revised to read as follows:

§ 413.124 Reduction to hospital outpatient operating costs.

(a) Except for sole community hospitals, as defined in § 412.92 of this chapter, and critical access hospitals, the reasonable costs of outpatient hospital services (other than capital-related costs of these services) are reduced by 5.8 percent for services furnished during portions of cost reporting periods occurring on or after October 1, 1990 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

* * * * *

Subpart G—Capital-Related Costs

8. In § 413.130, the heading to paragraph (j) and the introductory text to paragraph (j)(1) are republished, and paragraph (j)(1)(ii) is revised to read as follows:

§ 413.130 Introduction to capital-related costs.

* * * * *

(j) *Reduction to capital-related costs.* (1) Except for sole community hospitals and critical access hospitals, the amount of capital-related costs of all hospital outpatient services is reduced by—

* * * * *

(ii) 10 percent for portions of cost reporting periods occurring on or after October 1, 1991 and until the first date that the prospective payment system under part 419 of this chapter is implemented.

* * * * *

F. A new part 419, consisting of §§ 419.1, 419.2, 419.20, 419.21, 419.22, 419.30, 419.31, 419.32, 419.40, 419.41, 419.42, 419.43, 419.44, 419.50, 419.60, and 419.70, is added to read as follows:

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

Sec.

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

Subpart D—Payments to Hospitals

Subpart E—Updates

Subpart F—Limitations on Review

Subpart G—Transitional Corridors

Authority: Secs. 1102, 1833(t), and 1871 of the Social Security Act (42 U.S.C. 1302, 1395l(t), and 1395hh).

PART 419—PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Subpart A—General Provisions

§ 419.1 Basis and scope.

(a) *Basis.* This part implements section 1833(t) of the Act by establishing a prospective payment system for services furnished on or after July 1, 2000 by hospital outpatient departments to Medicare beneficiaries who are registered on hospital records as outpatients.

(b) *Scope.* This subpart describes the basis of payment for outpatient hospital services under the prospective payment system. Subpart B sets forth the categories of hospitals and services that are subject to the outpatient hospital prospective payment system and those categories of hospitals and services that are excluded from the outpatient hospital prospective payment system. Subpart C sets forth the basic methodology by which prospective payment rates for hospital outpatient services are determined. Subpart D describes Medicare payment amounts, beneficiary copayment amounts, and methods of payment to hospitals under the hospital outpatient prospective payment system. Subpart E describes how the hospital outpatient prospective payment system may be updated. Subpart F describes limitations on administrative and judicial review. Subpart G describes the transitional payment adjustments that are made before 2004 to limit declines in payment for outpatient services.

§ 419.2 Basis of payment.

(a) *Unit of payment.* Under the hospital outpatient prospective payment system, predetermined amounts are paid for designated services furnished to Medicare beneficiaries. These services are identified by codes established under the Health Care Financing Administration Common Procedure Coding System (HCPCS). The prospective payment rate for each service or procedure for which payment is allowed under the hospital outpatient prospective payment system is

determined according to the methodology described in subpart C of this part. The manner in which the Medicare payment amount and the beneficiary copayment amount for each service or procedure are determined is described in subpart D of this part.

(b) *Determination of hospital outpatient prospective payment rates: Included costs.* The prospective payment system establishes a national payment rate, standardized for geographic wage differences, that includes operating and capital-related costs that are directly related and integral to performing a procedure or furnishing a service on an outpatient basis. In general, these costs include, but are not limited to—

(1) Use of an operating suite, procedure room, or treatment room;

(2) Use of recovery room;

(3) Use of an observation bed;

(4) Anesthesia, certain drugs, biologicals, and other pharmaceuticals; medical and surgical supplies and equipment; surgical dressings; and devices used for external reduction of fractures and dislocations;

(5) Supplies and equipment for administering and monitoring anesthesia or sedation;

(6) Intraocular lenses (IOLs);

(7) Incidental services such as venipuncture;

(8) Capital-related costs;

(9) Implantable items used in connection with diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests;

(10) Durable medical equipment that is implantable;

(11) Implantable prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags and supplies directly related to colostomy care), including replacement of these devices; and

(12) Costs incurred to procure donor tissue other than corneal tissue.

(c) *Determination of hospital outpatient prospective payment rates: Excluded costs.* The following costs are excluded from the hospital outpatient prospective payment rates:

(1) Medical education costs for approved nursing and allied health education programs.

(2) Corneal tissue acquisition costs incurred by hospitals that are paid for on a reasonable cost basis.

(3) Costs for services listed in § 419.22.

Subpart B—Categories of Hospitals and Services Subject to and Excluded From the Hospital Outpatient Prospective Payment System

§ 419.20 Hospitals subject to the hospital outpatient prospective payment system.

(a) *Applicability.* The hospital outpatient prospective payment system is applicable to any hospital participating in the Medicare program, except those specified in paragraph (b) of this section, for services furnished on or after July 1, 2000.

(b) *Hospitals excluded from the outpatient prospective payment system.* (1) Those services furnished by Maryland hospitals that are paid under a cost containment waiver in accordance with section 1814(b)(3) of the Act are excluded from the hospital outpatient prospective payment system.

(2) Critical access hospitals (CAHs) are excluded from the hospital outpatient prospective payment system.

§ 419.21 Hospital outpatient services subject to the outpatient prospective payment system.

Except for services described in § 419.22, effective for services furnished on or after July 1, 2000, payment is made under the hospital outpatient prospective payment system for the following:

(a) Medicare Part B services furnished to hospital outpatients designated by the Secretary under this part.

(b) Services designated by the Secretary that are covered under Medicare Part B when furnished to hospital inpatients who are either not entitled to benefits under Part A or who have exhausted their Part A benefits but are entitled to benefits under Part B of the program.

(c) Partial hospitalization services furnished by community mental health centers (CMHCs).

(d) The following medical and other health services furnished by a comprehensive outpatient rehabilitation facility (CORF) when they are provided outside the patient's plan (of care); or by a home health agency (HHA) to patients who are not under an HHA plan or treatment; or by a hospice program furnishing services to patients outside the hospice benefit:

(1) Antigens.

(2) Splints and casts.

(3) Pneumococcal vaccine, influenza vaccine, and hepatitis B vaccine.

§ 419.22 Hospital outpatient services excluded from payment under the hospital outpatient prospective payment system.

The following services are not paid for under the hospital outpatient prospective payment system:

(a) Physician services that meet the requirements of § 415.102(a) of this chapter for payment on a fee schedule basis.

(b) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

(c) Physician assistant services, as defined in section 1861(s)(2)(K)(i) of the Act.

(d) Certified nurse-midwife services, as defined in section 1861(gg) of the Act.

(e) Services of qualified psychologists, as defined in section 1861(ii) of the Act.

(f) Services of an anesthetist as defined in § 410.69 of this chapter.

(g) Clinical social worker services as defined in section 1861(hh)(2) of the Act.

(h) Outpatient therapy services described in section 1833(a)(8) of the Act.

(i) Ambulance services, as described in section 1861(v)(1)(U) of the Act, or, if applicable, the fee schedule established under section 1834(l).

(j) Except as provided in § 419.22(b)(11), prosthetic devices, prosthetics, prosthetic supplies, and orthotic devices.

(k) Except as provided in § 419.2(b)(10), durable medical equipment supplied by the hospital for the patient to take home.

(l) Clinical diagnostic laboratory services.

(m) Services for patients with ESRD that are paid under the ESRD composite rate and drugs and supplies furnished during dialysis but not included in the composite rate.

(n) Services and procedures that the Secretary designates as requiring inpatient care.

(o) Hospital outpatient services furnished to SNF residents (as defined in § 411.15(p) of this chapter) as part of the patient's resident assessment or comprehensive care plan (and thus included under the SNF PPS) that are furnished by the hospital ''under arrangements'' but billable only by the SNF, regardless of whether or not the patient is in a Part A SNF stay.

(p) Services that are not covered by Medicare by statute.

(q) Services that are not reasonable or necessary for the diagnosis or treatment of an illness or disease.

Subpart C—Basic Methodology for Determining Prospective Payment Rates for Hospital Outpatient Services

§ 419.30 Base expenditure target for calendar year 1999.

(a) HCFA estimates the aggregate amount that would be payable for

hospital outpatient services in calendar year 1999 by summing—

(1) The total amounts that would be payable from the Trust Fund for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part; and

(2) The total amounts of coinsurance that would be payable by beneficiaries to hospitals for covered hospital outpatient services without regard to the outpatient prospective payment system described in this part.

(b) The estimated aggregate amount under paragraph (a) of this section is determined as though the deductible required under section 1833(b) of the Act did not apply.

§ 419.31 Ambulatory payment classification (APC) system and payment weights.

(a) *APC groups.* (1) HCFA classifies outpatient services and procedures that are comparable clinically and in terms of resource use into APC groups. Except as specified in paragraph (a)(2) of this section, items and services within a group are not comparable with respect to the use of resources if the highest median cost for an item or service within the group is more than 2 times greater than the lowest median cost for an item or service within the group.

(2) HCFA may make exceptions to the requirements set forth in paragraph (a)(1) in unusual cases, such as low volume items and services, but may not make such an exception in the case of a drug or biological that has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act.

(3) The payment rate determined for an APC group in accordance with § 419.32, and the copayment amount and program payment amount determined for an APC group in accordance with subpart D of this part, apply to every HCPCS code classified within an APC group.

(b) *APC weighting factors.* (1) Using hospital outpatient claims data from calendar year 1996 and data from the most recent available hospital cost reports, HCFA determines the median costs for the services and procedures within each APC group.

(2) HCFA assigns to each APC group an appropriate weighting factor to reflect the relative median costs for the services within the APC group compared to the median costs for the services in all APC groups.

(c) *Standardizing amounts.* (1) HCFA determines the portion of costs determined in paragraph (b)(1) of this section that is labor-related. This is known as the ''labor-related portion'' of hospital outpatient costs.

(2) HCFA standardizes the median costs determined in paragraph (b)(1) of this section by adjusting for variations in hospital labor costs across geographic areas.

§ 419.32 Calculation of prospective payment rates for hospital outpatient services.

(a) *Conversion factor for 1999.* HCFA calculates a conversion factor in such a manner that payment for hospital outpatient services furnished in 1999 would have equaled the base expenditure target calculated in § 419.30, taking into account APC group weights and estimated service frequencies and reduced by the amounts that would be payable in 1999 as outlier payments under § 419.43(d) and transitional pass-through payments under § 419.43(e).

(b) *Conversion factor for calendar year 2000 and subsequent years.* (1) Subject to paragraph (b)(2) of this section, the conversion factor for a calendar year is equal to the conversion factor calculated for the previous year adjusted as follows:

(i) For calendar years 2000, 2001, and 2002, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act reduced by one percentage point.

(ii) For calendar years 2003 and subsequent years, by the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(2) Beginning in calendar year 2000, HCFA may substitute for the hospital inpatient market basket percentage in paragraph (b) of this section a market basket percentage increase that is determined and applied to hospital outpatient services in the same manner that the hospital inpatient market basket percentage increase is determined and applied to inpatient hospital services.

(c) *Payment rates.* The payment rate for services and procedures for which payment is made under the hospital outpatient prospective payment system is the product of the conversion factor calculated under paragraph (a) or paragraph (b) of this section and the relative weight determined under § 419.31(b).

(d) *Budget neutrality.* HCFA adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral.

Subpart D—Payments to Hospitals

§ 419.40 Payment concepts.

(a) In addition to the payment rate described in § 419.32, for each APC group there is a predetermined beneficiary coinsurance amount as described in § 419.41(a). The Medicare program payment amount for each APC group is calculated by applying the program payment percentage as described in § 419.41(b).

(b) For purposes of this section—

(1) *Coinsurance percentage* is calculated as the difference between the program payment percentage and 100 percent. The coinsurance percentage in any year is thus defined for each APC group as the *greater* of the following: the ratio of the APC group unadjusted copayment amount *to* the annual APC group payment rate, or 20 percent.

(2) *Program payment percentage* is calculated as the *lower* of the following: the ratio of the APC group payment rate minus the APC group unadjusted coinsurance amount, *to* the APC group payment rate, *or* 80 percent.

(3) *Unadjusted coinsurance amount* is calculated as 20 percent of the wage-adjusted national median of charges for services within an APC group furnished during 1996, updated to 1999 using an actuarial projection of charge increases for hospital outpatient department services during the period 1996 to 1999.

(c) *Limitation of coinsurance amount to inpatient hospital deductible amount.* The coinsurance amount for a procedure performed in a year cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

§ 419.41 Calculation of national beneficiary coinsurance amounts and national Medicare program payment amounts.

(a) To calculate the unadjusted coinsurance amount for each APC group, HCFA—

(1) Standardizes 1996 hospital charges for the services within each APC group to offset variations in hospital labor costs across geographic areas;

(2) Identifies the median of the wage-neutralized 1996 charges for each APC group; and

(3) Determines the value equal to 20 percent of the wage-neutralized 1996 median charge for each APC group and multiplies that value by an actuarial projection of increases in charges for hospital outpatient department services during the period 1996 to 1999. The result is the unadjusted beneficiary coinsurance amount for the APC group.

(b) HCFA calculates annually the program payment percentage for every APC group on the basis of each group's unadjusted coinsurance amount and its payment rate after the payment rate is adjusted in accordance with § 419.32.

(c) To determine payment amounts due for a service paid under the hospital

outpatient prospective payment system, HCFA makes the following calculations:

(1) Makes the wage index adjustment in accordance with § 419.43.

(2) Subtracts the amount of the applicable Part B deductible provided under § 410.160 of this chapter.

(3) Multiplies the remainder by the program payment percentage for the group to determine the preliminary Medicare program payment amount.

(4) Subtracts the program payment amount from the amount determined in paragraph (c)(2) of this section to determine the coinsurance amount.

(i) The coinsurance amount for an APC cannot exceed the amount of the inpatient hospital deductible established under section 1813(b) of the Act for that year.

(ii) The coinsurance amount is computed as if the adjustments under § 419.43(d) and (e) (and any adjustment made under § 419.43(f) in relation to these adjustments) had not been paid.

(5) Adds the amount by which the coinsurance amount would have exceeded the inpatient hospital deductible for that year to the preliminary Medicare program payment amount determined in paragraph (c)(3) of this section to determine the final Medicare program payment amount.

§ 419.42 Hospital election to reduce coinsurance.

(a) A hospital may elect to reduce coinsurance for any or all APC groups on a calendar year basis. A hospital may *not* elect to reduce copayment for some, but not all, services within the same group.

(b) A hospital must notify its fiscal intermediary of its election to reduce coinsurance no later than—

(1) June 1, 2000, for coinsurance elections for the period July 1, 2000 through December 31, 2000; or

(2) December 1 preceding the beginning of each subsequent calendar year.

(c) The hospital's election must be properly documented. It must specifically identify the APCs to which it applies and the coinsurance amount (within the limits identified below) that the hospital has selected for each group.

(d) The election of reduced coinsurance remains in effect unchanged during the year for which the election was made.

(e) In electing reduced coinsurance, a hospital may elect a level that is less than that year's wage-adjusted coinsurance amount for the group but not less than 20 percent of the APC payment rate as determined in § 419.32.

(f) The hospital may advertise and otherwise disseminate information concerning the reduced level of coinsurance that it has elected. All advertisements and information furnished to Medicare beneficiaries must specify that the coinsurance reductions advertised apply only to the specified services of that hospital and that coinsurance reductions are available only for hospitals that choose to reduce coinsurance for hospital outpatient services and are not allowed in any other ambulatory settings or physician offices.

§ 419.43 Adjustments to national program payment and beneficiary coinsurance amounts.

(a) *General rule.* HCFA determines national prospective payment rates for hospital outpatient department services and determines a wage adjustment factor to adjust the portion of the APC payment and national beneficiary coinsurance amount attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner.

(b) *Labor-related portion of payment and copayment rates for hospital outpatient services.* HCFA determines the portion of hospital outpatient costs attributable to labor and labor-related costs (known as the ''labor-related portion'' of hospital outpatient costs) in accordance with § 419.31(c)(1).

(c) *Wage index factor.* HCFA uses the hospital inpatient prospective payment system wage index established in accordance with part 412 of this chapter to make the adjustment referred to in paragraph (a) of this section.

(d) *Outlier adjustment*—(1) *General rule.* Subject to paragraph (d)(4) of this section, HCFA provides for an additional payment for each hospital outpatient service (or group of services) for which a hospital's charges, adjusted to cost, exceed the following:

(i) A fixed multiple of the sum of—

(A) The applicable Medicare hospital outpatient payment amount determined under § 419.32(c), as adjusted under § 419.43 (other than for adjustments under this paragraph (d) or paragraph (e) of this section); and

(B) Any transitional pass-through payment under paragraph (e) of this section.

(ii) At the option of HCFA, a fixed dollar amount.

(2) *Amount of adjustment.* The amount of the additional payment under paragraph (d)(1) of this section is determined by HCFA and approximates the marginal cost of care beyond the applicable cutoff point under paragraph (d)(1) of this section.

(3) *Limit on aggregate outlier adjustments*—(i) *In general.* The total of the additional payments made under this paragraph (d) for covered hospital outpatient department services furnished in a year (as estimated by HCFA before the beginning of the year) may not exceed the applicable percentage specified in paragraph (d)(3)(ii) of this section of the total program payments (sum of both the Medicare and beneficiary payments to the hospital) estimated to be made under this part for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (d)(3)(i) of this section, the term ''applicable percentage'' means a percentage specified by HCFA up to (but not to exceed)—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, 3.0 percent.

(4) *Transitional authority.* In applying paragraph (d)(1) of this section for hospital outpatient services furnished before January 1, 2002, HCFA may—

(i) Apply paragraph (d)(1) of this section to a bill for these services related to an outpatient encounter (rather than for a specific service or group of services) using hospital outpatient payment amounts and transitional pass-through payments covered under the bill; and

(ii) Use an appropriate cost-to-charge ratio for the hospital or CMHC (as determined by HCFA), rather than for specific departments within the hospital.

(e) *Transitional pass-through for additional costs of innovative medical devices, drugs, and biologicals*—(1) *General rule.* HCFA provides for an additional payment under this paragraph for any of the following that are provided as part of a hospital outpatient service (or group of services):

(i) *Current orphan drugs.* A drug or biological that is used for a rare disease or condition with respect to which the drug or biological has been designated as an orphan drug under section 526 of the Federal Food, Drug and Cosmetic Act if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(ii) *Current cancer therapy drugs and biologicals and brachytherapy.* A drug or biological that is used in cancer therapy, including, but not limited to, a chemotherapeutic agent, an antiemetic,

a hematopoietic growth factor, a colony stimulating factor, a biological response modifier, a bisphosphonate, and a device of brachytherapy, if payment for the drug, biological, or device as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(iii) *Current radiopharmaceutical drugs and biological products.* A radiopharmaceutical drug or biological product used in diagnostic, monitoring, and therapeutic nuclear medicine procedures if payment for the drug or biological as an outpatient hospital service under this part was being made on the first date that the system under this part is implemented.

(iv) *New medical devices, drugs, and biologicals.* A medical device, drug, or biological not described in paragraph (e)(1)(i), (e)(1)(ii), or (e)(1)(iii) of this section if—

(A) Payment for the device, drug, or biological as an outpatient hospital service under this part was not being made as of December 31, 1996; and

(B) The cost of the device, drug, or biological is not insignificant (as defined in paragraph (e)(1)(iv)(C) of this section) in relation to the hospital outpatient fee schedule amount (as calculated under § 419.32(c)) payable for the service (or group of services) involved.

(C) The cost of the device, drug, or biological is considered not insignificant if it meets all of the following thresholds:

(*1*) Its expected reasonable cost exceeds 25 percent of the applicable fee schedule amount for the associated service.

(*2*) The expected reasonable cost of the new drug, biological, or device must exceed the current portion of the fee schedule amount determined to be associated with the drug, biological, or device by 25 percent.

(*3*) The difference between the expected reasonable cost of the item and the portion of the hospital outpatient fee schedule amount determined to be associated with the item exceeds 10 percent of the applicable hospital outpatient fee schedule amount.

(2) *Limited period of payment.* The payment under this paragraph (e) with respect to a medical device, drug, or biological applies during a period of at least 2 years, but not more than 3 years, that begins—

(i) On the first date this section is implemented in the case of a drug, biological, or device described in paragraphs (e)(2)(i), (e)(2)(ii), or (e)(2)(iii) of this section and in the case of a device, drug, or biological described in paragraph (e)(1)(iv) of this section and for which payment under this part is made as an outpatient hospital service before the first date; or

(ii) In the case of a device, drug, or biological described in paragraph (e)(1)(iv) of this section not described in paragraph (e)(2)(i) of this section, on the first date on which payment is made under this part for the device, drug, or biological as an outpatient hospital service.

(3) *Amount of additional payment.* Subject to paragraph (e)(4)(iii) of this section, the amount of the payment under this paragraph is—

(i) In the case of a drug or biological, the amount by which the amount determined under section 1842(o) of the Act for the drug or biological exceeds the portion of the otherwise applicable Medicare hospital outpatient fee schedule amount that HCFA determines is associated with the drug or biological; or

(ii) In the case of a medical device, the amount by which the hospital's charges for the device, adjusted to cost, exceeds the portion of the otherwise applicable Medicare hospital outpatient fee schedule amount that HCFA determines is associated with the device.

(4) *Limit on aggregate annual adjustment*—(i) *General rule.* The total of the additional payments made under this paragraph for hospital outpatient services furnished in a year, as estimated by HCFA before the beginning of the year, may not exceed the applicable percentage specified in paragraph (e)(4)(ii) of this section of the total program payments estimated to be made under this section for all hospital outpatient services furnished in that year. If this paragraph is first applied to less than a full year, the limit applies only to the portion of the year.

(ii) *Applicable percentage.* For purposes of paragraph (e)(4)(i) of this section, the term ''applicable percentage'' means—

(A) For a year (or portion of a year) before 2004, 2.5 percent; and

(B) For 2004 and thereafter, a percentage specified by HCFA up to (but not to exceed) 2.0 percent.

(iii) *Uniform prospective reduction if aggregate limit projected to be exceeded.* If HCFA estimates before the beginning of a year that the amount of the additional payments under this paragraph (e) for the year (or portion thereof) as determined under paragraph (e)(4)(i) of this section without regard to this paragraph (e)(4)(iii) would exceed the limit established under this paragraph (e)(4)(iii), HCFA reduces pro rata the amount of each of the additional payments under this paragraph for that year (or portion thereof) in order to ensure that the aggregate additional payments under this paragraph (as so estimated) do not exceed the limit.

(f) *Budget neutrality.* Outlier adjustments under paragraph (d) of this section and transitional pass-through payments under paragraph (e) of this section are established in a budget-neutral manner.

§ 419.44 Payment reductions for surgical procedures.

(a) *Multiple surgical procedures.* When more than one surgical procedure for which payment is made under the hospital outpatient prospective payment system is performed during a single surgical encounter, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts for the procedure with the highest APC payment rate; and

(2) One-half of the full program and the beneficiary payment amounts for all other covered procedures.

(b) *Terminated procedures.* When a surgical procedure is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary copayment amount are based on—

(1) The full amounts if the procedure is discontinued after the induction of anesthesia or after the procedure is started; or

(2) One-half of the full program and the beneficiary coinsurance amounts if the procedure is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before anesthesia is induced.

Subpart E—Updates

§ 419.50 Annual review.

(a) *General rule.* Not less often than annually, HCFA reviews and updates groups, relative payment weights, and the wage and other adjustments to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

(b) *Consultation requirement.* HCFA will consult with an expert outside advisory panel composed of an appropriate selection of representatives of providers to review (and advise HCFA concerning) the clinical integrity of the groups and weights. The panel may use data collected or developed by entities and organizations (other than the Department of Health and Human Services) in conducting the review.

(c) *Effective dates.* HCFA conducts the first annual review under paragraph (a) of this section in 2001 for payments made in 2002.

Subpart F—Limitations on Review

§ 419.60 Limitations on administrative and judicial review.

There can be no administrative or judicial review under sections 1869 and 1878 of the Act or otherwise of the following:

(a) The development of the APC system, including—

(1) Establishment of the groups and relative payment weights;

(2) Wage adjustment factors;

(3) Other adjustments; and

(4) Methods for controlling unnecessary increases in volume.

(b) The calculation of base amounts described in section 1833(t)(3) of the Act.

(c) Periodic adjustments described in section 1833(t)(9) of the Act.

(d) The establishment of a separate conversion factor for hospitals described in section 1886(d)(1)(B)(v) of the Act.

(e) The determination of the fixed multiple, or a fixed dollar cutoff amount, the marginal cost of care, or applicable percentage under § 419.43(d) or the determination of insignificance of cost, the duration of the additional payments (consistent with § 419.43(e)), the portion of the Medicare hospital outpatient fee schedule amount associated with particular devices, drugs, or biologicals, and the application of any pro rata reduction under § 419.43(e).

Subpart G—Transitional Corridors

§ 419.70 Transitional adjustment to limit decline in payment.

(a) *Before 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished before January 1, 2002, for which the prospective payment system amount (as defined in paragraph (e) of this section) is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount (as defined in paragraph (f) of this section), the amount of payment under this part is increased by 80 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.71 and the pre-BBA amount exceeds the product of 0.70 and the prospective payment system amount;

(3) At least 70 percent, but less than 80 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.63 and the pre-BBA amount, exceeds the product of 0.60 and the PPS amount; or

(4) Less than 70 percent of the pre-BBA amount, the amount of payment under this part shall be increased by 21 percent of the pre-BBA amount.

(b) *For 2002.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2002, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 70 percent of the amount of this difference;

(2) At least 80 percent, but less than 90 percent, of the pre-BBA amount, the amount of payment under this part is increased by the amount by which the product of 0.61 and the pre-BBA amount exceeds the product of 0.60 and the prospective payment system amount; or

(3) Less than 80 percent of the pre-BBA amount, the amount of payment under this part is increased by 13 percent of the pre-BBA amount.

(c) *For 2003.* Except as provided in paragraph (d) of this section, for covered hospital outpatient services furnished during 2003, for which the prospective payment system amount is—

(1) At least 90 percent, but less than 100 percent, of the pre-BBA amount, the amount of payment under this part is increased by 60 percent of the amount of this difference; or

(2) Less than 90 percent of the pre-BBA amount, the amount of payment under this part is increased by 6 percent of the pre-BBA amount.

(d) *Hold harmless provisions*—(1) *Temporary treatment for small rural hospitals.* For covered hospital outpatient services furnished in a calendar year before January 1, 2004 for which the prospective payment system amount is less than the pre-BBA amount, the amount of payment under this part is increased by the amount of that difference if the hospital—

(i) Is located in a rural area as defined in § 412.63(b) of this chapter or is treated as being located in a rural area under section 1886(d)(8)(E) of the Act; and

(ii) Has 100 or fewer beds as defined in § 412.105(b) of this chapter.

(2) *Permanent treatment for cancer hospitals.* In the case of a hospital described in § 412.23(f) of this chapter for which the prospective payment system amount is less than the pre-BBA amount for covered hospital outpatient services, the amount of payment under this part is increased by the amount of this difference.

(e) *Prospective payment system amount defined.* In this paragraph, the term ''prospective payment system amount'' means, with respect to covered hospital outpatient services, the amount payable under this part for these services (determined without regard to this paragraph or any reduction in coinsurance elected under § 419.42), including amounts payable as copayment under § 419.41, coinsurance under section 1866(a)(2)(A)(ii) of the Act, and the deductible under section 1833(b) of the Act.

(f) *Pre-BBA amount defined*—(1) *General rule.* In this paragraph, the ''pre-BBA amount'' means, with respect to covered hospital outpatient services furnished by a hospital or a community mental health center (CMHC) in a year, an amount equal to the product of the reasonable cost of the provider for these services for the portions of the provider's cost reporting period (or periods) occurring in the year and the base provider outpatient payment-to-cost ratio for the provider (as defined in paragraph (f)(2) of this section).

(2) *Base payment-to-cost-ratio defined.* For purposes of this paragraph, HCFA shall determine these ratios as if the amendments to sections 1833(i)(3)(B)(i)(II) and 1833(n)(1)(B)(i) of the Act made by section 4521 of the BBA, to require that the full amount beneficiaries paid as coinsurance under section 1862(a)(2)(A) of the Act are taken into account in determining Medicare Part B Trust Fund payment to the hospital, were in effect in 1996. The ''base payment-to-cost ratio'' for a hospital or CMHC means the ratio of—

(i) The provider's payment under this part for covered outpatient services furnished during the cost reporting period ending in 1996, including any payment for these services through cost-sharing described in paragraph (e) of this section; and

(ii) The reasonable cost of these services for this period, without applying the cost reductions under section 1861(v)(1)(S) of the Act.

(g) *Interim payments.* HCFA makes payments under this paragraph to hospitals and CMHCs on an interim basis, subject to retrospective adjustments based on settled cost reports.

(h) *No effect on coinsurance.* No payment made under this section affects the unadjusted coinsurance amount or the coinsurance amount described in § 419.41.

(i) *Application without regard to budget neutrality.* The additional payments made under this paragraph—

(1) Are not considered an adjustment under § 419.43(f); and

(2) Are not implemented in a budget neutral manner.

PART 424—CONDITIONS FOR MEDICARE PAYMENT

G. Part 424 is amended as set forth below:

1. The authority citation for part 424 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 424.24, the heading to paragraph (e) is republished, and a new paragraph (e)(3) is added to read as follows:

§ 424.24 Requirements for medical and other health services furnished by providers under Medicare Part B.

* * * * *

(e) *Partial hospitalization services: Content of certification and plan of treatment requirements*—

* * * * *

(3) *Recertification requirements.*

(i) *Signature.* The physician recertification must be signed by a physician who is treating the patient and has knowledge of the patient's response to treatment.

(ii) *Timing.* The first recertification is required as of the 18th day of partial hospitalization services. Subsequent recertifications are required at intervals established by the provider, but no less frequently than every 30 days.

(iii) *Content.* The recertification must specify that the patient would otherwise require inpatient psychiatric care in the absence of continued stay in the partial hospitalization program and describe the following:

(A) The patient's response to the therapeutic interventions provided by the partial hospitalization program.

(B) The patient's psychiatric symptoms that continue to place the patient at risk of hospitalization.

(C) Treatment goals for coordination of services to facilitate discharge from the partial hospitalization program.

* * * * *

PART 489—PROVIDER AGREEMENTS AND SUPPLIER APPROVAL

H. Part 489 is amended as set forth below:

1. The authority citation to part 489 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart B—Essentials of Provider Agreements

2. In § 489.20, the introductory text to the section is republished; the introductory text to paragraph (d) is revised; paragraphs (d)(3), (d)(4), and (d)(5) are redesignated as paragraphs (d)(4), (d)(5), and (d)(6), respectively; and a new paragraph (d)(3) is added to read as follows:

§ 489.20 Basic commitments.

The provider agrees to the following:

* * * * *

(d) In the case of a hospital or a CAH that furnishes services to Medicare beneficiaries, either to furnish directly or to make arrangements (as defined in § 409.3 of this chapter) for all Medicare-covered services to inpatients and outpatients of a hospital or a CAH except the following:

* * * * *

(3) Nurse practitioner and clinical nurse specialist services, as defined in section 1861(s)(2)(K)(ii) of the Act.

* * * * *

3. In § 489.24, the definition for ''Comes to the emergency department'' in paragraph (b) is revised, and a new paragraph (i) is added to read as follows:

§ 489.24 Special responsibilities of Medicare hospitals in emergency cases.

* * * * *

(b) * * *

Comes to the emergency department means, with respect to an individual requesting examination or treatment, that the individual is on the hospital property. For purposes of this section, ''property'' means the entire main hospital campus as defined in § 413.65(b) of this chapter, including the parking lot, sidewalk, and driveway, as well as any facility or organization that is located off the main hospital campus but has been determined under § 413.65 of this chapter to be a department of the hospital. The responsibilities of hospitals with respect to these off-campus facilities or organizations are described in paragraph (i) of this section. Property also includes ambulances owned and operated by the hospital even if the ambulance is not on hospital grounds. An individual in a nonhospital-owned ambulance on hospital property is considered to have come to the hospital's emergency department. An individual in a nonhospital-owned ambulance off hospital property is not considered to have come to the hospital's emergency department even if a member of the ambulance staff contacts the hospital by telephone or telemetry communications and informs the hospital that they want to transport the individual to the hospital for examination and treatment. In these situations, the hospital may deny access if it is in ''diversionary status,'' that is, it does not have the staff or facilities to accept any additional emergency patients. If, however, the ambulance staff disregards the hospital's instructions and transports the individual on to hospital property, the individual is considered to have come to the emergency department.

* * * * *

(i) *Off-campus departments.* If an individual comes to a facility or organization that is located off the main hospital campus but has been determined under § 416.35 of this chapter to be a department of the hospital and a request is made on the individual's behalf for examination or treatment of a potential emergency medical condition as otherwise described in paragraph (a) of this section, the hospital is obligated in accordance with the rules in this paragraph to provide the individual with an appropriate medical screening examination and any necessary stabilizing treatment or an appropriate transfer.

(1) *Capability of the hospital.* The capability of the hospital includes that of the hospital as a whole, not just the capability of the off-campus department. Except for cases described in paragraph (i)(3)(ii) of this section, the obligation of a hospital under this section must be discharged within the hospital as a whole. However, the hospital is not required to locate additional personnel or staff to off-campus departments to be on standby for possible emergencies.

(2) *Protocols for off-campus departments.* The hospital must establish protocols for the handling of individuals with potential emergency conditions at off-campus departments. These protocols must provide for direct contact between personnel at the off-campus department and emergency personnel at the main hospital campus and may provide for dispatch of practitioners, when appropriate, from the main hospital campus to the off-campus department to provide screening or stabilization services.

(i) If the off-campus department is an urgent care center, primary care center, or other facility that is routinely staffed by physicians, RNs, or LPNs, these department personnel must be trained, and given appropriate protocols, for the handling of emergency cases. At least one individual on duty at the off-campus department during its regular hours of operation must be designated

as a qualified medical person as described in paragraph (d) of this section. The qualified medical person must initiate screening of individuals who come to the off-campus department with a potential emergency medical condition, and may be able to complete the screening and provide any necessary stabilizing treatment at the off-campus department, or to arrange an appropriate transfer.

(ii) If the off-campus department is a physical therapy, radiology, or other facility not routinely staffed with physicians, RNs, or LPNs, the department's personnel must be given protocols that direct them to contact emergency personnel at the main hospital campus for direction. Under this direction, and in accordance with protocols established in advance by the hospital, the personnel at the off-campus department must describe patient appearance and report symptoms and, if appropriate, either arrange transportation of the individual to the main hospital campus in accordance with paragraph (i)(3)(i) of this section or assist in an appropriate transfer as described in paragraphs (i)(3)(ii) and (d)(2) of this section.

(3) *Movement or appropriate transfer from off-campus departments*—(i) If the main hospital campus has the capability required by the individual and movement of the individual to the main campus would not significantly jeopardize the life or health of the individual, the personnel at the off-campus department must assist in arranging this movement. Movement of the individual to the main campus of the hospital is not considered a transfer under this section, since the individual is simply being moved from one department of a hospital to another department or facility of the same hospital.

(ii) If transfer of an individual with a potential emergency condition to a medical facility other than the main hospital campus is warranted, either because the main hospital campus does not have the specialized capability or facilities required by the individual, or because the individual's condition is deteriorating so rapidly that taking the time needed to move the individual to the main hospital campus would significantly jeopardize the life or health of the individual, personnel at the off-campus department must, in accordance with protocols established in advance by the hospital, assist in arranging an appropriate transfer of the individual to a medical facility other than the main hospital. The protocols must include procedures and agreements established in advance with other hospitals or medical facilities in the area of the off-campus department to facilitate these appropriate transfers. Such a transfer would require—

(A) That there be either a request by or on behalf of the individual as described in paragraph (d)(1)(ii)(A) of this section or a certification by a physician or a qualified medical person as described in paragraph (d)(1)(ii)(B) or (d)(1)(ii)(C) of this section; and

(B) That the transfer comply with the requirements described in paragraph (d)(2) of this section.

(iii) If the individual is being appropriately transferred to another medical facility from the off-campus department, the requirement for the provision of medical treatment in paragraph (d)(2)(i) of this section would be met by provision of medical treatment within the capability of the transferring off-campus department.

PART 498—APPEALS PROCEDURES FOR DETERMINATIONS THAT AFFECT PARTICIPATION IN THE MEDICARE PROGRAM AND FOR DETERMINATIONS THAT AFFECT THE PARTICIPATION OF ICFs/MR AND CERTAIN NFs IN THE MEDICAID PROGRAM

I. Part 498 is amended as set forth below:

1. The authority citation for part 498 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

2. In § 498.2, the introductory text is republished, and the definition of ''Provider'' is revised to read as follows:

§ 498.2 Definitions.

As used in this part—

* * * * *

Provider means a hospital, critical access hospital (CAH), skilled nursing facility (SNF), comprehensive outpatient rehabilitation facility (CORF), home health agency (HHA), or hospice, that has in effect an agreement to participate in Medicare, that has in effect an agreement to participate in Medicaid, or a clinic, rehabilitation agency, or public health agency that has a similar agreement but only to furnish outpatient physical therapy or outpatient speech pathology services, and *prospective provider* means any of the listed entities that seeks to participate in Medicare as a provider or to have any facility or organization determined to be a department of the provider or provider-based entity under § 413.65 of this chapter.

* * * * *

3. In § 498.3, the introductory text to paragraph (b) is republished; paragraphs (b)(2) through (b)(15) are redesignated as paragraphs (b)(3) through (b)(16), respectively; and a new paragraph (b)(2) is added to read as follows:

§ 498.3 Scope and applicability.

* * * * *

(b) *Initial determinations by HCFA.* HCFA makes initial determinations with respect to the following matters:

* * * * *

(2) Whether a prospective department of a provider, remote location of a hospital, satellite facility, or provider-based entity qualifies for provider-based status under § 413.65 of this chapter, or whether such a facility or entity currently treated as a department of a provider, remote location of a hospital, satellite facility, or a provider-based entity no longer qualifies for that status under § 413.65 of this chapter.

* * * * *

PART 1003—CIVIL MONEY PENALTIES, ASSESSMENTS AND EXCLUSIONS

J. Part 1003 is amended as set forth below:

1. The authority citation for part 1003 is revised to read as follows:

Authority: 42 U.S.C. 1302, 1320–7, 1320a–7a, 1320a–7e, 1320b–10, 1395u(j), 1395u(k), 1395cc(g), 1395dd(d)(1), 1395mm, 1395nn(g), 1395ss(d), 1396(m), 11131(c), and 11137(b)(2).

2. Section 1003.100 is amended by revising paragraph (a), by republishing the introductory text to paragraphs (b) and (b)(1), by revising paragraphs (b)(1)(xi) and (b)(1)(xii), and by adding paragraph (b)(1)(xiii) to read as follows:

§ 1003.100 Basis and purpose.

(a) *Basis.* This part implements sections 1128(c), 1128A, 1128E, 1140, 1866(g), 1876(i), 1877(g), 1882(d) and 1903(m)(5) of the Social Security Act, and sections 421(c) and 427(b)(2) of Pub. L. 99–660 (42 U.S.C. 1320a–7, 1320a–7a, 1320a–7e, 1320a–7c, 1320b–10, 1395cc(g), 1395mm, 1395ss(d), 1396(m), 11131(c), and 11137(b)(2)).

(b) *Purpose.* This part—

(1) Provides for the imposition of civil money penalties and, as applicable, assessments against persons who—

* * * * *

(xi) Are physicians or entities that enter into an arrangement or scheme that they know or should know has as a principal purpose the assuring of referrals by the physician to a particular entity that, if made directly, would violate the provisions of § 411.353 of this title;

(xii) Violate the Federal health care programs' anti-kickback statute as set forth in section 1128B of the Act; or

(xiii) Knowingly and willfully present, or cause to be presented, a bill or request for payment for nonphysician services furnished to hospital patients (unless the services are furnished by the hospital, either directly or under an arrangement) in violation of sections 1862(a)(14) and 1866(a)(1)(H) of the Act.

* * * * *

3. Section 1003.102 is amended by republishing the introductory text to paragraph (b), by adding and reserving paragraphs (b)(12) through (b)(14), and by adding a new paragraph (b)(15) to read as follows:

§ 1003.102 Basis for civil money penalties and assessments.

* * * * *

(b) The OIG may impose a penalty, and where authorized, an assessment against any person (including an insurance company in the case of paragraphs (b)(5) and (b)(6) of this section) whom it determines in accordance with this part—

* * * * *

(15) Has knowingly and willfully presented, or caused to be presented, a bill or request for payment for items and services furnished to a hospital patient for which payment may be made under the Medicare or another Federal health care program, if that bill or request is inconsistent with an arrangement under section 1866(a)(1)(H) of the Act, or violates the requirements for such an arrangement.

* * * * *

4. Section 1003.103 is amended by revising paragraph (a), by adding and reserving paragraphs (i) and (j), and by adding a new paragraph (k) to read as follows:

§ 1003.103 Amount of penalty.

(a) Except as provided in paragraphs (b) and (d) through (k) of this section, the OIG may impose a penalty of not more than $10,000 for each item or service that is subject to a determination under § 1003.102.

* * * * *

(k) For violations of section 1862(a)(14) of the Act and § 1003.102(b)(15), the OIG may impose a penalty of not more than $2,000 for each bill or request for payment for items and services furnished to a hospital patient.

5. Section 1003.105 is amended by republishing the introductory text to paragraph (a)(1) and by revising paragraph (a)(1)(i) to read as follows:

§ 1003.105 Exclusion from participation in Medicare, Medicaid and other Federal health care programs.

(a)(1) Except as set forth in paragraph (b) of this section, in lieu of or in addition to any penalty or assessment, the OIG may exclude from participation in Medicare, Medicaid and other Federal health care programs the following persons for a period of time determined under § 1003.107—

(i) Any person who is subject to a penalty or assessment under § 1003.102(a), (b)(1) through (b)(4), or (b)(15).

* * * * *

(Catalog of Federal Domestic Assistance 93.774, Medicare—Supplementary Medical Insurance Program)

Dated: March 3, 2000.

Nancy-Ann Min DeParle,

Administrator, Health Care Financing Administration.

Dated: March 28, 2000.

June G. Brown,

Inspector General, Department of Health and Human Services.

Approved: March 29, 2000.

Donna E. Shalala,

Secretary.

Note: The following addenda will not appear in the Code of Federal Regulations.

Note to Addenda A, B, C, E and F: Addenda A, B, and C have a number of errors in the following columns: APC, status indicator, payment rate, and national unadjusted coinsurance and minimum unadjusted coinsurance. We identified these errors too late in preparing this rule for publication to correct them. Some of the errors are related to the status codes assigned to the HCPCS codes and APCs.

Some errors affect addenda B, C, and E. Several of these errors involve procedures incorrectly identified as inpatient procedures, and one inpatient procedure incorrectly identified as an outpatient procedure. Certain PET scan codes and other codes are shown in incorrect APCs. Screening sigmoidoscopy and colonoscopy APCs have the wrong HCPCS codes and incorrect payment rates and coinsurance amounts. Certain dental codes were inadvertently identified as errors, so their correct APC assignments, payment rate and coinsurance amounts were not shown in the addenda. Two breath tests are subject to the clinical diagnostic lab fee schedule. We have listed below the corrections that have payment implications.

Addendum F does not include status indicators G and H which identify items that are eligible for pass-through payments. (See section III.B.3 of the preamble for a complete description of all status indications used in conjunction with this final rule.)

We also note that the word ''proposed'' should not appear on any Addenda contained in this final rule such as on Addendum A or C.

The fiscal intermediaries will receive the necessary changes to process outpatient PPS claims correctly. We will post the corrected Addendum B on our Website and publish a correction document in the **Federal Register**.

Our Website address is *http://www.hcfa.gov/medicare/hopsmain.htm.*

LIST ACCOMPANYING NOTE TO ADDENDA A, B, C, E AND F

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Proposed Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
20979	E	US bone stimulation.					
31375	C	Partial removal of larynx.					
35481	T	Atherectomy, open	0081	19.36	$938.71	$434.25	$187.74
61795	S	Brain surgery using computer	0302	8.21	$398.08	$216.55	$79.62
61886	T	Implant neurostim arrays	0222	25.48	$1,235.45	$780.07	$247.09
75945	S	Intravascular us	0267	2.72	$131.88	$80.06	$26.38
75946	S	Intravascular us add-on	0267	2.72	$131.88	$80.06	$26.38
78267	A	Breath test attain/anal, c-14.					
78268	A	Breath test analysis, c-14.					
92978	S	Intravasc us, heart add-on	0267	2.72	$131.88	$80.06	$26.38
92979	S	Intravasc us, heart add-on	0267	2.72	$131.88	$80.06	$26.38
96570	T	Photodynamic Tx, 30 min	0973	5.16	$250.19	.....	$50.04
96571	T	Photodynamic Tx, addl 15 min	0973	5.16	$250.19	.....	$50.04
D0277	S	Vert bitewings-sev to eight	0330	1.51	$73.22	$14.64	$14.64
D0472	S	Gross exam, prep & report	0330	1.51	$73.22	$14.64	$14.64

LIST ACCOMPANYING NOTE TO ADDENDA A, B, C, E AND F—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Proposed Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D0473	S	Micro exam, prep & report	0330	1.51	$73.22	$14.64	$14.64
D0474	S	Micro w exam of surg margins	0330	1.51	$73.22	$14.64	$14.64
D0480	S	Cytopath smear prep & report	0330	1.51	$73.22	$14.64	$14.64
D4268	S	Surgical revision procedure	0330	1.51	$73.22	$14.64	$14.64
G0104	S	CA screen; flexible sigmoidscope	0159	2.83	$137.22	.....	$34.31
G0105	S	Colorectal screen; high risk ind	0158	7.98	$386.93	.....	$96.73
G0122	S	Colon ca scrn; barium enema	0157	1.79	$86.79	.....	$17.36
G0125	S	Lung Image (PET)	0981	46.40	$2,249.80	.....	$449.96
G0126	S	Lung Image (PET) staging	0981	46.40	$2,249.80	.....	$449.96
G0163	S	PET for rec of colorectal cancer	0981	46.40	$2,249.80	.....	$449.96
G0164	S	PET for lymphoma staging	0981	46.40	$2,249.80	.....	$449.96
G0165	S	PET, rec of melanoma/met cancer	0981	46.40	$2,249.80	.....	$449.96
G0168	T	Wound closure by adhesive	0970	0.52	$25.21	.....	$5.04
G0169	T	Removal tissue; no anesthesia	0013	0.91	$44.12	$17.66	$8.82
G0170	T	Skin biograft	0025	3.74	$181.34	$70.66	$36.27
G0171	T	Skin biograft add-on	0025	3.74	$181.34	$70.66	$36.27

ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0001	Photochemotherapy	S	0.47	$22.79	$8.49	$4.56
0002	Fine needle Biopsy/Aspiration	T	0.62	$30.06	$17.66	$6.01
0003	Bone Marrow Biopsy/Aspiration	T	0.98	$47.52	$27.99	$9.50
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow	T	1.84	$89.22	$32.57	$17.84
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow	T	5.41	$262.32	$119.75	$52.46
0006	Level I Incision & Drainage	T	2.00	$96.97	$33.95	$19.39
0007	Level II Incision & Drainage	T	3.68	$178.43	$72.03	$35.69
0008	Level III Incision & Drainage	T	6.15	$298.20	$113.67	$59.64
0009	Nail Procedures	T	0.74	$35.88	$9.63	$7.18
0010	Level I Destruction of Lesion	T	0.55	$26.67	$9.86	$5.33
0011	Level II Destruction of Lesion	T	2.72	$131.88	$50.01	$26.38
0012	Level I Debridement & Destruction	T	0.53	$25.70	$9.18	$5.14
0013	Level II Debridement & Destruction	T	0.91	$44.12	$17.66	$8.82
0014	Level III Debridement & Destruction	T	1.50	$72.73	$24.55	$14.55
0015	Level IV Debridement & Destruction	T	1.77	$85.82	$31.20	$17.16
0016	Level V Debridement & Destruction	T	3.53	$171.16	$74.67	$34.23
0017	Level VI Debridement & Destruction	T	12.45	$603.66	$289.16	$120.73
0018	Biopsy Skin, Subcutaneous Tissue or Mucous Membrane	T	0.94	$45.58	$17.66	$9.12
0019	Level I Excision/Biopsy	T	4.00	$193.95	$78.91	$38.79
0020	Level II Excision/Biopsy	T	6.51	$315.65	$130.53	$63.13
0021	Level III Excision/Biopsy	T	10.49	$508.63	$236.51	$101.73
0022	Level IV Excision/Biopsy	T	12.49	$605.60	$292.94	$121.12
0023	Exploration Penetrating Wound	T	1.98	$96.00	$40.37	$19.20
0024	Level I Skin Repair	T	2.43	$117.82	$44.50	$23.56
0025	Level II Skin Repair	T	3.74	$181.34	$70.66	$36.27
0026	Level III Skin Repair	T	12.11	$587.18	$277.92	$117.44
0027	Level IV Skin Repair	T	15.80	$766.10	$383.10	$153.22
0029	Incision/Excision Breast	T	12.85	$623.06	$303.50	$124.61
0030	Breast Reconstruction/Mastectomy	T	20.19	$978.95	$523.95	$195.79
0031	Hyperbaric Oxygen	S	3.00	$145.46	$140.85	$29.09
0032	Placement Transvenous Catheters/Arterial Cutdown	T	5.40	$261.83	$119.52	$52.37
0033	Partial Hospitalization	P	4.17	$202.19	$48.17	$40.44
0040	Arthrocentesis & Ligament/Tendon Injection	T	2.11	$102.31	$40.60	$20.46
0041	Arthroscopy	T	24.57	$1,191.33	$592.08	$238.27
0042	Arthroscopically-Aided Procedures	T	29.22	$1,416.79	$804.74	$283.36
0043	Closed Treatment Fracture Finger/Toe/Trunk	T	1.64	$79.52	$25.46	$15.90
0044	Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.17	$105.22	$38.08	$21.04
0045	Bone/Joint Manipulation Under Anesthesia	T	11.02	$534.33	$277.12	$106.87
0046	Open/Percutaneous Treatment Fracture or Dislocation	T	22.29	$1,080.78	$535.76	$216.16
0047	Arthroplasty without Prosthesis	T	22.09	$1,071.08	$537.03	$214.22
0048	Arthroplasty with Prosthesis	T	29.06	$1,409.03	$725.94	$281.81
0049	Level I Musculoskeletal Procedures Except Hand and Foot	T	15.04	$729.25	$356.95	$145.85
0050	Level II Musculoskeletal Procedures Except Hand and Foot	T	21.13	$1,024.53	$513.86	$204.91
0051	Level III Musculoskeletal Procedures Except Hand and Foot	T	27.76	$1,346.00	$675.24	$269.20
0052	Level IV Musculoskeletal Procedures Except Hand and Foot	T	36.16	$1,753.29	$930.91	$350.66
0053	Level I Hand Musculoskeletal Procedures	T	11.32	$548.87	$253.49	$109.77
0054	Level II Hand Musculoskeletal Procedures	T	19.66	$953.26	$472.33	$190.65
0055	Level I Foot Musculoskeletal Procedures	T	15.47	$750.10	$355.34	$150.02
0056	Level II Foot Musculoskeletal Procedures	T	17.30	$838.83	$405.81	$167.77

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The Payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0057	Bunion Procedures	T	21.00	$1,018.23	$496.65	$203.65
0058	Level I Strapping and Cast Application	S	1.09	$52.85	$19.27	$10.57
0059	Level II Strapping and Cast Application	S	1.74	$84.37	$29.59	$16.87
0060	Manipulation Therapy	S	0.77	$37.34	$7.80	$7.47
0070	Thoracentesis/Lavage Procedures	T	3.64	$176.49	$79.60	$35.30
0071	Level I Endoscopy Upper Airway	T	0.55	$26.67	$14.22	$5.33
0072	Level II Endoscopy Upper Airway	T	1.26	$61.09	$41.52	$12.22
0073	Level III Endoscopy Upper Airway	T	4.11	$199.28	$91.07	$39.86
0074	Level IV Endoscopy Upper Airway	T	13.61	$659.91	$347.54	$131.98
0075	Level V Endoscopy Upper Airway	T	18.55	$899.44	$467.29	$179.89
0076	Endoscopy Lower Airway	T	8.06	$390.81	$197.05	$78.16
0077	Level I Pulmonary Treatment	S	0.43	$20.85	$12.62	$4.17
0078	Level II Pulmonary Treatment	S	1.34	$64.97	$29.13	$12.99
0079	Ventilation Initiation and Management	S	3.18	$154.19	$107.70	$30.84
0080	Diagnostic Cardiac Catheterization	T	25.77	$1,249.51	$713.89	$249.90
0081	Non-Coronary Angioplasty or Atherectomy	T	19.36	$938.71	$434.25	$187.74
0082	Coronary Atherectomy	T	40.34	$1,955.97	$859.56	$391.19
0083	Coronary Angiosplasty	T	45.79	$2,220.22	$1,322.95	$444.04
0084	Level I Electrophysiologic Evaluation	S	10.70	$518.81	$177.79	$103.76
0085	Level II Electrophysiologic Evaluation	S	27.06	$1,312.06	$654.48	$262.41
0086	Ablate Heart Dysrhythm Focus	S	47.62	$2,308.95	$1,265.37	$461.79
0087	Cardiac Electrophysiologic Recording/Mapping	S	9.53	$462.08	$214.72	$92.42
0088	Thrombectomy	T	26.49	$1,284.42	$678.68	$256.88
0089	Level I Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device.	T	6.49	$314.68	$130.07	$62.94
0090	Level II Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device.	T	20.96	$1,016.29	$573.04	$203.26
0091	Level I Vascular Ligation	T	14.79	$717.12	$348.23	$143.42
0092	Level II Vascular Ligation	T	20.21	$979.92	$505.37	$195.98
0093	Vascular Repair/Fistula Construction	T	17.95	$870.34	$422.33	$174.07
0094	Resuscitation and Cardioversion	S	4.51	$218.68	$105.29	$43.74
0095	Cardiac Rehabilitation	S	0.64	$31.03	$16.98	$6.21
0096	Non-Invasive Vascular Studies	S	2.06	$99.88	$61.48	$19.98
0097	Cardiovascular Stress Test	S	1.62	$78.55	$62.40	$15.71
0098	Injection of Sclerosing Solution	T	1.19	$57.70	$20.88	$11.54
0099	Continuous Cardiac Monitoring	S	0.38	$18.43	$14.68	$3.69
0100	Continuous ECG	S	1.70	$82.43	$71.57	$16.49
0101	Tilt Table Evaluation	S	4.47	$216.74	$128.84	$43.35
0102	Electronic Analysis of Pacemakers/other Devices	S	0.45	$21.82	$12.62	$4.36
0109	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant	S	4.13	$200.25	$40.05	$40.05
0110	Transfusion	S	5.83	$282.68	$122.73	$56.54
0111	Blood Product Exchange	S	14.17	$687.06	$300.74	$137.41
0112	Extracorporeal Photopheresis	S	39.60	$1,920.09	$663.65	$384.02
0113	Excision Lymphatic System	T	13.89	$673.49	$326.55	$134.70
0114	Thyroid/Lymphadenectomy Procedures	T	19.56	$948.41	$493.78	$189.68
0116	Chemotherapy Administration by Other Technique Except Infusion	S	2.34	$113.46	$22.69	$22.69
0117	Chemotherapy Administration by Infusion Only	S	1.84	$89.22	$71.80	$17.84
0118	Chemotherapy Administration by Both Infusion and Other Technique	S	2.90	$140.61	$72.03	$28.12
0120	Infusion Therapy Except Chemotherapy	S	1.66	$80.49	$42.67	$16.10
0121	Level I Tube changes and Repositioning	T	2.36	$114.43	$52.53	$22.89
0122	Level II Tube changes and Repositioning	T	5.04	$244.37	$114.93	$48.88
0123	Level III Tube changes and Repositioning	T	13.89	$673.49	$350.75	$134.70
0130	Level I Laparoscopy	T	25.36	$1,229.63	$659.53	$245.93
0131	Level II Laparoscopy	T	41.81	$2,027.24	$1,089.88	$405.45
0132	Level III Laparoscopy	T	48.91	$2,371.50	$1,239.22	$474.30
0140	Esophageal Dilation without Endoscopy	T	4.74	$229.83	$107.24	$45.97
0141	Upper GI Procedures	T	7.15	$346.68	$184.67	$69.34
0142	Small Intestine Endoscopy	T	7.45	$361.23	$162.42	$72.25
0143	Lower GI Endoscopy	T	7.98	$386.93	$199.12	$77.39
0144	Diagnostic Anoscopy	T	2.23	$108.13	$49.32	$21.63
0145	Therapeutic Anoscopy	T	7.46	$361.71	$179.39	$72.34
0146	Level I Sigmoidoscopy	T	2.83	$137.22	$65.15	$27.44
0147	Level II Sigmoidoscopy	T	6.26	$303.53	$149.11	$60.71
0148	Level I Anal/Rectal Procedure	T	2.34	$113.46	$43.59	$22.69
0149	Level II Anal/Rectal Procedure	T	12.86	$623.54	$293.06	$124.71
0150	Level III Anal/Rectal Procedure	T	17.68	$857.25	$437.12	$171.45
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)	T	10.53	$510.57	$245.46	$102.11
0152	Percutaneous Biliary Endoscopic Procedures	T	8.22	$398.56	$207.38	$79.71
0153	Peritoneal and Abdominal Procedures	T	19.62	$951.32	$496.31	$190.26
0154	Hernia/Hydrocele Procedures	T	22.43	$1,087.57	$556.98	$217.51
[2] 0157	Colorectal Cancer Screening: Barium Enema	S	1.79	$86.79	.....	$17.36
[1] 0158	Colorectal Cancer Screening: Colonoscopy	S	7.98	$386.93	.....	$96.73
[1] 0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy	S	7.98	$137.22	.....	$34.31

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The Payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0160	Level I Cystourethroscopy and other Genitourinary Procedures	T	5.43	$263.28	$110.11	$52.66
0161	Level II Cystourethroscopy and other Genitourinary Procedures	T	10.94	$530.45	$249.36	$106.09
0162	Level III Cystourethroscopy and other Genitourinary Procedures	T	17.49	$848.04	$427.49	$169.61
0163	Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.98	$1,405.16	$792.58	$281.03
0164	Level I Urinary and Anal Procedures	T	2.17	$105.23	$33.03	$21.05
0165	Level II Urinary and Anal Procedures	T	3.89	$188.61	$91.76	$37.72
0166	Level I Urethral Procedures	T	10.17	$493.11	$218.73	$98.62
0167	Level II Urethral Procedures	T	21.06	$1,021.14	$555.84	$204.23
0168	Level III Urethral Procedures	T	24.94	$1,209.27	$536.11	$241.85
0169	Lithotripsy	T	46.72	$2,265.32	$1,384.20	$453.06
0170	Dialysis for Other Than ESRD Patients	S	6.68	$323.89	$72.26	$64.78
0180	Circumcision	T	13.62	$660.39	$304.87	$132.08
0181	Penile Procedures	T	32.37	$1,569.53	$906.36	$313.91
0182	Insertion of Penile Prosthesis	T	52.11	$2,526.66	$1,525.05	$505.33
0183	Testes/Epididymis Procedures	T	18.26	$885.37	$448.94	$177.07
0184	Prostate Biopsy	T	4.94	$239.53	$122.96	$47.91
0190	Surgical Hysteroscopy	T	17.85	$865.49	$443.89	$173.10
0191	Level I Female Reproductive Procedures	T	1.19	$57.70	$17.43	$11.54
0192	Level II Female Reproductive Procedures	T	2.38	$115.40	$35.33	$23.08
0193	Level III Female Reproductive Procedures	T	8.93	$432.99	$171.13	$86.60
0194	Level IV Female Reproductive Procedures	T	16.21	$785.98	$395.94	$157.20
0195	Level V Female Reproductive Procedures	T	18.68	$905.74	$483.80	$181.15
0196	Dilatation & Curettage	T	14.47	$701.61	$357.98	$140.32
0197	Infertility Procedures	T	2.40	$116.37	$49.55	$23.27
0198	Pregnancy and Neonatal Care Procedures	T	1.34	$64.97	$33.03	$12.99
0199	Vaginal Delivery	T	11.20	$543.06	$157.83	$108.61
0200	Therapeutic Abortion	T	13.89	$673.49	$373.23	$134.70
0201	Spontaneous Abortion	T	13.00	$630.33	$329.65	$126.07
0210	Spinal Tap	T	3.00	$145.46	$62.40	$29.09
0211	Level I Nervous System Injections	T	3.32	$160.98	$74.78	$32.20
0212	Level II Nervous System Injections	T	3.64	$176.49	$88.78	$35.30
0213	Extended EEG Studies and Sleep Studies	S	11.15	$540.63	$290.42	$108.13
0214	Electroencephalogram	S	2.32	$112.49	$58.50	$22.50
0215	Level I Nerve and Muscle Tests	S	1.15	$55.76	$30.05	$11.15
0216	Level II Nerve and Muscle Tests	S	2.87	$139.16	$64.69	$27.83
0217	Level III Nerve and Muscle Tests	S	5.87	$284.62	$156.68	$56.92
0220	Level I Nerve Procedures	T	13.96	$676.88	$326.21	$135.38
0221	Level II Nerve Procedures	T	18.36	$890.22	$463.62	$178.04
0222	Implantation of Neurological Device	T	25.48	$1,235.45	$780.07	$247.09
0223	Level I Revision/Removal Neurological Device	T	6.34	$307.41	$153.24	$61.48
0224	Level II Revision/Removal Neurological Device	T	15.94	$772.88	$374.61	$154.58
0225	Implantation of Neurostimulator Electrodes	T	3.43	$166.31	$64.46	$33.26
0230	Level I Eye Tests	S	0.98	$47.52	$22.48	$9.50
0231	Level II Eye Tests	S	2.64	$128.01	$59.87	$25.60
0232	Level I Anterior Segment Eye	T	6.04	$292.86	$134.66	$58.57
0233	Level II Anterior Segment Eye	T	13.79	$668.64	$331.60	$133.73
0234	Level III Anterior Segment Eye Procedures	T	20.64	$1,000.77	$502.16	$200.15
0235	Level I Posterior Segment Eye Procedures	T	2.94	$142.55	$78.91	$28.51
0236	Level II Posterior Segment Eye Procedures	T	6.70	$324.86	$147.96	$64.97
0237	Level III Posterior Segment Eye Procedures	T	33.96	$1,646.62	$852.68	$329.32
0238	Level I Repair and Plastic Eye Procedures	T	2.80	$135.76	$58.96	$27.15
0239	Level II Repair and Plastic Eye Procedures	T	6.26	$303.53	$123.42	$60.71
0240	Level III Repair and Plastic Eye Procedures	T	13.47	$653.12	$315.31	$130.62
0241	Level IV Repair and Plastic Eye Procedures	T	16.60	$804.89	$384.47	$160.98
0242	Level V Repair and Plastic Eye Procedures	T	23.70	$1,149.14	$597.36	$229.83
0243	Strabismus/Muscle Procedures	T	17.99	$872.28	$431.39	$174.46
0244	Corneal Transplant	T	32.88	$1,594.26	$851.42	$318.85
0245	Cataract Procedures without IOL Insert	T	26.55	$1,287.33	$623.85	$257.47
0246	Cataract Procedures with IOL Insert	T	26.55	$1,287.33	$623.85	$257.47
0247	Laser Eye Procedures Except Retinal	T	4.89	$237.10	$112.86	$47.42
0248	Laser Retinal Procedures	T	4.19	$203.16	$94.05	$40.63
0250	Nasal Cauterization/Packing	T	2.21	$107.16	$38.54	$21.43
0251	Level I ENT Procedures	T	1.68	$81.46	$27.99	$16.29
0252	Level II ENT Procedures	T	5.18	$251.16	$114.24	$50.23
0253	Level III ENT Procedures	T	12.02	$582.81	$284.00	$116.56
0254	Level IV ENT Procedures	T	12.45	$603.66	$272.41	$120.73
0256	Level V ENT Procedures	T	25.40	$1,231.57	$623.05	$246.31
0257	Implantation of Cochlear Device	T	115.31	$5,591.04	$3,498.58	$1,118.21
0258	Tonsil and Adenoid Procedures	T	18.62	$902.83	$462.81	$180.57
0260	Level I Plain Film Except Teeth	X	0.79	$38.30	$22.02	$7.66
0261	Level II Plain Film Except Teeth Including Bone Density Measurement.	X	1.38	$66.91	$38.77	$13.38
0262	Plain Film of Teeth	X	0.40	$19.39	$10.90	$3.88

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ADDENDUM A.—LIST OF HOSPITAL OUTPATIENT AMBULATORY PAYMENT CLASSES WITH STATUS INDICATORS, RELATIVE WEIGHTS, PAYMENT RATES, AND COINSURANCE AMOUNTS—Continued

APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0263	Level I Miscellaneous Radiology Procedures	X	1.68	$81.46	$45.88	$16.29
0264	Level II Miscellaneous Radiology Procedures	X	3.83	$185.71	$108.97	$37.14
0265	Level I Diagnostic Ultrasound Except Vascular	S	1.17	$56.73	$38.08	$11.35
0266	Level II Diagnostic Ultrasound Except Vascular	S	1.79	$86.79	$57.35	$17.36
0267	Vascular Ultrasound	S	2.72	$131.88	$80.06	$26.38
0268	Guidance Under Ultrasound	X	2.23	$108.13	$69.51	$21.63
0269	Echocardiogram Except Transesophageal	S	4.40	$213.34	$114.01	$42.67
0270	Transesophageal Echocardiogram	S	5.55	$269.10	$150.26	$53.82
0271	Mammography	S	0.70	$33.94	$19.50	$6.79
0272	Level I Fluoroscopy	X	1.40	$67.88	$39.00	$13.58
0273	Level II Fluoroscopy	X	2.49	$120.73	$61.02	$24.15
0274	Myelography	S	4.83	$234.19	$128.12	$46.84
0275	Arthrography	S	2.74	$132.85	$72.26	$26.57
0276	Level I Digestive Radiology	S	1.79	$86.79	$49.78	$17.36
0277	Level II Digestive Radiology	S	2.47	$119.76	$69.28	$23.95
0278	Diagnostic Urography	S	2.85	$138.19	$81.67	$27.64
0279	Level I Diagnostic Angiography and Venography Except Extremity	S	6.30	$305.47	$174.57	$61.09
0280	Level II Diagnostic Angiography and Venography Except Extremity	S	14.98	$726.34	$380.12	$145.27
0281	Venography of Extremity	S	4.40	$213.34	$115.16	$42.67
0282	Level I Computerized Axial Tomography	S	2.38	$115.40	$94.51	$23.08
0283	Level II Computerized Axial Tomography	S	4.89	$237.10	$179.39	$47.42
0284	Magnetic Resonance Imaging	S	8.02	$388.87	$257.39	$77.77
0285	Positron Emission Tomography (PET)	S	15.06	$730.22	$415.21	$146.04
0286	Myocardial Scans	S	7.28	$352.99	$200.04	$70.60
0290	Standard Non-Imaging Nuclear Medicine	S	1.94	$94.06	$55.51	$18.81
0291	Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.15	$152.73	$93.14	$30.55
0292	Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.36	$211.40	$126.63	$42.28
0294	Level I Therapeutic Nuclear Medicine	S	5.13	$248.74	$144.06	$49.75
0295	Level II Therapeutic Nuclear Medicine	S	19.85	$962.47	$609.17	$192.49
0296	Level I Therapeutic Radiologic Procedures	S	3.57	$173.10	$100.25	$34.62
0297	Level II Therapeutic Radiologic Procedures	S	6.13	$297.23	$172.51	$59.45
0300	Level I Radiation Therapy	S	1.98	$96.00	$47.72	$19.20
0301	Level II Radiation Therapy	S	2.21	$107.16	$52.53	$21.43
0302	Level III Radiation Therapy	S	8.21	$398.08	$216.55	$79.62
0303	Treatment Device Construction	X	2.83	$137.22	$69.28	$27.44
0304	Level I Therapeutic Radiation Treatment Preparation	X	1.49	$72.25	$41.52	$14.45
0305	Level II Therapeutic Radiation Treatment Preparation	X	4.06	$196.86	$97.50	$39.37
0310	Level III Therapeutic Radiation Treatment Preparation	X	13.98	$677.85	$339.05	$135.57
0311	Radiation Physics Services	X	1.32	$64.00	$31.66	$12.80
0312	Radioelement Applications	S	4.09	$198.31	$109.65	$39.66
0313	Brachytherapy	S	7.89	$382.56	$164.02	$76.51
0314	Hyperthermic Therapies	S	5.88	$285.10	$150.95	$57.02
0320	Electroconvulsive Therapy	S	3.68	$178.43	$80.06	$35.69
0321	Biofeedback and Other Training	S	1.26	$61.09	$29.25	$12.22
0322	Brief Individual Psychotherapy	S	1.32	$64.00	$14.22	$12.80
0323	Extended Individual Psychotherapy	S	1.85	$89.70	$22.48	$17.94
0324	Family Psychotherapy	S	1.87	$90.67	$20.19	$18.13
0325	Group Psychotherapy	S	1.55	$75.16	$19.96	$15.03
0330	Dental Procedures	S	1.51	$73.22	$14.64	$14.64
0340	Minor Ancillary Procedures	X	1.04	$50.43	$12.85	$10.09
0341	Immunology Tests	X	0.13	$6.30	$3.67	$1.26
0342	Level I Pathology	X	0.26	$12.61	$8.03	$2.52
0343	Level II Pathology	X	0.45	$21.82	$12.16	$4.36
0344	Level III Pathology	X	0.79	$38.30	$23.63	$7.66
[2] 0354	Administration of Influenza Vaccine	X	0.13	$6.19	.....	.....
0355	Level I Immunizations	X	0.19	$9.21	$5.05	$1.84
0356	Level II Immunizations	X	0.36	$17.46	$4.82	$3.49
0357	Level III Immunizations	X	1.85	$89.70	$38.31	$17.94
0358	Level IV Immunizations	X	6.98	$338.44	$126.74	$67.69
0359	Injections	X	0.96	$46.55	$9.31	$9.31
0360	Level I Alimentary Tests	X	1.38	$66.91	$34.75	$13.38
0361	Level II Alimentary Tests	X	3.53	$171.16	$88.09	$34.23
0362	Fitting of Vision Aids	X	0.51	$24.73	$9.63	$4.95
0363	Otorhinolaryngologic Function Tests	X	2.83	$137.22	$53.22	$27.44
0364	Level I Audiometry	X	0.68	$32.97	$13.31	$6.59
0365	Level II Audiometry	X	1.47	$71.28	$22.48	$14.26
0366	Electrocardiogram (ECG)	X	0.38	$18.43	$15.60	$3.69
0367	Level I Pulmonary Test	X	0.83	$40.24	$20.65	$8.05
0368	Level II Pulmonary Tests	X	1.66	$80.49	$42.44	$16.10
0369	Level III Pulmonary Tests	X	2.34	$113.46	$58.50	$22.69
0370	Allergy Tests	X	0.57	$27.64	$11.81	$5.53
0371	Allergy Injections	X	0.32	$15.52	$3.67	$3.10
0372	Therapeutic Phlebotomy	X	0.43	$20.85	$10.09	$4.17

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APC	Group Title	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0373	Neuropsychological Testing	X	3.21	$155.64	$44.96	$31.13
0374	Monitoring Psychiatric Drugs	X	1.17	$56.73	$13.08	$11.35
0600	Low Level Clinic Visits	V	0.98	$47.52	$9.50	$9.50
0601	Mid Level Clinic Visits	V	1.00	$48.49	$9.70	$9.70
0602	High Level Clinic Visits	V	1.66	$80.49	$16.29	$16.10
0603	Interdisciplinary Team Conference	V	1.66	$80.49	$16.29	$16.10
0610	Low Level Emergency Visits	V	1.34	$64.97	$20.65	$12.99
0611	Mid Level Emergency Visits	V	2.11	$102.31	$36.47	$20.46
0612	High Level Emergency Visits	V	3.19	$154.67	$54.14	$30.93
0620	Critical Care	S	8.60	$416.99	$152.78	$83.40
[3]0701	Strontium	X				$84.76
[3]0702	Samariam	X				$139.06
[3]0704	Satumomab Pendetide	X				$63.13
[3]0705	Tc99 Tetrofosmin	X				$71.08
[3]0725	Leucovorin Calcium	X				$1.07
[3]0726	Dexrazoxane Hydrochloride	X				$18.81
[3]0727	Injection, Etidronate Disodium	X				$9.31
[3]0728	Filgrastim (G–CSF)	X				$25.21
[3]0730	Pamidronate Disodium	X				$30.93
[3]0731	Sargramostim (GM–CSF)	X				$16.97
[3]0732	Mesna	X				$2.42
[3]0733	Epoetin Alpha	X				$1.75
[3]0750	Dolasetron Mesylate 10 mg	X				$1.94
[3]0754	Metoclopramide HCL	X				$.19
[3]0755	Thiethylperazine Maleate	X				$.68
[3]0761	Oral Substitute for IV Antiemtic	X				$.10
[3]0762	Dronabinol	X				$.48
[3]0763	Dolasetron Mesylate 100 mg Oral	X				$8.53
[3]0764	Granisetron HCL, 100 mcg	X				$2.33
[3]0765	Granisetron HCL, 1mg Oral	X				$3.20
[3]0768	Ondansetron Hydrochloride per 1 mg Injection	X				$.87
[3]0769	Ondansetron Hydrochloride 8 mg oral	X				$2.62
[3]0800	Leuprolide Acetate per 3.75 mg	X				$68.56
[3]0801	Cyclophosphamide	X				$.19
[3]0802	Etoposide	X				$3.10
[3]0803	Melphalan	X				$.19
[3]0807	Aldesleukin single use vial	X				$65.07
[3]0809	BCG (Intravesical) one vial	X				$19.78
[3]0810	Goserelin Acetate Implant, per 3.6 mg	X				$59.74
[3]0811	Carboplatin 50 mg	X				$13.96
[3]0812	Carmustine 100 mg	X				$10.57
[3]0813	Cisplatin 10 mg	X				$4.56
[3]0814	Asparaginase, 10,000 units	X				$8.34
[3]0815	Cyclophosphamide 100 mg	X				$.48
[3]0816	Cyclophosphamide, Lyophilized 100 mg	X				$1.16
[3]0817	Cytrabine 100 mg	X				$.68
[3]0818	Dactinomycin 0.5 mg	X				$1.75
[3]0819	Dacarbazine 100 mg	X				$1.26
[3]0820	Daunorubicin HCl 10 mg	X				$11.64
[3]0821	Daunorubicin Citrate, Liposomal Formulation, 10 mg	X				$7.76
[3]0822	Diethylstibestrol Diphosphate 250 mg	X				$2.13
[3]0823	Docetaxel 20 mg	X				$34.72
[3]0824	Etoposide 10 mg	X				$.58
[3]0826	Methotrexate Oral 2.5 mg	X				$.29
[3]0827	Floxuridine 500 mg	X				$18.81
[3]0828	Gemcitabine HCL 200 mg	X				$9.31
[3]0830	Irinotecan 20 mg	X				$14.16
[3]0831	Ifosfamide per 1 gram	X				$13.58
[3]0832	Idarubicin Hydrochloride 5 mg	X				$46.45
[3]0833	Interferon Alfacon-1, Recombinant, 1 mcg	X				$.19
[3]0834	Interferon, Alfa-2A, Recombinant 3 million units	X				$3.20
[3]0836	Interferon, Alfa-2B, Recombinant, 1 million units	X				$1.36
[3]0838	Interferon, Gamma 1-B, 3 million units	X				$22.79
[3]0839	Mechlorethamine HCI 10 mg	X				$1.65
[3]0840	Melphalan HCI 50 mg	X				$44.71
[3]0841	Methotrexate Sodium 5 mg	X				$.10
[3]0842	Fludarabine Phosphate 50 mg	X				$30.84
[3]0843	Pegaspargase per single dose vial	X				$178.72
[3]0844	Pentostatin 10 mg	X				$133.73
[3]0847	Doxorubicin HCL 10 mg	X				$2.81
[3]0849	Rituximab, 100 mg	X				$51.40
[3]0850	Streptozocin 1 gm	X				$14.64
[3]0851	Thiotepa 15 mg	X				$9.50

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[3] 0852	Topotecan 4 mg	X				$73.22
[3] 0853	Vinblastine Sulfate 1 mg	X				$.39
[3] 0854	Vincristine Sulfate 1 mg	X				$2.23
[3] 0855	Vinorelbine Tartrate per 10 mg	X				$9.60
[3] 0856	Porfimer Sodium 75 mg	X				$34.62
[3] 0857	Bleomycin Sulfate 15 units	X				$48.29
[3] 0858	Cladribine, 1mg	X				$8.24
[3] 0859	Fluorouracil	X				$.19
[3] 0860	Plicamycin 2.5 mg	X				$1.36
[3] 0861	Leuprolide Acetate 1 mg	X				$19.39
[3] 0862	Mitomycin, 5mg	X				$19.88
[3] 0863	Paclitaxel, 30mg	X				$30.16
[3] 0864	Mitoxantrone HCl, per 5mg	X				$25.80
[3] 0865	Interferon alfa-N3, 250,000 IU	X				$1.07
[3] 0884	Rho (D) Immune Globulin, Human one dose pack	X				$3.78
[2] 0886	Azathioprine, 50 mg oral	X	0.02	$.97		$.19
[2] 0887	Azathioprine, Parenteral 100 mg, 20 ml each injection	X	1.40	$67.88		$13.58
[2] 0888	Cyclosporine, Oral 100 mg	X	0.08	$3.88		$.78
[2] 0889	Cyclosporine, Parenteral	X	0.36	$17.46		$3.49
[2] 0890	Lymphocyte Immune Globulin 50 mg/ml, 5 ml each	X	3.79	$183.77		$36.75
[2] 0891	Tacrolimus per 1 mg oral	X	3.15	$152.73		$30.55
[3] 0892	Daclizumab, Parenteral, 25 mg	X				$54.11
[3] 0900	Injection, Alglucerase per 10 units	X				$5.14
[3] 0901	Alpha I, Proteinase Inhibitor, Human per 10mg	X				$15.22
[3] 0902	Botulinum Toxin, Type A per unit	X				$56.05
[3] 0903	CMV Immune Globulin	X				$54.11
[3] 0905	Immune Globulin per 500 mg	X				$6.40
[3] 0906	RSV Immune Globulin	X				$85.53
[2] 0907	Ganciclovir Sodium 500 mg injection	X	0.51	$24.73		$4.95
[2] 0908	Tetanus Immune Globulin, Human, up to 250 units	X	0.90	$43.64		$8.73
[3] 0909	Interferon Beta—1a 33 mcg	X				$28.70
[3] 0910	Interferon Beta—1b 0.25 mg	X				$8.44
[2] 0911	Streptokinase per 250,000 iu	X	1.64	$79.69		$15.94
[3] 0913	Ganciclovir 4.5 mg, Implant	X				$701.51
[2] 0914	Reteplase, 37.6 mg (Two Single Use Vials)	X	38.20	$1,852.21		$370.44
[2] 0915	Alteplase recombinant, 10mg	X	5.85	$283.70		$56.74
[3] 0916	Imiglucerase per unit	X				$.58
[2] 0917	Dipyridamole, 10mg Adenosine 6MG	X	0.36	$17.46		$3.49
[3] 0918	Brachytherapy Seeds, Any type, Each	S				$9.99
[3] 0925	Factor VIII (Antihemophilic Factor, Human) per iu	X				$.19
[3] 0926	Factor VIII (Antihemophilic Factor, Porcine) per iu	X				$.19
[3] 0927	Factor VIII (Antihemophilic Factor, Recombinant) per iu	X				$.19
[3] 0928	Factor IX, Complex	X				$.08
[3] 0929	Other Hemophilia Clotting Factors per iu	X				$.27
[3] 0930	Antithrombin III (Human) per iu	X				$.19
[3] 0931	Factor IX (Antihemophilic Factor, Purified, Non-Recombinant)	X				$.04
[3] 0932	Factor IX (Antihemophilic Factor, Recombinant)	X				$.10
[2] 0949	Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen	S	3.49	$169.22		$33.84
[2] 0950	Blood (Whole) For Transfusion	S	2.08	$101.02		$20.20
[2] 0952	Cryoprecipitate	S	0.70	$33.92		$6.78
[2] 0953	Fibrinogen Unit	S	0.48	$23.27		$4.65
[2] 0954	Leukocyte Poor Blood	S	2.83	$137.21		$27.44
[2] 0955	Plasma, Fresh Frozen	S	2.26	$109.35		$21.87
[2] 0956	Plasma Protein Fraction	S	1.26	$61.09		$12.22
[2] 0957	Platelet Concentrate	S	0.98	$47.46		$9.49
[2] 0958	Platelet Rich Plasma	S	1.16	$56.25		$11.25
[2] 0959	Red Blood Cells	S	2.04	$99.04		$19.81
[2] 0960	Washed Red Blood Cells	S	3.81	$184.53		$36.91
[2] 0961	Infusion, Albumin (Human) 5%, 500 ml	X	2.77	$134.31		$26.86
[2] 0962	Infusion, Albumin (Human) 25%, 50 ml	X	1.38	$66.91		$13.38
[2] 0970	New Technology—Level I ($0–$50)	T	0.52	$25.21		$5.04
[2] 0971	New Technology—Level II ($50–$100)	S	1.55	$75.16		$15.03
[2] 0972	New Technology—Level III ($100–$200)	T	3.09	$149.83		$29.97
[2] 0973	New Technology—Level IV ($200–$300)	T	5.16	$250.19		$50.04
[2] 0974	New Technology—Level V ($300–$500)	T	8.25	$400.02		$80.00
[2] 0975	New Technology—Level VI ($500–$750)	T	12.90	$625.48		$125.10
[2] 0976	New Technology—Level VII ($750–$1000)	T	18.05	$875.19		$175.04
[2] 0977	New Technology—Level VIII ($1000–$1250)	T	23.20	$1,124.90		$224.98
[2] 0978	New Technology—Level IX ($1250–$1500)	T	28.36	$1,375.09		$275.02
[2] 0979	New Technology—Level X ($1500–$1750)	T	33.51	$1,624.80		$324.96
[2] 0980	New Technology—Level XI ($1750–$2000)	S	38.67	$1,875.00		$375.00
[2] 0981	New Technology—Level XII ($2000–$2500)	T	46.40	$2,249.80		$449.96
[2] 0982	New Technology—Level XIII ($2500–$3500)	T	61.87	$2,999.90		$599.98

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[2] 0983	New Technology—Level XIV ($3500–$5000)	T	87.65	$4,249.89		$849.98
[2] 0984	New Technology—Level XV ($5000–$6000)	T	113.43	$5,499.89		$1,099.98
[3] 7000	Amifostine, 500 mg	X				$41.99
[3] 7001	Amphotericin B lipid complex, 50 mg, Inj	X				$12.12
[3] 7002	Clonidine, HCl, 1 MG	X				$4.17
[3] 7003	Epoprostenol, 0.5 MG, inj	X				$2.23
[3] 7004	Immune globulin intravenous human 5g, inj	X				$45.48
[3] 7005	Gonadorelin hcI, 100 mcg	X				$9.12
[2] 7007	Milrinone lacetate, per 5 ml, inj	X	0.47	$22.79		$4.56
[3] 7010	Morphine sulfate concentrate (preservative free) per 10 mg	X				$.68
[3] 7011	Oprelevekin, inj, 5 mg	X				$30.35
[3] 7012	Pentamidine isethionate, 300 mg	X				$8.73
[3] 7014	Fentanyl citrate, inj, up to 2 ml	X				$.19
[3] 7015	Busulfan, oral 2 mg	X				$.19
[3] 7019	Aprotinin, 10,000 kiu	X				$2.42
[3] 7021	Baclofen, intrathecal, 50 mcg	X				$.10
[3] 7022	Elliotts B Solution, per ml	X				$19.20
[3] 7023	Treatment for bladder calculi, I.e. Renacidin per 500 ml	X				$4.46
[3] 7024	Corticorelin ovine triflutate, 0.1 mg	X				$45.77
[3] 7025	Digoxin immune FAB (Ovine), 10 mg	X				$14.06
[3] 7026	Ethanolamine oleate, 1000 ml	X				$2.13
[3] 7027	Fomepizole, 1.5 G	X				$141.29
[3] 7028	Fosphenytoin, 50 mg	X				$.78
[3] 7029	Glatiramer acetate, 25 mg	X				$3.59
[3] 7030	Hemin, 1 mg	X				$.10
[3] 7031	Octreotide Acetate, 500 mcg	X				$5.43
[3] 7032	Sermorelin acetate, 0.5 mg	X				$53.34
[3] 7033	Somatrem, 5 mg	X				$28.03
[3] 7034	Somatropin, 1 mg	X				$5.04
[3] 7035	Teniposide, 50 mg	X				$20.85
[2] 7036	Urokinase, inj, IV, 250,000 I.U.	X	0.73	$35.40		$7.08
[3] 7037	Urofollitropin, 75 I.U.	X				$8.24
[3] 7038	Muromonab-CD3, 5 mg	X				$89.60
[3] 7039	Pegademase bovine inj 25 I.U.	X				$1.16
[3] 7040	Pentastarch 10% inj, 100 ml	X				$2.04
[2] 7041	Tirofiban HCL, 0.5 mg	X	0.02	$.97		$.19
[3] 7042	Capecitabine, oral 150 mg	X				$.19
[3] 7043	Infliximab, 10 MG	X				$6.89
[3] 7045	Trimetrexate Glucoronate	X				$8.15
[3] 7046	Doxorubicin Hcl Liposome	X				$39.18

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00100	N	Anesth, salivary gland					
00102	N	Anesth, repair of cleft lip					
00103	N	Anesth, blepharoplasty					
00104	N	Anesth, electroshock					
00120	N	Anesth, ear surgery					
00124	N	Anesth, ear exam					
00126	N	Anesth, tympanotomy					
00140	N	Anesth, procedures on eye					
00142	N	Anesth, lens surgery					
00144	N	Anesth, corneal transplant					
00145	N	Anesth, vitrectomy					
00147	N	Anesth, iridectomy					
00148	N	Anesth, eye exam					
00160	N	Anesth, nose/sinus surgery					
00162	N	Anesth, nose/sinus surgery					
00164	N	Anesth, biopsy of nose					
00170	N	Anesth, procedure on mouth					
00172	N	Anesth, cleft palate repair					
00174	C	Anesth, pharyngeal surgery					
00176	C	Anesth, pharyngeal surgery					
00190	N	Anesth, facial bone surgery					
00192	C	Anesth, facial bone surgery					
00210	N	Anesth, open head surgery					
00212	N	Anesth, skull drainage					

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00214	C	Anesth, skull drainage					
00215	C	Anesth, skull fracture					
00216	N	Anesth, head vessel surgery					
00218	N	Anesth, special head surgery					
00220	N	Anesth, spinal fluid shunt					
00222	N	Anesth, head nerve surgery					
00300	N	Anesth, head/neck/ptrunk					
00320	N	Anesth, neck organ surgery					
00322	N	Anesth, biopsy of thyroid					
00350	N	Anesth, neck vessel surgery					
00352	N	Anesth, neck vessel surgery					
00400	N	Anesth, skin, ext/per/atrunk					
00402	N	Anesth, surgery of breast					
00404	C	Anesth, surgery of breast					
00406	C	Anesth, surgery of breast					
00410	N	Anesth, correct heart rhythm					
00450	N	Anesth, surgery of shoulder					
00452	C	Anesth, surgery of shoulder					
00454	N	Anesth, collar bone biopsy					
00470	N	Anesth, removal of rib					
00472	N	Anesth, chest wall repair					
00474	C	Anesth, surgery of rib(s)					
00500	N	Anesth, esophageal surgery					
00520	N	Anesth, chest procedure					
00522	N	Anesth, chest lining biopsy					
00524	C	Anesth, chest drainage					
00528	N	Anesth, chest partition view					
00530	C	Anesth, pacemaker insertion					
00532	N	Anesth, vascular access					
00534	N	Anesth, cardioverter/defib					
00540	C	Anesth, chest surgery					
00542	C	Anesth, release of lung					
00544	C	Anesth, chest lining removal					
00546	C	Anesth, lung, chest wall surg					
00548	N	Anesth, trachea, bronchi surg					
00560	C	Anesth, open heart surgery					
00562	C	Anesth, open heart surgery					
00580	C	Anesth heart/lung transplant					
00600	N	Anesth, spine, cord surgery					
00604	C	Anesth, surgery of vertebra					
00620	N	Anesth, spine, cord surgery					
00622	C	Anesth, removal of nerves					
00630	N	Anesth, spine, cord surgery					
00632	C	Anesth, removal of nerves					
00634	C	Anesth for chemonucleolysis					
00670	C	Anesth, spine, cord surgery					
00700	N	Anesth, abdominal wall surg					
00702	N	Anesth, for liver biopsy					
00730	N	Anesth, abdominal wall surg					
00740	N	Anesth, upper gi visualize					
00750	N	Anesth, repair of hernia					
00752	N	Anesth, repair of hernia					
00754	N	Anesth, repair of hernia					
00756	N	Anesth, repair of hernia					
00770	N	Anesth, blood vessel repair					
00790	N	Anesth, surg upper abdomen					
00792	C	Anesth, part liver removal					
00794	C	Anesth, pancreas removal					
00796	C	Anesth, for liver transplant					
00800	N	Anesth, abdominal wall surg					
00802	C	Anesth, fat layer removal					
00810	N	Anesth, low intestine scope					
00820	N	Anesth, abdominal wall surg					
00830	N	Anesth, repair of hernia					
00832	N	Anesth, repair of hernia					
00840	N	Anesth, surg lower abdomen					
00842	N	Anesth, amniocentesis					
00844	C	Anesth, pelvis surgery					
00846	C	Anesth, hysterectomy					
00848	C	Anesth, pelvic organ surg					
00850	C	Anesth, cesarean section					
00855	C	Anesth, hysterectomy					
00857	C	Analgesia, labor & c-section					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
00860	N	Anesth, surgery of abdomen					
00862	N	Anesth, kidney/ureter surg					
00864	C	Anesth, removal of bladder					
00865	C	Anesth, removal of prostate					
00866	C	Anesth, removal of adrenal					
00868	C	Anesth, kidney transplant					
00870	N	Anesth, bladder stone surg					
00872	N	Anesth kidney stone destruct					
00873	N	Anesth kidney stone destruct					
00880	N	Anesth, abdomen vessel surg					
00882	C	Anesth, major vein ligation					
00884	C	Anesth, major vein revision					
00900	N	Anesth, perineal procedure					
00902	N	Anesth, anorectal surgery					
00904	C	Anesth, perineal surgery					
00906	N	Anesth, removal of vulva					
00908	C	Anesth, removal of prostate					
00910	N	Anesth, bladder surgery					
00912	N	Anesth, bladder tumor surg					
00914	N	Anesth, removal of prostate					
00916	N	Anesth, bleeding control					
00918	N	Anesth, stone removal					
00920	N	Anesth, genitalia surgery					
00922	N	Anesth, sperm duct surgery					
00924	N	Anesth, testis exploration					
00926	N	Anesth, removal of testis					
00928	C	Anesth, removal of testis					
00930	N	Anesth, testis suspension					
00932	C	Anesth, amputation of penis					
00934	C	Anesth, penis, nodes removal					
00936	C	Anesth, penis, nodes removal					
00938	N	Anesth, insert penis device					
00940	N	Anesth, vaginal procedures					
00942	N	Anesth, surgery on vagina					
00944	C	Anesth, vaginal hysterectomy					
00946	N	Anesth, vaginal delivery					
00948	N	Anesth, repair of cervix					
00950	N	Anesth, vaginal endoscopy					
00952	N	Anesth, hysteroscope/graph					
00955	C	Analgesia, vaginal delivery					
01120	N	Anesth, pelvis surgery					
01130	N	Anesth, body cast procedure					
01140	C	Anesth, amputation at pelvis					
01150	C	Anesth, pelvic tumor surgery					
01160	N	Anesth, pelvis procedure					
01170	N	Anesth, pelvis surgery					
01180	N	Anesth, pelvis nerve removal					
01190	C	Anesth, pelvis nerve removal					
01200	N	Anesth, hip joint procedure					
01202	N	Anesth, arthroscopy of hip					
01210	N	Anesth, hip joint surgery					
01212	C	Anesth, hip disarticulation					
01214	C	Anesth, replacement of hip					
01220	N	Anesth, procedure on femur					
01230	N	Anesth, surgery of femur					
01232	C	Anesth, amputation of femur					
01234	C	Anesth, radical femur surg					
01250	N	Anesth, upper leg surgery					
01260	N	Anesth, upper leg veins surg					
01270	N	Anesth, thigh arteries surg					
01272	C	Anesth, femoral artery surg					
01274	C	Anesth, femoral embolectomy					
01320	N	Anesth, knee area surgery					
01340	N	Anesth, knee area procedure					
01360	N	Anesth, knee area surgery					
01380	N	Anesth, knee joint procedure					
01382	N	Anesth, knee arthroscopy					
01390	N	Anesth, knee area procedure					
01392	N	Anesth, knee area surgery					
01400	N	Anesth, knee joint surgery					
01402	C	Anesth, replacement of knee					
01404	C	Anesth, amputation at knee					
01420	N	Anesth, knee joint casting					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
01430	N	Anesth, knee veins surgery					
01432	N	Anesth, knee vessel surg					
01440	N	Anesth, knee arteries surg					
01442	C	Anesth, knee artery surg					
01444	C	Anesth, knee artery repair					
01462	N	Anesth, lower leg procedure					
01464	N	Anesth, ankle arthroscopy					
01470	N	Anesth, lower leg surgery					
01472	N	Anesth, achilles tendon surg					
01474	N	Anesth, lower leg surgery					
01480	N	Anesth, lower leg bone surg					
01482	N	Anesth, radical leg surgery					
01484	N	Anesth, lower leg revision					
01486	C	Anesth, ankle replacement					
01490	N	Anesth, lower leg casting					
01500	N	Anesth, leg arteries surg					
01502	C	Anesth, lwr leg embolectomy					
01520	N	Anesth, lower leg vein surg					
01522	N	Anesth, lower leg vein surg					
01610	N	Anesth, surgery of shoulder					
01620	N	Anesth, shoulder procedure					
01622	N	Anesth, shoulder arthroscopy					
01630	N	Anesth, surgery of shoulder					
01632	C	Anesth, surgery of shoulder					
01634	C	Anesth, shoulder joint amput					
01636	C	Anesth, forequarter amput					
01638	C	Anesth, shoulder replacement					
01650	N	Anesth, shoulder artery surg					
01652	C	Anesth, shoulder vessel surg					
01654	C	Anesth, shoulder vessel surg					
01656	C	Anesth, arm-leg vessel surg					
01670	N	Anesth, shoulder vein surg					
01680	N	Anesth, shoulder casting					
01682	N	Anesth, airplane cast					
01710	N	Anesth, elbow area surgery					
01712	N	Anesth, uppr arm tendon surg					
01714	N	Anesth, uppr arm tendon surg					
01716	N	Anesth, biceps tendon repair					
01730	N	Anesth, uppr arm procedure					
01732	N	Anesth, elbow arthroscopy					
01740	N	Anesth, upper arm surgery					
01742	N	Anesth, humerus surgery					
01744	N	Anesth, humerus repair					
01756	C	Anesth, radical humerus surg					
01758	N	Anesth, humeral lesion surg					
01760	N	Anesth, elbow replacement					
01770	N	Anesth, uppr arm artery surg					
01772	C	Anesth, uppr arm embolectomy					
01780	N	Anesth, upper arm vein surg					
01782	C	Anesth, uppr arm vein repair					
01784	N	Anesth, av fistula repair					
01810	N	Anesth, lower arm surgery					
01820	N	Anesth, lower arm procedure					
01830	N	Anesth, lower arm surgery					
01832	N	Anesth, wrist replacement					
01840	N	Anesth, lwr arm artery surg					
01842	C	Anesth, lwr arm embolectomy					
01844	N	Anesth, vascular shunt surg					
01850	N	Anesth, lower arm vein surg					
01852	C	Anesth, lwr arm vein repair					
01860	N	Anesth, lower arm casting					
01904	C	Anesth, skull x-ray inject					
01906	N	Anesth, lumbar myelography					
01908	N	Anesth, cervical myelography					
01910	N	Anesth, skull myelography					
01912	N	Anesth, lumbar diskography					
01914	N	Anesth, cervical diskography					
01916	N	Anesth, head arteriogram					
01918	N	Anesth, limb arteriogram					
01920	N	Anesth, catheterize heart					
01921	N	Anesth, vessel surgery					
01922	N	Anesth, cat or MRI scan					
01990	C	Support for organ donor					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
01995	N	Regional anesthesia, limb	.....	.....	.....	.....	.....
01996	N	Manage daily drug therapy	.....	.....	.....	.....	.....
01999	N	Unlisted anesth procedure	.....	.....	.....	.....	.....
10040	T	Acne surgery of skin abscess	0006	2.00	$96.97	$33.95	$19.39
10060	T	Drainage of skin abscess	0006	2.00	$96.97	$33.95	$19.39
10061	T	Drainage of skin abscess	0006	2.00	$96.97	$33.95	$19.39
10080	T	Drainage of pilonidal cyst	0006	2.00	$96.97	$33.95	$19.39
10081	T	Drainage of pilonidal cyst	0007	3.68	$178.43	$72.03	$35.69
10120	T	Remove foreign body	0006	2.00	$96.97	$33.95	$19.39
10121	T	Remove foreign body	0020	6.51	$315.65	$130.53	$63.13
10140	T	Drainage of hematoma/fluid	0007	3.68	$178.43	$72.03	$35.69
10160	T	Puncture drainage of lesion	0006	2.00	$96.97	$33.95	$19.39
10180	T	Complex drainage, wound	0007	3.68	$178.43	$72.03	$35.69
11000	T	Debride infected skin	0015	1.77	$85.82	$31.20	$17.16
11001	T	Debride infected skin add-on	0015	1.77	$85.82	$31.20	$17.16
11010	T	Debride skin, fx	0022	12.49	$605.60	$292.94	$121.12
11011	T	Debride skin/muscle, fx	0022	12.49	$605.60	$292.94	$121.12
11012	T	Debride skin/muscle/bone, fx	0022	12.49	$605.60	$292.94	$121.12
11040	T	Debride skin, partial	0015	1.77	$85.82	$31.20	$17.16
11041	T	Debride skin, full	0015	1.77	$85.82	$31.20	$17.16
11042	T	Debride skin/tissue	0016	3.53	$171.16	$74.67	$34.23
11043	T	Debride tissue/muscle	0016	3.53	$171.16	$74.67	$34.23
11044	T	Debride tissue/muscle/bone	0017	12.45	$603.66	$289.16	$120.73
11055	T	Trim skin lesion	0015	1.77	$85.82	$31.20	$17.16
11056	T	Trim skin lesions, 2 to 4	0015	1.77	$85.82	$31.20	$17.16
11057	T	Trim skin lesions, over 4	0015	1.77	$85.82	$31.20	$17.16
11100	T	Biopsy of skin lesion	0018	0.94	$45.58	$17.66	$9.12
11101	T	Biopsy, skin add-on	0018	0.94	$45.58	$17.66	$9.12
11200	T	Removal of skin tags	0015	1.77	$85.82	$31.20	$17.16
11201	T	Remove skin tags add-on	0015	1.77	$85.82	$31.20	$17.16
11300	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11301	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11302	T	Shave skin lesion	0014	1.50	$72.73	$24.55	$14.55
11303	T	Shave skin lesion	0015	1.77	$85.82	$31.20	$17.16
11305	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11306	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11307	T	Shave skin lesion	0014	1.50	$72.73	$24.55	$14.55
11308	T	Shave skin lesion	0015	1.77	$85.82	$31.20	$17.16
11310	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11311	T	Shave skin lesion	0013	0.91	$44.12	$17.66	$8.82
11312	T	Shave skin lesion	0015	1.77	$85.82	$31.20	$17.16
11313	T	Shave skin lesion	0016	3.53	$171.16	$74.67	$34.23
11400	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11401	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11402	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11403	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11404	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11406	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11420	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11421	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11422	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11423	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11424	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11426	T	Removal of skin lesion	0022	12.49	$605.60	$292.94	$121.12
11440	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11441	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11442	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11443	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11444	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11446	T	Removal of skin lesion	0022	12.49	$605.60	$292.94	$121.12
11450	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11451	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11462	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11463	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11470	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11471	T	Removal, sweat gland lesion	0022	12.49	$605.60	$292.94	$121.12
11600	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11601	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11602	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11603	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11604	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11606	T	Removal of skin lesion	0021	10.49	$508.63	$236.51	$101.73
11620	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
11621	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11622	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11623	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11624	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11626	T	Removal of skin lesion	0022	12.49	$605.60	$292.94	$121.12
11640	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11641	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11642	T	Removal of skin lesion	0019	4.00	$193.95	$78.91	$38.79
11643	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11644	T	Removal of skin lesion	0020	6.51	$315.65	$130.53	$63.13
11646	T	Removal of skin lesion	0022	12.49	$605.60	$292.94	$121.12
11719	T	Trim nail(s)	0009	0.74	$35.88	$9.63	$7.18
11720	T	Debride nail, 1–5	0009	0.74	$35.88	$9.63	$7.18
11721	T	Debride nail, 6 or more	0009	0.74	$35.88	$9.63	$7.18
11730	T	Removal of nail plate	0013	0.91	$44.12	$17.66	$8.82
11732	T	Remove nail plate, add-on	0012	0.53	$25.70	$9.18	$5.14
11740	T	Drain blood from under nail	0009	0.74	$35.88	$9.63	$7.18
11750	T	Removal of nail bed	0019	4.00	$193.95	$78.91	$38.79
11752	T	Remove nail bed/finger tip	0022	12.49	$605.60	$292.94	$121.12
11755	T	Biopsy, nail unit	0019	4.00	$193.95	$78.91	$38.79
11760	T	Repair of nail bed	0024	2.43	$117.82	$44.50	$23.56
11762	T	Reconstruction of nail bed	0024	2.43	$117.82	$44.50	$23.56
11765	T	Excision of nail fold, toe	0015	1.77	$85.82	$31.20	$17.16
11770	T	Removal of pilonidal lesion	0021	10.49	$508.63	$236.51	$101.73
11771	T	Removal of pilonidal lesion	0022	12.49	$605.60	$292.94	$121.12
11772	T	Removal of pilonidal lesion	0022	12.49	$605.60	$292.94	$121.12
11900	T	Injection into skin lesions	0012	0.53	$25.70	$9.18	$5.14
11901	T	Added skin lesions injection	0013	0.91	$44.12	$17.66	$8.82
11920	T	Correct skin color defects	0024	2.43	$117.82	$44.50	$23.56
11921	T	Correct skin color defects	0024	2.43	$117.82	$44.50	$23.56
11922	T	Correct skin color defects	0024	2.43	$117.82	$44.50	$23.56
11950	T	Therapy for contour defects	0024	2.43	$117.82	$44.50	$23.56
11951	T	Therapy for contour defects	0024	2.43	$117.82	$44.50	$23.56
11952	T	Therapy for contour defects	0024	2.43	$117.82	$44.50	$23.56
11954	T	Therapy for contour defects	0024	2.43	$117.82	$44.50	$23.56
11960	T	Insert tissue expander(s)	0026	12.11	$587.18	$277.92	$117.44
11970	T	Replace tissue expander	0026	12.11	$587.18	$277.92	$117.44
11971	T	Remove tissue expander(s)	0022	12.49	$605.60	$292.94	$121.12
11975	E	Insert contraceptive cap	.....	.....	.....	.....	.....
11976	T	Removal of contraceptive cap	0019	4.00	$193.95	$78.91	$38.79
11977	E	Removal/reinsert contra cap	.....	.....	.....	.....	.....
11980	E	Implant hormone pellet(s)	.....	.....	.....	.....	.....
12001	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12002	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12004	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12005	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12006	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12007	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12011	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12013	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12014	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12015	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12016	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12017	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12018	T	Repair superficial wound(s)	0024	2.43	$117.82	$44.50	$23.56
12020	T	Closure of split wound	0024	2.43	$117.82	$44.50	$23.56
12021	T	Closure of split wound	0024	2.43	$117.82	$44.50	$23.56
12031	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12032	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12034	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12035	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12036	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12037	T	Layer closure of wound(s)	0026	12.11	$587.18	$277.92	$117.44
12041	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12042	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12044	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12045	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12046	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12047	T	Layer closure of wound(s)	0026	12.11	$587.18	$277.92	$117.44
12051	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12052	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12053	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12054	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
12055	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12056	T	Layer closure of wound(s)	0024	2.43	$117.82	$44.50	$23.56
12057	T	Layer closure of wound(s)	0026	12.11	$587.18	$277.92	$117.44
13100	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13101	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13102	T	Repair wound/lesion add-on	0025	3.74	$181.34	$70.66	$36.27
13120	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13121	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13122	T	Repair wound/lesion add-on	0025	3.74	$181.34	$70.66	$36.27
13131	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13132	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13133	T	Repair wound/lesion add-on	0025	3.74	$181.34	$70.66	$36.27
13150	T	Repair of wound or lesion	0026	12.11	$587.18	$277.92	$117.44
13151	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13152	T	Repair of wound or lesion	0025	3.74	$181.34	$70.66	$36.27
13153	T	Repair wound/lesion add-on	0025	3.74	$181.34	$70.66	$36.27
13160	T	Late closure of wound	0026	12.11	$587.18	$277.92	$117.44
14000	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14001	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14020	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14021	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14040	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14041	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14060	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14061	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14300	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
14350	T	Skin tissue rearrangement	0026	12.11	$587.18	$277.92	$117.44
15000	T	Skin graft	0026	12.11	$587.18	$277.92	$117.44
15001	T	Skin graft add-on	0026	12.11	$587.18	$277.92	$117.44
15050	T	Skin pinch graft	0026	12.11	$587.18	$277.92	$117.44
15100	T	Skin split graft	0026	12.11	$587.18	$277.92	$117.44
15101	T	Skin split graft add-on	0026	12.11	$587.18	$277.92	$117.44
15120	T	Skin split graft	0026	12.11	$587.18	$277.92	$117.44
15121	T	Skin split graft add-on	0026	12.11	$587.18	$277.92	$117.44
15200	T	Skin full graft	0026	12.11	$587.18	$277.92	$117.44
15201	T	Skin full graft add-on	0026	12.11	$587.18	$277.92	$117.44
15220	T	Skin full graft	0026	12.11	$587.18	$277.92	$117.44
15221	T	Skin full graft add-on	0026	12.11	$587.18	$277.92	$117.44
15240	T	Skin full graft	0026	12.11	$587.18	$277.92	$117.44
15241	T	Skin full graft add-on	0026	12.11	$587.18	$277.92	$117.44
15260	T	Skin full graft	0026	12.11	$587.18	$277.92	$117.44
15261	T	Skin full graft add-on	0026	12.11	$587.18	$277.92	$117.44
15350	T	Skin homograft	0026	12.11	$587.18	$277.92	$117.44
15351	T	Skin homograft add-on	0026	12.11	$587.18	$277.92	$117.44
15400	T	Skin heterograft	0026	12.11	$587.18	$277.92	$117.44
15401	T	Skin heterograft add-on	0026	12.11	$587.18	$277.92	$117.44
15570	T	Form skin pedicle flap	0026	12.11	$587.18	$277.92	$117.44
15572	T	Form skin pedicle flap	0026	12.11	$587.18	$277.92	$117.44
15574	T	Form skin pedicle flap	0026	12.11	$587.18	$277.92	$117.44
15576	T	Form skin pedicle flap	0026	12.11	$587.18	$277.92	$117.44
15600	T	Skin graft	0026	12.11	$587.18	$277.92	$117.44
15610	T	Skin graft	0026	12.11	$587.18	$277.92	$117.44
15620	T	Skin graft	0026	12.11	$587.18	$277.92	$117.44
15630	T	Skin graft	0026	12.11	$587.18	$277.92	$117.44
15650	T	Transfer skin pedicle flap	0026	12.11	$587.18	$277.92	$117.44
15732	T	Muscle-skin graft, head/neck	0027	15.80	$766.10	$383.10	$153.22
15734	T	Muscle-skin graft, trunk	0027	15.80	$766.10	$383.10	$153.22
15736	T	Muscle-skin graft, arm	0027	15.80	$766.10	$383.10	$153.22
15738	T	Muscle-skin graft, leg	0027	15.80	$766.10	$383.10	$153.22
15740	T	Island pedicle flap graft	0027	15.80	$766.10	$383.10	$153.22
15750	T	Neurovascular pedicle graft	0027	15.80	$766.10	$383.10	$153.22
15756	C	Free muscle flap, microvasc	.....	.....	.....	.....	.....
15757	C	Free skin flap, microvasc	.....	.....	.....	.....	.....
15758	C	Free fascial flap, microvasc	.....	.....	.....	.....	.....
15760	T	Composite skin graft	0027	15.80	$766.10	$383.10	$153.22
15770	T	Derma-fat-fascia graft	0027	15.80	$766.10	$383.10	$153.22
15775	T	Hair transplant punch grafts	0026	12.11	$587.18	$277.92	$117.44
15776	T	Hair transplant punch grafts	0026	12.11	$587.18	$277.92	$117.44
15780	T	Abrasion treatment of skin	0022	12.49	$605.60	$292.94	$121.12
15781	T	Abrasion treatment of skin	0022	12.49	$605.60	$292.94	$121.12
15782	T	Abrasion treatment of skin	0022	12.49	$605.60	$292.94	$121.12
15783	T	Abrasion treatment of skin	0015	1.77	$85.82	$31.20	$17.16
15786	T	Abrasion, lesion, single	0013	0.91	$44.12	$17.66	$8.82

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
15787	T	Abrasion, lesions, add-on	0016	3.53	$171.16	$74.67	$34.23
15788	T	Chemical peel, face, epiderm	0013	0.91	$44.12	$17.66	$8.82
15789	T	Chemical peel, face, dermal	0015	1.77	$85.82	$31.20	$17.16
15792	T	Chemical peel, nonfacial	0016	3.53	$171.16	$74.67	$34.23
15793	T	Chemical peel, nonfacial	0016	3.53	$171.16	$74.67	$34.23
15810	T	Salabrasion	0016	3.53	$171.16	$74.67	$34.23
15811	T	Salabrasion	0022	12.49	$605.60	$292.94	$121.12
15819	T	Plastic surgery, neck	0026	12.11	$587.18	$277.92	$117.44
15820	T	Revision of lower eyelid	0026	12.11	$587.18	$277.92	$117.44
15821	T	Revision of lower eyelid	0026	12.11	$587.18	$277.92	$117.44
15822	T	Revision of upper eyelid	0026	12.11	$587.18	$277.92	$117.44
15823	T	Revision of upper eyelid	0026	12.11	$587.18	$277.92	$117.44
15824	T	Removal of forehead wrinkles	0027	15.80	$766.10	$383.10	$153.22
15825	T	Removal of neck wrinkles	0026	12.11	$587.18	$277.92	$117.44
15826	T	Removal of brow wrinkles	0027	15.80	$766.10	$383.10	$153.22
15828	T	Removal of face wrinkles	0027	15.80	$766.10	$383.10	$153.22
15829	T	Removal of skin wrinkles	0026	12.11	$587.18	$277.92	$117.44
15831	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15832	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15833	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15834	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15835	T	Excise excessive skin tissue	0026	12.11	$587.18	$277.92	$117.44
15836	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15837	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15838	T	Excise excessive skin tissue	0022	12.49	$605.60	$292.94	$121.12
15839	T	Excise excessive skin tissue	0027	15.80	$766.10	$383.10	$153.22
15840	T	Graft for face nerve palsy	0027	15.80	$766.10	$383.10	$153.22
15841	T	Graft for face nerve palsy	0027	15.80	$766.10	$383.10	$153.22
15842	T	Graft for face nerve palsy	0027	15.80	$766.10	$383.10	$153.22
15845	T	Skin and muscle repair, face	0027	15.80	$766.10	$383.10	$153.22
15850	T	Removal of sutures	0013	0.91	$44.12	$17.66	$8.82
15851	T	Removal of sutures	0013	0.91	$44.12	$17.66	$8.82
15852	T	Dressing change, not for burn	0012	0.53	$25.70	$9.18	$5.14
15860	N	Test for blood flow in graft	.....	.....	.....	.....	.....
15876	T	Suction assisted lipectomy	0027	15.80	$766.10	$383.10	$153.22
15877	T	Suction assisted lipectomy	0027	15.80	$766.10	$383.10	$153.22
15878	T	Suction assisted lipectomy	0027	15.80	$766.10	$383.10	$153.22
15879	T	Suction assisted lipectomy	0027	15.80	$766.10	$383.10	$153.22
15920	T	Removal of tail bone ulcer	0022	12.49	$605.60	$292.94	$121.12
15922	T	Removal of tail bone ulcer	0027	15.80	$766.10	$383.10	$153.22
15931	T	Remove sacrum pressure sore	0022	12.49	$605.60	$292.94	$121.12
15933	T	Remove sacrum pressure sore	0022	12.49	$605.60	$292.94	$121.12
15934	T	Remove sacrum pressure sore	0027	15.80	$766.10	$383.10	$153.22
15935	T	Remove sacrum pressure sore	0027	15.80	$766.10	$383.10	$153.22
15936	T	Remove sacrum pressure sore	0027	15.80	$766.10	$383.10	$153.22
15937	T	Remove sacrum pressure sore	0027	15.80	$766.10	$383.10	$153.22
15940	T	Remove hip pressure sore	0022	12.49	$605.60	$292.94	$121.12
15941	T	Remove hip pressure sore	0022	12.49	$605.60	$292.94	$121.12
15944	T	Remove hip pressure sore	0027	15.80	$766.10	$383.10	$153.22
15945	T	Remove hip pressure sore	0027	15.80	$766.10	$383.10	$153.22
15946	T	Remove hip pressure sore	0027	15.80	$766.10	$383.10	$153.22
15950	T	Remove thigh pressure sore	0022	12.49	$605.60	$292.94	$121.12
15951	T	Remove thigh pressure sore	0022	12.49	$605.60	$292.94	$121.12
15952	T	Remove thigh pressure sore	0027	15.80	$766.10	$383.10	$153.22
15953	T	Remove thigh pressure sore	0027	15.80	$766.10	$383.10	$153.22
15956	T	Remove thigh pressure sore	0027	15.80	$766.10	$383.10	$153.22
15958	T	Remove thigh pressure sore	0027	15.80	$766.10	$383.10	$153.22
15999	T	Removal of pressure sore	0022	12.49	$605.60	$292.94	$121.12
16000	T	Initial treatment of burn(s)	0015	1.77	$85.82	$31.20	$17.16
16010	T	Treatment of burn(s)	0015	1.77	$85.82	$31.20	$17.16
16015	T	Treatment of burn(s)	0017	12.45	$603.66	$289.16	$120.73
16020	T	Treatment of burn(s)	0015	1.77	$85.82	$31.20	$17.16
16025	T	Treatment of burn(s)	0014	1.50	$72.73	$24.55	$14.55
16030	T	Treatment of burn(s)	0015	1.77	$85.82	$31.20	$17.16
16035	T	Incision of burn scab	0020	6.51	$315.65	$130.53	$63.13
17000	T	Destroy benign/premal lesion	0010	0.55	$26.67	$9.86	$5.33
17003	T	Destroy lesions, 2–14	0010	0.55	$26.67	$9.86	$5.33
17004	T	Destroy lesions, 15 or more	0011	2.72	$131.88	$50.01	$26.38
17106	T	Destruction of skin lesions	0011	2.72	$131.88	$50.01	$26.38
17107	T	Destruction of skin lesions	0011	2.72	$131.88	$50.01	$26.38
17108	T	Destruction of skin lesions	0011	2.72	$131.88	$50.01	$26.38
17110	T	Destruct lesion, 1–14	0010	0.55	$26.67	$9.86	$5.33
17111	T	Destruct lesion, 15 or more	0011	2.72	$131.88	$50.01	$26.38

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[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
17250	T	Chemical cautery, tissue	0014	1.50	$72.73	$24.55	$14.55
17260	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17261	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17262	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17263	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17264	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17266	T	Destruction of skin lesions	0016	3.53	$171.16	$74.67	$34.23
17270	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17271	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17272	T	Destruction of skin lesions	0013	0.91	$44.12	$17.66	$8.82
17273	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17274	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17276	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17280	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17281	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17282	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17283	T	Destruction of skin lesions	0015	1.77	$85.82	$31.20	$17.16
17284	T	Destruction of skin lesions	0016	3.53	$171.16	$74.67	$34.23
17286	T	Destruction of skin lesions	0016	3.53	$171.16	$74.67	$34.23
17304	T	Chemosurgery of skin lesion	0020	6.51	$315.65	$130.53	$63.13
17305	T	2nd stage chemosurgery	0020	6.51	$315.65	$130.53	$63.13
17306	T	3rd stage chemosurgery	0020	6.51	$315.65	$130.53	$63.13
17307	T	Followup skin lesion therapy	0020	6.51	$315.65	$130.53	$63.13
17310	T	Extensive skin chemosurgery	0020	6.51	$315.65	$130.53	$63.13
17340	T	Cryotherapy of skin	0012	0.53	$25.70	$9.18	$5.14
17360	T	Skin peel therapy	0016	3.53	$171.16	$74.67	$34.23
17380	T	Hair removal by electrolysis	0016	3.53	$171.16	$74.67	$34.23
17999	T	Skin tissue procedure	0004	1.84	$89.22	$32.57	$17.84
19000	T	Drainage of breast lesion	0004	1.84	$89.22	$32.57	$17.84
19001	T	Drain breast lesion add-on	0004	1.84	$89.22	$32.57	$17.84
19020	T	Incision of breast lesion	0008	6.15	$298.20	$113.67	$59.64
19030	N	Injection for breast x-ray					
19100	T	Biopsy of breast	0005	5.41	$262.32	$119.75	$52.46
19101	T	Biopsy of breast	0029	12.85	$623.06	$303.50	$124.61
19110	T	Nipple exploration	0029	12.85	$623.06	$303.50	$124.61
19112	T	Excise breast duct fistula	0029	12.85	$623.06	$303.50	$124.61
19120	T	Removal of breast lesion	0029	12.85	$623.06	$303.50	$124.61
19125	T	Excision, breast lesion	0029	12.85	$623.06	$303.50	$124.61
19126	T	Excision, addl breast lesion	0029	12.85	$623.06	$303.50	$124.61
19140	T	Removal of breast tissue	0029	12.85	$623.06	$303.50	$124.61
19160	T	Removal of breast tissue	0030	20.19	$978.95	$523.95	$195.79
19162	T	Remove breast tissue, nodes	0030	20.19	$978.95	$523.95	$195.79
19180	T	Removal of breast	0030	20.19	$978.95	$523.95	$195.79
19182	T	Removal of breast	0030	20.19	$978.95	$523.95	$195.79
19200	C	Removal of breast					
19220	C	Removal of breast					
19240	C	Removal of breast					
19260	C	Removal of chest wall lesion					
19271	C	Revision of chest wall					
19272	C	Extensive chest wall surgery					
19290	T	Place needle wire, breast	0029	12.85	$623.06	$303.50	$124.61
19291	T	Place needle wire, breast	0029	12.85	$623.06	$303.50	$124.61
19316	T	Suspension of breast	0030	20.19	$978.95	$523.95	$195.79
19318	T	Reduction of large breast	0030	20.19	$978.95	$523.95	$195.79
19324	T	Enlarge breast	0030	20.19	$978.95	$523.95	$195.79
19325	T	Enlarge breast with implant	0030	20.19	$978.95	$523.95	$195.79
19328	T	Removal of breast implant	0030	20.19	$978.95	$523.95	$195.79
19330	T	Removal of implant material	0030	20.19	$978.95	$523.95	$195.79
19340	T	Immediate breast prosthesis	0030	20.19	$978.95	$523.95	$195.79
19342	T	Delayed breast prosthesis	0030	20.19	$978.95	$523.95	$195.79
19350	T	Breast reconstruction	0030	20.19	$978.95	$523.95	$195.79
19355	T	Correct inverted nipple(s)	0030	20.19	$978.95	$523.95	$195.79
19357	T	Breast reconstruction	0030	20.19	$978.95	$523.95	$195.79
19361	C	Breast reconstruction					
19364	C	Breast reconstruction					
19366	T	Breast reconstruction	0030	20.19	$978.95	$523.95	$195.79
19367	C	Breast reconstruction					
19368	C	Breast reconstruction					
19369	C	Breast reconstruction					
19370	T	Surgery of breast capsule	0030	20.19	$978.95	$523.95	$195.79
19371	T	Removal of breast capsule	0030	20.19	$978.95	$523.95	$195.79
19380	T	Revise breast reconstruction	0030	20.19	$978.95	$523.95	$195.79
19396	T	Design custom breast implant	0029	12.85	$623.06	$303.50	$124.61

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
19499	T	Breast surgery procedure	0029	12.85	$623.06	$303.50	$124.61
20000	T	Incision of abscess	0006	2.00	$96.97	$33.95	$19.39
20005	T	Incision of deep abscess	0049	15.04	$729.25	$356.95	$145.85
20100	T	Explore wound, neck	0023	1.98	$96.00	$40.37	$19.20
20101	T	Explore wound, chest	0026	12.11	$587.18	$277.92	$117.44
20102	T	Explore wound, abdomen	0026	12.11	$587.18	$277.92	$117.44
20103	T	Explore wound, extremity	0023	1.98	$96.00	$40.37	$19.20
20150	T	Excise epiphyseal bar	0051	27.76	$1,346.00	$675.24	$269.20
20200	T	Muscle biopsy	0020	6.51	$315.65	$130.53	$63.13
20205	T	Deep muscle biopsy	0021	10.49	$508.63	$236.51	$101.73
20206	T	Needle biopsy, muscle	0005	5.41	$262.32	$119.75	$52.46
20220	T	Bone biopsy, trocar/needle	0019	4.00	$193.95	$78.91	$38.79
20225	T	Bone biopsy, trocar/needle	0020	6.51	$315.65	$130.53	$63.13
20240	T	Bone biopsy, excisional	0022	12.49	$605.60	$292.94	$121.12
20245	T	Bone biopsy, excisional	0022	12.49	$605.60	$292.94	$121.12
20250	T	Open bone biopsy	0049	15.04	$729.25	$356.95	$145.85
20251	T	Open bone biopsy	0049	15.04	$729.25	$356.95	$145.85
20500	T	Injection of sinus tract	0252	5.18	$251.16	$114.24	$50.23
20501	N	Inject sinus tract for x-ray					
20520	T	Removal of foreign body	0019	4.00	$193.95	$78.91	$38.79
20525	T	Removal of foreign body	0022	12.49	$605.60	$292.94	$121.12
20550	T	Inject tendon/ligament/cyst	0040	2.11	$102.31	$40.60	$20.46
20600	T	Drain/inject, joint/bursa	0040	2.11	$102.31	$40.60	$20.46
20605	T	Drain/inject, joint/bursa	0040	2.11	$102.31	$40.60	$20.46
20610	T	Drain/inject, joint/bursa	0040	2.11	$102.31	$40.60	$20.46
20615	T	Treatment of bone cyst	0004	1.84	$89.22	$32.57	$17.84
20650	T	Insert and remove bone pin	0049	15.04	$729.25	$356.95	$145.85
20660	C	Apply, remove fixation device					
20661	C	Application of head brace					
20662	C	Application of pelvis brace					
20663	C	Application of thigh brace					
20664	C	Halo brace application					
20665	N	Removal of fixation device					
20670	T	Removal of support implant	0021	10.49	$508.63	$236.51	$101.73
20680	T	Removal of support implant	0022	12.49	$605.60	$292.94	$121.12
20690	T	Apply bone fixation device	0050	21.13	$1,024.53	$513.86	$204.91
20692	T	Apply bone fixation device	0050	21.13	$1,024.53	$513.86	$204.91
20693	T	Adjust bone fixation device	0049	15.04	$729.25	$356.95	$145.85
20694	T	Remove bone fixation device	0049	15.04	$729.25	$356.95	$145.85
20802	C	Replantation, arm, complete					
20805	C	Replant, forearm, complete					
20808	C	Replantation hand, complete					
20816	C	Replantation digit, complete					
20822	C	Replantation digit, complete					
20824	C	Replantation thumb, complete					
20827	C	Replantation thumb, complete					
20838	C	Replantation foot, complete					
20900	T	Removal of bone for graft	0050	21.13	$1,024.53	$513.86	$204.91
20902	T	Removal of bone for graft	0050	21.13	$1,024.53	$513.86	$204.91
20910	T	Remove cartilage for graft	0026	12.11	$587.18	$277.92	$117.44
20912	T	Remove cartilage for graft	0026	12.11	$587.18	$277.92	$117.44
20920	T	Removal of fascia for graft	0026	12.11	$587.18	$277.92	$117.44
20922	T	Removal of fascia for graft	0026	12.11	$587.18	$277.92	$117.44
20924	T	Removal of tendon for graft	0050	21.13	$1,024.53	$513.86	$204.91
20926	T	Removal of tissue for graft	0026	12.11	$587.18	$277.92	$117.44
20930	C	Spinal bone allograft					
20931	C	Spinal bone allograft					
20936	C	Spinal bone autograft					
20937	C	Spinal bone autograft					
20938	C	Spinal bone autograft					
20950	T	Fluid pressure, muscle	0008	6.15	$298.20	$113.67	$59.64
20955	C	Fibula bone graft, microvasc					
20956	C	Iliac bone graft, microvasc					
20957	C	Mt bone graft, microvasc					
20962	C	Other bone graft, microvasc					
20969	C	Bone/skin graft, microvasc					
20970	C	Bone/skin graft, iliac crest					
20972	C	Bone/skin graft, metatarsal					
20973	C	Bone/skin graft, great toe					
20974	A	Electrical bone stimulation					
20975	T	Electrical bone stimulation	0049	15.04	$729.25	$356.95	$145.85
20979	T	Us bone stimulation	0049	15.04	$729.25	$356.95	$145.85
20999	N	Musculoskeletal surgery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21010	T	Incision of jaw joint	0254	12.45	$603.66	$272.41	$120.73
21015	T	Resection of facial tumor	0254	12.45	$603.66	$272.41	$120.73
21025	T	Excision of bone, lower jaw	0256	25.40	$1,231.57	$623.05	$246.31
21026	T	Excision of facial bone(s)	0256	25.40	$1,231.57	$623.05	$246.31
21029	T	Contour of face bone lesion	0256	25.40	$1,231.57	$623.05	$246.31
21030	T	Removal of face bone lesion	0254	12.45	$603.66	$272.41	$120.73
21031	T	Remove exostosis, mandible	0253	12.02	$582.81	$284.00	$116.56
21032	T	Remove exostosis, maxilla	0253	12.02	$582.81	$284.00	$116.56
21034	T	Removal of face bone lesion	0256	25.40	$1,231.57	$623.05	$246.31
21040	T	Removal of jaw bone lesion	0253	12.02	$582.81	$284.00	$116.56
21041	T	Removal of jaw bone lesion	0256	25.40	$1,231.57	$623.05	$246.31
21044	T	Removal of jaw bone lesion	0256	25.40	$1,231.57	$623.05	$246.31
21045	C	Extensive jaw surgery					
21050	T	Removal of jaw joint	0256	25.40	$1,231.57	$623.05	$246.31
21060	T	Remove jaw joint cartilage	0256	25.40	$1,231.57	$623.05	$246.31
21070	T	Remove coronoid process	0256	25.40	$1,231.57	$623.05	$246.31
21076	T	Prepare face/oral prosthesis	0254	12.45	$603.66	$272.41	$120.73
21077	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21079	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21080	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21081	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21082	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21083	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21084	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21085	T	Prepare face/oral prosthesis	0253	12.02	$582.81	$284.00	$116.56
21086	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21087	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21088	T	Prepare face/oral prosthesis	0256	25.40	$1,231.57	$623.05	$246.31
21089	T	Prepare face/oral prosthesis	0253	12.02	$582.81	$284.00	$116.56
21100	T	Maxillofacial fixation	0256	25.40	$1,231.57	$623.05	$246.31
21110	T	Interdental fixation	0254	12.45	$603.66	$272.41	$120.73
21116	N	Injection, jaw joint x-ray					
21120	T	Reconstruction of chin	0254	12.45	$603.66	$272.41	$120.73
21121	T	Reconstruction of chin	0254	12.45	$603.66	$272.41	$120.73
21122	T	Reconstruction of chin	0254	12.45	$603.66	$272.41	$120.73
21123	T	Reconstruction of chin	0254	12.45	$603.66	$272.41	$120.73
21125	T	Augmentation, lower jaw bone	0254	12.45	$603.66	$272.41	$120.73
21127	T	Augmentation, lower jaw bone	0256	25.40	$1,231.57	$623.05	$246.31
21137	T	Reduction of forehead	0254	12.45	$603.66	$272.41	$120.73
21138	T	Reduction of forehead	0256	25.40	$1,231.57	$623.05	$246.31
21139	T	Reduction of forehead	0256	25.40	$1,231.57	$623.05	$246.31
21141	C	Reconstruct midface, lefort					
21142	C	Reconstruct midface, lefort					
21143	C	Reconstruct midface, lefort					
21145	C	Reconstruct midface, lefort					
21146	C	Reconstruct midface, lefort					
21147	C	Reconstruct midface, lefort					
21150	C	Reconstruct midface, lefort					
21151	C	Reconstruct midface, lefort					
21154	C	Reconstruct midface, lefort					
21155	C	Reconstruct midface, lefort					
21159	C	Reconstruct midface, lefort					
21160	C	Reconstruct midface, lefort					
21172	C	Reconstruct orbit/forehead					
21175	C	Reconstruct orbit/forehead					
21179	C	Reconstruct entire forehead					
21180	C	Reconstruct entire forehead					
21181	T	Contour cranial bone lesion	0254	12.45	$603.66	$272.41	$120.73
21182	C	Reconstruct cranial bone					
21183	C	Reconstruct cranial bone					
21184	C	Reconstruct cranial bone					
21188	C	Reconstruction of midface					
21193	C	Reconstruct lower jaw bone					
21194	C	Reconstruct lower jaw bone					
21195	C	Reconstruct lower jaw bone					
21196	C	Reconstruct lower jaw bone					
21198	T	Reconstruct lower jaw bone	0256	25.40	$1,231.57	$623.05	$246.31
21206	T	Reconstruct upper jaw bone	0256	25.40	$1,231.57	$623.05	$246.31
21208	T	Augmentation of facial bones	0256	25.40	$1,231.57	$623.05	$246.31
21209	T	Reduction of facial bones	0256	25.40	$1,231.57	$623.05	$246.31
21210	T	Face bone graft	0256	25.40	$1,231.57	$623.05	$246.31
21215	T	Lower jaw bone graft	0256	25.40	$1,231.57	$623.05	$246.31
21230	T	Rib cartilage graft	0256	25.40	$1,231.57	$623.05	$246.31

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21235	T	Ear cartilage graft	0254	12.45	$603.66	$272.41	$120.73
21240	T	Reconstruction of jaw joint	0256	25.40	$1,231.57	$623.05	$246.31
21242	T	Reconstruction of jaw joint	0256	25.40	$1,231.57	$623.05	$246.31
21243	T	Reconstruction of jaw joint	0256	25.40	$1,231.57	$623.05	$246.31
21244	T	Reconstruction of lower jaw	0256	25.40	$1,231.57	$623.05	$246.31
21245	T	Reconstruction of jaw	0256	25.40	$1,231.57	$623.05	$246.31
21246	T	Reconstruction of jaw	0256	25.40	$1,231.57	$623.05	$246.31
21247	C	Reconstruct lower jaw bone					
21248	T	Reconstruction of jaw	0256	25.40	$1,231.57	$623.05	$246.31
21249	T	Reconstruction of jaw	0256	25.40	$1,231.57	$623.05	$246.31
21255	C	Reconstruct lower jaw bone					
21256	C	Reconstruction of orbit					
21260	T	Revise eye sockets	0256	25.40	$1,231.57	$623.05	$246.31
21261	T	Revise eye sockets	0256	25.40	$1,231.57	$623.05	$246.31
21263	T	Revise eye sockets	0256	25.40	$1,231.57	$623.05	$246.31
21267	T	Revise eye sockets	0256	25.40	$1,231.57	$623.05	$246.31
21268	C	Revise eye sockets					
21270	T	Augmentation, cheek bone	0256	25.40	$1,231.57	$623.05	$246.31
21275	T	Revision, orbitofacial bones	0256	25.40	$1,231.57	$623.05	$246.31
21280	T	Revision of eyelid	0256	25.40	$1,231.57	$623.05	$246.31
21282	T	Revision of eyelid	0253	12.02	$582.81	$284.00	$116.56
21295	T	Revision of jaw muscle/bone	0253	12.02	$582.81	$284.00	$116.56
21296	T	Revision of jaw muscle/bone	0254	12.45	$603.66	$272.41	$120.73
21299	T	Cranio/maxillofacial surgery	0253	12.02	$582.81	$284.00	$116.56
21300	T	Treatment of skull fracture	0253	12.02	$582.81	$284.00	$116.56
21310	T	Treatment of nose fracture	0253	12.02	$582.81	$284.00	$116.56
21315	T	Treatment of nose fracture	0253	12.02	$582.81	$284.00	$116.56
21320	T	Treatment of nose fracture	0253	12.02	$582.81	$284.00	$116.56
21325	T	Treatment of nose fracture	0253	12.02	$582.81	$284.00	$116.56
21330	T	Treatment of nose fracture	0254	12.45	$603.66	$272.41	$120.73
21335	T	Treatment of nose fracture	0254	12.45	$603.66	$272.41	$120.73
21336	T	Treat nasal septal fracture	0046	22.29	$1,080.78	$535.76	$216.16
21337	T	Treat nasal septal fracture	0253	12.02	$582.81	$284.00	$116.56
21338	T	Treat nasoethmoid fracture	0254	12.45	$603.66	$272.41	$120.73
21339	T	Treat nasoethmoid fracture	0254	12.45	$603.66	$272.41	$120.73
21340	T	Treatment of nose fracture	0256	25.40	$1,231.57	$623.05	$246.31
21343	C	Treatment of sinus fracture					
21344	C	Treatment of sinus fracture					
21345	T	Treat nose/jaw fracture	0254	12.45	$603.66	$272.41	$120.73
21346	C	Treat nose/jaw fracture					
21347	C	Treat nose/jaw fracture					
21348	C	Treat nose/jaw fracture					
21355	T	Treat cheek bone fracture	0256	25.40	$1,231.57	$623.05	$246.31
21356	C	Treat cheek bone fracture					
21360	C	Treat cheek bone fracture					
21365	C	Treat cheek bone fracture					
21366	C	Treat cheek bone fracture					
21385	C	Treat eye socket fracture					
21386	C	Treat eye socket fracture					
21387	C	Treat eye socket fracture					
21390	C	Treat eye socket fracture					
21395	C	Treat eye socket fracture					
21400	T	Treat eye socket fracture	0252	5.18	$251.16	$114.24	$50.23
21401	T	Treat eye socket fracture	0253	12.02	$582.81	$284.00	$116.56
21406	T	Treat eye socket fracture	0256	25.40	$1,231.57	$623.05	$246.31
21407	T	Treat eye socket fracture	0256	25.40	$1,231.57	$623.05	$246.31
21408	C	Treat eye socket fracture					
21421	T	Treat mouth roof fracture	0254	12.45	$603.66	$272.41	$120.73
21422	C	Treat mouth roof fracture					
21423	C	Treat mouth roof fracture					
21431	C	Treat craniofacial fracture					
21432	C	Treat craniofacial fracture					
21433	C	Treat craniofacial fracture					
21435	C	Treat craniofacial fracture					
21436	C	Treat craniofacial fracture					
21440	T	Treat dental ridge fracture	0253	12.02	$582.81	$284.00	$116.56
21445	T	Treat dental ridge fracture	0254	12.45	$603.66	$272.41	$120.73
21450	T	Treat lower jaw fracture	0251	1.68	$81.46	$27.99	$16.29
21451	T	Treat lower jaw fracture	0254	12.45	$603.66	$272.41	$120.73
21452	T	Treat lower jaw fracture	0253	12.02	$582.81	$284.00	$116.56
21453	T	Treat lower jaw fracture	0256	25.40	$1,231.57	$623.05	$246.31
21454	T	Treat lower jaw fracture	0254	12.45	$603.66	$272.41	$120.73
21461	T	Treat lower jaw fracture	0256	25.40	$1,231.57	$623.05	$246.31

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
21462	T	Treat lower jaw fracture	0256	25.40	$1,231.57	$623.05	$246.31
21465	T	Treat lower jaw fracture	0256	25.40	$1,231.57	$623.05	$246.31
21470	T	Treat lower jaw fracture	0256	25.40	$1,231.57	$623.05	$246.31
21480	T	Reset dislocated jaw	0251	1.68	$81.46	$27.99	$16.29
21485	T	Reset dislocated jaw	0253	12.02	$582.81	$284.00	$116.56
21490	T	Repair dislocated jaw	0256	25.40	$1,231.57	$623.05	$246.31
21493	T	Treat hyoid bone fracture	0252	5.18	$251.16	$114.24	$50.23
21494	T	Treat hyoid bone fracture	0252	5.18	$251.16	$114.24	$50.23
21495	C	Treat hyoid bone fracture					
21497	T	Interdental wiring	0253	12.02	$582.81	$284.00	$116.56
21499	T	Head surgery procedure	0253	12.02	$582.81	$284.00	$116.56
21501	T	Drain neck/chest lesion	0008	6.15	$298.20	$113.67	$59.64
21502	T	Drain chest lesion	0050	21.13	$1,024.53	$513.86	$204.91
21510	C	Drainage of bone lesion					
21550	T	Biopsy of neck/chest	0019	4.00	$193.95	$78.91	$38.79
21555	T	Remove lesion, neck/chest	0022	12.49	$605.60	$292.94	$121.12
21556	T	Remove lesion, neck/chest	0022	12.49	$605.60	$292.94	$121.12
21557	C	Remove tumor, neck/chest					
21600	T	Partial removal of rib	0050	21.13	$1,024.53	$513.86	$204.91
21610	T	Partial removal of rib	0050	21.13	$1,024.53	$513.86	$204.91
21615	C	Removal of rib					
21616	C	Removal of rib and nerves					
21620	C	Partial removal of sternum					
21627	C	Sternal debridement					
21630	C	Extensive sternum surgery					
21632	C	Extensive sternum surgery					
21700	T	Revision of neck muscle	0008	6.15	$298.20	$113.67	$59.64
21705	C	Revision of neck muscle/rib					
21720	T	Revision of neck muscle	0008	6.15	$298.20	$113.67	$59.64
21725	T	Revision of neck muscle	0008	6.15	$298.20	$113.67	$59.64
21740	C	Reconstruction of sternum					
21750	C	Repair of sternum separation					
21800	T	Treatment of rib fracture	0043	1.64	$79.52	$25.46	$15.90
21805	T	Treatment of rib fracture	0046	22.29	$1,080.78	$535.76	$216.16
21810	C	Treatment of rib fracture(s)					
21820	T	Treat sternum fracture	0043	1.64	$79.52	$25.46	$15.90
21825	C	Treat sternum fracture					
21899	T	Neck/chest surgery procedure	0252	5.18	$251.16	$114.24	$50.23
21920	T	Biopsy soft tissue of back	0020	6.51	$315.65	$130.53	$63.13
21925	T	Biopsy soft tissue of back	0022	12.49	$605.60	$292.94	$121.12
21930	T	Remove lesion, back or flank	0022	12.49	$605.60	$292.94	$121.12
1935	T	Remove tumor, back	0022	12.49	$605.60	$292.94	$121.12
22100	C	Remove part of neck vertebra					
22101	C	Remove part, thorax vertebra					
22102	C	Remove part, lumbar vertebra					
22103	C	Remove extra spine segment					
22110	C	Remove part of neck vertebra					
22112	C	Remove part, thorax vertebra					
22114	C	Remove part, lumbar vertebra					
22116	C	Remove extra spine segment					
22210	C	Revision of neck spine					
22212	C	Revision of thorax spine					
22214	C	Revision of lumbar spine					
22216	C	Revise, extra spine segment					
22220	C	Revision of neck spine					
22222	C	Revision of thorax spine					
22224	C	Revision of lumbar spine					
22226	C	Revise, extra spine segment					
22305	T	Treat spine process fracture	0043	1.64	$79.52	$25.46	$15.90
22310	T	Treat spine fracture	0043	1.64	$79.52	$25.46	$15.90
22315	T	Treat spine fracture	0043	1.64	$79.52	$25.46	$15.90
22318	C	Treat odontoid fx w/o graft					
22319	C	Treat odontoid fx w/graft					
22325	C	Treat spine fracture					
22326	C	Treat neck spine fracture					
22327	C	Treat thorax spine fracture					
22328	C	Treat each add spine fx					
22505	T	Manipulation of spine	0045	11.02	$534.33	$277.12	$106.87
22548	C	Neck spine fusion					
22554	C	Neck spine fusion					
22556	C	Thorax spine fusion					
22558	C	Lumbar spine fusion					
22585	C	Additional spinal fusion					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
22590	C	Spine & skull spinal fusion					
22595	C	Neck spinal fusion					
22600	C	Neck spine fusion					
22610	C	Thorax spine fusion					
22612	C	Lumbar spine fusion					
22614	C	Spine fusion, extra segment					
22630	C	Lumbar spine fusion					
22632	C	Spine fusion, extra segment					
22800	C	Fusion of spine					
22802	C	Fusion of spine					
22804	C	Fusion of spine					
22808	C	Fusion of spine					
22810	C	Fusion of spine					
22812	C	Fusion of spine					
22818	C	Kyphectomy, 1–2 segments					
22819	C	Kyphectomy, 3 or more					
22830	C	Exploration of spinal fusion					
22840	C	Insert spine fixation device					
22841	C	Insert spine fixation device					
22842	C	Insert spine fixation device					
22843	C	Insert spine fixation device					
22844	C	Insert spine fixation device					
22845	C	Insert spine fixation device					
22846	C	Insert spine fixation device					
22847	C	Insert spine fixation device					
22848	C	Insert pelv fixation device					
22849	C	Reinsert spinal fixation					
22850	C	Remove spine fixation device					
22851	C	Apply spine prosth device					
22852	C	Remove spine fixation device					
22855	C	Remove spine fixation device					
22899	T	Spine surgery procedure	0043	1.64	$79.52	$25.46	$15.90
22900	T	Remove abdominal wall lesion	0022	12.49	$605.60	$292.94	$121.12
22999	T	Abdomen surgery procedure	0022	12.49	$605.60	$292.94	$121.12
23000	T	Removal of calcium deposits	0021	10.49	$508.63	$236.51	$101.73
23020	T	Release shoulder joint	0051	27.76	$1,346.00	$675.24	$269.20
23030	T	Drain shoulder lesion	0008	6.15	$298.20	$113.67	$59.64
23031	T	Drain shoulder bursa	0008	6.15	$298.20	$113.67	$59.64
23035	C	Drain shoulder bone lesion					
23040	T	Exploratory shoulder surgery	0050	21.13	$1,024.53	$513.86	$204.91
23044	T	Exploratory shoulder surgery	0050	21.13	$1,024.53	$513.86	$204.91
23065	T	Biopsy shoulder tissues	0021	10.49	$508.63	$236.51	$101.73
23066	T	Biopsy shoulder tissues	0022	12.49	$605.60	$292.94	$121.12
23075	T	Removal of shoulder lesion	0021	10.49	$508.63	$236.51	$101.73
23076	T	Removal of shoulder lesion	0022	12.49	$605.60	$292.94	$121.12
23077	T	Remove tumor of shoulder	0022	12.49	$605.60	$292.94	$121.12
23100	T	Biopsy of shoulder joint	0049	15.04	$729.25	$356.95	$145.85
23101	T	Shoulder joint surgery	0050	21.13	$1,024.53	$513.86	$204.91
23105	T	Remove shoulder joint lining	0050	21.13	$1,024.53	$513.86	$204.91
23106	T	Incision of collarbone joint	0050	21.13	$1,024.53	$513.86	$204.91
23107	T	Explore treat shoulder joint	0050	21.13	$1,024.53	$513.86	$204.91
23120	T	Partial removal, collar bone	0051	27.76	$1,346.00	$675.24	$269.20
23125	C	Removal of collar bone					
23130	T	Remove shoulder bone, part	0051	27.76	$1,346.00	$675.24	$269.20
23140	T	Removal of bone lesion	0049	15.04	$729.25	$356.95	$145.85
23145	T	Removal of bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
23146	T	Removal of bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
23150	T	Removal of humerus lesion	0050	21.13	$1,024.53	$513.86	$204.91
23155	T	Removal of humerus lesion	0050	21.13	$1,024.53	$513.86	$204.91
23156	T	Removal of humerus lesion	0050	21.13	$1,024.53	$513.86	$204.91
23170	T	Remove collar bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
23172	T	Remove shoulder blade lesion	0050	21.13	$1,024.53	$513.86	$204.91
23174	T	Remove humerus lesion	0050	21.13	$1,024.53	$513.86	$204.91
23180	T	Remove collar bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
23182	T	Remove shoulder blade lesion	0050	21.13	$1,024.53	$513.86	$204.91
23184	T	Remove humerus lesion	0050	21.13	$1,024.53	$513.86	$204.91
23190	T	Partial removal of scapula	0050	21.13	$1,024.53	$513.86	$204.91
23195	C	Removal of head of humerus					
23200	C	Removal of collar bone					
23210	C	Removal of shoulder blade					
23220	C	Partial removal of humerus					
23221	C	Partial removal of humerus					
23222	C	Partial removal of humerus					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
23330	T	Remove shoulder foreign body	0019	4.00	$193.95	$78.91	$38.79
23331	T	Remove shoulder foreign body	0022	12.49	$605.60	$292.94	$121.12
23332	C	Remove shoulder foreign body					
23350	N	Injection for shoulder x-ray					
23395	C	Muscle transfer, shoulder/arm					
23397	C	Muscle transfers					
23400	C	Fixation of shoulder blade					
23405	T	Incision of tendon & muscle	0050	21.13	$1,024.53	$513.86	$204.91
23406	T	Incise tendon(s) & muscle(s)	0050	21.13	$1,024.53	$513.86	$204.91
23410	T	Repair of tendon(s)	0052	36.16	$1,753.29	$930.91	$350.66
23412	T	Repair of tendon(s)	0052	36.16	$1,753.29	$930.91	$350.66
23415	T	Release of shoulder ligament	0051	27.76	$1,346.00	$675.24	$269.20
23420	T	Repair of shoulder	0052	36.16	$1,753.29	$930.91	$350.66
23430	T	Repair biceps tendon	0052	36.16	$1,753.29	$930.91	$350.66
23440	C	Remove/transplant tendon					
23450	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23455	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23460	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23462	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23465	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23466	T	Repair shoulder capsule	0052	36.16	$1,753.29	$930.91	$350.66
23470	C	Reconstruct shoulder joint					
23472	C	Reconstruct shoulder joint					
23480	T	Revision of collar bone	0051	27.76	$1,346.00	$675.24	$269.20
23485	T	Revision of collar bone	0051	27.76	$1,346.00	$675.24	$269.20
23490	T	Reinforce clavicle	0051	27.76	$1,346.00	$675.24	$269.20
23491	T	Reinforce shoulder bones	0051	27.76	$1,346.00	$675.24	$269.20
23500	T	Treat clavicle fracture	0043	1.64	$79.52	$25.46	$15.90
23505	T	Treat clavicle fracture	0043	1.64	$79.52	$25.46	$15.90
23515	T	Treat clavicle fracture	0046	22.29	$1,080.78	$535.76	$216.16
23520	T	Treat clavicle dislocation	0043	1.64	$79.52	$25.46	$15.90
23525	T	Treat clavicle dislocation	0043	1.64	$79.52	$25.46	$15.90
23530	T	Treat clavicle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
23532	T	Treat clavicle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
23540	T	Treat clavicle dislocation	0043	1.64	$79.52	$25.46	$15.90
23545	T	Treat clavicle dislocation	0043	1.64	$79.52	$25.46	$15.90
23550	T	Treat clavicle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
23552	T	Treat clavicle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
23570	T	Treat shoulder blade fx	0043	1.64	$79.52	$25.46	$15.90
23575	T	Treat shoulder blade fx	0043	1.64	$79.52	$25.46	$15.90
23585	T	Treat scapula fracture	0046	22.29	$1,080.78	$535.76	$216.16
23600	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
23605	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
23615	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
23616	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
23620	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
23625	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
23630	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
23650	T	Treat shoulder dislocation	0043	1.64	$79.52	$25.46	$15.90
23655	T	Treat shoulder dislocation	0045	11.02	$534.33	$277.12	$106.87
23660	T	Treat shoulder dislocation	0046	22.29	$1,080.78	$535.76	$216.16
23665	T	Treat dislocation/fracture	0044	2.17	$105.22	$38.08	$21.04
23670	T	Treat dislocation/fracture	0046	22.29	$1,080.78	$535.76	$216.16
23675	T	Treat dislocation/fracture	0044	2.17	$105.22	$38.08	$21.04
23680	T	Treat dislocation/fracture	0046	22.29	$1,080.78	$535.76	$216.16
23700	T	Fixation of shoulder	0045	11.02	$534.33	$277.12	$106.87
23800	T	Fusion of shoulder joint	0051	27.76	$1,346.00	$675.24	$269.20
23802	T	Fusion of shoulder joint	0051	27.76	$1,346.00	$675.24	$269.20
23900	C	Amputation of arm & girdle					
23920	C	Amputation at shoulder joint					
23921	T	Amputation follow-up surgery	0026	12.11	$587.18	$277.92	$117.44
23929	T	Shoulder surgery procedure	0043	1.64	$79.52	$25.46	$15.90
23930	T	Drainage of arm lesion	0008	6.15	$298.20	$113.67	$59.64
23931	T	Drainage of arm bursa	0008	6.15	$298.20	$113.67	$59.64
23935	T	Drain arm/elbow bone lesion	0049	15.04	$729.25	$356.95	$145.85
24000	T	Exploratory elbow surgery	0050	21.13	$1,024.53	$513.86	$204.91
24006	T	Release elbow joint	0050	21.13	$1,024.53	$513.86	$204.91
24065	T	Biopsy arm/elbow soft tissue	0020	6.51	$315.65	$130.53	$63.13
24066	T	Biopsy arm/elbow soft tissue	0020	6.51	$315.65	$130.53	$63.13
24075	T	Remove arm/elbow lesion	0021	10.49	$508.63	$236.51	$101.73
24076	T	Remove arm/elbow lesion	0022	12.49	$605.60	$292.94	$121.12
24077	T	Remove tumor of arm/elbow	0022	12.49	$605.60	$292.94	$121.12
24100	T	Biopsy elbow joint lining	0049	15.04	$729.25	$356.95	$145.85

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
24101	T	Explore/treat elbow joint	0050	21.13	$1,024.53	$513.86	$204.91
24102	T	Remove elbow joint lining	0050	21.13	$1,024.53	$513.86	$204.91
24105	T	Removal of elbow bursa	0049	15.04	$729.25	$356.95	$145.85
24110	T	Remove humerus lesion	0049	15.04	$729.25	$356.95	$145.85
24115	T	Remove/graft bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24116	T	Remove/graft bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24120	T	Remove elbow lesion	0049	15.04	$729.25	$356.95	$145.85
24125	T	Remove/graft bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24126	T	Remove/graft bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24130	T	Removal of head of radius	0050	21.13	$1,024.53	$513.86	$204.91
24134	T	Removal of arm bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24136	T	Remove radius bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24138	T	Remove elbow bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
24140	T	Partial removal of arm bone	0050	21.13	$1,024.53	$513.86	$204.91
24145	T	Partial removal of radius	0050	21.13	$1,024.53	$513.86	$204.91
24147	T	Partial removal of elbow	0050	21.13	$1,024.53	$513.86	$204.91
24149	C	Radical resection of elbow					
24150	C	Extensive humerus surgery					
24151	C	Extensive humerus surgery					
24152	C	Extensive radius surgery					
24153	C	Extensive radius surgery					
24155	T	Removal of elbow joint	0051	27.76	$1,346.00	$675.24	$269.20
24160	T	Remove elbow joint implant	0050	21.13	$1,024.53	$513.86	$204.91
24164	T	Remove radius head implant	0050	21.13	$1,024.53	$513.86	$204.91
24200	T	Removal of arm foreign body	0019	4.00	$193.95	$78.91	$38.79
24201	T	Removal of arm foreign body	0021	10.49	$508.63	$236.51	$101.73
24220	N	Injection for elbow x-ray					
24301	T	Muscle/tendon transfer	0050	21.13	$1,024.53	$513.86	$204.91
24305	T	Arm tendon lengthening	0050	21.13	$1,024.53	$513.86	$204.91
24310	T	Revision of arm tendon	0049	15.04	$729.25	$356.95	$145.85
24320	T	Repair of arm tendon	0051	27.76	$1,346.00	$675.24	$269.20
24330	T	Revision of arm muscles	0051	27.76	$1,346.00	$675.24	$269.20
24331	T	Revision of arm muscles	0051	27.76	$1,346.00	$675.24	$269.20
24340	T	Repair of biceps tendon	0051	27.76	$1,346.00	$675.24	$269.20
24341	T	Repair arm tendon/muscle	0051	27.76	$1,346.00	$675.24	$269.20
24342	T	Repair of ruptured tendon	0051	27.76	$1,346.00	$675.24	$269.20
24350	T	Repair of tennis elbow	0050	21.13	$1,024.53	$513.86	$204.91
24351	T	Repair of tennis elbow	0050	21.13	$1,024.53	$513.86	$204.91
24352	T	Repair of tennis elbow	0050	21.13	$1,024.53	$513.86	$204.91
24354	T	Repair of tennis elbow	0050	21.13	$1,024.53	$513.86	$204.91
24356	T	Revision of tennis elbow	0050	21.13	$1,024.53	$513.86	$204.91
24360	T	Reconstruct elbow joint	0047	22.09	$1,071.08	$537.03	$214.22
24361	T	Reconstruct elbow joint	0048	29.06	$1,409.03	$725.94	$281.81
24362	T	Reconstruct elbow joint	0048	29.06	$1,409.03	$725.94	$281.81
24363	T	Replace elbow joint	0048	29.06	$1,409.03	$725.94	$281.81
24365	T	Reconstruct head of radius	0047	22.09	$1,071.08	$537.03	$214.22
24366	T	Reconstruct head of radius	0048	29.06	$1,409.03	$725.94	$281.81
24400	T	Revision of humerus	0050	21.13	$1,024.53	$513.86	$204.91
24410	T	Revision of humerus	0050	21.13	$1,024.53	$513.86	$204.91
24420	T	Revision of humerus	0051	27.76	$1,346.00	$675.24	$269.20
24430	T	Repair of humerus	0051	27.76	$1,346.00	$675.24	$269.20
24435	T	Repair humerus with graft	0051	27.76	$1,346.00	$675.24	$269.20
24470	T	Revision of elbow joint	0051	27.76	$1,346.00	$675.24	$269.20
24495	T	Decompression of forearm	0050	21.13	$1,024.53	$513.86	$204.91
24498	T	Reinforce humerus	0051	27.76	$1,346.00	$675.24	$269.20
24500	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24505	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24515	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24516	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24530	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24535	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24538	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24545	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24546	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24560	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24565	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24566	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24575	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24576	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24577	T	Treat humerus fracture	0044	2.17	$105.22	$38.08	$21.04
24579	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24582	T	Treat humerus fracture	0046	22.29	$1,080.78	$535.76	$216.16
24586	T	Treat elbow fracture	0046	22.29	$1,080.78	$535.76	$216.16

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
24587	T	Treat elbow fracture	0046	22.29	$1,080.78	$535.76	$216.16
24600	T	Treat elbow dislocation	0044	2.17	$105.22	$38.08	$21.04
24605	T	Treat elbow dislocation	0045	11.02	$534.33	$277.12	$106.87
24615	T	Treat elbow dislocation	0046	22.29	$1,080.78	$535.76	$216.16
24620	T	Treat elbow fracture	0044	2.17	$105.22	$38.08	$21.04
24635	T	Treat elbow fracture	0046	22.29	$1,080.78	$535.76	$216.16
24640	T	Treat elbow dislocation	0044	2.17	$105.22	$38.08	$21.04
24650	T	Treat radius fracture	0044	2.17	$105.22	$38.08	$21.04
24655	T	Treat radius fracture	0044	2.17	$105.22	$38.08	$21.04
24665	T	Treat radius fracture	0046	22.29	$1,080.78	$535.76	$216.16
24666	T	Treat radius fracture	0046	22.29	$1,080.78	$535.76	$216.16
24670	T	Treat ulnar fracture	0044	2.17	$105.22	$38.08	$21.04
24675	T	Treat ulnar fracture	0044	2.17	$105.22	$38.08	$21.04
24685	T	Treat ulnar fracture	0046	22.29	$1,080.78	$535.76	$216.16
24800	T	Fusion of elbow joint	0051	27.76	$1,346.00	$675.24	$269.20
24802	T	Fusion/graft of elbow joint	0051	27.76	$1,346.00	$675.24	$269.20
24900	C	Amputation of upper arm					
24920	C	Amputation of upper arm					
24925	T	Amputation follow-up surgery	0049	15.04	$729.25	$356.95	$145.85
24930	C	Amputation follow-up surgery					
24931	C	Amputate upper arm & implant					
24935	T	Revision of amputation	0052	36.16	$1,753.29	$930.91	$350.66
24940	C	Revision of upper arm					
24999	T	Upper arm/elbow surgery	0044	2.17	$105.22	$38.08	$21.04
25000	T	Incision of tendon sheath	0049	15.04	$729.25	$356.95	$145.85
25020	T	Decompression of forearm	0049	15.04	$729.25	$356.95	$145.85
25023	T	Decompression of forearm	0050	21.13	$1,024.53	$513.86	$204.91
25028	T	Drainage of forearm lesion	0049	15.04	$729.25	$356.95	$145.85
25031	T	Drainage of forearm bursa	0049	15.04	$729.25	$356.95	$145.85
25035	T	Treat forearm bone lesion	0049	15.04	$729.25	$356.95	$145.85
25040	T	Explore/treat wrist joint	0050	21.13	$1,024.53	$513.86	$204.91
25065	T	Biopsy forearm soft tissues	0020	6.51	$315.65	$130.53	$63.13
25066	T	Biopsy forearm soft tissues	0022	12.49	$605.60	$292.94	$121.12
25075	T	Removal of forearm lesion	0020	6.51	$315.65	$130.53	$63.13
25076	T	Removal of forearm lesion	0022	12.49	$605.60	$292.94	$121.12
25077	T	Remove tumor, forearm/wrist	0022	12.49	$605.60	$292.94	$121.12
25085	T	Incision of wrist capsule	0049	15.04	$729.25	$356.95	$145.85
25100	T	Biopsy of wrist joint	0049	15.04	$729.25	$356.95	$145.85
25101	T	Explore/treat wrist joint	0050	21.13	$1,024.53	$513.86	$204.91
25105	T	Remove wrist joint lining	0050	21.13	$1,024.53	$513.86	$204.91
25107	T	Remove wrist joint cartilage	0050	21.13	$1,024.53	$513.86	$204.91
25110	T	Remove wrist tendon lesion	0049	15.04	$729.25	$356.95	$145.85
25111	T	Remove wrist tendon lesion	0053	11.32	$548.87	$253.49	$109.77
25112	T	Reremove wrist tendon lesion	0053	11.32	$548.87	$253.49	$109.77
25115	T	Remove wrist/forearm lesion	0049	15.04	$729.25	$356.95	$145.85
25116	T	Remove wrist/forearm lesion	0049	15.04	$729.25	$356.95	$145.85
25118	T	Excise wrist tendon sheath	0050	21.13	$1,024.53	$513.86	$204.91
25119	T	Partial removal of ulna	0050	21.13	$1,024.53	$513.86	$204.91
25120	T	Removal of forearm lesion	0050	21.13	$1,024.53	$513.86	$204.91
25125	T	Remove/graft forearm lesion	0050	21.13	$1,024.53	$513.86	$204.91
25126	T	Remove/graft forearm lesion	0050	21.13	$1,024.53	$513.86	$204.91
25130	T	Removal of wrist lesion	0050	21.13	$1,024.53	$513.86	$204.91
25135	T	Remove & graft wrist lesion	0050	21.13	$1,024.53	$513.86	$204.91
25136	T	Remove & graft wrist lesion	0050	21.13	$1,024.53	$513.86	$204.91
25145	T	Remove forearm bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
25150	T	Partial removal of ulna	0050	21.13	$1,024.53	$513.86	$204.91
25151	T	Partial removal of radius	0050	21.13	$1,024.53	$513.86	$204.91
25170	C	Extensive forearm surgery					
25210	T	Removal of wrist bone	0054	19.66	$953.26	$472.33	$190.65
25215	T	Removal of wrist bones	0054	19.66	$953.26	$472.33	$190.65
25230	T	Partial removal of radius	0050	21.13	$1,024.53	$513.86	$204.91
25240	T	Partial removal of ulna	0050	21.13	$1,024.53	$513.86	$204.91
25246	N	Injection for wrist x-ray					
25248	T	Remove forearm foreign body	0049	15.04	$729.25	$356.95	$145.85
25250	T	Removal of wrist prosthesis	0050	21.13	$1,024.53	$513.86	$204.91
25251	T	Removal of wrist prosthesis	0050	21.13	$1,024.53	$513.86	$204.91
25260	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25263	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25265	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25270	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25272	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25274	T	Repair forearm tendon/muscle	0050	21.13	$1,024.53	$513.86	$204.91
25280	T	Revise wrist/forearm tendon	0050	21.13	$1,024.53	$513.86	$204.91

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
25290	T	Incise wrist/forearm tendon	0050	21.13	$1,024.53	$513.86	$204.91
25295	T	Release wrist/forearm tendon	0049	15.04	$729.25	$356.95	$145.85
25300	T	Fusion of tendons at wrist	0050	21.13	$1,024.53	$513.86	$204.91
25301	T	Fusion of tendons at wrist	0050	21.13	$1,024.53	$513.86	$204.91
25310	T	Transplant forearm tendon	0051	27.76	$1,346.00	$675.24	$269.20
25312	T	Transplant forearm tendon	0051	27.76	$1,346.00	$675.24	$269.20
25315	T	Revise palsy hand tendon(s)	0051	27.76	$1,346.00	$675.24	$269.20
25316	T	Revise palsy hand tendon(s)	0051	27.76	$1,346.00	$675.24	$269.20
25320	T	Repair/revise wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25332	T	Revise wrist joint	0047	22.09	$1,071.08	$537.03	$214.22
25335	T	Realignment of hand	0051	27.76	$1,346.00	$675.24	$269.20
25337	T	Reconstruct ulna/radioulnar	0051	27.76	$1,346.00	$675.24	$269.20
25350	T	Revision of radius	0051	27.76	$1,346.00	$675.24	$269.20
25355	T	Revision of radius	0051	27.76	$1,346.00	$675.24	$269.20
25360	T	Revision of ulna	0050	21.13	$1,024.53	$513.86	$204.91
25365	T	Revise radius & ulna	0050	21.13	$1,024.53	$513.86	$204.91
25370	T	Revise radius or ulna	0051	27.76	$1,346.00	$675.24	$269.20
25375	T	Revise radius & ulna	0051	27.76	$1,346.00	$675.24	$269.20
25390	C	Shorten radius or ulna					
25391	C	Lengthen radius or ulna					
25392	C	Shorten radius & ulna					
25393	C	Lengthen radius & ulna					
25400	T	Repair radius or ulna	0050	21.13	$1,024.53	$513.86	$204.91
25405	C	Repair/graft radius or ulna					
25415	T	Repair radius & ulna	0050	21.13	$1,024.53	$513.86	$204.91
25420	C	Repair/graft radius & ulna					
25425	T	Repair/graft radius or ulna	0051	27.76	$1,346.00	$675.24	$269.20
25426	T	Repair/graft radius & ulna	0051	27.76	$1,346.00	$675.24	$269.20
25440	T	Repair/graft wrist bone	0051	27.76	$1,346.00	$675.24	$269.20
25441	T	Reconstruct wrist joint	0048	29.06	$1,409.03	$725.94	$281.81
25442	T	Reconstruct wrist joint	0048	29.06	$1,409.03	$725.94	$281.81
25443	T	Reconstruct wrist joint	0048	29.06	$1,409.03	$725.94	$281.81
25444	T	Reconstruct wrist joint	0048	29.06	$1,409.03	$725.94	$281.81
25445	T	Reconstruct wrist joint	0048	29.06	$1,409.03	$725.94	$281.81
25446	T	Wrist replacement	0048	29.06	$1,409.03	$725.94	$281.81
25447	T	Repair wrist joint(s)	0047	22.09	$1,071.08	$537.03	$214.22
25449	T	Remove wrist joint implant	0047	22.09	$1,071.08	$537.03	$214.22
25450	T	Revision of wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25455	T	Revision of wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25490	T	Reinforce radius	0051	27.76	$1,346.00	$675.24	$269.20
25491	T	Reinforce ulna	0051	27.76	$1,346.00	$675.24	$269.20
25492	T	Reinforce radius and ulna	0051	27.76	$1,346.00	$675.24	$269.20
25500	T	Treat fracture of radius	0044	2.17	$105.22	$38.08	$21.04
25505	T	Treat fracture of radius	0044	2.17	$105.22	$38.08	$21.04
25515	T	Treat fracture of radius	0046	22.29	$1,080.78	$535.76	$216.16
25520	T	Treat fracture of radius	0044	2.17	$105.22	$38.08	$21.04
25525	T	Treat fracture of radius	0046	22.29	$1,080.78	$535.76	$216.16
25526	T	Treat fracture of radius	0046	22.29	$1,080.78	$535.76	$216.16
25530	T	Treat fracture of ulna	0044	2.17	$105.22	$38.08	$21.04
25535	T	Treat fracture of ulna	0044	2.17	$105.22	$38.08	$21.04
25545	T	Treat fracture of ulna	0046	22.29	$1,080.78	$535.76	$216.16
25560	T	Treat fracture radius & ulna	0044	2.17	$105.22	$38.08	$21.04
25565	T	Treat fracture radius & ulna	0044	2.17	$105.22	$38.08	$21.04
25574	T	Treat fracture radius & ulna	0046	22.29	$1,080.78	$535.76	$216.16
25575	T	Treat fracture radius/ulna	0046	22.29	$1,080.78	$535.76	$216.16
25600	T	Treat fracture radius/ulna	0044	2.17	$105.22	$38.08	$21.04
25605	T	Treat fracture radius/ulna	0044	2.17	$105.22	$38.08	$21.04
25611	T	Treat fracture radius/ulna	0046	22.29	$1,080.78	$535.76	$216.16
25620	T	Treat fracture radius/ulna	0046	22.29	$1,080.78	$535.76	$216.16
25622	T	Treat wrist bone fracture	0044	2.17	$105.22	$38.08	$21.04
25624	T	Treat wrist bone fracture	0044	2.17	$105.22	$38.08	$21.04
25628	T	Treat wrist bone fracture	0046	22.29	$1,080.78	$535.76	$216.16
25630	T	Treat wrist bone fracture	0044	2.17	$105.22	$38.08	$21.04
25635	T	Treat wrist bone fracture	0044	2.17	$105.22	$38.08	$21.04
25645	T	Treat wrist bone fracture	0046	22.29	$1,080.78	$535.76	$216.16
25650	T	Treat wrist bone fracture	0044	2.17	$105.22	$38.08	$21.04
25660	T	Treat wrist dislocation	0044	2.17	$105.22	$38.08	$21.04
25670	T	Treat wrist dislocation	0046	22.29	$1,080.78	$535.76	$216.16
25675	T	Treat wrist dislocation	0044	2.17	$105.22	$38.08	$21.04
25676	T	Treat wrist dislocation	0046	22.29	$1,080.78	$535.76	$216.16
25680	T	Treat wrist fracture	0044	2.17	$105.22	$38.08	$21.04
25685	T	Treat wrist fracture	0046	22.29	$1,080.78	$535.76	$216.16
25690	T	Treat wrist dislocation	0044	2.17	$105.22	$38.08	$21.04

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
25695	T	Treat wrist dislocation	0046	22.29	$1,080.78	$535.76	$216.16
25800	T	Fusion of wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25805	T	Fusion/graft of wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25810	T	Fusion/graft of wrist joint	0051	27.76	$1,346.00	$675.24	$269.20
25820	T	Fusion of hand bones	0053	11.32	$548.87	$253.49	$109.77
25825	T	Fuse hand bones with graft	0054	19.66	$953.26	$472.33	$190.65
25830	T	Fusion, radioulnar jnt/ulna	0051	27.76	$1,346.00	$675.24	$269.20
25900	C	Amputation of forearm					
25905	C	Amputation of forearm					
25907	T	Amputation follow-up surgery	0049	15.04	$729.25	$356.95	$145.85
25909	C	Amputation follow-up surgery					
25915	C	Amputation of forearm					
25920	C	Amputate hand at wrist					
25922	T	Amputate hand at wrist	0049	15.04	$729.25	$356.95	$145.85
25924	C	Amputation follow-up surgery					
25927	C	Amputation of hand					
25929	T	Amputation follow-up surgery	0026	12.11	$587.18	$277.92	$117.44
25931	C	Amputation follow-up surgery					
25999	T	Forearm or wrist surgery	0044	2.17	$105.22	$38.08	$21.04
26010	T	Drainage of finger abscess	0006	2.00	$96.97	$33.95	$19.39
26011	T	Drainage of finger abscess	0007	3.68	$178.43	$72.03	$35.69
26020	T	Drain hand tendon sheath	0053	11.32	$548.87	$253.49	$109.77
26025	T	Drainage of palm bursa	0053	11.32	$548.87	$253.49	$109.77
26030	T	Drainage of palm bursa(s)	0053	11.32	$548.87	$253.49	$109.77
26034	T	Treat hand bone lesion	0053	11.32	$548.87	$253.49	$109.77
26035	T	Decompress fingers/hand	0053	11.32	$548.87	$253.49	$109.77
26037	T	Decompress fingers/hand	0053	11.32	$548.87	$253.49	$109.77
26040	T	Release palm contracture	0054	19.66	$953.26	$472.33	$190.65
26045	T	Release palm contracture	0054	19.66	$953.26	$472.33	$190.65
26055	T	Incise finger tendon sheath	0053	11.32	$548.87	$253.49	$109.77
26060	T	Incision of finger tendon	0053	11.32	$548.87	$253.49	$109.77
26070	T	Explore/treat hand joint	0053	11.32	$548.87	$253.49	$109.77
26075	T	Explore/treat finger joint	0053	11.32	$548.87	$253.49	$109.77
26080	T	Explore/treat finger joint	0053	11.32	$548.87	$253.49	$109.77
26100	T	Biopsy hand joint lining	0053	11.32	$548.87	$253.49	$109.77
26105	T	Biopsy finger joint lining	0053	11.32	$548.87	$253.49	$109.77
26110	T	Biopsy finger joint lining	0053	11.32	$548.87	$253.49	$109.77
26115	T	Removal of hand lesion	0022	12.49	$605.60	$292.94	$121.12
26116	T	Removal of hand lesion	0022	12.49	$605.60	$292.94	$121.12
26117	T	Remove tumor, hand/finger	0022	12.49	$605.60	$292.94	$121.12
26121	T	Release palm contracture	0054	19.66	$953.26	$472.33	$190.65
26123	T	Release palm contracture	0054	19.66	$953.26	$472.33	$190.65
26125	T	Release palm contracture	0054	19.66	$953.26	$472.33	$190.65
26130	T	Remove wrist joint lining	0053	11.32	$548.87	$253.49	$109.77
26135	T	Revise finger joint, each	0054	19.66	$953.26	$472.33	$190.65
26140	T	Revise finger joint, each	0053	11.32	$548.87	$253.49	$109.77
26145	T	Tendon excision, palm/finger	0053	11.32	$548.87	$253.49	$109.77
26160	T	Remove tendon sheath lesion	0053	11.32	$548.87	$253.49	$109.77
26170	T	Removal of palm tendon, each	0053	11.32	$548.87	$253.49	$109.77
26180	T	Removal of finger tendon	0053	11.32	$548.87	$253.49	$109.77
26185	T	Remove finger bone	0053	11.32	$548.87	$253.49	$109.77
26200	T	Remove hand bone lesion	0053	11.32	$548.87	$253.49	$109.77
26205	T	Remove/graft bone lesion	0054	19.66	$953.26	$472.33	$190.65
26210	T	Removal of finger lesion	0053	11.32	$548.87	$253.49	$109.77
26215	T	Remove/graft finger lesion	0053	11.32	$548.87	$253.49	$109.77
26230	T	Partial removal of hand bone	0053	11.32	$548.87	$253.49	$109.77
26235	T	Partial removal, finger bone	0053	11.32	$548.87	$253.49	$109.77
26236	T	Partial removal, finger bone	0053	11.32	$548.87	$253.49	$109.77
26250	T	Extensive hand surgery	0053	11.32	$548.87	$253.49	$109.77
26255	T	Extensive hand surgery	0054	19.66	$953.26	$472.33	$190.65
26260	T	Extensive finger surgery	0053	11.32	$548.87	$253.49	$109.77
26261	T	Extensive finger surgery	0053	11.32	$548.87	$253.49	$109.77
26262	T	Partial removal of finger	0053	11.32	$548.87	$253.49	$109.77
26320	T	Removal of implant from hand	0020	6.51	$315.65	$130.53	$63.13
26350	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26352	T	Repair/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26356	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26357	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26358	T	Repair/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26370	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26372	T	Repair/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26373	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26390	T	Revise hand/finger tendon	0054	19.66	$953.26	$472.33	$190.65

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
26392	T	Repair/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26410	T	Repair hand tendon	0053	11.32	$548.87	$253.49	$109.77
26412	T	Repair/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26415	T	Excision, hand/finger tendon	0054	19.66	$953.26	$472.33	$190.65
26416	T	Graft hand or finger tendon	0054	19.66	$953.26	$472.33	$190.65
26418	T	Repair finger tendon	0053	11.32	$548.87	$253.49	$109.77
26420	T	Repair/graft finger tendon	0054	19.66	$953.26	$472.33	$190.65
26426	T	Repair finger/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26428	T	Repair/graft finger tendon	0054	19.66	$953.26	$472.33	$190.65
26432	T	Repair finger tendon	0053	11.32	$548.87	$253.49	$109.77
26433	T	Repair finger tendon	0053	11.32	$548.87	$253.49	$109.77
26434	T	Repair/graft finger tendon	0054	19.66	$953.26	$472.33	$190.65
26437	T	Realignment of tendons	0053	11.32	$548.87	$253.49	$109.77
26440	T	Release palm/finger tendon	0053	11.32	$548.87	$253.49	$109.77
26442	T	Release palm & finger tendon	0054	19.66	$953.26	$472.33	$190.65
26445	T	Release hand/finger tendon	0053	11.32	$548.87	$253.49	$109.77
26449	T	Release forearm/hand tendon	0054	19.66	$953.26	$472.33	$190.65
26450	T	Incision of palm tendon	0053	11.32	$548.87	$253.49	$109.77
26455	T	Incision of finger tendon	0053	11.32	$548.87	$253.49	$109.77
26460	T	Incise hand/finger tendon	0053	11.32	$548.87	$253.49	$109.77
26471	T	Fusion of finger tendons	0053	11.32	$548.87	$253.49	$109.77
26474	T	Fusion of finger tendons	0053	11.32	$548.87	$253.49	$109.77
26476	T	Tendon lengthening	0053	11.32	$548.87	$253.49	$109.77
26477	T	Tendon shortening	0053	11.32	$548.87	$253.49	$109.77
26478	T	Lengthening of hand tendon	0053	11.32	$548.87	$253.49	$109.77
26479	T	Shortening of hand tendon	0053	11.32	$548.87	$253.49	$109.77
26480	T	Transplant hand tendon	0054	19.66	$953.26	$472.33	$190.65
26483	T	Transplant/graft hand tendon	0054	19.66	$953.26	$472.33	$190.65
26485	T	Transplant palm tendon	0054	19.66	$953.26	$472.33	$190.65
26489	T	Transplant/graft palm tendon	0054	19.66	$953.26	$472.33	$190.65
26490	T	Revise thumb tendon	0054	19.66	$953.26	$472.33	$190.65
26492	T	Tendon transfer with graft	0054	19.66	$953.26	$472.33	$190.65
26494	T	Hand tendon/muscle transfer	0054	19.66	$953.26	$472.33	$190.65
26496	T	Revise thumb tendon	0054	19.66	$953.26	$472.33	$190.65
26497	T	Finger tendon transfer	0054	19.66	$953.26	$472.33	$190.65
26498	T	Finger tendon transfer	0054	19.66	$953.26	$472.33	$190.65
26499	T	Revision of finger	0054	19.66	$953.26	$472.33	$190.65
26500	T	Hand tendon reconstruction	0053	11.32	$548.87	$253.49	$109.77
26502	T	Hand tendon reconstruction	0054	19.66	$953.26	$472.33	$190.65
26504	T	Hand tendon reconstruction	0054	19.66	$953.26	$472.33	$190.65
26508	T	Release thumb contracture	0053	11.32	$548.87	$253.49	$109.77
26510	T	Thumb tendon transfer	0054	19.66	$953.26	$472.33	$190.65
26516	T	Fusion of knuckle joint	0054	19.66	$953.26	$472.33	$190.65
26517	T	Fusion of knuckle joints	0054	19.66	$953.26	$472.33	$190.65
26518	T	Fusion of knuckle joints	0054	19.66	$953.26	$472.33	$190.65
26520	T	Release knuckle contracture	0053	11.32	$548.87	$253.49	$109.77
26525	T	Release finger contracture	0053	11.32	$548.87	$253.49	$109.77
26530	T	Revise knuckle joint	0047	22.09	$1,071.08	$537.03	$214.22
26531	T	Revise knuckle with implant	0048	29.06	$1,409.03	$725.94	$281.81
26535	T	Revise finger joint	0047	22.09	$1,071.08	$537.03	$214.22
26536	T	Revise/implant finger joint	0048	29.06	$1,409.03	$725.94	$281.81
26540	T	Repair hand joint	0053	11.32	$548.87	$253.49	$109.77
26541	T	Repair hand joint with graft	0054	19.66	$953.26	$472.33	$190.65
26542	T	Repair hand joint with graft	0053	11.32	$548.87	$253.49	$109.77
26545	T	Reconstruct finger joint	0054	19.66	$953.26	$472.33	$190.65
26546	T	Repair nonunion hand	0054	19.66	$953.26	$472.33	$190.65
26548	T	Reconstruct finger joint	0054	19.66	$953.26	$472.33	$190.65
26550	T	Construct thumb replacement	0054	19.66	$953.26	$472.33	$190.65
26551	C	Great toe-hand transfer					
26553	C	Single transfer, toe-hand					
26554	C	Double transfer, toe-hand					
26555	T	Positional change of finger	0054	19.66	$953.26	$472.33	$190.65
26556	C	Toe joint transfer					
26560	T	Repair of web finger	0053	11.32	$548.87	$253.49	$109.77
26561	T	Repair of web finger	0054	19.66	$953.26	$472.33	$190.65
26562	T	Repair of web finger	0054	19.66	$953.26	$472.33	$190.65
26565	T	Correct metacarpal flaw	0054	19.66	$953.26	$472.33	$190.65
26567	T	Correct finger deformity	0054	19.66	$953.26	$472.33	$190.65
26568	T	Lengthen metacarpal/finger	0054	19.66	$953.26	$472.33	$190.65
26580	T	Repair hand deformity	0054	19.66	$953.26	$472.33	$190.65
26585	T	Repair finger deformity	0054	19.66	$953.26	$472.33	$190.65
26587	T	Reconstruct extra finger	0053	11.32	$548.87	$253.49	$109.77
26590	T	Repair finger deformity	0054	19.66	$953.26	$472.33	$190.65

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
26591	T	Repair muscles of hand	0054	19.66	$953.26	$472.33	$190.65
26593	T	Release muscles of hand	0053	11.32	$548.87	$253.49	$109.77
26596	T	Excision constricting tissue	0054	19.66	$953.26	$472.33	$190.65
26597	T	Release of scar contracture	0054	19.66	$953.26	$472.33	$190.65
26600	T	Treat metacarpal fracture	0044	2.17	$105.22	$38.08	$21.04
26605	T	Treat metacarpal fracture	0044	2.17	$105.22	$38.08	$21.04
26607	T	Treat metacarpal fracture	0044	2.17	$105.22	$38.08	$21.04
26608	T	Treat metacarpal fracture	0046	22.29	$1,080.78	$535.76	$216.16
26615	T	Treat metacarpal fracture	0046	22.29	$1,080.78	$535.76	$216.16
26641	T	Treat thumb dislocation	0044	2.17	$105.22	$38.08	$21.04
26645	T	Treat thumb fracture	0044	2.17	$105.22	$38.08	$21.04
26650	T	Treat thumb fracture	0046	22.29	$1,080.78	$535.76	$216.16
26665	T	Treat thumb fracture	0046	22.29	$1,080.78	$535.76	$216.16
26670	T	Treat hand dislocation	0044	2.17	$105.22	$38.08	$21.04
26675	T	Treat hand dislocation	0045	11.02	$534.33	$277.12	$106.87
26676	T	Pin hand dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26685	T	Treat hand dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26686	T	Treat hand dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26700	T	Treat knuckle dislocation	0043	1.64	$79.52	$25.46	$15.90
26705	T	Treat knuckle dislocation	0045	11.02	$534.33	$277.12	$106.87
26706	T	Pin knuckle dislocation	0044	2.17	$105.22	$38.08	$21.04
26715	T	Treat knuckle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26720	T	Treat finger fracture, each	0043	1.64	$79.52	$25.46	$15.90
26725	T	Treat finger fracture, each	0043	1.64	$79.52	$25.46	$15.90
26727	T	Treat finger fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
26735	T	Treat finger fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
26740	T	Treat finger fracture, each	0043	1.64	$79.52	$25.46	$15.90
26742	T	Treat finger fracture, each	0044	2.17	$105.22	$38.08	$21.04
26746	T	Treat finger fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
26750	T	Treat finger fracture, each	0043	1.64	$79.52	$25.46	$15.90
26755	T	Treat finger fracture, each	0043	1.64	$79.52	$25.46	$15.90
26756	T	Pin finger fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
26765	T	Treat finger fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
26770	T	Treat finger dislocation	0043	1.64	$79.52	$25.46	$15.90
26775	T	Treat finger dislocation	0045	11.02	$534.33	$277.12	$106.87
26776	T	Pin finger dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26785	T	Treat finger dislocation	0046	22.29	$1,080.78	$535.76	$216.16
26820	T	Thumb fusion with graft	0054	19.66	$953.26	$472.33	$190.65
26841	T	Fusion of thumb	0054	19.66	$953.26	$472.33	$190.65
26842	T	Thumb fusion with graft	0054	19.66	$953.26	$472.33	$190.65
26843	T	Fusion of hand joint	0054	19.66	$953.26	$472.33	$190.65
26844	T	Fusion/graft of hand joint	0054	19.66	$953.26	$472.33	$190.65
26850	T	Fusion of knuckle	0054	19.66	$953.26	$472.33	$190.65
26852	T	Fusion of knuckle with graft	0054	19.66	$953.26	$472.33	$190.65
26860	T	Fusion of finger joint	0054	19.66	$953.26	$472.33	$190.65
26861	T	Fusion of finger jnt, add-on	0054	19.66	$953.26	$472.33	$190.65
26862	T	Fusion/graft of finger joint	0054	19.66	$953.26	$472.33	$190.65
26863	T	Fuse/graft added joint	0054	19.66	$953.26	$472.33	$190.65
26910	T	Amputate metacarpal bone	0054	19.66	$953.26	$472.33	$190.65
26951	T	Amputation of finger/thumb	0053	11.32	$548.87	$253.49	$109.77
26952	T	Amputation of finger/thumb	0053	11.32	$548.87	$253.49	$109.77
26989	T	Hand/finger surgery	0043	1.64	$79.52	$25.46	$15.90
26990	T	Drainage of pelvis lesion	0049	15.04	$729.25	$356.95	$145.85
26991	T	Drainage of pelvis bursa	0049	15.04	$729.25	$356.95	$145.85
26992	C	Drainage of bone lesion					
27000	T	Incision of hip tendon	0049	15.04	$729.25	$356.95	$145.85
27001	T	Incision of hip tendon	0050	21.13	$1,024.53	$513.86	$204.91
27003	T	Incision of hip tendon	0050	21.13	$1,024.53	$513.86	$204.91
27005	C	Incision of hip tendon					
27006	C	Incision of hip tendons					
27025	C	Incision of hip/thigh fascia					
27030	C	Drainage of hip joint					
27033	T	Exploration of hip joint	0051	27.76	$1,346.00	$675.24	$269.20
27035	C	Denervation of hip joint					
27036	C	Excision of hip joint/muscle					
27040	T	Biopsy of soft tissues	0021	10.49	$508.63	$236.51	$101.73
27041	T	Biopsy of soft tissues	0022	12.49	$605.60	$292.94	$121.12
27047	T	Remove hip/pelvis lesion	0022	12.49	$605.60	$292.94	$121.12
27048	T	Remove hip/pelvis lesion	0022	12.49	$605.60	$292.94	$121.12
27049	T	Remove tumor, hip/pelvis	0022	12.49	$605.60	$292.94	$121.12
27050	T	Biopsy of sacroiliac joint	0049	15.04	$729.25	$356.95	$145.85
27052	T	Biopsy of hip joint	0049	15.04	$729.25	$356.95	$145.85
27054	C	Removal of hip joint lining					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27060	T	Removal of ischial bursa	0049	15.04	$729.25	$356.95	$145.85
27062	T	Remove femur lesion/bursa	0049	15.04	$729.25	$356.95	$145.85
27065	T	Removal of hip bone lesion	0049	15.04	$729.25	$356.95	$145.85
27066	T	Removal of hip bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
27067	T	Remove/graft hip bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
27070	C	Partial removal of hip bone					
27071	C	Partial removal of hip bone					
27075	C	Extensive hip surgery					
27076	C	Extensive hip surgery					
27077	C	Extensive hip surgery					
27078	C	Extensive hip surgery					
27079	C	Extensive hip surgery					
27080	T	Removal of tail bone	0050	21.13	$1,024.53	$513.86	$204.91
27086	T	Remove hip foreign body	0019	4.00	$193.95	$78.91	$38.79
27087	T	Remove hip foreign body	0049	15.04	$729.25	$356.95	$145.85
27090	C	Removal of hip prosthesis					
27091	C	Removal of hip prosthesis					
27093	N	Injection for hip x-ray					
27095	N	Injection for hip x-ray					
27096	N	Inject sacroiliac joint					
27097	T	Revision of hip tendon	0050	21.13	$1,024.53	$513.86	$204.91
27098	T	Transfer tendon to pelvis	0050	21.13	$1,024.53	$513.86	$204.91
27100	T	Transfer of abdominal muscle	0051	27.76	$1,346.00	$675.24	$269.20
27105	T	Transfer of spinal muscle	0051	27.76	$1,346.00	$675.24	$269.20
27110	T	Transfer of iliopsoas muscle	0051	27.76	$1,346.00	$675.24	$269.20
27111	T	Transfer of iliopsoas muscle	0051	27.76	$1,346.00	$675.24	$269.20
27120	C	Reconstruction of hip socket					
27122	C	Reconstruction of hip socket					
27125	C	Partial hip replacement					
27130	C	Total hip replacement					
27132	C	Total hip replacement					
27134	C	Revise hip joint replacement					
27137	C	Revise hip joint replacement					
27138	C	Revise hip joint replacement					
27140	C	Transplant femur ridge					
27146	C	Incision of hip bone					
27147	C	Revision of hip bone					
27151	C	Incision of hip bones					
27156	C	Revision of hip bones					
27158	C	Revision of pelvis					
27161	C	Incision of neck of femur					
27165	C	Incision/fixation of femur					
27170	C	Repair/graft femur head/neck					
27175	C	Treat slipped epiphysis					
27176	C	Treat slipped epiphysis					
27177	C	Treat slipped epiphysis					
27178	C	Treat slipped epiphysis					
27179	C	Revise head/neck of femur					
27181	C	Treat slipped epiphysis					
27185	C	Revision of femur epiphysis					
27187	C	Reinforce hip bones					
27193	T	Treat pelvic ring fracture	0044	2.17	$105.22	$38.08	$21.04
27194	T	Treat pelvic ring fracture	0045	11.02	$534.33	$277.12	$106.87
27200	T	Treat tail bone fracture	0043	1.64	$79.52	$25.46	$15.90
27202	T	Treat tail bone fracture	0046	22.29	$1,080.78	$535.76	$216.16
27215	C	Treat pelvic fracture(s)					
27216	C	Treat pelvic ring fracture					
27217	C	Treat pelvic ring fracture					
27218	C	Treat pelvic ring fracture					
27220	T	Treat hip socket fracture	0044	2.17	$105.22	$38.08	$21.04
27222	C	Treat hip socket fracture					
27226	C	Treat hip wall fracture					
27227	C	Treat hip fracture(s)					
27228	C	Treat hip fracture(s)					
27230	T	Treat thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27232	C	Treat thigh fracture					
27235	C	Treat thigh fracture					
27236	C	Treat thigh fracture					
27238	T	Treat thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27240	C	Treat thigh fracture					
27244	C	Treat thigh fracture					
27245	C	Treat thigh fracture					
27246	T	Treat thigh fracture	0044	2.17	$105.22	$38.08	$21.04

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27248	C	Treat thigh fracture					
27250	T	Treat hip dislocation	0044	2.17	$105.22	$38.08	$21.04
27252	T	Treat hip dislocation	0045	11.02	$534.33	$277.12	$106.87
27253	C	Treat hip dislocation					
27254	C	Treat hip dislocation					
27256	T	Treat hip dislocation	0044	2.17	$105.22	$38.08	$21.04
27257	T	Treat hip dislocation	0045	11.02	$534.33	$277.12	$106.87
27258	C	Treat hip dislocation					
27259	C	Treat hip dislocation					
27265	T	Treat hip dislocation	0044	2.17	$105.22	$38.08	$21.04
27266	T	Treat hip dislocation	0047	22.09	$1,071.08	$537.03	$214.22
27275	T	Manipulation of hip joint	0045	11.02	$534.33	$277.12	$106.87
27280	C	Fusion of sacroiliac joint					
27282	C	Fusion of pubic bones					
27284	C	Fusion of hip joint					
27286	C	Fusion of hip joint					
27290	C	Amputation of leg at hip					
27295	C	Amputation of leg at hip					
27299	T	Pelvis/hip joint surgery	0043	1.64	$79.52	$25.46	$15.90
27301	T	Drain thigh/knee lesion	0008	6.15	$298.20	$113.67	$59.64
27303	C	Drainage of bone lesion					
27305	T	Incise thigh tendon & fascia	0049	15.04	$729.25	$356.95	$145.85
27306	T	Incision of thigh tendon	0049	15.04	$729.25	$356.95	$145.85
27307	T	Incision of thigh tendons	0049	15.04	$729.25	$356.95	$145.85
27310	T	Exploration of knee joint	0050	21.13	$1,024.53	$513.86	$204.91
27315	T	Partial removal, thigh nerve	0220	13.96	$676.88	$326.21	$135.38
27320	T	Partial removal, thigh nerve	0220	13.96	$676.88	$326.21	$135.38
27323	T	Biopsy, thigh soft tissues	0021	10.49	$508.63	$236.51	$101.73
27324	T	Biopsy, thigh soft tissues	0022	12.49	$605.60	$292.94	$121.12
27327	T	Removal of thigh lesion	0022	12.49	$605.60	$292.94	$121.12
27328	T	Removal of thigh lesion	0022	12.49	$605.60	$292.94	$121.12
27329	T	Remove tumor, thigh/knee	0022	12.49	$605.60	$292.94	$121.12
27330	T	Biopsy, knee joint lining	0050	21.13	$1,024.53	$513.86	$204.91
27331	T	Explore/treat knee joint	0050	21.13	$1,024.53	$513.86	$204.91
27332	T	Removal of knee cartilage	0050	21.13	$1,024.53	$513.86	$204.91
27333	T	Removal of knee cartilage	0050	21.13	$1,024.53	$513.86	$204.91
27334	T	Remove knee joint lining	0050	21.13	$1,024.53	$513.86	$204.91
27335	T	Remove knee joint lining	0050	21.13	$1,024.53	$513.86	$204.91
27340	T	Removal of kneecap bursa	0049	15.04	$729.25	$356.95	$145.85
27345	T	Removal of knee cyst	0049	15.04	$729.25	$356.95	$145.85
27347	T	Remove knee cyst	0049	15.04	$729.25	$356.95	$145.85
27350	T	Removal of kneecap	0050	21.13	$1,024.53	$513.86	$204.91
27355	T	Remove femur lesion	0050	21.13	$1,024.53	$513.86	$204.91
27356	T	Remove femur lesion/graft	0050	21.13	$1,024.53	$513.86	$204.91
27357	T	Remove femur lesion/graft	0050	21.13	$1,024.53	$513.86	$204.91
27358	T	Remove femur lesion/fixation	0050	21.13	$1,024.53	$513.86	$204.91
27360	T	Partial removal, leg bone(s)	0050	21.13	$1,024.53	$513.86	$204.91
27365	C	Extensive leg surgery					
27370	N	Injection for knee x-ray					
27372	T	Removal of foreign body	0022	12.49	$605.60	$292.94	$121.12
27380	T	Repair of kneecap tendon	0049	15.04	$729.25	$356.95	$145.85
27381	T	Repair/graft kneecap tendon	0049	15.04	$729.25	$356.95	$145.85
27385	T	Repair of thigh muscle	0049	15.04	$729.25	$356.95	$145.85
27386	T	Repair/graft of thigh muscle	0049	15.04	$729.25	$356.95	$145.85
27390	T	Incision of thigh tendon	0049	15.04	$729.25	$356.95	$145.85
27391	T	Incision of thigh tendons	0049	15.04	$729.25	$356.95	$145.85
27392	T	Incision of thigh tendons	0049	15.04	$729.25	$356.95	$145.85
27393	T	Lengthening of thigh tendon	0050	21.13	$1,024.53	$513.86	$204.91
27394	T	Lengthening of thigh tendons	0050	21.13	$1,024.53	$513.86	$204.91
27395	T	Lengthening of thigh tendons	0051	27.76	$1,346.00	$675.24	$269.20
27396	T	Transplant of thigh tendon	0050	21.13	$1,024.53	$513.86	$204.91
27397	T	Transplants of thigh tendons	0051	27.76	$1,346.00	$675.24	$269.20
27400	T	Revise thigh muscles/tendons	0051	27.76	$1,346.00	$675.24	$269.20
27403	T	Repair of knee cartilage	0050	21.13	$1,024.53	$513.86	$204.91
27405	T	Repair of knee ligament	0051	27.76	$1,346.00	$675.24	$269.20
27407	T	Repair of knee ligament	0051	27.76	$1,346.00	$675.24	$269.20
27409	T	Repair of knee ligaments	0051	27.76	$1,346.00	$675.24	$269.20
27418	T	Repair degenerated kneecap	0051	27.76	$1,346.00	$675.24	$269.20
27420	T	Revision of unstable kneecap	0051	27.76	$1,346.00	$675.24	$269.20
27422	T	Revision of unstable kneecap	0051	27.76	$1,346.00	$675.24	$269.20
27424	T	Revision/removal of kneecap	0051	27.76	$1,346.00	$675.24	$269.20
27425	T	Lateral retinacular release	0050	21.13	$1,024.53	$513.86	$204.91
27427	T	Reconstruction, knee	0052	36.16	$1,753.29	$930.91	$350.66

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27428	T	Reconstruction, knee	0052	36.16	$1,753.29	$930.91	$350.66
27429	T	Reconstruction, knee	0052	36.16	$1,753.29	$930.91	$350.66
27430	T	Revision of thigh muscles	0051	27.76	$1,346.00	$675.24	$269.20
27435	T	Incision of knee joint	0051	27.76	$1,346.00	$675.24	$269.20
27437	T	Revise kneecap	0047	22.09	$1,071.08	$537.03	$214.22
27438	T	Revise kneecap with implant	0048	29.06	$1,409.03	$725.94	$281.81
27440	T	Revision of knee joint	0047	22.09	$1,071.08	$537.03	$214.22
27441	T	Revision of knee joint	0047	22.09	$1,071.08	$537.03	$214.22
27442	T	Revision of knee joint	0047	22.09	$1,071.08	$537.03	$214.22
27443	T	Revision of knee joint	0047	22.09	$1,071.08	$537.03	$214.22
27445	C	Revision of knee joint					
27446	C	Revision of knee joint					
27447	C	Total knee replacement					
27448	C	Incision of thigh					
27450	C	Incision of thigh					
27454	C	Realignment of thigh bone					
27455	C	Realignment of knee					
27457	C	Realignment of knee					
27465	C	Shortening of thigh bone					
27466	C	Lengthening of thigh bone					
27468	C	Shorten/lengthen thighs					
27470	C	Repair of thigh					
27472	C	Repair/graft of thigh					
27475	C	Surgery to stop leg growth					
27477	C	Surgery to stop leg growth					
27479	C	Surgery to stop leg growth					
27485	C	Surgery to stop leg growth					
27486	C	Revise/replace knee joint					
27487	C	Revise/replace knee joint					
27488	C	Removal of knee prosthesis					
27495	C	Reinforce thigh					
27496	T	Decompression of thigh/knee	0049	15.04	$729.25	$356.95	$145.85
27497	T	Decompression of thigh/knee	0049	15.04	$729.25	$356.95	$145.85
27498	T	Decompression of thigh/knee	0049	15.04	$729.25	$356.95	$145.85
27499	T	Decompression of thigh/knee	0049	15.04	$729.25	$356.95	$145.85
27500	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27501	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27502	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27503	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27506	C	Treatment of thigh fracture					
27507	C	Treatment of thigh fracture					
27508	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27509	T	Treatment of thigh fracture	0046	22.29	$1,080.78	$535.76	$216.16
27510	T	Treatment of thigh fracture	0044	2.17	$105.22	$38.08	$21.04
27511	C	Treatment of thigh fracture					
27513	C	Treatment of thigh fracture					
27514	C	Treatment of thigh fracture					
27516	T	Treat thigh fx growth plate	0044	2.17	$105.22	$38.08	$21.04
27517	T	Treat thigh fx growth plate	0044	2.17	$105.22	$38.08	$21.04
27519	C	Treat thigh fx growth plate					
27520	T	Treat kneecap fracture	0044	2.17	$105.22	$38.08	$21.04
27524	C	Treat kneecap fracture					
27530	T	Treat knee fracture	0044	2.17	$105.22	$38.08	$21.04
27532	T	Treat knee fracture	0044	2.17	$105.22	$38.08	$21.04
27535	C	Treat knee fracture					
27536	C	Treat knee fracture					
27538	T	Treat knee fracture(s)	0044	2.17	$105.22	$38.08	$21.04
27540	C	Treat knee fracture					
27550	T	Treat knee dislocation	0044	2.17	$105.22	$38.08	$21.04
27552	T	Treat knee dislocation	0045	11.02	$534.33	$277.12	$106.87
27556	T	Treat knee dislocation	0046	22.29	$1,080.78	$535.76	$216.16
27557	C	Treat knee dislocation					
27558	C	Treat knee dislocation					
27560	T	Treat kneecap dislocation	0044	2.17	$105.22	$38.08	$21.04
27562	T	Treat kneecap dislocation	0045	11.02	$534.33	$277.12	$106.87
27566	T	Treat kneecap dislocation	0046	22.29	$1,080.78	$535.76	$216.16
27570	T	Fixation of knee joint	0045	11.02	$534.33	$277.12	$106.87
27580	C	Fusion of knee					
27590	C	Amputate leg at thigh					
27591	C	Amputate leg at thigh					
27592	C	Amputate leg at thigh					
27594	T	Amputation follow-up surgery	0049	15.04	$729.25	$356.95	$145.85
27596	C	Amputation follow-up surgery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27598	C	Amputate lower leg at knee	.....	.....	.....	.....	.....
27599	T	Leg surgery procedure	0044	2.17	$105.22	$38.08	$21.04
27600	T	Decompression of lower leg	0049	15.04	$729.25	$356.95	$145.85
27601	T	Decompression of lower leg	0049	15.04	$729.25	$356.95	$145.85
27602	T	Decompression of lower leg	0049	15.04	$729.25	$356.95	$145.85
27603	T	Drain lower leg lesion	0008	6.15	$298.20	$113.67	$59.64
27604	T	Drain lower leg bursa	0049	15.04	$729.25	$356.95	$145.85
27605	T	Incision of achilles tendon	0055	15.47	$750.10	$355.34	$150.02
27606	T	Incision of achilles tendon	0049	15.04	$729.25	$356.95	$145.85
27607	T	Treat lower leg bone lesion	0049	15.04	$729.25	$356.95	$145.85
27610	T	Explore/treat ankle joint	0050	21.13	$1,024.53	$513.86	$204.91
27612	T	Exploration of ankle joint	0050	21.13	$1,024.53	$513.86	$204.91
27613	T	Biopsy lower leg soft tissue	0020	6.51	$315.65	$130.53	$63.13
27614	T	Biopsy lower leg soft tissue	0022	12.49	$605.60	$292.94	$121.12
27615	T	Remove tumor, lower leg	0046	22.29	$1,080.78	$535.76	$216.16
27618	T	Remove lower leg lesion	0021	10.49	$508.63	$236.51	$101.73
27619	T	Remove lower leg lesion	0022	12.49	$605.60	$292.94	$121.12
27620	T	Explore/treat ankle joint	0050	21.13	$1,024.53	$513.86	$204.91
27625	T	Remove ankle joint lining	0050	21.13	$1,024.53	$513.86	$204.91
27626	T	Remove ankle joint lining	0050	21.13	$1,024.53	$513.86	$204.91
27630	T	Removal of tendon lesion	0049	15.04	$729.25	$356.95	$145.85
27635	T	Remove lower leg bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
27637	T	Remove/graft leg bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
27638	T	Remove/graft leg bone lesion	0050	21.13	$1,024.53	$513.86	$204.91
27640	T	Partial removal of tibia	0051	27.76	$1,346.00	$675.24	$269.20
27641	T	Partial removal of fibula	0050	21.13	$1,024.53	$513.86	$204.91
27645	C	Extensive lower leg surgery	.....	.....	.....	.....	.....
27646	C	Extensive lower leg surgery	.....	.....	.....	.....	.....
27647	T	Extensive ankle/heel surgery	0051	27.76	$1,346.00	$675.24	$269.20
27648	N	Injection for ankle x-ray	.....	.....	.....	.....	.....
27650	T	Repair achilles tendon	0051	27.76	$1,346.00	$675.24	$269.20
27652	T	Repair/graft achilles tendon	0051	27.76	$1,346.00	$675.24	$269.20
27654	T	Repair of achilles tendon	0051	27.76	$1,346.00	$675.24	$269.20
27656	T	Repair leg fascia defect	0049	15.04	$729.25	$356.95	$145.85
27658	T	Repair of leg tendon, each	0049	15.04	$729.25	$356.95	$145.85
27659	T	Repair of leg tendon, each	0049	15.04	$729.25	$356.95	$145.85
27664	T	Repair of leg tendon, each	0049	15.04	$729.25	$356.95	$145.85
27665	T	Repair of leg tendon, each	0050	21.13	$1,024.53	$513.86	$204.91
27675	T	Repair lower leg tendons	0049	15.04	$729.25	$356.95	$145.85
27676	T	Repair lower leg tendons	0050	21.13	$1,024.53	$513.86	$204.91
27680	T	Release of lower leg tendon	0050	21.13	$1,024.53	$513.86	$204.91
27681	T	Release of lower leg tendons	0050	21.13	$1,024.53	$513.86	$204.91
27685	T	Revision of lower leg tendon	0050	21.13	$1,024.53	$513.86	$204.91
27686	T	Revise lower leg tendons	0050	21.13	$1,024.53	$513.86	$204.91
27687	T	Revision of calf tendon	0050	21.13	$1,024.53	$513.86	$204.91
27690	T	Revise lower leg tendon	0051	27.76	$1,346.00	$675.24	$269.20
27691	T	Revise lower leg tendon	0051	27.76	$1,346.00	$675.24	$269.20
27692	T	Revise additional leg tendon	0051	27.76	$1,346.00	$675.24	$269.20
27695	T	Repair of ankle ligament	0050	21.13	$1,024.53	$513.86	$204.91
27696	T	Repair of ankle ligaments	0050	21.13	$1,024.53	$513.86	$204.91
27698	T	Repair of ankle ligament	0050	21.13	$1,024.53	$513.86	$204.91
27700	T	Revision of ankle joint	0047	22.09	$1,071.08	$537.03	$214.22
27702	C	Reconstruct ankle joint	.....	.....	.....	.....	.....
27703	C	Reconstruction, ankle joint	.....	.....	.....	.....	.....
27704	T	Removal of ankle implant	0049	15.04	$729.25	$356.95	$145.85
27705	T	Incision of tibia	0051	27.76	$1,346.00	$675.24	$269.20
27707	T	Incision of fibula	0049	15.04	$729.25	$356.95	$145.85
27709	T	Incision of tibia & fibula	0050	21.13	$1,024.53	$513.86	$204.91
27712	C	Realignment of lower leg	.....	.....	.....	.....	.....
27715	C	Revision of lower leg	.....	.....	.....	.....	.....
27720	C	Repair of tibia	.....	.....	.....	.....	.....
27722	C	Repair/graft of tibia	.....	.....	.....	.....	.....
27724	C	Repair/graft of tibia	.....	.....	.....	.....	.....
27725	C	Repair of lower leg	.....	.....	.....	.....	.....
27727	C	Repair of lower leg	.....	.....	.....	.....	.....
27730	T	Repair of tibia epiphysis	0050	21.13	$1,024.53	$513.86	$204.91
27732	T	Repair of fibula epiphysis	0050	21.13	$1,024.53	$513.86	$204.91
27734	T	Repair lower leg epiphyses	0050	21.13	$1,024.53	$513.86	$204.91
27740	T	Repair of leg epiphyses	0050	21.13	$1,024.53	$513.86	$204.91
27742	T	Repair of leg epiphyses	0051	27.76	$1,346.00	$675.24	$269.20
27745	T	Reinforce tibia	0051	27.76	$1,346.00	$675.24	$269.20
27750	T	Treatment of tibia fracture	0044	2.17	$105.22	$38.08	$21.04
27752	T	Treatment of tibia fracture	0044	2.17	$105.22	$38.08	$21.04

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
27756	T	Treatment of tibia fracture	0046	22.29	$1,080.78	$535.76	$216.16
27758	T	Treatment of tibia fracture	0046	22.29	$1,080.78	$535.76	$216.16
27759	T	Treatment of tibia fracture	0046	22.29	$1,080.78	$535.76	$216.16
27760	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27762	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27766	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
27780	T	Treatment of fibula fracture	0044	2.17	$105.22	$38.08	$21.04
27781	T	Treatment of fibula fracture	0044	2.17	$105.22	$38.08	$21.04
27784	T	Treatment of fibula fracture	0046	22.29	$1,080.78	$535.76	$216.16
27786	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27788	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27792	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
27808	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27810	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27814	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
27816	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27818	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
27822	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
27823	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
27824	T	Treat lower leg fracture	0044	2.17	$105.22	$38.08	$21.04
27825	T	Treat lower leg fracture	0044	2.17	$105.22	$38.08	$21.04
27826	T	Treat lower leg fracture	0046	22.29	$1,080.78	$535.76	$216.16
27827	T	Treat lower leg fracture	0046	22.29	$1,080.78	$535.76	$216.16
27828	T	Treat lower leg fracture	0046	22.29	$1,080.78	$535.76	$216.16
27829	T	Treat lower leg joint	0046	22.29	$1,080.78	$535.76	$216.16
27830	T	Treat lower leg dislocation	0044	2.17	$105.22	$38.08	$21.04
27831	T	Treat lower leg dislocation	0045	11.02	$534.33	$277.12	$106.87
27832	T	Treat lower leg dislocation	0046	22.29	$1,080.78	$535.76	$216.16
27840	T	Treat ankle dislocation	0044	2.17	$105.22	$38.08	$21.04
27842	T	Treat ankle dislocation	0045	11.02	$534.33	$277.12	$106.87
27846	T	Treat ankle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
27848	T	Treat ankle dislocation	0046	22.29	$1,080.78	$535.76	$216.16
27860	T	Fixation of ankle joint	0045	11.02	$534.33	$277.12	$106.87
27870	T	Fusion of ankle joint	0051	27.76	$1,346.00	$675.24	$269.20
27871	T	Fusion of tibiofibular joint	0051	27.76	$1,346.00	$675.24	$269.20
27880	C	Amputation of lower leg					
27881	C	Amputation of lower leg					
27882	C	Amputation of lower leg					
27884	T	Amputation follow-up surgery	0049	15.04	$729.25	$356.95	$145.85
27886	C	Amputation follow-up surgery					
27888	C	Amputation of foot at ankle					
27889	T	Amputation of foot at ankle	0050	21.13	$1,024.53	$513.86	$204.91
27892	T	Decompression of leg	0049	15.04	$729.25	$356.95	$145.85
27893	T	Decompression of leg	0049	15.04	$729.25	$356.95	$145.85
27894	T	Decompression of leg	0049	15.04	$729.25	$356.95	$145.85
27899	T	Leg/ankle surgery procedure	0044	2.17	$105.22	$38.08	$21.04
28001	T	Drainage of bursa of foot	0008	6.15	$298.20	$113.67	$59.64
28002	T	Treatment of foot infection	0049	15.04	$729.25	$356.95	$145.85
28003	T	Treatment of foot infection	0049	15.04	$729.25	$356.95	$145.85
28005	T	Treat foot bone lesion	0055	15.47	$750.10	$355.34	$150.02
28008	T	Incision of foot fascia	0055	15.47	$750.10	$355.34	$150.02
28010	T	Incision of toe tendon	0055	15.47	$750.10	$355.34	$150.02
28011	T	Incision of toe tendons	0055	15.47	$750.10	$355.34	$150.02
28020	T	Exploration of foot joint	0055	15.47	$750.10	$355.34	$150.02
28022	T	Exploration of foot joint	0055	15.47	$750.10	$355.34	$150.02
28024	T	Exploration of toe joint	0055	15.47	$750.10	$355.34	$150.02
28030	T	Removal of foot nerve	0220	13.96	$676.88	$326.21	$135.38
28035	T	Decompression of tibia nerve	0220	13.96	$676.88	$326.21	$135.38
28043	T	Excision of foot lesion	0021	10.49	$508.63	$236.51	$101.73
28045	T	Excision of foot lesion	0055	15.47	$750.10	$355.34	$150.02
28046	T	Resection of tumor, foot	0055	15.47	$750.10	$355.34	$150.02
28050	T	Biopsy of foot joint lining	0055	15.47	$750.10	$355.34	$150.02
28052	T	Biopsy of foot joint lining	0055	15.47	$750.10	$355.34	$150.02
28054	T	Biopsy of toe joint lining	0055	15.47	$750.10	$355.34	$150.02
28060	T	Partial removal, foot fascia	0056	17.30	$838.83	$405.81	$167.77
28062	T	Removal of foot fascia	0056	17.30	$838.83	$405.81	$167.77
28070	T	Removal of foot joint lining	0056	17.30	$838.83	$405.81	$167.77
28072	T	Removal of foot joint lining	0056	17.30	$838.83	$405.81	$167.77
28080	T	Removal of foot lesion	0055	15.47	$750.10	$355.34	$150.02
28086	T	Excise foot tendon sheath	0055	15.47	$750.10	$355.34	$150.02
28088	T	Excise foot tendon sheath	0055	15.47	$750.10	$355.34	$150.02
28090	T	Removal of foot lesion	0055	15.47	$750.10	$355.34	$150.02
28092	T	Removal of toe lesions	0055	15.47	$750.10	$355.34	$150.02

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
28100	T	Removal of ankle/heel lesion	0055	15.47	$750.10	$355.34	$150.02
28102	T	Remove/graft foot lesion	0056	17.30	$838.83	$405.81	$167.77
28103	T	Remove/graft foot lesion	0056	17.30	$838.83	$405.81	$167.77
28104	T	Removal of foot lesion	0055	15.47	$750.10	$355.34	$150.02
28106	T	Remove/graft foot lesion	0056	17.30	$838.83	$405.81	$167.77
28107	T	Remove/graft foot lesion	0056	17.30	$838.83	$405.81	$167.77
28108	T	Removal of toe lesions	0055	15.47	$750.10	$355.34	$150.02
28110	T	Part removal of metatarsal	0057	21.00	$1,018.23	$496.65	$203.65
28111	T	Part removal of metatarsal	0055	15.47	$750.10	$355.34	$150.02
28112	T	Part removal of metatarsal	0055	15.47	$750.10	$355.34	$150.02
28113	T	Part removal of metatarsal	0055	15.47	$750.10	$355.34	$150.02
28114	T	Removal of metatarsal heads	0055	15.47	$750.10	$355.34	$150.02
28116	T	Revision of foot	0055	15.47	$750.10	$355.34	$150.02
28118	T	Removal of heel bone	0055	15.47	$750.10	$355.34	$150.02
28119	T	Removal of heel spur	0055	15.47	$750.10	$355.34	$150.02
28120	T	Part removal of ankle/heel	0055	15.47	$750.10	$355.34	$150.02
28122	T	Partial removal of foot bone	0055	15.47	$750.10	$355.34	$150.02
28124	T	Partial removal of toe	0055	15.47	$750.10	$355.34	$150.02
28126	T	Partial removal of toe	0055	15.47	$750.10	$355.34	$150.02
28130	T	Removal of ankle bone	0055	15.47	$750.10	$355.34	$150.02
28140	T	Removal of metatarsal	0055	15.47	$750.10	$355.34	$150.02
28150	T	Removal of toe	0055	15.47	$750.10	$355.34	$150.02
28153	T	Partial removal of toe	0055	15.47	$750.10	$355.34	$150.02
28160	T	Partial removal of toe	0055	15.47	$750.10	$355.34	$150.02
28171	T	Extensive foot surgery	0055	15.47	$750.10	$355.34	$150.02
28173	T	Extensive foot surgery	0055	15.47	$750.10	$355.34	$150.02
28175	T	Extensive foot surgery	0055	15.47	$750.10	$355.34	$150.02
28190	T	Removal of foot foreign body	0019	4.00	$193.95	$78.91	$38.79
28192	T	Removal of foot foreign body	0021	10.49	$508.63	$236.51	$101.73
28193	T	Removal of foot foreign body	0020	6.51	$315.65	$130.53	$63.13
28200	T	Repair of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28202	T	Repair/graft of foot tendon	0056	17.30	$838.83	$405.81	$167.77
28208	T	Repair of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28210	T	Repair/graft of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28220	T	Release of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28222	T	Release of foot tendons	0055	15.47	$750.10	$355.34	$150.02
28225	T	Release of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28226	T	Release of foot tendons	0055	15.47	$750.10	$355.34	$150.02
28230	T	Incision of foot tendon(s)	0055	15.47	$750.10	$355.34	$150.02
28232	T	Incision of toe tendon	0055	15.47	$750.10	$355.34	$150.02
28234	T	Incision of foot tendon	0055	15.47	$750.10	$355.34	$150.02
28238	T	Revision of foot tendon	0056	17.30	$838.83	$405.81	$167.77
28240	T	Release of big toe	0055	15.47	$750.10	$355.34	$150.02
28250	T	Revision of foot fascia	0056	17.30	$838.83	$405.81	$167.77
28260	T	Release of midfoot joint	0056	17.30	$838.83	$405.81	$167.77
28261	T	Revision of foot tendon	0056	17.30	$838.83	$405.81	$167.77
28262	T	Revision of foot and ankle	0056	17.30	$838.83	$405.81	$167.77
28264	T	Release of midfoot joint	0056	17.30	$838.83	$405.81	$167.77
28270	T	Release of foot contracture	0055	15.47	$750.10	$355.34	$150.02
28272	T	Release of toe joint, each	0055	15.47	$750.10	$355.34	$150.02
28280	T	Fusion of toes	0055	15.47	$750.10	$355.34	$150.02
28285	T	Repair of hammertoe	0055	15.47	$750.10	$355.34	$150.02
28286	T	Repair of hammertoe	0055	15.47	$750.10	$355.34	$150.02
28288	T	Partial removal of foot bone	0056	17.30	$838.83	$405.81	$167.77
28289	T	Repair hallux rigidus	0056	17.30	$838.83	$405.81	$167.77
28290	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28292	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28293	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28294	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28296	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28297	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28298	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28299	T	Correction of bunion	0057	21.00	$1,018.23	$496.65	$203.65
28300	T	Incision of heel bone	0056	17.30	$838.83	$405.81	$167.77
28302	T	Incision of ankle bone	0056	17.30	$838.83	$405.81	$167.77
28304	T	Incision of midfoot bones	0056	17.30	$838.83	$405.81	$167.77
28305	T	Incise/graft midfoot bones	0056	17.30	$838.83	$405.81	$167.77
28306	T	Incision of metatarsal	0056	17.30	$838.83	$405.81	$167.77
28307	T	Incision of metatarsal	0056	17.30	$838.83	$405.81	$167.77
28308	T	Incision of metatarsal	0056	17.30	$838.83	$405.81	$167.77
28309	T	Incision of metatarsals	0056	17.30	$838.83	$405.81	$167.77
28310	T	Revision of big toe	0055	15.47	$750.10	$355.34	$150.02
28312	T	Revision of toe	0055	15.47	$750.10	$355.34	$150.02

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
28313	T	Repair deformity of toe	0055	15.47	$750.10	$355.34	$150.02
28315	T	Removal of sesamoid bone	0055	15.47	$750.10	$355.34	$150.02
28320	T	Repair of foot bones	0056	17.30	$838.83	$405.81	$167.77
28322	T	Repair of metatarsals	0056	17.30	$838.83	$405.81	$167.77
28340	T	Resect enlarged toe tissue	0055	15.47	$750.10	$355.34	$150.02
28341	T	Resect enlarged toe	0055	15.47	$750.10	$355.34	$150.02
28344	T	Repair extra toe(s)	0056	17.30	$838.83	$405.81	$167.77
28345	T	Repair webbed toe(s)	0056	17.30	$838.83	$405.81	$167.77
28360	T	Reconstruct cleft foot	0056	17.30	$838.83	$405.81	$167.77
28400	T	Treatment of heel fracture	0044	2.17	$105.22	$38.08	$21.04
28405	T	Treatment of heel fracture	0044	2.17	$105.22	$38.08	$21.04
28406	T	Treatment of heel fracture	0046	22.29	$1,080.78	$535.76	$216.16
28415	T	Treat heel fracture	0046	22.29	$1,080.78	$535.76	$216.16
28420	T	Treat/graft heel fracture	0046	22.29	$1,080.78	$535.76	$216.16
28430	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
28435	T	Treatment of ankle fracture	0044	2.17	$105.22	$38.08	$21.04
28436	T	Treatment of ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
28445	T	Treat ankle fracture	0046	22.29	$1,080.78	$535.76	$216.16
28450	T	Treat midfoot fracture, each	0044	2.17	$105.22	$38.08	$21.04
28455	T	Treat midfoot fracture, each	0044	2.17	$105.22	$38.08	$21.04
28456	T	Treat midfoot fracture	0046	22.29	$1,080.78	$535.76	$216.16
28465	T	Treat midfoot fracture, each	0046	22.29	$1,080.78	$535.76	$216.16
28470	T	Treat metatarsal fracture	0044	2.17	$105.22	$38.08	$21.04
28475	T	Treat metatarsal fracture	0044	2.17	$105.22	$38.08	$21.04
28476	T	Treat metatarsal fracture	0046	22.29	$1,080.78	$535.76	$216.16
28485	T	Treat metatarsal fracture	0046	22.29	$1,080.78	$535.76	$216.16
28490	T	Treat big toe fracture	0043	1.64	$79.52	$25.46	$15.90
28495	T	Treat big toe fracture	0043	1.64	$79.52	$25.46	$15.90
28496	T	Treat big toe fracture	0046	22.29	$1,080.78	$535.76	$216.16
28505	T	Treat big toe fracture	0046	22.29	$1,080.78	$535.76	$216.16
28510	T	Treatment of toe fracture	0043	1.64	$79.52	$25.46	$15.90
28515	T	Treatment of toe fracture	0043	1.64	$79.52	$25.46	$15.90
28525	T	Treat toe fracture	0046	22.29	$1,080.78	$535.76	$216.16
28530	T	Treat sesamoid bone fracture	0044	2.17	$105.22	$38.08	$21.04
28531	T	Treat sesamoid bone fracture	0046	22.29	$1,080.78	$535.76	$216.16
28540	T	Treat foot dislocation	0044	2.17	$105.22	$38.08	$21.04
28545	T	Treat foot dislocation	0045	11.02	$534.33	$277.12	$106.87
28546	T	Treat foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28555	T	Repair foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28570	T	Treat foot dislocation	0044	2.17	$105.22	$38.08	$21.04
28575	T	Treat foot dislocation	0045	11.02	$534.33	$277.12	$106.87
28576	T	Treat foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28585	T	Repair foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28600	T	Treat foot dislocation	0044	2.17	$105.22	$38.08	$21.04
28605	T	Treat foot dislocation	0045	11.02	$534.33	$277.12	$106.87
28606	T	Treat foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28615	T	Repair foot dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28630	T	Treat toe dislocation	0043	1.64	$79.52	$25.46	$15.90
28635	T	Treat toe dislocation	0045	11.02	$534.33	$277.12	$106.87
28636	T	Treat toe dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28645	T	Repair toe dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28660	T	Treat toe dislocation	0043	1.64	$79.52	$25.46	$15.90
28665	T	Treat toe dislocation	0045	11.02	$534.33	$277.12	$106.87
28666	T	Treat toe dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28675	T	Repair of toe dislocation	0046	22.29	$1,080.78	$535.76	$216.16
28705	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28715	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28725	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28730	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28735	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28737	T	Revision of foot bones	0055	15.47	$750.10	$355.34	$150.02
28740	T	Fusion of foot bones	0056	17.30	$838.83	$405.81	$167.77
28750	T	Fusion of big toe joint	0055	15.47	$750.10	$355.34	$150.02
28755	T	Fusion of big toe joint	0055	15.47	$750.10	$355.34	$150.02
28760	T	Fusion of big toe joint	0056	17.30	$838.83	$405.81	$167.77
28800	C	Amputation of midfoot	.....	.....	.....	.....	.....
28805	C	Amputation thru metatarsal	.....	.....	.....	.....	.....
28810	T	Amputation toe & metatarsal	0055	15.47	$750.10	$355.34	$150.02
28820	T	Amputation of toe	0055	15.47	$750.10	$355.34	$150.02
28825	T	Partial amputation of toe	0055	15.47	$750.10	$355.34	$150.02
28899	T	Foot/toes surgery procedure	0043	1.64	$79.52	$25.46	$15.90
29000	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29010	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
29015	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29020	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29025	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29035	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29040	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29044	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29046	S	Application of body cast	0059	1.74	$84.37	$29.59	$16.87
29049	S	Application of figure eight	0059	1.74	$84.37	$29.59	$16.87
29055	S	Application of shoulder cast	0059	1.74	$84.37	$29.59	$16.87
29058	S	Application of shoulder cast	0059	1.74	$84.37	$29.59	$16.87
29065	S	Application of long arm cast	0059	1.74	$84.37	$29.59	$16.87
29075	S	Application of forearm cast	0059	1.74	$84.37	$29.59	$16.87
29085	S	Apply hand/wrist cast	0059	1.74	$84.37	$29.59	$16.87
29105	S	Apply long arm splint	0059	1.74	$84.37	$29.59	$16.87
29125	S	Apply forearm splint	0059	1.74	$84.37	$29.59	$16.87
29126	S	Apply forearm splint	0059	1.74	$84.37	$29.59	$16.87
29130	S	Application of finger splint	0059	1.74	$84.37	$29.59	$16.87
29131	S	Application of finger splint	0059	1.74	$84.37	$29.59	$16.87
29200	S	Strapping of chest	0059	1.74	$84.37	$29.59	$16.87
29220	S	Strapping of low back	0059	1.74	$84.37	$29.59	$16.87
29240	S	Strapping of shoulder	0059	1.74	$84.37	$29.59	$16.87
29260	S	Strapping of elbow or wrist	0059	1.74	$84.37	$29.59	$16.87
29280	S	Strapping of hand or finger	0059	1.74	$84.37	$29.59	$16.87
29305	S	Application of hip cast	0059	1.74	$84.37	$29.59	$16.87
29325	S	Application of hip casts	0059	1.74	$84.37	$29.59	$16.87
29345	S	Application of long leg cast	0059	1.74	$84.37	$29.59	$16.87
29355	S	Application of long leg cast	0059	1.74	$84.37	$29.59	$16.87
29358	S	Apply long leg cast brace	0059	1.74	$84.37	$29.59	$16.87
29365	S	Application of long leg cast	0059	1.74	$84.37	$29.59	$16.87
29405	S	Apply short leg cast	0059	1.74	$84.37	$29.59	$16.87
29425	S	Apply short leg cast	0059	1.74	$84.37	$29.59	$16.87
29435	S	Apply short leg cast	0059	1.74	$84.37	$29.59	$16.87
29440	S	Addition of walker to cast	0059	1.74	$84.37	$29.59	$16.87
29445	S	Apply rigid leg cast	0059	1.74	$84.37	$29.59	$16.87
29450	S	Application of leg cast	0059	1.74	$84.37	$29.59	$16.87
29505	S	Application, long leg splint	0058	1.09	$52.85	$19.27	$10.57
29515	S	Application lower leg splint	0058	1.09	$52.85	$19.27	$10.57
29520	S	Strapping of hip	0058	1.09	$52.85	$19.27	$10.57
29530	S	Strapping of knee	0058	1.09	$52.85	$19.27	$10.57
29540	S	Strapping of ankle	0058	1.09	$52.85	$19.27	$10.57
29550	S	Strapping of toes	0058	1.09	$52.85	$19.27	$10.57
29580	S	Application of paste boot	0058	1.09	$52.85	$19.27	$10.57
29590	S	Application of foot splint	0058	1.09	$52.85	$19.27	$10.57
29700	S	Removal/revision of cast	0058	1.09	$52.85	$19.27	$10.57
29705	S	Removal/revision of cast	0058	1.09	$52.85	$19.27	$10.57
29710	S	Removal/revision of cast	0058	1.09	$52.85	$19.27	$10.57
29715	S	Removal/revision of cast	0058	1.09	$52.85	$19.27	$10.57
29720	S	Repair of body cast	0058	1.09	$52.85	$19.27	$10.57
29730	S	Windowing of cast	0058	1.09	$52.85	$19.27	$10.57
29740	S	Wedging of cast	0058	1.09	$52.85	$19.27	$10.57
29750	S	Wedging of clubfoot cast	0058	1.09	$52.85	$19.27	$10.57
29799	S	Casting/strapping procedure	0058	1.09	$52.85	$19.27	$10.57
29800	T	Jaw arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29804	T	Jaw arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29815	T	Shoulder arthroscopy	0041	24.57	$1,191.33	$592.08	$238.27
29819	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29820	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29821	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29822	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29823	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29825	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29826	T	Shoulder arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29830	T	Elbow arthroscopy	0041	24.57	$1,191.33	$592.08	$238.27
29834	T	Elbow arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29835	T	Elbow arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29836	T	Elbow arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29837	T	Elbow arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29838	T	Elbow arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29840	T	Wrist arthroscopy	0041	24.57	$1,191.33	$592.08	$238.27
29843	T	Wrist arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29844	T	Wrist arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29845	T	Wrist arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29846	T	Wrist arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
29847	T	Wrist arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29848	T	Wrist endoscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29850	T	Knee arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29851	T	Knee arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29855	T	Tibial arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29856	T	Tibial arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29860	T	Hip arthroscopy, dx	0041	24.57	$1,191.33	$592.08	$238.27
29861	T	Hip arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29862	T	Hip arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29863	T	Hip arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29870	T	Knee arthroscopy, dx	0041	24.57	$1,191.33	$592.08	$238.27
29871	T	Knee arthroscopy/drainage	0041	24.57	$1,191.33	$592.08	$238.27
29874	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29875	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29876	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29877	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29879	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29880	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29881	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29882	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29883	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29884	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29885	T	Knee arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29886	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29887	T	Knee arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29888	T	Knee arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29889	T	Knee arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29891	T	Ankle arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29892	T	Ankle arthroscopy/surgery	0042	29.22	$1,416.79	$804.74	$283.36
29893	T	Scope, plantar fasciotomy	0055	15.47	$750.10	$355.34	$150.02
29894	T	Ankle arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29895	T	Ankle arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29897	T	Ankle arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29898	T	Ankle arthroscopy/surgery	0041	24.57	$1,191.33	$592.08	$238.27
29909	T	Arthroscopy of joint	0041	24.57	$1,191.33	$592.08	$238.27
30000	T	Drainage of nose lesion	0251	1.68	$81.46	$27.99	$16.29
30020	T	Drainage of nose lesion	0251	1.68	$81.46	$27.99	$16.29
30100	T	Intranasal biopsy	0252	5.18	$251.16	$114.24	$50.23
30110	T	Removal of nose polyp(s)	0253	12.02	$582.81	$284.00	$116.56
30115	T	Removal of nose polyp(s)	0253	12.02	$582.81	$284.00	$116.56
30117	T	Removal of intranasal lesion	0253	12.02	$582.81	$284.00	$116.56
30118	T	Removal of intranasal lesion	0254	12.45	$603.66	$272.41	$120.73
30120	T	Revision of nose	0253	12.02	$582.81	$284.00	$116.56
30124	T	Removal of nose lesion	0252	5.18	$251.16	$114.24	$50.23
30125	T	Removal of nose lesion	0256	25.40	$1,231.57	$623.05	$246.31
30130	T	Removal of turbinate bones	0253	12.02	$582.81	$284.00	$116.56
30140	T	Removal of turbinate bones	0253	12.02	$582.81	$284.00	$116.56
30150	T	Partial removal of nose	0256	25.40	$1,231.57	$623.05	$246.31
30160	T	Removal of nose	0256	25.40	$1,231.57	$623.05	$246.31
30200	T	Injection treatment of nose	0253	12.02	$582.81	$284.00	$116.56
30210	T	Nasal sinus therapy	0252	5.18	$251.16	$114.24	$50.23
30220	T	Insert nasal septal button	0252	5.18	$251.16	$114.24	$50.23
30300	T	Remove nasal foreign body	0251	1.68	$81.46	$27.99	$16.29
30310	T	Remove nasal foreign body	0253	12.02	$582.81	$284.00	$116.56
30320	T	Remove nasal foreign body	0253	12.02	$582.81	$284.00	$116.56
30400	T	Reconstruction of nose	0256	25.40	$1,231.57	$623.05	$246.31
30410	T	Reconstruction of nose	0256	25.40	$1,231.57	$623.05	$246.31
30420	T	Reconstruction of nose	0256	25.40	$1,231.57	$623.05	$246.31
30430	T	Revision of nose	0254	12.45	$603.66	$272.41	$120.73
30435	T	Revision of nose	0256	25.40	$1,231.57	$623.05	$246.31
30450	T	Revision of nose	0256	25.40	$1,231.57	$623.05	$246.31
30460	T	Revision of nose	0256	25.40	$1,231.57	$623.05	$246.31
30462	T	Revision of nose	0256	25.40	$1,231.57	$623.05	$246.31
30520	T	Repair of nasal septum	0256	25.40	$1,231.57	$623.05	$246.31
30540	T	Repair nasal defect	0256	25.40	$1,231.57	$623.05	$246.31
30545	T	Repair nasal defect	0256	25.40	$1,231.57	$623.05	$246.31
30560	T	Release of nasal adhesions	0251	1.68	$81.46	$27.99	$16.29
30580	T	Repair upper jaw fistula	0256	25.40	$1,231.57	$623.05	$246.31
30600	T	Repair mouth/nose fistula	0256	25.40	$1,231.57	$623.05	$246.31
30620	T	Intranasal reconstruction	0256	25.40	$1,231.57	$623.05	$246.31
30630	T	Repair nasal septum defect	0254	12.45	$603.66	$272.41	$120.73
30801	T	Cauterization, inner nose	0252	5.18	$251.16	$114.24	$50.23
30802	T	Cauterization, inner nose	0253	12.02	$582.81	$284.00	$116.56

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
30901	T	Control of nosebleed	0250	2.21	$107.16	$38.54	$21.43
30903	T	Control of nosebleed	0250	2.21	$107.16	$38.54	$21.43
30905	T	Control of nosebleed	0250	2.21	$107.16	$38.54	$21.43
30906	T	Repeat control of nosebleed	0250	2.21	$107.16	$38.54	$21.43
30915	T	Ligation, nasal sinus artery	0091	14.79	$717.12	$348.23	$143.42
30920	T	Ligation, upper jaw artery	0092	20.21	$979.92	$505.37	$195.98
30930	T	Therapy, fracture of nose	0253	12.02	$582.81	$284.00	$116.56
30999	T	Nasal surgery procedure	0251	1.68	$81.46	$27.99	$16.29
31000	T	Irrigation, maxillary sinus	0251	1.68	$81.46	$27.99	$16.29
31002	T	Irrigation, sphenoid sinus	0252	5.18	$251.16	$114.24	$50.23
31020	T	Exploration, maxillary sinus	0253	12.02	$582.81	$284.00	$116.56
31030	T	Exploration, maxillary sinus	0256	25.40	$1,231.57	$623.05	$246.31
31032	T	Explore sinus, remove polyps	0256	25.40	$1,231.57	$623.05	$246.31
31040	T	Exploration behind upper jaw	0254	12.45	$603.66	$272.41	$120.73
31050	T	Exploration, sphenoid sinus	0256	25.40	$1,231.57	$623.05	$246.31
31051	T	Sphenoid sinus surgery	0256	25.40	$1,231.57	$623.05	$246.31
31070	T	Exploration of frontal sinus	0254	12.45	$603.66	$272.41	$120.73
31075	T	Exploration of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31080	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31081	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31084	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31085	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31086	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31087	T	Removal of frontal sinus	0256	25.40	$1,231.57	$623.05	$246.31
31090	T	Exploration of sinuses	0256	25.40	$1,231.57	$623.05	$246.31
31200	T	Removal of ethmoid sinus	0256	25.40	$1,231.57	$623.05	$246.31
31201	T	Removal of ethmoid sinus	0256	25.40	$1,231.57	$623.05	$246.31
31205	T	Removal of ethmoid sinus	0256	25.40	$1,231.57	$623.05	$246.31
31225	C	Removal of upper jaw					
31230	C	Removal of upper jaw					
31231	T	Nasal endoscopy, dx	0071	0.55	$26.67	$14.22	$5.33
31233	T	Nasal/sinus endoscopy, dx	0072	1.26	$61.09	$41.52	$12.22
31235	T	Nasal/sinus endoscopy, dx	0074	13.61	$659.91	$347.54	$131.98
31237	T	Nasal/sinus endoscopy, surg	0074	13.61	$659.91	$347.54	$131.98
31238	T	Nasal/sinus endoscopy, surg	0074	13.61	$659.91	$347.54	$131.98
31239	T	Nasal/sinus endoscopy, surg	0075	18.55	$899.44	$467.29	$179.89
31240	T	Nasal/sinus endoscopy, surg	0074	13.61	$659.91	$347.54	$131.98
31254	T	Revision of ethmoid sinus	0075	18.55	$899.44	$467.29	$179.89
31255	T	Removal of ethmoid sinus	0075	18.55	$899.44	$467.29	$179.89
31256	T	Exploration maxillary sinus	0075	18.55	$899.44	$467.29	$179.89
31267	T	Endoscopy, maxillary sinus	0075	18.55	$899.44	$467.29	$179.89
31276	T	Sinus endoscopy, surgical	0075	18.55	$899.44	$467.29	$179.89
31287	T	Nasal/sinus endoscopy, surg	0075	18.55	$899.44	$467.29	$179.89
31288	T	Nasal/sinus endoscopy, surg	0075	18.55	$899.44	$467.29	$179.89
31290	C	Nasal/sinus endoscopy, surg					
31291	C	Nasal/sinus endoscopy, surg					
31292	C	Nasal/sinus endoscopy, surg					
31293	C	Nasal/sinus endoscopy, surg					
31294	C	Nasal/sinus endoscopy, surg					
31299	T	Sinus surgery procedure	0252	5.18	$251.16	$114.24	$50.23
31300	T	Removal of larynx lesion	0256	25.40	$1,231.57	$623.05	$246.31
31320	T	Diagnostic incision, larynx	0256	25.40	$1,231.57	$623.05	$246.31
31360	C	Removal of larynx					
31365	C	Removal of larynx					
31367	C	Partial removal of larynx					
31368	C	Partial removal of larynx					
31370	C	Partial removal of larynx					
31375	T	Partial removal of larynx	0256	25.40	$1,231.57	$623.05	$246.31
31380	C	Partial removal of larynx					
31382	C	Partial removal of larynx					
31390	C	Removal of larynx & pharynx					
31395	C	Reconstruct larynx & pharynx					
31400	T	Revision of larynx	0256	25.40	$1,231.57	$623.05	$246.31
31420	T	Removal of epiglottis	0256	25.40	$1,231.57	$623.05	$246.31
31500	S	Insert emergency airway	0094	4.51	$218.68	$105.29	$43.74
31502	T	Change of windpipe airway	0121	2.36	$114.43	$52.53	$22.89
31505	T	Diagnostic laryngoscopy	0072	1.26	$61.09	$41.52	$12.22
31510	T	Laryngoscopy with biopsy	0074	13.61	$659.91	$347.54	$131.98
31511	T	Remove foreign body, larynx	0072	1.26	$61.09	$41.52	$12.22
31512	T	Removal of larynx lesion	0074	13.61	$659.91	$347.54	$131.98
31513	T	Injection into vocal cord	0073	4.11	$199.28	$91.07	$39.86
31515	T	Laryngoscopy for aspiration	0074	13.61	$659.91	$347.54	$131.98
31520	T	Diagnostic laryngoscopy	0072	1.26	$61.09	$41.52	$12.22

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
31525	T	Diagnostic laryngoscopy	0074	13.61	$659.91	$347.54	$131.98
31526	T	Diagnostic laryngoscopy	0074	13.61	$659.91	$347.54	$131.98
31527	T	Laryngoscopy for treatment	0075	18.55	$899.44	$467.29	$179.89
31528	T	Laryngoscopy and dilatation	0074	13.61	$659.91	$347.54	$131.98
31529	T	Laryngoscopy and dilatation	0074	13.61	$659.91	$347.54	$131.98
31530	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31531	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31535	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31536	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31540	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31541	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31560	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31561	T	Operative laryngoscopy	0075	18.55	$899.44	$467.29	$179.89
31570	T	Laryngoscopy with injection	0075	18.55	$899.44	$467.29	$179.89
31571	T	Laryngoscopy with injection	0075	18.55	$899.44	$467.29	$179.89
31575	T	Diagnostic laryngoscopy	0071	0.55	$26.67	$14.22	$5.33
31576	T	Laryngoscopy with biopsy	0074	13.61	$659.91	$347.54	$131.98
31577	T	Remove foreign body, larynx	0073	4.11	$199.28	$91.07	$39.86
31578	T	Removal of larynx lesion	0074	13.61	$659.91	$347.54	$131.98
31579	T	Diagnostic laryngoscopy	0073	4.11	$199.28	$91.07	$39.86
31580	T	Revision of larynx	0256	25.40	$1,231.57	$623.05	$246.31
31582	C	Revision of larynx					
31584	C	Treat larynx fracture					
31585	T	Treat larynx fracture	0253	12.02	$582.81	$284.00	$116.56
31586	T	Treat larynx fracture	0256	25.40	$1,231.57	$623.05	$246.31
31587	C	Revision of larynx					
31588	T	Revision of larynx	0256	25.40	$1,231.57	$623.05	$246.31
31590	T	Reinnervate larynx	0256	25.40	$1,231.57	$623.05	$246.31
31595	T	Larynx nerve surgery	0256	25.40	$1,231.57	$623.05	$246.31
31599	T	Larynx surgery procedure	0253	12.02	$582.81	$284.00	$116.56
31600	T	Incision of windpipe	0254	12.45	$603.66	$272.41	$120.73
31601	T	Incision of windpipe	0254	12.45	$603.66	$272.41	$120.73
31603	T	Incision of windpipe	0254	12.45	$603.66	$272.41	$120.73
31605	T	Incision of windpipe	0254	12.45	$603.66	$272.41	$120.73
31610	T	Incision of windpipe	0254	12.45	$603.66	$272.41	$120.73
31611	T	Surgery/speech prosthesis	0254	12.45	$603.66	$272.41	$120.73
31612	T	Puncture/clear windpipe	0253	12.02	$582.81	$284.00	$116.56
31613	T	Repair windpipe opening	0254	12.45	$603.66	$272.41	$120.73
31614	T	Repair windpipe opening	0256	25.40	$1,231.57	$623.05	$246.31
31615	T	Visualization of windpipe	0076	8.06	$390.81	$197.05	$78.16
31622	T	Dx bronchoscope/wash	0076	8.06	$390.81	$197.05	$78.16
31623	T	Dx bronchoscope/brush	0076	8.06	$390.81	$197.05	$78.16
31624	T	Dx bronchoscope/lavage	0076	8.06	$390.81	$197.05	$78.16
31625	T	Bronchoscopy with biopsy	0076	8.06	$390.81	$197.05	$78.16
31628	T	Bronchoscopy with biopsy	0076	8.06	$390.81	$197.05	$78.16
31629	T	Bronchoscopy with biopsy	0076	8.06	$390.81	$197.05	$78.16
31630	T	Bronchoscopy with repair	0076	8.06	$390.81	$197.05	$78.16
31631	T	Bronchoscopy with dilation	0076	8.06	$390.81	$197.05	$78.16
31635	T	Remove foreign body, airway	0076	8.06	$390.81	$197.05	$78.16
31640	T	Bronchoscopy & remove lesion	0076	8.06	$390.81	$197.05	$78.16
31641	T	Bronchoscopy, treat blockage	0076	8.06	$390.81	$197.05	$78.16
31643	T	Diag bronchoscope/catheter	0076	8.06	$390.81	$197.05	$78.16
31645	T	Bronchoscopy, clear airways	0076	8.06	$390.81	$197.05	$78.16
31646	T	Bronchoscopy, reclear airway	0076	8.06	$390.81	$197.05	$78.16
31656	T	Bronchoscopy, inj for x-ray	0076	8.06	$390.81	$197.05	$78.16
31700	T	Insertion of airway catheter	0072	1.26	$61.09	$41.52	$12.22
31708	N	Instill airway contrast dye					
31710	N	Insertion of airway catheter					
31715	N	Injection for bronchus x-ray					
31717	T	Bronchial brush biopsy	0073	4.11	$199.28	$91.07	$39.86
31720	T	Clearance of airways	0072	1.26	$61.09	$41.52	$12.22
31725	C	Clearance of airways					
31730	T	Intro, windpipe wire/tube	0073	4.11	$199.28	$91.07	$39.86
31750	T	Repair of windpipe	0256	25.40	$1,231.57	$623.05	$246.31
31755	T	Repair of windpipe	0256	25.40	$1,231.57	$623.05	$246.31
31760	C	Repair of windpipe					
31766	C	Reconstruction of windpipe					
31770	C	Repair/graft of bronchus					
31775	C	Reconstruct bronchus					
31780	C	Reconstruct windpipe					
31781	C	Reconstruct windpipe					
31785	C	Remove windpipe lesion					
31786	C	Remove windpipe lesion					

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
31800	C	Repair of windpipe injury					
31805	C	Repair of windpipe injury					
31820	T	Closure of windpipe lesion	0253	12.02	$582.81	$284.00	$116.56
31825	T	Repair of windpipe defect	0254	12.45	$603.66	$272.41	$120.73
31830	T	Revise windpipe scar	0254	12.45	$603.66	$272.41	$120.73
31899	T	Airways surgical procedure	0076	8.06	$390.81	$197.05	$78.16
32000	T	Drainage of chest	0070	3.64	$176.49	$79.60	$35.30
32002	T	Treatment of collapsed lung	0070	3.64	$176.49	$79.60	$35.30
32005	T	Treat lung lining chemically	0070	3.64	$176.49	$79.60	$35.30
32020	T	Insertion of chest tube	0070	3.64	$176.49	$79.60	$35.30
32035	C	Exploration of chest					
32036	C	Exploration of chest					
32095	C	Biopsy through chest wall					
32100	C	Exploration/biopsy of chest					
32110	C	Explore/repair chest					
32120	C	Re-exploration of chest					
32124	C	Explore chest free adhesions					
32140	C	Removal of lung lesion(s)					
32141	C	Remove/treat lung lesions					
32150	C	Removal of lung lesion(s)					
32151	C	Remove lung foreign body					
32160	C	Open chest heart massage					
32200	C	Drain, open, lung lesion					
32201	C	Drain, percut, lung lesion					
32215	C	Treat chest lining					
32220	C	Release of lung					
32225	C	Partial release of lung					
32310	C	Removal of chest lining					
32320	C	Free/remove chest lining					
32400	T	Needle biopsy chest lining	0005	5.41	$262.32	$119.75	$52.46
32402	C	Open biopsy chest lining					
32405	T	Biopsy, lung or mediastinum	0005	5.41	$262.32	$119.75	$52.46
32420	T	Puncture/clear lung	0070	3.64	$176.49	$79.60	$35.30
32440	C	Removal of lung					
32442	C	Sleeve pneumonectomy					
32445	C	Removal of lung					
32480	C	Partial removal of lung					
32482	C	Bilobectomy					
32484	C	Segmentectomy					
32486	C	Sleeve lobectomy					
32488	C	Completion pneumonectomy					
32491	C	Lung volume reduction					
32500	C	Partial removal of lung					
32501	C	Repair bronchus add-on					
32520	C	Remove lung & revise chest					
32522	C	Remove lung & revise chest					
32525	C	Remove lung & revise chest					
32540	C	Removal of lung lesion					
32601	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32602	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32603	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32604	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32605	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32606	T	Thoracoscopy, diagnostic	0076	8.06	$390.81	$197.05	$78.16
32650	C	Thoracoscopy, surgical					
32651	C	Thoracoscopy, surgical					
32652	C	Thoracoscopy, surgical					
32653	C	Thoracoscopy, surgical					
32654	C	Thoracoscopy, surgical					
32655	C	Thoracoscopy, surgical					
32656	C	Thoracoscopy, surgical					
32657	C	Thoracoscopy, surgical					
32658	C	Thoracoscopy, surgical					
32659	C	Thoracoscopy, surgical					
32660	C	Thoracoscopy, surgical					
32661	C	Thoracoscopy, surgical					
32662	C	Thoracoscopy, surgical					
32663	C	Thoracoscopy, surgical					
32664	C	Thoracoscopy, surgical					
32665	C	Thoracoscopy, surgical					
32800	C	Repair lung hernia					
32810	C	Close chest after drainage					
32815	C	Close bronchial fistula					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
32820	C	Reconstruct injured chest					
32850	C	Donor pneumonectomy					
32851	C	Lung transplant, single					
32852	C	Lung transplant with bypass					
32853	C	Lung transplant, double					
32854	C	Lung transplant with bypass					
32900	C	Removal of rib(s)					
32905	C	Revise & repair chest wall					
32906	C	Revise & repair chest wall					
32940	C	Revision of lung					
32960	T	Therapeutic pneumothorax	0070	3.64	$176.49	$79.60	$35.30
32997	C	Total lung lavage					
32999	T	Chest surgery procedure	0070	3.64	$176.49	$79.60	$35.30
33010	T	Drainage of heart sac	0070	3.64	$176.49	$79.60	$35.30
33011	T	Repeat drainage of heart sac	0070	3.64	$176.49	$79.60	$35.30
33015	C	Incision of heart sac					
33020	C	Incision of heart sac					
33025	C	Incision of heart sac					
33030	C	Partial removal of heart sac					
33031	C	Partial removal of heart sac					
33050	C	Removal of heart sac lesion					
33120	C	Removal of heart lesion					
33130	C	Removal of heart lesion					
33140	C	Heart revascularize (tmr)					
33200	C	Insertion of heart pacemaker					
33201	C	Insertion of heart pacemaker					
33206	T	Insertion of heart pacemaker	0090	20.96	$1,016.29	$573.04	$203.26
33207	T	Insertion of heart pacemaker	0090	20.96	$1,016.29	$573.04	$203.26
33208	T	Insertion of heart pacemaker	0090	20.96	$1,016.29	$573.04	$203.26
33210	T	Insertion of heart electrode	0089	6.49	$314.68	$130.07	$62.94
33211	T	Insertion of heart electrode	0089	6.49	$314.68	$130.07	$62.94
33212	T	Insertion of pulse generator	0090	20.96	$1,016.29	$573.04	$203.26
33213	T	Insertion of pulse generator	0090	20.96	$1,016.29	$573.04	$203.26
33214	T	Upgrade of pacemaker system	0090	20.96	$1,016.29	$573.04	$203.26
33216	T	Revise eltrd pacing-defib	0090	20.96	$1,016.29	$573.04	$203.26
33217	T	Revise eltrd pacing-defib	0090	20.96	$1,016.29	$573.04	$203.26
33218	T	Revise eltrd pacing-defib	0090	20.96	$1,016.29	$573.04	$203.26
33220	T	Revise eltrd pacing-defib	0089	6.49	$314.68	$130.07	$62.94
33222	T	Revise pocket, pacemaker	0026	12.11	$587.18	$277.92	$117.44
33223	T	Revise pocket, pacing-defib	0026	12.11	$587.18	$277.92	$117.44
33233	T	Removal of pacemaker system	0090	20.96	$1,016.29	$573.04	$203.26
33234	T	Removal of pacemaker system	0090	20.96	$1,016.29	$573.04	$203.26
33235	T	Removal pacemaker electrode	0090	20.96	$1,016.29	$573.04	$203.26
33236	C	Remove electrode/thoracotomy					
33237	C	Remove electrode/thoracotomy					
33238	C	Remove electrode/thoracotomy					
33240	T	Insert pulse generator	0090	20.96	$1,016.29	$573.04	$203.26
33241	T	Remove pulse generator	0089	6.49	$314.68	$130.07	$62.94
33243	C	Remove eltrd/thoracotomy					
33244	T	Remove eltrd, transven	0090	20.96	$1,016.29	$573.04	$203.26
33245	C	Insert epic eltrd pace-defib					
33246	C	Insert epic eltrd/generator					
33249	T	Eltrd/insert pace-defib	0090	20.96	$1,016.29	$573.04	$203.26
33250	C	Ablate heart dysrhythm focus					
33251	C	Ablate heart dysrhythm focus					
33253	C	Reconstruct atria					
33261	C	Ablate heart dysrhythm focus					
33282	C	Implant pat-active ht record					
33284	C	Remove pat-active ht record					
33300	C	Repair of heart wound					
33305	C	Repair of heart wound					
33310	C	Exploratory heart surgery					
33315	C	Exploratory heart surgery					
33320	C	Repair major blood vessel(s)					
33321	C	Repair major vessel					
33322	C	Repair major blood vessel(s)					
33330	C	Insert major vessel graft					
33332	C	Insert major vessel graft					
33335	C	Insert major vessel graft					
33400	C	Repair of aortic valve					
33401	C	Valvuloplasty, open					
33403	C	Valvuloplasty, w/cp bypass					
33404	C	Prepare heart-aorta conduit					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
33405	C	Replacement of aortic valve					
33406	C	Replacement of aortic valve					
33410	C	Replacement of aortic valve					
33411	C	Replacement of aortic valve					
33412	C	Replacement of aortic valve					
33413	C	Replacement of aortic valve					
33414	C	Repair of aortic valve					
33415	C	Revision, subvalvular tissue					
33416	C	Revise ventricle muscle					
33417	C	Repair of aortic valve					
33420	C	Revision of mitral valve					
33422	C	Revision of mitral valve					
33425	C	Repair of mitral valve					
33426	C	Repair of mitral valve					
33427	C	Repair of mitral valve					
33430	C	Replacement of mitral valve					
33460	C	Revision of tricuspid valve					
33463	C	Valvuloplasty, tricuspid					
33464	C	Valvuloplasty, tricuspid					
33465	C	Replace tricuspid valve					
33468	C	Revision of tricuspid valve					
33470	C	Revision of pulmonary valve					
33471	C	Valvotomy, pulmonary valve					
33472	C	Revision of pulmonary valve					
33474	C	Revision of pulmonary valve					
33475	C	Replacement, pulmonary valve					
33476	C	Revision of heart chamber					
33478	C	Revision of heart chamber					
33496	C	Repair, prosth valve clot					
33500	C	Repair heart vessel fistula					
33501	C	Repair heart vessel fistula					
33502	C	Coronary artery correction					
33503	C	Coronary artery graft					
33504	C	Coronary artery graft					
33505	C	Repair artery w/tunnel					
33506	C	Repair artery, translocation					
33510	C	CABG, vein, single					
33511	C	CABG, vein, two					
33512	C	CABG, vein, three					
33513	C	CABG, vein, four					
33514	C	CABG, vein, five					
33516	C	Cabg, vein, six or more					
33517	C	CABG, artery-vein, single					
33518	C	CABG, artery-vein, two					
33519	C	CABG, artery-vein, three					
33521	C	CABG, artery-vein, four					
33522	C	CABG, artery-vein, five					
33523	C	Cabg, art-vein, six or more					
33530	C	Coronary artery, bypass/reop					
33533	C	CABG, arterial, single					
33534	C	CABG, arterial, two					
33535	C	CABG, arterial, three					
33536	C	Cabg, arterial, four or more					
33542	C	Removal of heart lesion					
33545	C	Repair of heart damage					
33572	C	Open coronary endarterectomy					
33600	C	Closure of valve					
33602	C	Closure of valve					
33606	C	Anastomosis/artery-aorta					
33608	C	Repair anomaly w/conduit					
33610	C	Repair by enlargement					
33611	C	Repair double ventricle					
33612	C	Repair double ventricle					
33615	C	Repair, simple fontan					
33617	C	Repair, modified fontan					
33619	C	Repair single ventricle					
33641	C	Repair heart septum defect					
33645	C	Revision of heart veins					
33647	C	Repair heart septum defects					
33660	C	Repair of heart defects					
33665	C	Repair of heart defects					
33670	C	Repair of heart chambers					
33681	C	Repair heart septum defect					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
33684	C	Repair heart septum defect					
33688	C	Repair heart septum defect					
33690	C	Reinforce pulmonary artery					
33692	C	Repair of heart defects					
33694	C	Repair of heart defects					
33697	C	Repair of heart defects					
33702	C	Repair of heart defects					
33710	C	Repair of heart defects					
33720	C	Repair of heart defect					
33722	C	Repair of heart defect					
33730	C	Repair heart-vein defect(s)					
33732	C	Repair heart-vein defect					
33735	C	Revision of heart chamber					
33736	C	Revision of heart chamber					
33737	C	Revision of heart chamber					
33750	C	Major vessel shunt					
33755	C	Major vessel shunt					
33762	C	Major vessel shunt					
33764	C	Major vessel shunt & graft					
33766	C	Major vessel shunt					
33767	C	Major vessel shunt					
33770	C	Repair great vessels defect					
33771	C	Repair great vessels defect					
33774	C	Repair great vessels defect					
33775	C	Repair great vessels defect					
33776	C	Repair great vessels defect					
33777	C	Repair great vessels defect					
33778	C	Repair great vessels defect					
33779	C	Repair great vessels defect					
33780	C	Repair great vessels defect					
33781	C	Repair great vessels defect					
33786	C	Repair arterial trunk					
33788	C	Revision of pulmonary artery					
33800	C	Aortic suspension					
33802	C	Repair vessel defect					
33803	C	Repair vessel defect					
33813	C	Repair septal defect					
33814	C	Repair septal defect					
33820	C	Revise major vessel					
33822	C	Revise major vessel					
33824	C	Revise major vessel					
33840	C	Remove aorta constriction					
33845	C	Remove aorta constriction					
33851	C	Remove aorta constriction					
33852	C	Repair septal defect					
33853	C	Repair septal defect					
33860	C	Ascending aortic graft					
33861	C	Ascending aortic graft					
33863	C	Ascending aortic graft					
33870	C	Transverse aortic arch graft					
33875	C	Thoracic aortic graft					
33877	C	Thoracoabdominal graft					
33910	C	Remove lung artery emboli					
33915	C	Remove lung artery emboli					
33916	C	Surgery of great vessel					
33917	C	Repair pulmonary artery					
33918	C	Repair pulmonary atresia					
33919	C	Repair pulmonary atresia					
33920	C	Repair pulmonary atresia					
33922	C	Transect pulmonary artery					
33924	C	Remove pulmonary shunt					
33930	C	Removal of donor heart/lung					
33935	C	Transplantation, heart/lung					
33940	C	Removal of donor heart					
33945	C	Transplantation of heart					
33960	C	External circulation assist					
33961	C	External circulation assist					
33968	C	Remove aortic assist device					
33970	C	Aortic circulation assist					
33971	C	Aortic circulation assist					
33973	C	Insert balloon device					
33974	C	Remove intra-aortic balloon					
33975	C	Implant ventricular device					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
33976	C	Implant ventricular device					
33977	C	Remove ventricular device					
33978	C	Remove ventricular device					
33999	T	Cardiac surgery procedure	0070	3.64	$176.49	$79.60	$35.30
34001	C	Removal of artery clot					
34051	C	Removal of artery clot					
34101	T	Removal of artery clot	0088	26.49	$1,284.42	$678.68	$256.88
34111	T	Removal of arm artery clot	0088	26.49	$1,284.42	$678.68	$256.88
34151	C	Removal of artery clot					
34201	T	Removal of artery clot	0088	26.49	$1,284.42	$678.68	$256.88
34203	T	Removal of leg artery clot	0088	26.49	$1,284.42	$678.68	$256.88
34401	C	Removal of vein clot					
34421	C	Removal of vein clot					
34451	C	Removal of vein clot					
34471	T	Removal of vein clot	0088	26.49	$1,284.42	$678.68	$256.88
34490	T	Removal of vein clot	0088	26.49	$1,284.42	$678.68	$256.88
34501	T	Repair valve, femoral vein	0088	26.49	$1,284.42	$678.68	$256.88
34502	C	Reconstruct vena cava					
34510	T	Transposition of vein valve	0088	26.49	$1,284.42	$678.68	$256.88
34520	T	Cross-over vein graft	0088	26.49	$1,284.42	$678.68	$256.88
34530	T	Leg vein fusion	0088	26.49	$1,284.42	$678.68	$256.88
35001	C	Repair defect of artery					
35002	C	Repair artery rupture, neck					
35005	C	Repair defect of artery					
35011	C	Repair defect of artery					
35013	C	Repair artery rupture, arm					
35021	C	Repair defect of artery					
35022	C	Repair artery rupture, chest					
35045	C	Repair defect of arm artery					
35081	C	Repair defect of artery					
35082	C	Repair artery rupture, aorta					
35091	C	Repair defect of artery					
35092	C	Repair artery rupture, aorta					
35102	C	Repair defect of artery					
35103	C	Repair artery rupture, groin					
35111	C	Repair defect of artery					
35112	C	Repair artery rupture, spleen					
35121	C	Repair defect of artery					
35122	C	Repair artery rupture, belly					
35131	C	Repair defect of artery					
35132	C	Repair artery rupture, groin					
35141	C	Repair defect of artery					
35142	C	Repair artery rupture, thigh					
35151	C	Repair defect of artery					
35152	C	Repair artery rupture, knee					
35161	C	Repair defect of artery					
35162	C	Repair artery rupture					
35180	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35182	C	Repair blood vessel lesion					
35184	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35188	T	Repair blood vessel lesion	0088	26.49	$1,284.42	$678.68	$256.88
35189	C	Repair blood vessel lesion					
35190	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35201	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35206	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35207	T	Repair blood vessel lesion	0088	26.49	$1,284.42	$678.68	$256.88
35211	C	Repair blood vessel lesion					
35216	C	Repair blood vessel lesion					
35221	C	Repair blood vessel lesion					
35226	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35231	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35236	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35241	C	Repair blood vessel lesion					
35246	C	Repair blood vessel lesion					
35251	C	Repair blood vessel lesion					
35256	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35261	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35266	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35271	C	Repair blood vessel lesion					
35276	C	Repair blood vessel lesion					
35281	C	Repair blood vessel lesion					
35286	T	Repair blood vessel lesion	0081	19.36	$938.71	$434.25	$187.74
35301	C	Rechanneling of artery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
35311	C	Rechanneling of artery					
35321	T	Rechanneling of artery	0081	19.36	$938.71	$434.25	$187.74
35331	C	Rechanneling of artery					
35341	C	Rechanneling of artery					
35351	C	Rechanneling of artery					
35355	C	Rechanneling of artery					
35361	C	Rechanneling of artery					
35363	C	Rechanneling of artery					
35371	C	Rechanneling of artery					
35372	C	Rechanneling of artery					
35381	C	Rechanneling of artery					
35390	C	Reoperation, carotid add-on					
35400	C	Angioscopy					
35450	C	Repair arterial blockage					
35452	C	Repair arterial blockage					
35454	C	Repair arterial blockage					
35456	C	Repair arterial blockage					
35458	C	Repair arterial blockage					
35459	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35460	T	Repair venous blockage	0081	19.36	$938.71	$434.25	$187.74
35470	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35471	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35472	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35473	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35474	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35475	T	Repair arterial blockage	0081	19.36	$938.71	$434.25	$187.74
35476	T	Repair venous blockage	0081	19.36	$938.71	$434.25	$187.74
35480	C	Atherectomy, open					
35481	C	Atherectomy, open					
35482	C	Atherectomy, open					
35483	C	Atherectomy, open					
35484	T	Atherectomy, open	0081	19.36	$938.71	$434.25	$187.74
35485	T	Atherectomy, open	0081	19.36	$938.71	$434.25	$187.74
35490	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35491	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35492	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35493	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35494	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35495	T	Atherectomy, percutaneous	0081	19.36	$938.71	$434.25	$187.74
35500	T	Harvest vein for bypass	0081	19.36	$938.71	$434.25	$187.74
35501	C	Artery bypass graft					
35506	C	Artery bypass graft					
35507	C	Artery bypass graft					
35508	C	Artery bypass graft					
35509	C	Artery bypass graft					
35511	C	Artery bypass graft					
35515	C	Artery bypass graft					
35516	C	Artery bypass graft					
35518	C	Artery bypass graft					
35521	C	Artery bypass graft					
35526	C	Artery bypass graft					
35531	C	Artery bypass graft					
35533	C	Artery bypass graft					
35536	C	Artery bypass graft					
35541	C	Artery bypass graft					
35546	C	Artery bypass graft					
35548	C	Artery bypass graft					
35549	C	Artery bypass graft					
35551	C	Artery bypass graft					
35556	C	Artery bypass graft					
35558	C	Artery bypass graft					
35560	C	Artery bypass graft					
35563	C	Artery bypass graft					
35565	C	Artery bypass graft					
35566	C	Artery bypass graft					
35571	C	Artery bypass graft					
35582	C	Vein bypass graft					
35583	C	Vein bypass graft					
35585	C	Vein bypass graft					
35587	C	Vein bypass graft					
35601	C	Artery bypass graft					
35606	C	Artery bypass graft					
35612	C	Artery bypass graft					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
35616	C	Artery bypass graft					
35621	C	Artery bypass graft					
35623	C	Bypass graft, not vein					
35626	C	Artery bypass graft					
35631	C	Artery bypass graft					
35636	C	Artery bypass graft					
35641	C	Artery bypass graft					
35642	C	Artery bypass graft					
35645	C	Artery bypass graft					
35646	C	Artery bypass graft					
35650	C	Artery bypass graft					
35651	C	Artery bypass graft					
35654	C	Artery bypass graft					
35656	C	Artery bypass graft					
35661	C	Artery bypass graft					
35663	C	Artery bypass graft					
35665	C	Artery bypass graft					
35666	C	Artery bypass graft					
35671	C	Artery bypass graft					
35681	C	Composite bypass graft					
35682	C	Composite bypass graft					
35683	C	Composite bypass graft					
35691	C	Arterial transposition					
35693	C	Arterial transposition					
35694	C	Arterial transposition					
35695	C	Arterial transposition					
35700	C	Reoperation, bypass graft					
35701	C	Exploration, carotid artery					
35721	C	Exploration, femoral artery					
35741	C	Exploration popliteal artery					
35761	C	Exploration of artery/vein					
35800	C	Explore neck vessels					
35820	C	Explore chest vessels					
35840	C	Explore abdominal vessels					
35860	C	Explore limb vessels					
35870	C	Repair vessel graft defect					
35875	T	Removal of clot in graft	0088	26.49	$1,284.42	$678.68	$256.88
35876	T	Removal of clot in graft	0088	26.49	$1,284.42	$678.68	$256.88
35879	T	Revise graft w/vein	0088	26.49	$1,284.42	$678.68	$256.88
35881	T	Revise graft w/vein	0088	26.49	$1,284.42	$678.68	$256.88
35901	C	Excision, graft, neck					
35903	C	Excision, graft, extremity					
35905	C	Excision, graft, thorax					
35907	C	Excision, graft, abdomen					
36000	N	Place needle in vein					
36005	N	Injection, venography					
36010	N	Place catheter in vein					
36011	N	Place catheter in vein					
36012	N	Place catheter in vein					
36013	N	Place catheter in artery					
36014	N	Place catheter in artery					
36015	N	Place catheter in artery					
36100	N	Establish access to artery					
36120	N	Establish access to artery					
36140	N	Establish access to artery					
36145	N	Artery to vein shunt					
36160	N	Establish access to aorta					
36200	N	Place catheter in aorta					
36215	N	Place catheter in artery					
36216	N	Place catheter in artery					
36217	N	Place catheter in artery					
36218	N	Place catheter in artery					
36245	N	Place catheter in artery					
36246	N	Place catheter in artery					
36247	N	Place catheter in artery					
36248	N	Place catheter in artery					
36260	T	Insertion of infusion pump	0093	17.95	$870.34	$422.33	$174.07
36261	T	Revision of infusion pump	0089	6.49	$314.68	$130.07	$62.94
36262	T	Removal of infusion pump	0089	6.49	$314.68	$130.07	$62.94
36299	T	Vessel injection procedure	0089	6.49	$314.68	$130.07	$62.94
36400	N	Drawing blood					
36405	N	Drawing blood					
36406	N	Drawing blood					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
36410	N	Drawing blood					
36415	E	Drawing blood					
36420	T	Establish access to vein	0032	5.40	$261.83	$119.52	$52.37
36425	T	Establish access to vein	0032	5.40	$261.83	$119.52	$52.37
36430	S	Blood transfusion service	0110	5.83	$282.68	$122.73	$56.54
36440	S	Blood transfusion service	0110	5.83	$282.68	$122.73	$56.54
36450	S	Exchange transfusion service	0110	5.83	$282.68	$122.73	$56.54
36455	S	Exchange transfusion service	0110	5.83	$282.68	$122.73	$56.54
36460	S	Transfusion service, fetal	0110	5.83	$282.68	$122.73	$56.54
36468	T	Injection(s), spider veins	0098	1.19	$57.70	$20.88	$11.54
36469	T	Injection(s), spider veins	0098	1.19	$57.70	$20.88	$11.54
36470	T	Injection therapy of vein	0098	1.19	$57.70	$20.88	$11.54
36471	T	Injection therapy of veins	0098	1.19	$57.70	$20.88	$11.54
36481	N	Insertion of catheter, vein					
36488	T	Insertion of catheter, vein	0032	5.40	$261.83	$119.52	$52.37
36489	T	Insertion of catheter, vein	0032	5.40	$261.83	$119.52	$52.37
36490	T	Insertion of catheter, vein	0032	5.40	$261.83	$119.52	$52.37
36491	T	Insertion of catheter, vein	0032	5.40	$261.83	$119.52	$52.37
36493	T	Repositioning of cvc	0032	5.40	$261.83	$119.52	$52.37
36500	N	Insertion of catheter, vein					
36510	C	Insertion of catheter, vein					
36520	S	Plasma and/or cell exchange	0111	14.17	$687.06	$300.74	$137.41
36521	S	Apheresis w/adsorp/reinfuse	0111	14.17	$687.06	$300.74	$137.41
36522	S	Photopheresis	0112	39.60	$1,920.09	$663.65	$384.02
36530	T	Insertion of infusion pump	0093	17.95	$870.34	$422.33	$174.07
36531	T	Revision of infusion pump	0089	6.49	$314.68	$130.07	$62.94
36532	T	Removal of infusion pump	0089	6.49	$314.68	$130.07	$62.94
36533	T	Insertion of access device	0093	17.95	$870.34	$422.33	$174.07
36534	T	Revision of access device	0089	6.49	$314.68	$130.07	$62.94
36535	T	Removal of access device	0089	6.49	$314.68	$130.07	$62.94
36550	C	Declot vascular device					
36600	N	Withdrawal of arterial blood					
36620	N	Insertion catheter, artery					
36625	N	Insertion catheter, artery					
36640	T	Insertion catheter, artery	0032	5.40	$261.83	$119.52	$52.37
36660	C	Insertion catheter, artery					
36680	S	Insert needle, bone cavity	0120	1.66	$80.49	$42.67	$16.10
36800	T	Insertion of cannula	0093	17.95	$870.34	$422.33	$174.07
36810	T	Insertion of cannula	0093	17.95	$870.34	$422.33	$174.07
36815	T	Insertion of cannula	0093	17.95	$870.34	$422.33	$174.07
36819	T	Av fusion by basilic vein	0093	17.95	$870.34	$422.33	$174.07
36821	T	Av fusion direct any site	0088	26.49	$1,284.42	$678.68	$256.88
36822	C	Insertion of cannula(s)					
36823	C	Insertion of cannula(s)					
36825	T	Artery-vein graft	0088	26.49	$1,284.42	$678.68	$256.88
36830	T	Artery-vein graft	0088	26.49	$1,284.42	$678.68	$256.88
36831	T	Av fistula excision	0088	26.49	$1,284.42	$678.68	$256.88
36832	T	Av fistula revision	0088	26.49	$1,284.42	$678.68	$256.88
36833	T	Av fistula revision	0088	26.49	$1,284.42	$678.68	$256.88
36834	C	Repair A–V aneurysm					
36835	T	Artery to vein shunt	0093	17.95	$870.34	$422.33	$174.07
36860	T	External cannula declotting	0090	20.96	$1,016.29	$573.04	$203.26
36861	T	Cannula declotting	0090	20.96	$1,016.29	$573.04	$203.26
37140	C	Revision of circulation					
37145	C	Revision of circulation					
37160	C	Revision of circulation					
37180	C	Revision of circulation					
37181	C	Splice spleen/kidney veins					
37195	C	Thrombolytic therapy, stroke					
37200	C	Transcatheter biopsy					
37201	C	Transcatheter therapy infuse					
37202	C	Transcatheter therapy infuse					
37203	T	Transcatheter retrieval	0089	6.49	$314.68	$130.07	$62.94
37204	T	Transcatheter occlusion	0081	19.36	$938.71	$434.25	$187.74
37205	T	Transcatheter stent	0081	19.36	$938.71	$434.25	$187.74
37206	T	Transcatheter stent add-on	0081	19.36	$938.71	$434.25	$187.74
37207	T	Transcatheter stent	0081	19.36	$938.71	$434.25	$187.74
37208	T	Transcatheter stent add-on	0081	19.36	$938.71	$434.25	$187.74
37209	T	Exchange arterial catheter	0081	19.36	$938.71	$434.25	$187.74
37250	T	Iv us first vessel add-on	0081	19.36	$938.71	$434.25	$187.74
37251	T	Iv us each add vessel add-on	0081	19.36	$938.71	$434.25	$187.74
37565	T	Ligation of neck vein	0081	19.36	$938.71	$434.25	$187.74
37600	T	Ligation of neck artery	0081	19.36	$938.71	$434.25	$187.74

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
37605	T	Ligation of neck artery	0091	14.79	$717.12	$348.23	$143.42
37606	T	Ligation of neck artery	0091	14.79	$717.12	$348.23	$143.42
37607	T	Ligation of a–v fistula	0092	20.21	$979.92	$505.37	$195.98
37609	T	Temporal artery procedure	0020	6.51	$315.65	$130.53	$63.13
37615	T	Ligation of neck artery	0091	14.79	$717.12	$348.23	$143.42
37616	C	Ligation of chest artery					
37617	C	Ligation of abdomen artery					
37618	E	Ligation of extremity artery					
37620	C	Revision of major vein					
37650	T	Revision of major vein	0091	14.79	$717.12	$348.23	$143.42
37660	C	Revision of major vein					
37700	T	Revise leg vein	0091	14.79	$717.12	$348.23	$143.42
37720	T	Removal of leg vein	0092	20.21	$979.92	$505.37	$195.98
37730	T	Removal of leg veins	0092	20.21	$979.92	$505.37	$195.98
37735	T	Removal of leg veins/lesion	0092	20.21	$979.92	$505.37	$195.98
37760	T	Revision of leg veins	0091	14.79	$717.12	$348.23	$143.42
37780	T	Revision of leg vein	0091	14.79	$717.12	$348.23	$143.42
37785	T	Revise secondary varicosity	0091	14.79	$717.12	$348.23	$143.42
37788	C	Revascularization, penis					
37790	T	Penile venous occlusion	0181	32.37	$1,569.53	$906.36	$313.91
37799	T	Vascular surgery procedure	0020	6.51	$315.65	$130.53	$63.13
38100	C	Removal of spleen, total					
38101	C	Removal of spleen, partial					
38102	C	Removal of spleen, total					
38115	C	Repair of ruptured spleen					
38120	T	Laparoscopy, splenectomy	0131	41.81	$2,027.24	$1,089.88	$405.45
38129	T	Laparoscope proc, spleen	0130	25.36	$1,229.63	$659.53	$245.93
38200	N	Injection for spleen x-ray					
38230	S	Bone marrow collection	0109	4.13	$200.25	$40.05	$40.05
38231	S	Stem cell collection	0111	14.17	$687.06	$300.74	$137.41
38240	S	Bone marrow/stem transplant	0109	4.13	$200.25	$40.05	$40.05
38241	S	Bone marrow/stem transplant	0109	4.13	$200.25	$40.05	$40.05
38300	T	Drainage, lymph node lesion	0008	6.15	$298.20	$113.67	$59.64
38305	T	Drainage, lymph node lesion	0008	6.15	$298.20	$113.67	$59.64
38308	T	Incision of lymph channels	0113	13.89	$673.49	$326.55	$134.70
38380	C	Thoracic duct procedure					
38381	C	Thoracic duct procedure					
38382	C	Thoracic duct procedure					
38500	T	Biopsy/removal, lymph nodes	0113	13.89	$673.49	$326.55	$134.70
38505	T	Needle biopsy, lymph nodes	0005	5.41	$262.32	$119.75	$52.46
38510	T	Biopsy/removal, lymph nodes	0113	13.89	$673.49	$326.55	$134.70
38520	T	Biopsy/removal, lymph nodes	0113	13.89	$673.49	$326.55	$134.70
38525	T	Biopsy/removal, lymph nodes	0113	13.89	$673.49	$326.55	$134.70
38530	T	Biopsy/removal, lymph nodes	0113	13.89	$673.49	$326.55	$134.70
38542	T	Explore deep node(s), neck	0114	19.56	$948.41	$493.78	$189.68
38550	T	Removal, neck/armpit lesion	0113	13.89	$673.49	$326.55	$134.70
38555	T	Removal, neck/armpit lesion	0114	19.56	$948.41	$493.78	$189.68
38562	C	Removal, pelvic lymph nodes					
38564	C	Removal, abdomen lymph nodes					
38570	T	Laparoscopy, lymph node biop	0131	41.81	$2,027.24	$1,089.88	$405.45
38571	T	Laparoscopy, lymphadenectomy	0132	48.91	$2,371.50	$1,239.22	$474.30
38572	T	Laparoscopy, lymphadenectomy	0131	41.81	$2,027.24	$1,089.88	$405.45
38589	T	Laparoscope proc, lymphatic	0130	25.36	$1,229.63	$659.53	$245.93
38700	C	Removal of lymph nodes, neck					
38720	T	Removal of lymph nodes, neck	0114	19.56	$948.41	$493.78	$189.68
38724	C	Removal of lymph nodes, neck					
38740	T	Remove armpit lymph nodes	0114	19.56	$948.41	$493.78	$189.68
38745	T	Remove armpit lymph nodes	0114	19.56	$948.41	$493.78	$189.68
38746	C	Remove thoracic lymph nodes					
38747	C	Remove abdominal lymph nodes					
38760	T	Remove groin lymph nodes	0114	19.56	$948.41	$493.78	$189.68
38765	C	Remove groin lymph nodes					
38770	C	Remove pelvis lymph nodes					
38780	C	Remove abdomen lymph nodes					
38790	N	Inject for lymphatic x-ray					
38792	N	Identify sentinel node					
38794	N	Access thoracic lymph duct					
38999	T	Blood/lymph system procedure	0008	6.15	$298.20	$113.67	$59.64
39000	C	Exploration of chest					
39010	C	Exploration of chest					
39200	C	Removal chest lesion					
39220	C	Removal chest lesion					
39400	T	Visualization of chest	0076	8.06	$390.81	$197.05	$78.16

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
39499	C	Chest procedure					
39501	C	Repair diaphragm laceration					
39502	C	Repair paraesophageal hernia					
39503	C	Repair of diaphragm hernia					
39520	C	Repair of diaphragm hernia					
39530	C	Repair of diaphragm hernia					
39531	C	Repair of diaphragm hernia					
39540	C	Repair of diaphragm hernia					
39541	C	Repair of diaphragm hernia					
39545	C	Revision of diaphragm					
39560	C	Resect diaphragm, simple					
39561	C	Resect diaphragm, complex					
39599	C	Diaphragm surgery procedure					
40490	T	Biopsy of lip	0252	5.18	$251.16	$114.24	$50.23
40500	T	Partial excision of lip	0253	12.02	$582.81	$284.00	$116.56
40510	T	Partial excision of lip	0254	12.45	$603.66	$272.41	$120.73
40520	T	Partial excision of lip	0253	12.02	$582.81	$284.00	$116.56
40525	T	Reconstruct lip with flap	0254	12.45	$603.66	$272.41	$120.73
40527	T	Reconstruct lip with flap	0254	12.45	$603.66	$272.41	$120.73
40530	T	Partial removal of lip	0254	12.45	$603.66	$272.41	$120.73
40650	T	Repair lip	0253	12.02	$582.81	$284.00	$116.56
40652	T	Repair lip	0253	12.02	$582.81	$284.00	$116.56
40654	T	Repair lip	0254	12.45	$603.66	$272.41	$120.73
40700	T	Repair cleft lip/nasal	0256	25.40	$1,231.57	$623.05	$246.31
40701	T	Repair cleft lip/nasal	0256	25.40	$1,231.57	$623.05	$246.31
40702	T	Repair cleft lip/nasal	0256	25.40	$1,231.57	$623.05	$246.31
40720	T	Repair cleft lip/nasal	0256	25.40	$1,231.57	$623.05	$246.31
40761	T	Repair cleft lip/nasal	0256	25.40	$1,231.57	$623.05	$246.31
40799	T	Lip surgery procedure	0253	12.02	$582.81	$284.00	$116.56
40800	T	Drainage of mouth lesion	0251	1.68	$81.46	$27.99	$16.29
40801	T	Drainage of mouth lesion	0252	5.18	$251.16	$114.24	$50.23
40804	T	Removal, foreign body, mouth	0251	1.68	$81.46	$27.99	$16.29
40805	T	Removal, foreign body, mouth	0252	5.18	$251.16	$114.24	$50.23
40806	T	Incision of lip fold	0251	1.68	$81.46	$27.99	$16.29
40808	T	Biopsy of mouth lesion	0251	1.68	$81.46	$27.99	$16.29
40810	T	Excision of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
40812	T	Excise/repair mouth lesion	0252	5.18	$251.16	$114.24	$50.23
40814	T	Excise/repair mouth lesion	0253	12.02	$582.81	$284.00	$116.56
40816	T	Excision of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
40818	T	Excise oral mucosa for graft	0251	1.68	$81.46	$27.99	$16.29
40819	T	Excise lip or cheek fold	0252	5.18	$251.16	$114.24	$50.23
40820	T	Treatment of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
40830	T	Repair mouth laceration	0251	1.68	$81.46	$27.99	$16.29
40831	T	Repair mouth laceration	0253	12.02	$582.81	$284.00	$116.56
40840	T	Reconstruction of mouth	0254	12.45	$603.66	$272.41	$120.73
40842	T	Reconstruction of mouth	0254	12.45	$603.66	$272.41	$120.73
40843	T	Reconstruction of mouth	0254	12.45	$603.66	$272.41	$120.73
40844	T	Reconstruction of mouth	0256	25.40	$1,231.57	$623.05	$246.31
40845	T	Reconstruction of mouth	0256	25.40	$1,231.57	$623.05	$246.31
40899	T	Mouth surgery procedure	0252	5.18	$251.16	$114.24	$50.23
41000	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41005	T	Drainage of mouth lesion	0251	1.68	$81.46	$27.99	$16.29
41006	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41007	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41008	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41009	T	Drainage of mouth lesion	0251	1.68	$81.46	$27.99	$16.29
41010	T	Incision of tongue fold	0253	12.02	$582.81	$284.00	$116.56
41015	T	Drainage of mouth lesion	0252	5.18	$251.16	$114.24	$50.23
41016	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41017	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41018	T	Drainage of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41100	T	Biopsy of tongue	0252	5.18	$251.16	$114.24	$50.23
41105	T	Biopsy of tongue	0253	12.02	$582.81	$284.00	$116.56
41108	T	Biopsy of floor of mouth	0252	5.18	$251.16	$114.24	$50.23
41110	T	Excision of tongue lesion	0253	12.02	$582.81	$284.00	$116.56
41112	T	Excision of tongue lesion	0253	12.02	$582.81	$284.00	$116.56
41113	T	Excision of tongue lesion	0253	12.02	$582.81	$284.00	$116.56
41114	T	Excision of tongue lesion	0254	12.45	$603.66	$272.41	$120.73
41115	T	Excision of tongue fold	0253	12.02	$582.81	$284.00	$116.56
41116	T	Excision of mouth lesion	0253	12.02	$582.81	$284.00	$116.56
41120	T	Partial removal of tongue	0256	25.40	$1,231.57	$623.05	$246.31
41130	C	Partial removal of tongue					
41135	C	Tongue and neck surgery					

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
41140	C	Removal of tongue					
41145	C	Tongue removal, neck surgery					
41150	C	Tongue, mouth, jaw surgery					
41153	C	Tongue, mouth, neck surgery					
41155	C	Tongue, jaw, & neck surgery					
41250	T	Repair tongue laceration	0251	1.68	$81.46	$27.99	$16.29
41251	T	Repair tongue laceration	0253	12.02	$582.81	$284.00	$116.56
41252	T	Repair tongue laceration	0253	12.02	$582.81	$284.00	$116.56
41500	T	Fixation of tongue	0253	12.02	$582.81	$284.00	$116.56
41510	T	Tongue to lip surgery	0253	12.02	$582.81	$284.00	$116.56
41520	T	Reconstruction, tongue fold	0253	12.02	$582.81	$284.00	$116.56
41599	T	Tongue and mouth surgery	0251	1.68	$81.46	$27.99	$16.29
41800	T	Drainage of gum lesion	0251	1.68	$81.46	$27.99	$16.29
41805	T	Removal foreign body, gum	0253	12.02	$582.81	$284.00	$116.56
41806	T	Removal foreign body, jawbone	0253	12.02	$582.81	$284.00	$116.56
41820	T	Excision, gum, each quadrant	0252	5.18	$251.16	$114.24	$50.23
41821	T	Excision of gum flap	0252	5.18	$251.16	$114.24	$50.23
41822	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41823	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41825	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41826	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41827	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41828	T	Excision of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41830	T	Removal of gum tissue	0253	12.02	$582.81	$284.00	$116.56
41850	T	Treatment of gum lesion	0253	12.02	$582.81	$284.00	$116.56
41870	T	Gum graft	0253	12.02	$582.81	$284.00	$116.56
41872	T	Repair gum	0253	12.02	$582.81	$284.00	$116.56
41874	T	Repair tooth socket	0253	12.02	$582.81	$284.00	$116.56
41899	T	Dental surgery procedure	0253	12.02	$582.81	$284.00	$116.56
42000	T	Drainage mouth roof lesion	0251	1.68	$81.46	$27.99	$16.29
42100	T	Biopsy roof of mouth	0252	5.18	$251.16	$114.24	$50.23
42104	T	Excision lesion, mouth roof	0253	12.02	$582.81	$284.00	$116.56
42106	T	Excision lesion, mouth roof	0253	12.02	$582.81	$284.00	$116.56
42107	T	Excision lesion, mouth roof	0254	12.45	$603.66	$272.41	$120.73
42120	T	Remove palate/lesion	0256	25.40	$1,231.57	$623.05	$246.31
42140	T	Excision of uvula	0252	5.18	$251.16	$114.24	$50.23
42145	T	Repair palate, pharynx/uvula	0254	12.45	$603.66	$272.41	$120.73
42160	T	Treatment mouth roof lesion	0253	12.02	$582.81	$284.00	$116.56
42180	T	Repair palate	0251	1.68	$81.46	$27.99	$16.29
42182	T	Repair palate	0256	25.40	$1,231.57	$623.05	$246.31
42200	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42205	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42210	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42215	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42220	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42225	T	Reconstruct cleft palate	0256	25.40	$1,231.57	$623.05	$246.31
42226	T	Lengthening of palate	0256	25.40	$1,231.57	$623.05	$246.31
42227	T	Lengthening of palate	0256	25.40	$1,231.57	$623.05	$246.31
42235	T	Repair palate	0254	12.45	$603.66	$272.41	$120.73
42260	T	Repair nose to lip fistula	0253	12.02	$582.81	$284.00	$116.56
42280	T	Preparation, palate mold	0251	1.68	$81.46	$27.99	$16.29
42281	T	Insertion, palate prosthesis	0253	12.02	$582.81	$284.00	$116.56
42299	T	Palate/uvula surgery	0251	1.68	$81.46	$27.99	$16.29
42300	T	Drainage of salivary gland	0253	12.02	$582.81	$284.00	$116.56
42305	T	Drainage of salivary gland	0253	12.02	$582.81	$284.00	$116.56
42310	T	Drainage of salivary gland	0251	1.68	$81.46	$27.99	$16.29
42320	T	Drainage of salivary gland	0251	1.68	$81.46	$27.99	$16.29
42325	T	Create salivary cyst drain	0252	5.18	$251.16	$114.24	$50.23
42326	T	Create salivary cyst drain	0252	5.18	$251.16	$114.24	$50.23
42330	T	Removal of salivary stone	0252	5.18	$251.16	$114.24	$50.23
42335	T	Removal of salivary stone	0253	12.02	$582.81	$284.00	$116.56
42340	T	Removal of salivary stone	0253	12.02	$582.81	$284.00	$116.56
42400	T	Biopsy of salivary gland	0004	1.84	$89.22	$32.57	$17.84
42405	T	Biopsy of salivary gland	0253	12.02	$582.81	$284.00	$116.56
42408	T	Excision of salivary cyst	0253	12.02	$582.81	$284.00	$116.56
42409	T	Drainage of salivary cyst	0253	12.02	$582.81	$284.00	$116.56
42410	T	Excise parotid gland/lesion	0256	25.40	$1,231.57	$623.05	$246.31
42415	T	Excise parotid gland/lesion	0256	25.40	$1,231.57	$623.05	$246.31
42420	T	Excise parotid gland/lesion	0256	25.40	$1,231.57	$623.05	$246.31
42425	T	Excise parotid gland/lesion	0256	25.40	$1,231.57	$623.05	$246.31
42426	C	Excise parotid gland/lesion					
42440	T	Excise submaxillary gland	0256	25.40	$1,231.57	$623.05	$246.31
42450	T	Excise sublingual gland	0253	12.02	$582.81	$284.00	$116.56

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
42500	T	Repair salivary duct	0254	12.45	$603.66	$272.41	$120.73
42505	T	Repair salivary duct	0256	25.40	$1,231.57	$623.05	$246.31
42507	T	Parotid duct diversion	0256	25.40	$1,231.57	$623.05	$246.31
42508	T	Parotid duct diversion	0256	25.40	$1,231.57	$623.05	$246.31
42509	T	Parotid duct diversion	0256	25.40	$1,231.57	$623.05	$246.31
42510	T	Parotid duct diversion	0256	25.40	$1,231.57	$623.05	$246.31
42550	N	Injection for salivary x-ray					
42600	T	Closure of salivary fistula	0253	12.02	$582.81	$284.00	$116.56
42650	T	Dilation of salivary duct	0252	5.18	$251.16	$114.24	$50.23
42660	T	Dilation of salivary duct	0252	5.18	$251.16	$114.24	$50.23
42665	T	Ligation of salivary duct	0253	12.02	$582.81	$284.00	$116.56
42699	T	Salivary surgery procedure	0253	12.02	$582.81	$284.00	$116.56
42700	T	Drainage of tonsil abscess	0251	1.68	$81.46	$27.99	$16.29
42720	T	Drainage of throat abscess	0253	12.02	$582.81	$284.00	$116.56
42725	T	Drainage of throat abscess	0256	25.40	$1,231.57	$623.05	$246.31
42800	T	Biopsy of throat	0252	5.18	$251.16	$114.24	$50.23
42802	T	Biopsy of throat	0253	12.02	$582.81	$284.00	$116.56
42804	T	Biopsy of upper nose/throat	0253	12.02	$582.81	$284.00	$116.56
42806	T	Biopsy of upper nose/throat	0253	12.02	$582.81	$284.00	$116.56
42808	T	Excise pharynx lesion	0253	12.02	$582.81	$284.00	$116.56
42809	T	Remove pharynx foreign body	0251	1.68	$81.46	$27.99	$16.29
42810	T	Excision of neck cyst	0253	12.02	$582.81	$284.00	$116.56
42815	T	Excision of neck cyst	0256	25.40	$1,231.57	$623.05	$246.31
42820	T	Remove tonsils and adenoids	0258	18.62	$902.83	$462.81	$180.57
42821	T	Remove tonsils and adenoids	0258	18.62	$902.83	$462.81	$180.57
42825	T	Removal of tonsils	0258	18.62	$902.83	$462.81	$180.57
42826	T	Removal of tonsils	0258	18.62	$902.83	$462.81	$180.57
42830	T	Removal of adenoids	0258	18.62	$902.83	$462.81	$180.57
42831	T	Removal of adenoids	0258	18.62	$902.83	$462.81	$180.57
42835	T	Removal of adenoids	0258	18.62	$902.83	$462.81	$180.57
42836	T	Removal of adenoids	0258	18.62	$902.83	$462.81	$180.57
42842	C	Extensive surgery of throat					
42844	T	Extensive surgery of throat	0256	25.40	$1,231.57	$623.05	$246.31
42845	C	Extensive surgery of throat					
42860	T	Excision of tonsil tags	0258	18.62	$902.83	$462.81	$180.57
42870	T	Excision of lingual tonsil	0258	18.62	$902.83	$462.81	$180.57
42890	T	Partial removal of pharynx	0256	25.40	$1,231.57	$623.05	$246.31
42892	T	Revision of pharyngeal walls	0256	25.40	$1,231.57	$623.05	$246.31
42894	C	Revision of pharyngeal walls					
42900	T	Repair throat wound	0253	12.02	$582.81	$284.00	$116.56
42950	T	Reconstruction of throat	0254	12.45	$603.66	$272.41	$120.73
42953	C	Repair throat, esophagus					
42955	T	Surgical opening of throat	0254	12.45	$603.66	$272.41	$120.73
42960	T	Control throat bleeding	0250	2.21	$107.16	$38.54	$21.43
42961	C	Control throat bleeding					
42962	T	Control throat bleeding	0256	25.40	$1,231.57	$623.05	$246.31
42970	T	Control nose/throat bleeding	0250	2.21	$107.16	$38.54	$21.43
42971	C	Control nose/throat bleeding					
42972	T	Control nose/throat bleeding	0253	12.02	$582.81	$284.00	$116.56
42999	T	Throat surgery procedure	0252	5.18	$251.16	$114.24	$50.23
43020	T	Incision of esophagus	0254	12.45	$603.66	$272.41	$120.73
43030	C	Throat muscle surgery					
43045	C	Incision of esophagus					
43100	C	Excision of esophagus lesion					
43101	C	Excision of esophagus lesion					
43107	C	Removal of esophagus					
43108	C	Removal of esophagus					
43112	C	Removal of esophagus					
43113	C	Removal of esophagus					
43116	C	Partial removal of esophagus					
43117	C	Partial removal of esophagus					
43118	C	Partial removal of esophagus					
43121	C	Partial removal of esophagus					
43122	C	Parital removal of esophagus					
43123	C	Partial removal of esophagus					
43124	C	Removal of esophagus					
43130	C	Removal of esophagus pouch					
43135	C	Removal of esophagus pouch					
43200	T	Esophagus endoscopy	0141	7.15	$346.68	$184.67	$69.34
43202	T	Esophagus endoscopy, biopsy	0141	7.15	$346.68	$184.67	$69.34
43204	T	Esophagus endoscopy & inject	0141	7.15	$346.68	$184.67	$69.34
43205	T	Esophagus endoscopy/ligation	0141	7.15	$346.68	$184.67	$69.34
43215	T	Esophagus endoscopy	0141	7.15	$346.68	$184.67	$69.34

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
43216	T	Esophagus endoscopy/lesion	0141	7.15	$346.68	$184.67	$69.34
43217	T	Esophagus endoscopy	0141	7.15	$346.68	$184.67	$69.34
43219	T	Esophagus endoscopy	0141	7.15	$346.68	$184.67	$69.34
43220	T	Esoph endoscopy, dilation	0141	7.15	$346.68	$184.67	$69.34
43226	T	Esoph endoscopy, dilation	0141	7.15	$346.68	$184.67	$69.34
43227	T	Esoph endoscopy, repair	0141	7.15	$346.68	$184.67	$69.34
43228	T	Esoph endoscopy, ablation	0141	7.15	$346.68	$184.67	$69.34
43234	T	Upper GI endoscopy, exam	0141	7.15	$346.68	$184.67	$69.34
43235	T	Uppr gi endoscopy, diagnosis	0141	7.15	$346.68	$184.67	$69.34
43239	T	Upper GI endoscopy, biopsy	0141	7.15	$346.68	$184.67	$69.34
43241	T	Upper GI endoscopy with tube	0141	7.15	$346.68	$184.67	$69.34
43243	T	Upper gi endoscopy & inject	0141	7.15	$346.68	$184.67	$69.34
43244	T	Upper GI endoscopy/ligation	0141	7.15	$346.68	$184.67	$69.34
43245	T	Operative upper GI endoscopy	0141	7.15	$346.68	$184.67	$69.34
43246	T	Place gastrostomy tube	0141	7.15	$346.68	$184.67	$69.34
43247	T	Operative upper GI endoscopy	0141	7.15	$346.68	$184.67	$69.34
43248	T	Uppr gi endoscopy/guide wire	0141	7.15	$346.68	$184.67	$69.34
43249	T	Esoph endoscopy, dilation	0141	7.15	$346.68	$184.67	$69.34
43250	T	Upper GI endoscopy/tumor	0141	7.15	$346.68	$184.67	$69.34
43251	T	Operative upper GI endoscopy	0141	7.15	$346.68	$184.67	$69.34
43255	T	Operative upper GI endoscopy	0141	7.15	$346.68	$184.67	$69.34
43258	T	Operative upper GI endoscopy	0141	7.15	$346.68	$184.67	$69.34
43259	T	Endoscopic ultrasound exam	0141	7.15	$346.68	$184.67	$69.34
43260	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43261	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43262	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43263	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43264	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43265	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43267	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43268	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43269	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43271	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43272	T	Endo cholangiopancreatograph	0151	10.53	$510.57	$245.46	$102.11
43280	T	Laparoscopy, fundoplasty	0132	48.91	$2,371.50	$1,239.22	$474.30
43289	T	Laparoscope proc, esoph	0130	25.36	$1,229.63	$659.53	$245.93
43300	C	Repair of esophagus					
43305	C	Repair esophagus and fistula					
43310	C	Repair of esophagus					
43312	C	Repair esophagus and fistula					
43320	C	Fuse esophagus & stomach					
43324	C	Revise esophagus & stomach					
43325	C	Revise esophagus & stomach					
43326	C	Revise esophagus & stomach					
43330	C	Repair of esophagus					
43331	C	Repair of esophagus					
43340	C	Fuse esophagus & intestine					
43341	C	Fuse esophagus & intestine					
43350	C	Surgical opening, esophagus					
43351	C	Surgical opening, esophagus					
43352	C	Surgical opening, esophagus					
43360	C	Gastrointestinal repair					
43361	C	Gastrointestinal repair					
43400	C	Ligate esophagus veins					
43401	C	Esophagus surgery for veins					
43405	C	Ligate/staple esophagus					
43410	C	Repair esophagus wound					
43415	C	Repair esophagus wound					
43420	C	Repair esophagus opening					
43425	C	Repair esophagus opening					
43450	T	Dilate esophagus	0140	4.74	$229.83	$107.24	$45.97
43453	T	Dilate esophagus	0140	4.74	$229.83	$107.24	$45.97
43456	T	Dilate esophagus	0140	4.74	$229.83	$107.24	$45.97
43458	T	Dilate esophagus	0140	4.74	$229.83	$107.24	$45.97
43460	C	Pressure treatment esophagus					
43496	C	Free jejunum flap, microvasc					
43499	T	Esophagus surgery procedure	0140	4.74	$229.83	$107.24	$45.97
43500	C	Surgical opening of stomach					
43501	C	Surgical repair of stomach					
43502	C	Surgical repair of stomach					
43510	C	Surgical opening of stomach					
43520	C	Incision of pyloric muscle					
43600	T	Biopsy of stomach	0141	7.15	$346.68	$184.67	$69.34

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
43605	C	Biopsy of stomach					
43610	C	Excision of stomach lesion					
43611	C	Excision of stomach lesion					
43620	C	Removal of stomach					
43621	C	Removal of stomach					
43622	C	Removal of stomach					
43631	C	Removal of stomach, partial					
43632	C	Removal of stomach, partial					
43633	C	Removal of stomach, partial					
43634	C	Removal of stomach, partial					
43635	C	Removal of stomach, partial					
43638	C	Removal of stomach, partial					
43639	C	Removal of stomach, partial					
43640	C	Vagotomy & pylorus repair					
43641	C	Vagotomy & pylorus repair					
43651	T	Laparoscopy, vagus nerve	0132	48.91	$2,371.50	$1,239.22	$474.30
43652	T	Laparoscopy, vagus nerve	0132	48.91	$2,371.50	$1,239.22	$474.30
43653	T	Laparoscopy, gastrostomy	0131	41.81	$2,027.24	$1,089.88	$405.45
43659	T	Laparoscope proc, stom	0130	25.36	$1,229.63	$659.53	$245.93
43750	T	Place gastrostomy tube	0141	7.15	$346.68	$184.67	$69.34
43760	T	Change gastrostomy tube	0121	2.36	$114.43	$52.53	$22.89
43761	T	Reposition gastrostomy tube	0121	2.36	$114.43	$52.53	$22.89
43800	C	Reconstruction of pylorus					
43810	C	Fusion of stomach and bowel					
43820	C	Fusion of stomach and bowel					
43825	C	Fusion of stomach and bowel					
43830	T	Place gastrostomy tube	0141	7.15	$346.68	$184.67	$69.34
43831	T	Place gastrostomy tube	0141	7.15	$346.68	$184.67	$69.34
43832	C	Place gastrostomy tube					
43840	C	Repair of stomach lesion					
43842	C	Gastroplasty for obesity					
43843	C	Gastroplasty for obesity					
43846	C	Gastric bypass for obesity					
43847	C	Gastric bypass for obesity					
43848	C	Revision gastroplasty					
43850	C	Revise stomach-bowel fusion					
43855	C	Revise stomach-bowel fusion					
43860	C	Revise stomach-bowel fusion					
43865	C	Revise stomach-bowel fusion					
43870	T	Repair stomach opening	0025	3.74	$181.34	$70.66	$36.27
43880	C	Repair stomach-bowel fistula					
43999	T	Stomach surgery procedure	0121	2.36	$114.43	$52.53	$22.89
44005	C	Freeing of bowel adhesion					
44010	C	Incision of small bowel					
44015	C	Insert needle cath bowel					
44020	C	Exploration of small bowel					
44021	C	Decompress small bowel					
44025	C	Incision of large bowel					
44050	C	Reduce bowel obstruction					
44055	C	Correct malrotation of bowel					
44100	T	Biopsy of bowel	0141	7.15	$346.68	$184.67	$69.34
44110	C	Excision of bowel lesion(s)					
44111	C	Excision of bowel lesion(s)					
44120	C	Removal of small intestine					
44121	C	Removal of small intestine					
44125	C	Removal of small intestine					
44130	C	Bowel to bowel fusion					
44139	C	Mobilization of colon					
44140	C	Partial removal of colon					
44141	C	Partial removal of colon					
44143	C	Partial removal of colon					
44144	C	Partial removal of colon					
44145	C	Partial removal of colon					
44146	C	Partial removal of colon					
44147	C	Partial removal of colon					
44150	C	Removal of colon					
44151	C	Removal of colon/ileostomy					
44152	C	Removal of colon/ileostomy					
44153	C	Removal of colon/ileostomy					
44155	C	Removal of colon/ileostomy					
44156	C	Removal of colon/ileostomy					
44160	C	Removal of colon					
44200	T	Laparoscopy, enterolysis	0131	41.81	$2,027.24	$1,089.88	$405.45

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
44201	T	Laparoscopy, jejunostomy	0131	41.81	$2,027.24	$1,089.88	$405.45
44202	C	Laparo, resect intestine					
44209	T	Laparoscope proc, intestine	0130	25.36	$1,229.63	$659.53	$245.93
44300	C	Open bowel to skin					
44310	C	Ileostomy/jejunostomy					
44312	T	Revision of ileostomy	0026	12.11	$587.18	$277.92	$117.44
44314	C	Revision of ileostomy					
44316	C	Devise bowel pouch					
44320	C	Colostomy					
44322	C	Colostomy with biopsies					
44340	T	Revision of colostomy	0026	12.11	$587.18	$277.92	$117.44
44345	C	Revision of colostomy					
44346	C	Revision of colostomy					
44360	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44361	T	Small bowel endoscopy/biopsy	0142	7.45	$361.23	$162.42	$72.25
44363	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44364	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44365	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44366	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44369	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44372	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44373	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44376	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44377	T	Small bowel endoscopy/biopsy	0142	7.45	$361.23	$162.42	$72.25
44378	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44380	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44382	T	Small bowel endoscopy	0142	7.45	$361.23	$162.42	$72.25
44385	T	Endoscopy of bowel pouch	0143	7.98	$386.93	$199.12	$77.39
44386	T	Endoscopy, bowel pouch/biop	0143	7.98	$386.93	$199.12	$77.39
44388	T	Colon endoscopy	0143	7.98	$386.93	$199.12	$77.39
44389	T	Colonoscopy with biopsy	0143	7.98	$386.93	$199.12	$77.39
44390	T	Colonoscopy for foreign body	0143	7.98	$386.93	$199.12	$77.39
44391	T	Colonoscopy for bleeding	0143	7.98	$386.93	$199.12	$77.39
44392	T	Colonoscopy & polypectomy	0143	7.98	$386.93	$199.12	$77.39
44393	T	Colonoscopy, lesion removal	0143	7.98	$386.93	$199.12	$77.39
44394	T	Colonoscopy w/snare	0143	7.98	$386.93	$199.12	$77.39
44500	C	Intro, gastrointestinal tube					
44602	C	Suture, small intestine					
44603	C	Suture, small intestine					
44604	C	Suture, large intestine					
44605	C	Repair of bowel lesion					
44615	C	Intestinal stricturoplasty					
44620	C	Repair bowel opening					
44625	C	Repair bowel opening					
44626	C	Repair bowel opening					
44640	C	Repair bowel-skin fistula					
44650	C	Repair bowel fistula					
44660	C	Repair bowel-bladder fistula					
44661	C	Repair bowel-bladder fistula					
44680	C	Surgical revision, intestine					
44700	C	Suspend bowel w/prosthesis					
44799	T	Intestine surgery procedure	0142	7.45	$361.23	$162.42	$72.25
44800	C	Excision of bowel pouch					
44820	C	Excision of mesentery lesion					
44850	C	Repair of mesentery					
44899	C	Bowel surgery procedure					
44900	C	Drain app abscess, open					
44901	C	Drain app abscess, percut					
44950	C	Appendectomy					
44955	C	Appendectomy add-on					
44960	C	Appendectomy					
44970	T	Laparoscopy, appendectomy	0130	25.36	$1,229.63	$659.53	$245.93
44979	T	Laparoscope proc, app	0130	25.36	$1,229.63	$659.53	$245.93
45000	T	Drainage of pelvic abscess	0149	12.86	$623.54	$293.06	$124.71
45005	T	Drainage of rectal abscess	0148	2.34	$113.46	$43.59	$22.69
45020	T	Drainage of rectal abscess	0149	12.86	$623.54	$293.06	$124.71
45100	T	Biopsy of rectum	0149	12.86	$623.54	$293.06	$124.71
45108	T	Removal of anorectal lesion	0150	17.68	$857.25	$437.12	$171.45
45110	C	Removal of rectum					
45111	C	Partial removal of rectum					
45112	C	Removal of rectum					
45113	C	Partial proctectomy					
45114	C	Partial removal of rectum					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
45116	C	Partial removal of rectum					
45119	C	Remove rectum w/reservoir					
45120	C	Removal of rectum					
45121	C	Removal of rectum and colon					
45123	C	Partial proctectomy					
45126	C	Pelvic exenteration					
45130	C	Excision of rectal prolapse					
45135	C	Excision of rectal prolapse					
45150	T	Excision of rectal stricture	0150	17.68	$857.25	$437.12	$171.45
45160	T	Excision of rectal lesion	0150	17.68	$857.25	$437.12	$171.45
45170	T	Excision of rectal lesion	0150	17.68	$857.25	$437.12	$171.45
45190	T	Destruction, rectal tumor	0150	17.68	$857.25	$437.12	$171.45
45300	T	Proctosigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45303	T	Proctosigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45305	T	Proctosigmoidoscopy & biopsy	0146	2.83	$137.22	$65.15	$27.44
45307	T	Proctosigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45308	T	Proctosigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45309	T	Proctosigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45315	T	Proctosigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45317	T	Proctosigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45320	T	Proctosigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45321	T	Proctosigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45330	T	Diagnostic sigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45331	T	Sigmoidoscopy and biopsy	0146	2.83	$137.22	$65.15	$27.44
45332	T	Sigmoidoscopy	0146	2.83	$137.22	$65.15	$27.44
45333	T	Sigmoidoscopy & polypectomy	0147	6.26	$303.53	$149.11	$60.71
45334	T	Sigmoidoscopy for bleeding	0147	6.26	$303.53	$149.11	$60.71
45337	T	Sigmoidoscopy & decompress	0147	6.26	$303.53	$149.11	$60.71
45338	T	Sigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45339	T	Sigmoidoscopy	0147	6.26	$303.53	$149.11	$60.71
45355	T	Surgical colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45378	T	Diagnostic colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45379	T	Colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45380	T	Colonoscopy and biopsy	0143	7.98	$386.93	$199.12	$77.39
45382	T	Colonoscopy/control bleeding	0143	7.98	$386.93	$199.12	$77.39
45383	T	Lesion removal colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45384	T	Colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45385	T	Lesion removal colonoscopy	0143	7.98	$386.93	$199.12	$77.39
45500	T	Repair of rectum	0150	17.68	$857.25	$437.12	$171.45
45505	T	Repair of rectum	0150	17.68	$857.25	$437.12	$171.45
45520	T	Treatment of rectal prolapse	0098	1.19	$57.70	$20.88	$11.54
45540	C	Correct rectal prolapse					
45541	C	Correct rectal prolapse					
45550	C	Repair rectum/remove sigmoid					
45560	T	Repair of rectocele	0150	17.68	$857.25	$437.12	$171.45
45562	C	Exploration/repair of rectum					
45563	C	Exploration/repair of rectum					
45800	C	Repair rect/bladder fistula					
45805	C	Repair fistula w/colostomy					
45820	C	Repair rectourethral fistula					
45825	C	Repair fistula w/colostomy					
45900	T	Reduction of rectal prolapse	0148	2.34	$113.46	$43.59	$22.69
45905	T	Dilation of anal sphincter	0149	12.86	$623.54	$293.06	$124.71
45910	T	Dilation of rectal narrowing	0149	12.86	$623.54	$293.06	$124.71
45915	T	Remove rectal obstruction	0148	2.34	$113.46	$43.59	$22.69
45999	T	Rectum surgery procedure	0148	2.34	$113.46	$43.59	$22.69
46030	T	Removal of rectal marker	0149	12.86	$623.54	$293.06	$124.71
46040	T	Incision of rectal abscess	0148	2.34	$113.46	$43.59	$22.69
46045	T	Incision of rectal abscess	0150	17.68	$857.25	$437.12	$171.45
46050	T	Incision of anal abscess	0148	2.34	$113.46	$43.59	$22.69
46060	T	Incision of rectal abscess	0150	17.68	$857.25	$437.12	$171.45
46070	T	Incision of anal septum	0148	2.34	$113.46	$43.59	$22.69
46080	T	Incision of anal sphincter	0149	12.86	$623.54	$293.06	$124.71
46083	T	Incise external hemorrhoid	0148	2.34	$113.46	$43.59	$22.69
46200	T	Removal of anal fissure	0150	17.68	$857.25	$437.12	$171.45
46210	T	Removal of anal crypt	0149	12.86	$623.54	$293.06	$124.71
46211	T	Removal of anal crypts	0150	17.68	$857.25	$437.12	$171.45
46220	T	Removal of anal tab	0149	12.86	$623.54	$293.06	$124.71
46221	T	Ligation of hemorrhoid(s)	0148	2.34	$113.46	$43.59	$22.69
46230	T	Removal of anal tabs	0149	12.86	$623.54	$293.06	$124.71
46250	T	Hemorrhoidectomy	0150	17.68	$857.25	$437.12	$171.45
46255	T	Hemorrhoidectomy	0150	17.68	$857.25	$437.12	$171.45
46257	T	Remove hemorrhoids & fissure	0150	17.68	$857.25	$437.12	$171.45

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
46258	T	Remove hemorrhoids & fistula	0150	17.68	$857.25	$437.12	$171.45
46260	T	Hemorrhoidectomy	0150	17.68	$857.25	$437.12	$171.45
46261	T	Remove hemorrhoids & fissure	0150	17.68	$857.25	$437.12	$171.45
46262	T	Remove hemorrhoids & fistula	0150	17.68	$857.25	$437.12	$171.45
46270	T	Removal of anal fistula	0150	17.68	$857.25	$437.12	$171.45
46275	T	Removal of anal fistula	0150	17.68	$857.25	$437.12	$171.45
46280	T	Removal of anal fistula	0150	17.68	$857.25	$437.12	$171.45
46285	T	Removal of anal fistula	0150	17.68	$857.25	$437.12	$171.45
46288	T	Repair anal fistula	0150	17.68	$857.25	$437.12	$171.45
46320	T	Removal of hemorrhoid clot	0148	2.34	$113.46	$43.59	$22.69
46500	T	Injection into hemorrhoids	0148	2.34	$113.46	$43.59	$22.69
46600	N	Diagnostic anoscopy					
46604	T	Anoscopy and dilation	0144	2.23	$108.13	$49.32	$21.63
46606	T	Anoscopy and biopsy	0145	7.46	$361.71	$179.39	$72.34
46608	T	Anoscopy/remove for body	0144	2.23	$108.13	$49.32	$21.63
46610	T	Anoscopy/remove lesion	0145	7.46	$361.71	$179.39	$72.34
46611	T	Anoscopy	0145	7.46	$361.71	$179.39	$72.34
46612	T	Anoscopy/remove lesions	0145	7.46	$361.71	$179.39	$72.34
46614	T	Anoscopy/control bleeding	0145	7.46	$361.71	$179.39	$72.34
46615	T	Anoscopy	0145	7.46	$361.71	$179.39	$72.34
46700	T	Repair of anal stricture	0150	17.68	$857.25	$437.12	$171.45
46705	C	Repair of anal stricture					
46715	C	Repair of anovaginal fistula					
46716	C	Repair of anovaginal fistula					
46730	C	Construction of absent anus					
46735	C	Construction of absent anus					
46740	C	Construction of absent anus					
46742	C	Repair of imperforated anus					
46744	C	Repair of cloacal anomaly					
46746	C	Repair of cloacal anomaly					
46748	C	Repair of cloacal anomaly					
46750	T	Repair of anal sphincter	0150	17.68	$857.25	$437.12	$171.45
46751	C	Repair of anal sphincter					
46753	T	Reconstruction of anus	0150	17.68	$857.25	$437.12	$171.45
46754	T	Removal of suture from anus	0149	12.86	$623.54	$293.06	$124.71
46760	T	Repair of anal sphincter	0150	17.68	$857.25	$437.12	$171.45
46761	T	Repair of anal sphincter	0150	17.68	$857.25	$437.12	$171.45
46762	T	Implant artificial sphincter	0150	17.68	$857.25	$437.12	$171.45
46900	T	Destruction, anal lesion(s)	0016	3.53	$171.16	$74.67	$34.23
46910	T	Destruction, anal lesion(s)	0016	3.53	$171.16	$74.67	$34.23
46916	T	Cryosurgery, anal lesion(s)	0016	3.53	$171.16	$74.67	$34.23
46917	T	Laser surgery, anal lesions	0014	1.50	$72.73	$24.55	$14.55
46922	T	Excision of anal lesion(s)	0017	12.45	$603.66	$289.16	$120.73
46924	T	Destruction, anal lesion(s)	0017	12.45	$603.66	$289.16	$120.73
46934	T	Destruction of hemorrhoids	0148	2.34	$113.46	$43.59	$22.69
46935	T	Destruction of hemorrhoids	0148	2.34	$113.46	$43.59	$22.69
46936	T	Destruction of hemorrhoids	0149	12.86	$623.54	$293.06	$124.71
46937	T	Cryotherapy of rectal lesion	0150	17.68	$857.25	$437.12	$171.45
46938	T	Cryotherapy of rectal lesion	0150	17.68	$857.25	$437.12	$171.45
46940	T	Treatment of anal fissure	0149	12.86	$623.54	$293.06	$124.71
46942	T	Treatment of anal fissure	0149	12.86	$623.54	$293.06	$124.71
46945	T	Ligation of hemorrhoids	0148	2.34	$113.46	$43.59	$22.69
46946	T	Ligation of hemorrhoids	0148	2.34	$113.46	$43.59	$22.69
46999	T	Anus surgery procedure	0149	12.86	$623.54	$293.06	$124.71
47000	T	Needle biopsy of liver	0005	5.41	$262.32	$119.75	$52.46
47001	C	Needle biopsy, liver add-on					
47010	C	Open drainage, liver lesion					
47011	C	Percut drain, liver lesion					
47015	C	Inject/aspirate liver cyst					
47100	C	Wedge biopsy of liver					
47120	C	Partial removal of liver					
47122	C	Extensive removal of liver					
47125	C	Partial removal of liver					
47130	C	Partial removal of liver					
47133	C	Removal of donor liver					
47134	C	Partial removal, donor liver					
47135	C	Transplantation of liver					
47136	C	Transplantation of liver					
47300	C	Surgery for liver lesion					
47350	C	Repair liver wound					
47360	C	Repair liver wound					
47361	C	Repair liver wound					
47362	C	Repair liver wound					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
47399	T	Liver surgery procedure	0005	5.41	$262.32	$119.75	$52.46
47400	C	Incision of liver duct					
47420	C	Incision of bile duct					
47425	C	Incision of bile duct					
47460	C	Incise bile duct sphincter					
47480	C	Incision of gallbladder					
47490	C	Incision of gallbladder					
47500	N	Injection for liver x-rays					
47505	N	Injection for liver x-rays					
47510	T	Insert catheter, bile duct	0152	8.22	$398.56	$207.38	$79.71
47511	T	Insert bile duct drain	0152	8.22	$398.56	$207.38	$79.71
47525	T	Change bile duct catheter	0122	5.04	$244.37	$114.93	$48.88
47530	T	Revise/reinsert bile tube	0121	2.36	$114.43	$52.53	$22.89
47550	C	Bile duct endoscopy add-on					
47552	T	Biliary endoscopy thru skin	0152	8.22	$398.56	$207.38	$79.71
47553	T	Biliary endoscopy thru skin	0152	8.22	$398.56	$207.38	$79.71
47554	T	Biliary endoscopy thru skin	0152	8.22	$398.56	$207.38	$79.71
47555	T	Biliary endoscopy thru skin	0152	8.22	$398.56	$207.38	$79.71
47556	T	Biliary endoscopy thru skin	0152	8.22	$398.56	$207.38	$79.71
47560	T	Laparoscopy w/cholangio	0130	25.36	$1,229.63	$659.53	$245.93
47561	T	Laparo w/cholangio/biopsy	0130	25.36	$1,229.63	$659.53	$245.93
47562	T	Laparoscopic cholecystectomy	0131	41.81	$2,027.24	$1,089.88	$405.45
47563	T	Laparo cholecystectomy/graph	0131	41.81	$2,027.24	$1,089.88	$405.45
47564	T	Laparo cholecystectomy/explr	0131	41.81	$2,027.24	$1,089.88	$405.45
47570	T	Laparo cholecystoenterostomy	0131	41.81	$2,027.24	$1,089.88	$405.45
47579	T	Laparoscope proc, biliary	0130	25.36	$1,229.63	$659.53	$245.93
47600	C	Removal of gallbladder					
47605	C	Removal of gallbladder					
47610	C	Removal of gallbladder					
47612	C	Removal of gallbladder					
47620	C	Removal of gallbladder					
47630	T	Remove bile duct stone	0152	8.22	$398.56	$207.38	$79.71
47700	C	Exploration of bile ducts					
47701	C	Bile duct revision					
47711	C	Excision of bile duct tumor					
47712	C	Excision of bile duct tumor					
47715	C	Excision of bile duct cyst					
47716	C	Fusion of bile duct cyst					
47720	C	Fuse gallbladder & bowel					
47721	C	Fuse upper gi structures					
47740	C	Fuse gallbladder & bowel					
47741	C	Fuse gallbladder & bowel					
47760	C	Fuse bile ducts and bowel					
47765	C	Fuse liver ducts & bowel					
47780	C	Fuse bile ducts and bowel					
47785	C	Fuse bile ducts and bowel					
47800	C	Reconstruction of bile ducts					
47801	C	Placement, bile duct support					
47802	C	Fuse liver duct & intestine					
47900	C	Suture bile duct injury					
47999	T	Bile tract surgery procedure	0121	2.36	$114.43	$52.53	$22.89
48000	C	Drainage of abdomen					
48001	C	Placement of drain, pancreas					
48005	C	Resect/debride pancreas					
48020	C	Removal of pancreatic stone					
48100	C	Biopsy of pancreas					
48102	T	Needle biopsy, pancreas	0005	5.41	$262.32	$119.75	$52.46
48120	C	Removal of pancreas lesion					
48140	C	Partial removal of pancreas					
48145	C	Partial removal of pancreas					
48146	C	Pancreatectomy					
48148	C	Removal of pancreatic duct					
48150	C	Partial removal of pancreas					
48152	C	Pancreatectomy					
48153	C	Pancreatectomy					
48154	C	Pancreatectomy					
48155	C	Removal of pancreas					
48160	E	Pancreas removal/transplant					
48180	C	Fuse pancreas and bowel					
48400	C	Injection, intraop add-on					
48500	C	Surgery of pancreas cyst					
48510	C	Drain pancreatic pseudocyst					
48511	C	Drain pancreatic pseudocyst					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
48520	C	Fuse pancreas cyst and bowel					
48540	C	Fuse pancreas cyst and bowel					
48545	C	Pancreatorrhaphy					
48547	C	Duodenal exclusion					
48550	E	Donor pancreatectomy					
48554	E	Transpl allograft pancreas					
48556	C	Removal, allograft pancreas					
48999	T	Pancreas surgery procedure	0005	5.41	$262.32	$119.75	$52.46
49000	C	Exploration of abdomen					
49002	C	Reopening of abdomen					
49010	C	Exploration behind abdomen					
49020	C	Drain abdominal abscess					
49021	C	Drain abdominal abscess					
49040	C	Drain, open, abdom abscess					
49041	C	Drain, percut, abdom abscess					
49060	C	Drain, open, retrop abscess					
49061	C	Drain, percut, retroper absc					
49062	C	Drain to peritoneal cavity					
49080	T	Puncture, peritoneal cavity	0070	3.64	$176.49	$79.60	$35.30
49081	T	Removal of abdominal fluid	0070	3.64	$176.49	$79.60	$35.30
49085	T	Remove abdomen foreign body	0153	19.62	$951.32	$496.31	$190.26
49180	T	Biopsy, abdominal mass	0005	5.41	$262.32	$119.75	$52.46
49200	C	Removal of abdominal lesion					
49201	C	Removal of abdominal lesion					
49215	C	Excise sacral spine tumor					
49220	C	Multiple surgery, abdomen					
49250	T	Excision of umbilicus	0153	19.62	$951.32	$496.31	$190.26
49255	C	Removal of omentum					
49320	T	Diag laparo separate proc	0130	25.36	$1,229.63	$659.53	$245.93
49321	T	Laparoscopy, biopsy	0130	25.36	$1,229.63	$659.53	$245.93
49322	T	Laparoscopy, aspiration	0130	25.36	$1,229.63	$659.53	$245.93
49323	T	Laparo drain lymphocele	0130	25.36	$1,229.63	$659.53	$245.93
49329	T	Laparo proc, abdm/per/oment	0130	25.36	$1,229.63	$659.53	$245.93
49400	N	Air injection into abdomen					
49420	T	Insert abdominal drain	0153	19.62	$951.32	$496.31	$190.26
49421	T	Insert abdominal drain	0153	19.62	$951.32	$496.31	$190.26
49422	T	Remove perm cannula/catheter	0123	13.89	$673.49	$350.75	$134.70
49423	T	Exchange drainage catheter	0153	19.62	$951.32	$496.31	$190.26
49424	N	Assess cyst, contrast inject					
49425	C	Insert abdomen-venous drain					
49426	T	Revise abdomen-venous shunt	0153	19.62	$951.32	$496.31	$190.26
49427	N	Injection, abdominal shunt					
49428	C	Ligation of shunt					
49429	T	Removal of shunt	0123	13.89	$673.49	$350.75	$134.70
49495	T	Repair inguinal hernia, init	0154	22.43	$1,087.57	$556.98	$217.51
49496	T	Repair inguinal hernia, init	0154	22.43	$1,087.57	$556.98	$217.51
49500	T	Repair inguinal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49501	T	Repair inguinal hernia, init	0154	22.43	$1,087.57	$556.98	$217.51
49505	T	Repair inguinal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49507	T	Repair inguinal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49520	T	Rerepair inguinal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49521	T	Repair inguinal hernia, rec	0154	22.43	$1,087.57	$556.98	$217.51
49525	T	Repair inguinal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49540	T	Repair lumbar hernia	0154	22.43	$1,087.57	$556.98	$217.51
49550	T	Repair femoral hernia	0154	22.43	$1,087.57	$556.98	$217.51
49553	T	Repair femoral hernia, init	0154	22.43	$1,087.57	$556.98	$217.51
49555	T	Repair femoral hernia	0154	22.43	$1,087.57	$556.98	$217.51
49557	T	Repair femoral hernia, recur	0154	22.43	$1,087.57	$556.98	$217.51
49560	T	Repair abdominal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49561	T	Repair incisional hernia	0154	22.43	$1,087.57	$556.98	$217.51
49565	T	Rerepair abdominal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49566	T	Repair incisional hernia	0154	22.43	$1,087.57	$556.98	$217.51
49568	T	Hernia repair w/mesh	0154	22.43	$1,087.57	$556.98	$217.51
49570	T	Repair epigastric hernia	0154	22.43	$1,087.57	$556.98	$217.51
49572	T	Repair epigastric hernia	0154	22.43	$1,087.57	$556.98	$217.51
49580	T	Repair umbilical hernia	0154	22.43	$1,087.57	$556.98	$217.51
49582	T	Repair umbilical hernia	0154	22.43	$1,087.57	$556.98	$217.51
49585	T	Repair umbilical hernia	0154	22.43	$1,087.57	$556.98	$217.51
49587	T	Repair umbilical hernia	0154	22.43	$1,087.57	$556.98	$217.51
49590	T	Repair abdominal hernia	0154	22.43	$1,087.57	$556.98	$217.51
49600	T	Repair umbilical lesion	0154	22.43	$1,087.57	$556.98	$217.51
49605	C	Repair umbilical lesion					
49606	C	Repair umbilical lesion					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
49610	C	Repair umbilical lesion					
49611	C	Repair umbilical lesion					
49650	T	Laparo hernia repair initial	0131	41.81	$2,027.24	$1,089.88	$405.45
49651	T	Laparo hernia repair recur	0131	41.81	$2,027.24	$1,089.88	$405.45
49659	T	Laparo proc, hernia repair	0131	41.81	$2,027.24	$1,089.88	$405.45
49900	C	Repair of abdominal wall					
49905	C	Omental flap					
49906	C	Free omental flap, microvasc					
49999	T	Abdomen surgery procedure	0121	2.36	$114.43	$52.53	$22.89
50010	C	Exploration of kidney					
50020	C	Renal abscess, open drain					
50021	C	Renal abscess, percut drain					
50040	C	Drainage of kidney					
50045	C	Exploration of kidney					
50060	C	Removal of kidney stone					
50065	C	Incision of kidney					
50070	C	Incision of kidney					
50075	C	Removal of kidney stone					
50080	T	Removal of kidney stone	0163	28.98	$1,405.16	$792.58	$281.03
50081	T	Removal of kidney stone	0163	28.98	$1,405.16	$792.58	$281.03
50100	C	Revise kidney blood vessels					
50120	C	Exploration of kidney					
50125	C	Explore and drain kidney					
50130	C	Removal of kidney stone					
50135	C	Exploration of kidney					
50200	T	Biopsy of kidney	0005	5.41	$262.32	$119.75	$52.46
50205	C	Biopsy of kidney					
50220	C	Removal of kidney					
50225	C	Removal of kidney					
50230	C	Removal of kidney					
50234	C	Removal of kidney & ureter					
50236	C	Removal of kidney & ureter					
50240	C	Partial removal of kidney					
50280	C	Removal of kidney lesion					
50290	C	Removal of kidney lesion					
50300	C	Removal of donor kidney					
50320	C	Removal of donor kidney					
50340	C	Removal of kidney					
50360	C	Transplantation of kidney					
50365	C	Transplantation of kidney					
50370	C	Remove transplanted kidney					
50380	C	Reimplantation of kidney					
50390	T	Drainage of kidney lesion	0005	5.41	$262.32	$119.75	$52.46
50392	T	Insert kidney drain	0160	5.43	$263.28	$110.11	$52.66
50393	T	Insert ureteral tube	0160	5.43	$263.28	$110.11	$52.66
50394	N	Injection for kidney x-ray					
50395	T	Create passage to kidney	0160	5.43	$263.28	$110.11	$52.66
50396	T	Measure kidney pressure	0165	3.89	$188.61	$91.76	$37.72
50398	T	Change kidney tube	0122	5.04	$244.37	$114.93	$48.88
50400	C	Revision of kidney/ureter					
50405	C	Revision of kidney/ureter					
50500	C	Repair of kidney wound					
50520	C	Close kidney-skin fistula					
50525	C	Repair renal-abdomen fistula					
50526	C	Repair renal-abdomen fistula					
50540	C	Revision of horseshoe kidney					
50541	T	Laparo ablate renal cyst	0131	41.81	$2,027.24	$1,089.88	$405.45
50544	T	Laparoscopy, pyeloplasty	0131	41.81	$2,027.24	$1,089.88	$405.45
50546	C	Laparoscopic nephrectomy					
50547	C	Laparo removal donor kidney					
50548	T	Laparo-asst remove k/ureter	0132	48.91	$2,371.50	$1,239.22	$474.30
50549	T	Laparoscope proc, renal	0130	25.36	$1,229.63	$659.53	$245.93
50551	T	Kidney endoscopy	0161	10.94	$530.45	$249.36	$106.09
50553	T	Kidney endoscopy	0161	10.94	$530.45	$249.36	$106.09
50555	T	Kidney endoscopy & biopsy	0161	10.94	$530.45	$249.36	$106.09
50557	T	Kidney endoscopy & treatment	0161	10.94	$530.45	$249.36	$106.09
50559	T	Renal endoscopy/radiotracer	0161	10.94	$530.45	$249.36	$106.09
50561	T	Kidney endoscopy & treatment	0161	10.94	$530.45	$249.36	$106.09
50570	C	Kidney endoscopy					
50572	C	Kidney endoscopy					
50574	C	Kidney endoscopy & biopsy					
50575	C	Kidney endoscopy					
50576	C	Kidney endoscopy & treatment					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
50578	C	Renal endoscopy/radiotracer					
50580	C	Kidney endoscopy & treatment					
50590	T	Fragmenting of kidney stone	0169	46.72	$2,265.32	$1,384.20	$453.06
50600	C	Exploration of ureter					
50605	C	Insert ureteral support					
50610	C	Removal of ureter stone					
50620	C	Removal of ureter stone					
50630	C	Removal of ureter stone					
50650	C	Removal of ureter					
50660	C	Removal of ureter					
50684	N	Injection for ureter x-ray					
50686	T	Measure ureter pressure	0165	3.89	$188.61	$91.76	$37.72
50688	T	Change of ureter tube	0121	2.36	$114.43	$52.53	$22.89
50690	N	Injection for ureter x-ray					
50700	C	Revision of ureter					
50715	C	Release of ureter					
50722	C	Release of ureter					
50725	C	Release/revise ureter					
50727	C	Revise ureter					
50728	C	Revise ureter					
50740	C	Fusion of ureter & kidney					
50750	C	Fusion of ureter & kidney					
50760	C	Fusion of ureters					
50770	C	Splicing of ureters					
50780	C	Reimplant ureter in bladder					
50782	C	Reimplant ureter in bladder					
50783	C	Reimplant ureter in bladder					
50785	C	Reimplant ureter in bladder					
50800	C	Implant ureter in bowel					
50810	C	Fusion of ureter & bowel					
50815	C	Urine shunt to bowel					
50820	C	Construct bowel bladder					
50825	C	Construct bowel bladder					
50830	C	Revise urine flow					
50840	C	Replace ureter by bowel					
50845	C	Appendico-vesicostomy					
50860	C	Transplant ureter to skin					
50900	C	Repair of ureter					
50920	C	Closure ureter/skin fistula					
50930	C	Closure ureter/bowel fistula					
50940	C	Release of ureter					
50945	T	Laparoscopy ureterolithotomy	0131	41.81	$2,027.24	$1,089.88	$405.45
50951	T	Endoscopy of ureter	0162	17.49	$848.04	$427.49	$169.61
50953	T	Endoscopy of ureter	0162	17.49	$848.04	$427.49	$169.61
50955	T	Ureter endoscopy & biopsy	0162	17.49	$848.04	$427.49	$169.61
50957	T	Ureter endoscopy & treatment	0162	17.49	$848.04	$427.49	$169.61
50959	T	Ureter endoscopy & tracer	0162	17.49	$848.04	$427.49	$169.61
50961	T	Ureter endoscopy & treatment	0162	17.49	$848.04	$427.49	$169.61
50970	C	Ureter endoscopy					
50972	C	Ureter endoscopy & catheter					
50974	C	Ureter endoscopy & biopsy					
50976	C	Ureter endoscopy & treatment					
50978	C	Ureter endoscopy & tracer					
50980	C	Ureter endoscopy & treatment					
51000	T	Drainage of bladder	0165	3.89	$188.61	$91.76	$37.72
51005	T	Drainage of bladder	0164	2.17	$105.23	$33.03	$21.05
51010	T	Drainage of bladder	0165	3.89	$188.61	$91.76	$37.72
51020	T	Incise & treat bladder	0162	17.49	$848.04	$427.49	$169.61
51030	T	Incise & treat bladder	0162	17.49	$848.04	$427.49	$169.61
51040	T	Incise & drain bladder	0162	17.49	$848.04	$427.49	$169.61
51045	T	Incise bladder/drain ureter	0162	17.49	$848.04	$427.49	$169.61
51050	T	Removal of bladder stone	0162	17.49	$848.04	$427.49	$169.61
51060	C	Removal of ureter stone					
51065	T	Removal of ureter stone	0162	17.49	$848.04	$427.49	$169.61
51080	T	Drainage of bladder abscess	0008	6.15	$298.20	$113.67	$59.64
51500	T	Removal of bladder cyst	0154	22.43	$1,087.57	$556.98	$217.51
51520	T	Removal of bladder lesion	0162	17.49	$848.04	$427.49	$169.61
51525	C	Removal of bladder lesion					
51530	C	Removal of bladder lesion					
51535	C	Repair of ureter lesion					
51550	C	Partial removal of bladder					
51555	C	Partial removal of bladder					
51565	C	Revise bladder & ureter(s)					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
51570	C	Removal of bladder					
51575	C	Removal of bladder & nodes					
51580	C	Remove bladder/revise tract					
51585	C	Removal of bladder & nodes					
51590	C	Remove bladder/revise tract					
51595	C	Remove bladder/revise tract					
51596	C	Remove bladder/create pouch					
51597	C	Removal of pelvic structures					
51600	N	Injection for bladder x-ray					
51605	N	Preparation for bladder x-ray					
51610	N	Injection for bladder x-ray					
51700	T	Irrigation of bladder	0164	2.17	$105.23	$33.03	$21.05
51705	T	Change of bladder tube	0121	2.36	$114.43	$52.53	$22.89
51710	T	Change of bladder tube	0121	2.36	$114.43	$52.53	$22.89
51715	T	Endoscopic injection/implant	0167	21.06	$1,021.14	$555.84	$204.23
51720	T	Treatment of bladder lesion	0165	3.89	$188.61	$91.76	$37.72
51725	T	Simple cystometrogram	0165	3.89	$188.61	$91.76	$37.72
51726	T	Complex cystometrogram	0165	3.89	$188.61	$91.76	$37.72
51736	T	Urine flow measurement	0164	2.17	$105.23	$33.03	$21.05
51741	T	Electro-uroflowmetry, first	0164	2.17	$105.23	$33.03	$21.05
51772	T	Urethra pressure profile	0165	3.89	$188.61	$91.76	$37.72
51784	T	Anal/urinary muscle study	0164	2.17	$105.23	$33.03	$21.05
51785	T	Anal/urinary muscle study	0164	2.17	$105.23	$33.03	$21.05
51792	T	Urinary reflex study	0165	3.89	$188.61	$91.76	$37.72
51795	T	Urine voiding pressure study	0164	2.17	$105.23	$33.03	$21.05
51797	T	Intraabdominal pressure test	0164	2.17	$105.23	$33.03	$21.05
51800	C	Revision of bladder/urethra					
51820	C	Revision of urinary tract					
51840	C	Attach bladder/urethra					
51841	C	Attach bladder/urethra					
51845	C	Repair bladder neck					
51860	C	Repair of bladder wound					
51865	C	Repair of bladder wound					
51880	T	Repair of bladder opening	0162	17.49	$848.04	$427.49	$169.61
51900	C	Repair bladder/vagina lesion					
51920	C	Close bladder-uterus fistula					
51925	C	Hysterectomy/bladder repair					
51940	C	Correction of bladder defect					
51960	C	Revision of bladder & bowel					
51980	C	Construct bladder opening					
51990	T	Laparo urethral suspension	0131	41.81	$2,027.24	$1,089.88	$405.45
51992	T	Laparo sling operation	0132	48.91	$2,371.50	$1,239.22	$474.30
52000	T	Cystoscopy	0160	5.43	$263.28	$110.11	$52.66
52005	T	Cystoscopy & ureter catheter	0161	10.94	$530.45	$249.36	$106.09
52007	T	Cystoscopy and biopsy	0161	10.94	$530.45	$249.36	$106.09
52010	T	Cystoscopy & duct catheter	0161	10.94	$530.45	$249.36	$106.09
52204	T	Cystoscopy	0161	10.94	$530.45	$249.36	$106.09
52214	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52224	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52234	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52235	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52240	T	Cystoscopy and treatment	0163	28.98	$1,405.16	$792.58	$281.03
52250	T	Cystoscopy and radiotracer	0162	17.49	$848.04	$427.49	$169.61
52260	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52265	T	Cystoscopy and treatment	0160	5.43	$263.28	$110.11	$52.66
52270	T	Cystoscopy & revise urethra	0161	10.94	$530.45	$249.36	$106.09
52275	T	Cystoscopy & revise urethra	0161	10.94	$530.45	$249.36	$106.09
52276	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52277	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52281	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52282	T	Cystoscopy, implant stent	0162	17.49	$848.04	$427.49	$169.61
52283	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52285	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52290	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52300	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52301	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52305	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52310	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52315	T	Cystoscopy and treatment	0161	10.94	$530.45	$249.36	$106.09
52317	T	Remove bladder stone	0162	17.49	$848.04	$427.49	$169.61
52318	T	Remove bladder stone	0162	17.49	$848.04	$427.49	$169.61
52320	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52325	T	Cystoscopy, stone removal	0162	17.49	$848.04	$427.49	$169.61

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
52327	T	Cystoscopy, inject material	0161	10.94	$530.45	$249.36	$106.09
52330	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52332	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52334	T	Create passage to kidney	0162	17.49	$848.04	$427.49	$169.61
52335	T	Endoscopy of urinary tract	0162	17.49	$848.04	$427.49	$169.61
52336	T	Cystoscopy, stone removal	0162	17.49	$848.04	$427.49	$169.61
52337	T	Cystoscopy, stone removal	0162	17.49	$848.04	$427.49	$169.61
52338	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52339	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52340	T	Cystoscopy and treatment	0162	17.49	$848.04	$427.49	$169.61
52450	T	Incision of prostate	0162	17.49	$848.04	$427.49	$169.61
52500	T	Revision of bladder neck	0162	17.49	$848.04	$427.49	$169.61
52510	T	Dilation prostatic urethra	0161	10.94	$530.45	$249.36	$106.09
52601	T	Prostatectomy (TURP)	0163	28.98	$1,405.16	$792.58	$281.03
52606	T	Control postop bleeding	0162	17.49	$848.04	$427.49	$169.61
52612	T	Prostatectomy, first stage	0163	28.98	$1,405.16	$792.58	$281.03
52614	T	Prostatectomy, second stage	0163	28.98	$1,405.16	$792.58	$281.03
52620	T	Remove residual prostate	0163	28.98	$1,405.16	$792.58	$281.03
52630	T	Remove prostate regrowth	0163	28.98	$1,405.16	$792.58	$281.03
52640	T	Relieve bladder contracture	0162	17.49	$848.04	$427.49	$169.61
52647	T	Laser surgery of prostate	0163	28.98	$1,405.16	$792.58	$281.03
52648	T	Laser surgery of prostate	0163	28.98	$1,405.16	$792.58	$281.03
52700	T	Drainage of prostate abscess	0162	17.49	$848.04	$427.49	$169.61
53000	T	Incision of urethra	0166	10.17	$493.11	$218.73	$98.62
53010	T	Incision of urethra	0166	10.17	$493.11	$218.73	$98.62
53020	T	Incision of urethra	0166	10.17	$493.11	$218.73	$98.62
53025	T	Incision of urethra	0166	10.17	$493.11	$218.73	$98.62
53040	T	Drainage of urethra abscess	0166	10.17	$493.11	$218.73	$98.62
53060	T	Drainage of urethra abscess	0166	10.17	$493.11	$218.73	$98.62
53080	T	Drainage of urinary leakage	0166	10.17	$493.11	$218.73	$98.62
53085	C	Drainage of urinary leakage	.....	.....	.....	.....	.....
53200	T	Biopsy of urethra	0166	10.17	$493.11	$218.73	$98.62
53210	T	Removal of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53215	T	Removal of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53220	T	Treatment of urethra lesion	0168	24.94	$1,209.27	$536.11	$241.85
53230	T	Removal of urethra lesion	0168	24.94	$1,209.27	$536.11	$241.85
53235	T	Removal of urethra lesion	0168	24.94	$1,209.27	$536.11	$241.85
53240	T	Surgery for urethra pouch	0168	24.94	$1,209.27	$536.11	$241.85
53250	T	Removal of urethra gland	0166	10.17	$493.11	$218.73	$98.62
53260	T	Treatment of urethra lesion	0166	10.17	$493.11	$218.73	$98.62
53265	T	Treatment of urethra lesion	0166	10.17	$493.11	$218.73	$98.62
53270	T	Removal of urethra gland	0167	21.06	$1,021.14	$555.84	$204.23
53275	T	Repair of urethra defect	0166	10.17	$493.11	$218.73	$98.62
53400	T	Revise urethra, stage 1	0168	24.94	$1,209.27	$536.11	$241.85
53405	T	Revise urethra, stage 2	0168	24.94	$1,209.27	$536.11	$241.85
53410	T	Reconstruction of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53415	C	Reconstruction of urethra	.....	.....	.....	.....	.....
53420	T	Reconstruct urethra, stage 1	0168	24.94	$1,209.27	$536.11	$241.85
53425	T	Reconstruct urethra, stage 2	0168	24.94	$1,209.27	$536.11	$241.85
53430	T	Reconstruction of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53440	T	Correct bladder function	0182	52.11	$2,526.66	$1,525.05	$505.33
53442	T	Remove perineal prosthesis	0166	10.17	$493.11	$218.73	$98.62
53443	C	Reconstruction of urethra	.....	.....	.....	.....	.....
53445	T	Correct urine flow control	0182	52.11	$2,526.66	$1,525.05	$505.33
53447	T	Remove artificial sphincter	0168	24.94	$1,209.27	$536.11	$241.85
53449	T	Correct artificial sphincter	0168	24.94	$1,209.27	$536.11	$241.85
53450	T	Revision of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53460	T	Revision of urethra	0168	24.94	$1,209.27	$536.11	$241.85
53502	T	Repair of urethra injury	0166	10.17	$493.11	$218.73	$98.62
53505	T	Repair of urethra injury	0167	21.06	$1,021.14	$555.84	$204.23
53510	T	Repair of urethra injury	0166	10.17	$493.11	$218.73	$98.62
53515	T	Repair of urethra injury	0168	24.94	$1,209.27	$536.11	$241.85
53520	T	Repair of urethra defect	0168	24.94	$1,209.27	$536.11	$241.85
53600	T	Dilate urethra stricture	0164	2.17	$105.23	$33.03	$21.05
53601	T	Dilate urethra stricture	0164	2.17	$105.23	$33.03	$21.05
53605	T	Dilate urethra stricture	0161	10.94	$530.45	$249.36	$106.09
53620	T	Dilate urethra stricture	0165	3.89	$188.61	$91.76	$37.72
53621	T	Dilate urethra stricture	0164	2.17	$105.23	$33.03	$21.05
53660	T	Dilation of urethra	0164	2.17	$105.23	$33.03	$21.05
53661	T	Dilation of urethra	0164	2.17	$105.23	$33.03	$21.05
53665	T	Dilation of urethra	0166	10.17	$493.11	$218.73	$98.62
53670	N	Insert urinary catheter	.....	.....	.....	.....	.....
53675	T	Insert urinary catheter	0164	2.17	$105.23	$33.03	$21.05

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[2]53850	T	Prostatic microwave thermotx	0980	38.67	$1,875.00	.....	$375.00
[2]53852	T	Prostatic rf thermotx	0980	38.67	$1,875.00	.....	$375.00
53899	T	Urology surgery procedure	0165	3.89	$188.61	$91.76	$37.72
54000	T	Slitting of prepuce	0166	10.17	$493.11	$218.73	$98.62
54001	T	Slitting of prepuce	0166	10.17	$493.11	$218.73	$98.62
54015	T	Drain penis lesion	0008	6.15	$298.20	$113.67	$59.64
54050	T	Destruction, penis lesion(s)	0013	0.91	$44.12	$17.66	$8.82
54055	T	Destruction, penis lesion(s)	0016	3.53	$171.16	$74.67	$34.23
54056	T	Cryosurgery, penis lesion(s)	0013	0.91	$44.12	$17.66	$8.82
54057	T	Laser surg, penis lesion(s)	0017	12.45	$603.66	$289.16	$120.73
54060	T	Excision of penis lesion(s)	0017	12.45	$603.66	$289.16	$120.73
54065	T	Destruction, penis lesion(s)	0017	12.45	$603.66	$289.16	$120.73
54100	T	Biopsy of penis	0020	6.51	$315.65	$130.53	$63.13
54105	T	Biopsy of penis	0021	10.49	$508.63	$236.51	$101.73
54110	T	Treatment of penis lesion	0181	32.37	$1,569.53	$906.36	$313.91
54111	T	Treat penis lesion, graft	0181	32.37	$1,569.53	$906.36	$313.91
54112	T	Treat penis lesion, graft	0181	32.37	$1,569.53	$906.36	$313.91
54115	T	Treatment of penis lesion	0008	6.15	$298.20	$113.67	$59.64
54120	T	Partial removal of penis	0181	32.37	$1,569.53	$906.36	$313.91
54125	C	Removal of penis	.....	.....	.....	.....	.....
54130	C	Remove penis & nodes	.....	.....	.....	.....	.....
54135	C	Remove penis & nodes	.....	.....	.....	.....	.....
54150	T	Circumcision	0180	13.62	$660.39	$304.87	$132.08
54152	T	Circumcision	0180	13.62	$660.39	$304.87	$132.08
54160	T	Circumcision	0180	13.62	$660.39	$304.87	$132.08
54161	T	Circumcision	0180	13.62	$660.39	$304.87	$132.08
54200	T	Treatment of penis lesion	0165	3.89	$188.61	$91.76	$37.72
54205	T	Treatment of penis lesion	0181	32.37	$1,569.53	$906.36	$313.91
54220	T	Treatment of penis lesion	0165	3.89	$188.61	$91.76	$37.72
54230	N	Prepare penis study	.....	.....	.....	.....	.....
54231	T	Dynamic cavernosometry	0165	3.89	$188.61	$91.76	$37.72
54235	T	Penile injection	0164	2.17	$105.23	$33.03	$21.05
54240	T	Penis study	0164	2.17	$105.23	$33.03	$21.05
54250	T	Penis study	0165	3.89	$188.61	$91.76	$37.72
54300	T	Revision of penis	0181	32.37	$1,569.53	$906.36	$313.91
54304	T	Revision of penis	0181	32.37	$1,569.53	$906.36	$313.91
54308	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54312	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54316	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54318	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54322	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54324	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54326	T	Reconstruction of urethra	0181	32.37	$1,569.53	$906.36	$313.91
54328	T	Revise penis/urethra	0181	32.37	$1,569.53	$906.36	$313.91
54332	C	Revise penis/urethra	.....	.....	.....	.....	.....
54336	C	Revise penis/urethra	.....	.....	.....	.....	.....
54340	T	Secondary urethral surgery	0181	32.37	$1,569.53	$906.36	$313.91
54344	T	Secondary urethral surgery	0181	32.37	$1,569.53	$906.36	$313.91
54348	T	Secondary urethral surgery	0181	32.37	$1,569.53	$906.36	$313.91
54352	T	Reconstruct urethra/penis	0181	32.37	$1,569.53	$906.36	$313.91
54360	T	Penis plastic surgery	0181	32.37	$1,569.53	$906.36	$313.91
54380	T	Repair penis	0181	32.37	$1,569.53	$906.36	$313.91
54385	T	Repair penis	0181	32.37	$1,569.53	$906.36	$313.91
54390	C	Repair penis and bladder	.....	.....	.....	.....	.....
54400	T	Insert semi-rigid prosthesis	0182	52.11	$2,526.66	$1,525.05	$505.33
54401	T	Insert self-contd prosthesis	0182	52.11	$2,526.66	$1,525.05	$505.33
54402	T	Remove penis prosthesis	0181	32.37	$1,569.53	$906.36	$313.91
54405	T	Insert multi-comp prosthesis	0182	52.11	$2,526.66	$1,525.05	$505.33
54407	T	Remove multi-comp prosthesis	0181	32.37	$1,569.53	$906.36	$313.91
54409	T	Revise penis prosthesis	0181	32.37	$1,569.53	$906.36	$313.91
54420	T	Revision of penis	0181	32.37	$1,569.53	$906.36	$313.91
54430	C	Revision of penis	.....	.....	.....	.....	.....
54435	T	Revision of penis	0181	32.37	$1,569.53	$906.36	$313.91
54440	T	Repair of penis	0181	32.37	$1,569.53	$906.36	$313.91
54450	T	Preputial stretching	0165	3.89	$188.61	$91.76	$37.72
54500	T	Biopsy of testis	0005	5.41	$262.32	$119.75	$52.46
54505	T	Biopsy of testis	0183	18.26	$885.37	$448.94	$177.07
54510	T	Removal of testis lesion	0183	18.26	$885.37	$448.94	$177.07
54520	T	Removal of testis	0183	18.26	$885.37	$448.94	$177.07
54530	T	Removal of testis	0154	22.43	$1,087.57	$556.98	$217.51
54535	C	Extensive testis surgery	.....	.....	.....	.....	.....
54550	T	Exploration for testis	0154	22.43	$1,087.57	$556.98	$217.51
54560	C	Exploration for testis	.....	.....	.....	.....	.....

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
54600	T	Reduce testis torsion	0183	18.26	$885.37	$448.94	$177.07
54620	T	Suspension of testis	0183	18.26	$885.37	$448.94	$177.07
54640	T	Suspension of testis	0154	22.43	$1,087.57	$556.98	$217.51
54650	C	Orchiopexy (Fowler-Stephens)					
54660	T	Revision of testis	0183	18.26	$885.37	$448.94	$177.07
54670	T	Repair testis injury	0183	18.26	$885.37	$448.94	$177.07
54680	T	Relocation of testis(es)	0183	18.26	$885.37	$448.94	$177.07
54690	T	Laparoscopy, orchiectomy	0131	41.81	$2,027.24	$1,089.88	$405.45
54692	T	Laparoscopy, orchiopexy	0132	48.91	$2,371.50	$1,239.22	$474.30
54699	T	Laparoscope proc, testis	0130	25.36	$1,229.63	$659.53	$245.93
54700	T	Drainage of scrotum	0183	18.26	$885.37	$448.94	$177.07
54800	T	Biopsy of epididymis	0004	1.84	$89.22	$32.57	$17.84
54820	T	Exploration of epididymis	0183	18.26	$885.37	$448.94	$177.07
54830	T	Remove epididymis lesion	0183	18.26	$885.37	$448.94	$177.07
54840	T	Remove epididymis lesion	0183	18.26	$885.37	$448.94	$177.07
54860	T	Removal of epididymis	0183	18.26	$885.37	$448.94	$177.07
54861	T	Removal of epididymis	0183	18.26	$885.37	$448.94	$177.07
54900	T	Fusion of spermatic ducts	0183	18.26	$885.37	$448.94	$177.07
54901	T	Fusion of spermatic ducts	0183	18.26	$885.37	$448.94	$177.07
55000	T	Drainage of hydrocele	0004	1.84	$89.22	$32.57	$17.84
55040	T	Removal of hydrocele	0154	22.43	$1,087.57	$556.98	$217.51
55041	T	Removal of hydroceles	0154	22.43	$1,087.57	$556.98	$217.51
55060	T	Repair of hydrocele	0183	18.26	$885.37	$448.94	$177.07
55100	T	Drainage of scrotum abscess	0008	6.15	$298.20	$113.67	$59.64
55110	T	Explore scrotum	0183	18.26	$885.37	$448.94	$177.07
55120	T	Removal of scrotum lesion	0183	18.26	$885.37	$448.94	$177.07
55150	T	Removal of scrotum	0183	18.26	$885.37	$448.94	$177.07
55175	T	Revision of scrotum	0183	18.26	$885.37	$448.94	$177.07
55180	T	Revision of scrotum	0183	18.26	$885.37	$448.94	$177.07
55200	T	Incision of sperm duct	0183	18.26	$885.37	$448.94	$177.07
55250	T	Removal of sperm duct(s)	0183	18.26	$885.37	$448.94	$177.07
55300	N	Prepare, sperm duct x-ray					
55400	T	Repair of sperm duct	0183	18.26	$885.37	$448.94	$177.07
55450	T	Ligation of sperm duct	0183	18.26	$885.37	$448.94	$177.07
55500	T	Removal of hydrocele	0183	18.26	$885.37	$448.94	$177.07
55520	T	Removal of sperm cord lesion	0183	18.26	$885.37	$448.94	$177.07
55530	T	Revise spermatic cord veins	0183	18.26	$885.37	$448.94	$177.07
55535	T	Revise spermatic cord veins	0154	22.43	$1,087.57	$556.98	$217.51
55540	T	Revise hernia & sperm veins	0154	22.43	$1,087.57	$556.98	$217.51
55550	T	Laparo ligate spermatic vein	0131	41.81	$2,027.24	$1,089.88	$405.45
55559	T	Laparo proc, spermatic cord	0130	25.36	$1,229.63	$659.53	$245.93
55600	C	Incise sperm duct pouch					
55605	C	Incise sperm duct pouch					
55650	C	Remove sperm duct pouch					
55680	T	Remove sperm pouch lesion	0183	18.26	$885.37	$448.94	$177.07
55700	T	Biopsy of prostate	0184	4.94	$239.53	$122.96	$47.91
55705	T	Biopsy of prostate	0184	4.94	$239.53	$122.96	$47.91
55720	T	Drainage of prostate abscess	0162	17.49	$848.04	$427.49	$169.61
55725	T	Drainage of prostate abscess	0162	17.49	$848.04	$427.49	$169.61
55801	C	Removal of prostate					
55810	C	Extensive prostate surgery					
55812	C	Extensive prostate surgery					
55815	C	Extensive prostate surgery					
55821	C	Removal of prostate					
55831	C	Removal of prostate					
55840	C	Extensive prostate surgery					
55842	C	Extensive prostate surgery					
55845	C	Extensive prostate surgery					
55859	T	Percut/needle insert, pros	0162	17.49	$848.04	$427.49	$169.61
55860	C	Surgical exposure, prostate					
55862	C	Extensive prostate surgery					
55865	C	Extensive prostate surgery					
55870	T	Electroejaculation	0197	2.40	$116.37	$49.55	$23.27
55899	T	Genital surgery procedure	0164	2.17	$105.23	$33.03	$21.05
55970	E	Sex transformation, M to F					
55980	E	Sex transformation, F to M					
56405	T	I & D of vulva/perineum	0192	2.38	$115.40	$35.33	$23.08
56420	T	Drainage of gland abscess	0192	2.38	$115.40	$35.33	$23.08
56440	T	Surgery for vulva lesion	0194	16.21	$785.98	$395.94	$157.20
56441	T	Lysis of labial lesion(s)	0193	8.93	$432.99	$171.13	$86.60
56501	T	Destruction, vulva lesion(s)	0016	3.53	$171.16	$74.67	$34.23
56515	T	Destruction, vulva lesion(s)	0017	12.45	$603.66	$289.16	$120.73
56605	T	Biopsy of vulva/perineum	0019	4.00	$193.95	$78.91	$38.79

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
56606	T	Biopsy of vulva/perineum	0019	4.00	$193.95	$78.91	$38.79
56620	T	Partial removal of vulva	0195	18.68	$905.74	$483.80	$181.15
56625	T	Complete removal of vulva	0195	18.68	$905.74	$483.80	$181.15
56630	C	Extensive vulva surgery					
56631	C	Extensive vulva surgery					
56632	C	Extensive vulva surgery					
56633	C	Extensive vulva surgery					
56634	C	Extensive vulva surgery					
56637	C	Extensive vulva surgery					
56640	C	Extensive vulva surgery					
56700	T	Partial removal of hymen	0194	16.21	$785.98	$395.94	$157.20
56720	T	Incision of hymen	0193	8.93	$432.99	$171.13	$86.60
56740	T	Remove vagina gland lesion	0194	16.21	$785.98	$395.94	$157.20
56800	T	Repair of vagina	0194	16.21	$785.98	$395.94	$157.20
56805	C	Repair clitoris					
56810	T	Repair of perineum	0194	16.21	$785.98	$395.94	$157.20
57000	T	Exploration of vagina	0194	16.21	$785.98	$395.94	$157.20
57010	T	Drainage of pelvic abscess	0194	16.21	$785.98	$395.94	$157.20
57020	T	Drainage of pelvic fluid	0193	8.93	$432.99	$171.13	$86.60
57061	T	Destruction vagina lesion(s)	0194	16.21	$785.98	$395.94	$157.20
57065	T	Destruction vagina lesion(s)	0194	16.21	$785.98	$395.94	$157.20
57100	T	Biopsy of vagina	0192	2.38	$115.40	$35.33	$23.08
57105	T	Biopsy of vagina	0194	16.21	$785.98	$395.94	$157.20
57106	T	Remove vagina wall, partial	0194	16.21	$785.98	$395.94	$157.20
57107	T	Remove vagina tissue, part	0194	16.21	$785.98	$395.94	$157.20
57109	T	Vaginectomy partial w/nodes	0194	16.21	$785.98	$395.94	$157.20
57110	C	Remove vagina wall, complete					
57111	C	Remove vagina tissue, compl					
57112	C	Vaginectomy w/nodes, compl					
57120	C	Closure of vagina					
57130	T	Remove vagina lesion	0194	16.21	$785.98	$395.94	$157.20
57135	T	Remove vagina lesion	0194	16.21	$785.98	$395.94	$157.20
57150	T	Treat vagina infection	0192	2.38	$115.40	$35.33	$23.08
57160	T	Insert pessary/other device	0191	1.19	$57.70	$17.43	$11.54
57170	T	Fitting of diaphragm/cap	0191	1.19	$57.70	$17.43	$11.54
57180	T	Treat vaginal bleeding	0192	2.38	$115.40	$35.33	$23.08
57200	T	Repair of vagina	0194	16.21	$785.98	$395.94	$157.20
57210	T	Repair vagina/perineum	0194	16.21	$785.98	$395.94	$157.20
57220	T	Revision of urethra	0195	18.68	$905.74	$483.80	$181.15
57230	T	Repair of urethral lesion	0194	16.21	$785.98	$395.94	$157.20
57240	T	Repair bladder & vagina	0195	18.68	$905.74	$483.80	$181.15
57250	T	Repair rectum & vagina	0195	18.68	$905.74	$483.80	$181.15
57260	T	Repair of vagina	0195	18.68	$905.74	$483.80	$181.15
57265	T	Extensive repair of vagina	0195	18.68	$905.74	$483.80	$181.15
57268	T	Repair of bowel bulge	0195	18.68	$905.74	$483.80	$181.15
57270	C	Repair of bowel pouch					
57280	C	Suspension of vagina					
57282	C	Repair of vaginal prolapse					
57284	T	Repair paravaginal defect	0195	18.68	$905.74	$483.80	$181.15
57288	T	Repair bladder defect	0195	18.68	$905.74	$483.80	$181.15
57289	T	Repair bladder & vagina	0195	18.68	$905.74	$483.80	$181.15
57291	T	Construction of vagina	0195	18.68	$905.74	$483.80	$181.15
57292	C	Construct vagina with graft					
57300	T	Repair rectum-vagina fistula	0195	18.68	$905.74	$483.80	$181.15
57305	C	Repair rectum-vagina fistula					
57307	C	Fistula repair & colostomy					
57308	C	Fistula repair, transperine					
57310	C	Repair urethrovaginal lesion					
57311	C	Repair urethrovaginal lesion					
57320	C	Repair bladder-vagina lesion					
57330	C	Repair bladder-vagina lesion					
57335	C	Repair vagina					
57400	T	Dilation of vagina	0194	16.21	$785.98	$395.94	$157.20
57410	T	Pelvic examination	0194	16.21	$785.98	$395.94	$157.20
57415	T	Remove vaginal foreign body	0194	16.21	$785.98	$395.94	$157.20
57452	T	Examination of vagina	0191	1.19	$57.70	$17.43	$11.54
57454	T	Vagina examination & biopsy	0192	2.38	$115.40	$35.33	$23.08
57460	T	Cervix excision	0193	8.93	$432.99	$171.13	$86.60
57500	T	Biopsy of cervix	0193	8.93	$432.99	$171.13	$86.60
57505	T	Endocervical curettage	0192	2.38	$115.40	$35.33	$23.08
57510	T	Cauterization of cervix	0193	8.93	$432.99	$171.13	$86.60
57511	T	Cryocautery of cervix	0192	2.38	$115.40	$35.33	$23.08
57513	T	Laser surgery of cervix	0193	8.93	$432.99	$171.13	$86.60

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
57520	T	Conization of cervix	0194	16.21	$785.98	$395.94	$157.20
57522	T	Conization of cervix	0195	18.68	$905.74	$483.80	$181.15
57530	T	Removal of cervix	0195	18.68	$905.74	$483.80	$181.15
57531	C	Removal of cervix, radical					
57540	C	Removal of residual cervix					
57545	C	Remove cervix/repair pelvis					
57550	T	Removal of residual cervix	0195	18.68	$905.74	$483.80	$181.15
57555	T	Remove cervix/repair vagina	0195	18.68	$905.74	$483.80	$181.15
57556	T	Remove cervix, repair bowel	0195	18.68	$905.74	$483.80	$181.15
57700	T	Revision of cervix	0194	16.21	$785.98	$395.94	$157.20
57720	T	Revision of cervix	0194	16.21	$785.98	$395.94	$157.20
57800	T	Dilation of cervical canal	0193	8.93	$432.99	$171.13	$86.60
57820	T	D & c of residual cervix	0196	14.47	$701.61	$357.98	$140.32
58100	T	Biopsy of uterus lining	0191	1.19	$57.70	$17.43	$11.54
58120	T	Dilation and curettage	0196	14.47	$701.61	$357.98	$140.32
58140	C	Removal of uterus lesion					
58145	T	Removal of uterus lesion	0195	18.68	$905.74	$483.80	$181.15
58150	C	Total hysterectomy					
58152	C	Total hysterectomy					
58180	C	Partial hysterectomy					
58200	C	Extensive hysterectomy					
58210	C	Extensive hysterectomy					
58240	C	Removal of pelvis contents					
58260	C	Vaginal hysterectomy					
58262	C	Vaginal hysterectomy					
58263	C	Vaginal hysterectomy					
58267	C	Hysterectomy & vagina repair					
58270	C	Hysterectomy & vagina repair					
58275	C	Hysterectomy/revise vagina					
58280	C	Hysterectomy/revise vagina					
58285	C	Extensive hysterectomy					
58300	E	Insert intrauterine device					
58301	T	Remove intrauterine device	0191	1.19	$57.70	$17.43	$11.54
58321	T	Artificial insemination	0197	2.40	$116.37	$49.55	$23.27
58322	T	Artificial insemination	0197	2.40	$116.37	$49.55	$23.27
58323	T	Sperm washing	0197	2.40	$116.37	$49.55	$23.27
58340	N	Catheter for hysterography					
58345	T	Reopen fallopian tube	0194	16.21	$785.98	$395.94	$157.20
58350	T	Reopen fallopian tube	0194	16.21	$785.98	$395.94	$157.20
58400	C	Suspension of uterus					
58410	C	Suspension of uterus					
58520	C	Repair of ruptured uterus					
58540	C	Revision of uterus					
58550	T	Laparo-asst vag hysterectomy	0132	48.91	$2,371.50	$1,239.22	$474.30
58551	T	Laparoscopy, remove myoma	0131	41.81	$2,027.24	$1,089.88	$405.45
58555	T	Hysteroscopy, dx, sep proc	0191	1.19	$57.70	$17.43	$11.54
58558	T	Hysteroscopy, biopsy	0190	17.85	$865.49	$443.89	$173.10
58559	T	Hysteroscopy, lysis	0190	17.85	$865.49	$443.89	$173.10
58560	T	Hysteroscopy, resect septum	0190	17.85	$865.49	$443.89	$173.10
58561	T	Hysteroscopy, remove myoma	0190	17.85	$865.49	$443.89	$173.10
58562	T	Hysteroscopy, remove fb	0190	17.85	$865.49	$443.89	$173.10
58563	T	Hysteroscopy, ablation	0190	17.85	$865.49	$443.89	$173.10
58578	T	Laparo proc, uterus	0190	17.85	$865.49	$443.89	$173.10
58579	T	Hysteroscope procedure	0190	17.85	$865.49	$443.89	$173.10
58600	C	Division of fallopian tube					
58605	C	Division of fallopian tube					
58611	C	Ligate oviduct(s) add-on					
58615	C	Occlude fallopian tube(s)					
58660	T	Laparoscopy, lysis	0131	41.81	$2,027.24	$1,089.88	$405.45
58661	T	Laparoscopy, remove adnexa	0131	41.81	$2,027.24	$1,089.88	$405.45
58662	T	Laparoscopy, excise lesions	0131	41.81	$2,027.24	$1,089.88	$405.45
58670	T	Laparoscopy, tubal cautery	0131	41.81	$2,027.24	$1,089.88	$405.45
58671	T	Laparoscopy, tubal block	0131	41.81	$2,027.24	$1,089.88	$405.45
58672	T	Laparoscopy, fimbrioplasty	0131	41.81	$2,027.24	$1,089.88	$405.45
58673	T	Laparoscopy, salpingostomy	0131	41.81	$2,027.24	$1,089.88	$405.45
58679	T	Laparo proc, oviduct-ovary	0130	25.36	$1,229.63	$659.53	$245.93
58700	C	Removal of fallopian tube					
58720	C	Removal of ovary/tube(s)					
58740	C	Revise fallopian tube(s)					
58750	C	Repair oviduct					
58752	C	Revise ovarian tube(s)					
58760	C	Remove tubal obstruction					
58770	C	Create new tubal opening					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
58800	T	Drainage of ovarian cyst(s)	0195	18.68	$905.74	$483.80	$181.15
58805	C	Drainage of ovarian cyst(s)					
58820	T	Drain ovary abscess, open	0195	18.68	$905.74	$483.80	$181.15
58822	C	Drain ovary abscess, percut					
58823	C	Drain pelvic abscess, percut					
58825	C	Transposition, ovary(s)					
58900	T	Biopsy of ovary(s)	0195	18.68	$905.74	$483.80	$181.15
58920	T	Partial removal of ovary(s)	0195	18.68	$905.74	$483.80	$181.15
58925	T	Removal of ovarian cyst(s)	0195	18.68	$905.74	$483.80	$181.15
58940	C	Removal of ovary(s)					
58943	C	Removal of ovary(s)					
58950	C	Resect ovarian malignancy					
58951	C	Resect ovarian malignancy					
58952	C	Resect ovarian malignancy					
58960	C	Exploration of abdomen					
58970	T	Retrieval of oocyte	0194	16.21	$785.98	$395.94	$157.20
58974	T	Transfer of embryo	0197	2.40	$116.37	$49.55	$23.27
58976	T	Transfer of embryo	0197	2.40	$116.37	$49.55	$23.27
58999	T	Genital surgery procedure	0019	4.00	$193.95	$78.91	$38.79
59000	T	Amniocentesis	0198	1.34	$64.97	$33.03	$12.99
59012	T	Fetal cord puncture, prenatal	0198	1.34	$64.97	$33.03	$12.99
59015	T	Chorion biopsy	0198	1.34	$64.97	$33.03	$12.99
59020	T	Fetal contract stress test	0198	1.34	$64.97	$33.03	$12.99
59025	T	Fetal non-stress test	0198	1.34	$64.97	$33.03	$12.99
59030	T	Fetal scalp blood sample	0198	1.34	$64.97	$33.03	$12.99
59050	T	Fetal monitor w/report	0198	1.34	$64.97	$33.03	$12.99
59051	E	Fetal monitor/interpret only					
59100	C	Remove uterus lesion					
59120	C	Treat ectopic pregnancy					
59121	C	Treat ectopic pregnancy					
59130	C	Treat ectopic pregnancy					
59135	C	Treat ectopic pregnancy					
59136	C	Treat ectopic pregnancy					
59140	C	Treat ectopic pregnancy					
59150	T	Treat ectopic pregnancy	0131	41.81	$2,027.24	$1,089.88	$405.45
59151	T	Treat ectopic pregnancy	0131	41.81	$2,027.24	$1,089.88	$405.45
59160	T	D & c after delivery	0196	14.47	$701.61	$357.98	$140.32
59200	T	Insert cervical dilator	0191	1.19	$57.70	$17.43	$11.54
59300	T	Episiotomy or vaginal repair	0194	16.21	$785.98	$395.94	$157.20
59320	T	Revision of cervix	0194	16.21	$785.98	$395.94	$157.20
59325	C	Revision of cervix					
59350	C	Repair of uterus					
59400	E	Obstetrical care					
59409	T	Obstetrical care	0199	11.20	$543.06	$157.83	$108.61
59410	E	Obstetrical care					
59412	T	Antepartum manipulation	0199	11.20	$543.06	$157.83	$108.61
59414	T	Deliver placenta	0199	11.20	$543.06	$157.83	$108.61
59425	E	Antepartum care only					
59426	E	Antepartum care only					
59430	E	Care after delivery					
59510	E	Cesarean delivery					
59514	C	Cesarean delivery only					
59515	E	Cesarean delivery					
59525	C	Remove uterus after cesarean					
59610	E	Vbac delivery					
59612	T	Vbac delivery only	0199	11.20	$543.06	$157.83	$108.61
59614	E	Vbac care after delivery					
59618	E	Attempted vbac delivery					
59620	C	Attempted vbac delivery only					
59622	E	Attempted vbac after care					
59812	T	Treatment of miscarriage	0201	13.00	$630.33	$329.65	$126.07
59820	T	Care of miscarriage	0201	13.00	$630.33	$329.65	$126.07
59821	T	Treatment of miscarriage	0201	13.00	$630.33	$329.65	$126.07
59830	C	Treat uterus infection					
59840	T	Abortion	0200	13.89	$673.49	$373.23	$134.70
59841	T	Abortion	0200	13.89	$673.49	$373.23	$134.70
59850	C	Abortion					
59851	C	Abortion					
59852	C	Abortion					
59855	C	Abortion					
59856	C	Abortion					
59857	C	Abortion					
59866	C	Abortion (mpr)					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
59870	T	Evacuate mole of uterus	0201	13.00	$630.33	$329.65	$126.07
59871	T	Remove cerclage suture	0194	16.21	$785.98	$395.94	$157.20
59898	T	Laparo proc, ob care/deliver	0130	25.36	$1,229.63	$659.53	$245.93
59899	T	Maternity care procedure	0198	1.34	$64.97	$33.03	$12.99
60000	T	Drain thyroid/tongue cyst	0253	12.02	$582.81	$284.00	$116.56
60001	T	Aspirate/inject thyriod cyst	0002	0.62	$30.06	$17.66	$6.01
60100	T	Biopsy of thyroid	0004	1.84	$89.22	$32.57	$17.84
60200	T	Remove thyroid lesion	0114	19.56	$948.41	$493.78	$189.68
60210	T	Partial thyroid excision	0114	19.56	$948.41	$493.78	$189.68
60212	C	Parital thyroid excision					
60220	T	Partial removal of thyroid	0114	19.56	$948.41	$493.78	$189.68
60225	T	Partial removal of thyroid	0114	19.56	$948.41	$493.78	$189.68
60240	T	Removal of thyroid	0114	19.56	$948.41	$493.78	$189.68
60252	C	Removal of thyroid					
60254	C	Extensive thyroid surgery					
60260	C	Repeat thyroid surgery					
60270	C	Removal of thyroid					
60271	C	Removal of thyroid					
60280	T	Remove thyroid duct lesion	0114	19.56	$948.41	$493.78	$189.68
60281	T	Remove thyroid duct lesion	0114	19.56	$948.41	$493.78	$189.68
60500	T	Explore parathyroid glands	0256	25.40	$1,231.57	$623.05	$246.31
60502	C	Re-explore parathyroids					
60505	C	Explore parathyroid glands					
60512	C	Autotransplant parathyroid					
60520	C	Removal of thymus gland					
60521	C	Removal of thymus gland					
60522	C	Removal of thymus gland					
60540	C	Explore adrenal gland					
60545	C	Explore adrenal gland					
60600	C	Remove carotid body lesion					
60605	C	Remove carotid body lesion					
60650	C	Laparoscopy adrenalectomy					
60659	T	Laparo proc, endocrine	0130	25.36	$1,229.63	$659.53	$245.93
60699	T	Endocrine surgery procedure	0004	1.84	$89.22	$32.57	$17.84
61000	T	Remove cranial cavity fluid	0212	3.64	$176.49	$88.78	$35.30
61001	T	Remove cranial cavity fluid	0212	3.64	$176.49	$88.78	$35.30
61020	T	Remove brain cavity fluid	0212	3.64	$176.49	$88.78	$35.30
61026	T	Injection into brain canal	0212	3.64	$176.49	$88.78	$35.30
61050	T	Remove brain canal fluid	0212	3.64	$176.49	$88.78	$35.30
61055	T	Injection into brain canal	0212	3.64	$176.49	$88.78	$35.30
61070	T	Brain canal shunt procedure	0212	3.64	$176.49	$88.78	$35.30
61105	C	Twist drill hole					
61107	C	Drill skull for implantation					
61108	C	Drill skull for drainage					
61120	C	Burr hole for puncture					
61140	C	Pierce skull for biopsy					
61150	C	Pierce skull for drainage					
61151	C	Pierce skull for drainage					
61154	C	Pierce skull & remove clot					
61156	C	Pierce skull for drainage					
61210	C	Pierce skull, implant device					
61215	T	Insert brain-fluid device	0222	25.48	$1,235.45	$780.07	$247.09
61250	C	Pierce skull & explore					
61253	C	Pierce skull & explore					
61304	C	Open skull for exploration					
61305	C	Open skull for exploration					
61312	C	Open skull for drainage					
61313	C	Open skull for drainage					
61314	C	Open skull for drainage					
61315	C	Open skull for drainage					
61320	C	Open skull for drainage					
61321	C	Open skull for drainage					
61330	T	Decompress eye socket	0256	25.40	$1,231.57	$623.05	$246.31
61332	C	Explore/biopsy eye socket					
61333	C	Explore orbit/remove lesion					
61334	C	Explore orbit/remove object					
61340	C	Relieve cranial pressure					
61343	C	Incise skull (press relief)					
61345	C	Relieve cranial pressure					
61440	C	Incise skull for surgery					
61450	C	Incise skull for surgery					
61458	C	Incise skull for brain wound					
61460	C	Incise skull for surgery					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
61470	C	Incise skull for surgery					
61480	C	Incise skull for surgery					
61490	C	Incise skull for surgery					
61500	C	Removal of skull lesion					
61501	C	Remove infected skull bone					
61510	C	Removal of brain lesion					
61512	C	Remove brain lining lesion					
61514	C	Removal of brain abscess					
61516	C	Removal of brain lesion					
61518	C	Removal of brain lesion					
61519	C	Remove brain lining lesion					
61520	C	Removal of brain lesion					
61521	C	Removal of brain lesion					
61522	C	Removal of brain abscess					
61524	C	Removal of brain lesion					
61526	C	Removal of brain lesion					
61530	C	Removal of brain lesion					
61531	C	Implant brain electrodes					
61533	C	Implant brain electrodes					
61534	C	Removal of brain lesion					
61535	C	Remove brain electrodes					
61536	C	Removal of brain lesion					
61538	C	Removal of brain tissue					
61539	C	Removal of brain tissue					
61541	C	Incision of brain tissue					
61542	C	Removal of brain tissue					
61543	C	Removal of brain tissue					
61544	C	Remove & treat brain lesion					
61545	C	Excision of brain tumor					
61546	C	Removal of pituitary gland					
61548	C	Removal of pituitary gland					
61550	C	Release of skull seams					
61552	C	Release of skull seams					
61556	C	Incise skull/sutures					
61557	C	Incise skull/sutures					
61558	C	Excision of skull/sutures					
61559	C	Excision of skull/sutures					
61563	C	Excision of skull tumor					
61564	C	Excision of skull tumor					
61570	C	Remove foreign body, brain					
61571	C	Incise skull for brain wound					
61575	C	Skull base/brainstem surgery					
61576	C	Skull base/brainstem surgery					
61580	C	Craniofacial approach, skull					
61581	C	Craniofacial approach, skull					
61582	C	Craniofacial approach, skull					
61583	C	Craniofacial approach, skull					
61584	C	Orbitocranial approach/skull					
61585	C	Orbitocranial approach/skull					
61586	C	Resect nasopharynx, skull					
61590	C	Infratemporal approach/skull					
61591	C	Infratemporal approach/skull					
61592	C	Orbitocranial approach/skull					
61595	C	Transtemporal approach/skull					
61596	C	Transcochlear approach/skull					
61597	C	Transcondylar approach/skull					
61598	C	Transpetrosal approach/skull					
61600	C	Resect/excise cranial lesion					
61601	C	Resect/excise cranial lesion					
61605	C	Resect/excise cranial lesion					
61606	C	Resect/excise cranial lesion					
61607	C	Resect/excise cranial lesion					
61608	C	Resect/excise cranial lesion					
61609	C	Transect artery, sinus					
61610	C	Transect artery, sinus					
61611	C	Transect artery, sinus					
61612	C	Transect artery, sinus					
61613	C	Remove aneurysm, sinus					
61615	C	Resect/excise lesion, skull					
61616	C	Resect/excise lesion, skull					
61618	C	Repair dura					
61619	C	Repair dura					
61624	C	Occlusion/embolization cath					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
61626	C	Occlusion/embolization cath					
61680	C	Intracranial vessel surgery					
61682	C	Intracranial vessel surgery					
61684	C	Intracranial vessel surgery					
61686	C	Intracranial vessel surgery					
61690	C	Intracranial vessel surgery					
61692	C	Intracranial vessel surgery					
61700	C	Inner skull vessel surgery					
61702	C	Inner skull vessel surgery					
61703	C	Clamp neck artery					
61705	C	Revise circulation to head					
61708	C	Revise circulation to head					
61710	C	Revise circulation to head					
61711	C	Fusion of skull arteries					
61720	C	Incise skull/brain surgery					
61735	C	Incise skull/brain surgery					
61750	C	Incise skull/brain biopsy					
61751	C	Brain biopsy w/ct/mr guide					
61760	C	Implant brain electrodes					
61770	C	Incise skull for treatment					
61790	T	Treat trigeminal nerve	0220	13.96	$676.88	$326.21	$135.38
61791	C	Treat trigeminal tract					
61793	E	Focus radiation beam					
61795	C	Brain surgery using computer					
61850	C	Implant neuroelectrodes					
61860	C	Implant neuroelectrodes					
61862	C	Implant neurostimul, subcort					
61870	C	Implant neuroelectrodes					
61875	C	Implant neuroelectrodes					
61880	C	Revise/remove neuroelectrode					
61885	T	Implant neurostim one array	0222	25.48	$1,235.45	$780.07	$247.09
61886	C	Implant neurostim arrays					
61888	C	Revise/remove neuroreceiver					
62000	C	Treat skull fracture					
62005	C	Treat skull fracture					
62010	C	Treatment of head injury					
62100	C	Repair brain fluid leakage					
62115	C	Reduction of skull defect					
62116	C	Reduction of skull defect					
62117	C	Reduction of skull defect					
62120	C	Repair skull cavity lesion					
62121	C	Incise skull repair					
62140	C	Repair of skull defect					
62141	C	Repair of skull defect					
62142	C	Remove skull plate/flap					
62143	C	Replace skull plate/flap					
62145	C	Repair of skull & brain					
62146	C	Repair of skull with graft					
62147	C	Repair of skull with graft					
62180	C	Establish brain cavity shunt					
62190	C	Establish brain cavity shunt					
62192	C	Establish brain cavity shunt					
62194	T	Replace/irrigate catheter	0121	2.36	$114.43	$52.53	$22.89
62200	C	Establish brain cavity shunt					
62201	C	Establish brain cavity shunt					
62220	C	Establish brain cavity shunt					
62223	C	Establish brain cavity shunt					
62225	T	Replace/irrigate catheter	0121	2.36	$114.43	$52.53	$22.89
62230	T	Replace/revise brain shunt	0224	15.94	$772.88	$374.61	$154.58
62256	C	Remove brain cavity shunt					
62258	C	Replace brain cavity shunt					
62263	T	Lysis epidural adhesions	0212	3.64	$176.49	$88.78	$35.30
62268	T	Drain spinal cord cyst	0212	3.64	$176.49	$88.78	$35.30
62269	T	Needle biopsy, spinal cord	0005	5.41	$262.32	$119.75	$52.46
62270	T	Spinal fluid tap, diagnostic	0210	3.00	$145.46	$62.40	$29.09
62272	T	Drain spinal fluid	0210	3.00	$145.46	$62.40	$29.09
62273	T	Treat epidural spine lesion	0212	3.64	$176.49	$88.78	$35.30
62280	T	Treat spinal cord lesion	0212	3.64	$176.49	$88.78	$35.30
62281	T	Treat spinal cord lesion	0212	3.64	$176.49	$88.78	$35.30
62282	T	Treat spinal canal lesion	0212	3.64	$176.49	$88.78	$35.30
62284	N	Injection for myelogram					
62287	T	Percutaneous diskectomy	0220	13.96	$676.88	$326.21	$135.38
62290	N	Inject for spine disk x-ray					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
62291	N	Inject for spine disk x-ray					
62292	T	Injection into disk lesion	0212	3.64	$176.49	$88.78	$35.30
62294	T	Injection into spinal artery	0212	3.64	$176.49	$88.78	$35.30
62310	T	Inject spine c/t	0212	3.64	$176.49	$88.78	$35.30
62311	T	Inject spine l/s (cd)	0212	3.64	$176.49	$88.78	$35.30
62318	T	Inject spine w/cath, c/t	0212	3.64	$176.49	$88.78	$35.30
62319	T	Inject spine w/cath l/s (cd)	0212	3.64	$176.49	$88.78	$35.30
62350	T	Implant spinal canal cath	0223	6.34	$307.41	$153.24	$61.48
62351	C	Implant spinal canal cath					
62355	T	Remove spinal canal catheter	0223	6.34	$307.41	$153.24	$61.48
62360	T	Insert spine infusion device	0222	25.48	$1,235.45	$780.07	$247.09
62361	T	Implant spine infusion pump	0222	25.48	$1,235.45	$780.07	$247.09
62362	T	Implant spine infusion pump	0222	25.48	$1,235.45	$780.07	$247.09
62365	T	Remove spine infusion device	0224	15.94	$772.88	$374.61	$154.58
62367	S	Analyze spine infusion pump	0102	0.45	$21.82	$12.62	$4.36
62368	S	Analyze spine infusion pump	0102	0.45	$21.82	$12.62	$4.36
63001	C	Removal of spinal lamina					
63003	C	Removal of spinal lamina					
63005	C	Removal of spinal lamina					
63011	C	Removal of spinal lamina					
63012	C	Removal of spinal lamina					
63015	C	Removal of spinal lamina					
63016	C	Removal of spinal lamina					
63017	C	Removal of spinal lamina					
63020	C	Neck spine disk surgery					
63030	C	Low back disk surgery					
63035	C	Spinal disk surgery add-on					
63040	C	Neck spine disk surgery					
63042	C	Low back disk surgery					
63045	C	Removal of spinal lamina					
63046	C	Removal of spinal lamina					
63047	C	Removal of spinal lamina					
63048	C	Remove spinal lamina add-on					
63055	C	Decompress spinal cord					
63056	C	Decompress spinal cord					
63057	C	Decompress spine cord add-on					
63064	C	Decompress spinal cord					
63066	C	Decompress spine cord add-on					
63075	C	Neck spine disk surgery					
63076	C	Neck spine disk surgery					
63077	C	Spine disk surgery, thorax					
63078	C	Spine disk surgery, thorax					
63081	C	Removal of vertebral body					
63082	C	Remove vertebral body add-on					
63085	C	Removal of vertebral body					
63086	C	Remove vertebral body add-on					
63087	C	Removal of vertebral body					
63088	C	Remove vertebral body add-on					
63090	C	Removal of vertebral body					
63091	C	Remove vertebral body add-on					
63170	C	Incise spinal cord tract(s)					
63172	C	Drainage of spinal cyst					
63173	C	Drainage of spinal cyst					
63180	C	Revise spinal cord ligaments					
63182	C	Revise spinal cord ligaments					
63185	C	Incise spinal column/nerves					
63190	C	Incise spinal column/nerves					
63191	C	Incise spinal column/nerves					
63194	C	Incise spinal column & cord					
63195	C	Incise spinal column & cord					
63196	C	Incise spinal column & cord					
63197	C	Incise spinal column & cord					
63198	C	Incise spinal column & cord					
63199	C	Incise spinal column & cord					
63200	C	Release of spinal cord					
63250	C	Revise spinal cord vessels					
63251	C	Revise spinal cord vessels					
63252	C	Revise spinal cord vessels					
63265	C	Excise intraspinal lesion					
63266	C	Excise intraspinal lesion					
63267	C	Excise intraspinal lesion					
63268	C	Excise intraspinal lesion					
63270	C	Excise intraspinal lesion					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
63271	C	Excise intraspinal lesion					
63272	C	Excise intraspinal lesion					
63273	C	Excise intraspinal lesion					
63275	C	Biopsy/excise spinal tumor					
63276	C	Biopsy/excise spinal tumor					
63277	C	Biopsy/excise spinal tumor					
63278	C	Biopsy/excise spinal tumor					
63280	C	Biopsy/excise spinal tumor					
63281	C	Biopsy/excise spinal tumor					
63282	C	Biopsy/excise spinal tumor					
63283	C	Biopsy/excise spinal tumor					
63285	C	Biopsy/excise spinal tumor					
63286	C	Biopsy/excise spinal tumor					
63287	C	Biopsy/excise spinal tumor					
63290	C	Biopsy/excise spinal tumor					
63300	C	Removal of vertebral body					
63301	C	Removal of vertebral body					
63302	C	Removal of vertebral body					
63303	C	Removal of vertebral body					
63304	C	Removal of vertebral body					
63305	C	Removal of vertebral body					
63306	C	Removal of vertebral body					
63307	C	Removal of vertebral body					
63308	C	Remove vertebral body add-on					
63600	T	Remove spinal cord lesion	0220	13.96	$676.88	$326.21	$135.38
63610	T	Stimulation of spinal cord	0220	13.96	$676.88	$326.21	$135.38
63615	T	Remove lesion of spinal cord	0220	13.96	$676.88	$326.21	$135.38
63650	T	Implant neuroelectrodes	0224	15.94	$772.88	$374.61	$154.58
63655	C	Implant neuroelectrodes					
63660	T	Revise/remove neuroelectrode	0224	15.94	$772.88	$374.61	$154.58
63685	T	Implant neuroreceiver	0222	25.48	$1,235.45	$780.07	$247.09
63688	T	Revise/remove neuroreceiver	0224	15.94	$772.88	$374.61	$154.58
63700	C	Repair of spinal herniation					
63702	C	Repair of spinal herniation					
63704	C	Repair of spinal herniation					
63706	C	Repair of spinal herniation					
63707	C	Repair spinal fluid leakage					
63709	C	Repair spinal fluid leakage					
63710	C	Graft repair of spine defect					
63740	C	Install spinal shunt					
63741	C	Install spinal shunt					
63744	T	Revision of spinal shunt	0224	15.94	$772.88	$374.61	$154.58
63746	T	Removal of spinal shunt	0223	6.34	$307.41	$153.24	$61.48
64400	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64402	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64405	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64408	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64410	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64412	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64413	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64415	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64417	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64418	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64420	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64421	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64425	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64430	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64435	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64445	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64450	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64470	T	Inj paravertebral c/t	0211	3.32	$160.98	$74.78	$32.20
64472	T	Inj paravertebral c/t add-on	0211	3.32	$160.98	$74.78	$32.20
64475	T	Inj paravertebral l/s	0211	3.32	$160.98	$74.78	$32.20
64476	T	Inj paravertebral l/s add-on	0211	3.32	$160.98	$74.78	$32.20
64479	T	Inj foramen epidural c/t	0211	3.32	$160.98	$74.78	$32.20
64480	T	Inj foramen epidural add-on	0211	3.32	$160.98	$74.78	$32.20
64483	T	Inj foramen epidural l/s	0211	3.32	$160.98	$74.78	$32.20
64484	T	Inj foramen epidural add-on	0211	3.32	$160.98	$74.78	$32.20
64505	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64508	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64510	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64520	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20
64530	T	Injection for nerve block	0211	3.32	$160.98	$74.78	$32.20

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
64550	A	Apply neurostimulator					
64553	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64555	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64560	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64565	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64573	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64575	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64577	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64580	T	Implant neuroelectrodes	0225	3.43	$166.31	$64.46	$33.26
64585	T	Revise/remove neuroelectrode	0225	3.43	$166.31	$64.46	$33.26
64590	T	Implant neuroreceiver	0222	25.48	$1,235.45	$780.07	$247.09
64595	T	Revise/remove neuroreceiver	0225	3.43	$166.31	$64.46	$33.26
64600	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64605	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64610	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64612	T	Destroy nerve, face muscle	0211	3.32	$160.98	$74.78	$32.20
64613	T	Destroy nerve, spine muscle	0211	3.32	$160.98	$74.78	$32.20
64620	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64622	T	Destr paravertebrl nerve l/s	0211	3.32	$160.98	$74.78	$32.20
64623	T	Destr paravertebral n add-on	0211	3.32	$160.98	$74.78	$32.20
64626	T	Destr paravertebrl nerve c/t	0211	3.32	$160.98	$74.78	$32.20
64627	T	Destr paravertebral n add-on	0211	3.32	$160.98	$74.78	$32.20
64630	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64640	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64680	T	Injection treatment of nerve	0211	3.32	$160.98	$74.78	$32.20
64702	T	Revise finger/toe nerve	0220	13.96	$676.88	$326.21	$135.38
64704	T	Revise hand/foot nerve	0220	13.96	$676.88	$326.21	$135.38
64708	T	Revise arm/leg nerve	0220	13.96	$676.88	$326.21	$135.38
64712	T	Revision of sciatic nerve	0220	13.96	$676.88	$326.21	$135.38
64713	T	Revision of arm nerve(s)	0220	13.96	$676.88	$326.21	$135.38
64714	T	Revise low back nerve(s)	0220	13.96	$676.88	$326.21	$135.38
64716	T	Revision of cranial nerve	0220	13.96	$676.88	$326.21	$135.38
64718	T	Revise ulnar nerve at elbow	0220	13.96	$676.88	$326.21	$135.38
64719	T	Revise ulnar nerve at wrist	0220	13.96	$676.88	$326.21	$135.38
64721	T	Carpal tunnel surgery	0220	13.96	$676.88	$326.21	$135.38
64722	T	Relieve pressure on nerve(s)	0220	13.96	$676.88	$326.21	$135.38
64726	T	Release foot/toe nerve	0220	13.96	$676.88	$326.21	$135.38
64727	T	Internal nerve revision	0220	13.96	$676.88	$326.21	$135.38
64732	T	Incision of brow nerve	0220	13.96	$676.88	$326.21	$135.38
64734	T	Incision of cheek nerve	0220	13.96	$676.88	$326.21	$135.38
64736	T	Incision of chin nerve	0220	13.96	$676.88	$326.21	$135.38
64738	T	Incision of jaw nerve	0220	13.96	$676.88	$326.21	$135.38
64740	T	Incision of tongue nerve	0220	13.96	$676.88	$326.21	$135.38
64742	T	Incision of facial nerve	0220	13.96	$676.88	$326.21	$135.38
64744	T	Incise nerve, back of head	0220	13.96	$676.88	$326.21	$135.38
64746	T	Incise diaphragm nerve	0220	13.96	$676.88	$326.21	$135.38
64752	C	Incision of vagus nerve					
64755	C	Incision of stomach nerves					
64760	C	Incision of vagus nerve					
64761	T	Incision of pelvis nerve	0220	13.96	$676.88	$326.21	$135.38
64763	C	Incise hip/thigh nerve					
64766	C	Incise hip/thigh nerve					
64771	T	Sever cranial nerve	0220	13.96	$676.88	$326.21	$135.38
64772	T	Incision of spinal nerve	0220	13.96	$676.88	$326.21	$135.38
64774	T	Remove skin nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64776	T	Remove digit nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64778	T	Digit nerve surgery add-on	0220	13.96	$676.88	$326.21	$135.38
64782	T	Remove limb nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64783	T	Limb nerve surgery add-on	0220	13.96	$676.88	$326.21	$135.38
64784	T	Remove nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64786	T	Remove sciatic nerve lesion	0221	18.36	$890.22	$463.62	$178.04
64787	T	Implant nerve end	0220	13.96	$676.88	$326.21	$135.38
64788	T	Remove skin nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64790	T	Removal of nerve lesion	0220	13.96	$676.88	$326.21	$135.38
64792	T	Removal of nerve lesion	0221	18.36	$890.22	$463.62	$178.04
64795	T	Biopsy of nerve	0220	13.96	$676.88	$326.21	$135.38
64802	C	Remove sympathetic nerves					
64804	C	Remove sympathetic nerves					
64809	C	Remove sympathetic nerves					
64818	C	Remove sympathetic nerves					
64820	C	Remove sympathetic nerves					
64831	T	Repair of digit nerve	0221	18.36	$890.22	$463.62	$178.04
64832	T	Repair nerve add-on	0221	18.36	$890.22	$463.62	$178.04

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
64834	T	Repair of hand or foot nerve	0221	18.36	$890.22	$463.62	$178.04
64835	T	Repair of hand or foot nerve	0221	18.36	$890.22	$463.62	$178.04
64836	T	Repair of hand or foot nerve	0221	18.36	$890.22	$463.62	$178.04
64837	T	Repair nerve add-on	0221	18.36	$890.22	$463.62	$178.04
64840	T	Repair of leg nerve	0221	18.36	$890.22	$463.62	$178.04
64856	T	Repair/transpose nerve	0221	18.36	$890.22	$463.62	$178.04
64857	T	Repair arm/leg nerve	0221	18.36	$890.22	$463.62	$178.04
64858	T	Repair sciatic nerve	0221	18.36	$890.22	$463.62	$178.04
64859	T	Nerve surgery	0221	18.36	$890.22	$463.62	$178.04
64861	T	Repair of arm nerves	0221	18.36	$890.22	$463.62	$178.04
64862	T	Repair of low back nerves	0221	18.36	$890.22	$463.62	$178.04
64864	T	Repair of facial nerve	0221	18.36	$890.22	$463.62	$178.04
64865	T	Repair of facial nerve	0221	18.36	$890.22	$463.62	$178.04
64866	C	Fusion of facial/other nerve					
64868	C	Fusion of facial/other nerve					
64870	T	Fusion of facial/other nerve	0221	18.36	$890.22	$463.62	$178.04
64872	T	Subsequent repair of nerve	0221	18.36	$890.22	$463.62	$178.04
64874	T	Repair & revise nerve add-on	0221	18.36	$890.22	$463.62	$178.04
64876	T	Repair nerve/shorten bone	0221	18.36	$890.22	$463.62	$178.04
64885	T	Nerve graft, head or neck	0221	18.36	$890.22	$463.62	$178.04
64886	T	Nerve graft, head or neck	0221	18.36	$890.22	$463.62	$178.04
64890	T	Nerve graft, hand or foot	0221	18.36	$890.22	$463.62	$178.04
64891	T	Nerve graft, hand or foot	0221	18.36	$890.22	$463.62	$178.04
64892	T	Nerve graft, arm or leg	0221	18.36	$890.22	$463.62	$178.04
64893	T	Nerve graft, arm or leg	0221	18.36	$890.22	$463.62	$178.04
64895	T	Nerve graft, hand or foot	0221	18.36	$890.22	$463.62	$178.04
64896	T	Nerve graft, hand or foot	0221	18.36	$890.22	$463.62	$178.04
64897	T	Nerve graft, arm or leg	0221	18.36	$890.22	$463.62	$178.04
64898	T	Nerve graft, arm or leg	0221	18.36	$890.22	$463.62	$178.04
64901	T	Nerve graft add-on	0221	18.36	$890.22	$463.62	$178.04
64902	T	Nerve graft add-on	0221	18.36	$890.22	$463.62	$178.04
64905	T	Nerve pedicle transfer	0221	18.36	$890.22	$463.62	$178.04
64907	T	Nerve pedicle transfer	0221	18.36	$890.22	$463.62	$178.04
64999	T	Nervous system surgery	0211	3.32	$160.98	$74.78	$32.20
65091	T	Revise eye	0242	23.70	$1,149.14	$597.36	$229.83
65093	T	Revise eye with implant	0241	16.60	$804.89	$384.47	$160.98
65101	T	Removal of eye	0242	23.70	$1,149.14	$597.36	$229.83
65103	T	Remove eye/insert implant	0242	23.70	$1,149.14	$597.36	$229.83
65105	T	Remove eye/attach implant	0242	23.70	$1,149.14	$597.36	$229.83
65110	T	Removal of eye	0242	23.70	$1,149.14	$597.36	$229.83
65112	T	Remove eye/revise socket	0242	23.70	$1,149.14	$597.36	$229.83
65114	T	Remove eye/revise socket	0242	23.70	$1,149.14	$597.36	$229.83
65125	T	Revise ocular implant	0240	13.47	$653.12	$315.31	$130.62
65130	T	Insert ocular implant	0241	16.60	$804.89	$384.47	$160.98
65135	T	Insert ocular implant	0241	16.60	$804.89	$384.47	$160.98
65140	T	Attach ocular implant	0242	23.70	$1,149.14	$597.36	$229.83
65150	T	Revise ocular implant	0241	16.60	$804.89	$384.47	$160.98
65155	T	Reinsert ocular implant	0242	23.70	$1,149.14	$597.36	$229.83
65175	T	Removal of ocular implant	0240	13.47	$653.12	$315.31	$130.62
65205	S	Remove foreign body from eye	0231	2.64	$128.01	$59.87	$25.60
65210	S	Remove foreign body from eye	0231	2.64	$128.01	$59.87	$25.60
65220	S	Remove foreign body from eye	0231	2.64	$128.01	$59.87	$25.60
65222	S	Remove foreign body from eye	0231	2.64	$128.01	$59.87	$25.60
65235	T	Remove foreign body from eye	0232	6.04	$292.86	$134.66	$58.57
65260	T	Remove foreign body from eye	0237	33.96	$1,646.62	$852.68	$329.32
65265	T	Remove foreign body from eye	0237	33.96	$1,646.62	$852.68	$329.32
65270	T	Repair of eye wound	0240	13.47	$653.12	$315.31	$130.62
65272	T	Repair of eye wound	0232	6.04	$292.86	$134.66	$58.57
65273	C	Repair of eye wound					
65275	T	Repair of eye wound	0233	13.79	$668.64	$331.60	$133.73
65280	T	Repair of eye wound	0233	13.79	$668.64	$331.60	$133.73
65285	T	Repair of eye wound	0234	20.64	$1,000.77	$502.16	$200.15
65286	T	Repair of eye wound	0232	6.04	$292.86	$134.66	$58.57
65290	T	Repair of eye socket wound	0243	17.99	$872.28	$431.39	$174.46
65400	T	Removal of eye lesion	0232	6.04	$292.86	$134.66	$58.57
65410	T	Biopsy of cornea	0233	13.79	$668.64	$331.60	$133.73
65420	T	Removal of eye lesion	0233	13.79	$668.64	$331.60	$133.73
65426	T	Removal of eye lesion	0233	13.79	$668.64	$331.60	$133.73
65430	S	Corneal smear	0231	2.64	$128.01	$59.87	$25.60
65435	T	Curette/treat cornea	0239	6.26	$303.53	$123.42	$60.71
65436	T	Curette/treat cornea	0232	6.04	$292.86	$134.66	$58.57
65450	T	Treatment of corneal lesion	0232	6.04	$292.86	$134.66	$58.57
65600	T	Revision of cornea	0240	13.47	$653.12	$315.31	$130.62

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
65710	T	Corneal transplant	0244	32.88	$1,594.26	$851.42	$318.85
65730	T	Corneal transplant	0244	32.88	$1,594.26	$851.42	$318.85
65750	T	Corneal transplant	0244	32.88	$1,594.26	$851.42	$318.85
65755	T	Corneal transplant	0244	32.88	$1,594.26	$851.42	$318.85
65760	E	Revision of cornea					
65765	E	Revision of cornea					
65767	E	Corneal tissue transplant					
65770	T	Revise cornea with implant	0244	32.88	$1,594.26	$851.42	$318.85
65771	E	Radial keratotomy					
65772	T	Correction of astigmatism	0232	6.04	$292.86	$134.66	$58.57
65775	T	Correction of astigmatism	0233	13.79	$668.64	$331.60	$133.73
65800	T	Drainage of eye	0232	6.04	$292.86	$134.66	$58.57
65805	T	Drainage of eye	0233	13.79	$668.64	$331.60	$133.73
65810	T	Drainage of eye	0233	13.79	$668.64	$331.60	$133.73
65815	T	Drainage of eye	0233	13.79	$668.64	$331.60	$133.73
65820	T	Relieve inner eye pressure	0232	6.04	$292.86	$134.66	$58.57
65850	T	Incision of eye	0234	20.64	$1,000.77	$502.16	$200.15
65855	T	Laser surgery of eye	0247	4.89	$237.10	$112.86	$47.42
65860	T	Incise inner eye adhesions	0247	4.89	$237.10	$112.86	$47.42
65865	T	Incise inner eye adhesions	0233	13.79	$668.64	$331.60	$133.73
65870	T	Incise inner eye adhesions	0233	13.79	$668.64	$331.60	$133.73
65875	T	Incise inner eye adhesions	0233	13.79	$668.64	$331.60	$133.73
65880	T	Incise inner eye adhesions	0232	6.04	$292.86	$134.66	$58.57
65900	T	Remove eye lesion	0232	6.04	$292.86	$134.66	$58.57
65920	T	Remove implant from eye	0233	13.79	$668.64	$331.60	$133.73
65930	T	Remove blood clot from eye	0233	13.79	$668.64	$331.60	$133.73
66020	T	Injection treatment of eye	0232	6.04	$292.86	$134.66	$58.57
66030	T	Injection treatment of eye	0232	6.04	$292.86	$134.66	$58.57
66130	T	Remove eye lesion	0233	13.79	$668.64	$331.60	$133.73
66150	T	Glaucoma surgery	0233	13.79	$668.64	$331.60	$133.73
66155	T	Glaucoma surgery	0234	20.64	$1,000.77	$502.16	$200.15
66160	T	Glaucoma surgery	0234	20.64	$1,000.77	$502.16	$200.15
66165	T	Glaucoma surgery	0234	20.64	$1,000.77	$502.16	$200.15
66170	T	Glaucoma surgery	0234	20.64	$1,000.77	$502.16	$200.15
66172	T	Incision of eye	0234	20.64	$1,000.77	$502.16	$200.15
66180	T	Implant eye shunt	0234	20.64	$1,000.77	$502.16	$200.15
66185	T	Revise eye shunt	0234	20.64	$1,000.77	$502.16	$200.15
66220	T	Repair eye lesion	0236	6.70	$324.86	$147.96	$64.97
66225	T	Repair/graft eye lesion	0234	20.64	$1,000.77	$502.16	$200.15
66250	T	Follow-up surgery of eye	0233	13.79	$668.64	$331.60	$133.73
66500	T	Incision of iris	0232	6.04	$292.86	$134.66	$58.57
66505	T	Incision of iris	0232	6.04	$292.86	$134.66	$58.57
66600	T	Remove iris and lesion	0233	13.79	$668.64	$331.60	$133.73
66605	T	Removal of iris	0233	13.79	$668.64	$331.60	$133.73
66625	T	Removal of iris	0232	6.04	$292.86	$134.66	$58.57
66630	T	Removal of iris	0233	13.79	$668.64	$331.60	$133.73
66635	T	Removal of iris	0233	13.79	$668.64	$331.60	$133.73
66680	T	Repair iris & ciliary body	0233	13.79	$668.64	$331.60	$133.73
66682	T	Repair iris & ciliary body	0233	13.79	$668.64	$331.60	$133.73
66700	T	Destruction, ciliary body	0232	6.04	$292.86	$134.66	$58.57
66710	T	Destruction, ciliary body	0232	6.04	$292.86	$134.66	$58.57
66720	T	Destruction, ciliary body	0232	6.04	$292.86	$134.66	$58.57
66740	T	Destruction, ciliary body	0233	13.79	$668.64	$331.60	$133.73
66761	T	Revision of iris	0247	4.89	$237.10	$112.86	$47.42
66762	T	Revision of iris	0247	4.89	$237.10	$112.86	$47.42
66770	T	Removal of inner eye lesion	0247	4.89	$237.10	$112.86	$47.42
66820	T	Incision, secondary cataract	0232	6.04	$292.86	$134.66	$58.57
66821	T	After cataract laser surgery	0247	4.89	$237.10	$112.86	$47.42
66825	T	Reposition intraocular lens	0233	13.79	$668.64	$331.60	$133.73
66830	T	Removal of lens lesion	0232	6.04	$292.86	$134.66	$58.57
66840	T	Removal of lens material	0245	26.55	$1,287.33	$623.85	$257.47
66850	T	Removal of lens material	0245	26.55	$1,287.33	$623.85	$257.47
66852	T	Removal of lens material	0245	26.55	$1,287.33	$623.85	$257.47
66920	T	Extraction of lens	0245	26.55	$1,287.33	$623.85	$257.47
66930	T	Extraction of lens	0245	26.55	$1,287.33	$623.85	$257.47
66940	T	Extraction of lens	0245	26.55	$1,287.33	$623.85	$257.47
66983	T	Remove cataract/insert lens	0246	26.55	$1,287.33	$623.85	$257.47
66984	T	Remove cataract/insert lens	0246	26.55	$1,287.33	$623.85	$257.47
66985	T	Insert lens prosthesis	0246	26.55	$1,287.33	$623.85	$257.47
66986	T	Exchange lens prosthesis	0246	26.55	$1,287.33	$623.85	$257.47
66999	T	Eye surgery procedure	0247	4.89	$237.10	$112.86	$47.42
67005	T	Partial removal of eye fluid	0237	33.96	$1,646.62	$852.68	$329.32
67010	T	Partial removal of eye fluid	0237	33.96	$1,646.62	$852.68	$329.32

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
67015	T	Release of eye fluid	0237	33.96	$1,646.62	$852.68	$329.32
67025	T	Replace eye fluid	0237	33.96	$1,646.62	$852.68	$329.32
67027	T	Implant eye drug system	0237	33.96	$1,646.62	$852.68	$329.32
67028	T	Injection eye drug	0236	6.70	$324.86	$147.96	$64.97
67030	T	Incise inner eye strands	0236	6.70	$324.86	$147.96	$64.97
67031	T	Laser surgery, eye strands	0247	4.89	$237.10	$112.86	$47.42
67036	T	Removal of inner eye fluid	0237	33.96	$1,646.62	$852.68	$329.32
67038	T	Strip retinal membrane	0237	33.96	$1,646.62	$852.68	$329.32
67039	T	Laser treatment of retina	0237	33.96	$1,646.62	$852.68	$329.32
67040	T	Laser treatment of retina	0237	33.96	$1,646.62	$852.68	$329.32
67101	T	Repair detached retina	0236	6.70	$324.86	$147.96	$64.97
67105	T	Repair detached retina	0248	4.19	$203.16	$94.05	$40.63
67107	T	Repair detached retina	0237	33.96	$1,646.62	$852.68	$329.32
67108	T	Repair detached retina	0237	33.96	$1,646.62	$852.68	$329.32
67110	T	Repair detached retina	0236	6.70	$324.86	$147.96	$64.97
67112	T	Rerepair detached retina	0237	33.96	$1,646.62	$852.68	$329.32
67115	T	Release encircling material	0236	6.70	$324.86	$147.96	$64.97
67120	T	Remove eye implant material	0236	6.70	$324.86	$147.96	$64.97
67121	T	Remove eye implant material	0237	33.96	$1,646.62	$852.68	$329.32
67141	T	Treatment of retina	0235	2.94	$142.55	$78.91	$28.51
67145	T	Treatment of retina	0248	4.19	$203.16	$94.05	$40.63
67208	T	Treatment of retinal lesion	0235	2.94	$142.55	$78.91	$28.51
67210	T	Treatment of retinal lesion	0248	4.19	$203.16	$94.05	$40.63
67218	T	Treatment of retinal lesion	0237	33.96	$1,646.62	$852.68	$329.32
67220	T	Treatment of choroid lesion	0237	33.96	$1,646.62	$852.68	$329.32
67227	T	Treatment of retinal lesion	0235	2.94	$142.55	$78.91	$28.51
67228	T	Treatment of retinal lesion	0248	4.19	$203.16	$94.05	$40.63
67250	T	Reinforce eye wall	0240	13.47	$653.12	$315.31	$130.62
67255	T	Reinforce/graft eye wall	0237	33.96	$1,646.62	$852.68	$329.32
67299	T	Eye surgery procedure	0248	4.19	$203.16	$94.05	$40.63
67311	T	Revise eye muscle	0243	17.99	$872.28	$431.39	$174.46
67312	T	Revise two eye muscles	0243	17.99	$872.28	$431.39	$174.46
67314	T	Revise eye muscle	0243	17.99	$872.28	$431.39	$174.46
67316	T	Revise two eye muscles	0243	17.99	$872.28	$431.39	$174.46
67318	T	Revise eye muscle(s)	0243	17.99	$872.28	$431.39	$174.46
67320	T	Revise eye muscle(s) add-on	0243	17.99	$872.28	$431.39	$174.46
67331	T	Eye surgery follow-up add-on	0243	17.99	$872.28	$431.39	$174.46
67332	T	Rerevise eye muscles add-on	0243	17.99	$872.28	$431.39	$174.46
67334	T	Revise eye muscle w/suture	0243	17.99	$872.28	$431.39	$174.46
67335	T	Eye suture during surgery	0243	17.99	$872.28	$431.39	$174.46
67340	T	Revise eye muscle add-on	0243	17.99	$872.28	$431.39	$174.46
67343	T	Release eye tissue	0243	17.99	$872.28	$431.39	$174.46
67345	T	Destroy nerve of eye muscle	0238	2.80	$135.76	$58.96	$27.15
67350	S	Biopsy eye muscle	0231	2.64	$128.01	$59.87	$25.60
67399	T	Eye muscle surgery procedure	0243	17.99	$872.28	$431.39	$174.46
67400	T	Explore/biopsy eye socket	0241	16.60	$804.89	$384.47	$160.98
67405	T	Explore/drain eye socket	0241	16.60	$804.89	$384.47	$160.98
67412	T	Explore/treat eye socket	0241	16.60	$804.89	$384.47	$160.98
67413	T	Explore/treat eye socket	0241	16.60	$804.89	$384.47	$160.98
67414	T	Explr/decompress eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67415	T	Aspiration, orbital contents	0239	6.26	$303.53	$123.42	$60.71
67420	T	Explore/treat eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67430	T	Explore/treat eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67440	T	Explore/drain eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67445	T	Explr/decompress eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67450	T	Explore/biopsy eye socket	0242	23.70	$1,149.14	$597.36	$229.83
67500	S	Inject/treat eye socket	0231	2.64	$128.01	$59.87	$25.60
67505	T	Inject/treat eye socket	0238	2.80	$135.76	$58.96	$27.15
67515	T	Inject/treat eye socket	0239	6.26	$303.53	$123.42	$60.71
67550	T	Insert eye socket implant	0242	23.70	$1,149.14	$597.36	$229.83
67560	T	Revise eye socket implant	0241	16.60	$804.89	$384.47	$160.98
67570	T	Decompress optic nerve	0242	23.70	$1,149.14	$597.36	$229.83
67599	T	Orbit surgery procedure	0239	6.26	$303.53	$123.42	$60.71
67700	T	Drainage of eyelid abscess	0238	2.80	$135.76	$58.96	$27.15
67710	T	Incision of eyelid	0239	6.26	$303.53	$123.42	$60.71
67715	T	Incision of eyelid fold	0240	13.47	$653.12	$315.31	$130.62
67800	T	Remove eyelid lesion	0238	2.80	$135.76	$58.96	$27.15
67801	T	Remove eyelid lesions	0239	6.26	$303.53	$123.42	$60.71
67805	T	Remove eyelid lesions	0238	2.80	$135.76	$58.96	$27.15
67808	T	Remove eyelid lesion(s)	0240	13.47	$653.12	$315.31	$130.62
67810	T	Biopsy of eyelid	0238	2.80	$135.76	$58.96	$27.15
67820	T	Revise eyelashes	0238	2.80	$135.76	$58.96	$27.15
67825	T	Revise eyelashes	0238	2.80	$135.76	$58.96	$27.15

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[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
67830	T	Revise eyelashes	0239	6.26	$303.53	$123.42	$60.71
67835	T	Revise eyelashes	0240	13.47	$653.12	$315.31	$130.62
67840	T	Remove eyelid lesion	0239	6.26	$303.53	$123.42	$60.71
67850	T	Treat eyelid lesion	0239	6.26	$303.53	$123.42	$60.71
67875	T	Closure of eyelid by suture	0239	6.26	$303.53	$123.42	$60.71
67880	T	Revision of eyelid	0232	6.04	$292.86	$134.66	$58.57
67882	T	Revision of eyelid	0240	13.47	$653.12	$315.31	$130.62
67900	T	Repair brow defect	0240	13.47	$653.12	$315.31	$130.62
67901	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67902	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67903	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67904	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67906	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67908	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67909	T	Revise eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67911	T	Revise eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67914	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67915	T	Repair eyelid defect	0239	6.26	$303.53	$123.42	$60.71
67916	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67917	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67921	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67922	T	Repair eyelid defect	0239	6.26	$303.53	$123.42	$60.71
67923	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67924	T	Repair eyelid defect	0240	13.47	$653.12	$315.31	$130.62
67930	T	Repair eyelid wound	0240	13.47	$653.12	$315.31	$130.62
67935	T	Repair eyelid wound	0240	13.47	$653.12	$315.31	$130.62
67938	T	Remove eyelid foreign body	0238	2.80	$135.76	$58.96	$27.15
67950	T	Revision of eyelid	0240	13.47	$653.12	$315.31	$130.62
67961	T	Revision of eyelid	0240	13.47	$653.12	$315.31	$130.62
67966	T	Revision of eyelid	0240	13.47	$653.12	$315.31	$130.62
67971	T	Reconstruction of eyelid	0241	16.60	$804.89	$384.47	$160.98
67973	T	Reconstruction of eyelid	0241	16.60	$804.89	$384.47	$160.98
67974	T	Reconstruction of eyelid	0241	16.60	$804.89	$384.47	$160.98
67975	T	Reconstruction of eyelid	0240	13.47	$653.12	$315.31	$130.62
67999	T	Revision of eyelid	0240	13.47	$653.12	$315.31	$130.62
68020	T	Incise/drain eyelid lining	0240	13.47	$653.12	$315.31	$130.62
68040	T	Treatment of eyelid lesions	0239	6.26	$303.53	$123.42	$60.71
68100	T	Biopsy of eyelid lining	0232	6.04	$292.86	$134.66	$58.57
68110	S	Remove eyelid lining lesion	0231	2.64	$128.01	$59.87	$25.60
68115	T	Remove eyelid lining lesion	0239	6.26	$303.53	$123.42	$60.71
68130	T	Remove eyelid lining lesion	0233	13.79	$668.64	$331.60	$133.73
68135	T	Remove eyelid lining lesion	0239	6.26	$303.53	$123.42	$60.71
68200	S	Treat eyelid by injection	0230	0.98	$47.52	$22.48	$9.50
68320	T	Revise/graft eyelid lining	0240	13.47	$653.12	$315.31	$130.62
68325	T	Revise/graft eyelid lining	0242	23.70	$1,149.14	$597.36	$229.83
68326	T	Revise/graft eyelid lining	0241	16.60	$804.89	$384.47	$160.98
68328	T	Revise/graft eyelid lining	0241	16.60	$804.89	$384.47	$160.98
68330	T	Revise eyelid lining	0233	13.79	$668.64	$331.60	$133.73
68335	T	Revise/graft eyelid lining	0241	16.60	$804.89	$384.47	$160.98
68340	T	Separate eyelid adhesions	0240	13.47	$653.12	$315.31	$130.62
68360	T	Revise eyelid lining	0234	20.64	$1,000.77	$502.16	$200.15
68362	T	Revise eyelid lining	0234	20.64	$1,000.77	$502.16	$200.15
68399	T	Eyelid lining surgery	0239	6.26	$303.53	$123.42	$60.71
68400	T	Incise/drain tear gland	0238	2.80	$135.76	$58.96	$27.15
68420	T	Incise/drain tear sac	0240	13.47	$653.12	$315.31	$130.62
68440	T	Incise tear duct opening	0238	2.80	$135.76	$58.96	$27.15
68500	T	Removal of tear gland	0241	16.60	$804.89	$384.47	$160.98
68505	T	Partial removal, tear gland	0241	16.60	$804.89	$384.47	$160.98
68510	T	Biopsy of tear gland	0240	13.47	$653.12	$315.31	$130.62
68520	T	Removal of tear sac	0241	16.60	$804.89	$384.47	$160.98
68525	T	Biopsy of tear sac	0240	13.47	$653.12	$315.31	$130.62
68530	T	Clearance of tear duct	0240	13.47	$653.12	$315.31	$130.62
68540	T	Remove tear gland lesion	0241	16.60	$804.89	$384.47	$160.98
68550	T	Remove tear gland lesion	0242	23.70	$1,149.14	$597.36	$229.83
68700	T	Repair tear ducts	0241	16.60	$804.89	$384.47	$160.98
68705	T	Revise tear duct opening	0238	2.80	$135.76	$58.96	$27.15
68720	T	Create tear sac drain	0242	23.70	$1,149.14	$597.36	$229.83
68745	T	Create tear duct drain	0241	16.60	$804.89	$384.47	$160.98
68750	T	Create tear duct drain	0242	23.70	$1,149.14	$597.36	$229.83
68760	T	Close tear duct opening	0238	2.80	$135.76	$58.96	$27.15
68761	S	Close tear duct opening	0231	2.64	$128.01	$59.87	$25.60
68770	T	Close tear system fistula	0240	13.47	$653.12	$315.31	$130.62
68801	S	Dilate tear duct opening	0231	2.64	$128.01	$59.87	$25.60

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
68810	S	Probe nasolacrimal duct	0231	2.64	$128.01	$59.87	$25.60
68811	T	Probe nasolacrimal duct	0240	13.47	$653.12	$315.31	$130.62
68815	T	Probe nasolacrimal duct	0240	13.47	$653.12	$315.31	$130.62
68840	S	Explore/irrigate tear ducts	0231	2.64	$128.01	$59.87	$25.60
68850	N	Injection for tear sac x-ray	.....	.....	.....	.....	.....
68899	S	Tear duct system surgery	0231	2.64	$128.01	$59.87	$25.60
69000	T	Drain external ear lesion	0006	2.00	$96.97	$33.95	$19.39
69005	T	Drain external ear lesion	0007	3.68	$178.43	$72.03	$35.69
69020	T	Drain outer ear canal lesion	0006	2.00	$96.97	$33.95	$19.39
69090	E	Pierce earlobes	.....	.....	.....	.....	.....
69100	T	Biopsy of external ear	0019	4.00	$193.95	$78.91	$38.79
69105	T	Biopsy of external ear canal	0253	12.02	$582.81	$284.00	$116.56
69110	T	Remove external ear, partial	0020	6.51	$315.65	$130.53	$63.13
69120	T	Removal of external ear	0253	12.02	$582.81	$284.00	$116.56
69140	T	Remove ear canal lesion(s)	0254	12.45	$603.66	$272.41	$120.73
69145	T	Remove ear canal lesion(s)	0020	6.51	$315.65	$130.53	$63.13
69150	C	Extensive ear canal surgery	.....	.....	.....	.....	.....
69155	C	Extensive ear/neck surgery	.....	.....	.....	.....	.....
69200	X	Clear outer ear canal	0340	1.04	$50.43	$12.85	$10.09
69205	T	Clear outer ear canal	0022	12.49	$605.60	$292.94	$121.12
69210	X	Remove impacted ear wax	0340	1.04	$50.43	$12.85	$10.09
69220	T	Clean out mastoid cavity	0012	0.53	$25.70	$9.18	$5.14
69222	T	Clean out mastoid cavity	0253	12.02	$582.81	$284.00	$116.56
69300	T	Revise external ear	0254	12.45	$603.66	$272.41	$120.73
69310	T	Rebuild outer ear canal	0256	25.40	$1,231.57	$623.05	$246.31
69320	T	Rebuild outer ear canal	0256	25.40	$1,231.57	$623.05	$246.31
69399	T	Outer ear surgery procedure	0252	5.18	$251.16	$114.24	$50.23
69400	T	Inflate middle ear canal	0251	1.68	$81.46	$27.99	$16.29
69401	N	Inflate middle ear canal	.....	.....	.....	.....	.....
69405	T	Catheterize middle ear canal	0252	5.18	$251.16	$114.24	$50.23
69410	T	Inset middle ear (baffle)	0252	5.18	$251.16	$114.24	$50.23
69420	T	Incision of eardrum	0252	5.18	$251.16	$114.24	$50.23
69421	T	Incision of eardrum	0253	12.02	$582.81	$284.00	$116.56
69424	T	Remove ventilating tube	0252	5.18	$251.16	$114.24	$50.23
69433	T	Create eardrum opening	0252	5.18	$251.16	$114.24	$50.23
69436	T	Create eardrum opening	0253	12.02	$582.81	$284.00	$116.56
69440	T	Exploration of middle ear	0253	12.02	$582.81	$284.00	$116.56
69450	T	Eardrum revision	0256	25.40	$1,231.57	$623.05	$246.31
69501	T	Mastoidectomy	0256	25.40	$1,231.57	$623.05	$246.31
69502	C	Mastoidectomy	.....	.....	.....	.....	.....
69505	T	Remove mastoid structures	0256	25.40	$1,231.57	$623.05	$246.31
69511	T	Extensive mastoid surgery	0256	25.40	$1,231.57	$623.05	$246.31
69530	T	Extensive mastoid surgery	0256	25.40	$1,231.57	$623.05	$246.31
69535	C	Remove part of temporal bone	.....	.....	.....	.....	.....
69540	T	Remove ear lesion	0253	12.02	$582.81	$284.00	$116.56
69550	T	Remove ear lesion	0256	25.40	$1,231.57	$623.05	$246.31
69552	T	Remove ear lesion	0256	25.40	$1,231.57	$623.05	$246.31
69554	C	Remove ear lesion	.....	.....	.....	.....	.....
69601	T	Mastoid surgery revision	0256	25.40	$1,231.57	$623.05	$246.31
69602	T	Mastoid surgery revision	0256	25.40	$1,231.57	$623.05	$246.31
69603	T	Mastoid surgery revision	0256	25.40	$1,231.57	$623.05	$246.31
69604	T	Mastoid surgery revision	0256	25.40	$1,231.57	$623.05	$246.31
69605	T	Mastoid surgery revision	0256	25.40	$1,231.57	$623.05	$246.31
69610	T	Repair of eardrum	0253	12.02	$582.81	$284.00	$116.56
69620	T	Repair of eardrum	0253	12.02	$582.81	$284.00	$116.56
69631	T	Repair eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69632	T	Rebuild eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69633	T	Rebuild eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69635	T	Repair eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69636	T	Rebuild eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69637	T	Rebuild eardrum structures	0256	25.40	$1,231.57	$623.05	$246.31
69641	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69642	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69643	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69644	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69645	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69646	T	Revise middle ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69650	T	Release middle ear bone	0254	12.45	$603.66	$272.41	$120.73
69660	T	Revise middle ear bone	0256	25.40	$1,231.57	$623.05	$246.31
69661	T	Revise middle ear bone	0256	25.40	$1,231.57	$623.05	$246.31
69662	T	Revise middle ear bone	0256	25.40	$1,231.57	$623.05	$246.31
69666	T	Repair middle ear structures	0256	25.40	$1,231.57	$623.05	$246.31
69667	T	Repair middle ear structures	0256	25.40	$1,231.57	$623.05	$246.31

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
69670	T	Remove mastoid air cells	0256	25.40	$1,231.57	$623.05	$246.31
69676	T	Remove middle ear nerve	0256	25.40	$1,231.57	$623.05	$246.31
69700	T	Close mastoid fistula	0256	25.40	$1,231.57	$623.05	$246.31
69710	E	Implant/replace hearing aid	.....	.....	.....	.....	.....
69711	T	Remove/repair hearing aid	0256	25.40	$1,231.57	$623.05	$246.31
69720	T	Release facial nerve	0256	25.40	$1,231.57	$623.05	$246.31
69725	T	Release facial nerve	0256	25.40	$1,231.57	$623.05	$246.31
69740	T	Repair facial nerve	0256	25.40	$1,231.57	$623.05	$246.31
69745	T	Repair facial nerve	0256	25.40	$1,231.57	$623.05	$246.31
69799	T	Middle ear surgery procedure	0253	12.02	$582.81	$284.00	$116.56
69801	T	Incise inner ear	0256	25.40	$1,231.57	$623.05	$246.31
69802	T	Incise inner ear	0256	25.40	$1,231.57	$623.05	$246.31
69805	T	Explore inner ear	0256	25.40	$1,231.57	$623.05	$246.31
69806	T	Explore inner ear	0256	25.40	$1,231.57	$623.05	$246.31
69820	T	Establish inner ear window	0256	25.40	$1,231.57	$623.05	$246.31
69840	T	Revise inner ear window	0256	25.40	$1,231.57	$623.05	$246.31
69905	T	Remove inner ear	0256	25.40	$1,231.57	$623.05	$246.31
69910	T	Remove inner ear & mastoid	0256	25.40	$1,231.57	$623.05	$246.31
69915	T	Incise inner ear nerve	0256	25.40	$1,231.57	$623.05	$246.31
69930	T	Implant cochlear device	0257	115.31	$5,591.04	$3,498.58	$1,118.21
69949	T	Inner ear surgery procedure	0253	12.02	$582.81	$284.00	$116.56
69950	C	Incise inner ear nerve	.....	.....	.....	.....	.....
69955	T	Release facial nerve	0256	25.40	$1,231.57	$623.05	$246.31
69960	T	Release inner ear canal	0256	25.40	$1,231.57	$623.05	$246.31
69970	C	Remove inner ear lesion	.....	.....	.....	.....	.....
69979	T	Temporal bone surgery	0252	5.18	$251.16	$114.24	$50.23
69990	N	Microsurgery add-on	.....	.....	.....	.....	.....
70010	S	Contrast x-ray of brain	0274	4.83	$234.19	$128.12	$46.84
70015	S	Contrast x-ray of brain	0274	4.83	$234.19	$128.12	$46.84
70030	X	X-ray eye for foreign body	0260	0.79	$38.30	$22.02	$7.66
70100	X	X-ray exam of jaw	0260	0.79	$38.30	$22.02	$7.66
70110	X	X-ray exam of jaw	0260	0.79	$38.30	$22.02	$7.66
70120	X	X-ray exam of mastoids	0260	0.79	$38.30	$22.02	$7.66
70130	X	X-ray exam of mastoids	0260	0.79	$38.30	$22.02	$7.66
70134	X	X-ray exam of middle ear	0261	1.38	$66.91	$38.77	$13.38
70140	X	X-ray exam of facial bones	0260	0.79	$38.30	$22.02	$7.66
70150	X	X-ray exam of facial bones	0260	0.79	$38.30	$22.02	$7.66
70160	X	X-ray exam of nasal bones	0260	0.79	$38.30	$22.02	$7.66
70170	X	X-ray exam of tear duct	0263	1.68	$81.46	$45.88	$16.29
70190	X	X-ray exam of eye sockets	0260	0.79	$38.30	$22.02	$7.66
70200	X	X-ray exam of eye sockets	0260	0.79	$38.30	$22.02	$7.66
70210	X	X-ray exam of sinuses	0260	0.79	$38.30	$22.02	$7.66
70220	X	X-ray exam of sinuses	0260	0.79	$38.30	$22.02	$7.66
70240	X	X-ray exam, pituitary saddle	0260	0.79	$38.30	$22.02	$7.66
70250	X	X-ray exam of skull	0260	0.79	$38.30	$22.02	$7.66
70260	X	X-ray exam of skull	0261	1.38	$66.91	$38.77	$13.38
70300	X	X-ray exam of teeth	0262	0.40	$19.39	$10.90	$3.88
70310	X	X-ray exam of teeth	0262	0.40	$19.39	$10.90	$3.88
70320	X	Full mouth x-ray of teeth	0262	0.40	$19.39	$10.90	$3.88
70328	X	X-ray exam of jaw joint	0260	0.79	$38.30	$22.02	$7.66
70330	X	X-ray exam of jaw joints	0260	0.79	$38.30	$22.02	$7.66
70332	S	X-ray exam of jaw joint	0275	2.74	$132.85	$72.26	$26.57
70336	S	Magnetic image, jaw joint	0284	8.02	$388.87	$257.39	$77.77
70350	X	X-ray head for orthodontia	0260	0.79	$38.30	$22.02	$7.66
70355	X	Panoramic x-ray of jaws	0260	0.79	$38.30	$22.02	$7.66
70360	X	X-ray exam of neck	0260	0.79	$38.30	$22.02	$7.66
70370	X	Throat x-ray & fluoroscopy	0273	2.49	$120.73	$61.02	$24.15
70371	X	Speech evaluation, complex	0272	1.40	$67.88	$39.00	$13.58
70373	X	Contrast x-ray of larynx	0263	1.68	$81.46	$45.88	$16.29
70380	X	X-ray exam of salivary gland	0260	0.79	$38.30	$22.02	$7.66
70390	X	X-ray exam of salivary duct	0263	1.68	$81.46	$45.88	$16.29
70450	S	CAT scan of head or brain	0283	4.89	$237.10	$179.39	$47.42
70460	S	Contrast CAT scan of head	0283	4.89	$237.10	$179.39	$47.42
70470	S	Contrast CAT scans of head	0283	4.89	$237.10	$179.39	$47.42
70480	S	CAT scan of skull	0283	4.89	$237.10	$179.39	$47.42
70481	S	Contrast CAT scan of skull	0283	4.89	$237.10	$179.39	$47.42
70482	S	Contrast CAT scans of skull	0283	4.89	$237.10	$179.39	$47.42
70486	S	Cat scan of face/jaw	0282	2.38	$115.40	$94.51	$23.08
70487	S	Contrast CAT scan, face/jaw	0283	4.89	$237.10	$179.39	$47.42
70488	S	Contrast cat scans, face/jaw	0283	4.89	$237.10	$179.39	$47.42
70490	S	CAT scan of neck tissue	0283	4.89	$237.10	$179.39	$47.42
70491	S	Contrast CAT of neck tissue	0283	4.89	$237.10	$179.39	$47.42
70492	S	Contrast CAT of neck tissue	0283	4.89	$237.10	$179.39	$47.42

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
70540	S	Magnetic image, face/neck	0284	8.02	$388.87	$257.39	$77.77
70541	S	Magnetic image, head (MRA)	0284	8.02	$388.87	$257.39	$77.77
70551	S	Magnetic image, brain (MRI)	0284	8.02	$388.87	$257.39	$77.77
70552	S	Magnetic image, brain (MRI)	0284	8.02	$388.87	$257.39	$77.77
70553	S	Magnetic image, brain (mri)	0284	8.02	$388.87	$257.39	$77.77
71010	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71015	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71020	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71021	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71022	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71023	X	Chest x-ray and fluoroscopy	0272	1.40	$67.88	$39.00	$13.58
71030	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71034	X	Chest x-ray and fluoroscopy	0272	1.40	$67.88	$39.00	$13.58
71035	X	Chest x-ray	0260	0.79	$38.30	$22.02	$7.66
71036	X	X-ray guidance for biopsy	0273	2.49	$120.73	$61.02	$24.15
71040	X	Contrast x-ray of bronchi	0263	1.68	$81.46	$45.88	$16.29
71060	X	Contrast x-ray of bronchi	0263	1.68	$81.46	$45.88	$16.29
71090	X	X-ray & pacemaker insertion	0273	2.49	$120.73	$61.02	$24.15
71100	X	X-ray exam of ribs	0260	0.79	$38.30	$22.02	$7.66
71101	X	X-ray exam of ribs/chest	0260	0.79	$38.30	$22.02	$7.66
71110	X	X-ray exam of ribs	0260	0.79	$38.30	$22.02	$7.66
71111	X	X-ray exam of ribs/chest	0261	1.38	$66.91	$38.77	$13.38
71120	X	X-ray exam of breastbone	0260	0.79	$38.30	$22.02	$7.66
71130	X	X-ray exam of breastbone	0260	0.79	$38.30	$22.02	$7.66
71250	S	Cat scan of chest	0283	4.89	$237.10	$179.39	$47.42
71260	S	Contrast CAT scan of chest	0283	4.89	$237.10	$179.39	$47.42
71270	S	Contrast CAT scans of chest	0283	4.89	$237.10	$179.39	$47.42
71550	S	Magnetic image, chest (mri)	0284	8.02	$388.87	$257.39	$77.77
71555	E	Magnetic image, chest (mra)					
72010	X	X-ray exam of spine	0261	1.38	$66.91	$38.77	$13.38
72020	X	X-ray exam of spine	0260	0.79	$38.30	$22.02	$7.66
72040	X	X-ray exam of neck spine	0260	0.79	$38.30	$22.02	$7.66
72050	X	X-ray exam of neck spine	0261	1.38	$66.91	$38.77	$13.38
72052	X	X-ray exam of neck spine	0261	1.38	$66.91	$38.77	$13.38
72069	X	X-ray exam of trunk spine	0260	0.79	$38.30	$22.02	$7.66
72070	X	X-ray exam of thoracic spine	0260	0.79	$38.30	$22.02	$7.66
72072	X	X-ray exam of thoracic spine	0260	0.79	$38.30	$22.02	$7.66
72074	X	X-ray exam of thoracic spine	0260	0.79	$38.30	$22.02	$7.66
72080	X	X-ray exam of trunk spine	0260	0.79	$38.30	$22.02	$7.66
72090	X	X-ray exam of trunk spine	0260	0.79	$38.30	$22.02	$7.66
72100	X	X-ray exam of lower spine	0260	0.79	$38.30	$22.02	$7.66
72110	X	X-ray exam of lower spine	0261	1.38	$66.91	$38.77	$13.38
72114	X	X-ray exam of lower spine	0261	1.38	$66.91	$38.77	$13.38
72120	X	X-ray exam of lower spine	0260	0.79	$38.30	$22.02	$7.66
72125	S	CAT scan of neck spine	0283	4.89	$237.10	$179.39	$47.42
72126	S	Contrast CAT scan of neck	0283	4.89	$237.10	$179.39	$47.42
72127	S	Contrast CAT scans of neck	0283	4.89	$237.10	$179.39	$47.42
72128	S	CAT scan of thorax spine	0283	4.89	$237.10	$179.39	$47.42
72129	S	Contrast CAT scan of thorax	0283	4.89	$237.10	$179.39	$47.42
72130	S	Contrast CAT scans of thorax	0283	4.89	$237.10	$179.39	$47.42
72131	S	CAT scan of lower spine	0283	4.89	$237.10	$179.39	$47.42
72132	S	Contrast CAT of lower spine	0283	4.89	$237.10	$179.39	$47.42
72133	S	Contrast cat scans, low spine	0283	4.89	$237.10	$179.39	$47.42
72141	S	Magnetic image, neck spine	0284	8.02	$388.87	$257.39	$77.77
72142	S	Magnetic image, neck spine	0284	8.02	$388.87	$257.39	$77.77
72146	S	Magnetic image, chest spine	0284	8.02	$388.87	$257.39	$77.77
72147	S	Magnetic image, chest spine	0284	8.02	$388.87	$257.39	$77.77
72148	S	Magnetic image, lumbar spine	0284	8.02	$388.87	$257.39	$77.77
72149	S	Magnetic image, lumbar spine	0284	8.02	$388.87	$257.39	$77.77
72156	S	Magnetic image, neck spine	0284	8.02	$388.87	$257.39	$77.77
72157	S	Magnetic image, chest spine	0284	8.02	$388.87	$257.39	$77.77
72158	S	Magnetic image, lumbar spine	0284	8.02	$388.87	$257.39	$77.77
72159	E	Magnetic image, spine (mra)					
72170	X	X-ray exam of pelvis	0260	0.79	$38.30	$22.02	$7.66
72190	X	X-ray exam of pelvis	0260	0.79	$38.30	$22.02	$7.66
72192	S	CAT scan of pelvis	0283	4.89	$237.10	$179.39	$47.42
72193	S	Contrast CAT scan of pelvis	0283	4.89	$237.10	$179.39	$47.42
72194	S	Contrast CAT scans of pelvis	0283	4.89	$237.10	$179.39	$47.42
72196	S	Magnetic image, pelvis	0284	8.02	$388.87	$257.39	$77.77
72198	E	Magnetic image, pelvis (mra)					
72200	X	X-ray exam sacroiliac joints	0260	0.79	$38.30	$22.02	$7.66
72202	X	X-ray exam sacroiliac joints	0260	0.79	$38.30	$22.02	$7.66
72220	X	X-ray exam of tailbone	0260	0.79	$38.30	$22.02	$7.66

[1] Not subject to national coinsurance. Minimum unadjusted coinsurance is 25% of the payment rate. The payment rate is the lower of the HOPD payment rate or the Ambulatory Surgical Center payment.

[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
72240	S	Contrast x-ray of neck spine	0274	4.83	$234.19	$128.12	$46.84
72255	S	Contrast x-ray, thorax spine	0274	4.83	$234.19	$128.12	$46.84
72265	S	Contrast x-ray, lower spine	0274	4.83	$234.19	$128.12	$46.84
72270	S	Contrast x-ray of spine	0274	4.83	$234.19	$128.12	$46.84
72275	S	Epidurography	0274	4.83	$234.19	$128.12	$46.84
72285	S	X-ray c/t spine disk	0274	4.83	$234.19	$128.12	$46.84
72295	S	X-ray of lower spine disk	0274	4.83	$234.19	$128.12	$46.84
73000	X	X-ray exam of collar bone	0260	0.79	$38.30	$22.02	$7.66
73010	X	X-ray exam of shoulder blade	0260	0.79	$38.30	$22.02	$7.66
73020	X	X-ray exam of shoulder	0260	0.79	$38.30	$22.02	$7.66
73030	X	X-ray exam of shoulder	0260	0.79	$38.30	$22.02	$7.66
73040	S	Contrast x-ray of shoulder	0275	2.74	$132.85	$72.26	$26.57
73050	X	X-ray exam of shoulders	0260	0.79	$38.30	$22.02	$7.66
73060	X	X-ray exam of humerus	0260	0.79	$38.30	$22.02	$7.66
73070	X	X-ray exam of elbow	0260	0.79	$38.30	$22.02	$7.66
73080	X	X-ray exam of elbow	0260	0.79	$38.30	$22.02	$7.66
73085	S	Contrast x-ray of elbow	0275	2.74	$132.85	$72.26	$26.57
73090	X	X-ray exam of forearm	0260	0.79	$38.30	$22.02	$7.66
73092	X	X-ray exam of arm, infant	0260	0.79	$38.30	$22.02	$7.66
73100	X	X-ray exam of wrist	0260	0.79	$38.30	$22.02	$7.66
73110	X	X-ray exam of wrist	0260	0.79	$38.30	$22.02	$7.66
73115	S	Contrast x-ray of wrist	0275	2.74	$132.85	$72.26	$26.57
73120	X	X-ray exam of hand	0260	0.79	$38.30	$22.02	$7.66
73130	X	X-ray exam of hand	0260	0.79	$38.30	$22.02	$7.66
73140	X	X-ray exam of finger(s)	0260	0.79	$38.30	$22.02	$7.66
73200	S	CAT scan of arm	0283	4.89	$237.10	$179.39	$47.42
73201	S	Contrast CAT scan of arm	0283	4.89	$237.10	$179.39	$47.42
73202	S	Contrast CAT scans of arm	0283	4.89	$237.10	$179.39	$47.42
73220	S	Magnetic image, arm/hand	0284	8.02	$388.87	$257.39	$77.77
73221	S	Magnetic image, joint of arm	0284	8.02	$388.87	$257.39	$77.77
73225	E	Magnetic image, upper (mra)	.....	.....	.....	.....	.....
73500	X	X-ray exam of hip	0260	0.79	$38.30	$22.02	$7.66
73510	X	X-ray exam of hip	0260	0.79	$38.30	$22.02	$7.66
73520	X	X-ray exam of hips	0260	0.79	$38.30	$22.02	$7.66
73525	S	Contrast x-ray of hip	0275	2.74	$132.85	$72.26	$26.57
73530	X	X-ray exam of hip	0261	1.38	$66.91	$38.77	$13.38
73540	X	X-ray exam of pelvis & hips	0260	0.79	$38.30	$22.02	$7.66
73542	S	X-ray exam, sacroiliac joint	0275	2.74	$132.85	$72.26	$26.57
73550	X	X-ray exam of thigh	0260	0.79	$38.30	$22.02	$7.66
73560	X	X-ray exam of knee, 1 or 2	0260	0.79	$38.30	$22.02	$7.66
73562	X	X-ray exam of knee, 3	0260	0.79	$38.30	$22.02	$7.66
73564	X	X-ray exam, knee, 4 or more	0260	0.79	$38.30	$22.02	$7.66
73565	X	X-ray exam of knees	0260	0.79	$38.30	$22.02	$7.66
73580	S	Contrast x-ray of knee joint	0275	2.74	$132.85	$72.26	$26.57
73590	X	X-ray exam of lower leg	0260	0.79	$38.30	$22.02	$7.66
73592	X	X-ray exam of leg, infant	0261	1.38	$66.91	$38.77	$13.38
73600	X	X-ray exam of ankle	0260	0.79	$38.30	$22.02	$7.66
73610	X	X-ray exam of ankle	0260	0.79	$38.30	$22.02	$7.66
73615	S	Contrast x-ray of ankle	0275	2.74	$132.85	$72.26	$26.57
73620	X	X-ray exam of foot	0260	0.79	$38.30	$22.02	$7.66
73630	X	X-ray exam of foot	0260	0.79	$38.30	$22.02	$7.66
73650	X	X-ray exam of heel	0260	0.79	$38.30	$22.02	$7.66
73660	X	X-ray exam of toe(s)	0260	0.79	$38.30	$22.02	$7.66
73700	S	CAT scan of leg	0283	4.89	$237.10	$179.39	$47.42
73701	S	Contrast CAT scan of leg	0283	4.89	$237.10	$179.39	$47.42
73702	S	Contrast CAT scans of leg	0283	4.89	$237.10	$179.39	$47.42
73720	S	Magnetic image, leg/foot	0284	8.02	$388.87	$257.39	$77.77
73721	S	Magnetic image, joint of leg	0284	8.02	$388.87	$257.39	$77.77
73725	E	Magnetic image/lower (mra)	.....	.....	.....	.....	.....
74000	X	X-ray exam of abdomen	0260	0.79	$38.30	$22.02	$7.66
74010	X	X-ray exam of abdomen	0260	0.79	$38.30	$22.02	$7.66
74020	X	X-ray exam of abdomen	0260	0.79	$38.30	$22.02	$7.66
74022	X	X-ray exam series, abdomen	0261	1.38	$66.91	$38.77	$13.38
74150	S	CAT scan of abdomen	0283	4.89	$237.10	$179.39	$47.42
74160	S	Contrast CAT scan of abdomen	0283	4.89	$237.10	$179.39	$47.42
74170	S	Contrast CAT scans, abdomen	0283	4.89	$237.10	$179.39	$47.42
74181	S	Magnetic image/abdomen (mri)	0284	8.02	$388.87	$257.39	$77.77
74185	E	Magnetic image/abdomen (MRA)	.....	.....	.....	.....	.....
74190	X	X-ray exam of peritoneum	0263	1.68	$81.46	$45.88	$16.29
74210	S	Contrast x-ray exam of throat	0276	1.79	$86.79	$49.78	$17.36
74220	S	Contrast x-ray, esophagus	0276	1.79	$86.79	$49.78	$17.36
74230	S	Cinema x-ray, throat/esoph	0276	1.79	$86.79	$49.78	$17.36
74235	S	Remove esophagus obstruction	0296	3.57	$173.10	$100.25	$34.62

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[2] Not subject to national coinsurance.

[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
74240	S	X-ray exam, upper gi tract	0276	1.79	$86.79	$49.78	$17.36
74241	S	X-ray exam, upper gi tract	0276	1.79	$86.79	$49.78	$17.36
74245	S	X-ray exam, upper gi tract	0277	2.47	$119.76	$69.28	$23.95
74246	S	Contrast x-ray uppr gi tract	0276	1.79	$86.79	$49.78	$17.36
74247	S	Contrast x-ray uppr gi tract	0276	1.79	$86.79	$49.78	$17.36
74249	S	Contrast x-ray uppr gi tract	0277	2.47	$119.76	$69.28	$23.95
74250	S	X-ray exam of small bowel	0276	1.79	$86.79	$49.78	$17.36
74251	S	X-ray exam of small bowel	0277	2.47	$119.76	$69.28	$23.95
74260	S	X-ray exam of small bowel	0277	2.47	$119.76	$69.28	$23.95
74270	S	Contrast x-ray exam of colon	0276	1.79	$86.79	$49.78	$17.36
74280	S	Contrast x-ray exam of colon	0277	2.47	$119.76	$69.28	$23.95
74283	S	Contrast x-ray exam of colon	0276	1.79	$86.79	$49.78	$17.36
74290	S	Contrast x-ray, gallbladder	0276	1.79	$86.79	$49.78	$17.36
74291	S	Contrast x-rays, gallbladder	0276	1.79	$86.79	$49.78	$17.36
74300	C	X-ray bile ducts/pancreas	.....	.....	.....	.....	.....
74301	C	X-rays at surgery add-on	.....	.....	.....	.....	.....
74305	X	X-ray bile ducts/pancreas	0263	1.68	$81.46	$45.88	$16.29
74320	X	Contrast x-ray of bile ducts	0264	3.83	$185.71	$108.97	$37.14
74327	S	X-ray bile stone removal	0296	3.57	$173.10	$100.25	$34.62
74328	X	X-ray bile duct endoscopy	0264	3.83	$185.71	$108.97	$37.14
74329	X	X-ray for pancreas endoscopy	0264	3.83	$185.71	$108.97	$37.14
74330	X	X-ray bile/panc endoscopy	0264	3.83	$185.71	$108.97	$37.14
74340	X	X-ray guide for GI tube	0272	1.40	$67.88	$39.00	$13.58
74350	X	X-ray guide, stomach tube	0264	3.83	$185.71	$108.97	$37.14
74355	X	X-ray guide, intestinal tube	0264	3.83	$185.71	$108.97	$37.14
74360	S	X-ray guide, GI dilation	0296	3.57	$173.10	$100.25	$34.62
74363	S	X-ray, bile duct dilation	0297	6.13	$297.23	$172.51	$59.45
74400	S	Contrast x-ray, urinary tract	0278	2.85	$138.19	$81.67	$27.64
74410	S	Contrast x-ray, urinary tract	0278	2.85	$138.19	$81.67	$27.64
74415	S	Contrast x-ray, urinary tract	0278	2.85	$138.19	$81.67	$27.64
74420	S	Contrast x-ray, urinary tract	0278	2.85	$138.19	$81.67	$27.64
74425	S	Contrast x-ray, urinary tract	0278	2.85	$138.19	$81.67	$27.64
74430	S	Contrast x-ray, bladder	0278	2.85	$138.19	$81.67	$27.64
74440	S	X-ray, male genital tract	0278	2.85	$138.19	$81.67	$27.64
74445	S	X-ray exam of penis	0278	2.85	$138.19	$81.67	$27.64
74450	S	X-ray, urethra/bladder	0278	2.85	$138.19	$81.67	$27.64
74455	S	X-ray, urethra/bladder	0278	2.85	$138.19	$81.67	$27.64
74470	X	X-ray exam of kidney lesion	0264	3.83	$185.71	$108.97	$37.14
74475	S	X-ray control, cath insert	0297	6.13	$297.23	$172.51	$59.45
74480	S	X-ray control, cath insert	0297	6.13	$297.23	$172.51	$59.45
74485	S	X-ray guide, GU dilation	0296	3.57	$173.10	$100.25	$34.62
74710	X	X-ray measurement of pelvis	0260	0.79	$38.30	$22.02	$7.66
74740	X	X-ray, female genital tract	0264	3.83	$185.71	$108.97	$37.14
74742	X	X-ray, fallopian tube	0264	3.83	$185.71	$108.97	$37.14
74775	S	X-ray exam of perineum	0278	2.85	$138.19	$81.67	$27.64
75552	S	Magnetic image, myocardium	0284	8.02	$388.87	$257.39	$77.77
75553	S	Magnetic image, myocardium	0284	8.02	$388.87	$257.39	$77.77
75554	S	Cardiac MRI/function	0284	8.02	$388.87	$257.39	$77.77
75555	S	Cardiac MRI/limited study	0284	8.02	$388.87	$257.39	$77.77
75556	E	Cardiac MRI/flow mapping	.....	.....	.....	.....	.....
75600	S	Contrast x-ray exam of aorta	0280	14.98	$726.34	$380.12	$145.27
75605	S	Contrast x-ray exam of aorta	0280	14.98	$726.34	$380.12	$145.27
75625	S	Contrast x-ray exam of aorta	0280	14.98	$726.34	$380.12	$145.27
75630	S	X-ray aorta, leg arteries	0280	14.98	$726.34	$380.12	$145.27
75650	S	Artery x-rays, head & neck	0280	14.98	$726.34	$380.12	$145.27
75658	S	Artery x-rays, arm	0280	14.98	$726.34	$380.12	$145.27
75660	S	Artery x-rays, head & neck	0279	6.30	$305.47	$174.57	$61.09
75662	S	Artery x-rays, head & neck	0279	6.30	$305.47	$174.57	$61.09
75665	S	Artery x-rays, head & neck	0280	14.98	$726.34	$380.12	$145.27
75671	S	Artery x-rays, head & neck	0280	14.98	$726.34	$380.12	$145.27
75676	S	Artery x-rays, neck	0280	14.98	$726.34	$380.12	$145.27
75680	S	Artery x-rays, neck	0280	14.98	$726.34	$380.12	$145.27
75685	S	Artery x-rays, spine	0279	6.30	$305.47	$174.57	$61.09
75705	S	Artery x-rays, spine	0279	6.30	$305.47	$174.57	$61.09
75710	S	Artery x-rays, arm/leg	0280	14.98	$726.34	$380.12	$145.27
75716	S	Artery x-rays, arms/legs	0280	14.98	$726.34	$380.12	$145.27
75722	S	Artery x-rays, kidney	0280	14.98	$726.34	$380.12	$145.27
75724	S	Artery x-rays, kidneys	0280	14.98	$726.34	$380.12	$145.27
75726	S	Artery x-rays, abdomen	0280	14.98	$726.34	$380.12	$145.27
75731	S	Artery x-rays, adrenal gland	0280	14.98	$726.34	$380.12	$145.27
75733	S	Artery x-rays, adrenals	0280	14.98	$726.34	$380.12	$145.27
75736	S	Artery x-rays, pelvis	0280	14.98	$726.34	$380.12	$145.27
75741	S	Artery x-rays, lung	0279	6.30	$305.47	$174.57	$61.09

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
75743	S	Artery x-rays, lungs	0280	14.98	$726.34	$380.12	$145.27
75746	S	Artery x-rays, lung	0279	6.30	$305.47	$174.57	$61.09
75756	S	Artery x-rays, chest	0279	6.30	$305.47	$174.57	$61.09
75774	S	Artery x-ray, each vessel	0280	14.98	$726.34	$380.12	$145.27
75790	S	Visualize A–V shunt	0281	4.40	$213.34	$115.16	$42.67
75801	X	Lymph vessel x-ray, arm/leg	0264	3.83	$185.71	$108.97	$37.14
75803	X	Lymph vessel x-ray, arms/legs	0264	3.83	$185.71	$108.97	$37.14
75805	X	Lymph vessel x-ray, trunk	0264	3.83	$185.71	$108.97	$37.14
75807	X	Lymph vessel x-ray, trunk	0264	3.83	$185.71	$108.97	$37.14
75809	X	Nonvascular shunt, x-ray	0264	3.83	$185.71	$108.97	$37.14
75810	S	Vein x-ray, spleen/liver	0279	6.30	$305.47	$174.57	$61.09
75820	S	Vein x-ray, arm/leg	0281	4.40	$213.34	$115.16	$42.67
75822	S	Vein x-ray, arms/legs	0281	4.40	$213.34	$115.16	$42.67
75825	S	Vein x-ray, trunk	0279	6.30	$305.47	$174.57	$61.09
75827	S	Vein x-ray, chest	0279	6.30	$305.47	$174.57	$61.09
75831	S	Vein x-ray, kidney	0279	6.30	$305.47	$174.57	$61.09
75833	S	Vein x-ray, kidneys	0279	6.30	$305.47	$174.57	$61.09
75840	S	Vein x-ray, adrenal gland	0279	6.30	$305.47	$174.57	$61.09
75842	S	Vein x-ray, adrenal glands	0279	6.30	$305.47	$174.57	$61.09
75860	S	Vein x-ray, neck	0279	6.30	$305.47	$174.57	$61.09
75870	S	Vein x-ray, skull	0279	6.30	$305.47	$174.57	$61.09
75872	S	Vein x-ray, skull	0279	6.30	$305.47	$174.57	$61.09
75880	S	Vein x-ray, eye socket	0279	6.30	$305.47	$174.57	$61.09
75885	S	Vein x-ray, liver	0279	6.30	$305.47	$174.57	$61.09
75887	S	Vein x-ray, liver	0280	14.98	$726.34	$380.12	$145.27
75889	S	Vein x-ray, liver	0279	6.30	$305.47	$174.57	$61.09
75891	S	Vein x-ray, liver	0279	6.30	$305.47	$174.57	$61.09
75893	N	Venous sampling by catheter					
75894	S	X-rays, transcath therapy	0297	6.13	$297.23	$172.51	$59.45
75896	S	X-rays, transcath therapy	0297	6.13	$297.23	$172.51	$59.45
75898	X	Follow-up angiogram	0264	3.83	$185.71	$108.97	$37.14
75900	C	Arterial catheter exchange					
75940	C	X-ray placement, vein filter					
75945	C	Intravascular us					
75946	C	Intravascular us add-on					
75960	C	Transcatheter intro, stent					
75961	C	Retrieval, broken catheter					
75962	C	Repair arterial blockage					
75964	C	Repair artery blockage, each					
75966	C	Repair arterial blockage					
75968	C	Repair artery blockage, each					
75970	C	Vascular biopsy					
75978	C	Repair venous blockage					
75980	S	Contrast x-ray exam bile duct	0297	6.13	$297.23	$172.51	$59.45
75982	S	Contrast x-ray exam bile duct	0297	6.13	$297.23	$172.51	$59.45
75984	S	X-ray control catheter change	0296	3.57	$173.10	$100.25	$34.62
75989	X	Abscess drainage under x-ray	0273	2.49	$120.73	$61.02	$24.15
75992	C	Atherectomy, x-ray exam					
75993	C	Atherectomy, x-ray exam					
75994	C	Atherectomy, x-ray exam					
75995	C	Atherectomy, x-ray exam					
75996	C	Atherectomy, x-ray exam					
76000	X	Fluoroscope examination	0272	1.40	$67.88	$39.00	$13.58
76001	X	Fluoroscope exam, extensive	0273	2.49	$120.73	$61.02	$24.15
76003	X	Needle localization by x-ray	0272	1.40	$67.88	$39.00	$13.58
76005	X	Fluoroguide for spine inject	0273	2.49	$120.73	$61.02	$24.15
76006	X	X-ray stress view	0261	1.38	$66.91	$38.77	$13.38
76010	X	X-ray, nose to rectum	0260	0.79	$38.30	$22.02	$7.66
76020	X	X-rays for bone age	0261	1.38	$66.91	$38.77	$13.38
76040	X	X-rays, bone evaluation	0260	0.79	$38.30	$22.02	$7.66
76061	X	X-rays, bone survey	0261	1.38	$66.91	$38.77	$13.38
76062	X	X-rays, bone survey	0261	1.38	$66.91	$38.77	$13.38
76065	X	X-rays, bone evaluation	0261	1.38	$66.91	$38.77	$13.38
76066	X	Joint(s) survey, single film	0260	0.79	$38.30	$22.02	$7.66
76070	E	CT scan, bone density study					
76075	X	Dual energy x-ray study	0261	1.38	$66.91	$38.77	$13.38
76076	X	Dual energy x-ray study	0261	1.38	$66.91	$38.77	$13.38
76078	X	Photodensitometry	0261	1.38	$66.91	$38.77	$13.38
76080	X	X-ray exam of fistula	0263	1.68	$81.46	$45.88	$16.29
76086	X	X-ray of mammary duct	0263	1.68	$81.46	$45.88	$16.29
76088	X	X-ray of mammary ducts	0263	1.68	$81.46	$45.88	$16.29
76090	S	Mammogram, one breast	0271	0.70	$33.94	$19.50	$6.79
76091	S	Mammogram, both breasts	0271	0.70	$33.94	$19.50	$6.79

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
76092	A	Mammogram, screening	.....	.....	.....	.....	.....
76093	S	Magnetic image, breast	0284	8.02	$388.87	$257.39	$77.77
76094	S	Magnetic image, both breasts	0284	8.02	$388.87	$257.39	$77.77
76095	X	Stereotactic breast biopsy	0264	3.83	$185.71	$108.97	$37.14
76096	X	X-ray of needle wire, breast	0263	1.68	$81.46	$45.88	$16.29
76098	X	X-ray exam, breast specimen	0260	0.79	$38.30	$22.02	$7.66
76100	X	X-ray exam of body section	0261	1.38	$66.91	$38.77	$13.38
76101	X	Complex body section x-ray	0263	1.68	$81.46	$45.88	$16.29
76102	X	Complex body section x-rays	0264	3.83	$185.71	$108.97	$37.14
76120	X	Cinematic x-rays	0261	1.38	$66.91	$38.77	$13.38
76125	X	Cinematic x-rays add-on	0261	1.38	$66.91	$38.77	$13.38
76140	E	X-ray consultation	.....	.....	.....	.....	.....
76150	X	X-ray exam, dry process	0260	0.79	$38.30	$22.02	$7.66
76350	N	Special x-ray contrast study	.....	.....	.....	.....	.....
76355	S	CAT scan for localization	0283	4.89	$237.10	$179.39	$47.42
76360	S	CAT scan for needle biopsy	0283	4.89	$237.10	$179.39	$47.42
76365	S	CAT scan for cyst aspiration	0283	4.89	$237.10	$179.39	$47.42
76370	S	CAT scan for therapy guide	0282	2.38	$115.40	$94.51	$23.08
76375	S	3D/holograph reconstr add-on	0282	2.38	$115.40	$94.51	$23.08
76380	S	CAT scan follow-up study	0282	2.38	$115.40	$94.51	$23.08
76390	S	Mr spectroscopy	0284	8.02	$388.87	$257.39	$77.77
76400	S	Magnetic image, bone marrow	0284	8.02	$388.87	$257.39	$77.77
76499	X	Radiographic procedure	0260	0.79	$38.30	$22.02	$7.66
76506	S	Echo exam of head	0266	1.79	$86.79	$57.35	$17.36
76511	S	Echo exam of eye	0266	1.79	$86.79	$57.35	$17.36
76512	S	Echo exam of eye	0266	1.79	$86.79	$57.35	$17.36
76513	S	Echo exam of eye, water bath	0265	1.17	$56.73	$38.08	$11.35
76516	S	Echo exam of eye	0266	1.79	$86.79	$57.35	$17.36
76519	S	Echo exam of eye	0266	1.79	$86.79	$57.35	$17.36
76529	S	Echo exam of eye	0265	1.17	$56.73	$38.08	$11.35
76536	S	Echo exam of head and neck	0265	1.17	$56.73	$38.08	$11.35
76604	S	Echo exam of chest	0266	1.79	$86.79	$57.35	$17.36
76645	S	Echo exam of breast(s)	0265	1.17	$56.73	$38.08	$11.35
76700	S	Echo exam of abdomen	0266	1.79	$86.79	$57.35	$17.36
76705	S	Echo exam of abdomen	0266	1.79	$86.79	$57.35	$17.36
76770	S	Echo exam abdomen back wall	0266	1.79	$86.79	$57.35	$17.36
76775	S	Echo exam abdomen back wall	0266	1.79	$86.79	$57.35	$17.36
76778	S	Echo exam kidney transplant	0266	1.79	$86.79	$57.35	$17.36
76800	S	Echo exam spinal canal	0266	1.79	$86.79	$57.35	$17.36
76805	S	Echo exam of pregnant uterus	0266	1.79	$86.79	$57.35	$17.36
76810	S	Echo exam of pregnant uterus	0265	1.17	$56.73	$38.08	$11.35
76815	S	Echo exam of pregnant uterus	0265	1.17	$56.73	$38.08	$11.35
76816	S	Echo exam follow-up/repeat	0265	1.17	$56.73	$38.08	$11.35
76818	S	Fetal biophysical profile	0266	1.79	$86.79	$57.35	$17.36
76825	S	Echo exam of fetal heart	0269	4.40	$213.34	$114.01	$42.67
76826	S	Echo exam of fetal heart	0269	4.40	$213.34	$114.01	$42.67
76827	S	Echo exam of fetal heart	0269	4.40	$213.34	$114.01	$42.67
76828	S	Echo exam of fetal heart	0269	4.40	$213.34	$114.01	$42.67
76830	S	Echo exam, transvaginal	0266	1.79	$86.79	$57.35	$17.36
76831	S	Echo exam, uterus	0266	1.79	$86.79	$57.35	$17.36
76856	S	Echo exam of pelvis	0266	1.79	$86.79	$57.35	$17.36
76857	S	Echo exam of pelvis	0265	1.17	$56.73	$38.08	$11.35
76870	S	Echo exam of scrotum	0266	1.79	$86.79	$57.35	$17.36
76872	S	Echo exam, transrectal	0266	1.79	$86.79	$57.35	$17.36
76873	S	Echograp trans r, pros study	0266	1.79	$86.79	$57.35	$17.36
76880	S	Echo exam of extremity	0266	1.79	$86.79	$57.35	$17.36
76885	S	Echo exam, infant hips	0266	1.79	$86.79	$57.35	$17.36
76886	S	Echo exam, infant hips	0266	1.79	$86.79	$57.35	$17.36
76930	X	Echo guide for heart sac tap	0268	2.23	$108.13	$69.51	$21.63
76932	X	Echo guide for heart biopsy	0268	2.23	$108.13	$69.51	$21.63
76934	X	Echo guide for chest tap	0268	2.23	$108.13	$69.51	$21.63
76936	X	Echo guide for artery repair	0268	2.23	$108.13	$69.51	$21.63
76938	X	Echo exam for drainage	0268	2.23	$108.13	$69.51	$21.63
76941	X	Echo guide for transfusion	0268	2.23	$108.13	$69.51	$21.63
76942	X	Echo guide for biopsy	0268	2.23	$108.13	$69.51	$21.63
76945	X	Echo guide, villus sampling	0268	2.23	$108.13	$69.51	$21.63
76946	X	Echo guide for amniocentesis	0268	2.23	$108.13	$69.51	$21.63
76948	X	Echo guide, ova aspiration	0268	2.23	$108.13	$69.51	$21.63
76950	X	Echo guidance radiotherapy	0268	2.23	$108.13	$69.51	$21.63
76960	X	Echo guidance radiotherapy	0268	2.23	$108.13	$69.51	$21.63
76965	X	Echo guidance radiotherapy	0268	2.23	$108.13	$69.51	$21.63
76970	S	Ultrasound exam follow-up	0265	1.17	$56.73	$38.08	$11.35
76975	S	GI endoscopic ultrasound	0266	1.79	$86.79	$57.35	$17.36

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
76977	S	Us bone density measure	0265	1.17	$56.73	$38.08	$11.35
76986	S	Echo exam at surgery	0266	1.79	$86.79	$57.35	$17.36
76999	S	Echo examination procedure	0266	1.79	$86.79	$57.35	$17.36
77261	E	Radiation therapy planning					
77262	E	Radiation therapy planning					
77263	E	Radiation therapy planning					
77280	X	Set radiation therapy field	0304	1.49	$72.25	$41.52	$14.45
77285	X	Set radiation therapy field	0305	4.06	$196.86	$97.50	$39.37
77290	X	Set radiation therapy field	0305	4.06	$196.86	$97.50	$39.37
77295	X	Set radiation therapy field	0310	13.98	$677.85	$339.05	$135.57
77299	E	Radiation therapy planning					
77300	X	Radiation therapy dose plan	0304	1.49	$72.25	$41.52	$14.45
77305	X	Radiation therapy dose plan	0304	1.49	$72.25	$41.52	$14.45
77310	X	Radiation therapy dose plan	0304	1.49	$72.25	$41.52	$14.45
77315	X	Radiation therapy dose plan	0305	4.06	$196.86	$97.50	$39.37
77321	X	Radiation therapy port plan	0305	4.06	$196.86	$97.50	$39.37
77326	X	Radiation therapy dose plan	0305	4.06	$196.86	$97.50	$39.37
77327	X	Radiation therapy dose plan	0305	4.06	$196.86	$97.50	$39.37
77328	X	Radiation therapy dose plan	0305	4.06	$196.86	$97.50	$39.37
77331	X	Special radiation dosimetry	0304	1.49	$72.25	$41.52	$14.45
77332	X	Radiation treatment aid(s)	0303	2.83	$137.22	$69.28	$27.44
77333	X	Radiation treatment aid(s)	0303	2.83	$137.22	$69.28	$27.44
77334	X	Radiation treatment aid(s)	0303	2.83	$137.22	$69.28	$27.44
77336	X	Radiation physics consult	0311	1.32	$64.00	$31.66	$12.80
77370	X	Radiation physics consult	0311	1.32	$64.00	$31.66	$12.80
77399	X	External radiation dosimetry	0311	1.32	$64.00	$31.66	$12.80
77401	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77402	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77403	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77404	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77406	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77407	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77408	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77409	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77411	S	Radiation treatment delivery	0301	2.21	$107.16	$52.53	$21.43
77412	S	Radiation treatment delivery	0301	2.21	$107.16	$52.53	$21.43
77413	S	Radiation treatment delivery	0301	2.21	$107.16	$52.53	$21.43
77414	S	Radiation treatment delivery	0300	1.98	$96.00	$47.72	$19.20
77416	S	Radiation treatment delivery	0301	2.21	$107.16	$52.53	$21.43
77417	X	Radiology port film(s)	0260	0.79	$38.30	$22.02	$7.66
77427	E	Radiation tx management, x5					
77431	E	Radiation therapy management					
77432	E	Stereotactic radiation trmt					
77470	S	Special radiation treatment	0302	8.21	$398.08	$216.55	$79.62
77499	E	Radiation therapy management					
77520	S	Proton beam delivery	0301	2.21	$107.16	$52.53	$21.43
77523	S	Proton beam delivery	0301	2.21	$107.16	$52.53	$21.43
77600	S	Hyperthermia treatment	0314	5.88	$285.10	$150.95	$57.02
77605	S	Hyperthermia treatment	0314	5.88	$285.10	$150.95	$57.02
77610	S	Hyperthermia treatment	0314	5.88	$285.10	$150.95	$57.02
77615	S	Hyperthermia treatment	0314	5.88	$285.10	$150.95	$57.02
77620	S	Hyperthermia treatment	0314	5.88	$285.10	$150.95	$57.02
77750	S	Infuse radioactive materials	0301	2.21	$107.16	$52.53	$21.43
77761	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77762	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77763	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77776	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77777	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77778	S	Radioelement application	0312	4.09	$198.31	$109.65	$39.66
77781	S	High intensity brachytherapy	0313	7.89	$382.56	$164.02	$76.51
77782	S	High intensity brachytherapy	0313	7.89	$382.56	$164.02	$76.51
77783	S	High intensity brachytherapy	0313	7.89	$382.56	$164.02	$76.51
77784	S	High intensity brachytherapy	0313	7.89	$382.56	$164.02	$76.51
77789	S	Radioelement application	0300	1.98	$96.00	$47.72	$19.20
77790	N	Radioelement handling					
77799	S	Radium/radioisotope therapy	0313	7.89	$382.56	$164.02	$76.51
78000	S	Thyroid, single uptake	0290	1.94	$94.06	$55.51	$18.81
78001	S	Thyroid, multiple uptakes	0290	1.94	$94.06	$55.51	$18.81
78003	S	Thyroid suppress/stimul	0290	1.94	$94.06	$55.51	$18.81
78006	S	Thyroid imaging with uptake	0291	3.15	$152.73	$93.14	$30.55
78007	S	Thyroid image, mult uptakes	0291	3.15	$152.73	$93.14	$30.55
78010	S	Thyroid imaging	0290	1.94	$94.06	$55.51	$18.81
78011	S	Thyroid imaging with flow	0290	1.94	$94.06	$55.51	$18.81

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
78015	S	Thyroid met imaging	0291	3.15	$152.73	$93.14	$30.55
78016	S	Thyroid met imaging/studies	0292	4.36	$211.40	$126.63	$42.28
78018	S	Thyroid met imaging, body	0292	4.36	$211.40	$126.63	$42.28
78020	S	Thyroid met uptake	0292	4.36	$211.40	$126.63	$42.28
78070	S	Parathyroid nuclear imaging	0292	4.36	$211.40	$126.63	$42.28
78075	S	Adrenal nuclear imaging	0292	4.36	$211.40	$126.63	$42.28
78099	S	Endocrine nuclear procedure	0290	1.94	$94.06	$55.51	$18.81
78102	S	Bone marrow imaging, ltd	0291	3.15	$152.73	$93.14	$30.55
78103	S	Bone marrow imaging, mult	0292	4.36	$211.40	$126.63	$42.28
78104	S	Bone marrow imaging, body	0292	4.36	$211.40	$126.63	$42.28
78110	S	Plasma volume, single	0291	3.15	$152.73	$93.14	$30.55
78111	S	Plasma volume, multiple	0291	3.15	$152.73	$93.14	$30.55
78120	S	Red cell mass, single	0291	3.15	$152.73	$93.14	$30.55
78121	S	Red cell mass, multiple	0291	3.15	$152.73	$93.14	$30.55
78122	S	Blood volume	0292	4.36	$211.40	$126.63	$42.28
78130	S	Red cell survival study	0292	4.36	$211.40	$126.63	$42.28
78135	S	Red cell survival kinetics	0292	4.36	$211.40	$126.63	$42.28
78140	S	Red cell sequestration	0292	4.36	$211.40	$126.63	$42.28
78160	S	Plasma iron turnover	0292	4.36	$211.40	$126.63	$42.28
78162	S	Iron absorption exam	0292	4.36	$211.40	$126.63	$42.28
78170	S	Red cell iron utilization	0292	4.36	$211.40	$126.63	$42.28
78172	S	Total body iron estimation	0292	4.36	$211.40	$126.63	$42.28
78185	S	Spleen imaging	0291	3.15	$152.73	$93.14	$30.55
78190	S	Platelet survival, kinetics	0291	3.15	$152.73	$93.14	$30.55
78191	S	Platelet survival	0291	3.15	$152.73	$93.14	$30.55
78195	S	Lymph system imaging	0292	4.36	$211.40	$126.63	$42.28
78199	S	Blood/lymph nuclear exam	0290	1.94	$94.06	$55.51	$18.81
78201	S	Liver imaging	0291	3.15	$152.73	$93.14	$30.55
78202	S	Liver imaging with flow	0291	3.15	$152.73	$93.14	$30.55
78205	S	Liver imaging (3D)	0292	4.36	$211.40	$126.63	$42.28
78206	S	Liver image (3D) w/flow	0292	4.36	$211.40	$126.63	$42.28
78215	S	Liver and spleen imaging	0291	3.15	$152.73	$93.14	$30.55
78216	S	Liver & spleen image/flow	0291	3.15	$152.73	$93.14	$30.55
78220	S	Liver function study	0292	4.36	$211.40	$126.63	$42.28
78223	S	Hepatobiliary imaging	0292	4.36	$211.40	$126.63	$42.28
78230	S	Salivary gland imaging	0291	3.15	$152.73	$93.14	$30.55
78231	S	Serial salivary imaging	0291	3.15	$152.73	$93.14	$30.55
78232	S	Salivary gland function exam	0291	3.15	$152.73	$93.14	$30.55
78258	S	Esophageal motility study	0291	3.15	$152.73	$93.14	$30.55
78261	S	Gastric mucosa imaging	0291	3.15	$152.73	$93.14	$30.55
78262	S	Gastroesophageal reflux exam	0291	3.15	$152.73	$93.14	$30.55
78264	S	Gastric emptying study	0292	4.36	$211.40	$126.63	$42.28
[2] 78267	T	Breath tst attain/anal c–14	0971	1.55	$75.16	.....	$15.03
[2] 78268	T	Breath test analysis, c–14	0970	0.52	$25.21	.....	$5.04
78270	S	Vit B–12 absorption exam	0290	1.94	$94.06	$55.51	$18.81
78271	S	Vit B–12 absorp exam, IF	0290	1.94	$94.06	$55.51	$18.81
78272	S	Vit B–12 absorp, combined	0291	3.15	$152.73	$93.14	$30.55
78278	S	Acute GI blood loss imaging	0292	4.36	$211.40	$126.63	$42.28
78282	S	GI protein loss exam	0290	1.94	$94.06	$55.51	$18.81
78290	S	Meckel's divert exam	0291	3.15	$152.73	$93.14	$30.55
78291	S	Leveen/shunt patency exam	0292	4.36	$211.40	$126.63	$42.28
78299	S	GI nuclear procedure	0290	1.94	$94.06	$55.51	$18.81
78300	S	Bone imaging, limited area	0291	3.15	$152.73	$93.14	$30.55
78305	S	Bone imaging, multiple areas	0292	4.36	$211.40	$126.63	$42.28
78306	S	Bone imaging, whole body	0292	4.36	$211.40	$126.63	$42.28
78315	S	Bone imaging, 3 phase	0292	4.36	$211.40	$126.63	$42.28
78320	S	Bone imaging (3D)	0292	4.36	$211.40	$126.63	$42.28
78350	X	Bone mineral, single photon	0261	1.38	$66.91	$38.77	$13.38
78351	E	Bone mineral, dual photon	.....	.....	.....	.....	.....
78399	S	Musculoskeletal nuclear exam	0290	1.94	$94.06	$55.51	$18.81
78414	S	Non-imaging heart function	0292	4.36	$211.40	$126.63	$42.28
78428	S	Cardiac shunt imaging	0292	4.36	$211.40	$126.63	$42.28
78445	S	Vascular flow imaging	0291	3.15	$152.73	$93.14	$30.55
78455	S	Venous thrombosis study	0291	3.15	$152.73	$93.14	$30.55
78456	S	Acute venous thrombus image	0291	3.15	$152.73	$93.14	$30.55
78457	S	Venous thrombosis imaging	0291	3.15	$152.73	$93.14	$30.55
78458	S	Ven thrombosis images, bilat	0291	3.15	$152.73	$93.14	$30.55
78459	E	Heart muscle imaging (PET)	.....	.....	.....	.....	.....
78460	S	Heart muscle blood, single	0286	7.28	$352.99	$200.04	$70.60
78461	S	Heart muscle blood, multiple	0286	7.28	$352.99	$200.04	$70.60
78464	S	Heart image (3D), single	0286	7.28	$352.99	$200.04	$70.60
78465	S	Heart image (3D), multiple	0286	7.28	$352.99	$200.04	$70.60
78466	S	Heart infarct image	0292	4.36	$211.40	$126.63	$42.28

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
78468	S	Heart infarct image (ef)	0292	4.36	$211.40	$126.63	$42.28
78469	S	Heart infarct image (3D)	0292	4.36	$211.40	$126.63	$42.28
78472	S	Gated heart, planar, single	0286	7.28	$352.99	$200.04	$70.60
78473	S	Gated heart, multiple	0286	7.28	$352.99	$200.04	$70.60
78478	S	Heart wall motion add-on	0286	7.28	$352.99	$200.04	$70.60
78480	S	Heart function add-on	0286	7.28	$352.99	$200.04	$70.60
78481	S	Heart first pass, single	0286	7.28	$352.99	$200.04	$70.60
78483	S	Heart first pass, multiple	0286	7.28	$352.99	$200.04	$70.60
78491	E	Heart image (pet), single					
78492	E	Heart image (pet), multiple					
78494	S	Heart image, spect	0296	3.57	$173.10	$100.25	$34.62
78496	S	Heart first pass add-on	0296	3.57	$173.10	$100.25	$34.62
78499	S	Cardiovascular nuclear exam	0292	4.36	$211.40	$126.63	$42.28
78580	S	Lung perfusion imaging	0291	3.15	$152.73	$93.14	$30.55
78584	S	Lung V/Q image single breath	0292	4.36	$211.40	$126.63	$42.28
78585	S	Lung V/Q imaging	0292	4.36	$211.40	$126.63	$42.28
78586	S	Aerosol lung image, single	0292	4.36	$211.40	$126.63	$42.28
78587	S	Aerosol lung image, multiple	0292	4.36	$211.40	$126.63	$42.28
78588	S	Perfusion lung image	0292	4.36	$211.40	$126.63	$42.28
78591	S	Vent image, 1 breath, 1 proj	0291	3.15	$152.73	$93.14	$30.55
78593	S	Vent image, 1 proj, gas	0292	4.36	$211.40	$126.63	$42.28
78594	S	Vent image, mult proj, gas	0292	4.36	$211.40	$126.63	$42.28
78596	S	Lung differential function	0292	4.36	$211.40	$126.63	$42.28
78599	S	Respiratory nuclear exam	0291	3.15	$152.73	$93.14	$30.55
78600	S	Brain imaging, ltd static	0292	4.36	$211.40	$126.63	$42.28
78601	S	Brain imaging, ltd w/flow	0292	4.36	$211.40	$126.63	$42.28
78605	S	Brain imaging, complete	0291	3.15	$152.73	$93.14	$30.55
78606	S	Brain imaging, compl w/flow	0292	4.36	$211.40	$126.63	$42.28
78607	S	Brain imaging (3D)	0292	4.36	$211.40	$126.63	$42.28
78608	E	Brain imaging (PET)					
78609	E	Brain imaging (PET)					
78610	S	Brain flow imaging only	0291	3.15	$152.73	$93.14	$30.55
78615	S	Cerebral blood flow imaging	0292	4.36	$211.40	$126.63	$42.28
78630	S	Cerebrospinal fluid scan	0292	4.36	$211.40	$126.63	$42.28
78635	S	CSF ventriculography	0292	4.36	$211.40	$126.63	$42.28
78645	S	CSF shunt evaluation	0292	4.36	$211.40	$126.63	$42.28
78647	S	Cerebrospinal fluid scan	0292	4.36	$211.40	$126.63	$42.28
78650	S	CSF leakage imaging	0292	4.36	$211.40	$126.63	$42.28
78655	S		0292	4.36	$211.40	$126.63	$42.28
78660	S	Nuclear exam of tear flow	0291	3.15	$152.73	$93.14	$30.55
78699	S	Nervous system nuclear exam	0292	4.36	$211.40	$126.63	$42.28
78700	S	Kidney imaging, static	0291	3.15	$152.73	$93.14	$30.55
78701	S	Kidney imaging with flow	0291	3.15	$152.73	$93.14	$30.55
78704	S	Imaging renogram	0292	4.36	$211.40	$126.63	$42.28
78707	S	Kidney flow/function image	0292	4.36	$211.40	$126.63	$42.28
78708	S	Kidney flow/function image	0292	4.36	$211.40	$126.63	$42.28
78709	S	Kidney flow/function image	0292	4.36	$211.40	$126.63	$42.28
78710	S	Kidney imaging (3D)	0292	4.36	$211.40	$126.63	$42.28
78715	S	Renal vascular flow exam	0291	3.15	$152.73	$93.14	$30.55
78725	S	Kidney function study	0291	3.15	$152.73	$93.14	$30.55
78730	S	Urinary bladder retention	0291	3.15	$152.73	$93.14	$30.55
78740	S	Ureteral reflux study	0291	3.15	$152.73	$93.14	$30.55
78760	S	Testicular imaging	0291	3.15	$152.73	$93.14	$30.55
78761	S	Testicular imaging/flow	0291	3.15	$152.73	$93.14	$30.55
78799	S	Genitourinary nuclear exam	0292	4.36	$211.40	$126.63	$42.28
78800	S	Tumor imaging, limited area	0292	4.36	$211.40	$126.63	$42.28
78801	S	Tumor imaging, mult areas	0292	4.36	$211.40	$126.63	$42.28
78802	S	Tumor imaging, whole body	0292	4.36	$211.40	$126.63	$42.28
78803	S	Tumor imaging (3D)	0292	4.36	$211.40	$126.63	$42.28
78805	S	Abscess imaging, ltd area	0292	4.36	$211.40	$126.63	$42.28
78806	S	Abscess imaging, whole body	0292	4.36	$211.40	$126.63	$42.28
78807	S	Nuclear localization/abscess	0292	4.36	$211.40	$126.63	$42.28
78810	E	Tumor imaging (PET)					
78890	N	Nuclear medicine data proc					
78891	N	Nuclear med data proc					
78990	N	Provide diag radionuclide(s)					
78999	S	Nuclear diagnostic exam	0291	3.15	$152.73	$93.14	$30.55
79000	S	Init hyperthyroid therapy	0294	5.13	$248.74	$144.06	$49.75
79001	S	Repeat hyperthyroid therapy	0294	5.13	$248.74	$144.06	$49.75
79020	S	Thyroid ablation	0294	5.13	$248.74	$144.06	$49.75
79030	S	Thyroid ablation, carcinoma	0294	5.13	$248.74	$144.06	$49.75
79035	S	Thyroid metastatic therapy	0294	5.13	$248.74	$144.06	$49.75
79100	S	Hematopoetic nuclear therapy	0294	5.13	$248.74	$144.06	$49.75

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
79200	S	Intracavitary nuclear trmt	0295	19.85	$962.47	$609.17	$192.49
79300	S	Interstitial nuclear therapy	0294	5.13	$248.74	$144.06	$49.75
79400	S	Nonhemato nuclear therapy	0295	19.85	$962.47	$609.17	$192.49
79420	S	Intravascular nuclear ther	0295	19.85	$962.47	$609.17	$192.49
79440	S	Nuclear joint therapy	0294	5.13	$248.74	$144.06	$49.75
79900	N	Provide ther radiopharm(s)					
79999	S	Nuclear medicine therapy	0294	5.13	$248.74	$144.06	$49.75
80048	A	Basic metabolic panel					
80050	A	General health panel					
80051	A	Electrolyte panel					
80053	A	Comprehen metabolic panel					
80055	A	Obstetric panel					
80061	A	Lipid panel					
80069	A	Renal function panel					
80072	A	Arthritis panel					
80074	A	Acute hepatitis panel					
80076	A	Hepatic function panel					
80090	A	Torch antibody panel					
80100	A	Drug screen					
80101	A	Drug screen					
80102	A	Drug confirmation					
80103	N	Drug analysis, tissue prep					
80150	A	Assay of amikacin					
80152	A	Assay of amitriptyline					
80154	A	Assay of benzodiazepines					
80156	A	Assay of carbamazepine					
80158	A	Assay of cyclosporine					
80160	A	Assay of desipramine					
80162	A	Assay of digoxin					
80164	A	Assay, dipropylacetic acid					
80166	A	Assay of doxepin					
80168	A	Assay of ethosuximide					
80170	A	Assay of gentamicin					
80172	A	Assay of gold					
80174	A	Assay of imipramine					
80176	A	Assay of lidocaine					
80178	A	Assay of lithium					
80182	A	Assay of nortriptyline					
80184	A	Assay of phenobarbital					
80185	A	Assay of phenytoin, total					
80186	A	Assay of phenytoin, free					
80188	A	Assay of primidone					
80190	A	Assay of procainamide					
80192	A	Assay of procainamide					
80194	A	Assay of quinidine					
80196	A	Assay of salicylate					
80197	A	Assay of tacrolimus					
80198	A	Assay of theophylline					
80200	A	Assay of tobramycin					
80201	A	Assay of topiramate					
80202	A	Assay of vancomycin					
80299	A	Quantitative assay, drug					
80400	A	Acth stimulation panel					
80402	A	Acth stimulation panel					
80406	A	Acth stimulation panel					
80408	A	Aldosterone suppression eval					
80410	A	Calcitonin stimul panel					
80412	A	CRH stimulation panel					
80414	A	Testosterone response					
80415	A	Estradiol response panel					
80416	A	Renin stimulation panel					
80417	A	Renin stimulation panel					
80418	A	Pituitary evaluation panel					
80420	A	Dexamethasone panel					
80422	A	Glucagon tolerance panel					
80424	A	Glucagon tolerance panel					
80426	A	Gonadotropin hormone panel					
80428	A	Growth hormone panel					
80430	A	Growth hormone panel					
80432	A	Insulin suppression panel					
80434	A	Insulin tolerance panel					
80435	A	Insulin tolerance panel					
80436	A	Metyrapone panel					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
80438	A	TRH stimulation panel					
80439	A	TRH stimulation panel					
80440	A	TRH stimulation panel					
80500	X	Lab pathology consultation	0343	0.45	$21.82	$12.16	$4.36
80502	X	Lab pathology consultation	0343	0.45	$21.82	$12.16	$4.36
81000	A	Urinalysis, nonauto w/scope					
81001	A	Urinalysis, auto w/scope					
81002	A	Urinalysis nonauto w/o scope					
81003	A	Urinalysis, auto, w/o scope					
81005	A	Urinalysis					
81007	A	Urine screen for bacteria					
81015	A	Microscopic exam of urine					
81020	A	Urinalysis, glass test					
81025	A	Urine pregnancy test					
81050	A	Urinalysis, volume measure					
81099	A	Urinalysis test procedure					
82000	A	Assay of blood acetaldehyde					
82003	A	Assay of acetaminophen					
82009	A	Test for acetone/ketones					
82010	A	Acetone assay					
82013	A	Acetylcholinesterase assay					
82016	A	Acylcarnitines, qual					
82017	A	Acylcarnitines, quant					
82024	A	Assay of acth					
82030	A	Assay of adp & amp					
82040	A	Assay of serum albumin					
82042	A	Assay of urine albumin					
82043	A	Microalbumin, quantitative					
82044	A	Microalbumin, semiquant					
82055	A	Assay of ethanol					
82075	A	Assay of breath ethanol					
82085	A	Assay of aldolase					
82088	A	Assay of aldosterone					
82101	A	Assay of urine alkaloids					
82103	A	Alpha-1-antitrypsin, total					
82104	A	Alpha-1-antitrypsin, pheno					
82105	A	Alpha-fetoprotein, serum					
82106	A	Alpha-fetoprotein, amniotic					
82108	A	Assay of aluminum					
82120	A	Amines, vaginal fluid qual					
82127	A	Amino acid, single qual					
82128	A	Amino acids, mult qual					
82131	A	Amino acids, single quant					
82135	A	Assay, aminolevulinic acid					
82136	A	Amino acids, quant, 2–5					
82139	A	Amino acids, quan, 6 or more					
82140	A	Assay of ammonia					
82143	A	Amniotic fluid scan					
82145	A	Assay of amphetamines					
82150	A	Assay of amylase					
82154	A	Androstanediol glucuronide					
82157	A	Assay of androstenedione					
82160	A	Assay of androsterone					
82163	A	Assay of angiotensin II					
82164	A	Angiotensin I enzyme test					
82172	A	Assay of apolipoprotein					
82175	A	Assay of arsenic					
82180	A	Assay of ascorbic acid					
82190	A	Atomic absorption					
82205	A	Assay of barbiturates					
82232	A	Assay of beta-2 protein					
82239	A	Bile acids, total					
82240	A	Bile acids, cholylglycine					
82247	A	Bilirubin, total					
82248	A	Bilirubin, direct					
82251	A	Assay of bilirubin					
82252	A	Fecal bilirubin test					
82261	A	Assay of biotinidase					
82270	A	Test for blood, feces					
82273	A	Test for blood, other source					
82286	A	Assay of bradykinin					
82300	A	Assay of cadmium					
82306	A	Assay of vitamin D					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
82307	A	Assay of vitamin D					
82308	A	Assay of calcitonin					
82310	A	Assay of calcium					
82330	A	Assay of calcium					
82331	A	Calcium infusion test					
82340	A	Assay of calcium in urine					
82355	A	Calculus (stone) analysis					
82360	A	Calculus (stone) assay					
82365	A	Calculus (stone) assay					
82370	A	X-ray assay, calculus					
82374	A	Assay, blood carbon dioxide					
82375	A	Assay, blood carbon monoxide					
82376	A	Test for carbon monoxide					
82378	A	Carcinoembryonic antigen					
82379	A	Assay of carnitine					
82380	A	Assay of carotene					
82382	A	Assay, urine catecholamines					
82383	A	Assay, blood catecholamines					
82384	A	Assay, three catecholamines					
82387	A	Assay of cathepsin-d					
82390	A	Assay of ceruloplasmin					
82397	A	Chemiluminescent assay					
82415	A	Assay of chloramphenicol					
82435	A	Assay of blood chloride					
82436	A	Assay of urine chloride					
82438	A	Assay, other fluid chlorides					
82441	A	Test for chlorohydrocarbons					
82465	A	Assay of serum cholesterol					
82480	A	Assay, serum cholinesterase					
82482	A	Assay, rbc cholinesterase					
82485	A	Assay, chondroitin sulfate					
82486	A	Gas/liquid chromatography					
82487	A	Paper chromatography					
82488	A	Paper chromatography					
82489	A	Thin layer chromatography					
82491	A	Chromotography, quant, sing					
82492	A	Chromotography, quant, mult					
82495	A	Assay of chromium					
82507	A	Assay of citrate					
82520	A	Assay of cocaine					
82523	A	Collagen crosslinks					
82525	A	Assay of copper					
82528	A	Assay of corticosterone					
82530	A	Cortisol, free					
82533	A	Total cortisol					
82540	A	Assay of creatine					
82541	A	Column chromotography, qual					
82542	A	Column chromotography, quant					
82543	A	Column chromotograph/isotope					
82544	A	Column chromotograph/isotope					
82550	A	Assay of ck (cpk)					
82552	A	Assay of cpk in blood					
82553	A	Creatine, MB fraction					
82554	A	Creatine, isoforms					
82565	A	Assay of creatinine					
82570	A	Assay of urine creatinine					
82575	A	Creatinine clearance test					
82585	A	Assay of cryofibrinogen					
82595	A	Assay of cryoglobulin					
82600	A	Assay of cyanide					
82607	A	Vitamin B–12					
82608	A	B–12 binding capacity					
82615	A	Test for urine cystines					
82626	A	Dehydroepiandrosterone					
82627	A	Dehydroepiandrosterone					
82633	A	Desoxycorticosterone					
82634	A	Deoxycortisol					
82638	A	Assay of dibucaine number					
82646	A	Assay of dihydrocodeinone					
82649	A	Assay of dihydromorphinone					
82651	A	Assay of dihydrotestosterone					
82652	A	Assay of dihydroxyvitamin d					
82654	A	Assay of dimethadione					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
82657	A	Enzyme cell activity					
82658	A	Enzyme cell activity, ra					
82664	A	Electrophoretic test					
82666	A	Assay of epiandrosterone					
82668	A	Assay of erythropoietin					
82670	A	Assay of estradiol					
82671	A	Assay of estrogens					
82672	A	Assay of estrogen					
82677	A	Assay of estriol					
82679	A	Assay of estrone					
82690	A	Assay of ethchlorvynol					
82693	A	Assay of ethylene glycol					
82696	A	Assay of etiocholanolone					
82705	A	Fats/lipids, feces, qual					
82710	A	Fats/lipids, feces, quant					
82715	A	Assay of fecal fat					
82725	A	Assay of blood fatty acids					
82726	A	Long chain fatty acids					
82728	A	Assay of ferritin					
82731	A	Assay of fetal fibronectin					
82735	A	Assay of fluoride					
82742	A	Assay of flurazepam					
82746	A	Blood folic acid serum					
82747	A	Assay of folic acid, rbc					
82757	A	Assay of semen fructose					
82759	A	Assay of rbc galactokinase					
82760	A	Assay of galactose					
82775	A	Assay galactose transferase					
82776	A	Galactose transferase test					
82784	A	Assay of gammaglobulin igm					
82785	A	Assay of gammaglobulin ige					
82787	A	Igg 1, 2, 3 and 4					
82800	A	Blood pH					
82803	A	Blood gases: pH, pO2 & pCO2					
82805	A	Blood gases W/02 saturation					
82810	A	Blood gases, O2 sat only					
82820	A	Hemoglobin-oxygen affinity					
82926	A	Assay of gastric acid					
82928	A	Assay of gastric acid					
82938	A	Gastrin test					
82941	A	Assay of gastrin					
82943	A	Assay of glucagon					
82946	A	Glucagon tolerance test					
82947	A	Assay of glucose, quant					
82948	A	Reagent strip/blood glucose					
82950	A	Glucose test					
82951	A	Glucose tolerance test (GTT)					
82952	A	GTT-added samples					
82953	A	Glucose-tolbutamide test					
82955	A	Assay of g6pd enzyme					
82960	A	Test for G6PD enzyme					
82962	A	Glucose blood test					
82963	A	Assay of glucosidase					
82965	A	Assay of gdh enzyme					
82975	A	Assay of glutamine					
82977	A	Assay of GGT					
82978	A	Assay of glutathione					
82979	A	Assay, rbc glutathione					
82980	A	Assay of glutethimide					
82985	A	Glycated protein					
83001	A	Gonadotropin (FSH)					
83002	A	Gonadotropin (LH)					
83003	A	Assay, growth hormone (hgh)					
83008	A	Assay of guanosine					
83010	A	Assay of haptoglobin, quant					
83012	A	Assay of haptoglobins					
83013	A	H pylori breath tst analysis					
83014	A	H pylori drug admin/collect					
83015	A	Heavy metal screen					
83018	A	Quantitative screen, metals					
83020	A	Hemoglobin electrophoresis					
83021	A	Hemoglobin chromotography					
83026	A	Hemoglobin, copper sulfate					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
83030	A	Fetal hemoglobin assay					
83033	A	Fetal fecal hemoglobin assay					
83036	A	Glycated hemoglobin test					
83045	A	Blood methemoglobin test					
83050	A	Blood methemoglobin assay					
83051	A	Assay of plasma hemoglobin					
83055	A	Blood sulfhemoglobin test					
83060	A	Blood sulfhemoglobin assay					
83065	A	Assay of hemoglobin heat					
83068	A	Hemoglobin stability screen					
83069	A	Assay of urine hemoglobin					
83070	A	Assay of hemosiderin, qual					
83071	A	Assay of hemosiderin, quant					
83080	A	Assay of b hexosaminidase					
83088	A	Assay of histamine					
83150	A	Assay of for hva					
83491	A	Assay of corticosteroids					
83497	A	Assay of 5-hiaa					
83498	A	Assay of progesterone					
83499	A	Assay of progesterone					
83500	A	Assay, free hydroxyproline					
83505	A	Assay, total hydroxyproline					
83516	A	Immunoassay, nonantibody					
83518	A	Immunoassay, dipstick					
83519	A	Immunoassay, nonantibody					
83520	A	Immunoassay, RIA					
83525	A	Assay of insulin					
83527	A	Assay of insulin					
83528	A	Assay of intrinsic factor					
83540	A	Assay of iron					
83550	A	Iron binding test					
83570	A	Assay of idh enzyme					
83582	A	Assay of ketogenic steroids					
83586	A	Assay 17-ketosteroids					
83593	A	Fractionation, ketosteroids					
83605	A	Assay of lactic acid					
83615	A	Lactate (LD) (LDH) enzyme					
83625	A	Assay of ldh enzymes					
83632	A	Placental lactogen					
83633	A	Test urine for lactose					
83634	A	Assay of urine for lactose					
83655	A	Assay of lead					
83661	A	Assay of l/s ratio					
83662	A	L/S ratio, foam stability					
83670	A	Assay of lap enzyme					
83690	A	Assay of lipase					
83715	A	Assay of blood lipoproteins					
83716	A	Assay of blood lipoproteins					
83718	A	Assay of lipoprotein					
83719	A	Assay of blood lipoprotein					
83721	A	Assay of blood lipoprotein					
83727	A	Assay of lrh hormone					
83735	A	Assay of magnesium					
83775	A	Assay of md enzyme					
83785	A	Assay of manganese					
83788	A	Mass spectrometry qual					
83789	A	Mass spectrometry quant					
83805	A	Assay of meprobamate					
83825	A	Assay of mercury					
83835	A	Assay of metanephrines					
83840	A	Assay of methadone					
83857	A	Assay of methemalbumin					
83858	A	Assay of methsuximide					
83864	A	Mucopolysaccharides					
83866	A	Mucopolysaccharides screen					
83872	A	Assay synovial fluid mucin					
83873	A	Assay of csf protein					
83874	A	Assay of myoglobin					
83883	A	Assay, nephelometry not spec					
83885	A	Assay of nickel					
83887	A	Assay of nicotine					
83890	A	Molecule isolate					
83891	A	Molecule isolate nucleic					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
83892	A	Molecular diagnostics					
83893	A	Molecule dot/slot/blot					
83894	A	Molecule gel electrophor					
83896	A	Molecular diagnostics					
83897	A	Molecule nucleic transfer					
83898	A	Molecule nucleic ampli					
83901	A	Molecule nucleic ampli					
83902	A	Molecular diagnostics					
83903	A	Molecule mutation scan					
83904	A	Molecule mutation identify					
83905	A	Molecule mutation identify					
83906	A	Molecule mutation identify					
83912	A	Genetic examination					
83915	A	Assay of nucleotidase					
83916	A	Oligoclonal bands					
83918	A	Assay, organic acids quant					
83919	A	Assay, organic acids qual					
83925	A	Assay of opiates					
83930	A	Assay of blood osmolality					
83935	A	Assay of urine osmolality					
83937	A	Assay of osteocalcin					
83945	A	Assay of oxalate					
83970	A	Assay of parathormone					
83986	A	Assay of body fluid acidity					
83992	A	Assay for phencyclidine					
84022	A	Assay of phenothiazine					
84030	A	Assay of blood pku					
84035	A	Assay of phenylketones					
84060	A	Assay acid phosphatase					
84061	A	Phosphatase, forensic exam					
84066	A	Assay prostate phosphatase					
84075	A	Assay alkaline phosphatase					
84078	A	Assay alkaline phosphatase					
84080	A	Assay alkaline phosphatases					
84081	A	Amniotic fluid enzyme test					
84085	A	Assay of rbc pg6d enzyme					
84087	A	Assay phosphohexose enzymes					
84100	A	Assay of phosphorus					
84105	A	Assay of urine phosphorus					
84106	A	Test for porphobilinogen					
84110	A	Assay of porphobilinogen					
84119	A	Test urine for porphyrins					
84120	A	Assay of urine porphyrins					
84126	A	Assay of feces porphyrins					
84127	A	Assay of feces porphyrins					
84132	A	Assay of serum potassium					
84133	A	Assay of urine potassium					
84134	A	Assay of prealbumin					
84135	A	Assay of pregnanediol					
84138	A	Assay of pregnanetriol					
84140	A	Assay of pregnenolone					
84143	A	Assay of 17-hydroxypregneno					
84144	A	Assay of progesterone					
84146	A	Assay of prolactin					
84150	A	Assay of prostaglandin					
84153	A	Assay of psa, total					
84154	A	Assay of psa, free					
84155	A	Assay of protein					
84160	A	Assay of serum protein					
84165	A	Assay of serum proteins					
84181	A	Western blot test					
84182	A	Protein, western blot test					
84202	A	Assay RBC protoporphyrin					
84203	A	Test RBC protoporphyrin					
84206	A	Assay of proinsulin					
84207	A	Assay of vitamin b–6					
84210	A	Assay of pyruvate					
84220	A	Assay of pyruvate kinase					
84228	A	Assay of quinine					
84233	A	Assay of estrogen					
84234	A	Assay of progesterone					
84235	A	Assay of endocrine hormone					
84238	A	Assay, nonendocrine receptor					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
84244	A	Assay of renin					
84252	A	Assay of vitamin b–2					
84255	A	Assay of selenium					
84260	A	Assay of serotonin					
84270	A	Assay of sex hormone globul					
84275	A	Assay of sialic acid					
84285	A	Assay of silica					
84295	A	Assay of serum sodium					
84300	A	Assay of urine sodium					
84305	A	Assay of somatomedin					
84307	A	Assay of somatostatin					
84311	A	Spectrophotometry					
84315	A	Body fluid specific gravity					
84375	A	Chromatogram assay, sugars					
84376	A	Sugars, single, qual					
84377	A	Sugars, multiple, qual					
84378	A	Sugars single quant					
84379	A	Sugars multiple quant					
84392	A	Assay of urine sulfate					
84402	A	Assay of testosterone					
84403	A	Assay of total testosterone					
84425	A	Assay of vitamin b–1					
84430	A	Assay of thiocyanate					
84432	A	Assay of thyroglobulin					
84436	A	Assay of total thyroxine					
84437	A	Assay of neonatal thyroxine					
84439	A	Assay of free thyroxine					
84442	A	Assay of thyroid activity					
84443	A	Assay thyroid stim hormone					
84445	A	Assay of tsi					
84446	A	Assay of vitamin e					
84449	A	Assay of transcortin					
84450	A	Transferase (AST) (SGOT)					
84460	A	Alanine amino (ALT) (SGPT)					
84466	A	Assay of transferrin					
84478	A	Assay of triglycerides					
84479	A	Assay of thyroid (t3 or t4)					
84480	A	Assay, triiodothyronine (t3)					
84481	A	Free assay (FT–3)					
84482	A	T3 reverse					
84484	A	Assay of troponin, quant					
84485	A	Assay duodenal fluid trypsin					
84488	A	Test feces for trypsin					
84490	A	Assay of feces for trypsin					
84510	A	Assay of tyrosine					
84512	A	Assay of troponin, qual					
84520	A	Assay of urea nitrogen					
84525	A	Urea nitrogen semi-quant					
84540	A	Assay of urine/urea-n					
84545	A	Urea-N clearance test					
84550	A	Assay of blood/uric acid					
84560	A	Assay of urine/uric acid					
84577	A	Assay of feces/urobilinogen					
84578	A	Test urine urobilinogen					
84580	A	Assay of urine urobilinogen					
84583	A	Assay of urine urobilinogen					
84585	A	Assay of urine vma					
84586	A	Assay of vip					
84588	A	Assay of vasopressin					
84590	A	Assay of vitamin a					
84597	A	Assay of vitamin k					
84600	A	Assay of volatiles					
84620	A	Xylose tolerance test					
84630	A	Assay of zinc					
84681	A	Assay of c-peptide					
84702	A	Chorionic gonadotropin test					
84703	A	Chorionic gonadotropin assay					
84830	A	Ovulation tests					
84999	A	Clinical chemistry test					
85002	A	Bleeding time test					
85007	A	Differential WBC count					
85008	A	Nondifferential WBC count					
85009	A	Differential WBC count					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
85013	A	Hematocrit					
85014	A	Hematocrit					
85018	A	Hemoglobin					
85021	A	Automated hemogram					
85022	A	Automated hemogram					
85023	A	Automated hemogram					
85024	A	Automated hemogram					
85025	A	Automated hemogram					
85027	A	Automated hemogram					
85031	A	Manual hemogram, cbc					
85041	A	Red blood cell (RBC) count					
85044	A	Reticulocyte count					
85045	A	Reticulocyte count					
85046	A	Reticyte/hgb concentrate					
85048	A	White blood cell (WBC) count					
85060	X	Blood smear interpretation	0342	0.26	$12.61	$8.03	$2.52
85095	T	Bone marrow aspiration	0003	0.98	$47.52	$27.99	$9.50
85097	X	Bone marrow interpretation	0344	0.79	$38.30	$23.63	$7.66
85102	T	Bone marrow biopsy	0003	0.98	$47.52	$27.99	$9.50
85130	A	Chromogenic substrate assay					
85170	A	Blood clot retraction					
85175	A	Blood clot lysis time					
85210	A	Blood clot factor II test					
85220	A	Blood clot factor V test					
85230	A	Blood clot factor VII test					
85240	A	Blood clot factor VIII test					
85244	A	Blood clot factor VIII test					
85245	A	Blood clot factor VIII test					
85246	A	Blood clot factor VIII test					
85247	A	Blood clot factor VIII test					
85250	A	Blood clot factor IX test					
85260	A	Blood clot factor X test					
85270	A	Blood clot factor XI test					
85280	A	Blood clot factor XII test					
85290	A	Blood clot factor XIII test					
85291	A	Blood clot factor XIII test					
85292	A	Blood clot factor assay					
85293	A	Blood clot factor assay					
85300	A	Antithrombin III test					
85301	A	Antithrombin III test					
85302	A	Blood clot inhibitor antigen					
85303	A	Blood clot inhibitor test					
85305	A	Blood clot inhibitor assay					
85306	A	Blood clot inhibitor test					
85335	A	Factor inhibitor test					
85337	A	Thrombomodulin					
85345	A	Coagulation time					
85347	A	Coagulation time					
85348	A	Coagulation time					
85360	A	Euglobulin lysis					
85362	A	Fibrin degradation products					
85366	A	Fibrinogen test					
85370	A	Fibrinogen test					
85378	A	Fibrin degradation					
85379	A	Fibrin degradation					
85384	A	Fibrinogen					
85385	A	Fibrinogen					
85390	A	Fibrinolysins screen					
85400	A	Fibrinolytic plasmin					
85410	A	Fibrinolytic antiplasmin					
85415	A	Fibrinolytic plasminogen					
85420	A	Fibrinolytic plasminogen					
85421	A	Fibrinolytic plasminogen					
85441	A	Heinz bodies, direct					
85445	A	Heinz bodies, induced					
85460	A	Hemoglobin, fetal					
85461	A	Hemoglobin, fetal					
85475	A	Hemolysin					
85520	A	Heparin assay					
85525	A	Heparin					
85530	A	Heparin-protamine tolerance					
85535	A	Iron stain, blood cells					
85540	A	Wbc alkaline phosphatase					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
85547	A	RBC mechanical fragility					
85549	A	Muramidase					
85555	A	RBC osmotic fragility					
85557	A	RBC osmotic fragility					
85576	A	Blood platelet aggregation					
85585	A	Blood platelet estimation					
85590	A	Platelet count, manual					
85595	A	Platelet count, automated					
85597	A	Platelet neutralization					
85610	A	Prothrombin time					
85611	A	Prothrombin test					
85612	A	Viper venom prothrombin time					
85613	A	Russell viper venom, diluted					
85635	A	Reptilase test					
85651	A	Rbc sed rate, nonautomated					
85652	A	Rbc sed rate, automated					
85660	A	RBC sickle cell test					
85670	A	Thrombin time, plasma					
85675	A	Thrombin time, titer					
85705	A	Thromboplastin inhibition					
85730	A	Thromboplastin time, partial					
85732	A	Thromboplastin time, partial					
85810	A	Blood viscosity examination					
85999	A	Hematology procedure					
86000	A	Agglutinins, febrile					
86003	A	Allergen specific IgE					
86005	A	Allergen specific IgE					
86021	A	WBC antibody identification					
86022	A	Platelet antibodies					
86023	A	Immunoglobulin assay					
86038	A	Antinuclear antibodies					
86039	A	Antinuclear antibodies (ANA)					
86060	A	Antistreptolysin o, titer					
86063	A	Antistreptolysin o, screen					
86077	X	Physician blood bank service	0343	0.45	$21.82	$12.16	$4.36
86078	X	Physician blood bank service	0344	0.79	$38.30	$23.63	$7.66
86079	X	Physician blood bank service	0344	0.79	$38.30	$23.63	$7.66
86140	A	C-reactive protein					
86147	A	Cardiolipin antibody					
86148	A	Phospholipid antibody					
86155	A	Chemotaxis assay					
86156	A	Cold agglutinin, screen					
86157	A	Cold agglutinin, titer					
86160	A	Complement, antigen					
86161	A	Complement/function activity					
86162	A	Complement, total (CH50)					
86171	A	Complement fixation, each					
86185	A	Counterimmunoelectrophoresis					
86215	A	Deoxyribonuclease, antibody					
86225	A	DNA antibody					
86226	A	DNA antibody, single strand					
86235	A	Nuclear antigen antibody					
86243	A	Fc receptor					
86255	A	Fluorescent antibody, screen					
86256	A	Fluorescent antibody, titer					
86277	A	Growth hormone antibody					
86280	A	Hemagglutination inhibition					
86308	A	Heterophile antibodies					
86309	A	Heterophile antibodies					
86310	A	Heterophile antibodies					
86316	A	Immunoassay, tumor antigen					
86317	A	Immunoassay, infectious agent					
86318	A	Immunoassay, infectious agent					
86320	A	Serum immunoelectrophoresis					
86325	A	Other immunoelectrophoresis					
86327	A	Immunoelectrophoresis assay					
86329	A	Immunodiffusion					
86331	A	Immunodiffusion ouchterlony					
86332	A	Immune complex assay					
86334	A	Immunofixation procedure					
86337	A	Insulin antibodies					
86340	A	Intrinsic factor antibody					
86341	A	Islet cell antibody					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
86343	A	Leukocyte histamine release					
86344	A	Leukocyte phagocytosis					
86353	A	Lymphocyte transformation					
86359	A	T cells, total count					
86360	A	T cell, absolute count/ratio					
86361	A	T cell, absolute count					
86376	A	Microsomal antibody					
86378	A	Migration inhibitory factor					
86382	A	Neutralization test, viral					
86384	A	Nitroblue tetrazolium dye					
86403	A	Particle agglutination test					
86406	A	Particle agglutination test					
86430	A	Rheumatoid factor test					
86431	A	Rheumatoid factor, quant					
86485	X	Skin test, candida	0341	0.13	$6.30	$3.67	$1.26
86490	X	Coccidioidomycosis skin test	0341	0.13	$6.30	$3.67	$1.26
86510	X	Histoplasmosis skin test	0341	0.13	$6.30	$3.67	$1.26
86580	X	TB intradermal test	0341	0.13	$6.30	$3.67	$1.26
86585	X	TB tine test	0341	0.13	$6.30	$3.67	$1.26
86586	X	Skin test, unlisted	0341	0.13	$6.30	$3.67	$1.26
86590	A	Streptokinase, antibody					
86592	A	Blood serology, qualitative					
86593	A	Blood serology, quantitative					
86602	A	Antinomyces antibody					
86603	A	Adenovirus antibody					
86606	A	Aspergillus antibody					
86609	A	Bacterium antibody					
86612	A	Blastomyces antibody					
86615	A	Bordetella antibody					
86617	A	Lyme disease antibody					
86618	A	Lyme disease antibody					
86619	A	Borrelia antibody					
86622	A	Brucella antibody					
86625	A	Campylobacter antibody					
86628	A	Candida antibody					
86631	A	Chlamydia antibody					
86632	A	Chlamydia igm antibody					
86635	A	Coccidioides antibody					
86638	A	Q fever antibody					
86641	A	Cryptococcus antibody					
86644	A	CMV antibody					
86645	A	CMV antibody, IgM					
86648	A	Diphtheria antibody					
86651	A	Encephalitis antibody					
86652	A	Encephalitis antibody					
86653	A	Encephalitis antibody					
86654	A	Encephalitis antibody					
86658	A	Enterovirus antibody					
86663	A	Epstein-barr antibody					
86664	A	Epstein-barr antibody					
86665	A	Epstein-barr antibody					
86668	A	Francisella tularensis					
86671	A	Fungus antibody					
86674	A	Giardia lamblia antibody					
86677	A	Helicobacter pylori					
86682	A	Helminth antibody					
86684	A	Hemophilus influenza					
86687	A	Htlv-i antibody					
86688	A	Htlv-ii antibody					
86689	A	HTLV/HIV confirmatory test					
86692	A	Hepatitis, delta agent					
86694	A	Herpes simplex test					
86695	A	Herpes simplex test					
86698	A	Histoplasma					
86701	A	HIV–1					
86702	A	HIV–2					
86703	A	HIV–1/HIV–2, single assay					
86704	A	Hep b core antibody, igg/igm					
86705	A	Hep b core antibody, igm					
86706	A	Hep b surface antibody					
86707	A	Hep be antibody					
86708	A	Hep a antibody, igg/igm					
86709	A	Hep a antibody, igm					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
86710	A	Influenza virus antibody					
86713	A	Legionella antibody					
86717	A	Leishmania antibody					
86720	A	Leptospira antibody					
86723	A	Listeria monocytogenes ab					
86727	A	Lymph choriomeningitis ab					
86729	A	Lympho venereum antibody					
86732	A	Mucormycosis antibody					
86735	A	Mumps antibody					
86738	A	Mycoplasma antibody					
86741	A	Neisseria meningitidis					
86744	A	Nocardia antibody					
86747	A	Parvovirus antibody					
86750	A	Malaria antibody					
86753	A	Protozoa antibody nos					
86756	A	Respiratory virus antibody					
86759	A	Rotavirus antibody					
86762	A	Rubella antibody					
86765	A	Rubeola antibody					
86768	A	Salmonella antibody					
86771	A	Shigella antibody					
86774	A	Tetanus antibody					
86777	A	Toxoplasma antibody					
86778	A	Toxoplasma antibody, igm					
86781	A	Treponema pallidum, confirm					
86784	A	Trichinella antibody					
86787	A	Varicella-zoster antibody					
86790	A	Virus antibody nos					
86793	A	Yersinia antibody					
86800	A	Thyroglobulin antibody					
86803	A	Hepatitis c ab test					
86804	A	Hep c ab test, confirm					
86805	A	Lymphocytotoxicity assay					
86806	A	Lymphocytotoxicity assay					
86807	A	Cytotoxic antibody screening					
86808	A	Cytotoxic antibody screening					
86812	A	HLA typing, A, B, or C					
86813	A	HLA typing, A, B, or C					
86816	A	HLA typing, DR/DQ					
86817	A	HLA typing, DR/DQ					
86821	A	Lymphocyte culture, mixed					
86822	A	Lymphocyte culture, primed					
86849	A	Immunology procedure					
86850	A	RBC antibody screen					
86860	A	RBC antibody elution					
86870	A	RBC antibody identification					
86880	A	Coombs test					
86885	A	Coombs test					
86886	A	Coombs test					
86890	A	Autologous blood process					
86891	A	Autologous blood, op salvage					
86900	A	Blood typing, ABO					
86901	A	Blood typing, Rh (D)					
86903	A	Blood typing, antigen screen					
86904	A	Blood typing, patient serum					
86905	A	Blood typing, RBC antigens					
86906	A	Blood typing, Rh phenotype					
86910	E	Blood typing, paternity test					
86911	E	Blood typing, antigen system					
86915	A	Bone marrow/stem cell prep					
86920	A	Compatibility test					
86921	A	Compatibility test					
86922	A	Compatibility test					
86927	A	Plasma, fresh frozen					
86930	A	Frozen blood prep					
86931	A	Frozen blood thaw					
86932	A	Frozen blood freeze/thaw					
86940	A	Hemolysins/agglutinins, auto					
86941	A	Hemolysins/agglutinins					
86945	A	Blood product/irradiation					
86950	A	Leukacyte transfusion					
86965	A	Pooling blood platelets					
86970	A	RBC pretreatment					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
86971	A	RBC pretreatment					
86972	A	RBC pretreatment					
86975	A	RBC pretreatment, serum					
86976	A	RBC pretreatment, serum					
86977	A	RBC pretreatment, serum					
86978	A	RBC pretreatment, serum					
86985	A	Split blood or products					
86999	A	Transfusion procedure					
87001	A	Small animal inoculation					
87003	A	Small animal inoculation					
87015	A	Specimen concentration					
87040	A	Blood culture for bacteria					
87045	A	Stool culture for bacteria					
87060	A	Nose/throat culture, bact					
87070	A	Culture specimen, bacteria					
87072	A	Culture of specimen by kit					
87075	A	Culture specimen, bacteria					
87076	A	Bacteria identification					
87081	A	Bacteria culture screen					
87082	A	Culture of specimen by kit					
87083	A	Culture of specimen by kit					
87084	A	Culture of specimen by kit					
87085	A	Culture of specimen by kit					
87086	A	Urine culture/colony count					
87087	A	Urine bacteria culture					
87088	A	Urine bacteria culture					
87101	A	Skin fungus culture					
87102	A	Fungus isolation culture					
87103	A	Blood fungus culture					
87106	A	Fungus identification					
87109	A	Mycoplasma culture					
87110	A	Culture, chlamydia					
87116	A	Mycobacteria culture					
87117	A	Mycobacteria culture					
87118	A	Mycobacteria identification					
87140	A	Culture typing, fluorescent					
87143	A	Culture typing, GLC method					
87145	A	Culture typing, phage method					
87147	A	Culture typing, serologic					
87151	A	Culture typing, serologic					
87155	A	Culture typing, precipitin					
87158	A	Culture typing, added method					
87163	A	Special microbiology culture					
87164	A	Dark field examination					
87166	A	Dark field examination					
87174	A	Endotoxin, bacterial					
87175	A	Assay, endotoxin, bacterial					
87176	A	Endotoxin, bacterial					
87177	A	Ova and parasites smears					
87181	A	Antibiotic sensitivity, each					
87184	A	Antibiotic sensitivity, each					
87186	A	Antibiotic sensitivity, MIC					
87187	A	Antibiotic sensitivity, MBC					
87188	A	Antibiotic sensitivity, each					
87190	A	TB antibiotic sensitivity					
87192	A	Antibiotic sensitivity, each					
87197	A	Bactericidal level, serum					
87205	A	Smear, stain & interpret					
87206	A	Smear, stain & interpret					
87207	A	Smear, stain & interpret					
87208	A	Smear, stain & interpret					
87210	A	Smear, stain & interpret					
87211	A	Smear, stain & interpret					
87220	A	Tissue exam for fungi					
87230	A	Assay, toxin or antitoxin					
87250	A	Virus inoculation for test					
87252	A	Virus inoculation for test					
87253	A	Virus inoculation for test					
87260	A	Adenovirus ag, dfa					
87265	A	Pertussis ag, dfa					
87270	A	Chylmd trach ag, dfa					
87272	A	Cryptosporidum ag, dfa					
87274	A	Herpes simplex ag, dfa					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
87276	A	Influenza ag, dfa					
87278	A	Legion pneumo ag, dfa					
87280	A	Resp syncytial ag, dfa					
87285	A	Trepon pallidum ag, dfa					
87290	A	Varicella ag, dfa					
87299	A	Ag detection nos, dfa					
87301	A	Adenovirus ag, eia					
87320	A	Chylmd trach ag, eia					
87324	A	Clostridium ag, eia					
87328	A	Cryptospor ag, eia					
87332	A	Cytomegalovirus ag, eia					
87335	A	E coli 0157 ag, eia					
87338	A	Hpylori, stool, eia					
87340	A	Hepatitis b surface ag, eia					
87350	A	Hepatitis be ag, eia					
87380	A	Hepatitis delta ag, eia					
87385	A	Histoplasma capsul ag, eia					
87390	A	Hiv–1 ag, eia					
87391	A	Hiv–2 ag, eia					
87420	A	Resp syncytial ag, eia					
87425	A	Rotavirus ag, eia					
87430	A	Strep a ag, eia					
87449	A	Ag detect nos, eia, mult					
87450	A	Ag detect nos, eia, single					
87470	A	Bartonella, dna, dir probe					
87471	A	Bartonella, dna, amp probe					
87472	A	Bartonella, dna, quant					
87475	A	Lyme dis, dna, dir probe					
87476	A	Lyme dis, dna, amp probe					
87477	A	Lyme dis, dna, quant					
87480	A	Candida, dna, dir probe					
87481	A	Candida, dna, amp probe					
87482	A	Candida, dna, quant					
87485	A	Chylmd pneum, dna, dir probe					
87486	A	Chylmd pneum, dna, amp probe					
87487	A	Chylmd pneum, dna, quant					
87490	A	Chylmd trach, dna, dir probe					
87491	A	Chylmd trach, dna, amp probe					
87492	A	Chylmd trach, dna, quant					
87495	A	Cytomeg, dna, dir probe					
87496	A	Cytomeg, dna, amp probe					
87497	A	Cytomeg, dna, quant					
87510	A	Gardner vag, dna, dir probe					
87511	A	Gardner vag, dna, amp probe					
87512	A	Gardner vag, dna, quant					
87515	A	Hepatitis b, dna, dir probe					
87516	A	Hepatitis b, dna, amp probe					
87517	A	Hepatitis b, dna, quant					
87520	A	Hepatitis c, rna, dir probe					
87521	A	Hepatitis c, rna, amp probe					
87522	A	Hepatitis c, rna, quant					
87525	A	Hepatitis g, dna, dir probe					
87526	A	Hepatitis g, dna, amp probe					
87527	A	Hepatitis g, dna, quant					
87528	A	Hsv, dna, dir probe					
87529	A	Hsv, dna, amp probe					
87530	A	Hsv, dna, quant					
87531	A	Hhv–6, dna, dir probe					
87532	A	Hhv–6, dna, amp probe					
87533	A	Hhv–6, dna, quant					
87534	A	Hiv–1, dna, dir probe					
87535	A	Hiv–1, dna, amp probe					
87536	A	Hiv–1, dna, quant					
87537	A	Hiv–2, dna, dir probe					
87538	A	Hiv–2, dna, amp probe					
87539	A	Hiv–2, dna, quant					
87540	A	Legion pneumo, dna, dir prob					
87541	A	Legion pneumo, dna, amp prob					
87542	A	Legion pneumo, dna, quant					
87550	A	Mycobacteria, dna, dir probe					
87551	A	Mycobacteria, dna, amp probe					
87552	A	Mycobacteria, dna, quant					
87555	A	M.tuberculo, dna, dir probe					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
87556	A	M.tuberculo, dna, amp probe					
87557	A	M.tuberculo, dna, quant					
87560	A	M.avium-intra, dna, dir prob					
87561	A	M.avium-intra, dna, amp prob					
87562	A	M.avium-intra, dna, quant					
87580	A	M.pneumon, dna, dir probe					
87581	A	M.pneumon, dna, amp probe					
87582	A	M.pneumon, dna, quant					
87590	A	N.gonorrhoeae, dna, dir prob					
87591	A	N.gonorrhoeae, dna, amp prob					
87592	A	N.gonorrhoeae, dna, quant					
87620	A	Hpv, dna, dir probe					
87621	A	Hpv, dna, amp probe					
87622	A	Hpv, dna, quant					
87650	A	Strep a, dna, dir probe					
87651	A	Strep a, dna, amp probe					
87652	A	Strep a, dna, quant					
87797	A	Detect agent nos, dna, dir					
87798	A	Detect agent nos, dna, amp					
87799	A	Detect agent nos, dna, quant					
87810	A	Chylmd trach assay w/optic					
87850	A	N. gonorrhoeae assay w/optic					
87880	A	Strep a assay w/optic					
87899	A	Agent nos assay w/optic					
87999	A	Microbiology procedure					
88000	E	Autopsy (necropsy), gross					
88005	E	Autopsy (necropsy), gross					
88007	E	Autopsy (necropsy), gross					
88012	E	Autopsy (necropsy), gross					
88014	E	Autopsy (necropsy), gross					
88016	E	Autopsy (necropsy), gross					
88020	E	Autopsy (necropsy), complete					
88025	E	Autopsy (necropsy), complete					
88027	E	Autopsy (necropsy), complete					
88028	E	Autopsy (necropsy), complete					
88029	E	Autopsy (necropsy), complete					
88036	E	Limited autopsy					
88037	E	Limited autopsy					
88040	E	Forensic autopsy (necropsy)					
88045	E	Coroner's autopsy (necropsy)					
88099	E	Necropsy (autopsy) procedure					
88104	X	Cytopathology, fluids	0343	0.45	$21.82	$12.16	$4.36
88106	X	Cytopathology, fluids	0343	0.45	$21.82	$12.16	$4.36
88107	X	Cytopathology, fluids	0343	0.45	$21.82	$12.16	$4.36
88108	X	Cytopath, concentrate tech	0343	0.45	$21.82	$12.16	$4.36
88125	X	Forensic cytopathology	0343	0.45	$21.82	$12.16	$4.36
88130	A	Sex chromatin identification					
88140	A	Sex chromatin identification					
88141	N	Cytopath, c/v, interpret					
88142	A	Cytopath, c/v, thin layer					
88143	A	Cytopath c/v thin layer redo					
88144	A	Cytopath, c/v thin lyr redo					
88145	A	Cytopath, c/v thin lyr sel					
88147	A	Cytopath, c/v, automated					
88148	A	Cytopath, c/v, auto rescreen					
88150	A	Cytopath, c/v, manual					
88152	A	Cytopath, c/v, auto redo					
88153	A	Cytopath, c/v, redo					
88154	A	Cytopath, c/v, select					
88155	A	Cytopath, c/v, index add-on					
88160	X	Cytopath smear, other source	0342	0.26	$12.61	$8.03	$2.52
88161	X	Cytopath smear, other source	0343	0.45	$21.82	$12.16	$4.36
88162	X	Cytopath smear, other source	0343	0.45	$21.82	$12.16	$4.36
88164	A	Cytopath tbs, c/v, manual					
88165	A	Cytopath tbs, c/v, redo					
88166	A	Cytopath tbs, c/v, auto redo					
88167	A	Cytopath tbs, c/v, select					
88170	T	Fine needle aspiration	0002	0.62	$30.06	$17.66	$6.01
88171	T	Fine needle aspiration	0002	0.62	$30.06	$17.66	$6.01
88172	X	Evaluation of smear	0343	0.45	$21.82	$12.16	$4.36
88173	X	Interpretation of smear	0343	0.45	$21.82	$12.16	$4.36
88180	X	Cell marker study	0344	0.79	$38.30	$23.63	$7.66
88182	X	Cell marker study	0344	0.79	$38.30	$23.63	$7.66

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
88199	X	Cytopathology procedure	0342	0.26	$12.61	$8.03	$2.52
88230	A	Tissue culture, lymphocyte					
88233	A	Tissue culture, skin/biopsy					
88235	A	Tissue culture, placenta					
88237	A	Tissue culture, bone marrow					
88239	A	Tissue culture, tumor					
88240	A	Cell cryopreserve/storage					
88241	A	Frozen cell preparation					
88245	A	Chromosome analysis, 20–25					
88248	A	Chromosome analysis, 50–100					
88249	A	Chromosome analysis, 100					
88261	A	Chromosome analysis, 5					
88262	A	Chromosome analysis, 15–20					
88263	A	Chromosome analysis, 45					
88264	A	Chromosome analysis, 20–25					
88267	A	Chromosome analys, placenta					
88269	A	Chromosome analys, amniotic					
88271	A	Cytogenetics, dna probe					
88272	A	Cytogenetics, 3–5					
88273	A	Cytogenetics, 10–30					
88274	A	Cytogenetics, 25–99					
88275	A	Cytogenetics, 100–300					
88280	A	Chromosome karyotype study					
88283	A	Chromosome banding study					
88285	A	Chromosome count, additional					
88289	A	Chromosome study, additional					
88291	A	Cyto/molecular report					
88299	A	Cytogenetic study					
88300	X	Surgical path, gross	0342	0.26	$12.61	$8.03	$2.52
88302	X	Tissue exam by pathologist	0342	0.26	$12.61	$8.03	$2.52
88304	X	Tissue exam by pathologist	0343	0.45	$21.82	$12.16	$4.36
88305	X	Tissue exam by pathologist	0343	0.45	$21.82	$12.16	$4.36
88307	X	Tissue exam by pathologist	0344	0.79	$38.30	$23.63	$7.66
88309	X	Tissue exam by pathologist	0344	0.79	$38.30	$23.63	$7.66
88311	X	Decalcify tissue	0342	0.26	$12.61	$8.03	$2.52
88312	X	Special stains	0343	0.45	$21.82	$12.16	$4.36
88313	X	Special stains	0342	0.26	$12.61	$8.03	$2.52
88314	X	Histochemical stain	0343	0.45	$21.82	$12.16	$4.36
88318	X	Chemical histochemistry	0343	0.45	$21.82	$12.16	$4.36
88319	X	Enzyme histochemistry	0342	0.26	$12.61	$8.03	$2.52
88321	X	Microslide consultation	0342	0.26	$12.61	$8.03	$2.52
88323	X	Microslide consultation	0343	0.45	$21.82	$12.16	$4.36
88325	X	Comprehensive review of data	0343	0.45	$21.82	$12.16	$4.36
88329	X	Pathology consult in surgery	0343	0.45	$21.82	$12.16	$4.36
88331	X	Pathology consult in surgery	0343	0.45	$21.82	$12.16	$4.36
88332	X	Pathology consult in surgery	0343	0.45	$21.82	$12.16	$4.36
88342	X	Immunocytochemistry	0344	0.79	$38.30	$23.63	$7.66
88346	X	Immunofluorescent study	0343	0.45	$21.82	$12.16	$4.36
88347	X	Immunofluorescent study	0344	0.79	$38.30	$23.63	$7.66
88348	X	Electron microscopy	0344	0.79	$38.30	$23.63	$7.66
88349	X	Scanning electron microscopy	0344	0.79	$38.30	$23.63	$7.66
88355	X	Analysis, skeletal muscle	0344	0.79	$38.30	$23.63	$7.66
88356	X	Analysis, nerve	0344	0.79	$38.30	$23.63	$7.66
88358	X	Analysis, tumor	0344	0.79	$38.30	$23.63	$7.66
88362	X	Nerve teasing preparations	0343	0.45	$21.82	$12.16	$4.36
88365	X	Tissue hybridization	0344	0.79	$38.30	$23.63	$7.66
88371	A	Protein, western blot tissue					
88372	A	Protein analysis w/probe					
88399	X	Surgical pathology procedure	0342	0.26	$12.61	$8.03	$2.52
89050	A	Body fluid cell count					
89051	A	Body fluid cell count					
89060	A	Exam, synovial fluid crystals					
89100	X	Sample intestinal contents	0361	3.53	$171.16	$88.09	$34.23
89105	X	Sample intestinal contents	0360	1.38	$66.91	$34.75	$13.38
89125	A	Specimen fat stain					
89130	X	Sample stomach contents	0360	1.38	$66.91	$34.75	$13.38
89132	X	Sample stomach contents	0360	1.38	$66.91	$34.75	$13.38
89135	X	Sample stomach contents	0360	1.38	$66.91	$34.75	$13.38
89136	X	Sample stomach contents	0360	1.38	$66.91	$34.75	$13.38
89140	X	Sample stomach contents	0360	1.38	$66.91	$34.75	$13.38
89141	X	Sample stomach contents	0361	3.53	$171.16	$88.09	$34.23
89160	A	Exam feces for meat fibers					
89190	A	Nasal smear for eosinophils					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
89250	A	Fertilization of oocyte					
89251	A	Culture oocyte w/embryos					
89252	A	Assist oocyte fertilization					
89253	A	Embryo hatching					
89254	A	Oocyte identification					
89255	A	Prepare embryo for transfer					
89256	A	Prepare cryopreserved embryo					
89257	A	Sperm identification					
89258	A	Cryopreservation, embryo					
89259	A	Cryopreservation, sperm					
89260	A	Sperm isolation, simple					
89261	A	Sperm isolation, complex					
89264	A	Identify sperm tissue					
89300	A	Semen analysis					
89310	A	Semen analysis					
89320	A	Semen analysis					
89325	A	Sperm antibody test					
89329	A	Sperm evaluation test					
89330	A	Evaluation, cervical mucus					
89350	X	Sputum specimen collection	0344	0.79	$38.30	$23.63	$7.66
89355	A	Exam feces for starch					
89360	X	Collect sweat for test	0344	0.79	$38.30	$23.63	$7.66
89365	A	Water load test					
89399	X	Pathology lab procedure	0343	0.45	$21.82	$12.16	$4.36
90281	E	Human ig, im					
90283	E	Human ig, iv					
90287	X	Botulinum antitoxin	0357	1.85	$89.70	$38.31	$17.94
90288	E	Botulism ig, iv					
90291	E	Cmv ig, iv					
90296	X	Diphtheria antitoxin	0357	1.85	$89.70	$38.31	$17.94
90371	X	Hep b ig, im	0356	0.36	$17.46	$4.82	$3.49
90375	X	Rabies ig, im/sc	0357	1.85	$89.70	$38.31	$17.94
90376	X	Rabies ig, heat treated	0357	1.85	$89.70	$38.31	$17.94
90378	X	Rsv ig, im	0357	1.85	$89.70	$38.31	$17.94
90379	X	Rsv ig, iv	0357	1.85	$89.70	$38.31	$17.94
90384	X	Rh ig, full-dose, im	0357	1.85	$89.70	$38.31	$17.94
90385	X	Rh ig, minidose, im	0357	1.85	$89.70	$38.31	$17.94
90386	X	Rh ig, iv	0357	1.85	$89.70	$38.31	$17.94
90389	X	Tetanus ig, im	0356	0.36	$17.46	$4.82	$3.49
90393	X	Vaccina ig, im	0357	1.85	$89.70	$38.31	$17.94
90396	X	Varicella-zoster ig, im	0356	0.36	$17.46	$4.82	$3.49
90399	E	Immune globulin					
90471	N	Immunization admin					
90472	N	Immunization admin, each add					
90476	X	Adenovirus vaccine, type 4	0356	0.36	$17.46	$4.82	$3.49
90477	X	Adenovirus vaccine, type 7	0356	0.36	$17.46	$4.82	$3.49
90581	X	Anthrax vaccine, sc	0357	1.85	$89.70	$38.31	$17.94
90585	X	Bcg vaccine, percut	0356	0.36	$17.46	$4.82	$3.49
90586	X	Bcg vaccine, intravesical	0356	0.36	$17.46	$4.82	$3.49
90632	X	Hep a vaccine, adult im	0356	0.36	$17.46	$4.82	$3.49
90633	X	Hep a vacc, ped/adol, 2 dose	0356	0.36	$17.46	$4.82	$3.49
90634	X	Hep a vacc, ped/adol, 3 dose	0356	0.36	$17.46	$4.82	$3.49
90636	X	Hep a/hep b vacc, adult im	0357	1.85	$89.70	$38.31	$17.94
90645	X	Hib vaccine, hboc, im	0355	0.19	$9.21	$5.05	$1.84
90646	X	Hib vaccine, prp-d, im	0355	0.19	$9.21	$5.05	$1.84
90647	X	Hib vaccine, prp-omp, im	0355	0.19	$9.21	$5.05	$1.84
90648	X	Hib vaccine, prp-t, im	0355	0.19	$9.21	$5.05	$1.84
90657	X	Flu vaccine, 6–35 mo, im	0355	0.19	$9.21	$5.05	$1.84
90658	X	Flu vaccine, 3 yrs, im	0355	0.19	$9.21	$5.05	$1.84
90659	X	Flu vaccine, whole, im	0355	0.19	$9.21	$5.05	$1.84
90660	X	Flu vaccine, nasal	0355	0.19	$9.21	$5.05	$1.84
90665	X	Lyme disease vaccine, im	0357	1.85	$89.70	$38.31	$17.94
90669	X	Pneumococcal vaccine, ped	0357	1.85	$89.70	$38.31	$17.94
90675	X	Rabies vaccine, im	0357	1.85	$89.70	$38.31	$17.94
90676	X	Rabies vaccine, id	0357	1.85	$89.70	$38.31	$17.94
90680	X	Rotovirus vaccine, oral	0356	0.36	$17.46	$4.82	$3.49
90690	X	Typhoid vaccine, oral	0356	0.36	$17.46	$4.82	$3.49
90691	X	Typhoid vaccine, im	0356	0.36	$17.46	$4.82	$3.49
90692	X	Typhoid vaccine, h-p, sc/id	0356	0.36	$17.46	$4.82	$3.49
90693	X	Typhoid vaccine, akd, sc	0356	0.36	$17.46	$4.82	$3.49
90700	X	Dtap vaccine, im	0355	0.19	$9.21	$5.05	$1.84
90701	X	Dtp vaccine, im	0356	0.36	$17.46	$4.82	$3.49
90702	X	Dt vaccine, im	0355	0.19	$9.21	$5.05	$1.84

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
90703	X	Tetanus vaccine, im	0356	0.36	$17.46	$4.82	$3.49
90704	X	Mumps vaccine, sc	0355	0.19	$9.21	$5.05	$1.84
90705	X	Measles vaccine, sc	0357	1.85	$89.70	$38.31	$17.94
90706	X	Rubella vaccine, sc	0358	6.98	$338.44	$126.74	$67.69
90707	X	Mmr vaccine, sc	0356	0.36	$17.46	$4.82	$3.49
90708	X	Measles-rubella vaccine, sc	0358	6.98	$338.44	$126.74	$67.69
90709	X	Rubella & mumps vaccine, sc	0358	6.98	$338.44	$126.74	$67.69
90710	X	Mmrv vaccine, sc	0356	0.36	$17.46	$4.82	$3.49
90712	X	Oral poliovirus vaccine	0356	0.36	$17.46	$4.82	$3.49
90713	X	Poliovirus, ipv, sc	0355	0.19	$9.21	$5.05	$1.84
90716	X	Chicken pox vaccine, sc	0355	0.19	$9.21	$5.05	$1.84
90717	X	Yellow fever vaccine, sc	0356	0.36	$17.46	$4.82	$3.49
90718	X	Td vaccine, im	0356	0.36	$17.46	$4.82	$3.49
90719	X	Diphtheria vaccine, im	0357	1.85	$89.70	$38.31	$17.94
90720	X	Dtp/hib vaccine, im	0355	0.19	$9.21	$5.05	$1.84
90721	X	Dtap/hib vaccine, im	0355	0.19	$9.21	$5.05	$1.84
90725	X	Cholera vaccine, injectable	0358	6.98	$338.44	$126.74	$67.69
90727	X	Plague vaccine, im	0355	0.19	$9.21	$5.05	$1.84
90732	X	Pneumococcal vaccine, adult	0355	0.19	$9.21	$5.05	$1.84
90733	X	Meningococcal vaccine, sc	0357	1.85	$89.70	$38.31	$17.94
90735	X	Encephalitis vaccine, sc	0357	1.85	$89.70	$38.31	$17.94
90744	X	Hep b vaccine, ped/adol, im	0356	0.36	$17.46	$4.82	$3.49
90746	X	Hep b vaccine, adult, im	0356	0.36	$17.46	$4.82	$3.49
90747	X	Hep b vaccine, ill pat, im	0356	0.36	$17.46	$4.82	$3.49
90748	X	Hep b/hib vaccine, im	0358	6.98	$338.44	$126.74	$67.69
90749	X	Vaccine toxoid	0355	0.19	$9.21	$5.05	$1.84
90780	E	IV infusion therapy, 1 hour					
90781	E	IV infusion, additional hour					
90782	X	Injection, sc/im	0359	0.96	$46.55	$9.31	$9.31
90783	X	Injection, ia	0359	0.96	$46.55	$9.31	$9.31
90784	X	Injection, iv	0359	0.96	$46.55	$9.31	$9.31
90788	X	Injection of antibiotic	0359	0.96	$46.55	$9.31	$9.31
90799	X	Ther/prophylactic/dx inject	0359	0.96	$46.55	$9.31	$9.31
90801	S	Psy dx interview	0323	1.85	$89.70	$22.48	$17.94
90802	S	Intac psy dx interview	0323	1.85	$89.70	$22.48	$17.94
90804	S	Psytx, office, 20–30 min	0322	1.32	$64.00	$14.22	$12.80
90805	S	Psytx, off, 20–30 min w/e&m	0322	1.32	$64.00	$14.22	$12.80
90806	S	Psytx, off, 45–50 min	0323	1.85	$89.70	$22.48	$17.94
90807	S	Psytx, off, 45–50 min w/e&m	0323	1.85	$89.70	$22.48	$17.94
90808	S	Psytx, office, 75–80 min	0323	1.85	$89.70	$22.48	$17.94
90809	S	Psytx, off, 75–80, w/e&m	0323	1.85	$89.70	$22.48	$17.94
90810	S	Intac psytx, off, 20–30 min	0322	1.32	$64.00	$14.22	$12.80
90811	S	Intac psytx, 20–30, w/e&m	0322	1.32	$64.00	$14.22	$12.80
90812	S	Intac psytx, off, 45–50 min	0323	1.85	$89.70	$22.48	$17.94
90813	S	Intac psytx, 45–50 min w/e&m	0323	1.85	$89.70	$22.48	$17.94
90814	S	Intac psytx, off, 75–80 min	0323	1.85	$89.70	$22.48	$17.94
90815	S	Intac psytx, 75–80 w/e&m	0323	1.85	$89.70	$22.48	$17.94
90816	S	Psytx, hosp, 20–30 min	0322	1.32	$64.00	$14.22	$12.80
90817	S	Psytx, hosp, 20–30 min w/e&m	0322	1.32	$64.00	$14.22	$12.80
90818	S	Psytx, hosp, 45–50 min	0323	1.85	$89.70	$22.48	$17.94
90819	S	Psytx, hosp, 45–50 min w/e&m	0323	1.85	$89.70	$22.48	$17.94
90821	S	Psytx, hosp, 75–80 min	0323	1.85	$89.70	$22.48	$17.94
90822	S	Psytx, hosp, 75–80 min w/e&m	0323	1.85	$89.70	$22.48	$17.94
90823	S	Intac psytx, hosp, 20–30 min	0322	1.32	$64.00	$14.22	$12.80
90824	S	Intac psytx, hsp 20–30 w/e&m	0322	1.32	$64.00	$14.22	$12.80
90826	S	Intac psytx, hosp, 45–50 min	0323	1.85	$89.70	$22.48	$17.94
90827	S	Intac psytx, hsp 45–50 w/e&m	0323	1.85	$89.70	$22.48	$17.94
90828	S	Intac psytx, hosp, 75–80 min	0323	1.85	$89.70	$22.48	$17.94
90829	S	Intac psytx, hsp 75–80 w/e&m	0323	1.85	$89.70	$22.48	$17.94
90845	S	Psychoanalysis	0323	1.85	$89.70	$22.48	$17.94
90846	S	Family psytx w/o patient	0324	1.87	$90.67	$20.19	$18.13
90847	S	Family psytx w/patient	0324	1.87	$90.67	$20.19	$18.13
90849	S	Multiple family group psytx	0325	1.55	$75.16	$19.96	$15.03
90853	S	Group psychotherapy	0325	1.55	$75.16	$19.96	$15.03
90857	S	Intac group psytx	0325	1.55	$75.16	$19.96	$15.03
90862	X	Medication management	0374	1.17	$56.73	$13.08	$11.35
90865	S	Narcosynthesis	0323	1.85	$89.70	$22.48	$17.94
90870	S	Electroconvulsive therapy	0320	3.68	$178.43	$80.06	$35.69
90871	S	Electroconvulsive therapy	0320	3.68	$178.43	$80.06	$35.69
90875	E	Psychophysiological therapy					
90876	E	Psychophysiological therapy					
90880	S	Hypnotherapy	0323	1.85	$89.70	$22.48	$17.94
90882	E	Environmental manipulation					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
90885	N	Psy evaluation of records					
90887	N	Consultation with family					
90889	N	Preparation of report					
90899	S	Psychiatric service/therapy	0322	1.32	$64.00	$14.22	$12.80
90901	S	Biofeedback train, any meth	0321	1.26	$61.09	$29.25	$12.22
90911	S	Biofeedback peri/uro/rectal	0321	1.26	$61.09	$29.25	$12.22
90918	A	ESRD related services, month					
90919	A	ESRD related services, month					
90920	A	ESRD related services, month					
90921	A	ESRD related services, month					
90922	A	ESRD related services, day					
90923	A	Esrd related services, day					
90924	A	Esrd related services, day					
90925	A	Esrd related services, day					
90935	S	Hemodialysis, one evaluation	0170	6.68	$323.89	$72.26	$64.78
90937	E	Hemodialysis, repeated eval					
90945	S	Dialysis, one evaluation	0170	6.68	$323.89	$72.26	$64.78
90947	E	Dialysis, repeated eval					
90989	E	Dialysis training, complete					
90993	E	Dialysis training, incompl					
90997	E	Hemoperfusion					
90999	E	Dialysis procedure					
91000	X	Esophageal intubation	0361	3.53	$171.16	$88.09	$34.23
91010	X	Esophagus motility study	0361	3.53	$171.16	$88.09	$34.23
91011	X	Esophagus motility study	0361	3.53	$171.16	$88.09	$34.23
91012	X	Esophagus motility study	0361	3.53	$171.16	$88.09	$34.23
91020	X	Gastric motility	0361	3.53	$171.16	$88.09	$34.23
91030	X	Acid perfusion of esophagus	0360	1.38	$66.91	$34.75	$13.38
91032	X	Esophagus, acid reflux test	0361	3.53	$171.16	$88.09	$34.23
91033	X	Prolonged acid reflux test	0361	3.53	$171.16	$88.09	$34.23
91052	X	Gastric analysis test	0361	3.53	$171.16	$88.09	$34.23
91055	X	Gastric intubation for smear	0360	1.38	$66.91	$34.75	$13.38
91060	X	Gastric saline load test	0361	3.53	$171.16	$88.09	$34.23
91065	X	Breath hydrogen test	0360	1.38	$66.91	$34.75	$13.38
91100	X	Pass intestine bleeding tube	0360	1.38	$66.91	$34.75	$13.38
91105	X	Gastric intubation treatment	0360	1.38	$66.91	$34.75	$13.38
91122	T	Anal pressure record	0165	3.89	$188.61	$91.76	$37.72
91299	X	Gastroenterology procedure	0360	1.38	$66.91	$34.75	$13.38
92002	V	Eye exam, new patient	0601	1.00	$48.49	$9.70	$9.70
92004	V	Eye exam, new patient	0602	1.66	$80.49	$16.29	$16.10
92012	V	Eye exam established pat	0601	1.00	$48.49	$9.70	$9.70
92014	V	Eye exam & treatment	0602	1.66	$80.49	$16.29	$16.10
92015	E	Refraction					
92018	S	New eye exam & treatment	0231	2.64	$128.01	$59.87	$25.60
92019	S	Eye exam & treatment	0231	2.64	$128.01	$59.87	$25.60
92020	S	Special eye evaluation	0230	0.98	$47.52	$22.48	$9.50
92060	S	Special eye evaluation	0230	0.98	$47.52	$22.48	$9.50
92065	S	Orthoptic/pleoptic training	0230	0.98	$47.52	$22.48	$9.50
92070	N	Fitting of contact lens					
92081	S	Visual field examination(s)	0230	0.98	$47.52	$22.48	$9.50
92082	S	Visual field examination(s)	0230	0.98	$47.52	$22.48	$9.50
92083	S	Visual field examination(s)	0230	0.98	$47.52	$22.48	$9.50
92100	N	Serial tonometry exam(s)					
92120	S	Tonography & eye evaluation	0230	0.98	$47.52	$22.48	$9.50
92130	S	Water provocation tonography	0230	0.98	$47.52	$22.48	$9.50
92135	S	Opthalmic dx imaging	0231	2.64	$128.01	$59.87	$25.60
92140	S	Glaucoma provocative tests	0231	2.64	$128.01	$59.87	$25.60
92225	S	Special eye exam, initial	0230	0.98	$47.52	$22.48	$9.50
92226	S	Special eye exam, subsequent	0231	2.64	$128.01	$59.87	$25.60
92230	S	Eye exam with photos	0231	2.64	$128.01	$59.87	$25.60
92235	S	Eye exam with photos	0231	2.64	$128.01	$59.87	$25.60
92240	S	Icg angiography	0231	2.64	$128.01	$59.87	$25.60
92250	S	Eye exam with photos	0230	0.98	$47.52	$22.48	$9.50
92260	S	Ophthalmoscopy/dynamometry	0230	0.98	$47.52	$22.48	$9.50
92265	S	Eye muscle evaluation	0230	0.98	$47.52	$22.48	$9.50
92270	S	Electro-oculography	0230	0.98	$47.52	$22.48	$9.50
92275	S	Electroretinography	0216	2.87	$139.16	$64.69	$27.83
92283	S	Color vision examination	0230	0.98	$47.52	$22.48	$9.50
92284	S	Dark adaptation eye exam	0231	2.64	$128.01	$59.87	$25.60
92285	S	Eye photography	0230	0.98	$47.52	$22.48	$9.50
92286	S	Internal eye photography	0231	2.64	$128.01	$59.87	$25.60
92287	T	Internal eye photography	0231	2.64	$128.01	$59.87	$25.60
92310	E	Contact lens fitting					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
92311	X	Contact lens fitting	0362	0.51	$24.73	$9.63	$4.95
92312	X	Contact lens fitting	0362	0.51	$24.73	$9.63	$4.95
92313	X	Contact lens fitting	0362	0.51	$24.73	$9.63	$4.95
92314	E	Prescription of contact lens					
92315	X	Prescription of contact lens	0362	0.51	$24.73	$9.63	$4.95
92316	X	Prescription of contact lens	0362	0.51	$24.73	$9.63	$4.95
92317	X	Prescription of contact lens	0362	0.51	$24.73	$9.63	$4.95
92325	X	Modification of contact lens	0362	0.51	$24.73	$9.63	$4.95
92326	X	Replacement of contact lens	0362	0.51	$24.73	$9.63	$4.95
92330	S	Fitting of artificial eye	0230	0.98	$47.52	$22.48	$9.50
92335	N	Fitting of artificial eye					
92340	E	Fitting of spectacles					
92341	E	Fitting of spectacles					
92342	E	Fitting of spectacles					
92352	X	Special spectacles fitting	0362	0.51	$24.73	$9.63	$4.95
92353	X	Special spectacles fitting	0362	0.51	$24.73	$9.63	$4.95
92354	X	Special spectacles fitting	0362	0.51	$24.73	$9.63	$4.95
92355	X	Special spectacles fitting	0362	0.51	$24.73	$9.63	$4.95
92358	X	Eye prosthesis service	0362	0.51	$24.73	$9.63	$4.95
92370	E	Repair & adjust spectacles					
92371	X	Repair & adjust spectacles	0362	0.51	$24.73	$9.63	$4.95
92390	E	Supply of spectacles					
92391	E	Supply of contact lenses					
92392	E	Supply of low vision aids					
92393	E	Supply of artificial eye					
92395	E	Supply of spectacles					
92396	E	Supply of contact lenses					
92499	S	Eye service or procedure	0230	0.98	$47.52	$22.48	$9.50
92502	T	Ear and throat examination	0251	1.68	$81.46	$27.99	$16.29
92504	N	Ear microscopy examination					
92506	A	Speech/hearing evaluation					
92507	A	Speech/hearing therapy					
92508	A	Speech/hearing therapy					
92510	A	Rehab for ear implant					
92511	T	Nasopharyngoscopy	0071	0.55	$26.67	$14.22	$5.33
92512	X	Nasal function studies	0363	2.83	$137.22	$53.22	$27.44
92516	X	Facial nerve function test	0363	2.83	$137.22	$53.22	$27.44
92520	X	Laryngeal function studies	0363	2.83	$137.22	$53.22	$27.44
92525	A	Oral function evaluation					
92526	A	Oral function therapy					
92531	N	Spontaneous nystagmus study					
92532	N	Positional nystagmus study					
92533	N	Caloric vestibular test					
92534	N	Optokinetic nystagmus					
92541	X	Spontaneous nystagmus test	0363	2.83	$137.22	$53.22	$27.44
92542	X	Positional nystagmus test	0363	2.83	$137.22	$53.22	$27.44
92543	X	Caloric vestibular test	0363	2.83	$137.22	$53.22	$27.44
92544	X	Optokinetic nystagmus test	0363	2.83	$137.22	$53.22	$27.44
92545	X	Oscillating tracking test	0363	2.83	$137.22	$53.22	$27.44
92546	X	Sinusoidal rotational test	0363	2.83	$137.22	$53.22	$27.44
92547	X	Supplemental electrical test	0363	2.83	$137.22	$53.22	$27.44
92548	X	Posturography	0363	2.83	$137.22	$53.22	$27.44
92551	E	Pure tone hearing test, air					
92552	X	Pure tone audiometry, air	0364	0.68	$32.97	$13.31	$6.59
92553	X	Audiometry, air & bone	0364	0.68	$32.97	$13.31	$6.59
92555	X	Speech threshold audiometry	0364	0.68	$32.97	$13.31	$6.59
92556	X	Speech audiometry, complete	0364	0.68	$32.97	$13.31	$6.59
92557	X	Comprehensive hearing test	0365	1.47	$71.28	$22.48	$14.26
92559	E	Group audiometric testing					
92560	E	Bekesy audiometry, screen					
92561	X	Bekesy audiometry, diagnosis	0365	1.47	$71.28	$22.48	$14.26
92562	X	Loudness balance test	0365	1.47	$71.28	$22.48	$14.26
92563	X	Tone decay hearing test	0365	1.47	$71.28	$22.48	$14.26
92564	X	Sisi hearing test	0365	1.47	$71.28	$22.48	$14.26
92565	X	Stenger test, pure tone	0365	1.47	$71.28	$22.48	$14.26
92567	X	Tympanometry	0364	0.68	$32.97	$13.31	$6.59
92568	X	Acoustic reflex testing	0365	1.47	$71.28	$22.48	$14.26
92569	X	Acoustic reflex decay test	0365	1.47	$71.28	$22.48	$14.26
92571	X	Filtered speech hearing test	0365	1.47	$71.28	$22.48	$14.26
92572	X	Staggered spondaic word test	0365	1.47	$71.28	$22.48	$14.26
92573	X	Lombard test	0365	1.47	$71.28	$22.48	$14.26
92575	X	Sensorineural acuity test	0365	1.47	$71.28	$22.48	$14.26
92576	X	Synthetic sentence test	0365	1.47	$71.28	$22.48	$14.26

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
92577	X	Stenger test, speech	0365	1.47	$71.28	$22.48	$14.26
92579	X	Visual audiometry (vra)	0365	1.47	$71.28	$22.48	$14.26
92582	X	Conditioning play audiometry	0365	1.47	$71.28	$22.48	$14.26
92583	X	Select picture audiometry	0365	1.47	$71.28	$22.48	$14.26
92584	X	Electrocochleography	0363	2.83	$137.22	$53.22	$27.44
92585	S	Auditory evoked potential	0216	2.87	$139.16	$64.69	$27.83
92587	X	Evoked auditory test	0363	2.83	$137.22	$53.22	$27.44
92588	X	Evoked auditory test	0363	2.83	$137.22	$53.22	$27.44
92589	X	Auditory function test(s)	0365	1.47	$71.28	$22.48	$14.26
92590	E	Hearing aid exam, one ear					
92591	E	Hearing aid exam, both ears					
92592	E	Hearing aid check, one ear					
92593	E	Hearing aid check, both ears					
92594	E	Electro hearng aid test, one					
92595	E	Electro hearng aid tst, both					
92596	X	Ear protector evaluation	0365	1.47	$71.28	$22.48	$14.26
92597	A	Oral speech device eval					
92598	A	Modify oral speech device					
92599	X	ENT procedure/service	0364	0.68	$32.97	$13.31	$6.59
92950	S	Heart/lung resuscitation cpr	0094	4.51	$218.68	$105.29	$43.74
92953	S	Temporary external pacing	0094	4.51	$218.68	$105.29	$43.74
92960	S	Cardioversion electric, ext	0094	4.51	$218.68	$105.29	$43.74
92961	S	Cardioversion, electric, int	0094	4.51	$218.68	$105.29	$43.74
92970	C	Cardioassist, internal					
92971	C	Cardioassist, external					
92975	C	Dissolve clot, heart vessel					
92977	C	Dissolve clot, heart vessel					
92978	C	Intravasc us, heart add-on					
92979	C	Intravasc us, heart add-on					
92980	T	Insert intracoronary stent	0083	45.79	$2,220.22	$1,322.95	$444.04
92981	T	Insert intracoronary stent	0083	45.79	$2,220.22	$1,322.95	$444.04
92982	T	Coronary artery dilation	0083	45.79	$2,220.22	$1,322.95	$444.04
92984	T	Coronary artery dilation	0083	45.79	$2,220.22	$1,322.95	$444.04
92986	C	Revision of aortic valve					
92987	C	Revision of mitral valve					
92990	C	Revision of pulmonary valve					
92992	C	Revision of heart chamber					
92993	C	Revision of heart chamber					
92995	T	Coronary atherectomy	0082	40.34	$1,955.97	$859.56	$391.19
92996	T	Coronary atherectomy add-on	0082	40.34	$1,955.97	$859.56	$391.19
92997	C	Pul art balloon repr, percut					
92998	C	Pul art balloon repr, percut					
93000	E	Electrocardiogram, complete					
93005	X	Electrocardiogram, tracing	0366	0.38	$18.43	$15.60	$3.69
93010	E	Electrocardiogram report					
93012	S	Transmission of ECG	0099	0.38	$18.43	$14.68	$3.69
93014	E	Report on transmitted ECG					
93015	E	Cardiovascular stress test					
93016	E	Cardiovascular stress test					
93017	S	Cardiovascular stress test	0097	1.62	$78.55	$62.40	$15.71
93018	E	Cardiovascular stress test					
93024	S	Cardiac drug stress test	0097	1.62	$78.55	$62.40	$15.71
93040	E	Rhythm ECG with report					
93041	X	Rhythm ECG, tracing	0366	0.38	$18.43	$15.60	$3.69
93042	E	Rhythm ECG, report					
93224	E	ECG monitor/report, 24 hrs					
93225	S	ECG monitor/record, 24 hrs	0100	1.70	$82.43	$71.57	$16.49
93226	S	ECG monitor/report, 24 hrs	0100	1.70	$82.43	$71.57	$16.49
93227	E	ECG monitor/review, 24 hrs					
93230	E	ECG monitor/report, 24 hrs					
93231	S	ECG monitor/record, 24 hrs	0100	1.70	$82.43	$71.57	$16.49
93232	S	ECG monitor/report, 24 hrs	0100	1.70	$82.43	$71.57	$16.49
93233	E	ECG monitor/review, 24 hrs					
93235	E	ECG monitor/report, 24 hrs					
93236	S	ECG monitor/report, 24 hrs	0100	1.70	$82.43	$71.57	$16.49
93237	E	ECG monitor/review, 24 hrs					
93268	S	ECG record/review	0100	1.70	$82.43	$71.57	$16.49
93270	S	ECG recording	0099	0.38	$18.43	$14.68	$3.69
93271	S	ECG/monitoring and analysis	0100	1.70	$82.43	$71.57	$16.49
93272	E	ECG/review, interpret only					
93278	S	ECG/signal-averaged	0099	0.38	$18.43	$14.68	$3.69
93303	S	Echo transthoracic	0269	4.40	$213.34	$114.01	$42.67
93304	S	Echo transthoracic	0269	4.40	$213.34	$114.01	$42.67

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
93307	S	Echo exam of heart	0269	4.40	$213.34	$114.01	$42.67
93308	S	Echo exam of heart	0269	4.40	$213.34	$114.01	$42.67
93312	S	Echo transesophageal	0270	5.55	$269.10	$150.26	$53.82
93313	S	Echo transesophageal	0270	5.55	$269.10	$150.26	$53.82
93314	N	Echo transesophageal					
93315	S	Echo transesophageal	0270	5.55	$269.10	$150.26	$53.82
93316	S	Echo transesophageal	0270	5.55	$269.10	$150.26	$53.82
93317	N	Echo transesophageal					
93320	S	Doppler echo exam, heart	0269	4.40	$213.34	$114.01	$42.67
93321	S	Doppler echo exam, heart	0269	4.40	$213.34	$114.01	$42.67
93325	S	Doppler color flow add-on	0269	4.40	$213.34	$114.01	$42.67
93350	S	Echo transthoracic	0269	4.40	$213.34	$114.01	$42.67
93501	T	Right heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93503	T	Insert/place heart catheter	0080	25.77	$1,249.51	$713.89	$249.90
93505	T	Biopsy of heart lining	0080	25.77	$1,249.51	$713.89	$249.90
93508	N	Cath placement, angiography					
93510	T	Left heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93511	T	Left heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93514	T	Left heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93524	T	Left heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93526	T	Rt & Lt heart catheters	0080	25.77	$1,249.51	$713.89	$249.90
93527	T	Rt & Lt heart catheters	0080	25.77	$1,249.51	$713.89	$249.90
93528	T	Rt & Lt heart catheters	0080	25.77	$1,249.51	$713.89	$249.90
93529	T	Rt, Lt heart catheterization	0080	25.77	$1,249.51	$713.89	$249.90
93530	T	Rt heart cath, congenital	0080	25.77	$1,249.51	$713.89	$249.90
93531	T	R & l heart cath, congenital	0080	25.77	$1,249.51	$713.89	$249.90
93532	T	R & l heart cath, congenital	0080	25.77	$1,249.51	$713.89	$249.90
93533	T	R & l heart cath, congenital	0080	25.77	$1,249.51	$713.89	$249.90
93536	T	Insert circulation assi	0080	25.77	$1,249.51	$713.89	$249.90
93539	N	Injection, cardiac cath					
93540	N	Injection, cardiac cath					
93541	N	Injection for lung angiogram					
93542	N	Injection for heart x-rays					
93543	N	Injection for heart x-rays					
93544	N	Injection for aortography					
93545	N	Inject for coronary x-rays					
93555	N	Imaging, cardiac cath					
93556	N	Imaging, cardiac cath					
93561	N	Cardiac output measurement					
93562	N	Cardiac output measurement					
93571	N	Heart flow reserve measure					
93572	N	Heart flow reserve measure					
93600	S	Bundle of His recording	0087	9.53	$462.08	$214.72	$92.42
93602	S	Intra-atrial recording	0087	9.53	$462.08	$214.72	$92.42
93603	S	Right ventricular recording	0087	9.53	$462.08	$214.72	$92.42
93607	S	Left ventricular recording	0087	9.53	$462.08	$214.72	$92.42
93609	S	Mapping of tachycardia	0087	9.53	$462.08	$214.72	$92.42
93610	S	Intra-atrial pacing	0087	9.53	$462.08	$214.72	$92.42
93612	S	Intraventricular pacing	0087	9.53	$462.08	$214.72	$92.42
93615	S	Esophageal recording	0087	9.53	$462.08	$214.72	$92.42
93616	S	Esophageal recording	0087	9.53	$462.08	$214.72	$92.42
93618	S	Heart rhythm pacing	0087	9.53	$462.08	$214.72	$92.42
93619	S	Electrophysiology evaluation	0085	27.06	$1,312.06	$654.48	$262.41
93620	S	Electrophysiology evaluation	0085	27.06	$1,312.06	$654.48	$262.41
93621	S	Electrophysiology evaluation	0085	27.06	$1,312.06	$654.48	$262.41
93622	S	Electrophysiology evaluation	0085	27.06	$1,312.06	$654.48	$262.41
93623	S	Stimulation, pacing heart	0087	9.53	$462.08	$214.72	$92.42
93624	S	Electrophysiologic study	0087	9.53	$462.08	$214.72	$92.42
93631	S	Heart pacing, mapping	0087	9.53	$462.08	$214.72	$92.42
93640	S	Evaluation heart device	0084	10.70	$518.81	$177.79	$103.76
93641	S	Electrophysiology evaluation	0084	10.70	$518.81	$177.79	$103.76
93642	S	Electrophysiology evaluation	0084	10.70	$518.81	$177.79	$103.76
93650	S	Ablate heart dysrhythm focus	0086	47.62	$2,308.95	$1,265.37	$461.79
93651	S	Ablate heart dysrhythm focus	0086	47.62	$2,308.95	$1,265.37	$461.79
93652	S	Ablate heart dysrhythm focus	0086	47.62	$2,308.95	$1,265.37	$461.79
93660	S	Tilt table evaluation	0101	4.47	$216.74	$128.84	$43.35
93720	E	Total body plethysmography					
93721	S	Plethysmography tracing	0096	2.06	$99.88	$61.48	$19.98
93722	E	Plethysmography report					
93724	S	Analyze pacemaker system	0100	1.70	$82.43	$71.57	$16.49
93727	S	Analyze ilr system	0102	0.45	$21.82	$12.62	$4.36
93731	S	Analyze pacemaker system	0102	0.45	$21.82	$12.62	$4.36
93732	S	Analyze pacemaker system	0102	0.45	$21.82	$12.62	$4.36

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
93733	S	Telephone analy, pacemaker	0102	0.45	$21.82	$12.62	$4.36
93734	S	Analyze pacemaker system	0102	0.45	$21.82	$12.62	$4.36
93735	S	Analyze pacemaker system	0102	0.45	$21.82	$12.62	$4.36
93736	S	Telephone analy, pacemaker	0102	0.45	$21.82	$12.62	$4.36
93737	S	Analyze cardio/defibrillator	0102	0.45	$21.82	$12.62	$4.36
93738	S	Analyze cardio/defibrillator	0102	0.45	$21.82	$12.62	$4.36
93740	S	Temperature gradient studies	0096	2.06	$99.88	$61.48	$19.98
93741	S	Analyze ht pace device sngl	0102	0.45	$21.82	$12.62	$4.36
93742	S	Analyze ht pace device sngl	0102	0.45	$21.82	$12.62	$4.36
93743	S	Analyze ht pace device dual	0102	0.45	$21.82	$12.62	$4.36
93744	S	Analyze ht pace device dual	0102	0.45	$21.82	$12.62	$4.36
93760	E	Cephalic thermogram					
93762	E	Peripheral thermogram					
93770	N	Measure venous pressure					
93784	E	Ambulatory BP monitoring					
93786	E	Ambulatory BP recording					
93788	E	Ambulatory BP analysis					
93790	E	Review/report BP recording					
93797	S	Cardiac rehab	0095	0.64	$31.03	$16.98	$6.21
93798	S	Cardiac rehab/monitor	0095	0.64	$31.03	$16.98	$6.21
93799	S	Cardiovascular procedure	0096	2.06	$99.88	$61.48	$19.98
93875	S	Extracranial study	0096	2.06	$99.88	$61.48	$19.98
93880	S	Extracranial study	0267	2.72	$131.88	$80.06	$26.38
93882	S	Extracranial study	0267	2.72	$131.88	$80.06	$26.38
93886	S	Intracranial study	0267	2.72	$131.88	$80.06	$26.38
93888	S	Intracranial study	0267	2.72	$131.88	$80.06	$26.38
93922	S	Extremity study	0096	2.06	$99.88	$61.48	$19.98
93923	S	Extremity study	0096	2.06	$99.88	$61.48	$19.98
93924	S	Extremity study	0096	2.06	$99.88	$61.48	$19.98
93925	S	Lower extremity study	0267	2.72	$131.88	$80.06	$26.38
93926	S	Lower extremity study	0267	2.72	$131.88	$80.06	$26.38
93930	S	Upper extremity study	0267	2.72	$131.88	$80.06	$26.38
93931	S	Upper extremity study	0267	2.72	$131.88	$80.06	$26.38
93965	S	Extremity study	0096	2.06	$99.88	$61.48	$19.98
93970	S	Extremity study	0267	2.72	$131.88	$80.06	$26.38
93971	S	Extremity study	0267	2.72	$131.88	$80.06	$26.38
93975	S	Vascular study	0267	2.72	$131.88	$80.06	$26.38
93976	S	Vascular study	0267	2.72	$131.88	$80.06	$26.38
93978	S	Vascular study	0267	2.72	$131.88	$80.06	$26.38
93979	S	Vascular study	0267	2.72	$131.88	$80.06	$26.38
93980	S	Penile vascular study	0267	2.72	$131.88	$80.06	$26.38
93981	S	Penile vascular study	0267	2.72	$131.88	$80.06	$26.38
93990	S	Doppler flow testing	0267	2.72	$131.88	$80.06	$26.38
94010	X	Breathing capacity test	0367	0.83	$40.24	$20.65	$8.05
94014	X	Patient recorded spirometry	0369	2.34	$113.46	$58.50	$22.69
94015	X	Patient recorded spirometry	0369	2.34	$113.46	$58.50	$22.69
94016	X	Review patient spirometry	0369	2.34	$113.46	$58.50	$22.69
94060	X	Evaluation of wheezing	0368	1.66	$80.49	$42.44	$16.10
94070	X	Evaluation of wheezing	0369	2.34	$113.46	$58.50	$22.69
94150	N	Vital capacity test					
94200	X	Lung function test (MBC/MVV)	0367	0.83	$40.24	$20.65	$8.05
94240	X	Residual lung capacity	0368	1.66	$80.49	$42.44	$16.10
94250	X	Expired gas collection	0367	0.83	$40.24	$20.65	$8.05
94260	X	Thoracic gas volume	0368	1.66	$80.49	$42.44	$16.10
94350	X	Lung nitrogen washout curve	0368	1.66	$80.49	$42.44	$16.10
94360	X	Measure airflow resistance	0368	1.66	$80.49	$42.44	$16.10
94370	X	Breath airway closing volume	0368	1.66	$80.49	$42.44	$16.10
94375	X	Respiratory flow volume loop	0367	0.83	$40.24	$20.65	$8.05
94400	X	CO2 breathing response curve	0367	0.83	$40.24	$20.65	$8.05
94450	X	Hypoxia response curve	0367	0.83	$40.24	$20.65	$8.05
94620	X	Pulmonary stress test/simple	0368	1.66	$80.49	$42.44	$16.10
94621	X	Pulm stress test/complex	0369	2.34	$113.46	$58.50	$22.69
94640	S	Airway inhalation treatment	0077	0.43	$20.85	$12.62	$4.17
94642	S	Aerosol inhalation treatment	0078	1.34	$64.97	$29.13	$12.99
94650	S	Pressure breathing (IPPB)	0077	0.43	$20.85	$12.62	$4.17
94651	S	Pressure breathing (IPPB)	0077	0.43	$20.85	$12.62	$4.17
94652	C	Pressure breathing (IPPB)					
94656	S	Initial ventilator mgmt	0079	3.18	$154.19	$107.70	$30.84
94657	S	Continued ventilator mgmt	0079	3.18	$154.19	$107.70	$30.84
94660	S	Pos airway pressure, CPAP	0079	3.18	$154.19	$107.70	$30.84
94662	S	Neg press ventilation, cnp	0079	3.18	$154.19	$107.70	$30.84
94664	S	Aerosol or vapor inhalations	0077	0.43	$20.85	$12.62	$4.17
94665	S	Aerosol or vapor inhalations	0077	0.43	$20.85	$12.62	$4.17

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
94667	S	Chest wall manipulation	0077	0.43	$20.85	$12.62	$4.17
94668	S	Chest wall manipulation	0077	0.43	$20.85	$12.62	$4.17
94680	X	Exhaled air analysis, o2	0367	0.83	$40.24	$20.65	$8.05
94681	X	Exhaled air analysis, o2/co2	0368	1.66	$80.49	$42.44	$16.10
94690	X	Exhaled air analysis	0367	0.83	$40.24	$20.65	$8.05
94720	X	Monoxide diffusing capacity	0367	0.83	$40.24	$20.65	$8.05
94725	X	Membrane diffusion capacity	0368	1.66	$80.49	$42.44	$16.10
94750	X	Pulmonary compliance study	0368	1.66	$80.49	$42.44	$16.10
94760	N	Measure blood oxygen level					
94761	N	Measure blood oxygen level					
94762	C	Measure blood oxygen level					
94770	X	Exhaled carbon dioxide test	0367	0.83	$40.24	$20.65	$8.05
94772	X	Breath recording, infant	0369	2.34	$113.46	$58.50	$22.69
94799	X	Pulmonary service/procedure	0367	0.83	$40.24	$20.65	$8.05
95004	X	Allergy skin tests	0370	0.57	$27.64	$11.81	$5.53
95010	X	Sensitivity skin tests	0370	0.57	$27.64	$11.81	$5.53
95015	X	Sensitivity skin tests	0370	0.57	$27.64	$11.81	$5.53
95024	X	Allergy skin tests	0370	0.57	$27.64	$11.81	$5.53
95027	X	Skin end point titration	0370	0.57	$27.64	$11.81	$5.53
95028	X	Allergy skin tests	0370	0.57	$27.64	$11.81	$5.53
95044	X	Allergy patch tests	0370	0.57	$27.64	$11.81	$5.53
95052	X	Photo patch test	0370	0.57	$27.64	$11.81	$5.53
95056	X	Photosensitivity tests	0370	0.57	$27.64	$11.81	$5.53
95060	X	Eye allergy tests	0370	0.57	$27.64	$11.81	$5.53
95065	X	Nose allergy test	0370	0.57	$27.64	$11.81	$5.53
95070	X	Bronchial allergy tests	0369	2.34	$113.46	$58.50	$22.69
95071	X	Bronchial allergy tests	0369	2.34	$113.46	$58.50	$22.69
95075	X	Ingestion challenge test	0361	3.53	$171.16	$88.09	$34.23
95078	X	Provocative testing	0370	0.57	$27.64	$11.81	$5.53
95115	X	Immunotherapy, one injection	0371	0.32	$15.52	$3.67	$3.10
95117	X	Immunotherapy injections	0371	0.32	$15.52	$3.67	$3.10
95120	E	Immunotherapy, one injection					
95125	E	Immunotherapy, many antigens					
95130	E	Immunotherapy, insect venom					
95131	E	Immunotherapy, insect venoms					
95132	E	Immunotherapy, insect venoms					
95133	E	Immunotherapy, insect venoms					
95134	E	Immunotherapy, insect venoms					
95144	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95145	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95146	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95147	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95148	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95149	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95165	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95170	X	Antigen therapy services	0371	0.32	$15.52	$3.67	$3.10
95180	X	Rapid desensitization	0370	0.57	$27.64	$11.81	$5.53
95199	X	Allergy immunology services	0370	0.57	$27.64	$11.81	$5.53
95805	S	Multiple sleep latency test	0213	11.15	$540.63	$290.42	$108.13
95806	S	Sleep study, unattended	0213	11.15	$540.63	$290.42	$108.13
95807	S	Sleep study, attended	0213	11.15	$540.63	$290.42	$108.13
95808	S	Polysomnography, 1–3	0213	11.15	$540.63	$290.42	$108.13
95810	S	Polysomnography, 4 or more	0213	11.15	$540.63	$290.42	$108.13
95811	S	Polysomnography w/cpap	0213	11.15	$540.63	$290.42	$108.13
95812	S	Electroencephalogram (EEG)	0213	11.15	$540.63	$290.42	$108.13
95813	S	Electroencephalogram (EEG)	0213	11.15	$540.63	$290.42	$108.13
95816	S	Electroencephalogram (EEG)	0214	2.32	$112.49	$58.50	$22.50
95819	S	Electroencephalogram (EEG)	0214	2.32	$112.49	$58.50	$22.50
95822	S	Sleep electroencephalogram	0214	2.32	$112.49	$58.50	$22.50
95824	S	Electroencephalography	0214	2.32	$112.49	$58.50	$22.50
95827	S	Night electroencephalogram	0213	11.15	$540.63	$290.42	$108.13
95829	S	Surgery electrocorticogram	0214	2.32	$112.49	$58.50	$22.50
95830	E	Insert electrodes for EEG					
95831	N	Limb muscle testing, manual					
95832	N	Hand muscle testing, manual					
95833	N	Body muscle testing, manual					
95834	N	Body muscle testing, manual					
95851	N	Range of motion measurements					
95852	N	Range of motion measurements					
95857	S	Tensilon test	0215	1.15	$55.76	$30.05	$11.15
95858	S	Tensilon test & myogram	0215	1.15	$55.76	$30.05	$11.15
95860	S	Muscle test, one limb	0215	1.15	$55.76	$30.05	$11.15
95861	S	Muscle test, two limbs	0215	1.15	$55.76	$30.05	$11.15

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
95863	S	Muscle test, 3 limbs	0216	2.87	$139.16	$64.69	$27.83
95864	S	Muscle test, 4 limbs	0215	1.15	$55.76	$30.05	$11.15
95867	S	Muscle test, head or neck	0216	2.87	$139.16	$64.69	$27.83
95868	S	Muscle test, head or neck	0216	2.87	$139.16	$64.69	$27.83
95869	S	Muscle test, thor paraspinal	0215	1.15	$55.76	$30.05	$11.15
95870	S	Muscle test, nonparaspinal	0215	1.15	$55.76	$30.05	$11.15
95872	S	Muscle test, one fiber	0215	1.15	$55.76	$30.05	$11.15
95875	S	Limb exercise test	0217	5.87	$284.62	$156.68	$56.92
95900	S	Motor nerve conduction test	0215	1.15	$55.76	$30.05	$11.15
95903	S	Motor nerve conduction test	0215	1.15	$55.76	$30.05	$11.15
95904	S	Sense/mixed n conduction tst	0215	1.15	$55.76	$30.05	$11.15
95920	C	Intraop nerve test add-on					
95921	S	Autonomic nerv function test	0216	2.87	$139.16	$64.69	$27.83
95922	S	Autonomic nerv function test	0216	2.87	$139.16	$64.69	$27.83
95923	S	Autonomic nerv function test	0216	2.87	$139.16	$64.69	$27.83
95925	S	Somatosensory testing	0216	2.87	$139.16	$64.69	$27.83
95926	S	Somatosensory testing	0216	2.87	$139.16	$64.69	$27.83
95927	S	Somatosensory testing	0216	2.87	$139.16	$64.69	$27.83
95930	S	Visual evoked potential test	0216	2.87	$139.16	$64.69	$27.83
95933	S	Blink reflex test	0215	1.15	$55.76	$30.05	$11.15
95934	S	H-reflex test	0215	1.15	$55.76	$30.05	$11.15
95936	S	H-reflex test	0216	2.87	$139.16	$64.69	$27.83
95937	S	Neuromuscular junction test	0215	1.15	$55.76	$30.05	$11.15
95950	S	Ambulatory eeg monitoring	0217	5.87	$284.62	$156.68	$56.92
95951	S	EEG monitoring/videorecord	0213	11.15	$540.63	$290.42	$108.13
95953	S	EEG monitoring/computer	0213	11.15	$540.63	$290.42	$108.13
95954	S	EEG monitoring/giving drugs	0213	11.15	$540.63	$290.42	$108.13
95955	S	EEG during surgery	0214	2.32	$112.49	$58.50	$22.50
95956	N	Eeg monitoring, cable/radio					
95957	N	EEG digital analysis					
95958	S	EEG monitoring/function test	0213	11.15	$540.63	$290.42	$108.13
95961	C	Electrode stimulation, brain					
95962	C	Electrode stim, brain add-on					
95970	S	Analyze neurostim, no prog	0102	0.45	$21.82	$12.62	$4.36
95971	S	Analyze neurostim, simple	0102	0.45	$21.82	$12.62	$4.36
95972	S	Analyze neurostim, complex	0102	0.45	$21.82	$12.62	$4.36
95973	S	Analyze neurostim, complex	0102	0.45	$21.82	$12.62	$4.36
95974	S	Cranial neurostim, complex	0102	0.45	$21.82	$12.62	$4.36
95975	S	Cranial neurostim, complex	0102	0.45	$21.82	$12.62	$4.36
95999	N	Neurological procedure					
96100	X	Psychological testing	0373	3.21	$155.64	$44.96	$31.13
96105	X	Assessment of aphasia	0373	3.21	$155.64	$44.96	$31.13
96110	X	Developmental test, lim	0373	3.21	$155.64	$44.96	$31.13
96111	X	Developmental test, extend	0373	3.21	$155.64	$44.96	$31.13
96115	X	Neurobehavior status exam	0373	3.21	$155.64	$44.96	$31.13
96117	X	Neuropsych test battery	0373	3.21	$155.64	$44.96	$31.13
96400	E	Chemotherapy, sc/im					
96405	E	Intralesional chemo admin					
96406	E	Intralesional chemo admin					
96408	E	Chemotherapy, push technique					
96410	E	Chemotherapy, infusion method					
96412	E	Chemo, infuse method add-on					
96414	E	Chemo, infuse method add-on					
96420	E	Chemotherapy, push technique					
96422	E	Chemotherapy, infusion method					
96423	E	Chemo, infuse method add-on					
96425	E	Chemotherapy, infusion method					
96440	E	Chemotherapy, intracavitary					
96445	E	Chemotherapy, intracavitary					
96450	E	Chemotherapy, into CNS					
96520	E	Pump refilling, maintenance					
96530	E	Pump refilling, maintenance					
96542	E	Chemotherapy injection					
96545	E	Provide chemotherapy agent					
96549	E	Chemotherapy, unspecified					
96570	T	Photodynamic tx, 30 min	0075	18.55	$899.44	$467.29	$179.89
96571	T	Photodynamic tx, addl 15 min	0075	18.55	$899.44	$467.29	$179.89
96900	S	Ultraviolet light therapy	0001	0.47	$22.79	$8.49	$4.56
96902	N	Trichogram					
96910	S	Photochemotherapy with UV–B	0001	0.47	$22.79	$8.49	$4.56
96912	S	Photochemotherapy with UV–A	0001	0.47	$22.79	$8.49	$4.56
96913	S	Photochemotherapy, UV–A or B	0001	0.47	$22.79	$8.49	$4.56
96999	S	Dermatological procedure	0001	0.47	$22.79	$8.49	$4.56

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
97001	A	Pt evaluation					
97002	A	Pt re-evaluation					
97003	A	Ot evaluation					
97004	A	Ot re-evaluation					
97010	A	Hot or cold packs therapy					
97012	A	Mechanical traction therapy					
97014	A	Electric stimulation therapy					
97016	A	Vasopneumatic device therapy					
97018	A	Paraffin bath therapy					
97020	A	Microwave therapy					
97022	A	Whirlpool therapy					
97024	A	Diathermy treatment					
97026	A	Infrared therapy					
97028	A	Ultraviolet therapy					
97032	A	Electrical stimulation					
97033	A	Electric current therapy					
97034	A	Contrast bath therapy					
97035	A	Ultrasound therapy					
97036	A	Hydrotherapy					
97039	A	Physical therapy treatment					
97110	A	Therapeutic exercises					
97112	A	Neuromuscular reeducation					
97113	A	Aquatic therapy/exercises					
97116	A	Gait training therapy					
97124	A	Massage therapy					
97139	A	Physical medicine procedure					
97140	A	Manual therapy					
97150	A	Group therapeutic procedures					
97504	A	Orthotic training					
97520	A	Prosthetic training					
97530	A	Therapeutic activities					
97535	A	Self care mngment training					
97537	A	Community/work reintegration					
97542	A	Wheelchair mngment training					
97545	A	Work hardening					
97546	A	Work hardening add-on					
97703	A	Prosthetic checkout					
97750	A	Physical performance test					
97770	A	Cognitive skills development					
97780	E	Acupuncture w/o stimul					
97781	E	Acupuncture w/stimul					
97799	A	Physical medicine procedure					
98925	S	Osteopathic manipulation	0060	0.77	$37.34	$7.80	$7.47
98926	S	Osteopathic manipulation	0060	0.77	$37.34	$7.80	$7.47
98927	S	Osteopathic manipulation	0060	0.77	$37.34	$7.80	$7.47
98928	S	Osteopathic manipulation	0060	0.77	$37.34	$7.80	$7.47
98929	S	Osteopathic manipulation	0060	0.77	$37.34	$7.80	$7.47
98940	S	Chiropractic manipulation	0060	0.77	$37.34	$7.80	$7.47
98941	S	Chiropractic manipulation	0060	0.77	$37.34	$7.80	$7.47
98942	S	Chiropractic manipulation	0060	0.77	$37.34	$7.80	$7.47
98943	E	Chiropractic manipulation					
99000	E	Specimen handling					
99001	E	Specimen handling					
99002	E	Device handling					
99024	E	Postop follow-up visit					
99025	E	Initial surgical evaluation					
99050	E	Medical services after hrs					
99052	E	Medical services at night					
99054	E	Medical servcs, unusual hrs					
99056	E	Non-office medical services					
99058	E	Office emergency care					
99070	E	Special supplies					
99071	E	Patient education materials					
99075	E	Medical testimony					
99078	E	Group health education					
99080	E	Special reports or forms					
99082	E	Unusual physician travel					
99090	E	Computer data analysis					
99100	E	Special anesthesia service					
99116	E	Anesthesia with hypothermia					
99135	E	Special anesthesia procedure					
99140	E	Emergency anesthesia					
99141	N	Sedation, iv/im or inhalant					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
99142	N	Sedation, oral/rectal/nasal					
99170	T	Anogenital exam, child	0192	2.38	$115.40	$35.33	$23.08
99173	N	Visual screening test					
99175	N	Induction of vomiting					
99183	S	Hyperbaric oxygen therapy	0031	3.00	$145.46	$140.85	$29.09
99185	N	Regional hypothermia					
99186	N	Total body hypothermia					
99190	C	Special pump services					
99191	C	Special pump services					
99192	C	Special pump services					
99195	X	Phlebotomy	0372	0.43	$20.85	$10.09	$4.17
99199	E	Special service/proc/report					
99201	V	Office/outpatient visit, new	0600	0.98	$47.52	$9.50	$9.50
99202	V	Office/outpatient visit, new	0600	0.98	$47.52	$9.50	$9.50
99203	V	Office/outpatient visit, new	0601	1.00	$48.49	$9.70	$9.70
99204	V	Office/outpatient visit, new	0602	1.66	$80.49	$16.29	$16.10
99205	V	Office/outpatient visit, new	0602	1.66	$80.49	$16.29	$16.10
99211	V	Office/outpatient visit, est	0600	0.98	$47.52	$9.50	$9.50
99212	V	Office/outpatient visit, est	0600	0.98	$47.52	$9.50	$9.50
99213	V	Office/outpatient visit, est	0601	1.00	$48.49	$9.70	$9.70
99214	V	Office/outpatient visit, est	0602	1.66	$80.49	$16.29	$16.10
99215	V	Office/outpatient visit, est	0602	1.66	$80.49	$16.29	$16.10
99217	N	Observation care discharge					
99218	N	Observation care					
99219	N	Observation care					
99220	N	Observation care					
99221	E	Initial hospital care					
99222	E	Initial hospital care					
99223	E	Initial hospital care					
99231	E	Subsequent hospital care					
99232	E	Subsequent hospital care					
99233	E	Subsequent hospital care					
99234	C	Observ/hosp same date					
99235	C	Observ/hosp same date					
99236	C	Observ/hosp same date					
99238	E	Hospital discharge day					
99239	E	Hospital discharge day					
99241	V	Office consultation	0600	0.98	$47.52	$9.50	$9.50
99242	V	Office consultation	0600	0.98	$47.52	$9.50	$9.50
99243	V	Office consultation	0601	1.00	$48.49	$9.70	$9.70
99244	V	Office consultation	0602	1.66	$80.49	$16.29	$16.10
99245	V	Office consultation	0602	1.66	$80.49	$16.29	$16.10
99251	C	Initial inpatient consult					
99252	C	Initial inpatient consult					
99253	C	Initial inpatient consult					
99254	C	Initial inpatient consult					
99255	C	Initial inpatient consult					
99261	C	Follow-up inpatient consult					
99262	C	Follow-up inpatient consult					
99263	C	Follow-up inpatient consult					
99271	V	Confirmatory consultation	0600	0.98	$47.52	$9.50	$9.50
99272	V	Confirmatory consultation	0600	0.98	$47.52	$9.50	$9.50
99273	V	Confirmatory consultation	0601	1.00	$48.49	$9.70	$9.70
99274	V	Confirmatory consultation	0602	1.66	$80.49	$16.29	$16.10
99275	V	Confirmatory consultation	0602	1.66	$80.49	$16.29	$16.10
99281	V	Emergency dept visit	0610	1.34	$64.97	$20.65	$12.99
99282	V	Emergency dept visit	0610	1.34	$64.97	$20.65	$12.99
99283	V	Emergency dept visit	0611	2.11	$102.31	$36.47	$20.46
99284	V	Emergency dept visit	0612	3.19	$154.67	$54.14	$30.93
99285	V	Emergency dept visit	0612	3.19	$154.67	$54.14	$30.93
99288	E	Direct advanced life support					
99291	S	Critical care, first hour	0620	8.60	$416.99	$152.78	$83.40
99292	N	Critical care, addl 30 min					
99295	C	Neonatal critical care					
99296	C	Neonatal critical care					
99297	C	Neonatal critical care					
99298	C	Neonatal critical care					
99301	E	Nursing facility care					
99302	E	Nursing facility care					
99303	E	Nursing facility care					
99311	E	Nursing fac care, subseq					
99312	E	Nursing fac care, subseq					
99313	E	Nursing fac care, subseq					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
99315	E	Nursing fac discharge day					
99316	E	Nursing fac discharge day					
99321	E	Rest home visit, new patient					
99322	E	Rest home visit, new patient					
99323	E	Rest home visit, new patient					
99331	E	Rest home visit, est pat					
99332	E	Rest home visit, est pat					
99333	E	Rest home visit, est pat					
99341	E	Home visit, new patient					
99342	E	Home visit, new patient					
99343	E	Home visit, new patient					
99344	E	Home visit, new patient					
99345	E	Home visit, new patient					
99347	E	Home visit, est patient					
99348	E	Home visit, est patient					
99349	E	Home visit, est patient					
99350	E	Home visit, est patient					
99354	N	Prolonged service, office					
99355	N	Prolonged service, office					
99356	C	Prolonged service, inpatient					
99357	C	Prolonged service, inpatient					
99358	N	Prolonged serv, w/o contact					
99359	N	Prolonged serv, w/o contact					
99360	E	Physician standby services					
99361	E	Physician/team conference					
99362	E	Physician/team conference					
99371	E	Physician phone consultation					
99372	E	Physician phone consultation					
99373	E	Physician phone consultation					
99374	E	Home health care supervision					
99375	E	Home health care supervision					
99377	E	Hospice care supervision					
99378	E	Hospice care supervision					
99379	E	Nursing fac care supervision					
99380	E	Nursing fac care supervision					
99381	E	Prev visit, new, infant					
99382	E	Prev visit, new, age 1–4					
99383	E	Prev visit, new, age 5–11					
99384	E	Prev visit, new, age 12–17					
99385	E	Prev visit, new, age 18–39					
99386	E	Prev visit, new, age 40–64					
99387	E	Prev visit, new, 65 & over					
99391	E	Prev visit, est, infant					
99392	E	Prev visit, est, age 1–4					
99393	E	Prev visit, est, age 5–11					
99394	E	Prev visit, est, age 12–17					
99395	E	Prev visit, est, age 18–39					
99396	E	Prev visit, est, age 40–64					
99397	E	Prev visit, est, 65 & over					
99401	E	Preventive counseling, indiv					
99402	E	Preventive counseling, indiv					
99403	E	Preventive counseling, indiv					
99404	E	Preventive counseling, indiv					
99411	E	Preventive counseling, group					
99412	E	Preventive counseling, group					
99420	E	Health risk assessment test					
99429	E	Unlisted preventive service					
99431	N	Initial care, normal newborn					
99432	N	Newborn care, not in hosp					
99433	C	Normal newborn care/hospital					
99435	E	Newborn discharge day hosp					
99436	N	Attendance, birth					
99440	S	Newborn resuscitation	0094	4.51	$218.68	$105.29	$43.74
99450	E	Life/disability evaluation					
99455	E	Disability examination					
99456	E	Disability examination					
99499	E	Unlisted e&m service					
A0021	E	Outside state ambulance serv					
A0030	A	Air ambulance service					
A0040	A	Helicopter ambulance service					
A0050	A	Water amb service emergency					
A0080	E	Noninterest escort in non er					
A0090	E	Interest escort in non er					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A0100	E	Nonemergency transport taxi					
A0110	E	Nonemergency transport bus					
A0120	E	Noner transport mini-bus					
A0130	E	Noner transport wheelch van					
A0140	E	Nonemergency transport air					
A0160	E	Noner transport case worker					
A0170	E	Noner transport parking fees					
A0180	E	Noner transport lodgng recip					
A0190	E	Noner transport meals recip					
A0200	E	Noner transport lodgng escrt					
A0210	E	Noner transport meals escort					
A0225	A	Neonatal emergency transport					
A0300	A	Ambulance basic non-emer all					
A0302	A	Ambulance basic emergeny all					
A0304	A	Amb adv non-er no serv all					
A0306	A	Amb adv non-er spec serv all					
A0308	A	Amb adv er no spec serv all					
A0310	A	Amb adv er spec serv all					
A0320	A	Amb basic non-er + supplies					
A0322	A	Amb basic emerg + supplies					
A0324	A	Adv non-er serv sep mileage					
A0326	A	Adv non-er no serv sep mile					
A0328	A	Adv er no serv sep mileage					
A0330	A	Adv er spec serv sep mile					
A0340	A	Amb basic non-er + mileage					
A0342	A	Ambul basic emer + mileage					
A0344	A	Amb adv non-er no serv +mile					
A0346	A	Amb adv non-er serv + mile					
A0348	A	Adv emer no spec serv + mile					
A0350	A	Adv emer spec serv + mileage					
A0360	A	Basic non-er sep mile & supp					
A0362	A	Basic emer sep mile & supply					
A0364	A	Adv non-er no serv sep mi&su					
A0366	A	Adv non-er serv sep mil&supp					
A0368	A	Adv er no serv sep mile&supp					
A0370	A	Adv er spec serv sep mi&supp					
A0380	A	Basic life support mileage					
A0382	A	Basic support routine suppls					
A0384	A	Bls defibrillation supplies					
A0390	A	Advanced life support mileag					
A0392	A	Als defibrillation supplies					
A0394	A	Als IV drug therapy supplies					
A0396	A	Als esophageal intub suppls					
A0398	A	Als routine disposble suppls					
A0420	A	Ambulance waiting 1/2 hr					
A0422	A	Ambulance 02 life sustaining					
A0424	A	Extra ambulance attendant					
A0888	E	Noncovered ambulance mileage					
A0999	A	Unlisted ambulance service					
A4206	A	1 CC sterile syringe & needle					
A4207	A	2 CC sterile syringe & needle					
A4208	A	3 CC sterile syringe & needle					
A4209	A	5+ CC sterile syringe & needle					
A4210	E	Nonneedle injection device					
A4211	A	Supp for self-adm injections					
A4212	A	Non coring needle or stylet					
A4213	A	20+ CC syringe only					
A4214	A	30 CC sterile water/saline					
A4215	A	Sterile needle					
A4220	A	Infusion pump refill kit					
A4221	A	Maint drug infus cath per wk					
A4222	A	Drug infusion pump supplies					
A4230	E	Infus insulin pump non needl					
A4231	E	Infusion insulin pump needle					
A4232	E	Syringe w/needle insulin 3cc					
A4244	A	Alcohol or peroxide per pint					
A4245	A	Alcohol wipes per box					
A4246	A	Betadine/phisohex solution					
A4247	A	Betadine/iodine swabs/wipes					
A4250	E	Urine reagent strips/tablets					
A4253	A	Blood glucose/reagent strips					
A4254	A	Battery for glucose monitor					
A4255	A	Glucose monitor platforms					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A4256	A	Calibrator solution/chips					
A4258	A	Lancet device each					
A4259	A	Lancets per box					
A4260	E	Levonorgestrel implant					
A4261	E	Cervical cap contraceptive					
A4262	N	Temporary tear duct plug					
A4263	A	Permanent tear duct plug					
A4265	A	Paraffin					
A4270	A	Disposable endoscope sheath					
A4280	A	Brst prsths adhsv attchmnt					
A4300	A	Cath impl vasc access portal					
A4301	A	Implantable access syst perc					
A4305	A	Drug delivery system >=50 ML					
A4306	A	Drug delivery system <=5 ML					
A4310	A	Insert tray w/o bag/cath					
A4311	A	Catheter w/o bag 2-way latex					
A4312	A	Cath w/o bag 2-way silicone					
A4313	A	Catheter w/bag 3-way					
A4314	A	Cath w/drainage 2-way latex					
A4315	A	Cath w/drainage 2-way silcne					
A4316	A	Cath w/drainage 3-way					
A4320	A	Irrigation tray					
A4321	A	Cath therapeutic irrig agent					
A4322	A	Irrigation syringe					
A4323	A	Saline irrigation solution					
A4326	A	Male external catheter					
A4327	A	Fem urinary collect dev cup					
A4328	A	Fem urinary collect pouch					
A4329	A	External catheter start set					
A4330	A	Stool collection pouch					
A4335	A	Incontinence supply					
A4338	A	Indwelling catheter latex					
A4340	A	Indwelling catheter special					
A4344	A	Cath indw foley 2 way silicn					
A4346	A	Cath indw foley 3 way					
A4347	A	Male external catheter					
A4351	A	Straight tip urine catheter					
A4352	A	Coude tip urinary catheter					
A4353	A	Intermittent urinary cath					
A4354	A	Cath insertion tray w/bag					
A4355	A	Bladder irrigation tubing					
A4356	A	Ext ureth clmp or compr dvc					
A4357	A	Bedside drainage bag					
A4358	A	Urinary leg bag					
A4359	A	Urinary suspensory w/o leg b					
A4361	A	Ostomy face plate					
A4362	A	Solid skin barrier					
A4364	A	Ostomy/cath adhesive					
A4365	A	Ostomy adhesive remover wipe					
A4367	A	Ostomy belt					
A4368	A	Ostomy filter					
A4369	A	Skin barrier liquid per oz					
A4370	A	Skin barrier paste per oz					
A4371	A	Skin barrier powder per oz					
A4372	A	Skin barrier solid 4x4 equiv					
A4373	A	Skin barrier with flange					
A4374	A	Skin barrier extended wear					
A4375	A	Drainable plastic pch w fcpl					
A4376	A	Drainable rubber pch w fcplt					
A4377	A	Drainable plstic pch w/o fp					
A4378	A	Drainable rubber pch w/o fp					
A4379	A	Urinary plastic pouch w fcpl					
A4380	A	Urinary rubber pouch w fcplt					
A4381	A	Urinary plastic pouch w/o fp					
A4382	A	Urinary hvy plstc pch w/o fp					
A4383	A	Urinary rubber pouch w/o fp					
A4384	A	Ostomy faceplt/silicone ring					
A4385	A	Ost skn barrier sld ext wear					
A4386	A	Ost skn barrier w flng ex wr					
A4387	A	Ost clsd pouch w att st barr					
A4388	A	Drainable pch w ex wear barr					
A4389	A	Drainable pch w st wear barr					
A4390	A	Drainable pch ex wear convex					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A4391	A	Urinary pouch w ex wear barr					
A4392	A	Urinary pouch w st wear barr					
A4393	A	Urine pch w ex wear bar conv					
A4394	A	Ostomy pouch liq deodorant					
A4395	A	Ostomy pouch solid deodorant					
A4397	A	Irrigation supply sleeve					
A4398	A	Ostomy irrigation bag					
A4399	A	Ostomy irrig cone/cath w brs					
A4400	A	Ostomy irrigation set					
A4402	A	Lubricant per ounce					
A4404	A	Ostomy ring each					
A4421	A	Ostomy supply misc					
A4454	A	Tape all types all sizes					
A4455	A	Adhesive remover per ounce					
A4460	A	Elastic compression bandage					
A4462	A	Abdmnl drssng holder/binder					
A4465	A	Non-elastic extremity binder					
A4470	A	Gravlee jet washer					
A4480	A	Vabra aspirator					
A4481	A	Tracheostoma filter					
A4483	A	Moisture exchanger					
A4490	E	Above knee surgical stocking					
A4495	E	Thigh length surg stocking					
A4500	E	Below knee surgical stocking					
A4510	E	Full length surg stocking					
A4550	E	Surgical trays					
A4554	E	Disposable underpads					
A4556	A	Electrodes, pair					
A4557	A	Lead wires, pair					
A4558	A	Conductive paste or gel					
A4560	A	Pessary					
A4565	A	Slings					
A4570	A	Splint					
A4572	A	Rib belt					
A4575	E	Hyperbaric o2 chamber disps					
A4580	A	Cast supplies (plaster)					
A4590	A	Special casting material					
A4595	A	TENS suppl 2 lead per month					
A4611	A	Heavy duty battery					
A4612	A	Battery cables					
A4613	A	Battery charger					
A4614	A	Hand-held PEFR meter					
A4615	A	Cannula nasal					
A4616	A	Tubing (oxygen) per foot					
A4617	A	Mouth piece					
A4618	A	Breathing circuits					
A4619	A	Face tent					
A4620	A	Variable concentration mask					
A4621	A	Tracheotomy mask or collar					
A4622	A	Tracheostomy or larngectomy					
A4623	A	Tracheostomy inner cannula					
A4624	A	Tracheal suction tube					
A4625	A	Trach care kit for new trach					
A4626	A	Tracheostomy cleaning brush					
A4627	E	Spacer bag/reservoir					
A4628	A	Oropharyngeal suction cath					
A4629	A	Tracheostomy care kit					
A4630	A	Repl bat t.e.n.s. own by pt					
A4631	A	Wheelchair battery					
A4635	A	Underarm crutch pad					
A4636	A	Handgrip for cane etc					
A4637	A	Repl tip cane/crutch/walker					
A4640	A	Alternating pressure pad					
A4641	N	Diagnostic imaging agent					
[3] A4642	X	Satumomab pendetide per dose	0704				$63.13
A4643	N	High dose contrast MRI					
A4644	N	Contrast 100–199 MGs iodine					
A4645	N	Contrast 200–299 MGs iodine					
A4646	N	Contrast 300–399 MGs iodine					
A4647	N	Supp-paramagnetic contr mat					
A4649	A	Surgical supplies					
A4650	A	Supp esrd centrifuge					
A4655	A	Esrd syringe/needle					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A4660	A	Esrd blood pressure device					
A4663	A	Esrd blood pressure cuff					
A4670	E	Auto blood pressure monitor					
A4680	A	Activated carbon filters					
A4690	A	Dialyzers					
A4700	A	Standard dialysate solution					
A4705	A	Bicarb dialysate solution					
A4712	A	Sterile water					
A4714	A	Treated water for dialysis					
A4730	A	Fistula cannulation set dial					
A4735	A	Local/topical anesthetics					
A4740	A	Esrd shunt accessory					
A4750	A	Arterial or venous tubing					
A4755	A	Arterial and venous tubing					
A4760	A	Standard testing solution					
A4765	A	Dialysate concentrate					
A4770	A	Blood testing supplies					
A4771	A	Blood clotting time tube					
A4772	A	Dextrostick/glucose strips					
A4773	A	Hemostix					
A4774	A	Ammonia test paper					
A4780	A	Esrd sterilizing agent					
A4790	A	Esrd cleansing agents					
A4800	A	Heparin/antidote dialysis					
A4820	A	Supplies hemodialysis kit					
A4850	A	Rubber tipped hemostats					
A4860	A	Disposable catheter caps					
A4870	A	Plumbing/electrical work					
A4880	A	Water storage tanks					
A4890	A	Contracts/repair/maintenance					
A4900	A	Capd supply kit					
A4901	A	Ccpd supply kit					
A4905	A	Ipd supply kit					
A4910	A	Esrd nonmedical supplies					
A4912	A	Gomco drain bottle					
A4913	A	Esrd supply					
A4914	A	Preparation kit					
A4918	A	Venous pressure clamp					
A4919	A	Supp dialysis dialyzer holde					
A4920	A	Harvard pressure clamp					
A4921	A	Measuring cylinder					
A4927	A	Gloves					
A5051	A	Pouch clsd w barr attached					
A5052	A	Clsd ostomy pouch w/o barr					
A5053	A	Clsd ostomy pouch faceplate					
A5054	A	Clsd ostomy pouch w/flange					
A5055	A	Stoma cap					
A5061	A	Pouch drainable w barrier at					
A5062	A	Drnble ostomy pouch w/o barr					
A5063	A	Drain ostomy pouch w/flange					
A5064	E	Drain ostomy pouch w/fceplte					
A5065	E	Drain ostomy pouch on fcplte					
A5071	A	Urinary pouch w/barrier					
A5072	A	Urinary pouch w/o barrier					
A5073	A	Urinary pouch on barr w/flng					
A5074	E	Urinary pouch w/faceplate					
A5075	E	Urinary pouch on faceplate					
A5081	A	Continent stoma plug					
A5082	A	Continent stoma catheter					
A5093	A	Ostomy accessory convex inse					
A5102	A	Bedside drain btl w/wo tube					
A5105	A	Urinary suspensory					
A5112	A	Urinary leg bag					
A5113	A	Latex leg strap					
A5114	A	Foam/fabric leg strap					
A5119	A	Skin barrier wipes box pr 50					
A5121	A	Solid skin barrier 6x6					
A5122	A	Solid skin barrier 8x8					
A5123	A	Skin barrier with flange					
A5126	A	Disk/foam pad +or- adhesive					
A5131	A	Appliance cleaner					
A5149	A	Incontinence/ostomy supply					
A5200	A	Percutaneous catheter anchor					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A5500	A	Diab shoe for density insert					
A5501	A	Diabetic custom molded shoe					
A5502	A	Diabetic shoe density insert					
A5503	A	Diabetic shoe w/roller/rockr					
A5504	A	Diabetic shoe with wedge					
A5505	A	Diab shoe w/metatarsal bar					
A5506	A	Diabetic shoe w/off set heel					
A5507	A	Modification diabetic shoe					
A5508	A	Diabetic deluxe shoe					
A6020	A	Collagen wound dressing					
A6025	E	Silicone gel sheet, each					
A6154	A	Wound pouch each					
A6196	A	Alginate dressing <=16 sq in					
A6197	A	Alginate drsg >16 <=48 sq in					
A6198	A	alginate dressing > 48 sq in					
A6199	A	Alginate drsg wound filler					
A6200	A	Compos drsg <=16 no border					
A6201	A	Compos drsg >16<=48 no bdr					
A6202	A	Compos drsg >48 no border					
A6203	A	Composite drsg <= 16 sq in					
A6204	A	Composite drsg >16<=48 sq in					
A6205	A	Composite drsg > 48 sq in					
A6206	A	Contact layer <= 16 sq in					
A6207	A	Contact layer >16<= 48 sq in					
A6208	A	Contact layer > 48 sq in					
A6209	A	Foam drsg <=16 sq in w/o bdr					
A6210	A	Foam drg >16<=48 sq in w/o b					
A6211	A	Foam drg > 48 sq in w/o brdr					
A6212	A	Foam drg <=16 sq in w/border					
A6213	A	Foam drg >16<=48 sq in w/bdr					
A6214	A	Foam drg > 48 sq in w/border					
A6215	A	Foam dressing wound filler					
A6216	A	Non-sterile gauze<=16 sq in					
A6217	A	Non-sterile gauze>16<=48 sq					
A6218	A	Non-sterile gauze > 48 sq in					
A6219	A	Gauze <= 16 sq in w/border					
A6220	A	Gauze >16 <=48 sq in w/bordr					
A6221	A	Gauze > 48 sq in w/border					
A6222	A	Gauze <=16 in no w/sal w/o b					
A6223	A	Gauze >16<=48 no w/sal w/o b					
A6224	A	Gauze > 48 in no w/sal w/o b					
A6228	A	Gauze <= 16 sq in water/sal					
A6229	A	Gauze >16<=48 sq in watr/sal					
A6230	A	Gauze > 48 sq in water/salne					
A6234	A	Hydrocolld drg <=16 w/o bdr					
A6235	A	Hydrocolld drg >16<=48 w/o b					
A6236	A	Hydrocolld drg > 48 in w/o b					
A6237	A	Hydrocolld drg <=16 in w/bdr					
A6238	A	Hydrocolld drg >16<=48 w/bdr					
A6239	A	Hydrocolld drg > 48 in w/bdr					
A6240	A	Hydrocolld drg filler paste					
A6241	A	Hydrocolloid drg filler dry					
A6242	A	Hydrogel drg <=16 in w/o bdr					
A6243	A	Hydrogel drg >16<=48 w/o bdr					
A6244	A	Hydrogel drg >48 in w/o bdr					
A6245	A	Hydrogel drg <= 16 in w/bdr					
A6246	A	Hydrogel drg >16<=48 in w/b					
A6247	A	Hydrogel drg > 48 sq in w/b					
A6248	A	Hydrogel drsg gel filler					
A6250	A	Skin seal protect moisturizr					
A6251	A	Absorpt drg <=16 sq in w/o b					
A6252	A	Absorpt drg >16 <=48 w/o bdr					
A6253	A	Absorpt drg > 48 sq in w/o b					
A6254	A	Absorpt drg <=16 sq in w/bdr					
A6255	A	Absorpt drg >16<=48 in w/bdr					
A6256	A	Absorpt drg > 48 sq in w/bdr					
A6257	A	Transparent film <= 16 sq in					
A6258	A	Transparent film >16<=48 in					
A6259	A	Transparent film > 48 sq in					
A6260	A	Wound cleanser any type/size					
A6261	A	Wound filler gel/paste/oz					
A6262	A	Wound filler dry form/gram					
A6263	A	Non-sterile elastic gauze/yd					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
A6264	A	Non-sterile no elastic gauze					
A6265	A	Tape per 18 sq inches					
A6266	A	Impreg gauze no h20/sal/yard					
A6402	A	Sterile gauze <= 16 sq in					
A6403	A	Sterile gauze>16 <= 48 sq in					
A6404	A	Sterile gauze > 48 sq in					
A6405	A	Sterile elastic gauze/yd					
A6406	A	Sterile non-elastic gauze/yd					
A7000	A	Disposable canister for pump					
A7001	A	Nondisposable pump canister					
A7002	A	Tubing used w suction pump					
A7003	A	Nebulizer administration set					
A7004	A	Disposable nebulizer sml vol					
A7005	A	Nondisposable nebulizer set					
A7006	A	Filtered nebulizer admin set					
A7007	A	Lg vol nebulizer disposable					
A7008	A	Disposable nebulizer prefill					
A7009	A	Nebulizer reservoir bottle					
A7010	A	Disposable corrugated tubing					
A7011	A	Nondispos corrugated tubing					
A7012	A	Nebulizer water collec devic					
A7013	A	Disposable compressor filter					
A7014	A	Compressor nondispos filter					
A7015	A	Aerosol mask used w nebulize					
A7016	A	Nebulizer dome & mouthpiece					
A7017	A	Nebulizer not used w oxygen					
A9150	E	Misc/exper non-prescript dru					
A9160	E	Podiatrist non-covered servi					
A9170	E	Chiropractor non-covered ser					
A9190	E	Misc/expe personal comfort i					
A9270	E	Non-covered item or service					
A9300	E	Exercise equipment					
A9500	N	Technetium TC 99m sestamibi					
[3] A9502	X	Technetium TC99M tetrofosmin	0705				$71.08
A9503	N	Technetium TC 99m medronate					
A9504	N	Technetium tc 99m apcitide					
A9505	N	Thallous chloride TL 201/mci					
A9507	N	Indium/111 capromab pendetid					
[3] A9600	X	Strontium-89 chloride	0701				$84.76
[3] A9605	X	Samarium sm153 lexidronamm	0702				$139.06
A9900	E	Supply/accessory/service					
A9901	E	Delivery/set up/dispensing					
B4034	A	Enter feed supkit syr by day					
B4035	A	Enteral feed supp pump per d					
B4036	A	Enteral feed sup kit grav by					
B4081	A	Enteral ng tubing w/stylet					
B4082	A	Enteral ng tubing w/o stylet					
B4083	A	Enteral stomach tube levine					
B4084	A	Gastrostomy/jejunostomy tubi					
B4085	A	Gastrostomy tube w/ring each					
B4150	A	Enteral formulae category i					
B4151	A	Enteral formulae category i-					
B4152	A	Enteral formulae category ii					
B4153	A	Enteral formulae category ii					
B4154	A	Enteral formulae category IV					
B4155	A	Enteral formulae category v					
B4156	A	Enteral formulae category vi					
B4164	A	Parenteral 50% dextrose solu					
B4168	A	Parenteral sol amino acid 3.					
B4172	A	Parenteral sol amino acid 5.					
B4176	A	Parenteral sol amino acid 7-					
B4178	A	Parenteral sol amino acid >					
B4180	A	Parenteral sol carb > 50%					
B4184	A	Parenteral sol lipids 10%					
B4186	A	Parenteral sol lipids 20%					
B4189	A	Parenteral sol amino acid &					
B4193	A	Parenteral sol 52–73 gm prot					
B4197	A	Parenteral sol 74–100 gm pro					
B4199	A	Parenteral sol > 100gm prote					
B4216	A	Parenteral nutrition additiv					
B4220	A	Parenteral supply kit premix					
B4222	A	Parenteral supply kit homemi					
B4224	A	Parenteral administration ki					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
B5000	A	Parenteral sol renal-amirosy					
B5100	A	Parenteral sol hepatic-fream					
B5200	A	Parenteral sol stres-brnch c					
B9000	A	Enter infusion pump w/o alrm					
B9002	A	Enteral infusion pump w/ala					
B9004	A	Parenteral infus pump portab					
B9006	A	Parenteral infus pump statio					
B9998	A	Enteral supp not otherwise c					
B9999	A	Parenteral supp not othrws c					
D0120	E	Periodic oral evaluation					
D0140	E	Limit oral eval problm focus					
D0150	S	Comprehensve oral evaluation	0330	1.51	$73.22	$14.64	$14.64
D0160	E	Extensv oral eval prob focus					
D0170	E	Re-eval, est pt, problem focus					
D0210	E	Intraor complete film series					
D0220	E	Intraoral periapical first f					
D0230	E	Intraoral periapical ea add					
D0240	S	Intraoral occlusal film	0330	1.51	$73.22	$14.64	$14.64
D0250	S	Extraoral first film	0330	1.51	$73.22	$14.64	$14.64
D0260	S	Extraoral ea additional film	0330	1.51	$73.22	$14.64	$14.64
D0270	S	Dental bitewing single film	0330	1.51	$73.22	$14.64	$14.64
D0272	S	Dental bitewings two films	0330	1.51	$73.22	$14.64	$14.64
D0274	S	Dental bitewings four films	0330	1.51	$73.22	$14.64	$14.64
D0277	E	Vert bitewings-sev to eight					
D0290	E	Dental film skull/facial bon					
D0310	E	Dental saliography					
D0320	E	Dental tmj arthrogram incl i					
D0321	E	Dental other tmj films					
D0322	E	Dental tomographic survey					
D0330	E	Dental panoramic film					
D0340	E	Dental cephalometric film					
D0350	E	Oral/facial images					
D0415	E	Bacteriologic study					
D0425	E	Caries susceptibility test					
D0460	S	Pulp vitality test	0330	1.51	$73.22	$14.64	$14.64
D0470	E	Diagnostic casts					
D0472	E	Gross exam, prep & report					
D0473	E	Micro exam, prep & report					
D0474	E	Micro w exam of surg margins					
D0480	E	Cytopath smear prep & report					
D0501	S	Histopathologic examinations	0330	1.51	$73.22	$14.64	$14.64
D0502	S	Other oral pathology procedu	0330	1.51	$73.22	$14.64	$14.64
D0999	S	Unspecified diagnostic proce	0330	1.51	$73.22	$14.64	$14.64
D1110	E	Dental prophylaxis adult					
D1120	E	Dental prophylaxis child					
D1201	E	Topical fluor w prophy child					
D1203	E	Topical fluor w/o prophy chi					
D1204	E	Topical fluor w/o prophy adu					
D1205	E	Topical fluoride w/prophy a					
D1310	E	Nutri counsel-control caries					
D1320	E	Tobacco counseling					
D1330	E	Oral hygiene instruction					
D1351	E	Dental sealant per tooth					
D1510	S	Space maintainer fxd unilat	0330	1.51	$73.22	$14.64	$14.64
D1515	S	Fixed bilat space maintainer	0330	1.51	$73.22	$14.64	$14.64
D1520	S	Remove unilat space maintain	0330	1.51	$73.22	$14.64	$14.64
D1525	S	Remove bilat space maintain	0330	1.51	$73.22	$14.64	$14.64
D1550	S	Recement space maintainer	0330	1.51	$73.22	$14.64	$14.64
D2110	E	Amalgam one surface primary					
D2120	E	Amalgam two surfaces primary					
D2130	E	Amalgam three surfaces prima					
D2131	E	Amalgam four/more surf prima					
D2140	E	Amalgam one surface permanen					
D2150	E	Amalgam two surfaces permane					
D2160	E	Amalgam three surfaces perma					
D2161	E	Amalgam 4 or > surfaces perm					
D2330	E	Resin one surface-anterior					
D2331	E	Resin two surfaces-anterior					
D2332	E	Resin three surfaces-anterio					
D2335	E	Resin 4/> surf or w incis an					
D2336	E	Composite resin crown					
D2337	E	Compo resin crown ant-perm					
D2380	E	Resin one surf poster primar					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D2381	E	Resin two surf poster primar					
D2382	E	Resin three/more surf post p					
D2385	E	Resin one surf poster perman					
D2386	E	Resin two surf poster perman					
D2387	E	Resin three/more surf post p					
D2388	E	Resin four/more, post perm					
D2410	E	Dental gold foil one surface					
D2420	E	Dental gold foil two surface					
D2430	E	Dental gold foil three surfa					
D2510	E	Dental inlay metalic 1 surf					
D2520	E	Dental inlay metallic 2 surf					
D2530	E	Dental inlay metl 3/more sur					
D2542	E	Dental onlay metallic 2 surf					
D2543	E	Dental onlay metallic 3 surf					
D2544	E	Dental onlay metl 4/more sur					
D2610	E	Inlay porcelain/ceramic 1 su					
D2620	E	Inlay porcelain/ceramic 2 su					
D2630	E	Dental onlay porc 3/more sur					
D2642	E	Dental onlay porcelin 2 surf					
D2643	E	Dental onlay porcelin 3 surf					
D2644	E	Dental onlay porc 4/more sur					
D2650	E	Inlay composite/resin one su					
D2651	E	Inlay composite/resin two su					
D2652	E	Dental inlay resin 3/mre sur					
D2662	E	Dental onlay resin 2 surface					
D2663	E	Dental onlay resin 3 surface					
D2664	E	Dental onlay resin 4/mre sur					
D2710	E	Crown resin laboratory					
D2720	E	Crown resin w/high noble me					
D2721	E	Crown resin w/base metal					
D2722	E	Crown resin w/noble metal					
D2740	E	Crown porcelain/ceramic subs					
D2750	E	Crown porcelain w/h noble m					
D2751	E	Crown porcelain fused base m					
D2752	E	Crown porcelain w/noble met					
D2780	E	Crown 3/4 cast hi noble met					
D2781	E	Crown 3/4 cast base metal					
D2782	E	Crown 3/4 cast noble metal					
D2783	E	Crown 3/4 porcelain/ceramic					
D2790	E	Crown full cast high noble m					
D2791	E	Crown full cast base metal					
D2792	E	Crown full cast noble metal					
D2799	E	Provisional crown					
D2910	E	Dental recement inlay					
D2920	E	Dental recement crown					
D2930	E	Prefab stnlss steel crwn pri					
D2931	E	Prefab stnlss steel crown pe					
D2932	E	Prefabricated resin crown					
D2933	E	Prefab stainless steel crown					
D2940	E	Dental sedative filling					
D2950	E	Core build-up incl any pins					
D2951	E	Tooth pin retention					
D2952	E	Post and core cast + crown					
D2953	E	Each addtnl cast post					
D2954	E	Prefab post/core + crown					
D2955	E	Post removal					
D2957	E	Each addtnl prefab post					
D2960	E	Laminate labial veneer					
D2961	E	Lab labial veneer resin					
D2962	E	Lab labial veneer porcelain					
D2970	S	Temporary-fractured tooth	0330	1.51	$73.22	$14.64	$14.64
D2980	E	Crown repair					
D2999	S	Dental unspec restorative pr	0330	1.51	$73.22	$14.64	$14.64
D3110	E	Pulp cap direct					
D3120	E	Pulp cap indirect					
D3220	E	Therapeutic pulpotomy					
D3221	E	Gross pulpal debridement					
D3230	E	Pulpal therapy anterior prim					
D3240	E	Pulpal therapy posterior pri					
D3310	E	Anterior					
D3320	E	Root canal therapy 2 canals					
D3330	E	Root canal therapy 3 canals					
D3331	E	Non-surg tx root canal obs					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D3332	E	Incomplete endodontic tx					
D3333	E	Internal root repair					
D3346	E	Retreat root canal anterior					
D3347	E	Retreat root canal bicuspid					
D3348	E	Retreat root canal molar					
D3351	E	Apexification/recalc initial					
D3352	E	Apexification/recalc interim					
D3353	E	Apexification/recalc final					
D3410	E	Apicoect/perirad surg anter					
D3421	E	Root surgery bicuspid					
D3425	E	Root surgery molar					
D3426	E	Root surgery ea add root					
D3430	E	Retrograde filling					
D3450	E	Root amputation					
D3460	S	Endodontic endosseous implan	0330	1.51	$73.22	$14.64	$14.64
D3470	E	Intentional replantation					
D3910	E	Isolation-tooth w rubb dam					
D3920	E	Tooth splitting					
D3950	E	Canal prep/fitting of dowel					
D3999	S	Endodontic procedure	0330	1.51	$73.22	$14.64	$14.64
D4210	E	Gingivectomy/plasty per quad					
D4211	E	Gingivectomy/plasty per toot					
D4220	E	Gingival curettage per quadr					
D4240	E	Gingival flap proc w/planin					
D4245	E	Apically positioned flap					
D4249	E	Crown lengthen hard tissue					
D4260	S	Osseous surgery per quadrant	0330	1.51	$73.22	$14.64	$14.64
D4263	S	Bone replce graft first site	0330	1.51	$73.22	$14.64	$14.64
D4264	S	Bone replce graft each add	0330	1.51	$73.22	$14.64	$14.64
D4266	E	Guided tiss regen resorble					
D4267	E	Guided tiss regen nonresorb					
D4268	E	Surgical revision procedure					
D4270	S	Pedicle soft tissue graft pr	0330	1.51	$73.22	$14.64	$14.64
D4271	S	Free soft tissue graft proc	0330	1.51	$73.22	$14.64	$14.64
D4273	S	Subepithelial tissue graft	0330	1.51	$73.22	$14.64	$14.64
D4274	E	Distal/proximal wedge proc					
D4320	E	Provision splnt intracoronal					
D4321	E	Provisional splint extracoro					
D4341	E	Periodontal scaling & root					
D4355	S	Full mouth debridement	0330	1.51	$73.22	$14.64	$14.64
D4381	S	Localized chemo delivery	0330	1.51	$73.22	$14.64	$14.64
D4910	E	Periodontal maint procedures					
D4920	E	Unscheduled dressing change					
D4999	E	Unspecified periodontal proc					
D5110	E	Dentures complete maxillary					
D5120	E	Dentures complete mandible					
D5130	E	Dentures immediat maxillary					
D5140	E	Dentures immediat mandible					
D5211	E	Dentures maxill part resin					
D5212	E	Dentures mand part resin					
D5213	E	Dentures maxill part metal					
D5214	E	Dentures mandibl part metal					
D5281	E	Removable partial denture					
D5410	E	Dentures adjust cmplt maxil					
D5411	E	Dentures adjust cmplt mand					
D5421	E	Dentures adjust part maxill					
D5422	E	Dentures adjust part mandbl					
D5510	E	Dentur repr broken compl bas					
D5520	E	Replace denture teeth complt					
D5610	E	Dentures repair resin base					
D5620	E	Rep part denture cast frame					
D5630	E	Rep partial denture clasp					
D5640	E	Replace part denture teeth					
D5650	E	Add tooth to partial denture					
D5660	E	Add clasp to partial denture					
D5710	E	Dentures rebase cmplt maxil					
D5711	E	Dentures rebase cmplt mand					
D5720	E	Dentures rebase part maxill					
D5721	E	Dentures rebase part mandbl					
D5730	E	Denture reln cmplt maxil ch					
D5731	E	Denture reln cmplt mand chr					
D5740	E	Denture reln part maxil chr					
D5741	E	Denture reln part mand chr					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D5750	E	Denture reln cmplt max lab					
D5751	E	Denture reln cmplt mand lab					
D5760	E	Denture reln part maxil lab					
D5761	E	Denture reln part mand lab					
D5810	E	Denture interm cmplt maxill					
D5811	E	Denture interm cmplt mandbl					
D5820	E	Denture interm part maxill					
D5821	E	Denture interm part mandbl					
D5850	E	Denture tiss conditn maxill					
D5851	E	Denture tiss condtin mandbl					
D5860	E	Overdenture complete					
D5861	E	Overdenture partial					
D5862	E	Precision attachment					
D5867	E	Replacement of precision att					
D5875	E	Prosthesis modification					
D5899	E	Removable prosthodontic proc					
D5911	S	Facial moulage sectional	0330	1.51	$73.22	$14.64	$14.64
D5912	S	Facial moulage complete	0330	1.51	$73.22	$14.64	$14.64
D5913	E	Nasal prosthesis					
D5914	E	Auricular prosthesis					
D5915	E	Orbital prosthesis					
D5916	E	Ocular prosthesis					
D5919	E	Facial prosthesis					
D5922	E	Nasal septal prosthesis					
D5923	E	Ocular prosthesis interim					
D5924	E	Cranial prosthesis					
D5925	E	Facial augmentation implant					
D5926	E	Replacement nasal prosthesis					
D5927	E	Auricular replacement					
D5928	E	Orbital replacement					
D5929	E	Facial replacement					
D5931	E	Surgical obturator					
D5932	E	Postsurgical obturator					
D5933	E	Refitting of obturator					
D5934	E	Mandibular flange prosthesis					
D5935	E	Mandibular denture prosth					
D5936	E	Temp obturator prosthesis					
D5937	E	Trismus appliance					
D5951	E	Feeding aid					
D5952	E	Pediatric speech aid					
D5953	E	Adult speech aid					
D5954	E	Superimposed prosthesis					
D5955	E	Palatal lift prosthesis					
D5958	E	Intraoral con def inter plt					
D5959	E	Intraoral con def mod palat					
D5960	E	Modify speech aid prosthesis					
D5982	E	Surgical stent					
D5983	S	Radiation applicator	0330	1.51	$73.22	$14.64	$14.64
D5984	S	Radiation shield	0330	1.51	$73.22	$14.64	$14.64
D5985	S	Radiation cone locator	0330	1.51	$73.22	$14.64	$14.64
D5986	E	Fluoride applicator					
D5987	S	Commissure splint	0330	1.51	$73.22	$14.64	$14.64
D5988	E	Surgical splint					
D5999	E	Maxillofacial prosthesis					
D6010	E	Odontics endosteal implant					
D6020	E	Odontics abutment placement					
D6040	E	Odontics eposteal implant					
D6050	E	Odontics transosteal implnt					
D6055	E	Implant connecting bar					
D6056	E	Prefabricated abutment					
D6057	E	Custom abutment					
D6058	E	Abutment supported crown					
D6059	E	Abutment supported mtl crown					
D6060	E	Abutment supported mtl crown					
D6061	E	Abutment supported mtl crown					
D6062	E	Abutment supported mtl crown					
D6063	E	Abutment supported mtl crown					
D6064	E	Abutment supported mtl crown					
D6065	E	Implant supported crown					
D6066	E	Implant supported mtl crown					
D6067	E	Implant supported mtl crown					
D6068	E	Abutment supported retainer					
D6069	E	Abutment supported retainer					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D6070	E	Abutment supported retainer					
D6071	E	Abutment supported retainer					
D6072	E	Abutment supported retainer					
D6073	E	Abutment supported retainer					
D6074	E	Abutment supported retainer					
D6075	E	Implant supported retainer					
D6076	E	Implant supported retainer					
D6077	E	Implant supported retainer					
D6078	E	Implnt/abut suprtd fixd dent					
D6079	E	Implnt/abut suprtd fixd dent					
D6080	E	Implant maintenance					
D6090	E	Repair implant					
D6095	E	Odontics repr abutment					
D6100	E	Removal of implant					
D6199	E	Implant procedure					
D6210	E	Prosthodont high noble metal					
D6211	E	Bridge base metal cast					
D6212	E	Bridge noble metal cast					
D6240	E	Bridge porcelain high noble					
D6241	E	Bridge porcelain base metal					
D6242	E	Bridge porcelain nobel metal					
D6245	E	Bridge porcelain/ceramic					
D6250	E	Bridge resin w/high noble					
D6251	E	Bridge resin base metal					
D6252	E	Bridge resin w/noble metal					
D6519	E	Inlay/onlay porce/ceramic					
D6520	E	Dental retainer two surfaces					
D6530	E	Retainer metallic 3+ surface					
D6543	E	Dental retainr onlay 3 surf					
D6544	E	Dental retainr onlay 4/more					
D6545	E	Dental retainr cast metl					
D6548	E	Porcelain/ceramic retainer					
D6720	E	Retain crown resin w hi nble					
D6721	E	Crown resin w/base metal					
D6722	E	Crown resin w/noble metal					
D6740	E	Crown porcelain/ceramic					
D6750	E	Crown porcelain high noble					
D6751	E	Crown porcelain base metal					
D6752	E	Crown porcelain noble metal					
D6780	E	Crown 3/4 high noble metal					
D6781	E	Crown 3/4 cast based metal					
D6782	E	Crown 3/4 cast noble metal					
D6783	E	Crown 3/4 porcelain/ceramic					
D6790	E	Crown full high noble metal					
D6791	E	Crown full base metal cast					
D6792	E	Crown full noble metal cast					
D6920	S	Dental connector bar	0330	1.51	$73.22	$14.64	$14.64
D6930	E	Dental recement bridge					
D6940	E	Stress breaker					
D6950	E	Precision attachment					
D6970	E	Post & core plus retainer					
D6971	E	Cast post bridge retainer					
D6972	E	Prefab post & core plus reta					
D6973	E	Core build up for retainer					
D6975	E	Coping metal					
D6976	E	Each addtnl cast post					
D6977	E	Each addtl prefab post					
D6980	E	Bridge repair					
D6999	E	Fixed prosthodontic proc					
D7110	S	Oral surgery single tooth	0330	1.51	$73.22	$14.64	$14.64
D7120	S	Each add tooth extraction	0330	1.51	$73.22	$14.64	$14.64
D7130	S	Tooth root removal	0330	1.51	$73.22	$14.64	$14.64
D7210	S	Rem imp tooth w mucoper flp	0330	1.51	$73.22	$14.64	$14.64
D7220	S	Impact tooth remov soft tiss	0330	1.51	$73.22	$14.64	$14.64
D7230	S	Impact tooth remov part bony	0330	1.51	$73.22	$14.64	$14.64
D7240	S	Impact tooth remov comp bony	0330	1.51	$73.22	$14.64	$14.64
D7241	S	Impact tooth rem bony w/comp	0330	1.51	$73.22	$14.64	$14.64
D7250	S	Tooth root removal	0330	1.51	$73.22	$14.64	$14.64
D7260	S	Oral antral fistula closure	0330	1.51	$73.22	$14.64	$14.64
D7270	E	Tooth reimplantation					
D7272	E	Tooth transplantation					
D7280	E	Exposure impact tooth orthod					
D7281	E	Exposure tooth aid eruption					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D7285	E	Biopsy of oral tissue hard					
D7286	E	Biopsy of oral tissue soft					
D7290	E	Repositioning of teeth					
D7291	S	Transseptal fiberotomy	0330	1.51	$73.22	$14.64	$14.64
D7310	E	Alveoplasty w/extraction					
D7320	E	Alveoplasty w/o extraction					
D7340	E	Vestibuloplasty ridge extens					
D7350	E	Vestibuloplasty exten graft					
D7410	E	Rad exc lesion up to 1.25 cm					
D7420	E	Lesion > 1.25 cm					
D7430	E	Exc benign tumor to 1.25 cm					
D7431	E	Benign tumor exc > 1.25 cm					
D7440	E	Malig tumor exc to 1.25 cm					
D7441	E	Malig tumor > 1.25 cm					
D7450	E	Rem odontogen cyst to 1.25cm					
D7451	E	Rem odontogen cyst > 1.25 cm					
D7460	E	Rem nonodonto cyst to 1.25cm					
D7461	E	Rem nonodonto cyst > 1.25 cm					
D7465	E	Lesion destruction					
D7471	E	Rem exostosis any site					
D7480	E	Partial ostectomy					
D7490	E	Mandible resection					
D7510	E	I&d absc intraoral soft tiss					
D7520	E	I&d abscess extraoral					
D7530	E	Removal fb skin/areolar tiss					
D7540	E	Removal of fb reaction					
D7550	E	Removal of sloughed off bone					
D7560	E	Maxillary sinusotomy					
D7610	E	Maxilla open reduct simple					
D7620	E	Clsd reduct simpl maxilla fx					
D7630	E	Open red simpl mandible fx					
D7640	E	Clsd red simpl mandible fx					
D7650	E	Open red simp malar/zygom fx					
D7660	E	Clsd red simp malar/zygom fx					
D7670	E	Closd rductn splint alveolus					
D7680	E	Reduct simple facial bone fx					
D7710	E	Maxilla open reduct compound					
D7720	E	Clsd reduct compd maxilla fx					
D7730	E	Open reduct compd mandble fx					
D7740	E	Clsd reduct compd mandble fx					
D7750	E	Open red comp malar/zygma fx					
D7760	E	Clsd red comp malar/zygma fx					
D7770	E	Open reduc compd alveolus fx					
D7780	E	Reduct compnd facial bone fx					
D7810	E	Tmj open reduct-dislocation					
D7820	E	Closed tmp manipulation					
D7830	E	Tmj manipulation under anest					
D7840	E	Removal of tmj condyle					
D7850	E	Tmj meniscectomy					
D7852	E	Tmj repair of joint disc					
D7854	E	Tmj excisn of joint membrane					
D7856	E	Tmj cutting of a muscle					
D7858	E	Tmj reconstruction					
D7860	E	Tmj cutting into joint					
D7865	E	Tmj reshaping components					
D7870	E	Tmj aspiration joint fluid					
D7871	E	Lysis + lavage w catheters					
D7872	E	Tmj diagnostic arthroscopy					
D7873	E	Tmj arthroscopy lysis adhesn					
D7874	E	Tmj arthroscopy disc reposit					
D7875	E	Tmj arthroscopy synovectomy					
D7876	E	Tmj arthroscopy discectomy					
D7877	E	Tmj arthroscopy debridement					
D7880	E	Occlusal orthotic appliance					
D7899	E	Tmj unspecified therapy					
D7910	E	Dent sutur recent wnd to 5cm					
D7911	E	Dental suture wound to 5 cm					
D7912	E	Suture complicate wnd > 5 cm					
D7920	E	Dental skin graft					
D7940	S	Reshaping bone orthognathic	0330	1.51	$73.22	$14.64	$14.64
D7941	E	Bone cutting ramus closed					
D7943	E	Cutting ramus open w/graft					
D7944	E	Bone cutting segmented					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
D7945	E	Bone cutting body mandible					
D7946	E	Reconstruction maxilla total					
D7947	E	Reconstruct maxilla segment					
D7948	E	Reconstruct midface no graft					
D7949	E	Reconstruct midface w/graft					
D7950	E	Mandible graft					
D7955	E	Repair maxillofacial defects					
D7960	E	Frenulectomy/frenulotomy					
D7970	E	Excision hyperplastic tissue					
D7971	E	Excision pericoronal gingiva					
D7980	E	Sialolithotomy					
D7981	E	Excision of salivary gland					
D7982	E	Sialodochoplasty					
D7983	E	Closure of salivary fistula					
D7990	E	Emergency tracheotomy					
D7991	E	Dental coronoidectomy					
D7995	E	Synthetic graft facial bones					
D7996	E	Implant mandible for augment					
D7997	E	Appliance removal					
D7999	E	Oral surgery procedure					
D8010	E	Limited dental tx primary					
D8020	E	Limited dental tx transition					
D8030	E	Limited dental tx adolescent					
D8040	E	Limited dental tx adult					
D8050	E	Intercep dental tx primary					
D8060	E	Intercep dental tx transitn					
D8070	E	Compre dental tx transition					
D8080	E	Compre dental tx adolescent					
D8090	E	Compre dental tx adult					
D8210	E	Orthodontic rem appliance tx					
D8220	E	Fixed appliance therapy habt					
D8660	E	Preorthodontic tx visit					
D8670	E	Periodic orthodontc tx visit					
D8680	E	Orthodontic retention					
D8690	E	Orthodontic treatment					
D8691	E	Repair ortho appliance					
D8692	E	Replacement retainer					
D8999	E	Orthodontic procedure					
D9110	N	Tx dental pain minor proc					
D9210	E	Dent anesthesia w/o surgery					
D9211	E	Regional block anesthesia					
D9212	E	Trigeminal block anesthesia					
D9215	E	Local anesthesia					
D9220	E	General anesthesia					
D9221	E	General anesthesia ea ad 15m					
D9230	N	Analgesia					
D9241	E	Intravenous sedation					
D9242	E	IV sedation ea ad 30 m					
D9248	E	Sedation (non-iv)					
D9310	E	Dental consultation					
D9410	E	Dental house call					
D9420	E	Hospital call					
D9430	E	Office visit during hours					
D9440	E	Office visit after hours					
D9610	E	Dent therapeutic drug inject					
D9630	S	Other drugs/medicaments	0330	1.51	$73.22	$14.64	$14.64
D9910	E	Dent appl desensitizing med					
D9911	E	Appl desensitizing resin					
D9920	E	Behavior management					
D9930	S	Treatment of complications	0330	1.51	$73.22	$14.64	$14.64
D9940	S	Dental occlusal guard	0330	1.51	$73.22	$14.64	$14.64
D9941	E	Fabrication athletic guard					
D9950	S	Occlusion analysis	0330	1.51	$73.22	$14.64	$14.64
D9951	S	Limited occlusal adjustment	0330	1.51	$73.22	$14.64	$14.64
D9952	S	Complete occlusal adjustment	0330	1.51	$73.22	$14.64	$14.64
D9970	E	Enamel microabrasion					
D9971	E	Odontoplasty 1–2 teeth					
D9972	E	Extrnl bleaching per arch					
D9973	E	Extrnl bleaching per tooth					
D9974	E	Intrnl bleaching per tooth					
D9999	E	Adjunctive procedure					
E0100	A	Cane adjust/fixed with tip					
E0105	A	Cane adjust/fixed quad/3 pro					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
E0110	A	Crutch forearm pair					
E0111	A	Crutch forearm each					
E0112	A	Crutch underarm pair wood					
E0113	A	Crutch underarm each wood					
E0114	A	Crutch underarm pair no wood					
E0116	A	Crutch underarm each no wood					
E0130	A	Walker rigid adjust/fixed ht					
E0135	A	Walker folding adjust/fixed					
E0141	A	Rigid walker wheeled wo seat					
E0142	A	Walker rigid wheeled with se					
E0143	A	Walker folding wheeled w/o s					
E0144	A	Enclosed walker w rear seat					
E0145	A	Walker whled seat/crutch att					
E0146	A	Folding walker wheels w seat					
E0147	A	Walker variable wheel resist					
E0153	A	Forearm crutch platform atta					
E0154	A	Walker platform attachment					
E0155	A	Walker wheel attachment, pair					
E0156	A	Walker seat attachment					
E0157	A	Walker crutch attachment					
E0158	A	Walker leg extenders set of4					
E0159	A	Brake for wheeled walker					
E0160	A	Sitz type bath or equipment					
E0161	A	Sitz bath/equipment w/faucet					
E0162	A	Sitz bath chair					
E0163	A	Commode chair stationry fxd					
E0164	A	Commode chair mobile fixed a					
E0165	A	Commode chair stationry det					
E0166	A	Commode chair mobile detach					
E0167	A	Commode chair pail or pan					
E0175	A	Commode chair foot rest					
E0176	A	Air pressre pad/cushion nonp					
E0177	A	Water press pad/cushion nonp					
E0178	A	Gel pressre pad/cushion nonp					
E0179	A	Dry pressre pad/cushion nonp					
E0180	A	Press pad alternating w pump					
E0181	A	Press pad alternating w/pum					
E0182	A	Pressure pad alternating pum					
E0184	A	Dry pressure mattress					
E0185	A	Gel pressure mattress pad					
E0186	A	Air pressure mattress					
E0187	A	Water pressure mattress					
E0188	E	Synthetic sheepskin pad					
E0189	E	Lambswool sheepskin pad					
E0191	A	Protector heel or elbow					
E0192	A	Pad wheelchr low press/posit					
E0193	A	Powered air flotation bed					
E0194	A	Air fluidized bed					
E0196	A	Gel pressure mattress					
E0197	A	Air pressure pad for mattres					
E0198	A	Water pressure pad for mattr					
E0199	A	Dry pressure pad for mattres					
E0200	A	Heat lamp without stand					
E0202	A	Phototherapy light w/photom					
E0205	A	Heat lamp with stand					
E0210	A	Electric heat pad standard					
E0215	A	Electric heat pad moist					
E0217	A	Water circ heat pad w pump					
E0218	A	Water circ cold pad w pump					
E0220	A	Hot water bottle					
E0225	A	Hydrocollator unit					
E0230	A	Ice cap or collar					
E0235	A	Paraffin bath unit portable					
E0236	A	Pump for water circulating p					
E0238	A	Heat pad non-electric moist					
E0239	A	Hydrocollator unit portable					
E0241	E	Bath tub wall rail					
E0242	E	Bath tub rail floor					
E0243	E	Toilet rail					
E0244	E	Toilet seat raised					
E0245	E	Tub stool or bench					
E0246	A	Transfer tub rail attachment					
E0249	A	Pad water circulating heat u					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
E0250	A	Hosp bed fixed ht w/mattres					
E0251	A	Hosp bed fixd ht w/o mattres					
E0255	A	Hospital bed var ht w/mattr					
E0256	A	Hospital bed var ht w/o matt					
E0260	A	Hosp bed semi-electr w/matt					
E0261	A	Hosp bed semi-electr w/o mat					
E0265	A	Hosp bed total electr w/mat					
E0266	A	Hosp bed total elec w/o matt					
E0270	A	Hospital bed institutional t					
E0271	A	Mattress innerspring					
E0272	A	Mattress foam rubber					
E0273	A	Bed board					
E0274	A	Over-bed table					
E0275	A	Bed pan standard					
E0276	A	Bed pan fracture					
E0277	A	Powered pres-redu air mattrs					
E0280	A	Bed cradle					
E0290	A	Hosp bed fx ht w/o rails w/m					
E0291	A	Hosp bed fx ht w/o rail w/o					
E0292	A	Hosp bed var ht w/o rail w/o					
E0293	A	Hosp bed var ht w/o rail w/					
E0294	A	Hosp bed semi-elect w/mattr					
E0295	A	Hosp bed semi-elect w/o matt					
E0296	A	Hosp bed total elect w/matt					
E0297	A	Hosp bed total elect w/o mat					
E0305	A	Rails bed side half length					
E0310	A	Rails bed side full length					
E0315	A	Bed accessory brd/tbl/supprt					
E0325	A	Urinal male jug-type					
E0326	A	Urinal female jug-type					
E0350	A	Control unit bowel system					
E0352	A	Disposable pack w/bowel syst					
E0370	A	Air elevator for heel					
E0371	A	Nonpower mattress overlay					
E0372	A	Powered air mattress overlay					
E0373	A	Nonpowered pressure mattress					
E0424	A	Stationary compressed gas 02					
E0425	A	Gas system stationary compre					
E0430	A	Oxygen system gas portable					
E0431	A	Portable gaseous 02					
E0434	A	Portable liquid 02					
E0435	A	Oxygen system liquid portabl					
E0439	A	Stationary liquid 02					
E0440	A	Oxygen system liquid station					
E0441	A	Oxygen contents gas per/unit					
E0442	A	Oxygen contents liq per/unit					
E0443	A	Port 02 contents gas/unit					
E0444	A	Port 02 contents liq/unit					
E0450	A	Volume vent stationary/porta					
E0455	A	Oxygen tent excl croup/ped t					
E0457	A	Chest shell					
E0459	A	Chest wrap					
E0460	A	Neg press vent portabl/statn					
E0462	A	Rocking bed w/ or w/o side r					
E0480	A	Percussor elect/pneum home m					
E0500	A	Ippb all types					
E0550	A	Humidif extens supple w ippb					
E0555	A	Humidifier for use w/regula					
E0560	A	Humidifier supplemental w/i					
E0565	A	Compressor air power source					
E0570	A	Nebulizer with compression					
E0575	A	Nebulizer ultrasonic					
E0580	A	Nebulizer for use w/regulat					
E0585	A	Nebulizer w/compressor & he					
E0590	A	Dispensing fee dme neb drug					
E0600	A	Suction pump portab hom modl					
E0601	A	Cont airway pressure device					
E0602	A	Breast pump					
E0605	A	Vaporizer room type					
E0606	A	Drainage board postural					
E0607	A	Blood glucose monitor home					
E0608	A	Apnea monitor					
E0609	A	Blood gluc mon w/special fea					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
E0610	A	Pacemaker monitr audible/vis					
E0615	A	Pacemaker monitr digital/vis					
E0616	A	Cardiac event recorder					
E0621	A	Patient lift sling or seat					
E0625	A	Patient lift bathroom or toi					
E0627	A	Seat lift incorp lift-chair					
E0628	A	Seat lift for pt furn-electr					
E0629	A	Seat lift for pt furn-non-el					
E0630	A	Patient lift hydraulic					
E0635	A	Patient lift electric					
E0650	A	Pneuma compresor non-segment					
E0651	A	Pneum compressor segmental					
E0652	A	Pneum compres w/cal pressure					
E0655	A	Pneumatic appliance half arm					
E0660	A	Pneumatic appliance full leg					
E0665	A	Pneumatic appliance full arm					
E0666	A	Pneumatic appliance half leg					
E0667	A	Seg pneumatic appl full leg					
E0668	A	Seg pneumatic appl full arm					
E0669	A	Seg pneumatic appli half leg					
E0671	A	Pressure pneum appl full leg					
E0672	A	Pressure pneum appl full arm					
E0673	A	Pressure pneum appl half leg					
E0690	A	Ultraviolet cabinet					
E0700	A	Safety equipment					
E0710	A	Restraints any type					
E0720	A	Tens two lead					
E0730	A	Tens four lead					
E0731	A	Conductive garment for tens/					
E0740	A	Incontinence treatment systm					
E0744	A	Neuromuscular stim for scoli					
E0745	A	Neuromuscular stim for shock					
E0746	A	Electromyograph biofeedback					
E0747	A	Elec osteogen stim not spine					
E0748	A	Elec osteogen stim spinal					
E0749	A	Elec osteogen stim implanted					
E0751	A	Pulse generator or receiver					
E0753	A	Neurostimulator electrodes					
E0755	A	Electronic salivary reflex s					
E0760	A	Osteogen ultrasound stimltor					
E0776	A	Iv pole					
E0779	A	Amb infusion pump mechanical					
E0780	A	Mech amb infusion pump <8hrs					
E0781	A	External ambulatory infus pu					
E0782	A	Non-programble infusion pump					
E0783	A	Programmable infusion pump					
E0784	A	Ext amb infusn pump insulin					
E0785	A	Replacement impl pump cathet					
E0791	A	Parenteral infusion pump sta					
E0840	A	Tract frame attach headboard					
E0850	A	Traction stand free standing					
E0855	A	Cervical traction equipment					
E0860	A	Tract equip cervical tract					
E0870	A	Tract frame attach footboard					
E0880	A	Trac stand free stand extrem					
E0890	A	Traction frame attach pelvic					
E0900	A	Trac stand free stand pelvic					
E0910	A	Trapeze bar attached to bed					
E0920	A	Fracture frame attached to b					
E0930	A	Fracture frame free standing					
E0935	A	Exercise device passive moti					
E0940	A	Trapeze bar free standing					
E0941	A	Gravity assisted traction de					
E0942	A	Cervical head harness/halter					
E0943	A	Cervical pillow					
E0944	A	Pelvic belt/harness/boot					
E0945	A	Belt/harness extremity					
E0946	A	Fracture frame dual w cross					
E0947	A	Fracture frame attachmnts pe					
E0948	A	Fracture frame attachmnts ce					
E0950	A	Tray					
E0951	A	Loop heel					
E0952	A	Loop tie					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
E0953	A	Pneumatic tire					
E0954	A	Wheelchair semi-pneumatic ca					
E0958	A	Whlchr att-conv 1 arm drive					
E0959	A	Amputee adapter					
E0961	A	Wheelchair brake extension					
E0962	A	Wheelchair 1 inch cushion					
E0963	A	Wheelchair 2 inch cushion					
E0964	A	Wheelchair 3 inch cushion					
E0965	A	Wheelchair 4 inch cushion					
E0966	A	Wheelchair head rest extensi					
E0967	A	Wheelchair hand rims					
E0968	A	Wheelchair commode seat					
E0969	A	Wheelchair narrowing device					
E0970	A	Wheelchair no. 2 footplates					
E0971	A	Wheelchair anti-tipping devi					
E0972	A	Transfer board or device					
E0973	A	Wheelchair adjustabl height					
E0974	A	Wheelchair grade-aid					
E0975	A	Wheelchair reinforced seat u					
E0976	A	Wheelchair reinforced back u					
E0977	A	Wheelchair wedge cushion					
E0978	A	Wheelchair belt w/airplane b					
E0979	A	Wheelchair belt with velcro					
E0980	A	Wheelchair safety vest					
E0990	A	Whellchair elevating leg res					
E0991	A	Wheelchair upholstry seat					
E0992	A	Wheelchair solid seat insert					
E0993	A	Wheelchair back upholstery					
E0994	A	Wheelchair arm rest					
E0995	A	Wheelchair calf rest					
E0996	A	Wheelchair tire solid					
E0997	A	Wheelchair caster w/a fork					
E0998	A	Wheelchair caster w/o a fork					
E0999	A	Wheelchr pneumatic tire w/wh					
E1000	A	Wheelchair tire pneumatic ca					
E1001	A	Wheelchair wheel					
E1031	A	Rollabout chair with casters					
E1050	A	Whelchr fxd full length arms					
E1060	A	Wheelchair detachable arms					
E1065	A	Wheelchair power attachment					
E1066	A	Wheelchair battery charger					
E1069	A	Wheelchair deep cycle batter					
E1070	A	Wheelchair detachable foot r					
E1083	A	Hemi-wheelchair fixed arms					
E1084	A	Hemi-wheelchair detachable a					
E1085	A	Hemi-wheelchair fixed arms					
E1086	A	Hemi-wheelchair detachable a					
E1087	A	Wheelchair lightwt fixed arm					
E1088	A	Wheelchair lightweight det a					
E1089	A	Wheelchair lightwt fixed arm					
E1090	A	Wheelchair lightweight det a					
E1091	A	Wheelchair youth					
E1092	A	Wheelchair wide w/leg rests					
E1093	A	Wheelchair wide w/foot rest					
E1100	A	Whchr s-recl fxd arm leg res					
E1110	A	Wheelchair semi-recl detach					
E1130	A	Whlchr stand fxd arm ft rest					
E1140	A	Wheelchair standard detach a					
E1150	A	Wheelchair standard w/leg r					
E1160	A	Wheelchair fixed arms					
E1170	A	Whlchr ampu fxd arm leg rest					
E1171	A	Wheelchair amputee w/o leg r					
E1172	A	Wheelchair amputee detach ar					
E1180	A	Wheelchair amputee w/foot r					
E1190	A	Wheelchair amputee w/leg re					
E1195	A	Wheelchair amputee heavy dut					
E1200	A	Wheelchair amputee fixed arm					
E1210	A	Whlchr moto ful arm leg rest					
E1211	A	Wheelchair motorized w/det					
E1212	A	Wheelchair motorized w full					
E1213	A	Wheelchair motorized w/det					
E1220	A	Whlchr special size/constrc					
E1221	A	Wheelchair spec size w foot					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
E1222	A	Wheelchair spec size w/leg					
E1223	A	Wheelchair spec size w foot					
E1224	A	Wheelchair spec size w/leg					
E1225	A	Wheelchair spec sz semi-recl					
E1226	A	Wheelchair spec sz full-recl					
E1227	A	Wheelchair spec sz spec ht a					
E1228	A	Wheelchair spec sz spec ht b					
E1230	A	Power operated vehicle					
E1240	A	Whchr litwt det arm leg rest					
E1250	A	Wheelchair lightwt fixed arm					
E1260	A	Wheelchair lightwt foot rest					
E1270	A	Wheelchair lightweight leg r					
E1280	A	Whchr h-duty det arm leg res					
E1285	A	Wheelchair heavy duty fixed					
E1290	A	Wheelchair hvy duty detach a					
E1295	A	Wheelchair heavy duty fixed					
E1296	A	Wheelchair special seat heig					
E1297	A	Wheelchair special seat dept					
E1298	A	Wheelchair spec seat depth/w					
E1300	A	Whirlpool portable					
E1310	A	Whirlpool non-portable					
E1340	A	Repair for DME, per 15 min					
E1353	A	Oxygen supplies regulator					
E1355	A	Oxygen supplies stand/rack					
E1372	A	Oxy suppl heater for nebuliz					
E1375	A	Oxygen suppl nebulizer porta					
E1377	A	Oxygen concentrator to 244 c					
E1378	A	Oxygen concentrator to 488 c					
E1379	A	Oxygen concentrator to 732 c					
E1380	A	Oxygen concentrator to 976 c					
E1381	A	Oxygen concentrat to 1220 cu					
E1382	A	Oxygen concentrat to 1464 cu					
E1383	A	Oxygen concentrat to 1708 cu					
E1384	A	Oxygen concentrat to 1952 cu					
E1385	A	Oxygen concentrator > 1952 c					
E1390	A	Oxygen concentrator					
E1399	A	Durable medical equipment mi					
E1405	A	O2/water vapor enrich w/heat					
E1406	A	O2/water vapor enrich w/o he					
E1510	A	Kidney dialysate delivry sys					
E1520	A	Heparin infusion pump for di					
E1530	A	Air bubble detector for dial					
E1540	A	Pressure alarm for dialysis					
E1550	A	Bath conductivity meter					
E1560	A	Blood leak detector for dial					
E1570	A	Adjustable chair for esrd pt					
E1575	A	Transducer protector/fluid b					
E1580	A	Unipuncture control system					
E1590	A	Hemodialysis machine					
E1592	A	Auto interm peritoneal dialy					
E1594	A	Cycler dialysis machine					
E1600	A	Deliv/install equip for dial					
E1610	A	Reverse osmosis water purifi					
E1615	A	Deionizer water purification					
E1620	A	Blood pump for dialysis					
E1625	A	Water softening system					
E1630	A	Reciprocating peritoneal dia					
E1632	A	Wearable artificial kidney					
E1635	A	Compact travel hemodialyzer					
E1636	A	Sorbent cartridges for dialy					
E1640	A	Replacement components for d					
E1699	A	Dialysis equipment unspecifi					
E1700	A	Jaw motion rehab system					
E1701	A	Repl cushions for jaw motion					
E1702	A	Repl measr scales jaw motion					
E1800	A	Adjust elbow ext/flex device					
E1805	A	Adjust wrist ext/flex device					
E1810	A	Adjust knee ext/flex device					
E1815	A	Adjust ankle ext/flex device					
E1820	A	Soft interface material					
E1825	A	Adjust finger ext/flex devc					
E1830	A	Adjust toe ext/flex device					
E1900	A	Speech communication device					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
G0001	A	Drawing blood for specimen					
G0002	N	Temporary urinary catheter					
G0004	S	ECG transm phys review & int	0100	1.70	$82.43	$71.57	$16.49
G0005	S	ECG 24 hour recording	0099	0.38	$18.43	$14.68	$3.69
G0006	S	ECG transmission & analysis	0100	1.70	$82.43	$71.57	$16.49
G0007	N	ECG phy review & interpret					
[2] G0008	X	Admin influenza virus vac	0354	0.13	$6.19		
G0009	N	Admin pneumococcal vaccine					
G0010	N	Admin hepatitis b vaccine					
G0015	S	Post symptom ECG tracing	0099	0.38	$18.43	$14.68	$3.69
G0016	N	Post symptom ECG md review					
G0025	X	Collagen skin test kit	0343	0.45	$21.82	$12.16	$4.36
G0026	A	Fecal leukocyte examination					
G0027	A	Semen analysis					
G0030	S	PET imaging prev PET single	0285	15.06	$730.22	$415.21	$146.04
G0031	S	PET imaging prev PET multple	0285	15.06	$730.22	$415.21	$146.04
G0032	S	PET follow SPECT 78464 singl	0285	15.06	$730.22	$415.21	$146.04
G0033	S	PET follow SPECT 78464 mult	0285	15.06	$730.22	$415.21	$146.04
G0034	S	PET follow SPECT 76865 singl	0285	15.06	$730.22	$415.21	$146.04
G0035	S	PET follow SPECT 78465 mult	0285	15.06	$730.22	$415.21	$146.04
G0036	S	PET follow cornry angio sing	0285	15.06	$730.22	$415.21	$146.04
G0037	S	PET follow cornry angio mult	0285	15.06	$730.22	$415.21	$146.04
G0038	S	PET follow myocard perf sing	0285	15.06	$730.22	$415.21	$146.04
G0039	S	PET follow myocard perf mult	0285	15.06	$730.22	$415.21	$146.04
G0040	S	PET follow stress echo singl	0285	15.06	$730.22	$415.21	$146.04
G0041	S	PET follow stress echo mult	0285	15.06	$730.22	$415.21	$146.04
G0042	S	PET follow ventriculogm sing	0285	15.06	$730.22	$415.21	$146.04
G0043	S	PET follow ventriculogm mult	0285	15.06	$730.22	$415.21	$146.04
G0044	S	PET following rest ECG singl	0285	15.06	$730.22	$415.21	$146.04
G0045	S	PET following rest ECG mult	0285	15.06	$730.22	$415.21	$146.04
G0046	S	PET follow stress ECG singl	0285	15.06	$730.22	$415.21	$146.04
G0047	S	PET follow stress ECG mult	0285	15.06	$730.22	$415.21	$146.04
G0050	S	Residual urine by ultrasound	0265	1.17	$56.73	$38.08	$11.35
G0101	V	CA screen; pelvic/breast exam	0601	1.00	$48.49	$9.70	$9.70
G0102	E	Prostate ca screening; dre					
G0103	E	Psa, total screening					
[1] G0104	S	CA screen; flexi sigmoidscope	0158	7.98	$386.93		$96.73
[1] G0105	S	Colorectal scrn; hi risk ind	0159	2.83	$137.22		$34.31
[2] G0106	S	Colon CA screen; barium enema	0157	1.79	$86.79		$17.36
G0107	A	CA screen; fecal blood test					
G0108	A	Diab manage trn per indiv					
G0109	A	Diab manage trn ind/group					
G0110	A	Nett pulm-rehab educ; ind					
G0111	A	Nett pulm-rehab educ; group					
G0112	A	Nett; nutrition guid, initial					
G0113	A	Nett; nutrition guid, subseqnt					
G0114	A	Nett; psychosocial consult					
G0115	A	Nett; psychological testing					
G0116	A	Nett; psychosocial counsel					
[2] G0120	S	Colon ca scrn; barium enema	0157	1.79	$86.79		$17.36
G0121	E	Colon ca scrn not hi rsk ind					
G0122	E	Colon ca scrn; barium enema					
G0123	E	Screen cerv/vag thin layer					
G0124	E	Screen c/v thin layer by MD					
[2] G0125	T	Lung image (PET)	0980	38.67	$1,875.00		$375.00
[2] G0126	T	Lung image (PET) staging	0980	38.67	$1,875.00		$375.00
G0127	T	Trim nail(s)	0009	0.74	$35.88	$9.63	$7.18
G0128	E	CORF skilled nursing service					
G0129	P	Partial hosp prog service	0033	4.17	$202.19	$48.17	$40.44
G0130	X	Single energy x-ray study	0261	1.38	$66.91	$38.77	$13.38
G0131	X	CT scan, bone density study	0261	1.38	$66.91	$38.77	$13.38
G0132	X	CT scan, bone density study	0261	1.38	$66.91	$38.77	$13.38
G0141	E	Scr c/v cyto, autosys and md					
G0143	E	Scr c/v cyto, thinlayer, rescr					
G0144	E	Scr c/v cyto, thinlayer, rescr					
G0145	E	Scr c/v cyto, thinlayer, rescr					
G0147	E	Scr c/v cyto, automated sys					
G0148	E	Scr c/v cyto, autosys, rescr					
G0151	E	HHCP-serv of pt, ea 15 min					
G0152	E	HHCP-serv of ot, ea 15 min					
G0153	E	HHCP-svs of s/l path, ea 15mn					
G0154	E	HHCP-svs of rn, ea 15 min					
G0155	E	HHCP-svs of csw, ea 15 min					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
G0156	E	HHCP-svs of aide, ea 15 min					
G0159	T	Perc declot dialysis graft	0088	26.49	$1,284.42	$678.68	$256.88
G0160	C	Cryo. ablation, prostate					
G0161	X	Echo guide for cryo probes	0268	2.23	$108.13	$69.51	$21.63
[2] G0163	T	Pet for rec of colorectal ca	0980	38.67	$1,875.00		$375.00
[2] G0164	T	Pet for lymphoma staging	0980	38.67	$1,875.00		$375.00
[2] G0165	T	Pet, rec of melanoma/met ca	0980	38.67	$1,875.00		$375.00
[2] G0166	T	Extrnl counterpulse, per tx	0972	3.09	$149.83		$29.97
G0167	S	Hyperbaric oz tx; no md reqrd	0031	3.00	$145.46	$140.85	$29.09
G0168	T	Wound closure by adhesive	0026	12.11	$587.18	$277.92	$117.44
G0169	T	Removal tissue; no anesthsia	0026	12.11	$587.18	$277.92	$117.44
G0170	T	Skin biograft	0026	12.11	$587.18	$277.92	$117.44
G0171	T	Skin biograft add-on	0026	12.11	$587.18	$277.92	$117.44
G0172	P	Partial hosp prog service	0033	4.17	$202.19	$48.17	$40.44
G0173	S	Stereotactic, one session	0302	8.21	$398.08	$216.55	$79.62
G0174	S	Stereotactic, mult session	0302	8.21	$398.08	$216.55	$79.62
G0175	V	Multidisciplinary team visit	0603	1.66	$80.49	$16.29	$16.10
J0120	N	Tetracyclin injection					
J0130	N	Abciximab injection					
[2] J0150	X	Injection adenosine 6 MG	0917	0.36	$17.46		$3.49
J0151	E	Adenosine injection					
J0170	N	Adrenalin epinephrin inject					
J0190	N	Inj biperiden lactate/5 mg					
J0200	N	Alatrofloxacin mesylate					
[3] J0205	X	Alglucerase injection	0900				$5.14
[3] J0207	X	Amifostine	7000				$41.99
J0210	N	Methyldopate hcl injection					
[3] J0256	X	Alpha 1 proteinase inhibitor	0901				$15.22
J0270	E	Alprostadil for injection					
J0275	E	Alprostadil urethral suppos					
J0280	N	Aminophyllin 250 MG inj					
J0285	N	Amphotericin B					
[3] J0286	X	Amphotericin B lipid complex	7001				$12.12
J0290	N	Ampicillin 500 MG inj					
J0295	N	Ampicillin sodium per 1.5 gm					
J0300	N	Amobarbital 125 MG inj					
J0330	N	Succinycholine chloride inj					
J0340	N	Nandrolon phenpropionate inj					
J0350	N	Injection anistreplase 30 u					
J0360	N	Hydralazine hcl injection					
J0380	N	Inj metaraminol bitartrate					
J0390	N	Chloroquine injection					
J0395	N	Arbutamine HCl injection					
J0400	N	Inj trimethaphan camsylate					
J0456	N	Azithromycin					
J0460	N	Atropine sulfate injection					
J0470	N	Dimecaprol injection					
J0475	N	Baclofen 10 MG injection					
[3] J0476	X	Baclofen intrathecal trial	7021				$.10
J0500	N	Dicyclomine injection					
J0510	N	Benzquinamide injection					
J0515	N	Inj benztropine mesylate					
J0520	N	Bethanechol chloride inject					
J0530	N	Penicillin g benzathine inj					
J0540	N	Penicillin g benzathine inj					
J0550	N	Penicillin g benzathine inj					
J0560	N	Penicillin g benzathine inj					
J0570	N	Penicillin g benzathine inj					
J0580	N	Penicillin g benzathine inj					
[3] J0585	X	Botulinum toxin a per unit	0902				$56.05
J0590	N	Ethylnorepinephrine hcl inj					
J0600	N	Edetate calcium disodium inj					
J0610	N	Calcium gluconate injection					
J0620	N	Calcium glycer & lact/10 ML					
J0630	N	Calcitonin salmon injection					
J0635	N	Calcitriol injection					
[3] J0640	X	Leucovorin calcium injection	0725				$1.07
J0670	N	Inj mepivacaine HCL/10 ml					
J0690	N	Cefazolin sodium injection					
J0694	N	Cefoxitin sodium injection					
J0695	N	Cefonocid sodium injection					
J0696	N	Ceftriaxone sodium injection					
J0697	N	Sterile cefuroxime injection					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
J0698	N	Cefotaxime sodium injection					
J0702	N	Betamethasone acet & sod phosp					
J0704	N	Betamethasone sod phosp/4 MG					
J0710	N	Cephapirin sodium injection					
J0713	N	Inj ceftazidime per 500 mg					
J0715	N	Ceftizoxime sodium/500 MG					
J0720	N	Chloramphenicol sodium injec					
J0725	N	Chorionic gonadotropin/1000u					
J0730	N	Chlorpheniramin maleate inj					
[3] J0735	X	Clonidine hydrochloride	7002				$4.17
J0740	N	Cidofovir injection					
J0743	N	Cilastatin sodium injection					
J0745	N	Inj codeine phosphate/30 MG					
J0760	N	Colchicine injection					
J0770	N	Colistimethate sodium inj					
J0780	N	Prochlorperazine injection					
J0800	N	Corticotropin injection					
J0810	N	Cortisone injection					
J0835	N	Inj cosyntropin per 0.25 MG					
[3] J0850	X	Cytomegalovirus imm IV/vial	0903				$54.11
J0895	N	Deferoxamine mesylate inj					
J0900	N	Testosterone enanthate inj					
J0945	N	Brompheniramine maleate inj					
J0970	N	Estradiol valerate injection					
J1000	N	Depo-estradiol cypionate inj					
J1020	N	Methylprednisolone 20 MG inj					
J1030	N	Methylprednisolone 40 MG inj					
J1040	N	Methylprednisolone 80 MG inj					
J1050	N	Medroxyprogesterone inj					
J1055	E	Medrxyprogester acetate inj					
J1060	N	Testosterone cypionate 1 ML					
J1070	N	Testosterone cypionat 100 MG					
J1080	N	Testosterone cypionat 200 MG					
J1090	N	Testosterone cypionate 50 MG					
J1095	N	Inj dexamethasone acetate					
J1100	N	Dexamethasone sodium phos					
J1110	N	Inj dihydroergotamine mesylt					
J1120	N	Acetazolamid sodium injectio					
J1160	N	Digoxin injection					
J1165	N	Phenytoin sodium injection					
J1170	N	Hydromorphone injection					
J1180	N	Dyphylline injection					
[3] J1190	X	Dexrazoxane HCl injection	0726				$18.81
J1200	N	Diphenhydramine hcl injectio					
J1205	N	Chlorothiazide sodium inj					
J1212	N	Dimethyl sulfoxide 50% 50 ML					
J1230	N	Methadone injection					
J1240	N	Dimenhydrinate injection					
[2] J1245	X	Dipyridamole injection	0917	0.36	$17.46		$3.49
J1250	N	Inj dobutamine HCL/250 mg					
[3] J1260	X	Dolasetron mesylate	0750				$1.94
J1320	N	Amitriptyline injection					
[3] J1325	X	Epoprostenol injection	7003				$2.23
J1327	N	Eptifibatide injection					
J1330	N	Ergonovine maleate injection					
J1362	N	Erythromycin glucep/250 MG					
J1364	N	Erythro lactobionate/500 MG					
J1380	N	Estradiol valerate 10 MG inj					
J1390	N	Estradiol valerate 20 MG inj					
J1410	N	Inj estrogen conjugate 25 MG					
J1435	N	Injection estrone per 1 MG					
J1436	X	Etidronate disodium inj	0727				$9.31
J1438	N	Etanercept injection					
[3] J1440	X	Filgrastim 300 mcg injeciton	0728				$25.21
J1441	E	Filgrastim 480 mcg injection					
J1450	N	Fluconazole					
J1455	N	Foscarnet sodium injection					
J1460	N	Gamma globulin 1 CC inj					
J1470	E	Gamma globulin 2 CC inj					
J1480	E	Gamma globulin 3 CC inj					
J1490	E	Gamma globulin 4 CC inj					
J1500	E	Gamma globulin 5 CC inj					
J1510	E	Gamma globulin 6 CC inj					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
J1520	E	Gamma globulin 7 CC inj					
J1530	E	Gamma globulin 8 CC inj					
J1540	E	Gamma globulin 9 CC inj					
J1550	E	Gamma globulin 10 CC inj					
J1560	E	Gamma globulin > 10 CC inj					
[3] J1561	X	Immune globulin 500 mg	0905				$6.40
[3] J1562	X	Immune globulin 5 gms	7004				$45.48
[3] J1565	X	RSV-ivig	0906				$85.53
[2] J1570	X	Ganciclovir sodium injection	0907	0.51	$24.73		$4.95
J1580	N	Garamycin gentamicin inj					
J1600	N	Gold sodium thiomaleate inj					
J1610	N	Glucagon hydrochloride/1 MG					
[3] J1620	X	Gonadorelin hydroch/100 mcg	7005				$9.12
[3] J1626	X	Granisetron HCl injection	0764				$2.33
J1630	N	Haloperidol injection					
J1631	N	Haloperidol decanoate inj					
J1642	N	Inj heparin sodium per 10 u					
J1644	N	Inj heparin sodium per 1000u					
J1645	N	Dalteparin sodium					
J1650	N	Inj enoxaparin sodium					
[2] J1670	X	Tetanus immune globulin inj	0908	0.90	$43.64		$8.73
J1690	N	Prednisolone tebutate inj					
J1700	N	Hydrocortisone acetate inj					
J1710	N	Hydrocortisone sodium ph inj					
J1720	N	Hydrocortisone sodium succ i					
J1730	N	Diazoxide injection					
J1739	N	Hydroxyprogesterone cap 125					
J1741	N	Hydroxyprogesterone cap 250					
J1742	N	Ibutilide fumarate injection					
[3] J1745	X	Infliximab injection	7043				$6.89
J1750	N	Iron dextran					
[3] J1785	X	Injection imiglucerase/unit	0916				$.58
J1790	N	Droperidol injection					
J1800	N	Propranolol injection					
J1810	N	Droperidol/fentanyl inj					
J1820	N	Insulin injection					
[3] J1825	X	Interferon beta-1a	0909				$28.70
[3] J1830	X	Interferon beta-1b/.25 MG	0910				$8.44
J1840	N	Kanamycin sulfate 500 MG inj					
J1850	N	Kanamycin sulfate 75 MG inj					
J1885	N	Ketorolac tromethamine inj					
J1890	N	Cephalothin sodium injection					
J1910	N	Kutapressin injection					
J1930	N	Propiomazine injection					
J1940	N	Furosemide injection					
[3] J1950	X	Leuprolide acetate/3.75 MG	0800				$68.56
J1955	E	Inj levocarnitine per 1 gm					
J1956	N	Levofloxacin injection					
J1960	N	Levorphanol tartrate inj					
J1970	N	Methotrimeprazine injection					
J1980	N	Hyoscyamine sulfate inj					
J1990	N	Chlordiazepoxide injection					
J2000	N	Lidocaine injection					
J2010	N	Lincomycin injection					
J2060	N	Lorazepam injection					
J2150	N	Mannitol injection					
J2175	N	Meperidine hydrochl/100 MG					
J2180	N	Meperidine/promethazine inj					
J2210	N	Methylergonovin maleate inj					
J2240	N	Metocurine iodide injection					
J2250	N	Inj midazolam hydrochloride					
[2] J2260	X	Inj milrinone lactate/5 ML	7007	0.47	$22.79		$4.56
J2270	N	Morphine sulfate injection					
J2271	N	Morphine so4 injection 100mg					
[3] J2275	X	Morphine sulfate injection	7010				$.68
J2300	N	Inj nalbuphine hydrochloride					
J2310	N	Inj naloxone hydrochloride					
J2320	N	Nandrolone decanoate 50 MG					
J2321	N	Nandrolone decanoate 100 MG					
J2322	N	Nandrolone decanoate 200 MG					
J2330	N	Thiothixene injection					
J2350	N	Niacinamide/niacin injection					
[3] J2352	N	Octreotide acetate injection	7031				$5.43

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CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[3] J2355	X	Oprelvekin injection	7011				$30.35
J2360	N	Orphenadrine injection					
J2370	N	Phenylephrine hcl injection					
J2400	N	Chloroprocaine hcl injection					
[3] J2405	X	Ondansetron hcl injection	0768				$.87
J2410	N	Oxymorphone hcl injection					
[3] J2430	X	Pamidronate disodium/30 MG	0730				$30.93
J2440	N	Papaverin hcl injection					
J2460	N	Oxytetracycline injection					
J2480	N	Hydrochlorides of opium inj					
J2500	N	Paricalcitol					
J2510	N	Penicillin g procaine inj					
J2512	N	Inj pentagastrin per 2 ML					
J2515	N	Pentobarbital sodium inj					
J2540	N	Penicillin g potassium inj					
J2543	N	Piperacillin/tazobactam					
[3] J2545	X	Pentamidine isethionte/300mg	7012				$8.73
J2550	N	Promethazine hcl injection					
J2560	N	Phenobarbital sodium inj					
J2590	N	Oxytocin injection					
J2597	E	Inj desmopressin acetate					
J2640	N	Prednisolone sodium ph inj					
J2650	N	Prednisolone acetate inj					
J2670	N	Totazoline hcl injection					
J2675	N	Inj progesterone per 50 MG					
J2680	N	Fluphenazine decanoate 25 MG					
J2690	N	Procainamide hcl injection					
J2700	N	Oxacillin sodium injeciton					
J2710	N	Neostigmine methylslfte inj					
J2720	N	Inj protamine sulfate/10 MG					
J2725	N	Inj protirelin per 250 mcg					
J2730	N	Pralidoxime chloride inj					
J2760	N	Phentolaine mesylate inj					
[3] J2765	X	Metoclopramide hcl injection	0754				$.19
J2780	N	Ranitidine hydrochloride inj					
[3] J2790	X	Rho d immune globulin inj	0884				$3.78
J2792	N	Rho(D) immune globulin h, sd					
J2800	N	Methocarbamol injection					
J2810	N	Inj theophylline per 40 MG					
[3] J2820	X	Sargramostim injection	0731				$16.97
J2860	N	Secobarbital sodium inj					
J2910	N	Aurothioglucose injeciton					
J2912	N	Sodium chloride injection					
J2920	N	Methylprednisolone injection					
J2930	N	Methylprednisolone injection					
J2950	N	Promazine hcl injeciton					
J2970	N	Methicillin sodium injection					
[2] J2994	X	Reteplase double bolus	0914	38.20	$1,852.21		$370.44
[2] J2995	X	Inj streptokinase/250000 IU	0911	1.64	$79.69		$15.94
[2] J2996	X	Alteplase recombinant inj	0915	5.85	$283.70		$56.74
J3000	N	Streptomycin injection					
[3] J3010	X	Fentanyl citrate injeciton	7014				$.19
J3030	N	Sumatriptan succinate/6 MG					
J3070	N	Pentazocine hcl injeciton					
J3080	N	Chlorprothixene injection					
J3105	N	Terbutaline sulfate inj					
J3120	N	Testosterone enanthate inj					
J3130	N	Testosterone enanthate inj					
J3140	N	Testosterone suspension inj					
J3150	N	Testosteron propionate inj					
J3230	N	Chlorpromazine hcl injection					
J3240	N	Thyrotropin injection					
[2] J3245	X	Tirofiban hydrochloride	7041	0.02	$.97		$.19
J3250	N	Trimethobenzamide hcl inj					
J3260	N	Tobramycin sulfate injection					
J3265	N	Injection torsemide 10 mg/ml					
J3270	N	Imipramine hcl injection					
[3] J3280	X	Thiethylperazine maleate inj	0755				$.68
J3301	N	Triamcinolone acetonide inj					
J3302	N	Triamcinolone diacetate inj					
J3303	N	Triamcinolone hexacetonl inj					
[3] J3305	X	Inj trimetrexate glucoronate	7045				$8.15
J3310	N	Perphenazine injeciton					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
J3320	N	Spectinomycn di-hcl inj					
J3350	N	Urea injection					
J3360	N	Diazepam injection					
J3364	N	Urokinase 5000 IU injection					
[2] J3365	X	Urokinase 250,000 IU inj	7036	0.73	$35.40		$7.08
J3370	N	Vancomycin hcl injeciton					
J3390	N	Methoxamine injection					
J3400	N	Triflupromazine hcl inj					
J3410	N	Hydroxyzine hcl injeciton					
J3420	N	Vitamin b12 injection					
J3430	N	Vitamin k phytonadione inj					
J3450	N	Mephentermine sulfate inj					
J3470	N	Hyaluronidase injection					
J3475	N	Inj magnesium sulfate					
J3480	N	Inj potassium chloride					
J3490	N	Drugs unclassified injection					
J3520	E	Edetate disodium per 150 mg					
J3530	N	Nasal vaccine inhalation					
J3535	E	Metered dose inhaler drug					
J3570	E	Laetrile amygdalin vit B17					
J7030	N	Normal saline solution infus					
J7040	N	Normal saline solution infus					
J7042	N	5% dextrose/normal saline					
J7050	N	Normal saline solution infus					
J7051	N	Sterile saline/water					
J7060	N	5% dextrose/water					
J7070	N	D5w infusion					
J7100	N	Dextran 40 infusion					
J7110	N	Dextran 75 infusion					
J7120	N	Ringers lactate infusion					
J7130	N	Hypertonic saline solution					
[3] J7190	X	Factor viii	0925				$.19
[3] J7191	X	Factor VIII (porcine)	0926				$.19
[3] J7192	X	Factor viii recombinant	0927				$.19
[3] J7194	X	Factor ix complex	0928				$.08
[3] J7197	X	Antithrombin iii injection	0930				$.19
[3] J7198	X	Anti-inhibitor	0929				$.27
J7199	E	Hemophilia clot factor noc					
J7300	E	Intraut copper contraceptive					
[3] J7310	X	Ganciclovir long act implant	0913				$701.51
J7315	N	Sodium hyaluronate injection					
J7320	N	Hylan G–F 20 injection					
[2] J7500	X	Azathioprine oral 50mg	0886	0.02	$.97		$.19
[2] J7501	X	Azathioprine parenteral	0887	1.40	$67.88		$13.58
[2] J7502	X	Cyclosporine oral 100 mg	0888	0.08	$3.88		$.78
[2] J7504	X	Lymphocyte immune globulin	0890	3.79	$183.77		$36.75
[3] J7505	E	Monoclonal antibodies	7038				$89.60
J7506	N	Prednisone oral					
[2] J7507	X	Tacrolimus oral per 1 MG	0891	3.15	$152.73		$30.55
J7508	E	Tacrolimus oral per 5 MG					
J7509	N	Methylprednisolone oral					
J7510	N	Prednisolone oral per 5 mg					
J7513	X	Daclizumab, parenteral					
J7515	N	Cyclosporine oral 25 mg					
[2] J7516	X	Cyclosporin parenteral 250mg	0889	0.36	$17.46		$3.49
J7517	N	Mycophenolate mofetil oral					
J7599	E	Immunosuppressive drug noc					
J7608	A	Acetylcysteine inh sol u d					
J7610	A	Acetylcysteine 10% injection					
J7615	A	Acetylcysteine 20% injection					
J7618	A	Albuterol inh sol con					
J7619	A	Albuterol inh sol u d					
J7620	A	Albuterol sulfate .083%/ml					
J7625	A	Albuterol sulfate .5% inj					
J7627	A	Bitolterolmesylate inhal sol					
J7628	A	Bitolterol mes inhal sol con					
J7629	A	Bitolterol mes inh sol u d					
J7630	A	Cromolyn sodium injeciton					
J7631	A	Cromolyn sodium inh sol u d					
J7635	A	Atropine inhal sol con					
J7636	A	Atropine inhal sol unit dose					
J7637	A	Dexamethasone inhal sol con					
J7638	A	Dexamethasone inhal sol u d					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
J7639	A	Dornase alpha inhal sol u d					
J7640	A	Epinephrine injection					
J7642	A	Glycopyrrolate inhal sol con					
J7643	A	Glycopyrrolate inhal sol u d					
J7644	A	Ipratropium brom inh sol u d					
J7645	A	Ipratropium bromide .02%/ml					
J7648	A	Isoetharine hcl inh sol con					
J7649	A	Isoetharine hcl inh sol u d					
J7650	A	Isoetharine hcl .1% inj					
J7651	A	Isoetharine hcl .125% inj					
J7652	A	Isoetharine hcl .167% inj					
J7653	A	Isoetharine hcl .2%/inj					
J7654	A	Isoetharine hcl .25% inj					
J7655	A	Isoetharine hcl 1% inj					
J7658	A	Isoproterenolhcl inh sol con					
J7659	A	Isoproterenol hcl inh sol ud					
J7660	A	Isoproterenol hcl .5% inj					
J7665	A	Isoproterenol hcl 1% inj					
J7668	A	Metaproterenol inh sol con					
J7669	A	Metaproterenol inh sol u d					
J7670	A	Metaproterenol sulfate .4%					
J7672	A	Metaproterenol sulfate .6%					
J7675	A	Metaproterenol sulfate 5%					
J7680	A	Terbutaline so4 inh sol con					
J7681	A	Terbutaline so4 inh sol u d					
J7682	A	Tobramycin inhalation sol					
J7683	A	Triamcinolone inh sol con					
J7684	A	Triamcinolone inh sol u d					
J7699	A	Inhalation solution for DME					
J7799	A	Non-inhalation drug for DME					
[3] J7913	X	Daclizumab, Parenteral, 25 m	0892				$54.11
J8499	E	Oral prescrip drug non chemo					
[3] J8510	X	Oral busulfan	7015				$.19
[3] J8520	X	Capecitabine, oral, 150 mg	7042				$.19
J8521	N	Capecitabine, oral, 500 mg					
[3] J8530	X	Cyclophosphamide oral 25 MG	0801				$.19
[3] J8560	X	Etoposide oral 50 MG	0802				$3.10
[3] J8600	X	Melphalan oral 2 MG	0803				$.19
[3] J8610	X	Methotrexate oral 2.5 MG	0826				$.29
J8999	E	Oral prescription drug chemo					
[3] J9000	X	Doxorubic hcl 10 MG vl chemo	0847				$2.81
[3] J9001	X	Doxorubicin hcl liposome inj	7046				$39.18
[3] J9015	X	Aldesleukin/single use vial	0807				$65.07
[3] J9020	X	Asparaginase injection	0814				$8.34
[3] J9031	X	Bcg live intravesical vac	0809				$19.78
[3] J9040	X	Bleomycin sulfate injection	0857				$48.29
[3] J9045	X	Carboplatin injection	0811				$13.96
[3] J9050	X	Carmus bischl nitro inj	0812				$10.57
[3] J9060	X	Cisplatin 10 MG injeciton	0813				$4.56
J9062	E	Cisplatin 50 MG injeciton					
[3] J9065	X	Inj cladribine per 1 MG	0858				$8.24
[3] J9070	X	Cyclophosphamide 100 MG inj	0815				$.48
J9080	E	Cyclophosphamide 200 MG inj					
J9090	E	Cyclophosphamide 500 MG inj					
J9091	E	Cyclophosphamide 1.0 grm inj					
J9092	E	Cyclophosphamide 2.0 grm inj					
[3] J9093	X	Cyclophosphamide lyophilized	0816				$1.16
J9094	E	Cyclophosphamide lyophilized					
J9095	E	Cyclophosphamide lyophilized					
J9096	E	Cyclophosphamide lyophilized					
J9097	E	Cyclophosphamide lyophilized					
[3] J9100	X	Cytarabine hcl 100 MG inj	0817				$.68
J9110	E	Cytarabine hcl 500 MG inj					
[3] J9120	X	Dactinomycin actinomycin d	0818				$1.75
[3] J9130	X	Dacarbazine 10 MG inj	0819				$1.26
J9140	E	Dacarbazine 200 MG inj					
[3] J9150	X	Daunorubicin	0820				$11.64
[3] J9151	X	Daunorubicin citrate liposom	0821				$7.76
[3] J9165	X	Diethylstilbestrol injection	0822				$2.13
[3] J9170	X	Docetaxel	0823				$34.72
[3] J9181	X	Etoposide 10 MG inj	0824				$.58
J9182	E	Etoposide 100 MG inj					
[3] J9185	X	Fludarabine phosphate inj	0842				$30.84

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[3] J9190	X	Fluorouracil injection	0859				$.19
[3] J9200	X	Floxuridine injection	0827				$18.81
[3] J9201	X	Gemcitabine HCl	0828				$9.31
[3] J9202	X	Goserelin acetate implant	0810				$59.74
[3] J9206	X	Irinotecan injection	0830				$14.16
[3] J9208	X	Ifosfomide injection	0831				$13.58
[3] J9209	X	Mesna injection	0732				$2.42
[3] J9211	X	Idarubicin hcl injeciton	0832				$46.45
[3] J9212	X	Interferon alfacon-1	0833				$.19
[3] J9213	X	Interferon alfa-2a inj	0834				$3.20
[3] J9214	X	Interferon alfa-2b inj	0836				$1.36
[3] J9215	X	Interferon alfa-n3 inj	0865				$1.07
[3] J9216	X	Interferon gamma 1–b inj	0838				$22.79
J9217	E	Leuprolide acetate suspnsion					
[3] J9218	X	Leuprolide acetate injeciton	0861				$19.39
[3] J9230	X	Mechlorethamine hcl inj	0839				$1.65
[3] J9245	X	Inj melphalan hydrochl 50 MG	0840				$44.71
[3] J9250	X	Methotrexate sodium inj	0841				$.10
J9260	E	Methotrexate sodium inj					
[3] J9265	X	Paclitaxel injection	0863				$30.16
[3] J9266	X	Pegaspargase/singl dose vial	0843				$178.72
[3] J9268	X	Pentostatin injection	0844				$133.73
[3] J9270	X	Plicamycin (mithramycin) inj	0860				$1.36
[3] J9280	X	Mitomycin 5 MG inj	0862				$19.88
J9290	E	Mitomycin 20 MG inj					
J9291	E	Mitomycin 40 MG inj					
[3] J9293	X	Mitoxantrone hydrochl/5 MG	0864				$25.80
[3] J9310	X	Rituximab cancer treatment	0849				$51.40
[3] J9320	X	Streptozocin injection	0850				$14.64
[3] J9340	X	Thiotepa injection	0851				$9.50
[3] J9350	X	Topotecan	0852				$73.22
J9355	N	Trastuzumab					
J9357	N	Valrubicin, 200 mg					
[3] J9360	X	Vinblastine sulfate inj	0853				$.39
[3] J9370	X	Vincristine sulfate 1 MG inj	0854				$2.23
J9375	E	Vincristine sulfate 2 MG inj					
J9380	E	Vincristine sulfate 5 MG inj					
[3] J9390	X	Vinorelbine tartrate/10 mg	0855				$9.60
[3] J9600	X	Porfimer sodium	0856				$34.62
J9999	E	Chemotherapy drug					
K0001	A	Standard wheelchair					
K0002	A	Stnd hemi (low seat) whlchr					
K0003	A	Lightweight wheelchair					
K0004	A	High strength ltwt whlchr					
K0005	A	Ultralightweight wheelchair					
K0006	A	Heavy duty wheelchair					
K0007	A	Extra heavy duty wheelchair					
K0008	A	Cstm manual wheelchair/base					
K0009	A	Other manual wheelchair/base					
K0010	A	Stnd wt frame power whlchr					
K0011	A	Stnd wt pwr whlchr w control					
K0012	A	Ltwt portbl power whlchr					
K0013	A	Custom power whlchr base					
K0014	A	Other power whlchr base					
K0015	A	Detach non-adjus hght armrst					
K0016	A	Detach adjust armrst cmplete					
K0017	A	Detach adjust armrest base					
K0018	A	Detach adjust armrst upper					
K0019	A	Arm pad each					
K0020	A	Fixed adjust armrest pair					
K0021	A	Anti-tipping device each					
K0022	A	Reinforced back upholstery					
K0023	A	Planr back insrt foam w/strp					
K0024	A	Plnr back insrt foam w/hrdwr					
K0025	A	Hook-on headrest extension					
K0026	A	Back upholst lgtwt whlchr					
K0027	A	Back upholst other whlchr					
K0028	A	Manual fully reclining back					
K0029	A	Reinforced seat upholstery					
K0030	A	Solid plnr seat sngl dnsfoam					
K0031	A	Safety belt/pelvic strap					
K0032	A	Seat uphols lgtwt whlchr					
K0033	A	Seat upholstery other whlchr					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
K0034	A	Heel loop each					
K0035	A	Heel loop with ankle strap					
K0036	A	Toe loop each					
K0037	A	High mount flip-up footrest					
K0038	A	Leg strap each					
K0039	A	Leg strap h style each					
K0040	A	Adjustable angle footplate					
K0041	A	Large size footplate each					
K0042	A	Standard size footplate each					
K0043	A	Ftrst lower extension tube					
K0044	A	Ftrst upper hanger bracket					
K0045	A	Footrest complete assembly					
K0046	A	Elevat legrst low extension					
K0047	A	Elevat legrst up hangr brack					
K0048	A	Elevate legrest complete					
K0049	A	Calf pad each					
K0050	A	Ratchet assembly					
K0051	A	Cam relese assem ftrst/lgrst					
K0052	A	Swingaway detach footrest					
K0053	A	Elevate footrest articulate					
K0054	A	Seat wdth 10–12/15/17/20 wc					
K0055	A	Seat dpth 15/17/18 ltwt wc					
K0056	A	Seat ht <17 or >=21 ltwt wc					
K0057	A	Seat wdth 19/20 hvy dty wc					
K0058	A	Seat dpth 17/18 power wc					
K0059	A	Plastic coated handrim each					
K0060	A	Steel handrim each					
K0061	A	Aluminum handrim each					
K0062	A	Handrim 8–10 vert/obliq proj					
K0063	A	Hndrm 12–16 vert/obliq proj					
K0064	A	Zero pressure tube flat free					
K0065	A	Spoke protectors					
K0066	A	Solid tire any size each					
K0067	A	Pneumatic tire any size each					
K0068	A	Pneumatic tire tube each					
K0069	A	Rear whl complete solid tire					
K0070	A	Rear whl compl pneum tire					
K0071	A	Front castr compl pneum tire					
K0072	A	Frnt cstr cmpl sem-pneum tir					
K0073	A	Caster pin lock each					
K0074	A	Pneumatic caster tire each					
K0075	A	Semi-pneumatic caster tire					
K0076	A	Solid caster tire each					
K0077	A	Front caster assem complete					
K0078	A	Pneumatic caster tire tube					
K0079	A	Wheel lock extension pair					
K0080	A	Anti-rollback device pair					
K0081	A	Wheel lock assembly complete					
K0082	A	22 nf deep cycl acid battery					
K0083	A	22 nf gel cell battery each					
K0084	A	Grp 24 deep cycl acid battry					
K0085	A	Group 24 gel cell battery					
K0086	A	U–1 lead acid battery each					
K0087	A	U–1 gel cell battery each					
K0088	A	Battry chrgr acid/gel cell					
K0089	A	Battery charger dual mode					
K0090	A	Rear tire power wheelchair					
K0091	A	Rear tire tube power whlchr					
K0092	A	Rear assem cmplt powr whlchr					
K0093	A	Rear zero pressure tire tube					
K0094	A	Wheel tire for power base					
K0095	A	Wheel tire tube each base					
K0096	A	Wheel assem powr base complt					
K0097	A	Wheel zero presure tire tube					
K0098	A	Drive belt power wheelchair					
K0099	A	Pwr wheelchair front caster					
K0100	A	Amputee adapter pair					
K0101	A	One-arm drive attachment					
K0102	A	Crutch and cane holder					
K0103	A	Transfer board < 25″					
K0104	A	Cylinder tank carrier					
K0105	A	Iv hanger					
K0106	A	Arm trough each					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
K0107	A	Wheelchair tray					
K0108	A	W/c component-accessory NOS					
K0112	A	Trunk vest supprt innr frame					
K0113	A	Trunk vest suprt w/o inr frm					
K0114	A	Whlchr back suprt inr frame					
K0115	A	Back module orthotic system					
K0116	A	Back & seat modul orthot sys					
K0182	A	Water distilled w/nebulizer					
K0183	A	Nasal application device					
K0184	A	Nasal pillows/seals pair					
K0185	A	Pos airway pressure headgear					
K0186	A	Pos airway prssure chinstrap					
K0187	A	Pos airway pressure tubing					
K0188	A	Pos airway pressure filter					
K0189	A	Filter nondisposable w PAP					
K0195	A	Elevating whlchair leg rests					
K0268	A	Humidifier nonheated w PAP					
K0269	A	Aerosol compressor cpap dev					
K0270	A	Ultrasonic generator w nebul					
K0280	A	Extension drainage tubing					
K0281	A	Lubricant catheter insertion					
K0283	A	Saline solution dispenser					
K0407	A	Urinary cath skin attachment					
K0408	A	Urinary cath leg strap					
K0409	A	Sterile H2O irrigation solut					
K0410	A	Male ext cath w/adh coating					
K0411	A	Male ext cath w/adh strip					
K0415	E	RX antiemetic drg, oral NOS					
K0416	E	Rx antiemetic drg, rectal NOS					
K0440	A	Nasal prosthesis					
K0441	A	Midfacial prosthesis					
K0442	A	Orbital prosthesis					
K0443	A	Upper facial prosthesis					
K0444	A	Hemi-facial prosthesis					
K0445	A	Auricular prosthesis					
K0446	A	Partial facial prosthesis					
K0447	A	Nasal septal prosthesis					
K0448	A	Unspec maxillofacial prosth					
K0449	A	Repair maxillofacial prosth					
K0450	A	Liq adhes for facial prosth					
K0451	A	Adhesive remover wipes					
K0452	A	Wheelchair bearings					
K0455	A	Pump uninterrupted infusion					
K0456	A	Heavyduty/xtra wide hosp bed					
K0457	A	Heavyduty/wide commode chair					
K0458	A	Heavyduty walker no wheels					
K0459	A	Heavy duty wheeled walker					
K0460	A	WC power add-on joystick					
K0461	A	WC power add-on tiller cntrl					
K0462	A	Temporary replacement eqpmnt					
K0501	A	Aerosol compressor for svneb					
K0529	A	Sterile H20 or nss w lv neb					
K0531	A	Heated humidifier used w pap					
K0532	A	Noninvasive assist wo backup					
K0533	A	Noninvasive assist w backup					
K0534	A	Invasive assist w backup					
L0100	A	Cerv craniosten helmet mold					
L0110	A	Cerv craniostenosis hel non-					
L0120	A	Cerv flexible non-adjustable					
L0130	A	Flex thermoplastic collar mo					
L0140	A	Cervical semi-rigid adjustab					
L0150	A	Cerv semi-rig adj molded chn					
L0160	A	Cerv semi-rig wire occ/mand					
L0170	A	Cervical collar molded to pt					
L0172	A	Cerv col thermplas foam 2 pi					
L0174	A	Cerv col foam 2 piece w thor					
L0180	A	Cer post col occ/man sup adj					
L0190	A	Cerv collar supp adj cerv ba					
L0200	A	Cerv col supp adj bar & thor					
L0210	A	Thoracic rib belt					
L0220	A	Thor rib belt custom fabrica					
L0300	A	TLSO flex surgical support					
L0310	A	Tlso flexible custom fabrica					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L0315	A	Tlso flex elas rigid post pa					
L0317	A	Tlso flex hypext elas post p					
L0320	A	Tlso a-p contrl w apron frnt					
L0330	A	Tlso ant-pos-lateral control					
L0340	A	Tlso a-p-l-rotary with apron					
L0350	A	Tlso flex compress jacket cu					
L0360	A	Tlso flex compress jacket mo					
L0370	A	Tlso a-p-l-rotary hyperexten					
L0380	A	Tlso a-p-l-rot w/pos extens					
L0390	A	Tlso a-p-l control molded					
L0400	A	Tlso a-p-l w interface mater					
L0410	A	Tlso a-p-l two piece constr					
L0420	A	Tlso a-p-l 2 piece w interfa					
L0430	A	Tlso a-p-l w interface custm					
L0440	A	Tlso a-p-l overlap frnt cust					
L0500	A	Lso flex surgical support					
L0510	A	Lso flexible custom fabricat					
L0515	A	Lso flex elas w/rig post pa					
L0520	A	Lso a-p-l control with apron					
L0530	A	Lso ant-pos control w apron					
L0540	A	Lso lumbar flexion a-p-l					
L0550	A	Lso a-p-l control molded					
L0560	A	Lso a-p-l w interface					
L0565	A	Lso a-p-l control custom					
L0600	A	Sacroiliac flex surg support					
L0610	A	Sacroiliac flexible custm fa					
L0620	A	Sacroiliac semi-rig w apron					
L0700	A	Ctlso a-p-l control molded					
L0710	A	Ctlso a-p-l control w/inter					
L0810	A	Halo cervical into jckt vest					
L0820	A	Halo cervical into body jack					
L0830	A	Halo cerv into milwaukee typ					
L0860	A	Magnetic resonanc image comp					
L0900	A	Torso/ptosis support					
L0910	A	Torso & ptosis supp custm fa					
L0920	A	Torso/pendulous abd support					
L0930	A	Pendulous abdomen supp custm					
L0940	A	Torso/postsurgical support					
L0950	A	Post surg support custom fab					
L0960	A	Post surgical support pads					
L0970	A	Tlso corset front					
L0972	A	Lso corset front					
L0974	A	Tlso full corset					
L0976	A	Lso full corset					
L0978	A	Axillary crutch extension					
L0980	A	Peroneal straps pair					
L0982	A	Stocking supp grips set of f					
L0984	A	Protective body sock each					
L0999	A	Add to spinal orthosis NOS					
L1000	A	Ctlso milwauke initial model					
L1010	A	Ctlso axilla sling					
L1020	A	Kyphosis pad					
L1025	A	Kyphosis pad floating					
L1030	A	Lumbar bolster pad					
L1040	A	Lumbar or lumbar rib pad					
L1050	A	Sternal pad					
L1060	A	Thoracic pad					
L1070	A	Trapezius sling					
L1080	A	Outrigger					
L1085	A	Outrigger bil w/vert extens					
L1090	A	Lumbar sling					
L1100	A	Ring flange plastic/leather					
L1110	A	Ring flange plas/leather mol					
L1120	A	Covers for upright each					
L1200	A	Furnsh initial orthosis only					
L1210	A	Lateral thoracic extension					
L1220	A	Anterior thoracic extension					
L1230	A	Milwaukee type superstructur					
L1240	A	Lumbar derotation pad					
L1250	A	Anterior asis pad					
L1260	A	Anterior thoracic derotation					
L1270	A	Abdominal pad					
L1280	A	Rib gusset (elastic) each					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L1290	A	Lateral trochanteric pad					
L1300	A	Body jacket mold to patient					
L1310	A	Post-operative body jacket					
L1499	A	Spinal orthosis NOS					
L1500	A	Thkao mobility frame					
L1510	A	Thkao standing frame					
L1520	A	Thkao swivel walker					
L1600	A	Abduct hip flex frejka w cvr					
L1610	A	Abduct hip flex frejka covr					
L1620	A	Abduct hip flex pavlik harne					
L1630	A	Abduct control hip semi-flex					
L1640	A	Pelv band/spread bar thigh c					
L1650	A	HO abduction hip adjustable					
L1660	A	HO abduction static plastic					
L1680	A	Pelvic & hip control thigh c					
L1685	A	Post-op hip abduct custom fa					
L1686	A	HO post-op hip abduction					
L1690	A	Combination bilateral HO					
L1700	A	Leg perthes orth toronto typ					
L1710	A	Legg perthes orth newington					
L1720	A	Legg perthes orthosis trilat					
L1730	A	Legg perthes orth scottish r					
L1750	A	Legg perthes sling					
L1755	A	Legg perthes patten bottom t					
L1800	A	Knee orthoses elas w stays					
L1810	A	Ko elastic with joints					
L1815	A	Elastic with condylar pads					
L1820	A	Ko elas w/condyle pads & jo					
L1825	A	Ko elastic knee cap					
L1830	A	Ko immobilizer canvas longit					
L1832	A	KO adj jnt pos rigid support					
L1834	A	Ko w/0 joint rigid molded to					
L1840	A	Ko derot ant cruciate custom					
L1843	A	KO single upright custom fit					
L1844	A	Ko w/adj jt rot cntrl molded					
L1845	A	Ko w/adj flex/ext rotat cus					
L1846	A	Ko w adj flex/ext rotat mold					
L1847	A	KO adjustable w air chambers					
L1850	A	Ko swedish type					
L1855	A	Ko plas doub upright jnt mol					
L1858	A	Ko polycentric pneumatic pad					
L1860	A	Ko supracondylar socket mold					
L1870	A	Ko doub upright lacers molde					
L1880	A	Ko doub upright cuffs/lacers					
L1885	A	Knee upright w/resistance					
L1900	A	Afo sprng wir drsflx calf bd					
L1902	A	Afo ankle gauntlet					
L1904	A	Afo molded ankle gauntlet					
L1906	A	Afo multiligamentus ankle su					
L1910	A	Afo sing bar clasp attach sh					
L1920	A	Afo sing upright w/adjust s					
L1930	A	Afo plastic					
L1940	A	Afo molded to patient plasti					
L1945	A	Afo molded plas rig ant tib					
L1950	A	Afo spiral molded to pt plas					
L1960	A	Afo pos solid ank plastic mo					
L1970	A	Afo plastic molded w/ankle j					
L1980	A	Afo sing solid stirrup calf					
L1990	A	Afo doub solid stirrup calf					
L2000	A	Kafo sing fre stirr thi/calf					
L2010	A	Kafo sng solid stirrup w/o j					
L2020	A	Kafo dbl solid stirrup band/					
L2030	A	Kafo dbl solid stirrup w/o j					
L2035	A	KAFO plastic pediatric size					
L2036	A	Kafo plas doub free knee mol					
L2037	A	Kafo plas sing free knee mol					
L2038	A	Kafo w/o joint multi-axis an					
L2039	A	KAFO, plstic, medlat rotat con					
L2040	A	Hkafo torsion bil rot straps					
L2050	A	Hkafo torsion cable hip pelv					
L2060	A	Hkafo torsion ball bearing j					
L2070	A	Hkafo torsion unilat rot str					
L2080	A	Hkafo unilat torsion cable					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L2090	A	Hkafo unilat torsion ball br					
L2102	A	Afo tibial fx cast plstr mol					
L2104	A	Afo tib fx cast synthetic mo					
L2106	A	Afo tib fx cast plaster mold					
L2108	A	Afo tib fx cast molded to pt					
L2112	A	Afo tibial fracture soft					
L2114	A	Afo tib fx semi-rigid					
L2116	A	Afo tibial fracture rigid					
L2122	A	Kafo fem fx cast plaster mol					
L2124	A	Kafo fem fx cast synthet mol					
L2126	A	Kafo fem fx cast thermoplas					
L2128	A	Kafo fem fx cast molded to p					
L2132	A	Kafo femoral fx cast soft					
L2134	A	Kafo fem fx cast semi-rigid					
L2136	A	Kafo femoral fx cast rigid					
L2180	A	Plas shoe insert w ank joint					
L2182	A	Drop lock knee					
L2184	A	Limited motion knee joint					
L2186	A	Adj motion knee jnt lerman t					
L2188	A	Quadrilateral brim					
L2190	A	Waist belt					
L2192	A	Pelvic band & belt thigh fla					
L2200	A	Limited ankle motion ea jnt					
L2210	A	Dorsiflexion assist each joi					
L2220	A	Dorsi & plantar flex ass/res					
L2230	A	Split flat caliper stirr & p					
L2240	A	Round caliper and plate atta					
L2250	A	Foot plate molded stirrup at					
L2260	A	Reinforced solid stirrup					
L2265	A	Long tongue stirrup					
L2270	A	Varus/valgus strap padded/li					
L2275	A	Plastic mod low ext pad/line					
L2280	A	Molded inner boot					
L2300	A	Abduction bar jointed adjust					
L2310	A	Abduction bar-straight					
L2320	A	Non-molded lacer					
L2330	A	Lacer molded to patient mode					
L2335	A	Anterior swing band					
L2340	A	Pre-tibial shell molded to p					
L2350	A	Prosthetic type socket molde					
L2360	A	Extended steel shank					
L2370	A	Patten bottom					
L2375	A	Torsion ank & half solid sti					
L2380	A	Torsion straight knee joint					
L2385	A	Straight knee joint heavy du					
L2390	A	Offset knee joint each					
L2395	A	Offset knee joint heavy duty					
L2397	A	Suspension sleeve lower ext					
L2405	A	Knee joint drop lock ea jnt					
L2415	A	Knee joint cam lock each joi					
L2425	A	Knee disc/dial lock/adj flex					
L2430	A	Knee jnt ratchet lock ea jnt					
L2435	A	Knee joint polycentric joint					
L2492	A	Knee lift loop drop lock rin					
L2500	A	Thi/glut/ischia wgt bearing					
L2510	A	Th/wght bear quad-lat brim m					
L2520	A	Th/wght bear quad-lat brim c					
L2525	A	Th/wght bear nar m-l brim mo					
L2526	A	Th/wght bear nar m-l brim cu					
L2530	A	Thigh/wght bear lacer non-mo					
L2540	A	Thigh/wght bear lacer molded					
L2550	A	Thigh/wght bear high roll cu					
L2570	A	Hip clevis type 2 posit jnt					
L2580	A	Pelvic control pelvic sling					
L2600	A	Hip clevis/thrust bearing fr					
L2610	A	Hip clevis/thrust bearing lo					
L2620	A	Pelvic control hip heavy dut					
L2622	A	Hip joint adjustable flexion					
L2624	A	Hip adj flex ext abduct cont					
L2627	A	Plastic mold recipro hip & c					
L2628	A	Metal frame recipro hip & ca					
L2630	A	Pelvic control band & belt u					
L2640	A	Pelvic control band & belt b					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L2650	A	Pelv & thor control gluteal					
L2660	A	Thoracic control thoracic ba					
L2670	A	Thorac cont paraspinal uprig					
L2680	A	Thorac cont lat support upri					
L2750	A	Plating chrome/nickel pr bar					
L2755	A	Carbon graphite lamination					
L2760	A	Extension per extension per					
L2770	A	Low ext orthosis per bar/jnt					
L2780	A	Non-corrosive finish					
L2785	A	Drop lock retainer each					
L2795	A	Knee control full kneecap					
L2800	A	Knee cap medial or lateral p					
L2810	A	Knee control condylar pad					
L2820	A	Soft interface below knee se					
L2830	A	Soft interface above knee se					
L2840	A	Tibial length sock fx or equ					
L2850	A	Femoral lgth sock fx or equa					
L2860	A	Torsion mechanism knee/ankle					
L2999	A	Lower extremity orthosis NOS					
L3000	A	Ft insert ucb berkeley shell					
L3001	A	Foot insert removmolded spe					
L3002	A	Foot insert plastazote or eq					
L3003	A	Foot insert silicone gel eac					
L3010	A	Foot longitudinal arch suppo					
L3020	A	Foot longitud/metatarsal sup					
L3030	A	Foot arch support removprem					
L3040	A	Ft arch suprt premold longit					
L3050	A	Foot arch supp premold metat					
L3060	A	Foot arch supp longitud/meta					
L3070	A	Arch suprt att to sho longit					
L3080	A	Arch supp att to shoe metata					
L3090	A	Arch supp att to shoe long/m					
L3100	A	Hallus-valgus nght dynamic s					
L3140	A	Abduction rotation bar shoe					
L3150	A	Abduct rotation bar w/o shoe					
L3160	A	Shoe styled positioning dev					
L3170	A	Foot plastic heel stabilizer					
L3201	A	Oxford w supinat/pronat inf					
L3202	A	Oxford w/supinat/pronator c					
L3203	A	Oxford w/supinator/pronator					
L3204	A	Hightop w/supp/pronator inf					
L3206	A	Hightop w/supp/pronator chi					
L3207	A	Hightop w/supp/pronator jun					
L3208	A	Surgical boot each infant					
L3209	A	Surgical boot each child					
L3211	A	Surgical boot each junior					
L3212	A	Benesch boot pair infant					
L3213	A	Benesch boot pair child					
L3214	A	Benesch boot pair junior					
L3215	A	Orthopedic ftwear ladies oxf					
L3216	A	Orthoped ladies shoes dpth i					
L3217	A	Ladies shoes hightop depth i					
L3218	A	Ladies surgical boot each					
L3219	A	Orthopedic mens shoes oxford					
L3221	A	Orthopedic mens shoes dpth i					
L3222	A	Mens shoes hightop depth inl					
L3223	A	Mens surgical boot each					
L3224	A	Woman's shoe oxford brace					
L3225	A	Man's shoe oxford brace					
L3230	A	Custom shoes depth inlay					
L3250	A	Custom mold shoe removprost					
L3251	A	Shoe molded to pt silicone s					
L3252	A	Shoe molded plastazote cust					
L3253	A	Shoe molded plastazote cust					
L3254	A	Orth foot non-stndard size/w					
L3255	A	Orth foot non-standard size/					
L3257	A	Orth foot add charge split s					
L3260	A	Ambulatory surgical boot eac					
L3265	A	Plastazote sandal each					
L3300	A	Sho lift taper to metatarsal					
L3310	A	Shoe lift elev heel/sole neo					
L3320	A	Shoe lift elev heel/sole cor					
L3330	A	Lifts elevation metal extens					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L3332	A	Shoe lifts tapered to one-ha					
L3334	A	Shoe lifts elevation heel/i					
L3340	A	Shoe wedge sach					
L3350	A	Shoe heel wedge					
L3360	A	Shoe sole wedge outside sole					
L3370	A	Shoe sole wedge between sole					
L3380	A	Shoe clubfoot wedge					
L3390	A	Shoe outflare wedge					
L3400	A	Shoe metatarsal bar wedge ro					
L3410	A	Shoe metatarsal bar between					
L3420	A	Full sole/heel wedge btween					
L3430	A	Sho heel count plast reinfor					
L3440	A	Heel leather reinforced					
L3450	A	Shoe heel sach cushion type					
L3455	A	Shoe heel new leather standa					
L3460	A	Shoe heel new rubber standar					
L3465	A	Shoe heel thomas with wedge					
L3470	A	Shoe heel thomas extend to b					
L3480	A	Shoe heel pad & depress for					
L3485	A	Shoe heel pad removable for					
L3500	A	Ortho shoe add leather insol					
L3510	A	Orthopedic shoe add rub insl					
L3520	A	O shoe add felt w leath insl					
L3530	A	Ortho shoe add half sole					
L3540	A	Ortho shoe add full sole					
L3550	A	O shoe add standard toe tap					
L3560	A	O shoe add horseshoe toe tap					
L3570	A	O shoe add instep extension					
L3580	A	O shoe add instep velcro clo					
L3590	A	O shoe convert to sof counte					
L3595	A	Ortho shoe add march bar					
L3600	A	Trans shoe calip plate exist					
L3610	A	Trans shoe caliper plate new					
L3620	A	Trans shoe solid stirrup exi					
L3630	A	Trans shoe solid stirrup new					
L3640	A	Shoe dennis browne splint bo					
L3649	A	Orthopedic shoe modifica NOS					
L3650	A	Shlder fig 8 abduct restrain					
L3660	A	Abduct restrainer canvas & web					
L3670	A	Acromio/clavicular canvas & we					
L3675	A	Canvas vest SO					
L3700	A	Elbow orthoses elas w stays					
L3710	A	Elbow elastic with metal joi					
L3720	A	Forearm/arm cuffs free motio					
L3730	A	Forearm/arm cuffs ext/flex a					
L3740	A	Cuffs adj lock w/active con					
L3800	A	Whfo short opponen no attach					
L3805	A	Whfo long opponens no attach					
L3807	A	Whfo w inflatable airchamber					
L3810	A	Whfo thumb abduction bar					
L3815	A	Whfo second m.p. abduction a					
L3820	A	Whfo ip ext asst w/mp ext s					
L3825	A	Whfo m.p. extension stop					
L3830	A	Whfo m.p. extension assist					
L3835	A	Whfo m.p. spring extension a					
L3840	A	Whfo spring swivel thumb					
L3845	A	Whfo thumb ip ext ass w/mp					
L3850	A	Action wrist w/dorsiflex as					
L3855	A	Whfo adj m.p. flexion contro					
L3860	A	Whfo adj m.p. flex ctrl & i.					
L3890	A	Torsion mechanism wrist/elbo					
L3900	A	Hinge extension/flex wrist/f					
L3901	A	Hinge ext/flex wrist finger					
L3902	A	Whfo ext power compress gas					
L3904	A	Whfo electric custom fitted					
L3906	A	Wrist gauntlet molded to pt					
L3907	A	Whfo wrst gauntlt thmb spica					
L3908	A	Wrist cock-up non-molded					
L3910	A	Whfo swanson design					
L3912	A	Flex glove w/elastic finger					
L3914	A	WHO wrist extension cock-up					
L3916	A	Whfo wrist extens w/outrigg					
L3918	A	HFO knuckle bender					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L3920	A	Knuckle bender with outrigge					
L3922	A	Knuckle bend 2 seg to flex j					
L3924	A	Oppenheimer					
L3926	A	Thomas suspension					
L3928	A	Finger extension w/clock sp					
L3930	A	Finger extension with wrist					
L3932	A	Safety pin spring wire					
L3934	A	Safety pin modified					
L3936	A	Palmer					
L3938	A	Dorsal wrist					
L3940	A	Dorsal wrist w/outrigger at					
L3942	A	Reverse knuckle bender					
L3944	A	Reverse knuckle bend w/outr					
L3946	A	HFO composite elastic					
L3948	A	Finger knuckle bender					
L3950	A	Oppenheimer w/knuckle bend					
L3952	A	Oppenheimer w/rev knuckle 2					
L3954	A	Spreading hand					
L3956	A	Add joint upper ext orthosis					
L3960	A	Sewho airplan desig abdu pos					
L3962	A	Sewho erbs palsey design abd					
L3963	A	Molded w/articulating elbow					
L3964	A	Seo mobile arm sup att to wc					
L3965	A	Arm supp att to wc rancho ty					
L3966	A	Mobile arm supports reclinin					
L3968	A	Friction dampening arm supp					
L3969	A	Monosuspension arm/hand supp					
L3970	A	Elevat proximal arm support					
L3972	A	Offset/lat rocker arm w/ela					
L3974	A	Mobile arm support supinator					
L3980	A	Upp ext fx orthosis humeral					
L3982	A	Upper ext fx orthosis rad/ul					
L3984	A	Upper ext fx orthosis wrist					
L3985	A	Forearm hand fx orth w/wr h					
L3986	A	Humeral rad/ulna wrist fx or					
L3995	A	Sock fracture or equal each					
L3999	A	Upper limb orthosis NOS					
L4000	A	Repl girdle milwaukee orth					
L4010	A	Replace trilateral socket br					
L4020	A	Replace quadlat socket brim					
L4030	A	Replace socket brim cust fit					
L4040	A	Replace molded thigh lacer					
L4045	A	Replace non-molded thigh lac					
L4050	A	Replace molded calf lacer					
L4055	A	Replace non-molded calf lace					
L4060	A	Replace high roll cuff					
L4070	A	Replace prox & dist upright					
L4080	A	Repl met band kafo-afo prox					
L4090	A	Repl met band kafo-afo calf/					
L4100	A	Repl leath cuff kafo prox th					
L4110	A	Repl leath cuff kafo-afo cal					
L4130	A	Replace pretibial shell					
L4205	A	Ortho dvc repair per 15 min					
L4210	A	Orth dev repair/repl minor p					
L4350	A	Pneumatic ankle cntrl splint					
L4360	A	Pneumatic walking splint					
L4370	A	Pneumatic full leg splint					
L4380	A	Pneumatic knee splint					
L4392	A	Replace AFO soft interface					
L4394	A	Replace foot drop spint					
L4396	A	Static AFO					
L4398	A	Foot drop splint recumbent					
L5000	A	Sho insert w arch toe filler					
L5010	A	Mold socket ank hgt w/toe f					
L5020	A	Tibial tubercle hgt w/toe f					
L5050	A	Ank symes mold sckt sach ft					
L5060	A	Symes met fr leath socket ar					
L5100	A	Molded socket shin sach foot					
L5105	A	Plast socket jts/thgh lacer					
L5150	A	Mold sckt ext knee shin sach					
L5160	A	Mold socket bent knee shin s					
L5200	A	Kne sing axis fric shin sach					
L5210	A	No knee/ankle joints w/ft b					

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[3] Eligible for pass-through payments. See Preamble for payment rate determination. See Addendum K for complete list of pass-through codes.

ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L5220	A	No knee joint with artic ali					
L5230	A	Fem focal defic constant fri					
L5250	A	Hip canad sing axi cons fric					
L5270	A	Tilt table locking hip sing					
L5280	A	Hemipelvect canad sing axis					
L5300	A	Bk sach soft cover & finish					
L5310	A	Knee disart sach soft cv/fin					
L5320	A	Ak open end sach soft cv/fin					
L5330	A	Hip canadian sach sft cv/fin					
L5340	A	Hemipelvectomy canad cv/fin					
L5400	A	Postop dress & 1 cast chg bk					
L5410	A	Postop dsg bk ea add cast ch					
L5420	A	Postop dsg & 1 cast chg ak/d					
L5430	A	Postop dsg ak ea add cast ch					
L5450	A	Postop app non-wgt bear dsg					
L5460	A	Postop app non-wgt bear dsg					
L5500	A	Init bk ptb plaster direct					
L5505	A	Init ak ischal plstr direct					
L5510	A	Prep BK ptb plaster molded					
L5520	A	Perp BK ptb thermopls direct					
L5530	A	Prep BK ptb thermopls molded					
L5535	A	Prep BK ptb open end socket					
L5540	A	Prep BK ptb laminated socket					
L5560	A	Prep AK ischial plast molded					
L5570	A	Prep AK ischial direct form					
L5580	A	Prep AK ischial thermo mold					
L5585	A	Prep AK ischial open end					
L5590	A	Prep AK ischial laminated					
L5595	A	Hip disartic sach thermopls					
L5600	A	Hip disart sach laminat mold					
L5610	A	Above knee hydracadence					
L5611	A	Ak 4 bar link w/fric swing					
L5613	A	Ak 4 bar ling w/hydraul swig					
L5614	A	4-bar link above knee w/swng					
L5616	A	Ak univ multiplex sys frict					
L5617	A	AK/BK self-aligning unit ea					
L5618	A	Test socket symes					
L5620	A	Test socket below knee					
L5622	A	Test socket knee disarticula					
L5624	A	Test socket above knee					
L5626	A	Test socket hip disarticulat					
L5628	A	Test socket hemipelvectomy					
L5629	A	Below knee acrylic socket					
L5630	A	Syme typ expandabl wall sckt					
L5631	A	Ak/knee disartic acrylic soc					
L5632	A	Symes type ptb brim design s					
L5634	A	Symes type poster opening so					
L5636	A	Symes type medial opening so					
L5637	A	Below knee total contact					
L5638	A	Below knee leather socket					
L5639	A	Below knee wood socket					
L5640	A	Knee disarticulat leather so					
L5642	A	Above knee leather socket					
L5643	A	Hip flex inner socket ext fr					
L5644	A	Above knee wood socket					
L5645	A	Ak flexibl inner socket ext					
L5646	A	Below knee air cushion socke					
L5647	A	Below knee suction socket					
L5648	A	Above knee air cushion socke					
L5649	A	Isch containmt/narrow m-l so					
L5650	A	Tot contact ak/knee disart s					
L5651	A	Ak flex inner socket ext fra					
L5652	A	Suction susp ak/knee disart					
L5653	A	Knee disart expand wall sock					
L5654	A	Socket insert symes					
L5655	A	Socket insert below knee					
L5656	A	Socket insert knee articulat					
L5658	A	Socket insert above knee					
L5660	A	Sock insrt syme silicone gel					
L5661	A	Multi-durometer symes					
L5662	A	Socket insert bk silicone ge					
L5663	A	Sock knee disartic silicone					
L5664	A	Socket insert ak silicone ge					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L5665	A	Multi-durometer below knee					
L5666	A	Below knee cuff suspension					
L5667	A	Socket insert w lock lower					
L5668	A	Socket insert w/o lock lower					
L5669	A	Below knee socket w/o lock					
L5670	A	Bk molded supracondylar susp					
L5672	A	Bk removable medial brim sus					
L5674	A	Bk latex sleeve suspension/e					
L5675	A	Bk latex sleeve susp/eq hvy					
L5676	A	Bk knee joints single axis p					
L5677	A	Bk knee joints polycentric p					
L5678	A	Bk joint covers pair					
L5680	A	Bk thigh lacer non-molded					
L5682	A	Bk thigh lacer glut/ischia m					
L5684	A	Bk fork strap					
L5686	A	Bk back check					
L5688	A	Bk waist belt webbing					
L5690	A	Bk waist belt padded and lin					
L5692	A	Ak pelvic control belt light					
L5694	A	Ak pelvic control belt pad/l					
L5695	A	Ak sleeve susp neoprene/equa					
L5696	A	Ak/knee disartic pelvic join					
L5697	A	Ak/knee disartic pelvic band					
L5698	A	Ak/knee disartic silesian ba					
L5699	A	Shoulder harness					
L5700	A	Replace socket below knee					
L5701	A	Replace socket above knee					
L5702	A	Replace socket hip					
L5704	A	Custom shape covr below knee					
L5705	A	Custm shape cover above knee					
L5706	A	Custm shape cvr knee disart					
L5707	A	Custm shape cover hip disart					
L5710	A	Kne-shin exo sng axi mnl loc					
L5711	A	Knee-shin exo mnl lock ultra					
L5712	A	Knee-shin exo frict swg & st					
L5714	A	Knee-shin exo variable frict					
L5716	A	Knee-shin exo mech stance ph					
L5718	A	Knee-shin exo frct swg & sta					
L5722	A	Knee-shin pneum swg frct exo					
L5724	A	Knee-shin exo fluid swing ph					
L5726	A	Knee-shin ext jnts fld swg e					
L5728	A	Knee-shin fluid swg & stance					
L5780	A	Knee-shin pneum/hydra pneum					
L5785	A	Exoskeletal bk ultralt mater					
L5790	A	Exoskeletal ak ultra-light m					
L5795	A	Exoskel hip ultra-light mate					
L5810	A	Endoskel knee-shin mnl lock					
L5811	A	Endo knee-shin mnl lck ultra					
L5812	A	Endo knee-shin frct swg & st					
L5814	A	Endo knee-shin hydral swg ph					
L5816	A	Endo knee-shin polyc mch sta					
L5818	A	Endo knee-shin frct swg & st					
L5822	A	Endo knee-shin pneum swg frc					
L5824	A	Endo knee-shin fluid swing p					
L5826	A	Miniature knee joint					
L5828	A	Endo knee-shin fluid swg/sta					
L5830	A	Endo knee-shin pneum/swg pha					
L5840	A	Multi-axial knee/shin system					
L5845	A	Knee-shin sys stance flexion					
L5846	A	Knee-shin sys microprocessor					
L5850	A	Endo ak/hip knee extens assi					
L5855	A	Mech hip extension assist					
L5910	A	Endo below knee alignable sy					
L5920	A	Endo ak/hip alignable system					
L5925	A	Above knee manual lock					
L5930	A	High activity knee frame					
L5940	A	Endo bk ultra-light material					
L5950	A	Endo ak ultra-light material					
L5960	A	Endo hip ultra-light materia					
L5962	A	Below knee flex cover system					
L5964	A	Above knee flex cover system					
L5966	A	Hip flexible cover system					
L5968	A	Multiaxial ankle w dorsiflex					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L5970	A	Foot external keel sach foot					
L5972	A	Flexible keel foot					
L5974	A	Foot single axis ankle/foot					
L5975	A	Combo ankle/foot prosthesis					
L5976	A	Energy storing foot					
L5978	A	Ft prosth multiaxial ankl/ft					
L5979	A	Multi-axial ankle/ft prosth					
L5980	A	Flex foot system					
L5981	A	Flex-walk sys low ext prosth					
L5982	A	Exoskeletal axial rotation u					
L5984	A	Endoskeletal axial rotation					
L5985	A	Lwr ext dynamic prosth pylon					
L5986	A	Multi-axial rotation unit					
L5987	A	Shank ft w vert load pylon					
L5988	A	Vertical shock reducing pylo					
L5999	A	Lowr extremity prosthes NOS					
L6000	A	Par hand robin-aids thum rem					
L6010	A	Hand robin-aids little/ring					
L6020	A	Part hand robin-aids no fing					
L6050	A	Wrst MLd sck flx hng tri pad					
L6055	A	Wrst mold sock w/exp interfa					
L6100	A	Elb mold sock flex hinge pad					
L6110	A	Elbow mold sock suspension t					
L6120	A	Elbow mold doub splt soc ste					
L6130	A	Elbow stump activated lock h					
L6200	A	Elbow mold outsid lock hinge					
L6205	A	Elbow molded w/expand inter					
L6250	A	Elbow inter loc elbow forarm					
L6300	A	Shlder disart int lock elbow					
L6310	A	Shoulder passive restor comp					
L6320	A	Shoulder passive restor cap					
L6350	A	Thoracic intern lock elbow					
L6360	A	Thoracic passive restor comp					
L6370	A	Thoracic passive restor cap					
L6380	A	Postop dsg cast chg wrst/elb					
L6382	A	Postop dsg cast chg elb dis/					
L6384	A	Postop dsg cast chg shlder/t					
L6386	A	Postop ea cast chg & realign					
L6388	A	Postop applicat rigid dsg on					
L6400	A	Below elbow prosth tiss shap					
L6450	A	Elb disart prosth tiss shap					
L6500	A	Above elbow prosth tiss shap					
L6550	A	Shldr disar prosth tiss shap					
L6570	A	Scap thorac prosth tiss shap					
L6580	A	Wrist/elbow bowden cable mol					
L6582	A	Wrist/elbow bowden cbl dir f					
L6584	A	Elbow fair lead cable molded					
L6586	A	Elbow fair lead cable dir fo					
L6588	A	Shdr fair lead cable molded					
L6590	A	Shdr fair lead cable direct					
L6600	A	Polycentric hinge pair					
L6605	A	Single pivot hinge pair					
L6610	A	Flexible metal hinge pair					
L6615	A	Disconnect locking wrist uni					
L6616	A	Disconnect insert locking wr					
L6620	A	Flexion-friction wrist unit					
L6623	A	Spring-ass rot wrst w/latch					
L6625	A	Rotation wrst w/cable lock					
L6628	A	Quick disconn hook adapter o					
L6629	A	Lamination collar w/couplin					
L6630	A	Stainless steel any wrist					
L6632	A	Latex suspension sleeve each					
L6635	A	Lift assist for elbow					
L6637	A	Nudge control elbow lock					
L6640	A	Shoulder abduction joint pai					
L6641	A	Excursion amplifier pulley t					
L6642	A	Excursion amplifier lever ty					
L6645	A	Shoulder flexion-abduction j					
L6650	A	Shoulder universal joint					
L6655	A	Standard control cable extra					
L6660	A	Heavy duty control cable					
L6665	A	Teflon or equal cable lining					
L6670	A	Hook to hand cable adapter					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L6672	A	Harness chest/shlder saddle					
L6675	A	Harness figure of 8 sing con					
L6676	A	Harness figure of 8 dual con					
L6680	A	Test sock wrist disart/bel e					
L6682	A	Test sock elbw disart/above					
L6684	A	Test socket shldr disart/tho					
L6686	A	Suction socket					
L6687	A	Frame typ socket bel elbow/w					
L6688	A	Frame typ sock above elb/dis					
L6689	A	Frame typ socket shoulder di					
L6690	A	Frame typ sock interscap-tho					
L6691	A	Removable insert each					
L6692	A	Silicone gel insert or equal					
L6693	A	Lockingelbow forearm cntrbal					
L6700	A	Terminal device model #3					
L6705	A	Terminal device model #5					
L6710	A	Terminal device model #5x					
L6715	A	Terminal device model #5xa					
L6720	A	Terminal device model #6					
L6725	A	Terminal device model #7					
L6730	A	Terminal device model #7lo					
L6735	A	Terminal device model #8					
L6740	A	Terminal device model #8x					
L6745	A	Terminal device model #88x					
L6750	A	Terminal device model #10p					
L6755	A	Terminal device model #10x					
L6765	A	Terminal device model #12p					
L6770	A	Terminal device model #99x					
L6775	A	Terminal device model #555					
L6780	A	Terminal device model #ss555					
L6790	A	Hooks-accu hook or equal					
L6795	A	Hooks-2 load or equal					
L6800	A	Hooks-aprl vc or equal					
L6805	A	Modifier wrist flexion unit					
L6806	A	Trs grip vc or equal					
L6807	A	Term device grip 1/2 or equal					
L6808	A	Term device infant or child					
L6809	A	Trs super sport passive					
L6810	A	Pincher tool otto bock or eq					
L6825	A	Hands dorrance vo					
L6830	A	Hand aprl vc					
L6835	A	Hand sierra vo					
L6840	A	Hand becker imperial					
L6845	A	Hand becker lock grip					
L6850	A	Term dvc-hand becker plylite					
L6855	A	Hand robin-aids vo					
L6860	A	Hand robin-aids vo soft					
L6865	A	Hand passive hand					
L6867	A	Hand detroit infant hand					
L6868	A	Passive inf hand steeper/hos					
L6870	A	Hand child mitt					
L6872	A	Hand nyu child hand					
L6873	A	Hand mech inf steeper or equ					
L6875	A	Hand bock vc					
L6880	A	Hand bock vo					
L6890	A	Production glove					
L6895	A	Custom glove					
L6900	A	Hand restorat thumb/1 finger					
L6905	A	Hand restoration multiple fi					
L6910	A	Hand restoration no fingers					
L6915	A	Hand restoration replacmnt g					
L6920	A	Wrist disarticul switch ctrl					
L6925	A	Wrist disart myoelectronic c					
L6930	A	Below elbow switch control					
L6935	A	Below elbow myoelectronic ct					
L6940	A	Elbow disarticulation switch					
L6945	A	Elbow disart myoelectronic c					
L6950	A	Above elbow switch control					
L6955	A	Above elbow myoelectronic ct					
L6960	A	Shldr disartic switch contro					
L6965	A	Shldr disartic myoelectronic					
L6970	A	Interscapular-thor switch ct					
L6975	A	Interscap-thor myoelectronic					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L7010	A	Hand otto back steeper/eq sw					
L7015	A	Hand sys teknik village swit					
L7020	A	Electronic greifer switch ct					
L7025	A	Electron hand myoelectronic					
L7030	A	Hand sys teknik vill myoelec					
L7035	A	Electron greifer myoelectro					
L7040	A	Prehensile actuator hosmer s					
L7045	A	Electron hook child michigan					
L7170	A	Electronic elbow hosmer swit					
L7180	A	Electronic elbow utah myoele					
L7185	A	Electron elbow adolescent sw					
L7186	A	Electron elbow child switch					
L7190	A	Elbow adolescent myoelectron					
L7191	A	Elbow child myoelectronic ct					
L7260	A	Electron wrist rotator otto					
L7261	A	Electron wrist rotator utah					
L7266	A	Servo control steeper or equ					
L7272	A	Analogue control unb or equa					
L7274	A	Proportional ctl 12 volt uta					
L7360	A	Six volt bat otto bock/eq ea					
L7362	A	Battery chrgr six volt otto					
L7364	A	Twelve volt battery utah/equ					
L7366	A	Battery chrgr 12 volt utah/e					
L7499	A	Upper extremity prosthes NOS					
L7500	A	Prosthetic dvc repair hourly					
L7510	A	Prosthetic device repair rep					
L7520	A	Repair prosthesis per 15 min					
L7900	A	Vacuum erection system					
L8000	A	Mastectomy bra					
L8010	A	Mastectomy sleeve					
L8015	A	Ext breastprosthesis garment					
L8020	A	Mastectomy form					
L8030	A	Breast prosthesis silicone/e					
L8035	A	Custom breast prosthesis					
L8039	A	Breast prosthesis NOS					
L8100	A	Compression stocking BK18–30					
L8110	A	Compression stocking BK30–40					
L8120	A	Compression stocking BK40–50					
L8130	A	Gc stocking thighlngth 18–30					
L8140	A	Gc stocking thighlngth 30–40					
L8150	A	Gc stocking thighlngth 40–50					
L8160	A	Gc stocking full lngth 18–30					
L8170	A	Gc stocking full lngth 30–40					
L8180	A	Gc stocking full lngth 40–50					
L8190	A	Gc stocking waistlngth 18–30					
L8195	A	Gc stocking waistlngth 30–40					
L8200	A	Gc stocking waistlngth 40–50					
L8210	A	Gc stocking custom made					
L8220	A	Gc stocking lymphedema					
L8230	A	Gc stocking garter belt					
L8239	A	G compression stocking NOS					
L8300	A	Truss single w/standard pad					
L8310	A	Truss double w/standard pad					
L8320	A	Truss addition to std pad wa					
L8330	A	Truss add to std pad scrotal					
L8400	A	Sheath below knee					
L8410	A	Sheath above knee					
L8415	A	Sheath upper limb					
L8417	A	Pros sheath/sock w gel cushn					
L8420	A	Prosthetic sock multi ply BK					
L8430	A	Prosthetic sock multi ply AK					
L8435	A	Pros sock multi ply upper lm					
L8440	A	Shrinker below knee					
L8460	A	Shrinker above knee					
L8465	A	Shrinker upper limb					
L8470	A	Pros sock single ply BK					
L8480	A	Pros sock single ply AK					
L8485	A	Pros sock single ply upper l					
L8490	A	Air seal suction reten systm					
L8499	A	Unlisted misc prosthetic ser					
L8500	A	Artificial larynx					
L8501	A	Tracheostomy speaking valve					
L8600	A	Implant breast silicone/eq					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
L8603	A	Collagen imp urinary 2.5 CC					
L8610	A	Ocular implant					
L8612	A	Aqueous shunt prosthesis					
L8613	A	Ossicular implant					
L8614	A	Cochlear device/system					
L8619	A	Replace cochlear processor					
L8630	A	Metacarpophalangeal implant					
L8641	A	Metatarsal joint implant					
L8642	A	Hallux implant					
L8658	A	Interphalangeal joint implnt					
L8670	A	Vascular graft, synthetic					
L8699	A	Prosthetic implant NOS					
L9900	A	O&P supply/accessory/service					
M0064	X	Visit for drug monitoring	0374	1.17	$56.73	$13.08	$11.35
M0075	E	Cellular therapy					
M0076	E	Prolotherapy					
M0100	E	Intragastric hypothermia					
M0300	E	IV chelationtherapy					
M0301	E	Fabric wrapping of aneurysm					
M0302	E	Assessment of cardiac output					
P2028	A	Cephalin floculation test					
P2029	A	Congo red blood test					
P2031	E	Hair analysis					
P2033	A	Blood thymol turbidity					
P2038	A	Blood mucoprotein					
P3000	A	Screen pap by tech w md supv					
P3001	E	Screening pap smear by phys					
P7001	E	Culture bacterial urine					
[2] P9010	S	Whole blood for transfusion	0950	2.08	$101.02		$20.20
P9011	S	Blood split unit					
[2] P9012	S	Cryoprecipitate each unit	0952	0.70	$33.92		$6.78
[2] P9013	S	Unit/s blood fibrinogen	0953	0.48	$23.27		$4.65
[2] P9016	S	Leukocyte poor blood, unit	0954	2.83	$137.21		$27.44
[2] P9017	S	One donor fresh frozn plasma	0955	2.26	$109.35		$21.87
[2] P9018	S	Plasma protein fract, unit	0956	1.26	$61.09		$12.22
[2] P9019	S	Platelet concentrate unit	0957	0.98	$47.46		$9.49
[2] P9020	S	Platelet rich plasma unit	0958	1.16	$56.25		$11.25
[2] P9021	S	Red blood cells unit	0959	2.04	$99.04		$19.81
[2] P9022	S	Washed red blood cells unit	0960	3.81	$184.53		$36.91
[2] P9023	S	Frozen plasma, pooled, sd	0949	3.49	$169.22		$33.84
P9603	A	One-way allow prorated miles					
P9604	A	One-way allow prorated trip					
P9612	N	Catheterize for urine spec					
P9615	N	Urine specimen collect mult					
[2] Q0034	X	Admin of influenza vaccine	0354	0.13	$6.19		
Q0035	X	Cardiokymography	0366	0.38	$18.43	$15.60	$3.69
Q0081	S	Infusion ther other than che	0120	1.66	$80.49	$42.67	$16.10
Q0082	P	Activity therapy w/partial h	0033	4.17	$202.19	$48.17	$40.44
Q0083	S	Chemo by other than infusion	0116	2.34	$113.46	$22.69	$22.69
Q0084	S	Chemotherapy by infusion	0117	1.84	$89.22	$71.80	$17.84
Q0085	S	Chemo by both infusion and o	0118	2.90	$140.61	$72.03	$28.12
Q0086	A	Physical therapy evaluation/					
Q0091	T	Obtaining screen pap smear	0191	1.19	$57.70	$17.43	$11.54
Q0092	N	Set up port x-ray equipment					
Q0111	A	Wet mounts/w preparations					
Q0112	A	Potassium hydroxide preps					
Q0113	A	Pinworm examinations					
Q0114	A	Fern test					
Q0115	A	Post-coital mucous exam					
[3] Q0136	X	Non esrd epoetin alpha inj	0733				$1.75
Q0144	E	Azithromycin dihydrate, oral					
[2] Q0156	X	Human albumin 5%	0961	2.77	$134.31		$26.86
[2] Q0157	X	Human albumin 25%	0962	1.38	$66.91		$13.38
[3] Q0160	X	Factor IX non-recombinant	0931				$.04
[3] Q0161	X	Factor IX recombinant	0932				$.10
[3] Q0163	X	Diphenhydramine HCl 50mg	0761				$.10
[3] Q0164	X	Prochlorperazine maleate 5mg	0761				$.10
Q0165	E	Prochlorperazine maleate10mg					
[3] Q0166	X	Granisetron HCl 1 mg oral	0765				$3.20
[3] Q0167	X	Dronabinol 2.5mg oral	0762				$.48
Q0168	E	Dronabinol 5mg oral					
[3] Q0169	X	Promethazine HCl 12.5mg oral	0761				$.10
Q0170	E	Promethazine HCl 25 mg oral					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[3]Q0171	X	Chlorpromazine HCl 10mg oral	0761				$.10
Q0172	E	Chlorpromazine HCl 25mg oral					
[3]Q0173	X	Trimethobenzamide HCl 250mg	0761				$.10
[3]Q0174	X	Thiethylperazine maleate10mg	0761				$.10
[3]Q0175	X	Perphenazine 4mg oral	0761				$.10
Q0176	E	Perphenazine 8mg oral					
[3]Q0177	X	Hydroxyzine pamoate 25mg	0761				$.10
Q0178	E	Hydroxyzine pamoate 50mg					
[3]Q0179	X	Ondansetron HCl 8mg oral	0769				$2.62
[3]Q0180	X	Dolasetron mesylate oral	0763				$8.53
Q0181	E	Unspecified oral anti-emetic					
Q0183	N	Nonmetabolic active tissue					
Q0184	N	Metabolically active tissue					
Q0185	N	Metabolic active D/E tissue					
Q0186	E	Paramedic intercept, rural					
[3]Q0187	X	Factor viia recombinant	0929				$.27
Q1001	E	Ntiol category 1					
Q1002	E	Ntiol category 2					
Q1003	E	Ntiol category 3					
Q1004	E	Ntiol category 4					
Q1005	E	Ntiol category 5					
Q2001	E	Cabergoline, 0.5 mg, oral					
[3]Q2002	X	Elliot's B solution	7022				$19.20
[3]Q2003	X	Aprotinin, 10,000 kiu	7019				$2.42
[3]Q2004	X	Treatment for bladder calcul	7023				$4.46
[3]Q2005	X	Corticorelin ovine triflutat	7024				$45.77
[3]Q2006	X	Digoxin immune FAB (Ovine),	7025				$14.06
[3]Q2007	X	Ethanolamine oleate, 1000 ml	7026				$2.13
[3]Q2008	X	Fomepizole, 1.5 G	7027				$141.29
[3]Q2009	X	Fosphenytoin, 50 mg	7028				$.78
[3]Q2010	X	Glatiramer acetate, 25 mgeny	7029				$3.59
[3]Q2011	X	Hemin, 1 mg	7030				$.10
[3]Q2012	X	Pegademase bovine inj 25 I.U	7039				$1.16
[3]Q2013	X	Pentastarch 10% inj, 100 ml	7040				$2.04
[3]Q2014	X	Sermorelin acetate, 0.5 mg	7032				$53.34
[3]Q2015	X	Somatrem, 5 mg	7033				$28.03
[3]Q2016	X	Somatropin, 1 mg	7034				$5.04
[3]Q2017	X	Teniposide, 50 mg	7035				$20.85
[3]Q2018	X	Urofollitropin, 75 I.U.	7037				$8.24
[3]Q3001	S	Brachytherapy Seeds	0918				$9.99
Q9920	A	Epoetin with hct <= 20					
Q9921	A	Epoetin with hct = 21					
Q9922	A	Epoetin with hct = 22					
Q9923	A	Epoetin with hct = 23					
Q9924	A	Epoetin with hct = 24					
Q9925	A	Epoetin with hct = 25					
Q9926	A	Epoetin with hct = 26					
Q9927	A	Epoetin with hct = 27					
Q9928	A	Epoetin with hct = 28					
Q9929	A	Epoetin with hct = 29					
Q9930	A	Epoetin with hct = 30					
Q9931	A	Epoetin with hct = 31					
Q9932	A	Epoetin with hct = 32					
Q9933	A	Epoetin with hct = 33					
Q9934	A	Epoetin with hct = 34					
Q9935	A	Epoetin with hct = 35					
Q9936	A	Epoetin with hct = 36					
Q9937	A	Epoetin with hct = 37					
Q9938	A	Epoetin with hct = 38					
Q9939	A	Epoetin with hct = 39					
Q9940	A	Epoetin with hct >= 40					
R0070	N	Transport portable x-ray					
R0075	N	Transport port x-ray multipl					
R0076	N	Transport portable EKG					
V2020	A	Vision svcs frames purchases					
V2025	E	Eyeglasses delux frames					
V2100	A	Lens spher single plano 4.00					
V2101	A	Single visn sphere 4.12–7.00					
V2102	A	Singl visn sphere 7.12–20.00					
V2103	A	Spherocylindr 4.00d/12–2.00d					
V2104	A	Spherocylindr 4.00d/2.12–4d					
V2105	A	Spherocylinder 4.00d/4.25–6d					
V2106	A	Spherocylinder 4.00d/>6.00d					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
V2107	A	Spherocylinder 4.25d/12–2d					
V2108	A	Spherocylinder 4.25d/2.12–4d					
V2109	A	Spherocylinder 4.25d/4.25–6d					
V2110	A	Spherocylinder 4.25d/over 6d					
V2111	A	Spherocylindr 7.25d/.25–2.25					
V2112	A	Spherocylindr 7.25d/2.25–4d					
V2113	A	Spherocylindr 7.25d/4.25–6d					
V2114	A	Spherocylinder over 12.00d					
V2115	A	Lens lenticular bifocal					
V2116	A	Nonaspheric lens bifocal					
V2117	A	Aspheric lens bifocal					
V2118	A	Lens aniseikonic single					
V2199	A	Lens single vision not oth c					
V2200	A	Lens spher bifoc plano 4.00d					
V2201	A	Lens sphere bifocal 4.12–7.0					
V2202	A	Lens sphere bifocal 7.12–20.					
V2203	A	Lens sphcyl bifocal 4.00d/.1					
V2204	A	Lens sphcy bifocal 4.00d/2.1					
V2205	A	Lens sphcy bifocal 4.00d/4.2					
V2206	A	Lens sphcy bifocal 4.00d/ove					
V2207	A	Lens sphcy bifocal 4.25–7d/.					
V2208	A	Lens sphcy bifocal 4.25–7/2.					
V2209	A	Lens sphcy bifocal 4.25–7/4.					
V2210	A	Lens sphcy bifocal 4.25–7/ov					
V2211	A	Lens sphcy bifo 7.25–12/.25–					
V2212	A	Lens sphcyl bifo 7.25–12/2.2					
V2213	A	Lens sphcyl bifo 7.25–12/4.2					
V2214	A	Lens sphcyl bifocal over 12.					
V2215	A	Lens lenticular bifocal					
V2216	A	Lens lenticular nonaspheric					
V2217	A	Lens lenticular aspheric bif					
V2218	A	Lens aniseikonic bifocal					
V2219	A	Lens bifocal seg width over					
V2220	A	Lens bifocal add over 3.25d					
V2299	A	Lens bifocal speciality					
V2300	A	Lens sphere trifocal 4.00d					
V2301	A	Lens sphere trifocal 4.12–7.					
V2302	A	Lens sphere trifocal 7.12–20					
V2303	A	Lens sphcy trifocal 4.0/.12–					
V2304	A	Lens sphcy trifocal 4.0/2.25					
V2305	A	Lens sphcy trifocal 4.0/4.25					
V2306	A	Lens sphcyl trifocal 4.00/>6					
V2307	A	Lens sphcy trifocal 4.25–7/.					
V2308	A	Lens sphc trifocal 4.25–7/2.					
V2309	A	Lens sphc trifocal 4.25–7/4.					
V2310	A	Lens sphc trifocal 4.25–7/>6					
V2311	A	Lens sphc trifo 7.25–12/.25–					
V2312	A	Lens sphc trifo 7.25–12/2.25					
V2313	A	Lens sphc trifo 7.25–12/4.25					
V2314	A	Lens sphcyl trifocal over 12					
V2315	A	Lens lenticular trifocal					
V2316	A	Lens lenticular nonaspheric					
V2317	A	Lens lenticular aspheric tri					
V2318	A	Lens aniseikonic trifocal					
V2319	A	Lens trifocal seg width > 28					
V2320	A	Lens trifocal add over 3.25d					
V2399	A	Lens trifocal speciality					
V2410	A	Lens variab asphericity sing					
V2430	A	Lens variable asphericity bi					
V2499	A	Variable asphericity lens					
V2500	A	Contact lens pmma spherical					
V2501	A	Cntct lens pmma-toric/prism					
V2502	A	Contact lens pmma bifocal					
V2503	A	Cntct lens pmma color vision					
V2510	A	Cntct gas permeable sphericl					
V2511	A	Cntct toric prism ballast					
V2512	A	Cntct lens gas permbl bifocl					
V2513	A	Contact lens extended wear					
V2520	A	Contact lens hydrophilic					
V2521	A	Cntct lens hydrophilic toric					
V2522	A	Cntct lens hydrophil bifocl					
V2523	A	Cntct lens hydrophil extend					
V2530	A	Contact lens gas impermeable					

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ADDENDUM B.—HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT STATUS BY HCPCS CODE AND RELATED INFORMATION—Continued

CPT/ HCPCS	HOPD Status Indicator	Description	APC	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
V2531	A	Contact lens gas permeable					
V2599	A	Contact lens/es other type					
V2600	A	Hand held low vision aids					
V2610	A	Single lens spectacle mount					
V2615	A	Telescop/othr compound lens					
V2623	A	Plastic eye prosth custom					
V2624	A	Polishing artifical eye					
V2625	A	Enlargemnt of eye prosthesis					
V2626	A	Reduction of eye prosthesis					
V2627	A	Scleral cover shell					
V2628	A	Fabrication & fitting					
V2629	A	Prosthetic eye other type					
V2630	N	Anter chamber intraocul lens					
V2631	N	Iris support intraoclr lens					
V2632	N	Post chmbr intraocular lens					
V2700	A	Balance lens					
V2710	A	Glass/plastic slab off prism					
V2715	A	Prism lens/es					
V2718	A	Fresnell prism press-on lens					
V2730	A	Special base curve					
V2740	A	Rose tint plastic					
V2741	A	Non-rose tint plastic					
V2742	A	Rose tint glass					
V2743	A	Non-rose tint glass					
V2744	A	Tint photochromatic lens/es					
V2750	A	Anti-reflective coating					
V2755	A	UV lens/es					
V2760	A	Scratch resistant coating					
V2770	A	Occluder lens/es					
V2780	A	Oversize lens/es					
V2781	A	Progressive lens per lens					
V2785	A	Corneal tissue processing					
V2799	A	Miscellaneous vision service					
V5008	E	Hearing screening					
V5010	E	Assessment for hearing aid					
V5011	E	Hearing aid fitting/checking					
V5014	E	Hearing aid repair/modifying					
V5020	E	Conformity evaluation					
V5030	E	Body-worn hearing aid air					
V5040	E	Body-worn hearing aid bone					
V5050	E	Body-worn hearing aid in ear					
V5060	E	Behind ear hearing aid					
V5070	E	Glasses air conduction					
V5080	E	Glasses bone conduction					
V5090	E	Hearing aid dispensing fee					
V5100	E	Body-worn bilat hearing aid					
V5110	E	Hearing aid dispensing fee					
V5120	E	Body-worn binaur hearing aid					
V5130	E	In ear binaural hearing aid					
V5140	E	Behind ear binaur hearing ai					
V5150	E	Glasses binaural hearing aid					
V5160	E	Dispensing fee binaural					
V5170	E	Within ear cros hearing aid					
V5180	E	Behind ear cros hearing aid					
V5190	E	Glasses cros hearing aid					
V5200	E	Cros hearing aid dispens fee					
V5210	E	In ear bicros hearing aid					
V5220	E	Behind ear bicros hearing ai					
V5230	E	Glasses bicros hearing aid					
V5240	E	Dispensing fee bicros					
V5299	A	Hearing service					
V5336	E	Repair communication device					
V5362	A	Speech screening					
V5363	A	Language screening					
V5364	A	Dysphagia screening					

ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0001		Photochemotherapy	S	0.47	$22.79	$8.49	$4.56

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	96900	Ultraviolet light therapy					
	96910	Photochemotherapy with UV–B					
	96912	Photochemotherapy with UV–A					
	96913	Photochemotherapy, UV–A or B					
	96999	Dermatological procedure					
0002	Fine needle Biopsy/Aspiration		T	0.62	$30.06	$17.66	$6.01
	60001	Aspirate/inject thyriod cyst					
	88170	Fine needle aspiration					
	88171	Fine needle aspiration					
0003	Bone Marrow Biopsy/Aspiration		T	0.98	$47.52	$27.99	$9.50
	85095	Bone marrow aspiration					
	85102	Bone marrow biopsy					
0004	Level I Needle Biopsy/Aspiration Except Bone Marrow		T	1.84	$89.22	$32.57	$17.84
	17999	Skin tissue procedure					
	19000	Drainage of breast lesion					
	19001	Drain breast lesion add-on					
	20615	Treatment of bone cyst					
	42400	Biopsy of salivary gland					
	54800	Biopsy of epididymis					
	55000	Drainage of hydrocele					
	60100	Biopsy of thyroid					
	60699	Endocrine surgery procedure					
0005	Level II Needle Biopsy/Aspiration Except Bone Marrow		T	5.41	$262.32	$119.75	$52.46
	19100	Biopsy of breast					
	20206	Needle biopsy, muscle					
	32400	Needle biopsy chest lining					
	32405	Biopsy, lung or mediastinum					
	38505	Needle biopsy, lymph nodes					
	47000	Needle biopsy of liver					
	47399	Liver surgery procedure					
	48102	Needle biopsy, pancreas					
	48999	Pancreas surgery procedure					
	49180	Biopsy, abdominal mass					
	50200	Biopsy of kidney					
	50390	Drainage of kidney lesion					
	54500	Biopsy of testis					
	62269	Needle biopsy, spinal cord					
0006	Level I Incision & Drainage		T	2.00	$96.97	$33.95	$19.39
	10040	Acne surgery of skin abscess					
	10060	Drainage of skin abscess					
	10061	Drainage of skin abscess					
	10080	Drainage of pilonidal cyst					
	10120	Remove foreign body					
	10160	Puncture drainage of lesion					
	20000	Incision of abscess					
	26010	Drainage of finger abscess					
	69000	Drain external ear lesion					
	69020	Drain outer ear canal lesion					
0007	Level II Incision & Drainage		T	3.68	$178.43	$72.03	$35.69
	10081	Drainage of pilonidal cyst					
	10140	Drainage of hematoma/fluid					
	10180	Complex drainage, wound					
	26011	Drainage of finger abscess					
	69005	Drain external ear lesion					
0008	Level III Incision & Drainage		T	6.15	$298.20	$113.67	$59.64
	19020	Incision of breast lesion					
	20950	Fluid pressure, muscle					
	21501	Drain neck/chest lesion					
	21700	Revision of neck muscle					
	21720	Revision of neck muscle					
	21725	Revision of neck muscle					
	23030	Drain shoulder lesion					
	23031	Drain shoulder bursa					
	23930	Drainage of arm lesion					
	23931	Drainage of arm bursa					
	27301	Drain thigh/knee lesion					
	27603	Drain lower leg lesion					
	28001	Drainage of bursa of foot					
	38300	Drainage, lymph node lesion					
	38305	Drainage, lymph node lesion					
	38999	Blood/lymph system procedure					
	51080	Drainage of bladder abscess					
	54015	Drain penis lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	54115	Treatment of penis lesion					
	55100	Drainage of scrotum abscess					
0009	Nail Procedures		T	0.74	$35.88	$9.63	$7.18
	11719	Trim nail(s)					
	11720	Debride nail, 1–5					
	11721	Debride nail, 6 or more					
	11740	Drain blood from under nail					
	G0127	Trim nail(s)					
0010	Level I Destruction of Lesion		T	0.55	$26.67	$9.86	$5.33
	17000	Destroy benign/premal lesion					
	17003	Destroy lesions, 2–14					
	17110	Destruct lesion, 1–14					
0011	Level II Destruction of Lesion		T	2.72	$131.88	$50.01	$26.38
	17004	Destroy lesions, 15 or more					
	17106	Destruction of skin lesions					
	17107	Destruction of skin lesions					
	17108	Destruction of skin lesions					
	17111	Destruct lesion, 15 or more					
0012	Level I Debridement & Destruction		T	0.53	$25.70	$9.18	$5.14
	11732	Remove nail plate, add-on					
	11900	Injection into skin lesions					
	15852	Dressing change, not for burn					
	17340	Cryotherapy of skin					
	69220	Clean out mastoid cavity					
0013	Level II Debridement & Destruction		T	0.91	$44.12	$17.66	$8.82
	11300	Shave skin lesion					
	11301	Shave skin lesion					
	11305	Shave skin lesion					
	11306	Shave skin lesion					
	11310	Shave skin lesion					
	11311	Shave skin lesion					
	11730	Removal of nail plate					
	11901	Added skin lesions injection					
	15786	Abrasion, lesion, single					
	15788	Chemical peel, face, epiderm					
	15850	Removal of sutures					
	15851	Removal of sutures					
	17260	Destruction of skin lesions					
	17261	Destruction of skin lesions					
	17262	Destruction of skin lesions					
	17263	Destruction of skin lesions					
	17271	Destruction of skin lesions					
	17272	Destruction of skin lesions					
	54050	Destruction, penis lesion(s)					
	54056	Cryosurgery, penis lesion(s)					
0014	Level III Debridement & Destruction		T	1.50	$72.73	$24.55	$14.55
	11302	Shave skin lesion					
	11307	Shave skin lesion					
	16025	Treatment of burn(s)					
	17250	Chemical cautery, tissue					
	46917	Laser surgery, anal lesions					
0015	Level IV Debridement & Destruction		T	1.77	$85.82	$31.20	$17.16
	11000	Debride infected skin					
	11001	Debride infected skin add-on					
	11040	Debride skin, partial					
	11041	Debride skin, full					
	11055	Trim skin lesion					
	11056	Trim skin lesions, 2 to 4					
	11057	Trim skin lesions, over 4					
	11200	Removal of skin tags					
	11201	Remove skin tags add-on					
	11303	Shave skin lesion					
	11308	Shave skin lesion					
	11312	Shave skin lesion					
	11765	Excision of nail fold, toe					
	15783	Abrasion treatment of skin					
	15789	Chemical peel, face, dermal					
	16000	Initial treatment of burn(s)					
	16010	Treatment of burn(s)					
	16020	Treatment of burn(s)					
	16030	Treatment of burn(s)					
	17264	Destruction of skin lesions					
	17270	Destruction of skin lesions					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	17273	Destruction of skin lesions					
	17274	Destruction of skin lesions					
	17276	Destruction of skin lesions					
	17280	Destruction of skin lesions					
	17281	Destruction of skin lesions					
	17282	Destruction of skin lesions					
	17283	Destruction of skin lesions					
0016	Level V Debridement & Destruction		T	3.53	$171.16	$74.67	$34.23
	11042	Debride skin/tissue					
	11043	Debride tissue/muscle					
	11313	Shave skin lesion					
	15787	Abrasion, lesions, add-on					
	15792	Chemical peel, nonfacial					
	15793	Chemical peel, nonfacial					
	15810	Salabrasion					
	17266	Destruction of skin lesions					
	17284	Destruction of skin lesions					
	17286	Destruction of skin lesions					
	17360	Skin peel therapy					
	17380	Hair removal by electrolysis					
	46900	Destruction, anal lesion(s)					
	46910	Destruction, anal lesion(s)					
	46916	Cryosurgery, anal lesion(s)					
	54055	Destruction, penis lesion(s)					
	56501	Destruction, vulva lesion(s)					
0017	Level VI Debridement & Destruction		T	12.45	$603.66	$289.16	$120.73
	11044	Debride tissue/muscle/bone					
	16015	Treatment of burn(s)					
	46922	Excision of anal lesion(s)					
	46924	Destruction, anal lesion(s)					
	54057	Laser surg, penis lesion(s)					
	54060	Excision of penis lesion(s)					
	54065	Destruction, penis lesion(s)					
	56515	Destruction, vulva lesion(s)					
0018	Biopsy Skin, Subcutaneous Tissue or Mucous Membrane		T	0.94	$45.58	$17.66	$9.12
	11100	Biopsy of skin lesion					
	11101	Biopsy, skin add-on					
0019	Level I Excision/Biopsy		T	4.00	$193.95	$78.91	$38.79
	11400	Removal of skin lesion					
	11401	Removal of skin lesion					
	11402	Removal of skin lesion					
	11420	Removal of skin lesion					
	11421	Removal of skin lesion					
	11422	Removal of skin lesion					
	11440	Removal of skin lesion					
	11441	Removal of skin lesion					
	11442	Removal of skin lesion					
	11600	Removal of skin lesion					
	11601	Removal of skin lesion					
	11602	Removal of skin lesion					
	11620	Removal of skin lesion					
	11621	Removal of skin lesion					
	11622	Removal of skin lesion					
	11640	Removal of skin lesion					
	11641	Removal of skin lesion					
	11642	Removal of skin lesion					
	11750	Removal of nail bed					
	11755	Biopsy, nail unit					
	11976	Removal of contraceptive cap					
	20220	Bone biopsy, trocar/needle					
	20520	Removal of foreign body					
	21550	Biopsy of neck/chest					
	23330	Remove shoulder foreign body					
	24200	Removal of arm foreign body					
	27086	Remove hip foreign body					
	28190	Removal of foot foreign body					
	56605	Biopsy of vulva/perineum					
	56606	Biopsy of vulva/perineum					
	58999	Genital surgery procedure					
	69100	Biopsy of external ear					
0020	Level II Excision/Biopsy		T	6.51	$315.65	$130.53	$63.13
	10121	Remove foreign body					
	11403	Removal of skin lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	11404	Removal of skin lesion					
	11406	Removal of skin lesion					
	11423	Removal of skin lesion					
	11424	Removal of skin lesion					
	11443	Removal of skin lesion					
	11444	Removal of skin lesion					
	11603	Removal of skin lesion					
	11604	Removal of skin lesion					
	11623	Removal of skin lesion					
	11624	Removal of skin lesion					
	11643	Removal of skin lesion					
	11644	Removal of skin lesion					
	16035	Incision of burn scab					
	17304	Chemosurgery of skin lesion					
	17305	2nd stage chemosurgery					
	17306	3rd stage chemosurgery					
	17307	Followup skin lesion therapy					
	17310	Extensive skin chemosurgery					
	20200	Muscle biopsy					
	20225	Bone biopsy, trocar/needle					
	21920	Biopsy soft tissue of back					
	24065	Biopsy arm/elbow soft tissue					
	24066	Biopsy arm/elbow soft tissue					
	25065	Biopsy forearm soft tissues					
	25075	Removal of forearm lesion					
	26320	Removal of implant from hand					
	27613	Biopsy lower leg soft tissue					
	28193	Removal of foot foreign body					
	37609	Temporal artery procedure					
	37799	Vascular surgery procedure					
	54100	Biopsy of penis					
	69110	Remove external ear, partial					
	69145	Remove ear canal lesion(s)					
0021	Level III Excision/Biopsy		T	10.49	$508.63	$236.51	$101.73
	11606	Removal of skin lesion					
	11770	Removal of pilonidal lesion					
	20205	Deep muscle biopsy					
	20670	Removal of support implant					
	23000	Removal of calcium deposits					
	23065	Biopsy shoulder tissues					
	23075	Removal of shoulder lesion					
	24075	Remove arm/elbow lesion					
	24201	Removal of arm foreign body					
	27040	Biopsy of soft tissues					
	27323	Biopsy, thigh soft tissues					
	27618	Remove lower leg lesion					
	28043	Excision of foot lesion					
	28192	Removal of foot foreign body					
	54105	Biopsy of penis					
0022	Level IV Excision/Biopsy		T	12.49	$605.60	$292.94	$121.12
	11010	Debride skin, fx					
	11011	Debride skin/muscle, fx					
	11012	Debride skin/muscle/bone, fx					
	11426	Removal of skin lesion					
	11446	Removal of skin lesion					
	11450	Removal, sweat gland lesion					
	11451	Removal, sweat gland lesion					
	11462	Removal, sweat gland lesion					
	11463	Removal, sweat gland lesion					
	11470	Removal, sweat gland lesion					
	11471	Removal, sweat gland lesion					
	11626	Removal of skin lesion					
	11646	Removal of skin lesion					
	11752	Remove nail bed/finger tip					
	11771	Removal of pilonidal lesion					
	11772	Removal of pilonidal lesion					
	11971	Remove tissue expander(s)					
	15780	Abrasion treatment of skin					
	15781	Abrasion treatment of skin					
	15782	Abrasion treatment of skin					
	15811	Salabrasion					
	15838	Excise excessive skin tissue					
	15920	Removal of tail bone ulcer					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	15931	Remove sacrum pressure sore					
	15933	Remove sacrum pressure sore					
	15940	Remove hip pressure sore					
	15941	Remove hip pressure sore					
	15950	Remove thigh pressure sore					
	15951	Remove thigh pressure sore					
	15999	Removal of pressure sore					
	20240	Bone biopsy, excisional					
	20245	Bone biopsy, excisional					
	20525	Removal of foreign body					
	20680	Removal of support implant					
	21555	Remove lesion, neck/chest					
	21556	Remove lesion, neck/chest					
	21925	Biopsy soft tissue of back					
	21930	Remove lesion, back or flank					
	21935	Remove tumor, back					
	22900	Remove abdominal wall lesion					
	22999	Abdomen surgery procedure					
	23066	Biopsy shoulder tissues					
	23076	Removal of shoulder lesion					
	23077	Remove tumor of shoulder					
	23331	Remove shoulder foreign body					
	24076	Remove arm/elbow lesion					
	24077	Remove tumor of arm/elbow					
	25066	Biopsy forearm soft tissues					
	25076	Removal of forearm lesion					
	25077	Remove tumor, forearm/wrist					
	26115	Removal of hand lesion					
	26116	Removal of hand lesion					
	26117	Remove tumor, hand/finger					
	27041	Biopsy of soft tissues					
	27047	Remove hip/pelvis lesion					
	27048	Remove hip/pelvis lesion					
	27049	Remove tumor, hip/pelvis					
	27324	Biopsy, thigh soft tissues					
	27327	Removal of thigh lesion					
	27328	Removal of thigh lesion					
	27329	Remove tumor, thigh/knee					
	27372	Removal of foreign body					
	27614	Biopsy lower leg soft tissue					
	27619	Remove lower leg lesion					
	69205	Clear outer ear canal					
0023	Exploration Penetrating Wound		T	1.98	$96.00	$40.37	$19.20
	20100	Explore wound, neck					
	20103	Explore wound, extremity					
0024	Level I Skin Repair		T	2.43	$117.82	$44.50	$23.56
	11760	Repair of nail bed					
	11762	Reconstruction of nail bed					
	11920	Correct skin color defects					
	11921	Correct skin color defects					
	11922	Correct skin color defects					
	11950	Therapy for contour defects					
	11951	Therapy for contour defects					
	11952	Therapy for contour defects					
	11954	Therapy for contour defects					
	12001	Repair superficial wound(s)					
	12002	Repair superficial wound(s)					
	12004	Repair superficial wound(s)					
	12005	Repair superficial wound(s)					
	12006	Repair superficial wound(s)					
	12007	Repair superficial wound(s)					
	12011	Repair superficial wound(s)					
	12013	Repair superficial wound(s)					
	12014	Repair superficial wound(s)					
	12015	Repair superficial wound(s)					
	12016	Repair superficial wound(s)					
	12017	Repair superficial wound(s)					
	12018	Repair superficial wound(s)					
	12020	Closure of split wound					
	12021	Closure of split wound					
	12031	Layer closure of wound(s)					
	12032	Layer closure of wound(s)					
	12034	Layer closure of wound(s)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	12035	Layer closure of wound(s)					
	12036	Layer closure of wound(s)					
	12041	Layer closure of wound(s)					
	12042	Layer closure of wound(s)					
	12044	Layer closure of wound(s)					
	12045	Layer closure of wound(s)					
	12046	Layer closure of wound(s)					
	12051	Layer closure of wound(s)					
	12052	Layer closure of wound(s)					
	12053	Layer closure of wound(s)					
	12054	Layer closure of wound(s)					
	12055	Layer closure of wound(s)					
	12056	Layer closure of wound(s)					
0025	Level II Skin Repair		T	3.74	$181.34	$70.66	$36.27
	13100	Repair of wound or lesion					
	13101	Repair of wound or lesion					
	13102	Repair wound/lesion add-on					
	13120	Repair of wound or lesion					
	13121	Repair of wound or lesion					
	13122	Repair wound/lesion add-on					
	13131	Repair of wound or lesion					
	13132	Repair of wound or lesion					
	13133	Repair wound/lesion add-on					
	13151	Repair of wound or lesion					
	13152	Repair of wound or lesion					
	13153	Repair wound/lesion add-on					
	43870	Repair stomach opening					
0026	Level III Skin Repair		T	12.11	$587.18	$277.92	$117.44
	11960	Insert tissue expander(s)					
	11970	Replace tissue expander					
	12037	Layer closure of wound(s)					
	12047	Layer closure of wound(s)					
	12057	Layer closure of wound(s)					
	13150	Repair of wound or lesion					
	13160	Late closure of wound					
	14000	Skin tissue rearrangement					
	14001	Skin tissue rearrangement					
	14020	Skin tissue rearrangement					
	14021	Skin tissue rearrangement					
	14040	Skin tissue rearrangement					
	14041	Skin tissue rearrangement					
	14060	Skin tissue rearrangement					
	14061	Skin tissue rearrangement					
	14300	Skin tissue rearrangement					
	14350	Skin tissue rearrangement					
	15000	Skin graft					
	15001	Skin graft add-on					
	15050	Skin pinch graft					
	15100	Skin split graft					
	15101	Skin split graft add-on					
	15120	Skin split graft					
	15121	Skin split graft add-on					
	15200	Skin full graft					
	15201	Skin full graft add-on					
	15220	Skin full graft					
	15221	Skin full graft add-on					
	15240	Skin full graft					
	15241	Skin full graft add-on					
	15260	Skin full graft					
	15261	Skin full graft add-on					
	15350	Skin homograft					
	15351	Skin homograft add-on					
	15400	Skin heterograft					
	15401	Skin heterograft add-on					
	15570	Form skin pedicle flap					
	15572	Form skin pedicle flap					
	15574	Form skin pedicle flap					
	15576	Form skin pedicle flap					
	15600	Skin graft					
	15610	Skin graft					
	15620	Skin graft					
	15630	Skin graft					
	15650	Transfer skin pedicle flap					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	15775	Hair transplant punch grafts					
	15776	Hair transplant punch grafts					
	15819	Plastic surgery, neck					
	15820	Revision of lower eyelid					
	15821	Revision of lower eyelid					
	15822	Revision of upper eyelid					
	15823	Revision of upper eyelid					
	15825	Removal of neck wrinkles					
	15829	Removal of skin wrinkles					
	15835	Excise excessive skin tissue					
	20101	Explore wound, chest					
	20102	Explore wound, abdomen					
	20910	Remove cartilage for graft					
	20912	Remove cartilage for graft					
	20920	Removal of fascia for graft					
	20922	Removal of fascia for graft					
	20926	Removal of tissue for graft					
	23921	Amputation follow-up surgery					
	25929	Amputation follow-up surgery					
	33222	Revise pocket, pacemaker					
	33223	Revise pocket, pacing-defib					
	44312	Revision of ileostomy					
	44340	Revision of colostomy					
	G0168	Wound closure by adhesive					
	G0169	Removal tissue; no anesthsia					
	G0170	Skin biograft					
	G0171	Skin biograft add-on					
0027	Level IV Skin Repair		T	15.80	$766.10	$383.10	$153.22
	15732	Muscle-skin graft, head/neck					
	15734	Muscle-skin graft, trunk					
	15736	Muscle-skin graft, arm					
	15738	Muscle-skin graft, leg					
	15740	Island pedicle flap graft					
	15750	Neurovascular pedicle graft					
	15760	Composite skin graft					
	15770	Derma-fat-fascia graft					
	15824	Removal of forehead wrinkles					
	15826	Removal of brow wrinkles					
	15828	Removal of face wrinkles					
	15831	Excise excessive skin tissue					
	15832	Excise excessive skin tissue					
	15833	Excise excessive skin tissue					
	15834	Excise excessive skin tissue					
	15836	Excise excessive skin tissue					
	15837	Excise excessive skin tissue					
	15839	Excise excessive skin tissue					
	15840	Graft for face nerve palsy					
	15841	Graft for face nerve palsy					
	15842	Graft for face nerve palsy					
	15845	Skin and muscle repair, face					
	15876	Suction assisted lipectomy					
	15877	Suction assisted lipectomy					
	15878	Suction assisted lipectomy					
	15879	Suction assisted lipectomy					
	15922	Removal of tail bone ulcer					
	15934	Remove sacrum pressure sore					
	15935	Remove sacrum pressure sore					
	15936	Remove sacrum pressure sore					
	15937	Remove sacrum pressure sore					
	15944	Remove hip pressure sore					
	15945	Remove hip pressure sore					
	15946	Remove hip pressure sore					
	15952	Remove thigh pressure sore					
	15953	Remove thigh pressure sore					
	15956	Remove thigh pressure sore					
	15958	Remove thigh pressure sore					
0029	Incision/Excision Breast		T	12.85	$623.06	$303.50	$124.61
	19101	Biopsy of breast					
	19110	Nipple exploration					
	19112	Excise breast duct fistula					
	19120	Removal of breast lesion					
	19125	Excision, breast lesion					
	19126	Excision, addl breast lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	19140	Removal of breast tissue					
	19290	Place needle wire, breast					
	19291	Place needle wire, breast					
	19396	Design custom breast implant					
	19499	Breast surgery procedure					
0030	Breast Reconstruction/Mastectomy		T	20.19	$978.95	$523.95	$195.79
	19160	Removal of breast tissue					
	19162	Remove breast tissue, nodes					
	19180	Removal of breast					
	19182	Removal of breast					
	19316	Suspension of breast					
	19318	Reduction of large breast					
	19324	Enlarge breast					
	19325	Enlarge breast with implant					
	19328	Removal of breast implant					
	19330	Removal of implant material					
	19340	Immediate breast prosthesis					
	19342	Delayed breast prosthesis					
	19350	Breast reconstruction					
	19355	Correct inverted nipple(s)					
	19357	Breast reconstruction					
	19366	Breast reconstruction					
	19370	Surgery of breast capsule					
	19371	Removal of breast capsule					
	19380	Revise breast reconstruction					
0031	Hyperbaric Oxygen		S	3.00	$145.46	$140.85	$29.09
	99183	Hyperbaric oxygen therapy					
	G0167	Hyperbaric oz tx; no md reqrd					
0032	Placement Transvenous Catheters/Arterial Cutdown		T	5.40	$261.83	$119.52	$52.37
	36420	Establish access to vein					
	36425	Establish access to vein					
	36488	Insertion of catheter, vein					
	36489	Insertion of catheter, vein					
	36490	Insertion of catheter, vein					
	36491	Insertion of catheter, vein					
	36493	Repositioning of cvc					
	36640	Insertion catheter, artery					
0033	Partial Hospitalization		P	4.17	$202.19	$48.17	$40.44
	G0129	Partial hosp prog service					
	G0172	Partial hosp prog service					
	Q0082	Activity therapy w/partial h					
0040	Arthrocentesis & Ligament/Tendon Injection		T	2.11	$102.31	$40.60	$20.46
	20550	Inject tendon/ligament/cyst					
	20600	Drain/inject, joint/bursa					
	20605	Drain/inject, joint/bursa					
	20610	Drain/inject, joint/bursa					
0041	Arthroscopy		T	24.57	$1,191.33	$592.08	$238.27
	29800	Jaw arthroscopy/surgery					
	29804	Jaw arthroscopy/surgery					
	29815	Shoulder arthroscopy					
	29819	Shoulder arthroscopy/surgery					
	29820	Shoulder arthroscopy/surgery					
	29821	Shoulder arthroscopy/surgery					
	29822	Shoulder arthroscopy/surgery					
	29823	Shoulder arthroscopy/surgery					
	29825	Shoulder arthroscopy/surgery					
	29826	Shoulder arthroscopy/surgery					
	29830	Elbow arthroscopy					
	29834	Elbow arthroscopy/surgery					
	29835	Elbow arthroscopy/surgery					
	29836	Elbow arthroscopy/surgery					
	29837	Elbow arthroscopy/surgery					
	29838	Elbow arthroscopy/surgery					
	29840	Wrist arthroscopy					
	29843	Wrist arthroscopy/surgery					
	29844	Wrist arthroscopy/surgery					
	29845	Wrist arthroscopy/surgery					
	29846	Wrist arthroscopy/surgery					
	29847	Wrist arthroscopy/surgery					
	29848	Wrist endoscopy/surgery					
	29860	Hip arthroscopy, dx					
	29861	Hip arthroscopy/surgery					
	29862	Hip arthroscopy/surgery					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	29863	Hip arthroscopy/surgery					
	29870	Knee arthroscopy, dx					
	29871	Knee arthroscopy/drainage					
	29874	Knee arthroscopy/surgery					
	29875	Knee arthroscopy/surgery					
	29876	Knee arthroscopy/surgery					
	29877	Knee arthroscopy/surgery					
	29879	Knee arthroscopy/surgery					
	29880	Knee arthroscopy/surgery					
	29881	Knee arthroscopy/surgery					
	29882	Knee arthroscopy/surgery					
	29883	Knee arthroscopy/surgery					
	29884	Knee arthroscopy/surgery					
	29886	Knee arthroscopy/surgery					
	29887	Knee arthroscopy/surgery					
	29891	Ankle arthroscopy/surgery					
	29894	Ankle arthroscopy/surgery					
	29895	Ankle arthroscopy/surgery					
	29897	Ankle arthroscopy/surgery					
	29898	Ankle arthroscopy/surgery					
	29909	Arthroscopy of joint					
0042		Arthroscopically-Aided Procedures	T	29.22	$1,416.79	$804.74	$283.36
	29850	Knee arthroscopy/surgery					
	29851	Knee arthroscopy/surgery					
	29855	Tibial arthroscopy/surgery					
	29856	Tibial arthroscopy/surgery					
	29885	Knee arthroscopy/surgery					
	29888	Knee arthroscopy/surgery					
	29889	Knee arthroscopy/surgery					
	29892	Ankle arthroscopy/surgery					
0043		Closed Treatment Fracture Finger/Toe/Trunk	T	1.64	$79.52	$25.46	$15.90
	21800	Treatment of rib fracture					
	21820	Treat sternum fracture					
	22305	Treat spine process fracture					
	22310	Treat spine fracture					
	22315	Treat spine fracture					
	22899	Spine surgery procedure					
	23500	Treat clavicle fracture					
	23505	Treat clavicle fracture					
	23520	Treat clavicle dislocation					
	23525	Treat clavicle dislocation					
	23540	Treat clavicle dislocation					
	23545	Treat clavicle dislocation					
	23570	Treat shoulder blade fx					
	23575	Treat shoulder blade fx					
	23650	Treat shoulder dislocation					
	23929	Shoulder surgery procedure					
	26700	Treat knuckle dislocation					
	26720	Treat finger fracture, each					
	26725	Treat finger fracture, each					
	26740	Treat finger fracture, each					
	26750	Treat finger fracture, each					
	26755	Treat finger fracture, each					
	26770	Treat finger dislocation					
	26989	Hand/finger surgery					
	27200	Treat tail bone fracture					
	27299	Pelvis/hip joint surgery					
	28490	Treat big toe fracture					
	28495	Treat big toe fracture					
	28510	Treatment of toe fracture					
	28515	Treatment of toe fracture					
	28630	Treat toe dislocation					
	28660	Treat toe dislocation					
	28899	Foot/toes surgery procedure					
0044		Closed Treatment Fracture/Dislocation Except Finger/Toe/Trunk	T	2.17	$105.22	$38.08	$21.04
	23600	Treat humerus fracture					
	23605	Treat humerus fracture					
	23620	Treat humerus fracture					
	23625	Treat humerus fracture					
	23665	Treat dislocation/fracture					
	23675	Treat dislocation/fracture					
	24500	Treat humerus fracture					
	24505	Treat humerus fracture					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	24530	Treat humerus fracture					
	24535	Treat humerus fracture					
	24560	Treat humerus fracture					
	24565	Treat humerus fracture					
	24576	Treat humerus fracture					
	24577	Treat humerus fracture					
	24600	Treat elbow dislocation					
	24620	Treat elbow fracture					
	24640	Treat elbow dislocation					
	24650	Treat radius fracture					
	24655	Treat radius fracture					
	24670	Treat ulnar fracture					
	24675	Treat ulnar fracture					
	24999	Upper arm/elbow surgery					
	25500	Treat fracture of radius					
	25505	Treat fracture of radius					
	25520	Treat fracture of radius					
	25530	Treat fracture of ulna					
	25535	Treat fracture of ulna					
	25560	Treat fracture radius & ulna					
	25565	Treat fracture radius & ulna					
	25600	Treat fracture radius/ulna					
	25605	Treat fracture radius/ulna					
	25622	Treat wrist bone fracture					
	25624	Treat wrist bone fracture					
	25630	Treat wrist bone fracture					
	25635	Treat wrist bone fracture					
	25650	Treat wrist bone fracture					
	25660	Treat wrist dislocation					
	25675	Treat wrist dislocation					
	25680	Treat wrist fracture					
	25690	Treat wrist dislocation					
	25999	Forearm or wrist surgery					
	26600	Treat metacarpal fracture					
	26605	Treat metacarpal fracture					
	26607	Treat metacarpal fracture					
	26641	Treat thumb dislocation					
	26645	Treat thumb fracture					
	26670	Treat hand dislocation					
	26706	Pin knuckle dislocation					
	26742	Treat finger fracture, each					
	27193	Treat pelvic ring fracture					
	27220	Treat hip socket fracture					
	27230	Treat thigh fracture					
	27238	Treat thigh fracture					
	27246	Treat thigh fracture					
	27250	Treat hip dislocation					
	27256	Treat hip dislocation					
	27265	Treat hip dislocation					
	27500	Treatment of thigh fracture					
	27501	Treatment of thigh fracture					
	27502	Treatment of thigh fracture					
	27503	Treatment of thigh fracture					
	27508	Treatment of thigh fracture					
	27510	Treatment of thigh fracture					
	27516	Treat thigh fx growth plate					
	27517	Treat thigh fx growth plate					
	27520	Treat kneecap fracture					
	27530	Treat knee fracture					
	27532	Treat knee fracture					
	27538	Treat knee fracture(s)					
	27550	Treat knee dislocation					
	27560	Treat kneecap dislocation					
	27599	Leg surgery procedure					
	27750	Treatment of tibia fracture					
	27752	Treatment of tibia fracture					
	27760	Treatment of ankle fracture					
	27762	Treatment of ankle fracture					
	27780	Treatment of fibula fracture					
	27781	Treatment of fibula fracture					
	27786	Treatment of ankle fracture					
	27788	Treatment of ankle fracture					
	27808	Treatment of ankle fracture					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	27810	Treatment of ankle fracture					
	27816	Treatment of ankle fracture					
	27818	Treatment of ankle fracture					
	27824	Treat lower leg fracture					
	27825	Treat lower leg fracture					
	27830	Treat lower leg dislocation					
	27840	Treat ankle dislocation					
	27899	Leg/ankle surgery procedure					
	28400	Treatment of heel fracture					
	28405	Treatment of heel fracture					
	28430	Treatment of ankle fracture					
	28435	Treatment of ankle fracture					
	28450	Treat midfoot fracture, each					
	28455	Treat midfoot fracture, each					
	28470	Treat metatarsal fracture					
	28475	Treat metatarsal fracture					
	28530	Treat sesamoid bone fracture					
	28540	Treat foot dislocation					
	28570	Treat foot dislocation					
	28600	Treat foot dislocation					
0045	Bone/Joint Manipulation Under Anesthesia		T	11.02	$534.33	$277.12	$106.87
	22505	Manipulation of spine					
	23655	Treat shoulder dislocation					
	23700	Fixation of shoulder					
	24605	Treat elbow dislocation					
	26675	Treat hand dislocation					
	26705	Treat knuckle dislocation					
	26775	Treat finger dislocation					
	27194	Treat pelvic ring fracture					
	27252	Treat hip dislocation					
	27257	Treat hip dislocation					
	27275	Manipulation of hip joint					
	27552	Treat knee dislocation					
	27562	Treat kneecap dislocation					
	27570	Fixation of knee joint					
	27831	Treat lower leg dislocation					
	27842	Treat ankle dislocation					
	27860	Fixation of ankle joint					
	28545	Treat foot dislocation					
	28575	Treat foot dislocation					
	28605	Treat foot dislocation					
	28635	Treat toe dislocation					
	28665	Treat toe dislocation					
0046	Open/Percutaneous Treatment Fracture or Dislocation		T	22.29	$1,080.78	$535.76	$216.16
	21336	Treat nasal septal fracture					
	21805	Treatment of rib fracture					
	23515	Treat clavicle fracture					
	23530	Treat clavicle dislocation					
	23532	Treat clavicle dislocation					
	23550	Treat clavicle dislocation					
	23552	Treat clavicle dislocation					
	23585	Treat scapula fracture					
	23615	Treat humerus fracture					
	23616	Treat humerus fracture					
	23630	Treat humerus fracture					
	23660	Treat shoulder dislocation					
	23670	Treat dislocation/fracture					
	23680	Treat dislocation/fracture					
	24515	Treat humerus fracture					
	24516	Treat humerus fracture					
	24538	Treat humerus fracture					
	24545	Treat humerus fracture					
	24546	Treat humerus fracture					
	24566	Treat humerus fracture					
	24575	Treat humerus fracture					
	24579	Treat humerus fracture					
	24582	Treat humerus fracture					
	24586	Treat elbow fracture					
	24587	Treat elbow fracture					
	24615	Treat elbow dislocation					
	24635	Treat elbow fracture					
	24665	Treat radius fracture					
	24666	Treat radius fracture					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	24685	Treat ulnar fracture					
	25515	Treat fracture of radius					
	25525	Treat fracture of radius					
	25526	Treat fracture of radius					
	25545	Treat fracture of ulna					
	25574	Treat fracture radius & ulna					
	25575	Treat fracture radius/ulna					
	25611	Treat fracture radius/ulna					
	25620	Treat fracture radius/ulna					
	25628	Treat wrist bone fracture					
	25645	Treat wrist bone fracture					
	25670	Treat wrist dislocation					
	25676	Treat wrist dislocation					
	25685	Treat wrist fracture					
	25695	Treat wrist dislocation					
	26608	Treat metacarpal fracture					
	26615	Treat metacarpal fracture					
	26650	Treat thumb fracture					
	26665	Treat thumb fracture					
	26676	Pin hand dislocation					
	26685	Treat hand dislocation					
	26686	Treat hand dislocation					
	26715	Treat knuckle dislocation					
	26727	Treat finger fracture, each					
	26735	Treat finger fracture, each					
	26746	Treat finger fracture, each					
	26756	Pin finger fracture, each					
	26765	Treat finger fracture, each					
	26776	Pin finger dislocation					
	26785	Treat finger dislocation					
	27202	Treat tail bone fracture					
	27509	Treatment of thigh fracture					
	27556	Treat knee dislocation					
	27566	Treat kneecap dislocation					
	27615	Remove tumor, lower leg					
	27756	Treatment of tibia fracture					
	27758	Treatment of tibia fracture					
	27759	Treatment of tibia fracture					
	27766	Treatment of ankle fracture					
	27784	Treatment of fibula fracture					
	27792	Treatment of ankle fracture					
	27814	Treatment of ankle fracture					
	27822	Treatment of ankle fracture					
	27823	Treatment of ankle fracture					
	27826	Treat lower leg fracture					
	27827	Treat lower leg fracture					
	27828	Treat lower leg fracture					
	27829	Treat lower leg joint					
	27832	Treat lower leg dislocation					
	27846	Treat ankle dislocation					
	27848	Treat ankle dislocation					
	28406	Treatment of heel fracture					
	28415	Treat heel fracture					
	28420	Treat/graft heel fracture					
	28436	Treatment of ankle fracture					
	28445	Treat ankle fracture					
	28456	Treat midfoot fracture					
	28465	Treat midfoot fracture, each					
	28476	Treat metatarsal fracture					
	28485	Treat metatarsal fracture					
	28496	Treat big toe fracture					
	28505	Treat big toe fracture					
	28525	Treat toe fracture					
	28531	Treat sesamoid bone fracture					
	28546	Treat foot dislocation					
	28555	Repair foot dislocation					
	28576	Treat foot dislocation					
	28585	Repair foot dislocation					
	28606	Treat foot dislocation					
	28615	Repair foot dislocation					
	28636	Treat toe dislocation					
	28645	Repair toe dislocation					
	28666	Treat toe dislocation					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	28675	Repair of toe dislocation					
0047	Arthroplasty without Prosthesis		T	22.09	$1,071.08	$537.03	$214.22
	24360	Reconstruct elbow joint					
	24365	Reconstruct head of radius					
	25332	Revise wrist joint					
	25447	Repair wrist joint(s)					
	25449	Remove wrist joint implant					
	26530	Revise knuckle joint					
	26535	Revise finger joint					
	27266	Treat hip dislocation					
	27437	Revise kneecap					
	27440	Revision of knee joint					
	27441	Revision of knee joint					
	27442	Revision of knee joint					
	27443	Revision of knee joint					
	27700	Revision of ankle joint					
0048	Arthroplasty with Prosthesis		T	29.06	$1,409.03	$725.94	$281.81
	24361	Reconstruct elbow joint					
	24362	Reconstruct elbow joint					
	24363	Replace elbow joint					
	24366	Reconstruct head of radius					
	25441	Reconstruct wrist joint					
	25442	Reconstruct wrist joint					
	25443	Reconstruct wrist joint					
	25444	Reconstruct wrist joint					
	25445	Reconstruct wrist joint					
	25446	Wrist replacement					
	26531	Revise knuckle with implant					
	26536	Revise/implant finger joint					
	27438	Revise kneecap with implant					
0049	Level I Musculoskeletal Procedures Except Hand and Foot		T	15.04	$729.25	$356.95	$145.85
	20005	Incision of deep abscess					
	20250	Open bone biopsy					
	20251	Open bone biopsy					
	20650	Insert and remove bone pin					
	20693	Adjust bone fixation device					
	20694	Remove bone fixation device					
	20975	Electrical bone stimulation					
	20979	Us bone stimulation					
	23100	Biopsy of shoulder joint					
	23140	Removal of bone lesion					
	23935	Drain arm/elbow bone lesion					
	24100	Biopsy elbow joint lining					
	24105	Removal of elbow bursa					
	24110	Remove humerus lesion					
	24120	Remove elbow lesion					
	24310	Revision of arm tendon					
	24925	Amputation follow-up surgery					
	25000	Incision of tendon sheath					
	25020	Decompression of forearm					
	25028	Drainage of forearm lesion					
	25031	Drainage of forearm bursa					
	25035	Treat forearm bone lesion					
	25085	Incision of wrist capsule					
	25100	Biopsy of wrist joint					
	25110	Remove wrist tendon lesion					
	25115	Remove wrist/forearm lesion					
	25116	Remove wrist/forearm lesion					
	25248	Remove forearm foreign body					
	25295	Release wrist/forearm tendon					
	25907	Amputation follow-up surgery					
	25922	Amputate hand at wrist					
	26990	Drainage of pelvis lesion					
	26991	Drainage of pelvis bursa					
	27000	Incision of hip tendon					
	27050	Biopsy of sacroiliac joint					
	27052	Biopsy of hip joint					
	27060	Removal of ischial bursa					
	27062	Remove femur lesion/bursa					
	27065	Removal of hip bone lesion					
	27087	Remove hip foreign body					
	27305	Incise thigh tendon & fascia					
	27306	Incision of thigh tendon					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	27307	Incision of thigh tendons					
	27340	Removal of kneecap bursa					
	27345	Removal of knee cyst					
	27347	Remove knee cyst					
	27380	Repair of kneecap tendon					
	27381	Repair/graft kneecap tendon					
	27385	Repair of thigh muscle					
	27386	Repair/graft of thigh muscle					
	27390	Incision of thigh tendon					
	27391	Incision of thigh tendons					
	27392	Incision of thigh tendons					
	27496	Decompression of thigh/knee					
	27497	Decompression of thigh/knee					
	27498	Decompression of thigh/knee					
	27499	Decompression of thigh/knee					
	27594	Amputation follow-up surgery					
	27600	Decompression of lower leg					
	27601	Decompression of lower leg					
	27602	Decompression of lower leg					
	27604	Drain lower leg bursa					
	27606	Incision of achilles tendon					
	27607	Treat lower leg bone lesion					
	27630	Removal of tendon lesion					
	27656	Repair leg fascia defect					
	27658	Repair of leg tendon, each					
	27659	Repair of leg tendon, each					
	27664	Repair of leg tendon, each					
	27675	Repair lower leg tendons					
	27704	Removal of ankle implant					
	27707	Incision of fibula					
	27884	Amputation follow-up surgery					
	27892	Decompression of leg					
	27893	Decompression of leg					
	27894	Decompression of leg					
	28002	Treatment of foot infection					
	28003	Treatment of foot infection					
0050	Level II Musculoskeletal Procedures Except Hand and Foot		T	21.13	$1,024.53	$513.86	$204.91
	20690	Apply bone fixation device					
	20692	Apply bone fixation device					
	20900	Removal of bone for graft					
	20902	Removal of bone for graft					
	20924	Removal of tendon for graft					
	21502	Drain chest lesion					
	21600	Partial removal of rib					
	21610	Partial removal of rib					
	23040	Exploratory shoulder surgery					
	23044	Exploratory shoulder surgery					
	23101	Shoulder joint surgery					
	23105	Remove shoulder joint lining					
	23106	Incision of collarbone joint					
	23107	Explore treat shoulder joint					
	23145	Removal of bone lesion					
	23146	Removal of bone lesion					
	23150	Removal of humerus lesion					
	23155	Removal of humerus lesion					
	23156	Removal of humerus lesion					
	23170	Remove collar bone lesion					
	23172	Remove shoulder blade lesion					
	23174	Remove humerus lesion					
	23180	Remove collar bone lesion					
	23182	Remove shoulder blade lesion					
	23184	Remove humerus lesion					
	23190	Partial removal of scapula					
	23405	Incision of tendon & muscle					
	23406	Incise tendon(s) & muscle(s)					
	24000	Exploratory elbow surgery					
	24006	Release elbow joint					
	24101	Explore/treat elbow joint					
	24102	Remove elbow joint lining					
	24115	Remove/graft bone lesion					
	24116	Remove/graft bone lesion					
	24125	Remove/graft bone lesion					
	24126	Remove/graft bone lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	24130	Removal of head of radius					
	24134	Removal of arm bone lesion					
	24136	Remove radius bone lesion					
	24138	Remove elbow bone lesion					
	24140	Partial removal of arm bone					
	24145	Partial removal of radius					
	24147	Partial removal of elbow					
	24160	Remove elbow joint implant					
	24164	Remove radius head implant					
	24301	Muscle/tendon transfer					
	24305	Arm tendon lengthening					
	24350	Repair of tennis elbow					
	24351	Repair of tennis elbow					
	24352	Repair of tennis elbow					
	24354	Repair of tennis elbow					
	24356	Revision of tennis elbow					
	24400	Revision of humerus					
	24410	Revision of humerus					
	24495	Decompression of forearm					
	25023	Decompression of forearm					
	25040	Explore/treat wrist joint					
	25101	Explore/treat wrist joint					
	25105	Remove wrist joint lining					
	25107	Remove wrist joint cartilage					
	25118	Excise wrist tendon sheath					
	25119	Partial removal of ulna					
	25120	Removal of forearm lesion					
	25125	Remove/graft forearm lesion					
	25126	Remove/graft forearm lesion					
	25130	Removal of wrist lesion					
	25135	Remove & graft wrist lesion					
	25136	Remove & graft wrist lesion					
	25145	Remove forearm bone lesion					
	25150	Partial removal of ulna					
	25151	Partial removal of radius					
	25230	Partial removal of radius					
	25240	Partial removal of ulna					
	25250	Removal of wrist prosthesis					
	25251	Removal of wrist prosthesis					
	25260	Repair forearm tendon/muscle					
	25263	Repair forearm tendon/muscle					
	25265	Repair forearm tendon/muscle					
	25270	Repair forearm tendon/muscle					
	25272	Repair forearm tendon/muscle					
	25274	Repair forearm tendon/muscle					
	25280	Revise wrist/forearm tendon					
	25290	Incise wrist/forearm tendon					
	25300	Fusion of tendons at wrist					
	25301	Fusion of tendons at wrist					
	25360	Revision of ulna					
	25365	Revise radius & ulna					
	25400	Repair radius or ulna					
	25415	Repair radius & ulna					
	27001	Incision of hip tendon					
	27003	Incision of hip tendon					
	27066	Removal of hip bone lesion					
	27067	Remove/graft hip bone lesion					
	27080	Removal of tail bone					
	27097	Revision of hip tendon					
	27098	Transfer tendon to pelvis					
	27310	Exploration of knee joint					
	27330	Biopsy, knee joint lining					
	27331	Explore/treat knee joint					
	27332	Removal of knee cartilage					
	27333	Removal of knee cartilage					
	27334	Remove knee joint lining					
	27335	Remove knee joint lining					
	27350	Removal of kneecap					
	27355	Remove femur lesion					
	27356	Remove femur lesion/graft					
	27357	Remove femur lesion/graft					
	27358	Remove femur lesion/fixation					
	27360	Partial removal, leg bone(s)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	27393	Lengthening of thigh tendon					
	27394	Lengthening of thigh tendons					
	27396	Transplant of thigh tendon					
	27403	Repair of knee cartilage					
	27425	Lateral retinacular release					
	27610	Explore/treat ankle joint					
	27612	Exploration of ankle joint					
	27620	Explore/treat ankle joint					
	27625	Remove ankle joint lining					
	27626	Remove ankle joint lining					
	27635	Remove lower leg bone lesion					
	27637	Remove/graft leg bone lesion					
	27638	Remove/graft leg bone lesion					
	27641	Partial removal of fibula					
	27665	Repair of leg tendon, each					
	27676	Repair lower leg tendons					
	27680	Release of lower leg tendon					
	27681	Release of lower leg tendons					
	27685	Revision of lower leg tendon					
	27686	Revise lower leg tendons					
	27687	Revision of calf tendon					
	27695	Repair of ankle ligament					
	27696	Repair of ankle ligaments					
	27698	Repair of ankle ligament					
	27709	Incision of tibia & fibula					
	27730	Repair of tibia epiphysis					
	27732	Repair of fibula epiphysis					
	27734	Repair lower leg epiphyses					
	27740	Repair of leg epiphyses					
	27889	Amputation of foot at ankle					
0051	Level III Musculoskeletal Procedures Except Hand and Foot		T	27.76	$1,346.00	$675.24	$269.20
	20150	Excise epiphyseal bar					
	23020	Release shoulder joint					
	23120	Partial removal, collar bone					
	23130	Remove shoulder bone, part					
	23415	Release of shoulder ligament					
	23480	Revision of collar bone					
	23485	Revision of collar bone					
	23490	Reinforce clavicle					
	23491	Reinforce shoulder bones					
	23800	Fusion of shoulder joint					
	23802	Fusion of shoulder joint					
	24155	Removal of elbow joint					
	24320	Repair of arm tendon					
	24330	Revision of arm muscles					
	24331	Revision of arm muscles					
	24340	Repair of biceps tendon					
	24341	Repair arm tendon/muscle					
	24342	Repair of ruptured tendon					
	24420	Revision of humerus					
	24430	Repair of humerus					
	24435	Repair humerus with graft					
	24470	Revision of elbow joint					
	24498	Reinforce humerus					
	24800	Fusion of elbow joint					
	24802	Fusion/graft of elbow joint					
	25310	Transplant forearm tendon					
	25312	Transplant forearm tendon					
	25315	Revise palsy hand tendon(s)					
	25316	Revise palsy hand tendon(s)					
	25320	Repair/revise wrist joint					
	25335	Realignment of hand					
	25337	Reconstruct ulna/radioulnar					
	25350	Revision of radius					
	25355	Revision of radius					
	25370	Revise radius or ulna					
	25375	Revise radius & ulna					
	25425	Repair/graft radius or ulna					
	25426	Repair/graft radius & ulna					
	25440	Repair/graft wrist bone					
	25450	Revision of wrist joint					
	25455	Revision of wrist joint					
	25490	Reinforce radius					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	25491	Reinforce ulna					
	25492	Reinforce radius and ulna					
	25800	Fusion of wrist joint					
	25805	Fusion/graft of wrist joint					
	25810	Fusion/graft of wrist joint					
	25830	Fusion, radioulnar jnt/ulna					
	27033	Exploration of hip joint					
	27100	Transfer of abdominal muscle					
	27105	Transfer of spinal muscle					
	27110	Transfer of iliopsoas muscle					
	27111	Transfer of iliopsoas muscle					
	27395	Lengthening of thigh tendons					
	27397	Transplants of thigh tendons					
	27400	Revise thigh muscles/tendons					
	27405	Repair of knee ligament					
	27407	Repair of knee ligament					
	27409	Repair of knee ligaments					
	27418	Repair degenerated kneecap					
	27420	Revision of unstable kneecap					
	27422	Revision of unstable kneecap					
	27424	Revision/removal of kneecap					
	27430	Revision of thigh muscles					
	27435	Incision of knee joint					
	27640	Partial removal of tibia					
	27647	Extensive ankle/heel surgery					
	27650	Repair achilles tendon					
	27652	Repair/graft achilles tendon					
	27654	Repair of achilles tendon					
	27690	Revise lower leg tendon					
	27691	Revise lower leg tendon					
	27692	Revise additional leg tendon					
	27705	Incision of tibia					
	27742	Repair of leg epiphyses					
	27745	Reinforce tibia					
	27870	Fusion of ankle joint					
	27871	Fusion of tibiofibular joint					
0052	Level IV Musculoskeletal Procedures Except Hand and Foot		T	36.16	$1,753.29	$930.91	$350.66
	23410	Repair of tendon(s)					
	23412	Repair of tendon(s)					
	23420	Repair of shoulder					
	23430	Repair biceps tendon					
	23450	Repair shoulder capsule					
	23455	Repair shoulder capsule					
	23460	Repair shoulder capsule					
	23462	Repair shoulder capsule					
	23465	Repair shoulder capsule					
	23466	Repair shoulder capsule					
	24935	Revision of amputation					
	27427	Reconstruction, knee					
	27428	Reconstruction, knee					
	27429	Reconstruction, knee					
0053	Level I Hand Musculoskeletal Procedures		T	11.32	$548.87	$253.49	$109.77
	25111	Remove wrist tendon lesion					
	25112	Reremove wrist tendon lesion					
	25820	Fusion of hand bones					
	26020	Drain hand tendon sheath					
	26025	Drainage of palm bursa					
	26030	Drainage of palm bursa(s)					
	26034	Treat hand bone lesion					
	26035	Decompress fingers/hand					
	26037	Decompress fingers/hand					
	26055	Incise finger tendon sheath					
	26060	Incision of finger tendon					
	26070	Explore/treat hand joint					
	26075	Explore/treat finger joint					
	26080	Explore/treat finger joint					
	26100	Biopsy hand joint lining					
	26105	Biopsy finger joint lining					
	26110	Biopsy finger joint lining					
	26130	Remove wrist joint lining					
	26140	Revise finger joint, each					
	26145	Tendon excision, palm/finger					
	26160	Remove tendon sheath lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	26170	Removal of palm tendon, each					
	26180	Removal of finger tendon					
	26185	Remove finger bone					
	26200	Remove hand bone lesion					
	26210	Removal of finger lesion					
	26215	Remove/graft finger lesion					
	26230	Partial removal of hand bone					
	26235	Partial removal, finger bone					
	26236	Partial removal, finger bone					
	26250	Extensive hand surgery					
	26260	Extensive finger surgery					
	26261	Extensive finger surgery					
	26262	Partial removal of finger					
	26410	Repair hand tendon					
	26418	Repair finger tendon					
	26432	Repair finger tendon					
	26433	Repair finger tendon					
	26437	Realignment of tendons					
	26440	Release palm/finger tendon					
	26445	Release hand/finger tendon					
	26450	Incision of palm tendon					
	26455	Incision of finger tendon					
	26460	Incise hand/finger tendon					
	26471	Fusion of finger tendons					
	26474	Fusion of finger tendons					
	26476	Tendon lengthening					
	26477	Tendon shortening					
	26478	Lengthening of hand tendon					
	26479	Shortening of hand tendon					
	26500	Hand tendon reconstruction					
	26508	Release thumb contracture					
	26520	Release knuckle contracture					
	26525	Release finger contracture					
	26540	Repair hand joint					
	26542	Repair hand joint with graft					
	26560	Repair of web finger					
	26587	Reconstruct extra finger					
	26593	Release muscles of hand					
	26951	Amputation of finger/thumb					
	26952	Amputation of finger/thumb					
0054	Level II Hand Musculoskeletal Procedures		T	19.66	$953.26	$472.33	$190.65
	25210	Removal of wrist bone					
	25215	Removal of wrist bones					
	25825	Fuse hand bones with graft					
	26040	Release palm contracture					
	26045	Release palm contracture					
	26121	Release palm contracture					
	26123	Release palm contracture					
	26125	Release palm contracture					
	26135	Revise finger joint, each					
	26205	Remove/graft bone lesion					
	26255	Extensive hand surgery					
	26350	Repair finger/hand tendon					
	26352	Repair/graft hand tendon					
	26356	Repair finger/hand tendon					
	26357	Repair finger/hand tendon					
	26358	Repair/graft hand tendon					
	26370	Repair finger/hand tendon					
	26372	Repair/graft hand tendon					
	26373	Repair finger/hand tendon					
	26390	Revise hand/finger tendon					
	26392	Repair/graft hand tendon					
	26412	Repair/graft hand tendon					
	26415	Excision, hand/finger tendon					
	26416	Graft hand or finger tendon					
	26420	Repair/graft finger tendon					
	26426	Repair finger/hand tendon					
	26428	Repair/graft finger tendon					
	26434	Repair/graft finger tendon					
	26442	Release palm & finger tendon					
	26449	Release forearm/hand tendon					
	26480	Transplant hand tendon					
	26483	Transplant/graft hand tendon					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	26485	Transplant palm tendon					
	26489	Transplant/graft palm tendon					
	26490	Revise thumb tendon					
	26492	Tendon transfer with graft					
	26494	Hand tendon/muscle transfer					
	26496	Revise thumb tendon					
	26497	Finger tendon transfer					
	26498	Finger tendon transfer					
	26499	Revision of finger					
	26502	Hand tendon reconstruction					
	26504	Hand tendon reconstruction					
	26510	Thumb tendon transfer					
	26516	Fusion of knuckle joint					
	26517	Fusion of knuckle joints					
	26518	Fusion of knuckle joints					
	26541	Repair hand joint with graft					
	26545	Reconstruct finger joint					
	26546	Repair nonunion hand					
	26548	Reconstruct finger joint					
	26550	Construct thumb replacement					
	26555	Positional change of finger					
	26561	Repair of web finger					
	26562	Repair of web finger					
	26565	Correct metacarpal flaw					
	26567	Correct finger deformity					
	26568	Lengthen metacarpal/finger					
	26580	Repair hand deformity					
	26585	Repair finger deformity					
	26590	Repair finger deformity					
	26591	Repair muscles of hand					
	26596	Excision constricting tissue					
	26597	Release of scar contracture					
	26820	Thumb fusion with graft					
	26841	Fusion of thumb					
	26842	Thumb fusion with graft					
	26843	Fusion of hand joint					
	26844	Fusion/graft of hand joint					
	26850	Fusion of knuckle					
	26852	Fusion of knuckle with graft					
	26860	Fusion of finger joint					
	26861	Fusion of finger jnt, add-on					
	26862	Fusion/graft of finger joint					
	26863	Fuse/graft added joint					
	26910	Amputate metacarpal bone					
0055	Level I Foot Musculoskeletal Procedures		T	15.47	$750.10	$355.34	$150.02
	27605	Incision of achilles tendon					
	28005	Treat foot bone lesion					
	28008	Incision of foot fascia					
	28010	Incision of toe tendon					
	28011	Incision of toe tendons					
	28020	Exploration of foot joint					
	28022	Exploration of foot joint					
	28024	Exploration of toe joint					
	28045	Excision of foot lesion					
	28046	Resection of tumor, foot					
	28050	Biopsy of foot joint lining					
	28052	Biopsy of foot joint lining					
	28054	Biopsy of toe joint lining					
	28080	Removal of foot lesion					
	28086	Excise foot tendon sheath					
	28088	Excise foot tendon sheath					
	28090	Removal of foot lesion					
	28092	Removal of toe lesions					
	28100	Removal of ankle/heel lesion					
	28104	Removal of foot lesion					
	28108	Removal of toe lesions					
	28111	Part removal of metatarsal					
	28112	Part removal of metatarsal					
	28113	Part removal of metatarsal					
	28114	Removal of metatarsal heads					
	28116	Revision of foot					
	28118	Removal of heel bone					
	28119	Removal of heel spur					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	28120	Part removal of ankle/heel					
	28122	Partial removal of foot bone					
	28124	Partial removal of toe					
	28126	Partial removal of toe					
	28130	Removal of ankle bone					
	28140	Removal of metatarsal					
	28150	Removal of toe					
	28153	Partial removal of toe					
	28160	Partial removal of toe					
	28171	Extensive foot surgery					
	28173	Extensive foot surgery					
	28175	Extensive foot surgery					
	28200	Repair of foot tendon					
	28208	Repair of foot tendon					
	28210	Repair/graft of foot tendon					
	28220	Release of foot tendon					
	28222	Release of foot tendons					
	28225	Release of foot tendon					
	28226	Release of foot tendons					
	28230	Incision of foot tendon(s)					
	28232	Incision of toe tendon					
	28234	Incision of foot tendon					
	28240	Release of big toe					
	28270	Release of foot contracture					
	28272	Release of toe joint, each					
	28280	Fusion of toes					
	28285	Repair of hammertoe					
	28286	Repair of hammertoe					
	28310	Revision of big toe					
	28312	Revision of toe					
	28313	Repair deformity of toe					
	28315	Removal of sesamoid bone					
	28340	Resect enlarged toe tissue					
	28341	Resect enlarged toe					
	28737	Revision of foot bones					
	28750	Fusion of big toe joint					
	28755	Fusion of big toe joint					
	28810	Amputation toe & metatarsal					
	28820	Amputation of toe					
	28825	Partial amputation of toe					
	29893	Scope, plantar fasciotomy					
0056	Level II Foot Musculoskeletal Procedures		T	17.30	$838.83	$405.81	$167.77
	28060	Partial removal, foot fascia					
	28062	Removal of foot fascia					
	28070	Removal of foot joint lining					
	28072	Removal of foot joint lining					
	28102	Remove/graft foot lesion					
	28103	Remove/graft foot lesion					
	28106	Remove/graft foot lesion					
	28107	Remove/graft foot lesion					
	28202	Repair/graft of foot tendon					
	28238	Revision of foot tendon					
	28250	Revision of foot fascia					
	28260	Release of midfoot joint					
	28261	Revision of foot tendon					
	28262	Revision of foot and ankle					
	28264	Release of midfoot joint					
	28288	Partial removal of foot bone					
	28289	Repair hallux rigidus					
	28300	Incision of heel bone					
	28302	Incision of ankle bone					
	28304	Incision of midfoot bones					
	28305	Incise/graft midfoot bones					
	28306	Incision of metatarsal					
	28307	Incision of metatarsal					
	28308	Incision of metatarsal					
	28309	Incision of metatarsals					
	28320	Repair of foot bones					
	28322	Repair of metatarsals					
	28344	Repair extra toe(s)					
	28345	Repair webbed toe(s)					
	28360	Reconstruct cleft foot					
	28705	Fusion of foot bones					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	28715	Fusion of foot bones					
	28725	Fusion of foot bones					
	28730	Fusion of foot bones					
	28735	Fusion of foot bones					
	28740	Fusion of foot bones					
	28760	Fusion of big toe joint					
0057	Bunion Procedures		T	21.00	$1,018.23	$496.65	$203.65
	28110	Part removal of metatarsal					
	28290	Correction of bunion					
	28292	Correction of bunion					
	28293	Correction of bunion					
	28294	Correction of bunion					
	28296	Correction of bunion					
	28297	Correction of bunion					
	28298	Correction of bunion					
	28299	Correction of bunion					
0058	Level I Strapping and Cast Application		S	1.09	$52.85	$19.27	$10.57
	29505	Application, long leg splint					
	29515	Application lower leg splint					
	29520	Strapping of hip					
	29530	Strapping of knee					
	29540	Strapping of ankle					
	29550	Strapping of toes					
	29580	Application of paste boot					
	29590	Application of foot splint					
	29700	Removal/revision of cast					
	29705	Removal/revision of cast					
	29710	Removal/revision of cast					
	29715	Removal/revision of cast					
	29720	Repair of body cast					
	29730	Windowing of cast					
	29740	Wedging of cast					
	29750	Wedging of clubfoot cast					
	29799	Casting/strapping procedure					
0059	Level II Strapping and Cast Application		S	1.74	$84.37	$29.59	$16.87
	29000	Application of body cast					
	29010	Application of body cast					
	29015	Application of body cast					
	29020	Application of body cast					
	29025	Application of body cast					
	29035	Application of body cast					
	29040	Application of body cast					
	29044	Application of body cast					
	29046	Application of body cast					
	29049	Application of figure eight					
	29055	Application of shoulder cast					
	29058	Application of shoulder cast					
	29065	Application of long arm cast					
	29075	Application of forearm cast					
	29085	Apply hand/wrist cast					
	29105	Apply long arm splint					
	29125	Apply forearm splint					
	29126	Apply forearm splint					
	29130	Application of finger splint					
	29131	Application of finger splint					
	29200	Strapping of chest					
	29220	Strapping of low back					
	29240	Strapping of shoulder					
	29260	Strapping of elbow or wrist					
	29280	Strapping of hand or finger					
	29305	Application of hip cast					
	29325	Application of hip casts					
	29345	Application of long leg cast					
	29355	Application of long leg cast					
	29358	Apply long leg cast brace					
	29365	Application of long leg cast					
	29405	Apply short leg cast					
	29425	Apply short leg cast					
	29435	Apply short leg cast					
	29440	Addition of walker to cast					
	29445	Apply rigid leg cast					
	29450	Application of leg cast					
0060	Manipulation Therapy		S	0.77	$37.34	$7.80	$7.47

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	98925	Osteopathic manipulation					
	98926	Osteopathic manipulation					
	98927	Osteopathic manipulation					
	98928	Osteopathic manipulation					
	98929	Osteopathic manipulation					
	98940	Chiropractic manipulation					
	98941	Chiropractic manipulation					
	98942	Chiropractic manipulation					
0070	Thoracentesis/Lavage Procedures		T	3.64	$176.49	$79.60	$35.30
	32000	Drainage of chest					
	32002	Treatment of collapsed lung					
	32005	Treat lung lining chemically					
	32020	Insertion of chest tube					
	32420	Puncture/clear lung					
	32960	Therapeutic pneumothorax					
	32999	Chest surgery procedure					
	33010	Drainage of heart sac					
	33011	Repeat drainage of heart sac					
	33999	Cardiac surgery procedure					
	49080	Puncture, peritoneal cavity					
	49081	Removal of abdominal fluid					
0071	Level I Endoscopy Upper Airway		T	0.55	$26.67	$14.22	$5.33
	31231	Nasal endoscopy, dx					
	31575	Diagnostic laryngoscopy					
	92511	Nasopharyngoscopy					
0072	Level II Endoscopy Upper Airway		T	1.26	$61.09	$41.52	$12.22
	31233	Nasal/sinus endoscopy, dx					
	31505	Diagnostic laryngoscopy					
	31511	Remove foreign body, larynx					
	31520	Diagnostic laryngoscopy					
	31700	Insertion of airway catheter					
	31720	Clearance of airways					
0073	Level III Endoscopy Upper Airway		T	4.11	$199.28	$91.07	$39.86
	31513	Injection into vocal cord					
	31577	Remove foreign body, larynx					
	31579	Diagnostic laryngoscopy					
	31717	Bronchial brush biopsy					
	31730	Intro, windpipe wire/tube					
0074	Level IV Endoscopy Upper Airway		T	13.61	$659.91	$347.54	$131.98
	31235	Nasal/sinus endoscopy, dx					
	31237	Nasal/sinus endoscopy, surg					
	31238	Nasal/sinus endoscopy, surg					
	31240	Nasal/sinus endoscopy, surg					
	31510	Laryngoscopy with biopsy					
	31512	Removal of larynx lesion					
	31515	Laryngoscopy for aspiration					
	31525	Diagnostic laryngoscopy					
	31526	Diagnostic laryngoscopy					
	31528	Laryngoscopy and dilatation					
	31529	Laryngoscopy and dilatation					
	31576	Laryngoscopy with biopsy					
	31578	Removal of larynx lesion					
0075	Level V Endoscopy Upper Airway		T	18.55	$899.44	$467.29	$179.89
	31239	Nasal/sinus endoscopy, surg					
	31254	Revision of ethmoid sinus					
	31255	Removal of ethmoid sinus					
	31256	Exploration maxillary sinus					
	31267	Endoscopy, maxillary sinus					
	31276	Sinus endoscopy, surgical					
	31287	Nasal/sinus endoscopy, surg					
	31288	Nasal/sinus endoscopy, surg					
	31527	Laryngoscopy for treatment					
	31530	Operative laryngoscopy					
	31531	Operative laryngoscopy					
	31535	Operative laryngoscopy					
	31536	Operative laryngoscopy					
	31540	Operative laryngoscopy					
	31541	Operative laryngoscopy					
	31560	Operative laryngoscopy					
	31561	Operative laryngoscopy					
	31570	Laryngoscopy with injection					
	31571	Laryngoscopy with injection					
	96570	Photodynamic tx, 30 min					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	96571	Photodynamic tx, addl 15 min					
0076	Endoscopy Lower Airway		T	8.06	$390.81	$197.05	$78.16
	31615	Visualization of windpipe					
	31622	Dx bronchoscope/wash					
	31623	Dx bronchoscope/brush					
	31624	Dx bronchoscope/lavage					
	31625	Bronchoscopy with biopsy					
	31628	Bronchoscopy with biopsy					
	31629	Bronchoscopy with biopsy					
	31630	Bronchoscopy with repair					
	31631	Bronchoscopy with dilation					
	31635	Remove foreign body, airway					
	31640	Bronchoscopy & remove lesion					
	31641	Bronchoscopy, treat blockage					
	31643	Diag bronchoscope/catheter					
	31645	Bronchoscopy, clear airways					
	31646	Bronchoscopy, reclear airway					
	31656	Bronchoscopy, inj for x-ray					
	31899	Airways surgical procedure					
	32601	Thoracoscopy, diagnostic					
	32602	Thoracoscopy, diagnostic					
	32603	Thoracoscopy, diagnostic					
	32604	Thoracoscopy, diagnostic					
	32605	Thoracoscopy, diagnostic					
	32606	Thoracoscopy, diagnostic					
	39400	Visualization of chest					
0077	Level I Pulmonary Treatment		S	0.43	$20.85	$12.62	$4.17
	94640	Airway inhalation treatment					
	94650	Pressure breathing (IPPB)					
	94651	Pressure breathing (IPPB)					
	94664	Aerosol or vapor inhalations					
	94665	Aerosol or vapor inhalations					
	94667	Chest wall manipulation					
	94668	Chest wall manipulation					
0078	Level II Pulmonary Treatment		S	1.34	$64.97	$29.13	$12.99
	94642	Aerosol inhalation treatment					
0079	Ventilation Initiation and Management		S	3.18	$154.19	$107.70	$30.84
	94656	Initial ventilator mgmt					
	94657	Continued ventilator mgmt					
	94660	Pos airway pressure, CPAP					
	94662	Neg press ventilation, cnp					
0080	Diagnostic Cardiac Catheterization		T	25.77	$1,249.51	$713.89	$249.90
	93501	Right heart catheterization					
	93503	Insert/place heart catheter					
	93505	Biopsy of heart lining					
	93510	Left heart catheterization					
	93511	Left heart catheterization					
	93514	Left heart catheterization					
	93524	Left heart catheterization					
	93526	Rt & Lt heart catheters					
	93527	Rt & Lt heart catheters					
	93528	Rt & Lt heart catheters					
	93529	Rt, Lt heart catheterization					
	93530	Rt heart cath, congenital					
	93531	R & l heart cath, congenital					
	93532	R & l heart cath, congenital					
	93533	R & l heart cath, congenital					
	93536	Insert circulation assi					
0081	Non-Coronary Angioplasty or Atherectomy		T	19.36	$938.71	$434.25	$187.74
	35180	Repair blood vessel lesion					
	35184	Repair blood vessel lesion					
	35190	Repair blood vessel lesion					
	35201	Repair blood vessel lesion					
	35206	Repair blood vessel lesion					
	35226	Repair blood vessel lesion					
	35231	Repair blood vessel lesion					
	35236	Repair blood vessel lesion					
	35256	Repair blood vessel lesion					
	35261	Repair blood vessel lesion					
	35266	Repair blood vessel lesion					
	35286	Repair blood vessel lesion					
	35321	Rechanneling of artery					
	35459	Repair arterial blockage					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	35460	Repair venous blockage					
	35470	Repair arterial blockage					
	35471	Repair arterial blockage					
	35472	Repair arterial blockage					
	35473	Repair arterial blockage					
	35474	Repair arterial blockage					
	35475	Repair arterial blockage					
	35476	Repair venous blockage					
	35484	Atherectomy, open					
	35485	Atherectomy, open					
	35490	Atherectomy, percutaneous					
	35491	Atherectomy, percutaneous					
	35492	Atherectomy, percutaneous					
	35493	Atherectomy, percutaneous					
	35494	Atherectomy, percutaneous					
	35495	Atherectomy, percutaneous					
	35500	Harvest vein for bypass					
	37204	Transcatheter occlusion					
	37205	Transcatheter stent					
	37206	Transcatheter stent add-on					
	37207	Transcatheter stent					
	37208	Transcatheter stent add-on					
	37209	Exchange arterial catheter					
	37250	Iv us first vessel add-on					
	37251	Iv us each add vessel add-on					
	37565	Ligation of neck vein					
	37600	Ligation of neck artery					
0082	Coronary Atherectomy		T	40.34	$1,955.97	$859.56	$391.19
	92995	Coronary atherectomy					
	92996	Coronary atherectomy add-on					
0083	Coronary Angiosplasty		T	45.79	$2,220.22	$1,322.95	$444.04
	92980	Insert intracoronary stent					
	92981	Insert intracoronary stent					
	92982	Coronary artery dilation					
	92984	Coronary artery dilation					
0084	Level I Electrophysiologic Evaluation		S	10.70	$518.81	$177.79	$103.76
	93640	Evaluation heart device					
	93641	Electrophysiology evaluation					
	93642	Electrophysiology evaluation					
0085	Level II Electrophysiologic Evaluation		S	27.06	$1,312.06	$654.48	$262.41
	93619	Electrophysiology evaluation					
	93620	Electrophysiology evaluation					
	93621	Electrophysiology evaluation					
	93622	Electrophysiology evaluation					
0086	Ablate Heart Dysrhythm Focus		S	47.62	$2,308.95	$1,265.37	$461.79
	93650	Ablate heart dysrhythm focus					
	93651	Ablate heart dysrhythm focus					
	93652	Ablate heart dysrhythm focus					
0087	Cardiac Electrophysiologic Recording/Mapping		S	9.53	$462.08	$214.72	$92.42
	93600	Bundle of His recording					
	93602	Intra-atrial recording					
	93603	Right ventricular recording					
	93607	Left ventricular recording					
	93609	Mapping of tachycardia					
	93610	Intra-atrial pacing					
	93612	Intraventricular pacing					
	93615	Esophageal recording					
	93616	Esophageal recording					
	93618	Heart rhythm pacing					
	93623	Stimulation, pacing heart					
	93624	Electrophysiologic study					
	93631	Heart pacing, mapping					
0088	Thrombectomy		T	26.49	$1,284.42	$678.68	$256.88
	34101	Removal of artery clot					
	34111	Removal of arm artery clot					
	34201	Removal of artery clot					
	34203	Removal of leg artery clot					
	34471	Removal of vein clot					
	34490	Removal of vein clot					
	34501	Repair valve, femoral vein					
	34510	Transposition of vein valve					
	34520	Cross-over vein graft					
	34530	Leg vein fusion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	35188	Repair blood vessel lesion					
	35207	Repair blood vessel lesion					
	35875	Removal of clot in graft					
	35876	Removal of clot in graft					
	35879	Revise graft w/vein					
	35881	Revise graft w/vein					
	36821	Av fusion direct any site					
	36825	Artery-vein graft					
	36830	Artery-vein graft					
	36831	Av fistula excision					
	36832	Av fistula revision					
	36833	Av fistula revision					
	G0159	Perc declot dialysis graft					
0089	Level I Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device		T	6.49	$314.68	$130.07	$62.94
	33210	Insertion of heart electrode					
	33211	Insertion of heart electrode					
	33220	Revise eltrd pacing-defib					
	33241	Remove pulse generator					
	36261	Revision of infusion pump					
	36262	Removal of infusion pump					
	36299	Vessel injection procedure					
	36531	Revision of infusion pump					
	36532	Removal of infusion pump					
	36534	Revision of access device					
	36535	Removal of access device					
	37203	Transcatheter retrieval					
0090	Level II Implantation/Removal/Revision of Pacemaker, AICD or Vascular Device		T	20.96	$1,016.29	$573.04	$203.26
	33206	Insertion of heart pacemaker					
	33207	Insertion of heart pacemaker					
	33208	Insertion of heart pacemaker					
	33212	Insertion of pulse generator					
	33213	Insertion of pulse generator					
	33214	Upgrade of pacemaker system					
	33216	Revise eltrd pacing-defib					
	33217	Revise eltrd pacing-defib					
	33218	Revise eltrd pacing-defib					
	33233	Removal of pacemaker system					
	33234	Removal of pacemaker system					
	33235	Removal pacemaker electrode					
	33240	Insert pulse generator					
	33244	Remove eltrd, transven					
	33249	Eltrd/insert pace-defib					
	36860	External cannula declotting					
	36861	Cannula declotting					
0091	Level I Vascular Ligation		T	14.79	$717.12	$348.23	$143.42
	30915	Ligation, nasal sinus artery					
	37605	Ligation of neck artery					
	37606	Ligation of neck artery					
	37615	Ligation of neck artery					
	37650	Revision of major vein					
	37700	Revise leg vein					
	37760	Revision of leg veins					
	37780	Revision of leg vein					
	37785	Revise secondary varicosity					
0092	Level II Vascular Ligation		T	20.21	$979.92	$505.37	$195.98
	30920	Ligation, upper jaw artery					
	37607	Ligation of a–v fistula					
	37720	Removal of leg vein					
	37730	Removal of leg veins					
	37735	Removal of leg veins/lesion					
0093	Vascular Repair/Fistula Construction		T	17.95	$870.34	$422.33	$174.07
	36260	Insertion of infusion pump					
	36530	Insertion of infusion pump					
	36533	Insertion of access device					
	36800	Insertion of cannula					
	36810	Insertion of cannula					
	36815	Insertion of cannula					
	36819	Av fusion by basilic vein					
	36835	Artery to vein shunt					
0094	Resuscitation and Cardioversion		S	4.51	$218.68	$105.29	$43.74
	31500	Insert emergency airway					
	92950	Heart/lung resuscitation cpr					
	92953	Temporary external pacing					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	92960	Cardioversion electric, ext					
	92961	Cardioversion, electric, int					
	99440	Newborn resuscitation					
0095	Cardiac Rehabilitation		S	0.64	$31.03	$16.98	$6.21
	93797	Cardiac rehab					
	93798	Cardiac rehab/monitor					
0096	Non-Invasive Vascular Studies		S	2.06	$99.88	$61.48	$19.98
	93721	Plethysmography tracing					
	93740	Temperature gradient studies					
	93799	Cardiovascular procedure					
	93875	Extracranial study					
	93922	Extremity study					
	93923	Extremity study					
	93924	Extremity study					
	93965	Extremity study					
0097	Cardiovascular Stress Test		S	1.62	$78.55	$62.40	$15.71
	93017	Cardiovascular stress test					
	93024	Cardiac drug stress test					
0098	Injection of Sclerosing Solution		T	1.19	$57.70	$20.88	$11.54
	36468	Injection(s), spider veins					
	36469	Injection(s), spider veins					
	36470	Injection therapy of vein					
	36471	Injection therapy of veins					
	45520	Treatment of rectal prolapse					
0099	Continuous Cardiac Monitoring		S	0.38	$18.43	$14.68	$3.69
	93012	Transmission of ecg					
	93270	ECG recording					
	93278	ECG/signal-averaged					
	G0005	ECG 24 hour recording					
	G0015	Post symptom ECG tracing					
0100	Continuous ECG		S	1.70	$82.43	$71.57	$16.49
	93225	ECG monitor/record, 24 hrs					
	93226	ECG monitor/report, 24 hrs					
	93231	Ecg monitor/record, 24 hrs					
	93232	ECG monitor/report, 24 hrs					
	93236	ECG monitor/report, 24 hrs					
	93268	ECG record/review					
	93271	Ecg/monitoring and analysis					
	93724	Analyze pacemaker system					
	G0004	ECG transm phys review & int					
	G0006	ECG transmission & analysis					
0101	Tilt Table Evaluation		S	4.47	$216.74	$128.84	$43.35
	93660	Tilt table evaluation					
0102	Electronic Analysis of Pacemakers/other Devices		S	0.45	$21.82	$12.62	$4.36
	62367	Analyze spine infusion pump					
	62368	Analyze spine infusion pump					
	93727	Analyze ilr system					
	93731	Analyze pacemaker system					
	93732	Analyze pacemaker system					
	93733	Telephone analy, pacemaker					
	93734	Analyze pacemaker system					
	93735	Analyze pacemaker system					
	93736	Telephone analy, pacemaker					
	93737	Analyze cardio/defibrillator					
	93738	Analyze cardio/defibrillator					
	93741	Analyze ht pace device sngl					
	93742	Analyze ht pace device sngl					
	93743	Analyze ht pace device dual					
	93744	Analyze ht pace device dual					
	95970	Analyze neurostim, no prog					
	95971	Analyze neurostim, simple					
	95972	Analyze neurostim, complex					
	95973	Analyze neurostim, complex					
	95974	Cranial neurostim, complex					
	95975	Cranial neurostim, complex					
0109	Bone Marrow Harvesting and Bone Marrow/Stem Cell Transplant		S	4.13	$200.25	$40.05	$40.05
	38230	Bone marrow collection					
	38240	Bone marrow/stem transplant					
	38241	Bone marrow/stem transplant					
0110	Transfusion		S	5.83	$282.68	$122.73	$56.54
	36430	Blood transfusion service					
	36440	Blood transfusion service					
	36450	Exchange transfusion service					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	36455	Exchange transfusion service					
	36460	Transfusion service, fetal					
0111	Blood Product Exchange		S	14.17	$687.06	$300.74	$137.41
	36520	Plasma and/or cell exchange					
	36521	Apheresis w/adsorp/reinfuse					
	38231	Stem cell collection					
0112	Extracorporeal Photopheresis		S	39.60	$1,920.09	$663.65	$384.02
	36522	Photopheresis					
0113	Excision Lymphatic System		T	13.89	$673.49	$326.55	$134.70
	38308	Incision of lymph channels					
	38500	Biopsy/removal, lymph nodes					
	38510	Biopsy/removal, lymph nodes					
	38520	Biopsy/removal, lymph nodes					
	38525	Biopsy/removal, lymph nodes					
	38530	Biopsy/removal, lymph nodes					
	38550	Removal, neck/armpit lesion					
0114	Thyroid/Lymphadenectomy Procedures		T	19.56	$948.41	$493.78	$189.68
	38542	Explore deep node(s), neck					
	38555	Removal, neck/armpit lesion					
	38720	Removal of lymph nodes, neck					
	38740	Remove armpit lymph nodes					
	38745	Remove armpit lymph nodes					
	38760	Remove groin lymph nodes					
	60200	Remove thyroid lesion					
	60210	Partial thyroid excision					
	60220	Partial removal of thyroid					
	60225	Partial removal of thyroid					
	60240	Removal of thyroid					
	60280	Remove thyroid duct lesion					
	60281	Remove thyroid duct lesion					
0116	Chemotherapy Administration by Other Technique Except Infusion		S	2.34	$113.46	$22.69	$22.69
	Q0083	Chemo by other than infusion					
0117	Chemotherapy Administration by Infusion Only		S	1.84	$89.22	$71.80	$17.84
	Q0084	Chemotherapy by infusion					
0118	Chemotherapy Administration by Both Infusion and Other Technique		S	2.90	$140.61	$72.03	$28.12
	Q0085	Chemo by both infusion and o					
0120	Infusion Therapy Except Chemotherapy		S	1.66	$80.49	$42.67	$16.10
	36680	Insert needle, bone cavity					
	Q0081	Infusion ther other than che					
0121	Level I Tube changes and Repositioning		T	2.36	$114.43	$52.53	$22.89
	31502	Change of windpipe airway					
	43760	Change gastrostomy tube					
	43761	Reposition gastrostomy tube					
	43999	Stomach surgery procedure					
	47530	Revise/reinsert bile tube					
	47999	Bile tract surgery procedure					
	49999	Abdomen surgery procedure					
	50688	Change of ureter tube					
	51705	Change of bladder tube					
	51710	Change of bladder tube					
	62194	Replace/irrigate catheter					
	62225	Replace/irrigate catheter					
0122	Level II Tube changes and Repositioning		T	5.04	$244.37	$114.93	$48.88
	47525	Change bile duct catheter					
	50398	Change kidney tube					
0123	Level III Tube changes and Repositioning		T	13.89	$673.49	$350.75	$134.70
	49422	Remove perm cannula/catheter					
	49429	Removal of shunt					
0130	Level I Laparoscopy		T	25.36	$1,229.63	$659.53	$245.93
	38129	Laparoscope proc, spleen					
	38589	Laparoscope proc, lymphatic					
	43289	Laparoscope proc, esoph					
	43659	Laparoscope proc, stom					
	44209	Laparoscope proc, intestine					
	44970	Laparoscopy, appendectomy					
	44979	Laparoscope proc, app					
	47560	Laparoscopy w/cholangio					
	47561	Laparo w/cholangio/biopsy					
	47579	Laparoscope proc, biliary					
	49320	Diag laparo separate proc					
	49321	Laparoscopy, biopsy					
	49322	Laparoscopy, aspiration					
	49323	Laparo drain lymphocele					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	49329	Laparo proc, abdm/per/oment					
	50549	Laparoscope proc, renal					
	54699	Laparoscope proc, testis					
	55559	Laparo proc, spermatic cord					
	58679	Laparo proc, oviduct-ovary					
	59898	Laparo proc, ob care/deliver					
	60659	Laparo proc, endocrine					
0131	Level II Laparoscopy		T	41.81	$2,027.24	$1,089.88	$405.45
	38120	Laparoscopy, splenectomy					
	38570	Laparoscopy, lymph node biop					
	38572	Laparoscopy, lymphadenectomy					
	43653	Laparoscopy, gastrostomy					
	44200	Laparoscopy, enterolysis					
	44201	Laparoscopy, jejunostomy					
	47562	Laparoscopic cholecystectomy					
	47563	Laparo cholecystectomy/graph					
	47564	Laparo cholecystectomy/explr					
	47570	Laparo cholecystoenterostomy					
	49650	Laparo hernia repair initial					
	49651	Laparo hernia repair recur					
	49659	Laparo proc, hernia repair					
	50541	Laparo ablate renal cyst					
	50544	Laparoscopy, pyeloplasty					
	50945	Laparoscopy ureterolithotomy					
	51990	Laparo urethral suspension					
	54690	Laparoscopy, orchiectomy					
	55550	Laparo ligate spermatic vein					
	58551	Laparoscopy, remove myoma					
	58660	Laparoscopy, lysis					
	58661	Laparoscopy, remove adnexa					
	58662	Laparoscopy, excise lesions					
	58670	Laparoscopy, tubal cautery					
	58671	Laparoscopy, tubal block					
	58672	Laparoscopy, fimbrioplasty					
	58673	Laparoscopy, salpingostomy					
	59150	Treat ectopic pregnancy					
	59151	Treat ectopic pregnancy					
0132	Level III Laparoscopy		T	48.91	$2,371.50	$1,239.22	$474.30
	38571	Laparoscopy, lymphadenectomy					
	43280	Laparoscopy, fundoplasty					
	43651	Laparoscopy, vagus nerve					
	43652	Laparoscopy, vagus nerve					
	50548	Laparo-asst remove k/ureter					
	51992	Laparo sling operation					
	54692	Laparoscopy, orchiopexy					
	58550	Laparo-asst vag hysterectomy					
0140	Esophageal Dilation without Endoscopy		T	4.74	$229.83	$107.24	$45.97
	43450	Dilate esophagus					
	43453	Dilate esophagus					
	43456	Dilate esophagus					
	43458	Dilate esophagus					
	43499	Esophagus surgery procedure					
0141	Upper GI Procedures		T	7.15	$346.68	$184.67	$69.34
	43200	Esophagus endoscopy					
	43202	Esophagus endoscopy, biopsy					
	43204	Esophagus endoscopy & inject					
	43205	Esophagus endoscopy/ligation					
	43215	Esophagus endoscopy					
	43216	Esophagus endoscopy/lesion					
	43217	Esophagus endoscopy					
	43219	Esophagus endoscopy					
	43220	Esoph endoscopy, dilation					
	43226	Esoph endoscopy, dilation					
	43227	Esoph endoscopy, repair					
	43228	Esoph endoscopy, ablation					
	43234	Upper GI endoscopy, exam					
	43235	Uppr gi endoscopy, diagnosis					
	43239	Upper GI endoscopy, biopsy					
	43241	Upper GI endoscopy with tube					
	43243	Upper gi endoscopy & inject					
	43244	Upper GI endoscopy/ligation					
	43245	Operative upper GI endoscopy					
	43246	Place gastrostomy tube					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	43247	Operative upper GI endoscopy					
	43248	Uppr gi endoscopy/guide wire					
	43249	Esoph endoscopy, dilation					
	43250	Upper GI endoscopy/tumor					
	43251	Operative upper GI endoscopy					
	43255	Operative upper GI endoscopy					
	43258	Operative upper GI endoscopy					
	43259	Endoscopic ultrasound exam					
	43600	Biopsy of stomach					
	43750	Place gastrostomy tube					
	43830	Place gastrostomy tube					
	43831	Place gastrostomy tube					
	44100	Biopsy of bowel					
0142	Small Intestine Endoscopy		T	7.45	$361.23	$162.42	$72.25
	44360	Small bowel endoscopy					
	44361	Small bowel endoscopy/biopsy					
	44363	Small bowel endoscopy					
	44364	Small bowel endoscopy					
	44365	Small bowel endoscopy					
	44366	Small bowel endoscopy					
	44369	Small bowel endoscopy					
	44372	Small bowel endoscopy					
	44373	Small bowel endoscopy					
	44376	Small bowel endoscopy					
	44377	Small bowel endoscopy/biopsy					
	44378	Small bowel endoscopy					
	44380	Small bowel endoscopy					
	44382	Small bowel endoscopy					
	44799	Intestine surgery procedure					
0143	Lower GI Endoscopy		T	7.98	$386.93	$199.12	$77.39
	44385	Endoscopy of bowel pouch					
	44386	Endoscopy, bowel pouch/biop					
	44388	Colon endoscopy					
	44389	Colonoscopy with biopsy					
	44390	Colonoscopy for foreign body					
	44391	Colonoscopy for bleeding					
	44392	Colonoscopy & polypectomy					
	44393	Colonoscopy, lesion removal					
	44394	Colonoscopy w/snare					
	45355	Surgical colonoscopy					
	45378	Diagnostic colonoscopy					
	45379	Colonoscopy					
	45380	Colonoscopy and biopsy					
	45382	Colonoscopy/control bleeding					
	45383	Lesion removal colonoscopy					
	45384	Colonoscopy					
	45385	Lesion removal colonoscopy					
0144	Diagnostic Anoscopy		T	2.23	$108.13	$49.32	$21.63
	46604	Anoscopy and dilation					
	46608	Anoscopy/remove for body					
0145	Therapeutic Anoscopy		T	7.46	$361.71	$179.39	$72.34
	46606	Anoscopy and biopsy					
	46610	Anoscopy/remove lesion					
	46611	Anoscopy					
	46612	Anoscopy/remove lesions					
	46614	Anoscopy/control bleeding					
	46615	Anoscopy					
0146	Level I Sigmoidoscopy		T	2.83	$137.22	$65.15	$27.44
	45300	Proctosigmoidoscopy					
	45303	Proctosigmoidoscopy					
	45305	Proctosigmoidoscopy & biopsy					
	45307	Proctosigmoidoscopy					
	45317	Proctosigmoidoscopy					
	45330	Diagnostic sigmoidoscopy					
	45331	Sigmoidoscopy and biopsy					
	45332	Sigmoidoscopy					
0147	Level II Sigmoidoscopy		T	6.26	$303.53	$149.11	$60.71
	45308	Proctosigmoidoscopy					
	45309	Proctosigmoidoscopy					
	45315	Proctosigmoidoscopy					
	45320	Proctosigmoidoscopy					
	45321	Proctosigmoidoscopy					
	45333	Sigmoidoscopy & polypectomy					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	45334	Sigmoidoscopy for bleeding					
	45337	Sigmoidoscopy & decompress					
	45338	Sigmoidoscopy					
	45339	Sigmoidoscopy					
0148	Level I Anal/Rectal Procedure		T	2.34	$113.46	$43.59	$22.69
	45005	Drainage of rectal abscess					
	45900	Reduction of rectal prolapse					
	45915	Remove rectal obstruction					
	45999	Rectum surgery procedure					
	46040	Incision of rectal abscess					
	46050	Incision of anal abscess					
	46070	Incision of anal septum					
	46083	Incise external hemorrhoid					
	46221	Ligation of hemorrhoid(s)					
	46320	Removal of hemorrhoid clot					
	46500	Injection into hemorrhoids					
	46934	Destruction of hemorrhoids					
	46935	Destruction of hemorrhoids					
	46945	Ligation of hemorrhoids					
	46946	Ligation of hemorrhoids					
0149	Level II Anal/Rectal Procedure		T	12.86	$623.54	$293.06	$124.71
	45000	Drainage of pelvic abscess					
	45020	Drainage of rectal abscess					
	45100	Biopsy of rectum					
	45905	Dilation of anal sphincter					
	45910	Dilation of rectal narrowing					
	46030	Removal of rectal marker					
	46080	Incision of anal sphincter					
	46210	Removal of anal crypt					
	46220	Removal of anal tab					
	46230	Removal of anal tabs					
	46754	Removal of suture from anus					
	46936	Destruction of hemorrhoids					
	46940	Treatment of anal fissure					
	46942	Treatment of anal fissure					
	46999	Anus surgery procedure					
0150	Level III Anal/Rectal Procedure		T	17.68	$857.25	$437.12	$171.45
	45108	Removal of anorectal lesion					
	45150	Excision of rectal stricture					
	45160	Excision of rectal lesion					
	45170	Excision of rectal lesion					
	45190	Destruction, rectal tumor					
	45500	Repair of rectum					
	45505	Repair of rectum					
	45560	Repair of rectocele					
	46045	Incision of rectal abscess					
	46060	Incision of rectal abscess					
	46200	Removal of anal fissure					
	46211	Removal of anal crypts					
	46250	Hemorrhoidectomy					
	46255	Hemorrhoidectomy					
	46257	Remove hemorrhoids & fissure					
	46258	Remove hemorrhoids & fistula					
	46260	Hemorrhoidectomy					
	46261	Remove hemorrhoids & fissure					
	46262	Remove hemorrhoids & fistula					
	46270	Removal of anal fistula					
	46275	Removal of anal fistula					
	46280	Removal of anal fistula					
	46285	Removal of anal fistula					
	46288	Repair anal fistula					
	46700	Repair of anal stricture					
	46750	Repair of anal sphincter					
	46753	Reconstruction of anus					
	46760	Repair of anal sphincter					
	46761	Repair of anal sphincter					
	46762	Implant artificial sphincter					
	46937	Cryotherapy of rectal lesion					
	46938	Cryotherapy of rectal lesion					
0151	Endoscopic Retrograde Cholangio-Pancreatography (ERCP)		T	10.53	$510.57	$245.46	$102.11
	43260	Endo cholangiopancreatograph					
	43261	Endo cholangiopancreatograph					
	43262	Endo cholangiopancreatograph					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	43263	Endo cholangiopancreatograph					
	43264	Endo cholangiopancreatograph					
	43265	Endo cholangiopancreatograph					
	43267	Endo cholangiopancreatograph					
	43268	Endo cholangiopancreatograph					
	43269	Endo cholangiopancreatograph					
	43271	Endo cholangiopancreatograph					
	43272	Endo cholangiopancreatograph					
0152	Percutaneous Biliary Endoscopic Procedures		T	8.22	$398.56	$207.38	$79.71
	47510	Insert catheter, bile duct					
	47511	Insert bile duct drain					
	47552	Biliary endoscopy thru skin					
	47553	Biliary endoscopy thru skin					
	47554	Biliary endoscopy thru skin					
	47555	Biliary endoscopy thru skin					
	47556	Biliary endoscopy thru skin					
	47630	Remove bile duct stone					
0153	Peritoneal and Abdominal Procedures		T	19.62	$951.32	$496.31	$190.26
	49085	Remove abdomen foreign body					
	49250	Excision of umbilicus					
	49420	Insert abdominal drain					
	49421	Insert abdominal drain					
	49423	Exchange drainage catheter					
	49426	Revise abdomen-venous shunt					
0154	Hernia/Hydrocele Procedures		T	22.43	$1,087.57	$556.98	$217.51
	49495	Repair inguinal hernia, init					
	49496	Repair inguinal hernia, init					
	49500	Repair inguinal hernia					
	49501	Repair inguinal hernia, init					
	49505	Repair inguinal hernia					
	49507	Repair inguinal hernia					
	49520	Rerepair inguinal hernia					
	49521	Repair inguinal hernia, rec					
	49525	Repair inguinal hernia					
	49540	Repair lumbar hernia					
	49550	Repair femoral hernia					
	49553	Repair femoral hernia, init					
	49555	Repair femoral hernia					
	49557	Repair femoral hernia, recur					
	49560	Repair abdominal hernia					
	49561	Repair incisional hernia					
	49565	Rerepair abdominal hernia					
	49566	Repair incisional hernia					
	49568	Hernia repair w/mesh					
	49570	Repair epigastric hernia					
	49572	Repair epigastric hernia					
	49580	Repair umbilical hernia					
	49582	Repair umbilical hernia					
	49585	Repair umbilical hernia					
	49587	Repair umbilical hernia					
	49590	Repair abdominal hernia					
	49600	Repair umbilical lesion					
	51500	Removal of bladder cyst					
	54530	Removal of testis					
	54550	Exploration for testis					
	54640	Suspension of testis					
	55040	Removal of hydrocele					
	55041	Removal of hydroceles					
	55535	Revise spermatic cord veins					
	55540	Revise hernia & sperm veins					
[2] 0157	Colorectal Cancer Screening: Barium Enema		S	1.79	$86.79		$17.36
	G0106	Colon CA screen; barium enema					
	G0120	Colon ca scrn; barium enema					
[1] 0158	Colorectal Cancer Screening: Colonoscopy		S	7.98	$386.93		$96.73
	G0104	CA screen; flexi sigmoidscope					
[1] 0159	Colorectal Cancer Screening: Flexible Sigmoidoscopy		S	7.98	$137.22		$34.31
	G0105	Colorectal scrn; hi risk ind					
0160	Level I Cystourethroscopy and other Genitourinary Procedures		T	5.43	$263.28	$110.11	$52.66
	50392	Insert kidney drain					
	50393	Insert ureteral tube					
	50395	Create passage to kidney					
	52000	Cystoscopy					
	52265	Cystoscopy and treatment					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0161		Level II Cystourethroscopy and other Genitourinary Procedures	T	10.94	$530.45	$249.36	$106.09
	50551	Kidney endoscopy					
	50553	Kidney endoscopy					
	50555	Kidney endoscopy & biopsy					
	50557	Kidney endoscopy & treatment					
	50559	Renal endoscopy/radiotracer					
	50561	Kidney endoscopy & treatment					
	52005	Cystoscopy & ureter catheter					
	52007	Cystoscopy and biopsy					
	52010	Cystoscopy & duct catheter					
	52204	Cystoscopy					
	52214	Cystoscopy and treatment					
	52224	Cystoscopy and treatment					
	52260	Cystoscopy and treatment					
	52270	Cystoscopy & revise urethra					
	52275	Cystoscopy & revise urethra					
	52276	Cystoscopy and treatment					
	52281	Cystoscopy and treatment					
	52283	Cystoscopy and treatment					
	52285	Cystoscopy and treatment					
	52290	Cystoscopy and treatment					
	52300	Cystoscopy and treatment					
	52301	Cystoscopy and treatment					
	52305	Cystoscopy and treatment					
	52310	Cystoscopy and treatment					
	52315	Cystoscopy and treatment					
	52327	Cystoscopy, inject material					
	52510	Dilation prostatic urethra					
	53605	Dilate urethra stricture					
0162		Level III Cystourethroscopy and other Genitourinary Procedures	T	17.49	$848.04	$427.49	$169.61
	50951	Endoscopy of ureter					
	50953	Endoscopy of ureter					
	50955	Ureter endoscopy & biopsy					
	50957	Ureter endoscopy & treatment					
	50959	Ureter endoscopy & tracer					
	50961	Ureter endoscopy & treatment					
	51020	Incise & treat bladder					
	51030	Incise & treat bladder					
	51040	Incise & drain bladder					
	51045	Incise bladder/drain ureter					
	51050	Removal of bladder stone					
	51065	Removal of ureter stone					
	51520	Removal of bladder lesion					
	51880	Repair of bladder opening					
	52234	Cystoscopy and treatment					
	52235	Cystoscopy and treatment					
	52250	Cystoscopy and radiotracer					
	52277	Cystoscopy and treatment					
	52282	Cystoscopy, implant stent					
	52317	Remove bladder stone					
	52318	Remove bladder stone					
	52320	Cystoscopy and treatment					
	52325	Cystoscopy, stone removal					
	52330	Cystoscopy and treatment					
	52332	Cystoscopy and treatment					
	52334	Create passage to kidney					
	52335	Endoscopy of urinary tract					
	52336	Cystoscopy, stone removal					
	52337	Cystoscopy, stone removal					
	52338	Cystoscopy and treatment					
	52339	Cystoscopy and treatment					
	52340	Cystoscopy and treatment					
	52450	Incision of prostate					
	52500	Revision of bladder neck					
	52606	Control postop bleeding					
	52640	Relieve bladder contracture					
	52700	Drainage of prostate abscess					
	55720	Drainage of prostate abscess					
	55725	Drainage of prostate abscess					
	55859	Percut/needle insert, pros					
0163		Level IV Cystourethroscopy and other Genitourinary Procedures	T	28.98	$1,405.16	$792.58	$281.03
	50080	Removal of kidney stone					
	50081	Removal of kidney stone					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	52240	Cystoscopy and treatment					
	52601	Prostatectomy (TURP)					
	52612	Prostatectomy, first stage					
	52614	Prostatectomy, second stage					
	52620	Remove residual prostate					
	52630	Remove prostate regrowth					
	52647	Laser surgery of prostate					
	52648	Laser surgery of prostate					
0164	Level I Urinary and Anal Procedures		T	2.17	$105.23	$33.03	$21.05
	51005	Drainage of bladder					
	51700	Irrigation of bladder					
	51736	Urine flow measurement					
	51741	Electro-uroflowmetry, first					
	51784	Anal/urinary muscle study					
	51785	Anal/urinary muscle study					
	51795	Urine voiding pressure study					
	51797	Intraabdominal pressure test					
	53600	Dilate urethra stricture					
	53601	Dilate urethra stricture					
	53621	Dilate urethra stricture					
	53660	Dilation of urethra					
	53661	Dilation of urethra					
	53675	Insert urinary catheter					
	54235	Penile injection					
	54240	Penis study					
	55899	Genital surgery procedure					
0165	Level II Urinary and Anal Procedures		T	3.89	$188.61	$91.76	$37.72
	50396	Measure kidney pressure					
	50686	Measure ureter pressure					
	51000	Drainage of bladder					
	51010	Drainage of bladder					
	51720	Treatment of bladder lesion					
	51725	Simple cystometrogram					
	51726	Complex cystometrogram					
	51772	Urethra pressure profile					
	51792	Urinary reflex study					
	53620	Dilate urethra stricture					
	53899	Urology surgery procedure					
	54200	Treatment of penis lesion					
	54220	Treatment of penis lesion					
	54231	Dynamic cavernosometry					
	54250	Penis study					
	54450	Preputial stretching					
	91122	Anal pressure record					
0166	Level I Urethral Procedures		T	10.17	$493.11	$218.73	$98.62
	53000	Incision of urethra					
	53010	Incision of urethra					
	53020	Incision of urethra					
	53025	Incision of urethra					
	53040	Drainage of urethra abscess					
	53060	Drainage of urethra abscess					
	53080	Drainage of urinary leakage					
	53200	Biopsy of urethra					
	53250	Removal of urethra gland					
	53260	Treatment of urethra lesion					
	53265	Treatment of urethra lesion					
	53275	Repair of urethra defect					
	53442	Remove perineal prosthesis					
	53502	Repair of urethra injury					
	53510	Repair of urethra injury					
	53665	Dilation of urethra					
	54000	Slitting of prepuce					
	54001	Slitting of prepuce					
0167	Level II Urethral Procedures		T	21.06	$1,021.14	$555.84	$204.23
	51715	Endoscopic injection/implant					
	53270	Removal of urethra gland					
	53505	Repair of urethra injury					
0168	Level III Urethral Procedures		T	24.94	$1,209.27	$536.11	$241.85
	53210	Removal of urethra					
	53215	Removal of urethra					
	53220	Treatment of urethra lesion					
	53230	Removal of urethra lesion					
	53235	Removal of urethra lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	53240	Surgery for urethra pouch					
	53400	Revise urethra, stage 1					
	53405	Revise urethra, stage 2					
	53410	Reconstruction of urethra					
	53420	Reconstruct urethra, stage 1					
	53425	Reconstruct urethra, stage 2					
	53430	Reconstruction of urethra					
	53447	Remove artificial sphincter					
	53449	Correct artificial sphincter					
	53450	Revision of urethra					
	53460	Revision of urethra					
	53515	Repair of urethra injury					
	53520	Repair of urethra defect					
0169	Lithotripsy		T	46.72	$2,265.32	$1,384.20	$453.06
	50590	Fragmenting of kidney stone					
0170	Dialysis for Other Than ESRD Patients		S	6.68	$323.89	$72.26	$64.78
	90935	Hemodialysis, one evaluation					
	90945	Dialysis, one evaluation					
0180	Circumcision		T	13.62	$660.39	$304.87	$132.08
	54150	Circumcision					
	54152	Circumcision					
	54160	Circumcision					
	54161	Circumcision					
0181	Penile Procedures		T	32.37	$1,569.53	$906.36	$313.91
	37790	Penile venous occlusion					
	54110	Treatment of penis lesion					
	54111	Treat penis lesion, graft					
	54112	Treat penis lesion, graft					
	54120	Partial removal of penis					
	54205	Treatment of penis lesion					
	54300	Revision of penis					
	54304	Revision of penis					
	54308	Reconstruction of urethra					
	54312	Reconstruction of urethra					
	54316	Reconstruction of urethra					
	54318	Reconstruction of urethra					
	54322	Reconstruction of urethra					
	54324	Reconstruction of urethra					
	54326	Reconstruction of urethra					
	54328	Revise penis/urethra					
	54340	Secondary urethral surgery					
	54344	Secondary urethral surgery					
	54348	Secondary urethral surgery					
	54352	Reconstruct urethra/penis					
	54360	Penis plastic surgery					
	54380	Repair penis					
	54385	Repair penis					
	54402	Remove penis prosthesis					
	54407	Remove multi-comp prosthesis					
	54409	Revise penis prosthesis					
	54420	Revision of penis					
	54435	Revision of penis					
	54440	Repair of penis					
0182	Insertion of Penile Prosthesis		T	52.11	$2,526.66	$1,525.05	$505.33
	53440	Correct bladder function					
	53445	Correct urine flow control					
	54400	Insert semi-rigid prosthesis					
	54401	Insert self-contd prosthesis					
	54405	Insert multi-comp prosthesis					
0183	Testes/Epididymis Procedures		T	18.26	$885.37	$448.94	$177.07
	54505	Biopsy of testis					
	54510	Removal of testis lesion					
	54520	Removal of testis					
	54600	Reduce testis torsion					
	54620	Suspension of testis					
	54660	Revision of testis					
	54670	Repair testis injury					
	54680	Relocation of testis(es)					
	54700	Drainage of scrotum					
	54820	Exploration of epididymis					
	54830	Remove epididymis lesion					
	54840	Remove epididymis lesion					
	54860	Removal of epididymis					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	54861	Removal of epididymis					
	54900	Fusion of spermatic ducts					
	54901	Fusion of spermatic ducts					
	55060	Repair of hydrocele					
	55110	Explore scrotum					
	55120	Removal of scrotum lesion					
	55150	Removal of scrotum					
	55175	Revision of scrotum					
	55180	Revision of scrotum					
	55200	Incision of sperm duct					
	55250	Removal of sperm duct(s)					
	55400	Repair of sperm duct					
	55450	Ligation of sperm duct					
	55500	Removal of hydrocele					
	55520	Removal of sperm cord lesion					
	55530	Revise spermatic cord veins					
	55680	Remove sperm pouch lesion					
0184	Prostate Biopsy		T	4.94	$239.53	$122.96	$47.91
	55700	Biopsy of prostate					
	55705	Biopsy of prostate					
0190	Surgical Hysteroscopy		T	17.85	$865.49	$443.89	$173.10
	58558	Hysteroscopy, biopsy					
	58559	Hysteroscopy, lysis					
	58560	Hysteroscopy, resect septum					
	58561	Hysteroscopy, remove myoma					
	58562	Hysteroscopy, remove fb					
	58563	Hysteroscopy, ablation					
	58578	Laparo proc, uterus					
	58579	Hysteroscope procedure					
0191	Level I Female Reproductive Procedures		T	1.19	$57.70	$17.43	$11.54
	57160	Insert pessary/other device					
	57170	Fitting of diaphragm/cap					
	57452	Examination of vagina					
	58100	Biopsy of uterus lining					
	58301	Remove intrauterine device					
	58555	Hysteroscopy, dx, sep proc					
	59200	Insert cervical dilator					
	Q0091	Obtaining screen pap smear					
0192	Level II Female Reproductive Procedures		T	2.38	$115.40	$35.33	$23.08
	56405	I & D of vulva/perineum					
	56420	Drainage of gland abscess					
	57100	Biopsy of vagina					
	57150	Treat vagina infection					
	57180	Treat vaginal bleeding					
	57454	Vagina examination & biopsy					
	57505	Endocervical curettage					
	57511	Cryocautery of cervix					
	99170	Anogenital exam, child					
0193	Level III Female Reproductive Procedures		T	8.93	$432.99	$171.13	$86.60
	56441	Lysis of labial lesion(s)					
	56720	Incision of hymen					
	57020	Drainage of pelvic fluid					
	57460	Cervix excision					
	57500	Biopsy of cervix					
	57510	Cauterization of cervix					
	57513	Laser surgery of cervix					
	57800	Dilation of cervical canal					
0194	Level IV Female Reproductive Procedures		T	16.21	$785.98	$395.94	$157.20
	56440	Surgery for vulva lesion					
	56700	Partial removal of hymen					
	56740	Remove vagina gland lesion					
	56800	Repair of vagina					
	56810	Repair of perineum					
	57000	Exploration of vagina					
	57010	Drainage of pelvic abscess					
	57061	Destruction vagina lesion(s)					
	57065	Destruction vagina lesion(s)					
	57105	Biopsy of vagina					
	57106	Remove vagina wall, partial					
	57107	Remove vagina tissue, part					
	57109	Vaginectomy partial w/nodes					
	57130	Remove vagina lesion					
	57135	Remove vagina lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	57200	Repair of vagina					
	57210	Repair vagina/perineum					
	57230	Repair of urethral lesion					
	57400	Dilation of vagina					
	57410	Pelvic examination					
	57415	Remove vaginal foreign body					
	57520	Conization of cervix					
	57700	Revision of cervix					
	57720	Revision of cervix					
	58345	Reopen fallopian tube					
	58350	Reopen fallopian tube					
	58970	Retrieval of oocyte					
	59300	Episiotomy or vaginal repair					
	59320	Revision of cervix					
	59871	Remove cerclage suture					
0195	Level V Female Reproductive Procedures		T	18.68	$905.74	$483.80	$181.15
	56620	Partial removal of vulva					
	56625	Complete removal of vulva					
	57220	Revision of urethra					
	57240	Repair bladder & vagina					
	57250	Repair rectum & vagina					
	57260	Repair of vagina					
	57265	Extensive repair of vagina					
	57268	Repair of bowel bulge					
	57284	Repair paravaginal defect					
	57288	Repair bladder defect					
	57289	Repair bladder & vagina					
	57291	Construction of vagina					
	57300	Repair rectum-vagina fistula					
	57522	Conization of cervix					
	57530	Removal of cervix					
	57550	Removal of residual cervix					
	57555	Remove cervix/repair vagina					
	57556	Remove cervix, repair bowel					
	58145	Removal of uterus lesion					
	58800	Drainage of ovarian cyst(s)					
	58820	Drain ovary abscess, open					
	58900	Biopsy of ovary(s)					
	58920	Partial removal of ovary(s)					
	58925	Removal of ovarian cyst(s)					
0196	Dilatation & Curettage		T	14.47	$701.61	$357.98	$140.32
	57820	D & c of residual cervix					
	58120	Dilation and curettage					
	59160	D & c after delivery					
0197	Infertility Procedures		T	2.40	$116.37	$49.55	$23.27
	55870	Electroejaculation					
	58321	Artificial insemination					
	58322	Artificial insemination					
	58323	Sperm washing					
	58974	Transfer of embryo					
	58976	Transfer of embryo					
0198	Pregnancy and Neonatal Care Procedures		T	1.34	$64.97	$33.03	$12.99
	59000	Amniocentesis					
	59012	Fetal cord puncture, prenatal					
	59015	Chorion biopsy					
	59020	Fetal contract stress test					
	59025	Fetal non-stress test					
	59030	Fetal scalp blood sample					
	59050	Fetal monitor w/report					
	59899	Maternity care procedure					
0199	Vaginal Delivery		T	11.20	$543.06	$157.83	$108.61
	59409	Obstetrical care					
	59412	Antepartum manipulation					
	59414	Deliver placenta					
	59612	Vbac delivery only					
0200	Therapeutic Abortion		T	13.89	$673.49	$373.23	$134.70
	59840	Abortion					
	59841	Abortion					
0201	Spontaneous Abortion		T	13.00	$630.33	$329.65	$126.07
	59812	Treatment of miscarriage					
	59820	Care of miscarriage					
	59821	Treatment of miscarriage					
	59870	Evacuate mole of uterus					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0210	Spinal Tap		T	3.00	$145.46	$62.40	$29.09
	62270	Spinal fluid tap, diagnostic					
	62272	Drain spinal fluid					
0211	Level I Nervous System Injections		T	3.32	$160.98	$74.78	$32.20
	64400	Injection for nerve block					
	64402	Injection for nerve block					
	64405	Injection for nerve block					
	64408	Injection for nerve block					
	64410	Injection for nerve block					
	64412	Injection for nerve block					
	64413	Injection for nerve block					
	64415	Injection for nerve block					
	64417	Injection for nerve block					
	64418	Injection for nerve block					
	64420	Injection for nerve block					
	64421	Injection for nerve block					
	64425	Injection for nerve block					
	64430	Injection for nerve block					
	64435	Injection for nerve block					
	64445	Injection for nerve block					
	64450	Injection for nerve block					
	64470	Inj paravertebral c/t					
	64472	Inj paravertebral c/t add-on					
	64475	Inj paravertebral l/s					
	64476	Inj paravertebral l/s add-on					
	64479	Inj foramen epidural c/t					
	64480	Inj foramen epidural add-on					
	64483	Inj foramen epidural l/s					
	64484	Inj foramen epidural add-on					
	64505	Injection for nerve block					
	64508	Injection for nerve block					
	64510	Injection for nerve block					
	64520	Injection for nerve block					
	64530	Injection for nerve block					
	64600	Injection treatment of nerve					
	64605	Injection treatment of nerve					
	64610	Injection treatment of nerve					
	64612	Destroy nerve, face muscle					
	64613	Destroy nerve, spine muscle					
	64620	Injection treatment of nerve					
	64622	Destr paravertebrl nerve l/s					
	64623	Destr paravertebral n add-on					
	64626	Destr paravertebrl nerve c/t					
	64627	Destr paravertebral n add-on					
	64630	Injection treatment of nerve					
	64640	Injection treatment of nerve					
	64680	Injection treatment of nerve					
	64999	Nervous system surgery					
0212	Level II Nervous System Injections		T	3.64	$176.49	$88.78	$35.30
	61000	Remove cranial cavity fluid					
	61001	Remove cranial cavity fluid					
	61020	Remove brain cavity fluid					
	61026	Injection into brain canal					
	61050	Remove brain canal fluid					
	61055	Injection into brain canal					
	61070	Brain canal shunt procedure					
	62263	Lysis epidural adhesions					
	62268	Drain spinal cord cyst					
	62273	Treat epidural spine lesion					
	62280	Treat spinal cord lesion					
	62281	Treat spinal cord lesion					
	62282	Treat spinal canal lesion					
	62292	Injection into disk lesion					
	62294	Injection into spinal artery					
	62310	Inject spine c/t					
	62311	Inject spine l/s (cd)					
	62318	Inject spine w/cath, c/t					
	62319	Inject spine w/cath l/s (cd)					
0213	Extended EEG Studies and Sleep Studies		S	11.15	$540.63	$290.42	$108.13
	95805	Multiple sleep latency test					
	95806	Sleep study, unattended					
	95807	Sleep study, attended					
	95808	Polysomnography, 1–3					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	95810	Polysomnography, 4 or more					
	95811	Polysomnography w/cpap					
	95812	Electroencephalogram (EEG)					
	95813	Electroencephalogram (EEG)					
	95827	Night electroencephalogram					
	95951	EEG monitoring/videorecord					
	95953	EEG monitoring/computer					
	95954	EEG monitoring/giving drugs					
	95958	EEG monitoring/function test					
0214	Electroencephalogram		S	2.32	$112.49	$58.50	$22.50
	95816	Electroencephalogram (EEG)					
	95819	Electroencephalogram (EEG)					
	95822	Sleep electroencephalogram					
	95824	Electroencephalography					
	95829	Surgery electrocorticogram					
	95955	EEG during surgery					
0215	Level I Nerve and Muscle Tests		S	1.15	$55.76	$30.05	$11.15
	95857	Tensilon test					
	95858	Tensilon test & myogram					
	95860	Muscle test, one limb					
	95861	Muscle test, two limbs					
	95864	Muscle test, 4 limbs					
	95869	Muscle test, thor paraspinal					
	95870	Muscle test, nonparaspinal					
	95872	Muscle test, one fiber					
	95900	Motor nerve conduction test					
	95903	Motor nerve conduction test					
	95904	Sense/mixed n conduction tst					
	95933	Blink reflex test					
	95934	H-reflex test					
	95937	Neuromuscular junction test					
0216	Level II Nerve and Muscle Tests		S	2.87	$139.16	$64.69	$27.83
	92275	Electroretinography					
	92585	Auditory evoked potential					
	95863	Muscle test, 3 limbs					
	95867	Muscle test, head or neck					
	95868	Muscle test, head or neck					
	95921	Autonomic nerv function test					
	95922	Autonomic nerv function test					
	95923	Autonomic nerv function test					
	95925	Somatosensory testing					
	95926	Somatosensory testing					
	95927	Somatosensory testing					
	95930	Visual evoked potential test					
	95936	H-reflex test					
0217	Level III Nerve and Muscle Tests		S	5.87	$284.62	$156.68	$56.92
	95875	Limb exercise test					
	95950	Ambulatory eeg monitoring					
0220	Level I Nerve Procedures		T	13.96	$676.88	$326.21	$135.38
	27315	Partial removal, thigh nerve					
	27320	Partial removal, thigh nerve					
	28030	Removal of foot nerve					
	28035	Decompression of tibia nerve					
	61790	Treat trigeminal nerve					
	62287	Percutaneous diskectomy					
	63600	Remove spinal cord lesion					
	63610	Stimulation of spinal cord					
	63615	Remove lesion of spinal cord					
	64702	Revise finger/toe nerve					
	64704	Revise hand/foot nerve					
	64708	Revise arm/leg nerve					
	64712	Revision of sciatic nerve					
	64713	Revision of arm nerve(s)					
	64714	Revise low back nerve(s)					
	64716	Revision of cranial nerve					
	64718	Revise ulnar nerve at elbow					
	64719	Revise ulnar nerve at wrist					
	64721	Carpal tunnel surgery					
	64722	Relieve pressure on nerve(s)					
	64726	Release foot/toe nerve					
	64727	Internal nerve revision					
	64732	Incision of brow nerve					
	64734	Incision of cheek nerve					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	64736	Incision of chin nerve					
	64738	Incision of jaw nerve					
	64740	Incision of tongue nerve					
	64742	Incision of facial nerve					
	64744	Incise nerve, back of head					
	64746	Incise diaphragm nerve					
	64761	Incision of pelvis nerve					
	64771	Sever cranial nerve					
	64772	Incision of spinal nerve					
	64774	Remove skin nerve lesion					
	64776	Remove digit nerve lesion					
	64778	Digit nerve surgery add-on					
	64782	Remove limb nerve lesion					
	64783	Limb nerve surgery add-on					
	64784	Remove nerve lesion					
	64787	Implant nerve end					
	64788	Remove skin nerve lesion					
	64790	Removal of nerve lesion					
	64795	Biopsy of nerve					
0221	Level II Nerve Procedures		T	18.36	$890.22	$463.62	$178.04
	64786	Remove sciatic nerve lesion					
	64792	Removal of nerve lesion					
	64831	Repair of digit nerve					
	64832	Repair nerve add-on					
	64834	Repair of hand or foot nerve					
	64835	Repair of hand or foot nerve					
	64836	Repair of hand or foot nerve					
	64837	Repair nerve add-on					
	64840	Repair of leg nerve					
	64856	Repair/transpose nerve					
	64857	Repair arm/leg nerve					
	64858	Repair sciatic nerve					
	64859	Nerve surgery					
	64861	Repair of arm nerves					
	64862	Repair of low back nerves					
	64864	Repair of facial nerve					
	64865	Repair of facial nerve					
	64870	Fusion of facial/other nerve					
	64872	Subsequent repair of nerve					
	64874	Repair & revise nerve add-on					
	64876	Repair nerve/shorten bone					
	64885	Nerve graft, head or neck					
	64886	Nerve graft, head or neck					
	64890	Nerve graft, hand or foot					
	64891	Nerve graft, hand or foot					
	64892	Nerve graft, arm or leg					
	64893	Nerve graft, arm or leg					
	64895	Nerve graft, hand or foot					
	64896	Nerve graft, hand or foot					
	64897	Nerve graft, arm or leg					
	64898	Nerve graft, arm or leg					
	64901	Nerve graft add-on					
	64902	Nerve graft add-on					
	64905	Nerve pedicle transfer					
	64907	Nerve pedicle transfer					
0222	Implantation of Neurological Device		T	25.48	$1,235.45	$780.07	$247.09
	61215	Insert brain-fluid device					
	61885	Implant neurostim one array					
	62360	Insert spine infusion device					
	62361	Implant spine infusion pump					
	62362	Implant spine infusion pump					
	63685	Implant neuroreceiver					
	64590	Implant neuroreceiver					
0223	Level I Revision/Removal Neurological Device		T	6.34	$307.41	$153.24	$61.48
	62350	Implant spinal canal cath					
	62355	Remove spinal canal catheter					
	63746	Removal of spinal shunt					
0224	Level II Revision/Removal Neurological Device		T	15.94	$772.88	$374.61	$154.58
	62230	Replace/revise brain shunt					
	62365	Remove spine infusion device					
	63650	Implant neuroelectrodes					
	63660	Revise/remove neuroelectrode					
	63688	Revise/remove neuroreceiver					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	63744	Revision of spinal shunt					
0225	Implantation of Neurostimulator Electrodes		T	3.43	$166.31	$64.46	$33.26
	64553	Implant neuroelectrodes					
	64555	Implant neuroelectrodes					
	64560	Implant neuroelectrodes					
	64565	Implant neuroelectrodes					
	64573	Implant neuroelectrodes					
	64575	Implant neuroelectrodes					
	64577	Implant neuroelectrodes					
	64580	Implant neuroelectrodes					
	64585	Revise/remove neuroelectrode					
	64595	Revise/remove neuroreceiver					
0230	Level I Eye Tests		S	0.98	$47.52	$22.48	$9.50
	68200	Treat eyelid by injection					
	92020	Special eye evaluation					
	92060	Special eye evaluation					
	92065	Orthoptic/pleoptic training					
	92081	Visual field examination(s)					
	92082	Visual field examination(s)					
	92083	Visual field examination(s)					
	92120	Tonography & eye evaluation					
	92130	Water provocation tonography					
	92225	Special eye exam, initial					
	92250	Eye exam with photos					
	92260	Ophthalmoscopy/dynamometry					
	92265	Eye muscle evaluation					
	92270	Electro-oculography					
	92283	Color vision examination					
	92285	Eye photography					
	92330	Fitting of artificial eye					
	92499	Eye service or procedure					
0231	Level II Eye Tests		S	2.64	$128.01	$59.87	$25.60
	65205	Remove foreign body from eye					
	65210	Remove foreign body from eye					
	65220	Remove foreign body from eye					
	65222	Remove foreign body from eye					
	65430	Corneal smear					
	67350	Biopsy eye muscle					
	67500	Inject/treat eye socket					
	68110	Remove eyelid lining lesion					
	68761	Close tear duct opening					
	68801	Dilate tear duct opening					
	68810	Probe nasolacrimal duct					
	68840	Explore/irrigate tear ducts					
	68899	Tear duct system surgery					
	92018	New eye exam & treatment					
	92019	Eye exam & treatment					
	92135	Opthalmic dx imaging					
	92140	Glaucoma provocative tests					
	92226	Special eye exam, subsequent					
	92230	Eye exam with photos					
	92235	Eye exam with photos					
	92240	Icg angiography					
	92284	Dark adaptation eye exam					
	92286	Internal eye photography					
	92287	Internal eye photography					
0232	Level I Anterior Segment Eye		T	6.04	$292.86	$134.66	$58.57
	65235	Remove foreign body from eye					
	65272	Repair of eye wound					
	65286	Repair of eye wound					
	65400	Removal of eye lesion					
	65436	Curette/treat cornea					
	65450	Treatment of corneal lesion					
	65772	Correction of astigmatism					
	65800	Drainage of eye					
	65820	Relieve inner eye pressure					
	65880	Incise inner eye adhesions					
	65900	Remove eye lesion					
	66020	Injection treatment of eye					
	66030	Injection treatment of eye					
	66500	Incision of iris					
	66505	Incision of iris					
	66625	Removal of iris					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	66700	Destruction, ciliary body					
	66710	Destruction, ciliary body					
	66720	Destruction, ciliary body					
	66820	Incision, secondary cataract					
	66830	Removal of lens lesion					
	67880	Revision of eyelid					
	68100	Biopsy of eyelid lining					
0233	Level II Anterior Segment Eye		T	13.79	$668.64	$331.60	$133.73
	65275	Repair of eye wound					
	65280	Repair of eye wound					
	65410	Biopsy of cornea					
	65420	Removal of eye lesion					
	65426	Removal of eye lesion					
	65775	Correction of astigmatism					
	65805	Drainage of eye					
	65810	Drainage of eye					
	65815	Drainage of eye					
	65865	Incise inner eye adhesions					
	65870	Incise inner eye adhesions					
	65875	Incise inner eye adhesions					
	65920	Remove implant from eye					
	65930	Remove blood clot from eye					
	66130	Remove eye lesion					
	66150	Glaucoma surgery					
	66250	Follow-up surgery of eye					
	66600	Remove iris and lesion					
	66605	Removal of iris					
	66630	Removal of iris					
	66635	Removal of iris					
	66680	Repair iris & ciliary body					
	66682	Repair iris & ciliary body					
	66740	Destruction, ciliary body					
	66825	Reposition intraocular lens					
	68130	Remove eyelid lining lesion					
	68330	Revise eyelid lining					
0234	Level III Anterior Segment Eye Procedures		T	20.64	$1,000.77	$502.16	$200.15
	65285	Repair of eye wound					
	65850	Incision of eye					
	66155	Glaucoma surgery					
	66160	Glaucoma surgery					
	66165	Glaucoma surgery					
	66170	Glaucoma surgery					
	66172	Incision of eye					
	66180	Implant eye shunt					
	66185	Revise eye shunt					
	66225	Repair/graft eye lesion					
	68360	Revise eyelid lining					
	68362	Revise eyelid lining					
0235	Level I Posterior Segment Eye Procedures		T	2.94	$142.55	$78.91	$28.51
	67141	Treatment of retina					
	67208	Treatment of retinal lesion					
	67227	Treatment of retinal lesion					
0236	Level II Posterior Segment Eye Procedures		T	6.70	$324.86	$147.96	$64.97
	66220	Repair eye lesion					
	67028	Injection eye drug					
	67030	Incise inner eye strands					
	67101	Repair detached retina					
	67110	Repair detached retina					
	67115	Release encircling material					
	67120	Remove eye implant material					
0237	Level III Posterior Segment Eye Procedures		T	33.96	$1,646.62	$852.68	$329.32
	65260	Remove foreign body from eye					
	65265	Remove foreign body from eye					
	67005	Partial removal of eye fluid					
	67010	Partial removal of eye fluid					
	67015	Release of eye fluid					
	67025	Replace eye fluid					
	67027	Implant eye drug system					
	67036	Removal of inner eye fluid					
	67038	Strip retinal membrane					
	67039	Laser treatment of retina					
	67040	Laser treatment of retina					
	67107	Repair detached retina					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	67108	Repair detached retina					
	67112	Rerepair detached retina					
	67121	Remove eye implant material					
	67218	Treatment of retinal lesion					
	67220	Treatment of choroid lesion					
	67255	Reinforce/graft eye wall					
0238	Level I Repair and Plastic Eye Procedures		T	2.80	$135.76	$58.96	$27.15
	67345	Destroy nerve of eye muscle					
	67505	Inject/treat eye socket					
	67700	Drainage of eyelid abscess					
	67800	Remove eyelid lesion					
	67805	Remove eyelid lesions					
	67810	Biopsy of eyelid					
	67820	Revise eyelashes					
	67825	Revise eyelashes					
	67938	Remove eyelid foreign body					
	68400	Incise/drain tear gland					
	68440	Incise tear duct opening					
	68705	Revise tear duct opening					
	68760	Close tear duct opening					
0239	Level II Repair and Plastic Eye Procedures		T	6.26	$303.53	$123.42	$60.71
	65435	Curette/treat cornea					
	67415	Aspiration, orbital contents					
	67515	Inject/treat eye socket					
	67599	Orbit surgery procedure					
	67710	Incision of eyelid					
	67801	Remove eyelid lesions					
	67830	Revise eyelashes					
	67840	Remove eyelid lesion					
	67850	Treat eyelid lesion					
	67875	Closure of eyelid by suture					
	67915	Repair eyelid defect					
	67922	Repair eyelid defect					
	68040	Treatment of eyelid lesions					
	68115	Remove eyelid lining lesion					
	68135	Remove eyelid lining lesion					
	68399	Eyelid lining surgery					
0240	Level III Repair and Plastic Eye Procedures		T	13.47	$653.12	$315.31	$130.62
	65125	Revise ocular implant					
	65175	Removal of ocular implant					
	65270	Repair of eye wound					
	65600	Revision of cornea					
	67250	Reinforce eye wall					
	67715	Incision of eyelid fold					
	67808	Remove eyelid lesion(s)					
	67835	Revise eyelashes					
	67882	Revision of eyelid					
	67900	Repair brow defect					
	67901	Repair eyelid defect					
	67902	Repair eyelid defect					
	67903	Repair eyelid defect					
	67904	Repair eyelid defect					
	67906	Repair eyelid defect					
	67908	Repair eyelid defect					
	67909	Revise eyelid defect					
	67911	Revise eyelid defect					
	67914	Repair eyelid defect					
	67916	Repair eyelid defect					
	67917	Repair eyelid defect					
	67921	Repair eyelid defect					
	67923	Repair eyelid defect					
	67924	Repair eyelid defect					
	67930	Repair eyelid wound					
	67935	Repair eyelid wound					
	67950	Revision of eyelid					
	67961	Revision of eyelid					
	67966	Revision of eyelid					
	67975	Reconstruction of eyelid					
	67999	Revision of eyelid					
	68020	Incise/drain eyelid lining					
	68320	Revise/graft eyelid lining					
	68340	Separate eyelid adhesions					
	68420	Incise/drain tear sac					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	68510	Biopsy of tear gland					
	68525	Biopsy of tear sac					
	68530	Clearance of tear duct					
	68770	Close tear system fistula					
	68811	Probe nasolacrimal duct					
	68815	Probe nasolacrimal duct					
0241	Level IV Repair and Plastic Eye Procedures		T	16.60	$804.89	$384.47	$160.98
	65093	Revise eye with implant					
	65130	Insert ocular implant					
	65135	Insert ocular implant					
	65150	Revise ocular implant					
	67400	Explore/biopsy eye socket					
	67405	Explore/drain eye socket					
	67412	Explore/treat eye socket					
	67413	Explore/treat eye socket					
	67560	Revise eye socket implant					
	67971	Reconstruction of eyelid					
	67973	Reconstruction of eyelid					
	67974	Reconstruction of eyelid					
	68326	Revise/graft eyelid lining					
	68328	Revise/graft eyelid lining					
	68335	Revise/graft eyelid lining					
	68500	Removal of tear gland					
	68505	Partial removal, tear gland					
	68520	Removal of tear sac					
	68540	Remove tear gland lesion					
	68700	Repair tear ducts					
	68745	Create tear duct drain					
0242	Level V Repair and Plastic Eye Procedures		T	23.70	$1,149.14	$597.36	$229.83
	65091	Revise eye					
	65101	Removal of eye					
	65103	Remove eye/insert implant					
	65105	Remove eye/attach implant					
	65110	Removal of eye					
	65112	Remove eye/revise socket					
	65114	Remove eye/revise socket					
	65140	Attach ocular implant					
	65155	Reinsert ocular implant					
	67414	Explr/decompress eye socket					
	67420	Explore/treat eye socket					
	67430	Explore/treat eye socket					
	67440	Explore/drain eye socket					
	67445	Explr/decompress eye socket					
	67450	Explore/biopsy eye socket					
	67550	Insert eye socket implant					
	67570	Decompress optic nerve					
	68325	Revise/graft eyelid lining					
	68550	Remove tear gland lesion					
	68720	Create tear sac drain					
	68750	Create tear duct drain					
0243	Strabismus/Muscle Procedures		T	17.99	$872.28	$431.39	$174.46
	65290	Repair of eye socket wound					
	67311	Revise eye muscle					
	67312	Revise two eye muscles					
	67314	Revise eye muscle					
	67316	Revise two eye muscles					
	67318	Revise eye muscle(s)					
	67320	Revise eye muscle(s) add-on					
	67331	Eye surgery follow-up add-on					
	67332	Rerevise eye muscles add-on					
	67334	Revise eye muscle w/suture					
	67335	Eye suture during surgery					
	67340	Revise eye muscle add-on					
	67343	Release eye tissue					
	67399	Eye muscle surgery procedure					
0244	Corneal Transplant		T	32.88	$1,594.26	$851.42	$318.85
	65710	Corneal transplant					
	65730	Corneal transplant					
	65750	Corneal transplant					
	65755	Corneal transplant					
	65770	Revise cornea with implant					
0245	Cataract Procedures without IOL Insert		T	26.55	$1,287.33	$623.85	$257.47
	66840	Removal of lens material					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	66850	Removal of lens material					
	66852	Removal of lens material					
	66920	Extraction of lens					
	66930	Extraction of lens					
	66940	Extraction of lens					
0246	Cataract Procedures with IOL Insert		T	26.55	$1,287.33	$623.85	$257.47
	66983	Remove cataract/insert lens					
	66984	Remove cataract/insert lens					
	66985	Insert lens prosthesis					
	66986	Exchange lens prosthesis					
0247	Laser Eye Procedures Except Retinal		T	4.89	$237.10	$112.86	$47.42
	65855	Laser surgery of eye					
	65860	Incise inner eye adhesions					
	66761	Revision of iris					
	66762	Revision of iris					
	66770	Removal of inner eye lesion					
	66821	After cataract laser surgery					
	66999	Eye surgery procedure					
	67031	Laser surgery, eye strands					
0248	Laser Retinal Procedures		T	4.19	$203.16	$94.05	$40.63
	67105	Repair detached retina					
	67145	Treatment of retina					
	67210	Treatment of retinal lesion					
	67228	Treatment of retinal lesion					
	67299	Eye surgery procedure					
0250	Nasal Cauterization/Packing		T	2.21	$107.16	$38.54	$21.43
	30901	Control of nosebleed					
	30903	Control of nosebleed					
	30905	Control of nosebleed					
	30906	Repeat control of nosebleed					
	42960	Control throat bleeding					
	42970	Control nose/throat bleeding					
0251	Level I ENT Procedures		T	1.68	$81.46	$27.99	$16.29
	21450	Treat lower jaw fracture					
	21480	Reset dislocated jaw					
	30000	Drainage of nose lesion					
	30020	Drainage of nose lesion					
	30300	Remove nasal foreign body					
	30560	Release of nasal adhesions					
	30999	Nasal surgery procedure					
	31000	Irrigation, maxillary sinus					
	40800	Drainage of mouth lesion					
	40804	Removal, foreign body, mouth					
	40806	Incision of lip fold					
	40808	Biopsy of mouth lesion					
	40818	Excise oral mucosa for graft					
	40830	Repair mouth laceration					
	41005	Drainage of mouth lesion					
	41009	Drainage of mouth lesion					
	41250	Repair tongue laceration					
	41599	Tongue and mouth surgery					
	41800	Drainage of gum lesion					
	42000	Drainage mouth roof lesion					
	42180	Repair palate					
	42280	Preparation, palate mold					
	42299	Palate/uvula surgery					
	42310	Drainage of salivary gland					
	42320	Drainage of salivary gland					
	42700	Drainage of tonsil abscess					
	42809	Remove pharynx foreign body					
	69400	Inflate middle ear canal					
	92502	Ear and throat examination					
0252	Level II ENT Procedures		T	5.18	$251.16	$114.24	$50.23
	20500	Injection of sinus tract					
	21400	Treat eye socket fracture					
	21493	Treat hyoid bone fracture					
	21494	Treat hyoid bone fracture					
	21899	Neck/chest surgery procedure					
	30100	Intranasal biopsy					
	30124	Removal of nose lesion					
	30210	Nasal sinus therapy					
	30220	Insert nasal septal button					
	30801	Cauterization, inner nose					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	31002	Irrigation, sphenoid sinus					
	31299	Sinus surgery procedure					
	40490	Biopsy of lip					
	40801	Drainage of mouth lesion					
	40805	Removal, foreign body, mouth					
	40812	Excise/repair mouth lesion					
	40819	Excise lip or cheek fold					
	40899	Mouth surgery procedure					
	41015	Drainage of mouth lesion					
	41100	Biopsy of tongue					
	41108	Biopsy of floor of mouth					
	41820	Excision, gum, each quadrant					
	41821	Excision of gum flap					
	42100	Biopsy roof of mouth					
	42140	Excision of uvula					
	42325	Create salivary cyst drain					
	42326	Create salivary cyst drain					
	42330	Removal of salivary stone					
	42650	Dilation of salivary duct					
	42660	Dilation of salivary duct					
	42800	Biopsy of throat					
	42999	Throat surgery procedure					
	69399	Outer ear surgery procedure					
	69405	Catheterize middle ear canal					
	69410	Inset middle ear (baffle)					
	69420	Incision of eardrum					
	69424	Remove ventilating tube					
	69433	Create eardrum opening					
	69979	Temporal bone surgery					
0253	Level III ENT Procedures		T	12.02	$582.81	$284.00	$116.56
	21031	Remove exostosis, mandible					
	21032	Remove exostosis, maxilla					
	21040	Removal of jaw bone lesion					
	21085	Prepare face/oral prosthesis					
	21089	Prepare face/oral prosthesis					
	21282	Revision of eyelid					
	21295	Revision of jaw muscle/bone					
	21299	Cranio/maxillofacial surgery					
	21300	Treatment of skull fracture					
	21310	Treatment of nose fracture					
	21315	Treatment of nose fracture					
	21320	Treatment of nose fracture					
	21325	Treatment of nose fracture					
	21337	Treat nasal septal fracture					
	21401	Treat eye socket fracture					
	21440	Treat dental ridge fracture					
	21452	Treat lower jaw fracture					
	21485	Reset dislocated jaw					
	21497	Interdental wiring					
	21499	Head surgery procedure					
	30110	Removal of nose polyp(s)					
	30115	Removal of nose polyp(s)					
	30117	Removal of intranasal lesion					
	30120	Revision of nose					
	30130	Removal of turbinate bones					
	30140	Removal of turbinate bones					
	30200	Injection treatment of nose					
	30310	Remove nasal foreign body					
	30320	Remove nasal foreign body					
	30802	Cauterization, inner nose					
	30930	Therapy, fracture of nose					
	31020	Exploration, maxillary sinus					
	31585	Treat larynx fracture					
	31599	Larynx surgery procedure					
	31612	Puncture/clear windpipe					
	31820	Closure of windpipe lesion					
	40500	Partial excision of lip					
	40520	Partial excision of lip					
	40650	Repair lip					
	40652	Repair lip					
	40799	Lip surgery procedure					
	40810	Excision of mouth lesion					
	40814	Excise/repair mouth lesion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	40816	Excision of mouth lesion					
	40820	Treatment of mouth lesion					
	40831	Repair mouth laceration					
	41000	Drainage of mouth lesion					
	41006	Drainage of mouth lesion					
	41007	Drainage of mouth lesion					
	41008	Drainage of mouth lesion					
	41010	Incision of tongue fold					
	41016	Drainage of mouth lesion					
	41017	Drainage of mouth lesion					
	41018	Drainage of mouth lesion					
	41105	Biopsy of tongue					
	41110	Excision of tongue lesion					
	41112	Excision of tongue lesion					
	41113	Excision of tongue lesion					
	41115	Excision of tongue fold					
	41116	Excision of mouth lesion					
	41251	Repair tongue laceration					
	41252	Repair tongue laceration					
	41500	Fixation of tongue					
	41510	Tongue to lip surgery					
	41520	Reconstruction, tongue fold					
	41805	Removal foreign body, gum					
	41806	Removal foreign body, jawbone					
	41822	Excision of gum lesion					
	41823	Excision of gum lesion					
	41825	Excision of gum lesion					
	41826	Excision of gum lesion					
	41827	Excision of gum lesion					
	41828	Excision of gum lesion					
	41830	Removal of gum tissue					
	41850	Treatment of gum lesion					
	41870	Gum graft					
	41872	Repair gum					
	41874	Repair tooth socket					
	41899	Dental surgery procedure					
	42104	Excision lesion, mouth roof					
	42106	Excision lesion, mouth roof					
	42160	Treatment mouth roof lesion					
	42260	Repair nose to lip fistula					
	42281	Insertion, palate prosthesis					
	42300	Drainage of salivary gland					
	42305	Drainage of salivary gland					
	42335	Removal of salivary stone					
	42340	Removal of salivary stone					
	42405	Biopsy of salivary gland					
	42408	Excision of salivary cyst					
	42409	Drainage of salivary cyst					
	42450	Excise sublingual gland					
	42600	Closure of salivary fistula					
	42665	Ligation of salivary duct					
	42699	Salivary surgery procedure					
	42720	Drainage of throat abscess					
	42802	Biopsy of throat					
	42804	Biopsy of upper nose/throat					
	42806	Biopsy of upper nose/throat					
	42808	Excise pharynx lesion					
	42810	Excision of neck cyst					
	42900	Repair throat wound					
	42972	Control nose/throat bleeding					
	60000	Drain thyroid/tongue cyst					
	69105	Biopsy of external ear canal					
	69120	Removal of external ear					
	69222	Clean out mastoid cavity					
	69421	Incision of eardrum					
	69436	Create eardrum opening					
	69440	Exploration of middle ear					
	69540	Remove ear lesion					
	69610	Repair of eardrum					
	69620	Repair of eardrum					
	69799	Middle ear surgery procedure					
	69949	Inner ear surgery procedure					
0254	Level IV ENT Procedures		T	12.45	$603.66	$272.41	$120.73

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	21010	Incision of jaw joint					
	21015	Resection of facial tumor					
	21030	Removal of face bone lesion					
	21076	Prepare face/oral prosthesis					
	21110	Interdental fixation					
	21120	Reconstruction of chin					
	21121	Reconstruction of chin					
	21122	Reconstruction of chin					
	21123	Reconstruction of chin					
	21125	Augmentation, lower jaw bone					
	21137	Reduction of forehead					
	21181	Contour cranial bone lesion					
	21235	Ear cartilage graft					
	21296	Revision of jaw muscle/bone					
	21330	Treatment of nose fracture					
	21335	Treatment of nose fracture					
	21338	Treat nasoethmoid fracture					
	21339	Treat nasoethmoid fracture					
	21345	Treat nose/jaw fracture					
	21421	Treat mouth roof fracture					
	21445	Treat dental ridge fracture					
	21451	Treat lower jaw fracture					
	21454	Treat lower jaw fracture					
	30118	Removal of intranasal lesion					
	30430	Revision of nose					
	30630	Repair nasal septum defect					
	31040	Exploration behind upper jaw					
	31070	Exploration of frontal sinus					
	31600	Incision of windpipe					
	31601	Incision of windpipe					
	31603	Incision of windpipe					
	31605	Incision of windpipe					
	31610	Incision of windpipe					
	31611	Surgery/speech prosthesis					
	31613	Repair windpipe opening					
	31825	Repair of windpipe defect					
	31830	Revise windpipe scar					
	40510	Partial excision of lip					
	40525	Reconstruct lip with flap					
	40527	Reconstruct lip with flap					
	40530	Partial removal of lip					
	40654	Repair lip					
	40840	Reconstruction of mouth					
	40842	Reconstruction of mouth					
	40843	Reconstruction of mouth					
	41114	Excision of tongue lesion					
	42107	Excision lesion, mouth roof					
	42145	Repair palate, pharynx/uvula					
	42235	Repair palate					
	42500	Repair salivary duct					
	42950	Reconstruction of throat					
	42955	Surgical opening of throat					
	43020	Incision of esophagus					
	69140	Remove ear canal lesion(s)					
	69300	Revise external ear					
	69650	Release middle ear bone					
0256	Level V ENT Procedures		T	25.40	$1,231.57	$623.05	$246.31
	21025	Excision of bone, lower jaw					
	21026	Excision of facial bone(s)					
	21029	Contour of face bone lesion					
	21034	Removal of face bone lesion					
	21041	Removal of jaw bone lesion					
	21044	Removal of jaw bone lesion					
	21050	Removal of jaw joint					
	21060	Remove jaw joint cartilage					
	21070	Remove coronoid process					
	21077	Prepare face/oral prosthesis					
	21079	Prepare face/oral prosthesis					
	21080	Prepare face/oral prosthesis					
	21081	Prepare face/oral prosthesis					
	21082	Prepare face/oral prosthesis					
	21083	Prepare face/oral prosthesis					
	21084	Prepare face/oral prosthesis					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	21086	Prepare face/oral prosthesis					
	21087	Prepare face/oral prosthesis					
	21088	Prepare face/oral prosthesis					
	21100	Maxillofacial fixation					
	21127	Augmentation, lower jaw bone					
	21138	Reduction of forehead					
	21139	Reduction of forehead					
	21198	Reconstruct lower jaw bone					
	21206	Reconstruct upper jaw bone					
	21208	Augmentation of facial bones					
	21209	Reduction of facial bones					
	21210	Face bone graft					
	21215	Lower jaw bone graft					
	21230	Rib cartilage graft					
	21240	Reconstruction of jaw joint					
	21242	Reconstruction of jaw joint					
	21243	Reconstruction of jaw joint					
	21244	Reconstruction of lower jaw					
	21245	Reconstruction of jaw					
	21246	Reconstruction of jaw					
	21248	Reconstruction of jaw					
	21249	Reconstruction of jaw					
	21260	Revise eye sockets					
	21261	Revise eye sockets					
	21263	Revise eye sockets					
	21267	Revise eye sockets					
	21270	Augmentation, cheek bone					
	21275	Revision, orbitofacial bones					
	21280	Revision of eyelid					
	21340	Treatment of nose fracture					
	21355	Treat cheek bone fracture					
	21406	Treat eye socket fracture					
	21407	Treat eye socket fracture					
	21453	Treat lower jaw fracture					
	21461	Treat lower jaw fracture					
	21462	Treat lower jaw fracture					
	21465	Treat lower jaw fracture					
	21470	Treat lower jaw fracture					
	21490	Repair dislocated jaw					
	30125	Removal of nose lesion					
	30150	Partial removal of nose					
	30160	Removal of nose					
	30400	Reconstruction of nose					
	30410	Reconstruction of nose					
	30420	Reconstruction of nose					
	30435	Revision of nose					
	30450	Revision of nose					
	30460	Revision of nose					
	30462	Revision of nose					
	30520	Repair of nasal septum					
	30540	Repair nasal defect					
	30545	Repair nasal defect					
	30580	Repair upper jaw fistula					
	30600	Repair mouth/nose fistula					
	30620	Intranasal reconstruction					
	31030	Exploration, maxillary sinus					
	31032	Explore sinus, remove polyps					
	31050	Exploration, sphenoid sinus					
	31051	Sphenoid sinus surgery					
	31075	Exploration of frontal sinus					
	31080	Removal of frontal sinus					
	31081	Removal of frontal sinus					
	31084	Removal of frontal sinus					
	31085	Removal of frontal sinus					
	31086	Removal of frontal sinus					
	31087	Removal of frontal sinus					
	31090	Exploration of sinuses					
	31200	Removal of ethmoid sinus					
	31201	Removal of ethmoid sinus					
	31205	Removal of ethmoid sinus					
	31300	Removal of larynx lesion					
	31320	Diagnostic incision, larynx					
	31375	Partial removal of larynx					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	31400	Revision of larynx					
	31420	Removal of epiglottis					
	31580	Revision of larynx					
	31586	Treat larynx fracture					
	31588	Revision of larynx					
	31590	Reinnervate larynx					
	31595	Larynx nerve surgery					
	31614	Repair windpipe opening					
	31750	Repair of windpipe					
	31755	Repair of windpipe					
	40700	Repair cleft lip/nasal					
	40701	Repair cleft lip/nasal					
	40702	Repair cleft lip/nasal					
	40720	Repair cleft lip/nasal					
	40761	Repair cleft lip/nasal					
	40844	Reconstruction of mouth					
	40845	Reconstruction of mouth					
	41120	Partial removal of tongue					
	42120	Remove palate/lesion					
	42182	Repair palate					
	42200	Reconstruct cleft palate					
	42205	Reconstruct cleft palate					
	42210	Reconstruct cleft palate					
	42215	Reconstruct cleft palate					
	42220	Reconstruct cleft palate					
	42225	Reconstruct cleft palate					
	42226	Lengthening of palate					
	42227	Lengthening of palate					
	42410	Excise parotid gland/lesion					
	42415	Excise parotid gland/lesion					
	42420	Excise parotid gland/lesion					
	42425	Excise parotid gland/lesion					
	42440	Excise submaxillary gland					
	42505	Repair salivary duct					
	42507	Parotid duct diversion					
	42508	Parotid duct diversion					
	42509	Parotid duct diversion					
	42510	Parotid duct diversion					
	42725	Drainage of throat abscess					
	42815	Excision of neck cyst					
	42844	Extensive surgery of throat					
	42890	Partial removal of pharynx					
	42892	Revision of pharyngeal walls					
	42962	Control throat bleeding					
	60500	Explore parathyroid glands					
	61330	Decompress eye socket					
	69310	Rebuild outer ear canal					
	69320	Rebuild outer ear canal					
	69450	Eardrum revision					
	69501	Mastoidectomy					
	69505	Remove mastoid structures					
	69511	Extensive mastoid surgery					
	69530	Extensive mastoid surgery					
	69550	Remove ear lesion					
	69552	Remove ear lesion					
	69601	Mastoid surgery revision					
	69602	Mastoid surgery revision					
	69603	Mastoid surgery revision					
	69604	Mastoid surgery revision					
	69605	Mastoid surgery revision					
	69631	Repair eardrum structures					
	69632	Rebuild eardrum structures					
	69633	Rebuild eardrum structures					
	69635	Repair eardrum structures					
	69636	Rebuild eardrum structures					
	69637	Rebuild eardrum structures					
	69641	Revise middle ear & mastoid					
	69642	Revise middle ear & mastoid					
	69643	Revise middle ear & mastoid					
	69644	Revise middle ear & mastoid					
	69645	Revise middle ear & mastoid					
	69646	Revise middle ear & mastoid					
	69660	Revise middle ear bone					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	69661	Revise middle ear bone					
	69662	Revise middle ear bone					
	69666	Repair middle ear structures					
	69667	Repair middle ear structures					
	69670	Remove mastoid air cells					
	69676	Remove middle ear nerve					
	69700	Close mastoid fistula					
	69711	Remove/repair hearing aid					
	69720	Release facial nerve					
	69725	Release facial nerve					
	69740	Repair facial nerve					
	69745	Repair facial nerve					
	69801	Incise inner ear					
	69802	Incise inner ear					
	69805	Explore inner ear					
	69806	Explore inner ear					
	69820	Establish inner ear window					
	69840	Revise inner ear window					
	69905	Remove inner ear					
	69910	Remove inner ear & mastoid					
	69915	Incise inner ear nerve					
	69955	Release facial nerve					
	69960	Release inner ear canal					
0257	Implantation of Cochlear Device		T	115.31	$5,591.04	$3,498.58	$1,118.21
	69930	Implant cochlear device					
0258	Tonsil and Adenoid Procedures		T	18.62	$902.83	$462.81	$180.57
	42820	Remove tonsils and adenoids					
	42821	Remove tonsils and adenoids					
	42825	Removal of tonsils					
	42826	Removal of tonsils					
	42830	Removal of adenoids					
	42831	Removal of adenoids					
	42835	Removal of adenoids					
	42836	Removal of adenoids					
	42860	Excision of tonsil tags					
	42870	Excision of lingual tonsil					
0260	Level I Plain Film Except Teeth		X	0.79	$38.30	$22.02	$7.66
	70030	X-ray eye for foreign body					
	70100	X-ray exam of jaw					
	70110	X-ray exam of jaw					
	70120	X-ray exam of mastoids					
	70130	X-ray exam of mastoids					
	70140	X-ray exam of facial bones					
	70150	X-ray exam of facial bones					
	70160	X-ray exam of nasal bones					
	70190	X-ray exam of eye sockets					
	70200	X-ray exam of eye sockets					
	70210	X-ray exam of sinuses					
	70220	X-ray exam of sinuses					
	70240	X-ray exam, pituitary saddle					
	70250	X-ray exam of skull					
	70328	X-ray exam of jaw joint					
	70330	X-ray exam of jaw joints					
	70350	X-ray head for orthodontia					
	70355	Panoramic x-ray of jaws					
	70360	X-ray exam of neck					
	70380	X-ray exam of salivary gland					
	71010	Chest x-ray					
	71015	Chest x-ray					
	71020	Chest x-ray					
	71021	Chest x-ray					
	71022	Chest x-ray					
	71030	Chest x-ray					
	71035	Chest x-ray					
	71100	X-ray exam of ribs					
	71101	X-ray exam of ribs/chest					
	71110	X-ray exam of ribs					
	71120	X-ray exam of breastbone					
	71130	X-ray exam of breastbone					
	72020	X-ray exam of spine					
	72040	X-ray exam of neck spine					
	72069	X-ray exam of trunk spine					
	72070	X-ray exam of thoracic spine					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	72072	X-ray exam of thoracic spine					
	72074	X-ray exam of thoracic spine					
	72080	X-ray exam of trunk spine					
	72090	X-ray exam of trunk spine					
	72100	X-ray exam of lower spine					
	72120	X-ray exam of lower spine					
	72170	X-ray exam of pelvis					
	72190	X-ray exam of pelvis					
	72200	X-ray exam sacroiliac joints					
	72202	X-ray exam sacroiliac joints					
	72220	X-ray exam of tailbone					
	73000	X-ray exam of collar bone					
	73010	X-ray exam of shoulder blade					
	73020	X-ray exam of shoulder					
	73030	X-ray exam of shoulder					
	73050	X-ray exam of shoulders					
	73060	X-ray exam of humerus					
	73070	X-ray exam of elbow					
	73080	X-ray exam of elbow					
	73090	X-ray exam of forearm					
	73092	X-ray exam of arm, infant					
	73100	X-ray exam of wrist					
	73110	X-ray exam of wrist					
	73120	X-ray exam of hand					
	73130	X-ray exam of hand					
	73140	X-ray exam of finger(s)					
	73500	X-ray exam of hip					
	73510	X-ray exam of hip					
	73520	X-ray exam of hips					
	73540	X-ray exam of pelvis & hips					
	73550	X-ray exam of thigh					
	73560	X-ray exam of knee, 1 or 2					
	73562	X-ray exam of knee, 3					
	73564	X-ray exam, knee, 4 or more					
	73565	X-ray exam of knees					
	73590	X-ray exam of lower leg					
	73600	X-ray exam of ankle					
	73610	X-ray exam of ankle					
	73620	X-ray exam of foot					
	73630	X-ray exam of foot					
	73650	X-ray exam of heel					
	73660	X-ray exam of toe(s)					
	74000	X-ray exam of abdomen					
	74010	X-ray exam of abdomen					
	74020	X-ray exam of abdomen					
	74710	X-ray measurement of pelvis					
	76010	X-ray, nose to rectum					
	76040	X-rays, bone evaluation					
	76066	Joint(s) survey, single film					
	76098	X-ray exam, breast specimen					
	76150	X-ray exam, dry process					
	76499	Radiographic procedure					
	77417	Radiology port film(s)					
0261	Level II Plain Film Except Teeth Including Bone Density Measurement		X	1.38	$66.91	$38.77	$13.38
	70134	X-ray exam of middle ear					
	70260	X-ray exam of skull					
	71111	X-ray exam of ribs/chest					
	72010	X-ray exam of spine					
	72050	X-ray exam of neck spine					
	72052	X-ray exam of neck spine					
	72110	X-ray exam of lower spine					
	72114	X-ray exam of lower spine					
	73530	X-ray exam of hip					
	73592	X-ray exam of leg, infant					
	74022	X-ray exam series, abdomen					
	76006	X-ray stress view					
	76020	X-rays for bone age					
	76061	X-rays, bone survey					
	76062	X-rays, bone survey					
	76065	X-rays, bone evaluation					
	76075	Dual energy x-ray study					
	76076	Dual energy x-ray study					
	76078	Photodensitometry					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	76100	X-ray exam of body section					
	76120	Cinematic x-rays					
	76125	Cinematic x-rays add-on					
	78350	Bone mineral, single photon					
	G0130	Single energy x-ray study					
	G0131	CT scan, bone density study					
	G0132	CT scan, bone density study					
0262	Plain Film of Teeth		X	0.40	$19.39	$10.90	$3.88
	70300	X-ray exam of teeth					
	70310	X-ray exam of teeth					
	70320	Full mouth x-ray of teeth					
0263	Level I Miscellaneous Radiology Procedures		X	1.68	$81.46	$45.88	$16.29
	70170	X-ray exam of tear duct					
	70373	Contrast x-ray of larynx					
	70390	X-ray exam of salivary duct					
	71040	Contrast x-ray of bronchi					
	71060	Contrast x-ray of bronchi					
	74190	X-ray exam of peritoneum					
	74305	X-ray bile ducts/pancreas					
	76080	X-ray exam of fistula					
	76086	X-ray of mammary duct					
	76088	X-ray of mammary ducts					
	76096	X-ray of needle wire, breast					
	76101	Complex body section x-ray					
0264	Level II Miscellaneous Radiology Procedures		X	3.83	$185.71	$108.97	$37.14
	74320	Contrast x-ray of bile ducts					
	74328	X-ray bile duct endoscopy					
	74329	X-ray for pancreas endoscopy					
	74330	X-ray bile/panc endoscopy					
	74350	X-ray guide, stomach tube					
	74355	X-ray guide, intestinal tube					
	74470	X-ray exam of kidney lesion					
	74740	X-ray, female genital tract					
	74742	X-ray, fallopian tube					
	75801	Lymph vessel x-ray, arm/leg					
	75803	Lymph vessel x-ray, arms/legs					
	75805	Lymph vessel x-ray, trunk					
	75807	Lymph vessel x-ray, trunk					
	75809	Nonvascular shunt, x-ray					
	75898	Follow-up angiogram					
	76095	Stereotactic breast biopsy					
	76102	Complex body section x-rays					
0265	Level I Diagnostic Ultrasound Except Vascular		S	1.17	$56.73	$38.08	$11.35
	76513	Echo exam of eye, water bath					
	76529	Echo exam of eye					
	76536	Echo exam of head and neck					
	76645	Echo exam of breast(s)					
	76810	Echo exam of pregnant uterus					
	76815	Echo exam of pregnant uterus					
	76816	Echo exam follow-up/repeat					
	76857	Echo exam of pelvis					
	76970	Ultrasound exam follow-up					
	76977	Us bone density measure					
	G0050	Residual urine by ultrasound					
0266	Level II Diagnostic Ultrasound Except Vascular		S	1.79	$86.79	$57.35	$17.36
	76506	Echo exam of head					
	76511	Echo exam of eye					
	76512	Echo exam of eye					
	76516	Echo exam of eye					
	76519	Echo exam of eye					
	76604	Echo exam of chest					
	76700	Echo exam of abdomen					
	76705	Echo exam of abdomen					
	76770	Echo exam abdomen back wall					
	76775	Echo exam abdomen back wall					
	76778	Echo exam kidney transplant					
	76800	Echo exam spinal canal					
	76805	Echo exam of pregnant uterus					
	76818	Fetal biophysical profile					
	76830	Echo exam, transvaginal					
	76831	Echo exam, uterus					
	76856	Echo exam of pelvis					
	76870	Echo exam of scrotum					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	76872	Echo exam, transrectal					
	76873	Echograp trans r, pros study					
	76880	Echo exam of extremity					
	76885	Echo exam, infant hips					
	76886	Echo exam, infant hips					
	76975	GI endoscopic ultrasound					
	76986	Echo exam at surgery					
	76999	Echo examination procedure					
0267	Vascular Ultrasound		S	2.72	$131.88	$80.06	$26.38
	93880	Extracranial study					
	93882	Extracranial study					
	93886	Intracranial study					
	93888	Intracranial study					
	93925	Lower extremity study					
	93926	Lower extremity study					
	93930	Upper extremity study					
	93931	Upper extremity study					
	93970	Extremity study					
	93971	Extremity study					
	93975	Vascular study					
	93976	Vascular study					
	93978	Vascular study					
	93979	Vascular study					
	93980	Penile vascular study					
	93981	Penile vascular study					
	93990	Doppler flow testing					
0268	Guidance Under Ultrasound		X	2.23	$108.13	$69.51	$21.63
	76930	Echo guide for heart sac tap					
	76932	Echo guide for heart biopsy					
	76934	Echo guide for chest tap					
	76936	Echo guide for artery repair					
	76938	Echo exam for drainage					
	76941	Echo guide for transfusion					
	76942	Echo guide for biopsy					
	76945	Echo guide, villus sampling					
	76946	Echo guide for amniocentesis					
	76948	Echo guide, ova aspiration					
	76950	Echo guidance radiotherapy					
	76960	Echo guidance radiotherapy					
	76965	Echo guidance radiotherapy					
	G0161	Echo guide for cryo probes					
0269	Echocardiogram Except Transesophageal		S	4.40	$213.34	$114.01	$42.67
	76825	Echo exam of fetal heart					
	76826	Echo exam of fetal heart					
	76827	Echo exam of fetal heart					
	76828	Echo exam of fetal heart					
	93303	Echo transthoracic					
	93304	Echo transthoracic					
	93307	Echo exam of heart					
	93308	Echo exam of heart					
	93320	Doppler echo exam, heart					
	93321	Doppler echo exam, heart					
	93325	Doppler color flow add-on					
	93350	Echo transthoracic					
0270	Transesophageal Echocardiogram		S	5.55	$269.10	$150.26	$53.82
	93312	Echo transesophageal					
	93313	Echo transesophageal					
	93315	Echo transesophageal					
	93316	Echo transesophageal					
0271	Mammography		S	0.70	$33.94	$19.50	$6.79
	76090	Mammogram, one breast					
	76091	Mammogram, both breasts					
0272	Level I Fluoroscopy		X	1.40	$67.88	$39.00	$13.58
	70371	Speech evaluation, complex					
	71023	Chest x-ray and fluoroscopy					
	71034	Chest x-ray and fluoroscopy					
	74340	X-ray guide for GI tube					
	76000	Fluoroscope examination					
	76003	Needle localization by x-ray					
0273	Level II Fluoroscopy		X	2.49	$120.73	$61.02	$24.15
	70370	Throat x-ray & fluoroscopy					
	71036	X-ray guidance for biopsy					
	71090	X-ray & pacemaker insertion					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	75989	Abscess drainage under x-ray					
	76001	Fluoroscope exam, extensive					
	76005	Fluoroguide for spine inject					
0274	Myelography		S	4.83	$234.19	$128.12	$46.84
	70010	Contrast x-ray of brain					
	70015	Contrast x-ray of brain					
	72240	Contrast x-ray of neck spine					
	72255	Contrast x-ray, thorax spine					
	72265	Contrast x-ray, lower spine					
	72270	Contrast x-ray of spine					
	72275	Epidurography					
	72285	X-ray c/t spine disk					
	72295	X-ray of lower spine disk					
0275	Arthrography		S	2.74	$132.85	$72.26	$26.57
	70332	X-ray exam of jaw joint					
	73040	Contrast x-ray of shoulder					
	73085	Contrast x-ray of elbow					
	73115	Contrast x-ray of wrist					
	73525	Contrast x-ray of hip					
	73542	X-ray exam, sacroiliac joint					
	73580	Contrast x-ray of knee joint					
	73615	Contrast x-ray of ankle					
0276	Level I Digestive Radiology		S	1.79	$86.79	$49.78	$17.36
	74210	Contrst x-ray exam of throat					
	74220	Contrast x-ray, esophagus					
	74230	Cinema x-ray, throat/esoph					
	74240	X-ray exam, upper gi tract					
	74241	X-ray exam, upper gi tract					
	74246	Contrst x-ray uppr gi tract					
	74247	Contrst x-ray uppr gi tract					
	74250	X-ray exam of small bowel					
	74270	Contrast x-ray exam of colon					
	74283	Contrast x-ray exam of colon					
	74290	Contrast x-ray, gallbladder					
	74291	Contrast x-rays, gallbladder					
0277	Level II Digestive Radiology		S	2.47	$119.76	$69.28	$23.95
	74245	X-ray exam, upper gi tract					
	74249	Contrst x-ray uppr gi tract					
	74251	X-ray exam of small bowel					
	74260	X-ray exam of small bowel					
	74280	Contrast x-ray exam of colon					
0278	Diagnostic Urography		S	2.85	$138.19	$81.67	$27.64
	74400	Contrst x-ray, urinary tract					
	74410	Contrst x-ray, urinary tract					
	74415	Contrst x-ray, urinary tract					
	74420	Contrst x-ray, urinary tract					
	74425	Contrst x-ray, urinary tract					
	74430	Contrast x-ray, bladder					
	74440	X-ray, male genital tract					
	74445	X-ray exam of penis					
	74450	X-ray, urethra/bladder					
	74455	X-ray, urethra/bladder					
	74775	X-ray exam of perineum					
0279	Level I Diagnostic Angiography and Venography Except Extremity		S	6.30	$305.47	$174.57	$61.09
	75660	Artery x-rays, head & neck					
	75662	Artery x-rays, head & neck					
	75685	Artery x-rays, spine					
	75705	Artery x-rays, spine					
	75741	Artery x-rays, lung					
	75746	Artery x-rays, lung					
	75756	Artery x-rays, chest					
	75810	Vein x-ray, spleen/liver					
	75825	Vein x-ray, trunk					
	75827	Vein x-ray, chest					
	75831	Vein x-ray, kidney					
	75833	Vein x-ray, kidneys					
	75840	Vein x-ray, adrenal gland					
	75842	Vein x-ray, adrenal glands					
	75860	Vein x-ray, neck					
	75870	Vein x-ray, skull					
	75872	Vein x-ray, skull					
	75880	Vein x-ray, eye socket					
	75885	Vein x-ray, liver					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	75889	Vein x-ray, liver					
	75891	Vein x-ray, liver					
0280	Level II Diagnostic Angiography and Venography Except Extremity		S	14.98	$726.34	$380.12	$145.27
	75600	Contrast x-ray exam of aorta					
	75605	Contrast x-ray exam of aorta					
	75625	Contrast x-ray exam of aorta					
	75630	X-ray aorta, leg arteries					
	75650	Artery x-rays, head & neck					
	75658	Artery x-rays, arm					
	75665	Artery x-rays, head & neck					
	75671	Artery x-rays, head & neck					
	75676	Artery x-rays, neck					
	75680	Artery x-rays, neck					
	75710	Artery x-rays, arm/leg					
	75716	Artery x-rays, arms/legs					
	75722	Artery x-rays, kidney					
	75724	Artery x-rays, kidneys					
	75726	Artery x-rays, abdomen					
	75731	Artery x-rays, adrenal gland					
	75733	Artery x-rays, adrenals					
	75736	Artery x-rays, pelvis					
	75743	Artery x-rays, lungs					
	75774	Artery x-ray, each vessel					
	75887	Vein x-ray, liver					
0281	Venography of Extremity		S	4.40	$213.34	$115.16	$42.67
	75790	Visualize A–V shunt					
	75820	Vein x-ray, arm/leg					
	75822	Vein x-ray, arms/legs					
0282	Level I Computerized Axial Tomography		S	2.38	$115.40	$94.51	$23.08
	70486	Cat scan of face/jaw					
	76370	CAT scan for therapy guide					
	76375	3d/holograph reconstr add-on					
	76380	CAT scan follow-up study					
0283	Level II Computerized Axial Tomography		S	4.89	$237.10	$179.39	$47.42
	70450	CAT scan of head or brain					
	70460	Contrast CAT scan of head					
	70470	Contrast CAT scans of head					
	70480	CAT scan of skull					
	70481	Contrast CAT scan of skull					
	70482	Contrast CAT scans of skull					
	70487	Contrast CAT scan, face/jaw					
	70488	Contrast cat scans, face/jaw					
	70490	CAT scan of neck tissue					
	70491	Contrast CAT of neck tissue					
	70492	Contrast CAT of neck tissue					
	71250	Cat scan of chest					
	71260	Contrast CAT scan of chest					
	71270	Contrast CAT scans of chest					
	72125	CAT scan of neck spine					
	72126	Contrast CAT scan of neck					
	72127	Contrast CAT scans of neck					
	72128	CAT scan of thorax spine					
	72129	Contrast CAT scan of thorax					
	72130	Contrast CAT scans of thorax					
	72131	CAT scan of lower spine					
	72132	Contrast CAT of lower spine					
	72133	Contrst cat scans, low spine					
	72192	CAT scan of pelvis					
	72193	Contrast CAT scan of pelvis					
	72194	Contrast CAT scans of pelvis					
	73200	CAT scan of arm					
	73201	Contrast CAT scan of arm					
	73202	Contrast CAT scans of arm					
	73700	CAT scan of leg					
	73701	Contrast CAT scan of leg					
	73702	Contrast CAT scans of leg					
	74150	CAT scan of abdomen					
	74160	Contrast CAT scan of abdomen					
	74170	Contrast CAT scans, abdomen					
	76355	CAT scan for localization					
	76360	CAT scan for needle biopsy					
	76365	CAT scan for cyst aspiration					
0284	Magnetic Resonance Imaging		S	8.02	$388.87	$257.39	$77.77

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	70336	Magnetic image, jaw joint					
	70540	Magnetic image, face/neck					
	70541	Magnetic image, head (MRA)					
	70551	Magnetic image, brain (MRI)					
	70552	Magnetic image, brain (MRI)					
	70553	Magnetic image, brain (mri)					
	71550	Magnetic image, chest (mri)					
	72141	Magnetic image, neck spine					
	72142	Magnetic image, neck spine					
	72146	Magnetic image, chest spine					
	72147	Magnetic image, chest spine					
	72148	Magnetic image, lumbar spine					
	72149	Magnetic image, lumbar spine					
	72156	Magnetic image, neck spine					
	72157	Magnetic image, chest spine					
	72158	Magnetic image, lumbar spine					
	72196	Magnetic image, pelvis					
	73220	Magnetic image, arm/hand					
	73221	Magnetic image, joint of arm					
	73720	Magnetic image, leg/foot					
	73721	Magnetic image, joint of leg					
	74181	Magnetic image/abdomen (mri)					
	75552	Magnetic image, myocardium					
	75553	Magnetic image, myocardium					
	75554	Cardiac MRI/function					
	75555	Cardiac MRI/limited study					
	76093	Magnetic image, breast					
	76094	Magnetic image, both breasts					
	76390	Mr spectroscopy					
	76400	Magnetic image, bone marrow					
0285	Positron Emission Tomography (PET)		S	15.06	$730.22	$415.21	$146.04
	G0030	PET imaging prev PET single					
	G0031	PET imaging prev PET multple					
	G0032	PET follow SPECT 78464 singl					
	G0033	PET follow SPECT 78464 mult					
	G0034	PET follow SPECT 76865 singl					
	G0035	PET follow SPECT 78465 mult					
	G0036	PET follow cornry angio sing					
	G0037	PET follow cornry angio mult					
	G0038	PET follow myocard perf sing					
	G0039	PET follow myocard perf mult					
	G0040	PET follow stress echo singl					
	G0041	PET follow stress echo mult					
	G0042	PET follow ventriculogm sing					
	G0043	PET follow ventriculogm mult					
	G0044	PET following rest ECG singl					
	G0045	PET following rest ECG mult					
	G0046	PET follow stress ECG singl					
	G0047	PET follow stress ECG mult					
0286	Myocardial Scans		S	7.28	$352.99	$200.04	$70.60
	78460	Heart muscle blood, single					
	78461	Heart muscle blood, multiple					
	78464	Heart image (3d), single					
	78465	Heart image (3d), multiple					
	78472	Gated heart, planar, single					
	78473	Gated heart, multiple					
	78478	Heart wall motion add-on					
	78480	Heart function add-on					
	78481	Heart first pass, single					
	78483	Heart first pass, multiple					
0290	Standard Non-Imaging Nuclear Medicine		S	1.94	$94.06	$55.51	$18.81
	78000	Thyroid, single uptake					
	78001	Thyroid, multiple uptakes					
	78003	Thyroid suppress/stimul					
	78010	Thyroid imaging					
	78011	Thyroid imaging with flow					
	78099	Endocrine nuclear procedure					
	78199	Blood/lymph nuclear exam					
	78270	Vit B–12 absorption exam					
	78271	Vit B–12 absorp exam, IF					
	78282	GI protein loss exam					
	78299	GI nuclear procedure					
	78399	Musculoskeletal nuclear exam					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
0291		Level I Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	3.15	$152.73	$93.14	$30.55
	78006	Thyroid imaging with uptake					
	78007	Thyroid image, mult uptakes					
	78015	Thyroid met imaging					
	78102	Bone marrow imaging, ltd					
	78110	Plasma volume, single					
	78111	Plasma volume, multiple					
	78120	Red cell mass, single					
	78121	Red cell mass, multiple					
	78185	Spleen imaging					
	78190	Platelet survival, kinetics					
	78191	Platelet survival					
	78201	Liver imaging					
	78202	Liver imaging with flow					
	78215	Liver and spleen imaging					
	78216	Liver & spleen image/flow					
	78230	Salivary gland imaging					
	78231	Serial salivary imaging					
	78232	Salivary gland function exam					
	78258	Esophageal motility study					
	78261	Gastric mucosa imaging					
	78262	Gastroesophageal reflux exam					
	78272	Vit B–12 absorp, combined					
	78290	Meckel's divert exam					
	78300	Bone imaging, limited area					
	78445	Vascular flow imaging					
	78455	Venous thrombosis study					
	78456	Acute venous thrombus image					
	78457	Venous thrombosis imaging					
	78458	Ven thrombosis images, bilat					
	78580	Lung perfusion imaging					
	78591	Vent image, 1 breath, 1 proj					
	78599	Respiratory nuclear exam					
	78605	Brain imaging, complete					
	78610	Brain flow imaging only					
	78660	Nuclear exam of tear flow					
	78700	Kidney imaging, static					
	78701	Kidney imaging with flow					
	78715	Renal vascular flow exam					
	78725	Kidney function study					
	78730	Urinary bladder retention					
	78740	Ureteral reflux study					
	78760	Testicular imaging					
	78761	Testicular imaging/flow					
	78999	Nuclear diagnostic exam					
0292		Level II Diagnostic Nuclear Medicine Excluding Myocardial Scans	S	4.36	$211.40	$126.63	$42.28
	78016	Thyroid met imaging/studies					
	78018	Thyroid met imaging, body					
	78020	Thyroid met uptake					
	78070	Parathyroid nuclear imaging					
	78075	Adrenal nuclear imaging					
	78103	Bone marrow imaging, mult					
	78104	Bone marrow imaging, body					
	78122	Blood volume					
	78130	Red cell survival study					
	78135	Red cell survival kinetics					
	78140	Red cell sequestration					
	78160	Plasma iron turnover					
	78162	Iron absorption exam					
	78170	Red cell iron utilization					
	78172	Total body iron estimation					
	78195	Lymph system imaging					
	78205	Liver imaging (3D)					
	78206	Liver image (3d) w/flow					
	78220	Liver function study					
	78223	Hepatobiliary imaging					
	78264	Gastric emptying study					
	78278	Acute GI blood loss imaging					
	78291	Leveen/shunt patency exam					
	78305	Bone imaging, multiple areas					
	78306	Bone imaging, whole body					
	78315	Bone imaging, 3 phase					
	78320	Bone imaging (3D)					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	78414	Non-imaging heart function					
	78428	Cardiac shunt imaging					
	78466	Heart infarct image					
	78468	Heart infarct image (ef)					
	78469	Heart infarct image (3D)					
	78499	Cardiovascular nuclear exam					
	78584	Lung V/Q image single breath					
	78585	Lung V/Q imaging					
	78586	Aerosol lung image, single					
	78587	Aerosol lung image, multiple					
	78588	Perfusion lung image					
	78593	Vent image, 1 proj, gas					
	78594	Vent image, mult proj, gas					
	78596	Lung differential function					
	78600	Brain imaging, ltd static					
	78601	Brain imaging, ltd w/flow					
	78606	Brain imaging, compl w/flow					
	78607	Brain imaging (3D)					
	78615	Cerebral blood flow imaging					
	78630	Cerebrospinal fluid scan					
	78635	CSF ventriculography					
	78645	CSF shunt evaluation					
	78647	Cerebrospinal fluid scan					
	78650	CSF leakage imaging					
	78699	Nervous system nuclear exam					
	78704	Imaging renogram					
	78707	Kidney flow/function image					
	78708	Kidney flow/function image					
	78709	Kidney flow/function image					
	78710	Kidney imaging (3D)					
	78799	Genitourinary nuclear exam					
	78800	Tumor imaging, limited area					
	78801	Tumor imaging, mult areas					
	78802	Tumor imaging, whole body					
	78803	Tumor imaging (3D)					
	78805	Abscess imaging, ltd area					
	78806	Abscess imaging, whole body					
	78807	Nuclear localization/abscess					
0294	Level I Therapeutic Nuclear Medicine		S	5.13	$248.74	$144.06	$49.75
	79000	Init hyperthyroid therapy					
	79001	Repeat hyperthyroid therapy					
	79020	Thyroid ablation					
	79030	Thyroid ablation, carcinoma					
	79035	Thyroid metastatic therapy					
	79100	Hematopoetic nuclear therapy					
	79300	Interstitial nuclear therapy					
	79440	Nuclear joint therapy					
	79999	Nuclear medicine therapy					
0295	Level II Therapeutic Nuclear Medicine		S	19.85	$962.47	$609.17	$192.49
	79200	Intracavitary nuclear trmt					
	79400	Nonhemato nuclear therapy					
	79420	Intravascular nuclear ther					
0296	Level I Therapeutic Radiologic Procedures		S	3.57	$173.10	$100.25	$34.62
	74235	Remove esophagus obstruction					
	74327	X-ray bile stone removal					
	74360	X-ray guide, GI dilation					
	74485	X-ray guide, GU dilation					
	75984	X-ray control catheter change					
	78494	Heart image, spect					
	78496	Heart first pass add-on					
0297	Level II Therapeutic Radiologic Procedures		S	6.13	$297.23	$172.51	$59.45
	74363	X-ray, bile duct dilation					
	74475	X-ray control, cath insert					
	74480	X-ray control, cath insert					
	75894	X-rays, transcath therapy					
	75896	X-rays, transcath therapy					
	75980	Contrast x-ray exam bile duct					
	75982	Contrast x-ray exam bile duct					
0300	Level I Radiation Therapy		S	1.98	$96.00	$47.72	$19.20
	77401	Radiation treatment delivery					
	77402	Radiation treatment delivery					
	77403	Radiation treatment delivery					
	77404	Radiation treatment delivery					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	77406	Radiation treatment delivery					
	77407	Radiation treatment delivery					
	77408	Radiation treatment delivery					
	77409	Radiation treatment delivery					
	77414	Radiation treatment delivery					
	77789	Radioelement application					
0301	Level II Radiation Therapy		S	2.21	$107.16	$52.53	$21.43
	77411	Radiation treatment delivery					
	77412	Radiation treatment delivery					
	77413	Radiation treatment delivery					
	77416	Radiation treatment delivery					
	77520	Proton beam delivery					
	77523	Proton beam delivery					
	77750	Infuse radioactive materials					
0302	Level III Radiation Therapy		S	8.21	$398.08	$216.55	$79.62
	77470	Special radiation treatment					
	G0173	Stereotactic, one session					
	G0174	Stereotactic, mult session					
0303	Treatment Device Construction		X	2.83	$137.22	$69.28	$27.44
	77332	Radiation treatment aid(s)					
	77333	Radiation treatment aid(s)					
	77334	Radiation treatment aid(s)					
0304	Level I Therapeutic Radiation Treatment Preparation		X	1.49	$72.25	$41.52	$14.45
	77280	Set radiation therapy field					
	77300	Radiation therapy dose plan					
	77305	Radiation therapy dose plan					
	77310	Radiation therapy dose plan					
	77331	Special radiation dosimetry					
0305	Level II Therapeutic Radiation Treatment Preparation		X	4.06	$196.86	$97.50	$39.37
	77285	Set radiation therapy field					
	77290	Set radiation therapy field					
	77315	Radiation therapy dose plan					
	77321	Radiation therapy port plan					
	77326	Radiation therapy dose plan					
	77327	Radiation therapy dose plan					
	77328	Radiation therapy dose plan					
0310	Level III Therapeutic Radiation Treatment Preparation		X	13.98	$677.85	$339.05	$135.57
	77295	Set radiation therapy field					
0311	Radiation Physics Services		X	1.32	$64.00	$31.66	$12.80
	77336	Radiation physics consult					
	77370	Radiation physics consult					
	77399	External radiation dosimetry					
0312	Radioelement Applications		S	4.09	$198.31	$109.65	$39.66
	77761	Radioelement application					
	77762	Radioelement application					
	77763	Radioelement application					
	77776	Radioelement application					
	77777	Radioelement application					
	77778	Radioelement application					
0313	Brachytherapy		S	7.89	$382.56	$164.02	$76.51
	77781	High intensity brachytherapy					
	77782	High intensity brachytherapy					
	77783	High intensity brachytherapy					
	77784	High intensity brachytherapy					
	77799	Radium/radioisotope therapy					
0314	Hyperthermic Therapies		S	5.88	$285.10	$150.95	$57.02
	77600	Hyperthermia treatment					
	77605	Hyperthermia treatment					
	77610	Hyperthermia treatment					
	77615	Hyperthermia treatment					
	77620	Hyperthermia treatment					
0320	Electroconvulsive Therapy		S	3.68	$178.43	$80.06	$35.69
	90870	Electroconvulsive therapy					
	90871	Electroconvulsive therapy					
0321	Biofeedback and Other Training		S	1.26	$61.09	$29.25	$12.22
	90901	Biofeedback train, any meth					
	90911	Biofeedback peri/uro/rectal					
0322	Brief Individual Psychotherapy		S	1.32	$64.00	$14.22	$12.80
	90804	Psytx, office, 20–30 min					
	90805	Psytx, off, 20–30 min w/e&m					
	90810	Intac psytx, off, 20–30 min					
	90811	Intac psytx, 20–30, w/e&m					
	90816	Psytx, hosp, 20–30 min					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	90817	Psytx, hosp, 20–30 min w/e&m					
	90823	Intac psytx, hosp, 20–30 min					
	90824	Intac psytx, hsp 20–30 w/e&m					
	90899	Psychiatric service/therapy					
0323	Extended	Individual Psychotherapy	S	1.85	$89.70	$22.48	$17.94
	90801	Psy dx interview					
	90802	Intac psy dx interview					
	90806	Psytx, off, 45–50 min					
	90807	Psytx, off, 45–50 min w/e&m					
	90808	Psytx, office, 75–80 min					
	90809	Psytx, off, 75–80, w/e&m					
	90812	Intac psytx, off, 45–50 min					
	90813	Intac psytx, 45–50 min w/e&m					
	90814	Intac psytx, off, 75–80 min					
	90815	Intac psytx, 75–80 w/e&m					
	90818	Psytx, hosp, 45–50 min					
	90819	Psytx, hosp, 45–50 min w/e&m					
	90821	Psytx, hosp, 75–80 min					
	90822	Psytx, hosp, 75–80 min w/e&m					
	90826	Intac psytx, hosp, 45–50 min					
	90827	Intac psytx, hsp 45–50 w/e&m					
	90828	Intac psytx, hosp, 75–80 min					
	90829	Intac psytx, hsp 75–80 w/e&m					
	90845	Psychoanalysis					
	90865	Narcosynthesis					
	90880	Hypnotherapy					
0324	Family Psychotherapy		S	1.87	$90.67	$20.19	$18.13
	90846	Family psytx w/o patient					
	90847	Family psytx w/patient					
0325	Group Psychotherapy		S	1.55	$75.16	$19.96	$15.03
	90849	Multiple family group psytx					
	90853	Group psychotherapy					
	90857	Intac group psytx					
0330	Dental Procedures		S	1.51	$73.22	$14.64	$14.64
	D0150	Comprehensve oral evaluation					
	D0240	Intraoral occlusal film					
	D0250	Extraoral first film					
	D0260	Extraoral ea additional film					
	D0270	Dental bitewing single film					
	D0272	Dental bitewings two films					
	D0274	Dental bitewings four films					
	D0460	Pulp vitality test					
	D0501	Histopathologic examinations					
	D0502	Other oral pathology procedu					
	D0999	Unspecified diagnostic proce					
	D1510	Space maintainer fxd unilat					
	D1515	Fixed bilat space maintainer					
	D1520	Remove unilat space maintain					
	D1525	Remove bilat space maintain					
	D1550	Recement space maintainer					
	D2970	Temporary-fractured tooth					
	D2999	Dental unspec restorative pr					
	D3460	Endodontic endosseous implan					
	D3999	Endodontic procedure					
	D4260	Osseous surgery per quadrant					
	D4263	Bone replce graft first site					
	D4264	Bone replce graft each add					
	D4270	Pedicle soft tissue graft pr					
	D4271	Free soft tissue graft proc					
	D4273	Subepithelial tissue graft					
	D4355	Full mouth debridement					
	D4381	Localized chemo delivery					
	D5911	Facial moulage sectional					
	D5912	Facial moulage complete					
	D5983	Radiation applicator					
	D5984	Radiation shield					
	D5985	Radiation cone locator					
	D5987	Commissure splint					
	D6920	Dental connector bar					
	D7110	Oral surgery single tooth					
	D7120	Each add tooth extraction					
	D7130	Tooth root removal					
	D7210	Rem imp tooth w mucoper flp					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	D7220	Impact tooth remov soft tiss					
	D7230	Impact tooth remov part bony					
	D7240	Impact tooth remov comp bony					
	D7241	Impact tooth rem bony w/comp					
	D7250	Tooth root removal					
	D7260	Oral antral fistula closure					
	D7291	Transseptal fiberotomy					
	D7940	Reshaping bone orthognathic					
	D9630	Other drugs/medicaments					
	D9930	Treatment of complications					
	D9940	Dental occlusal guard					
	D9950	Occlusion analysis					
	D9951	Limited occlusal adjustment					
	D9952	Complete occlusal adjustment					
0340	Minor Ancillary Procedures		X	1.04	$50.43	$12.85	$10.09
	69200	Clear outer ear canal					
	69210	Remove impacted ear wax					
0341	Immunology Tests		X	0.13	$6.30	$3.67	$1.26
	86485	Skin test, candida					
	86490	Coccidioidomycosis skin test					
	86510	Histoplasmosis skin test					
	86580	TB intradermal test					
	86585	TB tine test					
	86586	Skin test, unlisted					
0342	Level I Pathology		X	0.26	$12.61	$8.03	$2.52
	85060	Blood smear interpretation					
	88160	Cytopath smear, other source					
	88199	Cytopathology procedure					
	88300	Surgical path, gross					
	88302	Tissue exam by pathologist					
	88311	Decalcify tissue					
	88313	Special stains					
	88319	Enzyme histochemistry					
	88321	Microslide consultation					
	88399	Surgical pathology procedure					
0343	Level II Pathology		X	0.45	$21.82	$12.16	$4.36
	80500	Lab pathology consultation					
	80502	Lab pathology consultation					
	86077	Physician blood bank service					
	88104	Cytopathology, fluids					
	88106	Cytopathology, fluids					
	88107	Cytopathology, fluids					
	88108	Cytopath, concentrate tech					
	88125	Forensic cytopathology					
	88161	Cytopath smear, other source					
	88162	Cytopath smear, other source					
	88172	Evaluation of smear					
	88173	Interpretation of smear					
	88304	Tissue exam by pathologist					
	88305	Tissue exam by pathologist					
	88312	Special stains					
	88314	Histochemical stain					
	88318	Chemical histochemistry					
	88323	Microslide consultation					
	88325	Comprehensive review of data					
	88329	Pathology consult in surgery					
	88331	Pathology consult in surgery					
	88332	Pathology consult in surgery					
	88346	Immunofluorescent study					
	88362	Nerve teasing preparations					
	89399	Pathology lab procedure					
	G0025	Collagen skin test kit					
0344	Level III Pathology		X	0.79	$38.30	$23.63	$7.66
	85097	Bone marrow interpretation					
	86078	Physician blood bank service					
	86079	Physician blood bank service					
	88180	Cell marker study					
	88182	Cell marker study					
	88307	Tissue exam by pathologist					
	88309	Tissue exam by pathologist					
	88342	Immunocytochemistry					
	88347	Immunofluorescent study					
	88348	Electron microscopy					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	88349	Scanning electron microscopy					
	88355	Analysis, skeletal muscle					
	88356	Analysis, nerve					
	88358	Analysis, tumor					
	88365	Tissue hybridization					
	89350	Sputum specimen collection					
	89360	Collect sweat for test					
[2] 0354	Administration of Influenza Vaccine		X	0.13	$6.19	.....	.....
	G0008	Admin influenza virus vac					
	Q0034	Admin of influenza vaccine					
0355	Level I Immunizations		X	0.19	$9.21	$5.05	$1.84
	90645	Hib vaccine, hboc, im					
	90646	Hib vaccine, prp-d, im					
	90647	Hib vaccine, prp-omp, im					
	90648	Hib vaccine, prp-t, im					
	90657	Flu vaccine, 6–35 mo, im					
	90658	Flu vaccine, 3 yrs, im					
	90659	Flu vaccine, whole, im					
	90660	Flu vaccine, nasal					
	90700	Dtap vaccine, im					
	90702	Dt vaccine, im					
	90704	Mumps vaccine, sc					
	90713	Poliovirus, ipv, sc					
	90716	Chicken pox vaccine, sc					
	90720	Dtp/hib vaccine, im					
	90721	Dtap/hib vaccine, im					
	90727	Plague vaccine, im					
	90732	Pneumococcal vaccine, adult					
	90749	Vaccine toxoid					
0356	Level II Immunizations		X	0.36	$17.46	$4.82	$3.49
	90371	Hep b ig, im					
	90389	Tetanus ig, im					
	90396	Varicella-zoster ig, im					
	90476	Adenovirus vaccine, type 4					
	90477	Adenovirus vaccine, type 7					
	90585	Bcg vaccine, percut					
	90586	Bcg vaccine, intravesical					
	90632	Hep a vaccine, adult im					
	90633	Hep a vacc, ped/adol, 2 dose					
	90634	Hep a vacc, ped/adol, 3 dose					
	90680	Rotovirus vaccine, oral					
	90690	Typhoid vaccine, oral					
	90691	Typhoid vaccine, im					
	90692	Typhoid vaccine, h-p, sc/id					
	90693	Typhoid vaccine, akd, sc					
	90701	Dtp vaccine, im					
	90703	Tetanus vaccine, im					
	90707	Mmr vaccine, sc					
	90710	Mmrv vaccine, sc					
	90712	Oral poliovirus vaccine					
	90717	Yellow fever vaccine, sc					
	90718	Td vaccine, im					
	90744	Hep b vaccine, ped/adol, im					
	90746	Hep b vaccine, adult, im					
	90747	Hep b vaccine, ill pat, im					
0357	Level III Immunizations		X	1.85	$89.70	$38.31	$17.94
	90287	Botulinum antitoxin					
	90296	Diphtheria antitoxin					
	90375	Rabies ig, im/sc					
	90376	Rabies ig, heat treated					
	90378	Rsv ig, im					
	90379	Rsv ig, iv					
	90384	Rh ig, full-dose, im					
	90385	Rh ig, minidose, im					
	90386	Rh ig, iv					
	90393	Vaccina ig, im					
	90581	Anthrax vaccine, sc					
	90636	Hep a/hep b vacc, adult im					
	90665	Lyme disease vaccine, im					
	90669	Pneumococcal vaccine, ped					
	90675	Rabies vaccine, im					
	90676	Rabies vaccine, id					
	90705	Measles vaccine, sc					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	90719	Diphtheria vaccine, im					
	90733	Meningococcal vaccine, sc					
	90735	Encephalitis vaccine, sc					
0358	Level IV Immunizations		X	6.98	$338.44	$126.74	$67.69
	90706	Rubella vaccine, sc					
	90708	Measles-rubella vaccine, sc					
	90709	Rubella & mumps vaccine, sc					
	90725	Cholera vaccine, injectable					
	90748	Hep b/hib vaccine, im					
0359	Injections		X	0.96	$46.55	$9.31	$9.31
	90782	Injection, sc/im					
	90783	Injection, ia					
	90784	Injection, iv					
	90788	Injection of antibiotic					
	90799	Ther/prophylactic/dx inject					
0360	Level I Alimentary Tests		X	1.38	$66.91	$34.75	$13.38
	89105	Sample intestinal contents					
	89130	Sample stomach contents					
	89132	Sample stomach contents					
	89135	Sample stomach contents					
	89136	Sample stomach contents					
	89140	Sample stomach contents					
	91030	Acid perfusion of esophagus					
	91055	Gastric intubation for smear					
	91065	Breath hydrogen test					
	91100	Pass intestine bleeding tube					
	91105	Gastric intubation treatment					
	91299	Gastroenterology procedure					
0361	Level II Alimentary Tests		X	3.53	$171.16	$88.09	$34.23
	89100	Sample intestinal contents					
	89141	Sample stomach contents					
	91000	Esophageal intubation					
	91010	Esophagus motility study					
	91011	Esophagus motility study					
	91012	Esophagus motility study					
	91020	Gastric motility					
	91032	Esophagus, acid reflux test					
	91033	Prolonged acid reflux test					
	91052	Gastric analysis test					
	91060	Gastric saline load test					
	95075	Ingestion challenge test					
0362	Fitting of Vision Aids		X	0.51	$24.73	$9.63	$4.95
	92311	Contact lens fitting					
	92312	Contact lens fitting					
	92313	Contact lens fitting					
	92315	Prescription of contact lens					
	92316	Prescription of contact lens					
	92317	Prescription of contact lens					
	92325	Modification of contact lens					
	92326	Replacement of contact lens					
	92352	Special spectacles fitting					
	92353	Special spectacles fitting					
	92354	Special spectacles fitting					
	92355	Special spectacles fitting					
	92358	Eye prosthesis service					
	92371	Repair & adjust spectacles					
0363	Otorhinolaryngologic Function Tests		X	2.83	$137.22	$53.22	$27.44
	92512	Nasal function studies					
	92516	Facial nerve function test					
	92520	Laryngeal function studies					
	92541	Spontaneous nystagmus test					
	92542	Positional nystagmus test					
	92543	Caloric vestibular test					
	92544	Optokinetic nystagmus test					
	92545	Oscillating tracking test					
	92546	Sinusoidal rotational test					
	92547	Supplemental electrical test					
	92548	Posturography					
	92584	Electrocochleography					
	92587	Evoked auditory test					
	92588	Evoked auditory test					
0364	Level I Audiometry		X	0.68	$32.97	$13.31	$6.59
	92552	Pure tone audiometry, air					

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APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	92553	Audiometry, air & bone					
	92555	Speech threshold audiometry					
	92556	Speech audiometry, complete					
	92567	Tympanometry					
	92599	ENT procedure/service					
0365	Level II Audiometry		X	1.47	$71.28	$22.48	$14.26
	92557	Comprehensive hearing test					
	92561	Bekesy audiometry, diagnosis					
	92562	Loudness balance test					
	92563	Tone decay hearing test					
	92564	Sisi hearing test					
	92565	Stenger test, pure tone					
	92568	Acoustic reflex testing					
	92569	Acoustic reflex decay test					
	92571	Filtered speech hearing test					
	92572	Staggered spondaic word test					
	92573	Lombard test					
	92575	Sensorineural acuity test					
	92576	Synthetic sentence test					
	92577	Stenger test, speech					
	92579	Visual audiometry (vra)					
	92582	Conditioning play audiometry					
	92583	Select picture audiometry					
	92589	Auditory function test(s)					
	92596	Ear protector evaluation					
0366	Electrocardiogram (ECG)		X	0.38	$18.43	$15.60	$3.69
	93005	Electrocardiogram, tracing					
	93041	Rhythm ECG, tracing					
	Q0035	Cardiokymography					
0367	Level I Pulmonary Test		X	0.83	$40.24	$20.65	$8.05
	94010	Breathing capacity test					
	94200	Lung function test (MBC/MVV)					
	94250	Expired gas collection					
	94375	Respiratory flow volume loop					
	94400	CO2 breathing response curve					
	94450	Hypoxia response curve					
	94680	Exhaled air analysis, o2					
	94690	Exhaled air analysis					
	94720	Monoxide diffusing capacity					
	94770	Exhaled carbon dioxide test					
	94799	Pulmonary service/procedure					
0368	Level II Pulmonary Tests		X	1.66	$80.49	$42.44	$16.10
	94060	Evaluation of wheezing					
	94240	Residual lung capacity					
	94260	Thoracic gas volume					
	94350	Lung nitrogen washout curve					
	94360	Measure airflow resistance					
	94370	Breath airway closing volume					
	94620	Pulmonary stress test/simple					
	94681	Exhaled air analysis, o2/co2					
	94725	Membrane diffusion capacity					
	94750	Pulmonary compliance study					
0369	Level III Pulmonary Tests		X	2.34	$113.46	$58.50	$22.69
	94014	Patient recorded spirometry					
	94015	Patient recorded spirometry					
	94016	Review patient spirometry					
	94070	Evaluation of wheezing					
	94621	Pulm stress test/complex					
	94772	Breath recording, infant					
	95070	Bronchial allergy tests					
	95071	Bronchial allergy tests					
0370	Allergy Tests		X	0.57	$27.64	$11.81	$5.53
	95004	Allergy skin tests					
	95010	Sensitivity skin tests					
	95015	Sensitivity skin tests					
	95024	Allergy skin tests					
	95027	Skin end point titration					
	95028	Allergy skin tests					
	95044	Allergy patch tests					
	95052	Photo patch test					
	95056	Photosensitivity tests					
	95060	Eye allergy tests					
	95065	Nose allergy test					

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APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	95078	Provocative testing					
	95180	Rapid desensitization					
	95199	Allergy immunology services					
0371	Allergy Injections		X	0.32	$15.52	$3.67	$3.10
	95115	Immunotherapy, one injection					
	95117	Immunotherapy injections					
	95144	Antigen therapy services					
	95145	Antigen therapy services					
	95146	Antigen therapy services					
	95147	Antigen therapy services					
	95148	Antigen therapy services					
	95149	Antigen therapy services					
	95165	Antigen therapy services					
	95170	Antigen therapy services					
0372	Therapeutic Phlebotomy		X	0.43	$20.85	$10.09	$4.17
	99195	Phlebotomy					
0373	Neuropsychological Testing		X	3.21	$155.64	$44.96	$31.13
	96100	Psychological testing					
	96105	Assessment of aphasia					
	96110	Developmental test, lim					
	96111	Developmental test, extend					
	96115	Neurobehavior status exam					
	96117	Neuropsych test battery					
0374	Monitoring Psychiatric Drugs		X	1.17	$56.73	$13.08	$11.35
	90862	Medication management					
	M0064	Visit for drug monitoring					
0600	Low Level Clinic Visits		V	0.98	$47.52	$9.50	$9.50
	99201	Office/outpatient visit, new					
	99202	Office/outpatient visit, new					
	99211	Office/outpatient visit, est					
	99212	Office/outpatient visit, est					
	99241	Office consultation					
	99242	Office consultation					
	99271	Confirmatory consultation					
	99272	Confirmatory consultation					
0601	Mid Level Clinic Visits		V	1.00	$48.49	$9.70	$9.70
	92002	Eye exam, new patient					
	92012	Eye exam established pat					
	99203	Office/outpatient visit, new					
	99213	Office/outpatient visit, est					
	99243	Office consultation					
	99273	Confirmatory consultation					
	G0101	CA screen; pelvic/breast exam					
0602	High Level Clinic Visits		V	1.66	$80.49	$16.29	$16.10
	92004	Eye exam, new patient					
	92014	Eye exam & treatment					
	99204	Office/outpatient visit, new					
	99205	Office/outpatient visit, new					
	99214	Office/outpatient visit, est					
	99215	Office/outpatient visit, est					
	99244	Office consultation					
	99245	Office consultation					
	99274	Confirmatory consultation					
	99275	Confirmatory consultation					
0603	Interdisciplinary Team Conference		V	1.66	$80.49	$16.29	$16.10
G0175	Multidisciplinary team visit						
0610	Low Level Emergency Visits		V	1.34	$64.97	$20.65	$12.99
	99281	Emergency dept visit					
	99282	Emergency dept visit					
0611	Mid Level Emergency Visits		V	2.11	$102.31	$36.47	$20.46
	99283	Emergency dept visit					
0612	High Level Emergency Visits		V	3.19	$154.67	$54.14	$30.93
	99284	Emergency dept visit					
	99285	Emergency dept visit					
0620	Critical Care		S	8.60	$416.99	$152.78	$83.40
	99291	Critical care, first hour					
[3]0701	Strontium		X				$84.76
	A9600	Strontium-89 chloride					
[3]0702	Samariam		X				$139.06
	A9605	Samarium sm153 lexidronamm					
[3]0704	Satumomab Pendetide		X				$63.13
	A4642	Satumomab pendetide per dose					
[3]0705	Tc99 Tetrofosmin		X				$71.08

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	A9502	Technetium TC99M tetrofosmin					
[3]0725		Leucovorin Calcium	X				$1.07
	J0640	Leucovorin calcium injection					
[3]0726		Dexrazoxane Hydrochloride	X				$18.81
	J1190	Dexrazoxane HCl injection					
[3]0727		Injection, Etidronate Disodium	X				$9.31
	J1436	Etidronate disodium inj					
[3]0728		Filgrastim (G–CSF)	X				$25.21
	J1440	Filgrastim 300 mcg injection					
[3]0730		Pamidronate Disodium	X				$30.93
	J2430	Pamidronate disodium/30 MG					
[3]0731		Sargramostim (GM–CSF)	X				$16.97
	J2820	Sargramostim injection					
[3]0732		Mesna	X				$2.42
	J9209	Mesna injection					
[3]0733		Epoetin Alpha	X				$1.75
	Q0136	Non esrd epoetin alpha inj					
[3]0750		Dolasetron Mesylate 10 mg	X				$1.94
	J1260	Dolasetron mesylate					
[3]0754		Metoclopramide HCL	X				$0.19
	J2765	Metoclopramide hcl injection					
[3]0755		Thiethylperazine Maleate	X				$0.68
	J3280	Thiethylperazine maleate inj					
[3]0761		Oral Substitute for IV Antiemtic	X				$0.10
	Q0163	Diphenhydramine HCl 50mg					
	Q0164	Prochlorperazine maleate 5mg					
	Q0169	Promethazine HCl 12.5mg oral					
	Q0171	Chlorpromazine HCl 10mg oral					
	Q0173	Trimethobenzamide HCl 250mg					
	Q0174	Thiethylperazine maleate10mg					
	Q0175	Perphenazine 4mg oral					
	Q0177	Hydroxyzine pamoate 25mg					
[3]0762		Dronabinol	X				$0.48
	Q0167	Dronabinol 2.5mg oral					
[3]0763		Dolasetron Mesylate 100 mg Oral	X				$8.53
	Q0180	Dolasetron mesylate oral					
[3]0764		Granisetron HCL, 100 mcg	X				$2.33
	J1626	Granisetron HCl injection					
[3]0765		Granisetron HCL, 1mg Oral	X				$3.20
	Q0166	Granisetron HCl 1 mg oral					
[3]0768		Ondansetron Hydrochloride per 1 mg Injection	X				$0.87
	J2405	Ondansetron hcl injection					
[3]0769		Ondansetron Hydrochloride 8 mg oral	X				$2.62
	Q0179	Ondansetron HCl 8mg oral					
[3]0800		Leuprolide Acetate per 3.75 mg	X				$68.56
	J1950	Leuprolide acetate/3.75 MG					
[3]0801		Cyclophosphamide	X				$.19
	J8530	Cyclophosphamide oral 25 MG					
[3]0802		Etoposide	X				$3.10
	J8560	Etoposide oral 50 MG					
[3]0803		Melphalan	X				$0.19
	J8600	Melphalan oral 2 MG					
[3]0807		Aldesleukin single use vial	X				$65.07
	J9015	Aldesleukin/single use vial					
[3]0809		BCG (Intravesical) one vial	X				$19.78
	J9031	Bcg live intravesical vac					
[3]0810		Goserelin Acetate Implant, per 3.6 mg	X				$59.74
	J9202	Goserelin acetate implant					
[3]0811		Carboplatin 50 mg	X				$13.96
	J9045	Carboplatin injection					
[3]0812		Carmustine 100 mg	X				$10.57
	J9050	Carmus bischl nitro inj					
[3]0813		Cisplatin 10 mg	X				$4.56
	J9060	Cisplatin 10 MG injeciton					
[3]0814		Asparaginase, 10,000 units	X				$8.34
	J9020	Asparaginase injection					
[3]0815		Cyclophosphamide 100 mg	X				$0.48
	J9070	Cyclophosphamide 100 MG inj					
[3]0816		Cyclophosphamide, Lyophilized 100 mg	X				$1.16
	J9093	Cyclophosphamide lyophilized					
[3]0817		Cytrabine 100 mg	X				$0.68
	J9100	Cytarabine hcl 100 MG inj					
[3]0818		Dactinomycin 0.5 mg	X				$1.75

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	J9120	Dactinomycin actinomycin d					
[3]0819		Dacarbazine 100 mg	X				$1.26
	J9130	Dacarbazine 10 MG inj					
[3]0820		Daunorubicin HCl 10 mg	X				$11.64
	J9150	Daunorubicin					
[3]0821		Daunorubicin Citrate, Liposomal Formulation, 10 mg	X				$7.76
	J9151	Daunorubicin citrate liposom					
[3]0822		Diethylstibestrol Diphosphate 250 mg	X				$2.13
	J9165	Diethylstilbestrol injection					
[3]0823		Docetaxel 20 mg	X				$34.72
	J9170	Docetaxel					
[3]0824		Etoposide 10 mg	X				$.58
	J9181	Etoposide 10 MG inj					
[3]0826		Methotrexate Oral 2.5 mg	X				$.29
	J8610	Methotrexate oral 2.5 MG					
[3]0827		Floxuridine 500 mg	X				$18.81
	J9200	Floxuridine injection					
[3]0828		Gemcitabine HCL 200 mg	X				$9.31
	J9201	Gemcitabine HCl					
[3]0830		Irinotecan 20 mg	X				$14.16
	J9206	Irinotecan injection					
[3]0831		Ifosfamide per 1 gram	X				$13.58
	J9208	Ifosfomide injection					
[3]0832		Idarubicin Hydrochloride 5 mg	X				$46.45
	J9211	Idarubicin hcl injeciton					
[3]0833		Interferon Alfacon-1, Recombinant, 1 mcg	X				$0.19
	J9212	Interferon alfacon-1					
[3]0834		Interferon, Alfa-2A, Recombinant 3 million units	X				$3.20
	J9213	Interferon alfa-2a inj					
[3]0836		Interferon, Alfa-2B, Recombinant, 1 million units	X				$1.36
	J9214	Interferon alfa-2b inj					
[3]0838		Interferon, Gamma 1–B, 3 million units	X				$22.79
	J9216	Interferon gamma 1–b inj					
[3]0839		Mechlorethamine HCl 10 mg	X				$1.65
	J9230	Mechlorethamine hcl inj					
[3]0840		Melphalan HCl 50 mg	X				$44.71
	J9245	Inj melphalan hydrochl 50 MG					
[3]0841		Methotrexate Sodium 5 mg	X				$.10
	J9250	Methotrexate sodium inj					
[3]0842		Fludarabine Phosphate 50 mg	X				$30.84
	J9185	Fludarabine phosphate inj					
[3]0843		Pegaspargase per single dose vial	X				$178.72
	J9266	Pegaspargase/singl dose vial					
[3]0844		Pentostatin 10 mg	X				$133.73
	J9268	Pentostatin injection					
[3]0847		Doxorubicin HCL 10 mg	X				$2.81
	J9000	Doxorubic hcl 10 MG vl chemo					
[3]0849		Rituximab, 100 mg	X				$51.40
	J9310	Rituximab cancer treatment					
[3]0850		Streptozocin 1 gm	X				$14.64
	J9320	Streptozocin injection					
[3]0851		Thiotepa 15 mg	X				$9.50
	J9340	Thiotepa injection					
[3]0852		Topotecan 4 mg	X				$73.22
	J9350	Topotecan					
[3]0853		Vinblastine Sulfate 1 mg	X				$.39
	J9360	Vinblastine sulfate inj					
[3]0854		Vincristine Sulfate 1 mg	X				$2.23
	J9370	Vincristine sulfate 1 MG inj					
[3]0855		Vinorelbine Tartrate per 10 mg	X				$9.60
	J9390	Vinorelbine tartrate/10 mg					
[3]0856		Porfimer Sodium 75 mg	X				$34.62
	J9600	Porfimer sodium					
[3]0857		Bleomycin Sulfate 15 units	X				$48.29
	J9040	Bleomycin sulfate injection					
[3]0858		Cladribine, 1mg	X				$8.24
	J9065	Inj cladribine per 1 MG					
[3]0859		Fluorouracil	X				$0.19
	J9190	Fluorouracil injection					
[3]0860		Plicamycin 2.5 mg	X				$1.36
	J9270	Plicamycin (mithramycin) inj					
[3]0861		Leuprolide Acetate 1 mg	X				$19.39
	J9218	Leuprolide acetate injeciton					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[3]0862		Mitomycin, 5mg	X				$19.88
	J9280	Mitomycin 5 MG inj					
[3]0863		Paclitaxel, 30mg	X				$30.16
	J9265	Paclitaxel injection					
[3]0864		Mitoxantrone HCl, per 5mg	X				$25.80
	J9293	Mitoxantrone hydrochl/5 MG					
[3]0865		Interferon alfa-N3, 250,000 IU	X				$1.07
	J9215	Interferon alfa-n3 inj					
[3]0884		Rho (D) Immune Globulin, Human one dose pack	X				$3.78
	J2790	Rho d immune globulin inj					
[2]0886		Azathioprine, 50 mg oral	X	0.02	$.97		$0.19
	J7500	Azathioprine oral 50mg					
[2]0887		Azathioprine, Parenteral 100 mg, 20 ml each injection	X	1.40	$67.88		$13.58
	J7501	Azathioprine parenteral					
[2]0888		Cyclosporine, Oral 100 mg	X	0.08	$3.88		$0.78
	J7502	Cyclosporine oral 100 mg					
[2]0889		Cyclosporine, Parenteral	X	0.36	$17.46		$3.49
	J7516	Cyclosporin parenteral 250mg					
[2]0890		Lymphocyte Immune Globulin 50 mg/ml, 5 ml each	X	3.79	$183.77		$36.75
	J7504	Lymphocyte immune globulin					
[2]0891		Tacrolimus per 1 mg oral	X	3.15	$152.73		$30.55
	J7507	Tacrolimus oral per 1 MG					
[3]0892		Daclizumab, Parenteral, 25 mg	X				$54.11
	J7913	Daclizumab, Parenteral, 25 m					
[3]0900		Injection, Alglucerase per 10 units	X				$5.14
	J0205	Alglucerase injection					
[3]0901		Alpha I, Proteinase Inhibitor, Human per 10mg	X				$15.22
	J0256	Alpha 1 proteinase inhibitor					
[3]0902		Botulinum Toxin, Type A per unit	X				$56.05
	J0585	Botulinum toxin a per unit					
[3]0903		CMV Immune Globulin	X				$54.11
	J0850	Cytomegalovirus imm IV/vial					
[3]0905		Immune Globulin per 500 mg	X				$6.40
	J1561	Immune globulin 500 mg					
[3]0906		RSV Immune Globulin	X				$85.53
	J1565	RSV-ivig					
[2]0907		Ganciclovir Sodium 500 mg injection	X	0.51	$24.73		$4.95
	J1570	Ganciclovir sodium injection					
[2]0908		Tetanus Immune Globulin, Human, up to 250 units	X	0.90	$43.64		$8.73
	J1670	Tetanus immune globulin inj					
[3]0909		Interferon Beta-1a 33 mcg	X				$28.70
	J1825	Interferon beta-1a					
[3]0910		Interferon Beta-1b 0.25 mg	X				$8.44
	J1830	Interferon beta-1b/.25 MG					
[2]0911		Streptokinase per 250,000 iu	X	1.64	$79.69		$15.94
	J2995	Inj streptokinase/250000 IU					
[3]0913		Ganciclovir 4.5 mg, Implant	X				$701.51
	J7310	Ganciclovir long act implant					
[2]0914		Reteplase, 37.6 mg (Two Single Use Vials)	X	38.20	$1,852.21		$370.44
	J2994	Reteplase double bolus					
[2]0915		Alteplase recombinant, 10mg	X	5.85	$283.70		$56.74
	J2996	Alteplase recombinant inj					
[3]0916		Imiglucerase per unit	X				$0.58
	J1785	Injection imiglucerase/unit					
[2]0917		Dipyridamole, 10 mg/Adenosine 6MG	X	0.36	$17.46		$3.49
	J0150	Injection adenosine 6 MG					
	J1245	Dipyridamole injection					
[3]0918		Brachytherapy Seeds, Any type, Each	S				$9.99
	Q3001	Brachytherapy Seeds					
[3]0925		Factor VIII (Antihemophilic Factor, Human) per iu	X				$0.19
	J7190	Factor viii					
[3]0926		Factor VIII (Antihemophilic Factor, Porcine) per iu	X				$0.19
	J7191	Factor VIII (porcine)					
[3]0927		Factor VIII (Antihemophilic Factor, Recombinant) per iu	X				$0.19
	J7192	Factor viii recombinant					
[3]0928		Factor IX, Complex	X				$0.08
	J7194	Factor ix complex					
[3]0929		Other Hemophilia Clotting Factors per iu	X				$0.27
	J7198	Anti-inhibitor					
	Q0187	Factor viia recombinant					
[3]0930		Antithrombin III (Human) per iu	X				$0.19
	J7197	Antithrombin iii injection					
[3]0931		Factor IX (Antihemophilic Factor, Purified, Non-Recombinant)	X				$0.04

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
	Q0160	Factor IX non-recombinant					
[3]0932		Factor IX (Antihemophilic Factor, Recombinant)	X				$0.10
	Q0161	Factor IX recombinant					
[2]0949		Plasma, Pooled Multiple Donor, Solvent/Detergent Treated, Frozen	S	3.49	$169.22		$33.84
	P9023	Frozen plasma, pooled, sd					
[2]0950		Blood (Whole) For Transfusion	S	2.08	$101.02		$20.20
	P9010	Whole blood for transfusion					
[2]0952		Cryoprecipitate	S	0.70	$33.92		$6.78
	P9012	Cryoprecipitate each unit					
[2]0953		Fibrinogen Unit	S	0.48	$23.27		$4.65
	P9013	Unit/s blood fibrinogen					
[2]0954		Leukocyte Poor Blood	S	2.83	$137.21		$27.44
	P9016	Leukocyte poor blood, unit					
[2]0955		Plasma, Fresh Frozen	S	2.26	$109.35		$21.87
	P9017	One donor fresh frozn plasma					
[2]0956		Plasma Protein Fraction	S	1.26	$61.09		$12.22
	P9018	Plasma protein fract, unit					
[2]0957		Platelet Concentrate	S	0.98	$47.46		$9.49
	P9019	Platelet concentrate unit					
[2]0958		Platelet Rich Plasma	S	1.16	$56.25		$11.25
	P9020	Platelet rich plasma unit					
[2]0959		Red Blood Cells	S	2.04	$99.04		$19.81
	P9021	Red blood cells unit					
[2]0960		Washed Red Blood Cells	S	3.81	$184.53		$36.91
	P9022	Washed red blood cells unit					
[2]0961		Infusion, Albumin (Human) 5%, 500 ml	X	2.77	$134.31		$26.86
	Q0156	Human albumin 5%					
[2]0962		Infusion, Albumin (Human) 25%, 50 ml	X	1.38	$66.91		$13.38
	Q0157	Human albumin 25%					
[2]0970		New Technology - Level I ($0–$50)	T	0.52	$25.21		$5.04
	78268	Breath test analysis, c–14					
[2]0971		New Technology - Level II ($50–$100)	S	1.55	$75.16		$15.03
	78267	Breath tst attain/anal c–14					
[2]0972		New Technology - Level III ($100–$200)	T	3.09	$149.83		$29.97
	G0166	Extrnl counterpulse, per tx					
[2]0980		New Technology - Level XI ($1750–$2000)	S	38.67	$1,875.00		$375.00
	53850	Prostatic microwave thermotx					
	53852	Prostatic rf thermotx					
	G0125	Lung image (PET)					
	G0126	Lung image (PET) staging					
	G0163	Pet for rec of colorectal ca					
	G0164	Pet for lymphoma staging					
	G0165	Pet, rec of melanoma/met ca					
[3]7000		Amifostine, 500 mg	X				$41.99
	J0207	Amifostine					
[3]7001		Amphotericin B lipid complex, 50 mg, Inj	X				$12.12
	J0286	Amphotericin B lipid complex					
[3]7002		Clonidine, HCl, 1 MG	X				$4.17
	J0735	Clonidine hydrochloride					
[3]7003		Epoprostenol, 0.5 MG, inj	X				$2.23
	J1325	Epoprostenol injection					
[3]7004		Immune globulin intravenous human 5g, inj	X				$45.48
	J1562	Immune globulin 5 gms					
[3]7005		Gonadorelin hcI, 100 mcg	X				$9.12
	J1620	Gonadorelin hydroch/100 mcg					
[2]7007		Milrinone lacetate, per 5 ml, inj	X	0.47	$22.79		$4.56
	J2260	Inj milrinone lactate/5 ML					
[3]7010		Morphine sulfate concentrate (preservative free) per 10 mg	X				$.68
	J2275	Morphine sulfate injection					
[3]7011		Oprelevekin, inj, 5 mg	X				$30.35
	J2355	Oprelvekin injection					
[3]7012		Pentamidine isethionate, 300 mg	X				$8.73
	J2545	Pentamidine isethionte/300mg					
[3]7014		Fentanyl citrate, inj, up to 2 ml	X				$.19
	J3010	Fentanyl citrate injeciton					
[3]7015		Busulfan, oral 2 mg	X				$0.19
	J8510	Oral busulfan					
[3]7019		Aprotinin, 10,000 kiu	X				$2.42
	Q2003	Aprotinin, 10,000 kiu					
[3]7021		Baclofen, intrathecal, 50 mcg	X				$0.10
	J0476	Baclofen intrathecal trial					
[3]7022		Elliotts B Solution, per ml	X				$19.20
	Q2002	Elliot's B solution					

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ADDENDUM C.—PROPOSED HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT FOR PROCEDURES BY APC—Continued

APC	CPT/ HCPCS	HCPCS Description	Status Indicator	Relative Weight	Payment Rate	National Unadjusted Coinsurance	Minimum Unadjusted Coinsurance
[3]7023		Treatment for bladder calculi, I.e. Renacidin per 500 ml	X				$4.46
	Q2004	Treatment for bladder calcul					
[3]7024		Corticorelin ovine triflutate, 0.1 mg	X				$45.77
	Q2005	Corticorelin ovine triflutat					
[3]7025		Digoxin immune FAB (Ovine), 10 mg	X				$14.06
	Q2006	Digoxin immune FAB (Ovine),					
[3]7026		Ethanolamine oleate, 1000 ml	X				$2.13
	Q2007	Ethanolamine oleate, 1000 ml					
[3]7027		Fomepizole, 1.5 G	X				$141.29
	Q2008	Fomepizole, 1.5 G					
[3]7028		Fosphenytoin, 50 mg	X				$0.78
	Q2009	Fosphenytoin, 50 mg					
[3]7029		Glatiramer acetate, 25 mg	X				$3.59
	Q2010	Glatiramer acetate, 25 mgeny					
[3]7030		Hemin, 1 mg	X				$0.10
	Q2011	Hemin, 1 mg					
[3]7031		Octreotide Acetate, 500 mcg	X				$5.43
	J2352	Octreotide acetate injection					
[3]7032		Sermorelin acetate, 0.5 mg	X				$53.34
	Q2014	Sermorelin acetate, 0.5 mg					
[3]7033		Somatrem, 5 mg	X				$28.03
	Q2015	Somatrem, 5 mg					
[3]7034		Somatropin, 1 mg	X				$5.04
	Q2016	Somatropin, 1 mg					
[3]7035		Teniposide, 50 mg	X				$20.85
	Q2017	Teniposide, 50 mg					
[2]7036		Urokinase, inj, IV, 250,000 I.U.	X	0.73	$35.40		$7.08
	J3365	Urokinase 250,000 IU inj					
[3]7037		Urofollitropin, 75 I.U.	X				$8.24
	Q2018	Urofollitropin, 75 I.U.					
[3]7038		Muromonab-CD3, 5 mg	X				$89.60
	J7505	Monoclonal antibodies					
[3]7039		Pegademase bovine inj 25 I.U.	X				$1.16
	Q2012	Pegademase bovine inj 25 I.U					
[3]7040		Pentastarch 10% inj, 100 ml	X				$2.04
	Q2013	Pentastarch 10% inj, 100 ml					
[2]7041		Tirofiban HCL, 0.5 mg	X	0.02	$.97		$0.19
	J3245	Tirofiban hydrochloride					
[3]7042		Capecitabine, oral 150 mg	X				$0.19
	J8520	Capecitabine, oral, 150 mg					
[3]7043		Infliximab, 10 MG	X				$6.89
	J1745	Infliximab injection					
[3]7045		Trimetrexate Glucoronate	X				$8.15
	J3305	Inj trimetrexate glucoronate					
[3]7046		Doxorubicin Hcl Liposome	X				$39.18
	J9001	Doxorubicin hcl liposome inj					

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY

CPT/HCPCS	Termination Date
00420	12/31/1999
01000	12/31/1999
01110	12/31/1999
01240	12/31/1999
01300	12/31/1999
01460	12/31/1999
01600	12/31/1999
01700	12/31/1999
01800	12/31/1999
01900	12/31/1999
01902	12/31/1999
11050	12/31/1997
11051	12/31/1997
11052	12/31/1997
11700	12/31/1996
11701	12/31/1996

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
11710	12/31/1996
11711	12/31/1996
11731	12/31/1998
13300	12/31/1999
15580	12/31/1999
15625	12/31/1999
15755	12/31/1996
16040	12/31/1998
16041	12/31/1998
16042	12/31/1998
17001	12/31/1997
17002	12/31/1997
17010	12/31/1997
17100	12/31/1997
17101	12/31/1997
17102	12/31/1997

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
17104	12/31/1997
17105	12/31/1997
17200	12/31/1997
17201	12/31/1997
20960	12/31/1996
20971	12/31/1996
25330	12/31/1996
25331	12/31/1996
26552	12/31/1996
26557	12/31/1996
26558	12/31/1996
26559	12/31/1996
32001	12/31/1999
33242	12/31/1999
33247	12/31/1999
42880	12/31/1996

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
53640	12/31/1996
56300	12/31/1999
56301	12/31/1999
56302	12/31/1999
56303	12/31/1999
56304	12/31/1999
56305	12/31/1999
56306	12/31/1999
56307	12/31/1999
56308	12/31/1999
56309	12/31/1999
56310	12/31/1999
56311	12/31/1999
56312	12/31/1999
56313	12/31/1999
56314	12/31/1999
56315	12/31/1999
56316	12/31/1999
56317	12/31/1999
56318	12/31/1999
56320	12/31/1999
56321	12/31/1999
56322	12/31/1999
56323	12/31/1999
56324	12/31/1999
56340	12/31/1999
56341	12/31/1999
56342	12/31/1999
56343	12/31/1999
56344	12/31/1999
56345	12/31/1999
56346	12/31/1999
56347	12/31/1999
56348	12/31/1999
56349	12/31/1999
56350	12/31/1999
56351	12/31/1999
56352	12/31/1999
56353	12/31/1999
56354	12/31/1999
56355	12/31/1999
56356	12/31/1999
56360	12/31/1996
56361	12/31/1996
56362	12/31/1999
56363	12/31/1999
56399	12/31/1999
57108	12/31/1998
61106	12/31/1998
61130	12/31/1998
61712	12/31/1998
61855	12/31/1999
61865	12/31/1999
62274	12/31/1999
62275	12/31/1999
62276	12/31/1999
62277	12/31/1999
62278	12/31/1999
62279	12/31/1999
62288	12/31/1999
62289	12/31/1999
62298	12/31/1999
63690	12/31/1998
63691	12/31/1998
64440	12/31/1999
64441	12/31/1999

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
64442	12/31/1999
64443	12/31/1999
64830	12/31/1998
68800	12/31/1996
68820	12/31/1996
68825	12/31/1996
68830	12/31/1996
71038	12/31/1998
74405	12/31/1998
77380	12/31/1999
77381	12/31/1999
77419	12/31/1999
77420	12/31/1999
77425	12/31/1999
77430	12/31/1999
78017	12/31/1998
78726	12/31/1997
78727	12/31/1997
80002	12/31/1997
80003	12/31/1997
80004	12/31/1997
80005	12/31/1997
80006	12/31/1997
80007	12/31/1997
80008	12/31/1997
80009	12/31/1997
80010	12/31/1997
80011	12/31/1997
80012	12/31/1997
80016	12/31/1997
80018	12/31/1997
80019	12/31/1997
80049	12/31/1999
80054	12/31/1999
80058	12/31/1999
80059	12/31/1999
80091	12/31/1999
80092	12/31/1999
82130	12/31/1998
82250	12/31/1998
83019	12/31/1998
83717	12/31/1998
85029	12/31/1998
85030	12/31/1998
86287	12/31/1997
86289	12/31/1997
86290	12/31/1997
86291	12/31/1997
86293	12/31/1997
86295	12/31/1997
86296	12/31/1997
86299	12/31/1997
86302	12/31/1997
86303	12/31/1997
86306	12/31/1997
86311	12/31/1997
86313	12/31/1997
86315	12/31/1997
86588	12/31/1999
87178	12/31/1997
87179	12/31/1997
88151	12/31/1997
88156	12/31/1998
88157	12/31/1997
88158	12/31/1998
88250	12/31/1998

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
88260	12/31/1998
90592	12/31/1999
90711	12/31/1998
90714	12/31/1998
90724	12/31/1998
90726	12/31/1998
90728	12/31/1998
90730	12/31/1998
90737	12/31/1998
90741	12/31/1998
90742	12/31/1998
90745	12/31/1999
90820	12/31/1997
90825	12/31/1997
90835	12/31/1997
90841	12/31/1997
90842	12/31/1997
90843	12/31/1997
90844	12/31/1997
90855	12/31/1997
90900	12/31/1996
90902	12/31/1996
90904	12/31/1996
90906	12/31/1996
90908	12/31/1996
90910	12/31/1996
90915	12/31/1996
93201	12/31/1996
93202	12/31/1996
93204	12/31/1996
93205	12/31/1996
93208	12/31/1996
93209	12/31/1996
93210	12/31/1996
93220	12/31/1996
93221	12/31/1996
93222	12/31/1996
94160	12/31/1996
97122	12/31/1998
97250	12/31/1998
97260	12/31/1998
97261	12/31/1998
97265	12/31/1998
97500	12/31/1996
97501	12/31/1996
97521	12/31/1996
99351	12/31/1997
99352	12/31/1997
99353	12/31/1997
99376	12/31/1997
A2000	12/31/1997
A4190	12/31/1996
A4200	12/31/1996
A4202	12/31/1996
A4203	12/31/1996
A4204	12/31/1996
A4205	12/31/1996
A4363	12/31/1999
A4581	12/31/1996
A4610	12/31/1996
D0471	12/31/1999
D2210	12/31/1999
D2810	12/31/1999
D3960	12/31/1999
D4250	12/31/1999
D7470	12/31/1999

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
D7942	12/31/1999
D9240	12/31/1999
E0237	12/31/1996
E0452	12/31/1999
E0453	12/31/1999
E1350	12/31/1996
E1400	12/31/1999
E1401	12/31/1999
E1402	12/31/1999
E1403	12/31/1999
E1404	12/31/1999
G0051	12/31/1997
G0052	12/31/1997
G0053	12/31/1997
G0054	09/30/1996
G0055	09/30/1996
G0056	09/30/1996
G0057	09/30/1996
G0058	12/31/1997
G0059	12/31/1997
G0060	12/31/1997
G0061	12/31/1996
G0062	12/31/1997
G0063	12/31/1997
G0064	12/31/1997
G0065	12/31/1997
G0066	12/31/1997
G0071	12/31/1997
G0072	12/31/1997
G0073	12/31/1997
G0074	12/31/1997
G0075	12/31/1997
G0076	12/31/1997
G0077	12/31/1997
G0078	12/31/1997
G0079	12/31/1997
G0080	12/31/1997
G0081	12/31/1997
G0082	12/31/1997
G0083	12/31/1997
G0084	12/31/1997
G0085	12/31/1997
G0086	12/31/1997
G0087	12/31/1997
G0088	12/31/1997
G0089	12/31/1997
G0090	12/31/1997
G0091	12/31/1997
G0092	12/31/1997
G0093	12/31/1997
G0094	12/31/1997
G0095	12/31/1997
G0096	12/31/1997
G0097	12/31/1997
G0098	12/31/1997
G0100	12/31/1997
G0133	12/31/1998
H5300	12/31/1997
J1625	12/31/1997
J1760	12/31/1999
J1770	12/31/1999
J1780	12/31/1999
J2050	12/31/1996
J3005	12/31/1997
J7140	12/31/1996
J7150	12/31/1996

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
J7196	12/31/1999
J7503	12/31/1999
J9010	12/31/1996
K0109	09/30/1999
K0110	12/31/1996
K0111	12/31/1996
K0119	12/31/1999
K0120	12/31/1999
K0121	12/31/1999
K0122	12/31/1999
K0123	12/31/1999
K0124	12/31/1996
K0125	12/31/1996
K0126	12/31/1996
K0127	12/31/1996
K0128	12/31/1996
K0129	12/31/1996
K0130	12/31/1996
K0137	12/31/1999
K0138	12/31/1999
K0139	12/31/1999
K0140	03/31/1997
K0141	03/31/1997
K0142	03/31/1997
K0143	03/31/1997
K0144	03/31/1997
K0145	03/31/1997
K0146	03/31/1997
K0152	12/31/1996
K0154	12/31/1996
K0163	12/31/1996
K0168	12/31/1999
K0169	12/31/1999
K0170	12/31/1999
K0171	12/31/1999
K0172	12/31/1999
K0173	12/31/1999
K0174	12/31/1999
K0175	12/31/1999
K0176	12/31/1999
K0177	12/31/1999
K0178	12/31/1999
K0179	12/31/1999
K0180	12/31/1999
K0181	12/31/1999
K0190	12/31/1999
K0191	12/31/1999
K0192	12/31/1999
K0193	09/30/1999
K0194	09/30/1999
K0196	12/31/1996
K0197	12/31/1996
K0198	12/31/1996
K0199	12/31/1996
K0203	12/31/1996
K0204	12/31/1996
K0205	12/31/1996
K0206	12/31/1996
K0207	12/31/1996
K0208	12/31/1996
K0209	12/31/1996
K0210	12/31/1996
K0211	12/31/1996
K0212	12/31/1996
K0213	12/31/1996
K0214	12/31/1996

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
K0215	12/31/1996
K0216	12/31/1996
K0217	12/31/1996
K0218	12/31/1996
K0219	12/31/1996
K0220	12/31/1996
K0221	12/31/1996
K0222	12/31/1996
K0223	12/31/1996
K0224	12/31/1996
K0228	12/31/1996
K0229	12/31/1996
K0230	12/31/1996
K0234	12/31/1996
K0235	12/31/1996
K0236	12/31/1996
K0237	12/31/1996
K0238	12/31/1996
K0239	12/31/1996
K0240	12/31/1996
K0241	12/31/1996
K0242	12/31/1996
K0243	12/31/1996
K0244	12/31/1996
K0245	12/31/1996
K0246	12/31/1996
K0247	12/31/1996
K0248	12/31/1996
K0249	12/31/1996
K0250	12/31/1996
K0251	12/31/1996
K0252	12/31/1996
K0253	12/31/1996
K0254	12/31/1996
K0255	12/31/1996
K0256	12/31/1996
K0257	12/31/1996
K0258	12/31/1996
K0259	12/31/1996
K0260	12/31/1996
K0261	12/31/1996
K0262	12/31/1996
K0263	12/31/1996
K0264	12/31/1996
K0265	12/31/1996
K0266	12/31/1996
K0271	06/30/1996
K0272	06/30/1996
K0273	06/30/1996
K0274	06/30/1996
K0275	06/30/1996
K0276	06/30/1996
K0277	12/31/1999
K0278	12/31/1999
K0279	12/31/1999
K0284	12/31/1999
K0285	12/31/1996
K0400	12/31/1999
K0401	12/31/1999
K0402	12/31/1996
K0403	12/31/1996
K0404	12/31/1996
K0405	12/31/1996
K0406	12/31/1996
K0412	12/31/1999
K0413	12/31/1997

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
K0414	12/31/1997
K0417	12/31/1999
K0418	12/31/1999
K0419	12/31/1999
K0420	12/31/1999
K0421	12/31/1999
K0422	12/31/1999
K0423	12/31/1999
K0424	12/31/1999
K0425	12/31/1999
K0426	12/31/1999
K0427	12/31/1999
K0428	12/31/1999
K0429	12/31/1999
K0430	12/31/1999
K0431	12/31/1999
K0432	12/31/1999
K0433	12/31/1999
K0434	12/31/1999
K0435	12/31/1999
K0436	12/31/1999
K0437	12/31/1999
K0438	12/31/1999
K0439	12/31/1999
K0453	12/31/1998
K0454	12/31/1997
K0503	12/31/1999
K0504	12/31/1999
K0505	12/31/1999
K0506	12/31/1999
K0507	12/31/1999
K0508	12/31/1999
K0509	12/31/1999
K0511	12/31/1999
K0512	12/31/1999
K0513	12/31/1999
K0514	12/31/1999
K0515	12/31/1999
K0516	12/31/1999
K0518	12/31/1999
K0519	12/31/1999
K0520	12/31/1999
K0521	12/31/1999
K0522	12/31/1999
K0523	12/31/1999
K0524	12/31/1999
K0525	12/31/1999
K0526	12/31/1999
K0527	12/31/1999
K0528	12/31/1999
K0530	12/31/1999
L4200	12/31/1996
L4310	12/31/1998
L4320	12/31/1998
L4390	12/31/1998
L7160	12/31/1996
L7165	12/31/1996
L8605	12/31/1997
L8611	12/31/1997
L8615	12/31/1997
L8616	12/31/1997
L8617	12/31/1997
L8618	12/31/1997
L8620	12/31/1997
L8621	12/31/1997
L8622	12/31/1997

ADDENDUM D.—1996 HCPC CODES USED TO CALCULATE PAY—Continued

CPT/HCPCS	Termination Date
L8623	12/31/1997
L8624	12/31/1997
L8625	12/31/1997
L8626	12/31/1997
L8627	12/31/1997
L8628	12/31/1997
L8629	12/31/1997
L8640	12/31/1997
L8655	12/31/1997
L8656	12/31/1997
L8657	12/31/1997
L8680	12/31/1997
L8690	12/31/1997
L9999	12/31/1996
M0005	12/31/1997
M0006	12/31/1997
M0007	12/31/1997
M0008	12/31/1997
M0101	12/31/1998
P9014	12/31/1998
P9015	12/31/1998
P9610	12/31/1998
Q0068	12/31/1999
Q0103	12/31/1997
Q0104	12/31/1997
Q0109	12/31/1997
Q0110	12/31/1997
Q0116	09/30/1996
Q0132	12/31/1999
Q0158	12/31/1997
Q0159	12/31/1998
Q0162	12/31/1998
Q0182	12/31/1998

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES

CPT/HCPCS	HOPD Status Indicator	Description
00174	C	Anesth, pharyngeal surgery
00176	C	Anesth, pharyngeal surgery
00192	C	Anesth, facial bone surgery
00214	C	Anesth, skull drainage
00215	C	Anesth, skull fracture
00404	C	Anesth, surgery of breast
00406	C	Anesth, surgery of breast
00452	C	Anesth, surgery of shoulder
00474	C	Anesth, surgery of rib(s)
00524	C	Anesth, chest drainage
00530	C	Anesth, pacemaker insertion
00540	C	Anesth, chest surgery
00542	C	Anesth, release of lung
00544	C	Anesth, chest lining removal
00546	C	Anesth, lung, chest wall surg
00560	C	Anesth, open heart surgery
00562	C	Anesth, open heart surgery
00580	C	Anesth heart/lung transplant
00604	C	Anesth, surgery of vertebra
00622	C	Anesth, removal of nerves
00632	C	Anesth, removal of nerves
00634	C	Anesth for chemonucleolysis
00670	C	Anesth, spine, cord surgery
00792	C	Anesth, part liver removal
00794	C	Anesth, pancreas removal
00796	C	Anesth, for liver transplant

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/HCPCS	HOPD Status Indicator	Description
00802	C	Anesth, fat layer removal
00844	C	Anesth, pelvis surgery
00846	C	Anesth, hysterectomy
00848	C	Anesth, pelvic organ surg
00850	C	Anesth, cesarean section
00855	C	Anesth, hysterectomy
00857	C	Analgesia, labor & c-section
00864	C	Anesth, removal of bladder
00865	C	Anesth, removal of prostate
00866	C	Anesth, removal of adrenal
00868	C	Anesth, kidney transplant
00882	C	Anesth, major vein ligation
00884	C	Anesth, major vein revision
00904	C	Anesth, perineal surgery
00908	C	Anesth, removal of prostate
00928	C	Anesth, removal of testis
00932	C	Anesth, amputation of penis
00934	C	Anesth, penis, nodes removal
00936	C	Anesth, penis, nodes removal
00944	C	Anesth, vaginal hysterectomy
00955	C	Analgesia, vaginal delivery
01140	C	Anesth, amputation at pelvis
01150	C	Anesth, pelvic tumor surgery
01190	C	Anesth, pelvis nerve removal
01212	C	Anesth, hip disarticulation
01214	C	Anesth, replacement of hip
01232	C	Anesth, amputation of femur
01234	C	Anesth, radical femur surg
01272	C	Anesth, femoral artery surg
01274	C	Anesth, femoral embolectomy
01402	C	Anesth, replacement of knee
01404	C	Anesth, amputation at knee
01442	C	Anesth, knee artery surg
01444	C	Anesth, knee artery repair
01486	C	Anesth, ankle replacement
01502	C	Anesth, lwr leg embolectomy
01632	C	Anesth, surgery of shoulder
01634	C	Anesth, shoulder joint amput
01636	C	Anesth, forequarter amput
01638	C	Anesth, shoulder replacement
01652	C	Anesth, shoulder vessel surg
01654	C	Anesth, shoulder vessel surg
01656	C	Anesth, arm-leg vessel surg
01756	C	Anesth, radical humerus surg
01772	C	Anesth, uppr arm embolectomy
01782	C	Anesth, uppr arm vein repair
01842	C	Anesth, lwr arm embolectomy
01852	C	Anesth, lwr arm vein repair
01904	C	Anesth, skull x-ray inject
01990	C	Support for organ donor
15756	C	Free muscle flap, microvasc
15757	C	Free skin flap, microvasc
15758	C	Free fascial flap, microvasc
19200	C	Removal of breast
19220	C	Removal of breast
19240	C	Removal of breast
19260	C	Removal of chest wall lesion
19271	C	Revision of chest wall
19272	C	Extensive chest wall surgery
19361	C	Breast reconstruction
19364	C	Breast reconstruction
19367	C	Breast reconstruction
19368	C	Breast reconstruction
19369	C	Breast reconstruction
20660	C	Apply, remove fixation device
20661	C	Application of head brace
20662	C	Application of pelvis brace
20663	C	Application of thigh brace
20664	C	Halo brace application
20802	C	Replantation, arm, complete
20805	C	Replant, forearm, complete

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
20808	C	Replantation hand, complete
20816	C	Replantation digit, complete
20822	C	Replantation digit, complete
20824	C	Replantation thumb, complete
20827	C	Replantation thumb, complete
20838	C	Replantation foot, complete
20930	C	Spinal bone allograft
20931	C	Spinal bone allograft
20936	C	Spinal bone autograft
20937	C	Spinal bone autograft
20938	C	Spinal bone autograft
20955	C	Fibula bone graft, microvasc
20956	C	Iliac bone graft, microvasc
20957	C	Mt bone graft, microvasc
20962	C	Other bone graft, microvasc
20969	C	Bone/skin graft, microvasc
20970	C	Bone/skin graft, iliac crest
20972	C	Bone/skin graft, metatarsal
20973	C	Bone/skin graft, great toe
21045	C	Extensive jaw surgery
21141	C	Reconstruct midface, lefort
21142	C	Reconstruct midface, lefort
21143	C	Reconstruct midface, lefort
21145	C	Reconstruct midface, lefort
21146	C	Reconstruct midface, lefort
21147	C	Reconstruct midface, lefort
21150	C	Reconstruct midface, lefort
21151	C	Reconstruct midface, lefort
21154	C	Reconstruct midface, lefort
21155	C	Reconstruct midface, lefort
21159	C	Reconstruct midface, lefort
21160	C	Reconstruct midface, lefort
21172	C	Reconstruct orbit/forehead
21175	C	Reconstruct orbit/forehead
21179	C	Reconstruct entire forehead
21180	C	Reconstruct entire forehead
21182	C	Reconstruct cranial bone
21183	C	Reconstruct cranial bone
21184	C	Reconstruct cranial bone
21188	C	Reconstruction of midface
21193	C	Reconstruct lower jaw bone
21194	C	Reconstruct lower jaw bone
21195	C	Reconstruct lower jaw bone
21196	C	Reconstruct lower jaw bone
21247	C	Reconstruct lower jaw bone
21255	C	Reconstruct lower jaw bone
21256	C	Reconstruction of orbit
21268	C	Revise eye sockets
21343	C	Treatment of sinus fracture
21344	C	Treatment of sinus fracture
21346	C	Treat nose/jaw fracture
21347	C	Treat nose/jaw fracture
21348	C	Treat nose/jaw fracture
21356	C	Treat cheek bone fracture
21360	C	Treat cheek bone fracture
21365	C	Treat cheek bone fracture
21366	C	Treat cheek bone fracture
21385	C	Treat eye socket fracture
21386	C	Treat eye socket fracture
21387	C	Treat eye socket fracture
21390	C	Treat eye socket fracture
21395	C	Treat eye socket fracture
21408	C	Treat eye socket fracture
21422	C	Treat mouth roof fracture
21423	C	Treat mouth roof fracture
21431	C	Treat craniofacial fracture
21432	C	Treat craniofacial fracture
21433	C	Treat craniofacial fracture
21435	C	Treat craniofacial fracture
21436	C	Treat craniofacial fracture
21495	C	Treat hyoid bone fracture
21510	C	Drainage of bone lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
21557	C	Remove tumor, neck/chest
21615	C	Removal of rib
21616	C	Removal of rib and nerves
21620	C	Partial removal of sternum
21627	C	Sternal debridement
21630	C	Extensive sternum surgery
21632	C	Extensive sternum surgery
21705	C	Revision of neck muscle/rib
21740	C	Reconstruction of sternum
21750	C	Repair of sternum separation
21810	C	Treatment of rib fracture(s)
21825	C	Treat sternum fracture
22100	C	Remove part of neck vertebra
22101	C	Remove part, thorax vertebra
22102	C	Remove part, lumbar vertebra
22103	C	Remove extra spine segment
22110	C	Remove part of neck vertebra
22112	C	Remove part, thorax vertebra
22114	C	Remove part, lumbar vertebra
22116	C	Remove extra spine segment
22210	C	Revision of neck spine
22212	C	Revision of thorax spine
22214	C	Revision of lumbar spine
22216	C	Revise, extra spine segment
22220	C	Revision of neck spine
22222	C	Revision of thorax spine
22224	C	Revision of lumbar spine
22226	C	Revise, extra spine segment
22318	C	Treat odontoid fx w/o graft
22319	C	Treat odontoid fx w/graft
22325	C	Treat spine fracture
22326	C	Treat neck spine fracture
22327	C	Treat thorax spine fracture
22328	C	Treat each add spine fx
22548	C	Neck spine fusion
22554	C	Neck spine fusion
22556	C	Thorax spine fusion
22558	C	Lumbar spine fusion
22585	C	Additional spinal fusion
22590	C	Spine & skull spinal fusion
22595	C	Neck spinal fusion
22600	C	Neck spine fusion
22610	C	Thorax spine fusion
22612	C	Lumbar spine fusion
22614	C	Spine fusion, extra segment
22630	C	Lumbar spine fusion
22632	C	Spine fusion, extra segment
22800	C	Fusion of spine
22802	C	Fusion of spine
22804	C	Fusion of spine
22808	C	Fusion of spine
22810	C	Fusion of spine
22812	C	Fusion of spine
22818	C	Kyphectomy, 1–2 segments
22819	C	Kyphectomy, 3 or more
22830	C	Exploration of spinal fusion
22840	C	Insert spine fixation device
22841	C	Insert spine fixation device
22842	C	Insert spine fixation device
22843	C	Insert spine fixation device
22844	C	Insert spine fixation device
22845	C	Insert spine fixation device
22846	C	Insert spine fixation device
22847	C	Insert spine fixation device
22848	C	Insert pelv fixation device
22849	C	Reinsert spinal fixation
22850	C	Remove spine fixation device
22851	C	Apply spine prosth device
22852	C	Remove spine fixation device
22855	C	Remove spine fixation device
23035	C	Drain shoulder bone lesion
23125	C	Removal of collar bone

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
23195	C	Removal of head of humerus
23200	C	Removal of collar bone
23210	C	Removal of shoulder blade
23220	C	Partial removal of humerus
23221	C	Partial removal of humerus
23222	C	Partial removal of humerus
23332	C	Remove shoulder foreign body
23395	C	Muscle transfer, shoulder/arm
23397	C	Muscle transfers
23400	C	Fixation of shoulder blade
23440	C	Remove/transplant tendon
23470	C	Reconstruct shoulder joint
23472	C	Reconstruct shoulder joint
23900	C	Amputation of arm & girdle
23920	C	Amputation at shoulder joint
24149	C	Radical resection of elbow
24150	C	Extensive humerus surgery
24151	C	Extensive humerus surgery
24152	C	Extensive radius surgery
24153	C	Extensive radius surgery
24900	C	Amputation of upper arm
24920	C	Amputation of upper arm
24930	C	Amputation follow-up surgery
24931	C	Amputate upper arm & implant
24940	C	Revision of upper arm
25170	C	Extensive forearm surgery
25390	C	Shorten radius or ulna
25391	C	Lengthen radius or ulna
25392	C	Shorten radius & ulna
25393	C	Lengthen radius & ulna
25405	C	Repair/graft radius or ulna
25420	C	Repair/graft radius & ulna
25900	C	Amputation of forearm
25905	C	Amputation of forearm
25909	C	Amputation follow-up surgery
25915	C	Amputation of forearm
25920	C	Amputate hand at wrist
25924	C	Amputation follow-up surgery
25927	C	Amputation of hand
25931	C	Amputation follow-up surgery
26551	C	Great toe-hand transfer
26553	C	Single transfer, toe-hand
26554	C	Double transfer, toe-hand
26556	C	Toe joint transfer
26992	C	Drainage of bone lesion
27005	C	Incision of hip tendon
27006	C	Incision of hip tendons
27025	C	Incision of hip/thigh fascia
27030	C	Drainage of hip joint
27035	C	Denervation of hip joint
27036	C	Excision of hip joint/muscle
27054	C	Removal of hip joint lining
27070	C	Partial removal of hip bone
27071	C	Partial removal of hip bone
27075	C	Extensive hip surgery
27076	C	Extensive hip surgery
27077	C	Extensive hip surgery
27078	C	Extensive hip surgery
27079	C	Extensive hip surgery
27090	C	Removal of hip prosthesis
27091	C	Removal of hip prosthesis
27120	C	Reconstruction of hip socket
27122	C	Reconstruction of hip socket
27125	C	Partial hip replacement
27130	C	Total hip replacement
27132	C	Total hip replacement
27134	C	Revise hip joint replacement
27137	C	Revise hip joint replacement
27138	C	Revise hip joint replacement
27140	C	Transplant femur ridge
27146	C	Incision of hip bone
27147	C	Revision of hip bone

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
27151	C	Incision of hip bones
27156	C	Revision of hip bones
27158	C	Revision of pelvis
27161	C	Incision of neck of femur
27165	C	Incision/fixation of femur
27170	C	Repair/graft femur head/neck
27175	C	Treat slipped epiphysis
27176	C	Treat slipped epiphysis
27177	C	Treat slipped epiphysis
27178	C	Treat slipped epiphysis
27179	C	Revise head/neck of femur
27181	C	Treat slipped epiphysis
27185	C	Revision of femur epiphysis
27187	C	Reinforce hip bones
27215	C	Treat pelvic fracture(s)
27216	C	Treat pelvic ring fracture
27217	C	Treat pelvic ring fracture
27218	C	Treat pelvic ring fracture
27222	C	Treat hip socket fracture
27226	C	Treat hip wall fracture
27227	C	Treat hip fracture(s)
27228	C	Treat hip fracture(s)
27232	C	Treat thigh fracture
27235	C	Treat thigh fracture
27236	C	Treat thigh fracture
27240	C	Treat thigh fracture
27244	C	Treat thigh fracture
27245	C	Treat thigh fracture
27248	C	Treat thigh fracture
27253	C	Treat hip dislocation
27254	C	Treat hip dislocation
27258	C	Treat hip dislocation
27259	C	Treat hip dislocation
27280	C	Fusion of sacroiliac joint
27282	C	Fusion of pubic bones
27284	C	Fusion of hip joint
27286	C	Fusion of hip joint
27290	C	Amputation of leg at hip
27295	C	Amputation of leg at hip
27303	C	Drainage of bone lesion
27365	C	Extensive leg surgery
27445	C	Revision of knee joint
27446	C	Revision of knee joint
27447	C	Total knee replacement
27448	C	Incision of thigh
27450	C	Incision of thigh
27454	C	Realignment of thigh bone
27455	C	Realignment of knee
27457	C	Realignment of knee
27465	C	Shortening of thigh bone
27466	C	Lengthening of thigh bone
27468	C	Shorten/lengthen thighs
27470	C	Repair of thigh
27472	C	Repair/graft of thigh
27475	C	Surgery to stop leg growth
27477	C	Surgery to stop leg growth
27479	C	Surgery to stop leg growth
27485	C	Surgery to stop leg growth
27486	C	Revise/replace knee joint
27487	C	Revise/replace knee joint
27488	C	Removal of knee prosthesis
27495	C	Reinforce thigh
27506	C	Treatment of thigh fracture
27507	C	Treatment of thigh fracture
27511	C	Treatment of thigh fracture
27513	C	Treatment of thigh fracture
27514	C	Treatment of thigh fracture
27519	C	Treat thigh fx growth plate
27524	C	Treat kneecap fracture
27535	C	Treat knee fracture
27536	C	Treat knee fracture
27540	C	Treat knee fracture

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
27557	C	Treat knee dislocation
27558	C	Treat knee dislocation
27580	C	Fusion of knee
27590	C	Amputate leg at thigh
27591	C	Amputate leg at thigh
27592	C	Amputate leg at thigh
27596	C	Amputation follow-up surgery
27598	C	Amputate lower leg at knee
27645	C	Extensive lower leg surgery
27646	C	Extensive lower leg surgery
27702	C	Reconstruct ankle joint
27703	C	Reconstruction, ankle joint
27712	C	Realignment of lower leg
27715	C	Revision of lower leg
27720	C	Repair of tibia
27722	C	Repair/graft of tibia
27724	C	Repair/graft of tibia
27725	C	Repair of lower leg
27727	C	Repair of lower leg
27880	C	Amputation of lower leg
27881	C	Amputation of lower leg
27882	C	Amputation of lower leg
27886	C	Amputation follow-up surgery
27888	C	Amputation of foot at ankle
28800	C	Amputation of midfoot
28805	C	Amputation thru metatarsal
31225	C	Removal of upper jaw
31230	C	Removal of upper jaw
31290	C	Nasal/sinus endoscopy, surg
31291	C	Nasal/sinus endoscopy, surg
31292	C	Nasal/sinus endoscopy, surg
31293	C	Nasal/sinus endoscopy, surg
31294	C	Nasal/sinus endoscopy, surg
31360	C	Removal of larynx
31365	C	Removal of larynx
31367	C	Partial removal of larynx
31368	C	Partial removal of larynx
31370	C	Partial removal of larynx
31380	C	Partial removal of larynx
31382	C	Partial removal of larynx
31390	C	Removal of larynx & pharynx
31395	C	Reconstruct larynx & pharynx
31582	C	Revision of larynx
31584	C	Treat larynx fracture
31587	C	Revision of larynx
31725	C	Clearance of airways
31760	C	Repair of windpipe
31766	C	Reconstruction of windpipe
31770	C	Repair/graft of bronchus
31775	C	Reconstruct bronchus
31780	C	Reconstruct windpipe
31781	C	Reconstruct windpipe
31785	C	Remove windpipe lesion
31786	C	Remove windpipe lesion
31800	C	Repair of windpipe injury
31805	C	Repair of windpipe injury
32035	C	Exploration of chest
32036	C	Exploration of chest
32095	C	Biopsy through chest wall
32100	C	Exploration/biopsy of chest
32110	C	Explore/repair chest
32120	C	Re-exploration of chest
32124	C	Explore chest free adhesions
32140	C	Removal of lung lesion(s)
32141	C	Remove/treat lung lesions
32150	C	Removal of lung lesion(s)
32151	C	Remove lung foreign body
32160	C	Open chest heart massage
32200	C	Drain, open, lung lesion
32201	C	Drain, percut, lung lesion
32215	C	Treat chest lining
32220	C	Release of lung

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
32225	C	Partial release of lung
32310	C	Removal of chest lining
32320	C	Free/remove chest lining
32402	C	Open biopsy chest lining
32440	C	Removal of lung
32442	C	Sleeve pneumonectomy
32445	C	Removal of lung
32480	C	Partial removal of lung
32482	C	Bilobectomy
32484	C	Segmentectomy
32486	C	Sleeve lobectomy
32488	C	Completion pneumonectomy
32491	C	Lung volume reduction
32500	C	Partial removal of lung
32501	C	Repair bronchus add-on
32520	C	Remove lung & revise chest
32522	C	Remove lung & revise chest
32525	C	Remove lung & revise chest
32540	C	Removal of lung lesion
32650	C	Thoracoscopy, surgical
32651	C	Thoracoscopy, surgical
32652	C	Thoracoscopy, surgical
32653	C	Thoracoscopy, surgical
32654	C	Thoracoscopy, surgical
32655	C	Thoracoscopy, surgical
32656	C	Thoracoscopy, surgical
32657	C	Thoracoscopy, surgical
32658	C	Thoracoscopy, surgical
32659	C	Thoracoscopy, surgical
32660	C	Thoracoscopy, surgical
32661	C	Thoracoscopy, surgical
32662	C	Thoracoscopy, surgical
32663	C	Thoracoscopy, surgical
32664	C	Thoracoscopy, surgical
32665	C	Thoracoscopy, surgical
32800	C	Repair lung hernia
32810	C	Close chest after drainage
32815	C	Close bronchial fistula
32820	C	Reconstruct injured chest
32850	C	Donor pneumonectomy
32851	C	Lung transplant, single
32852	C	Lung transplant with bypass
32853	C	Lung transplant, double
32854	C	Lung transplant with bypass
32900	C	Removal of rib(s)
32905	C	Revise & repair chest wall
32906	C	Revise & repair chest wall
32940	C	Revision of lung
32997	C	Total lung lavage
33015	C	Incision of heart sac
33020	C	Incision of heart sac
33025	C	Incision of heart sac
33030	C	Partial removal of heart sac
33031	C	Partial removal of heart sac
33050	C	Removal of heart sac lesion
33120	C	Removal of heart lesion
33130	C	Removal of heart lesion
33140	C	Heart revascularize (tmr)
33200	C	Insertion of heart pacemaker
33201	C	Insertion of heart pacemaker
33236	C	Remove electrode/ thoracotomy
33237	C	Remove electrode/ thoracotomy
33238	C	Remove electrode/ thoracotomy
33243	C	Remove eltrd/thoracotomy
33245	C	Insert epic eltrd pace-defib
33246	C	Insert epic eltrd/generator
33250	C	Ablate heart dysrhythm focus
33251	C	Ablate heart dysrhythm focus
33253	C	Reconstruct atria

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
33261	C	Ablate heart dysrhythm focus
33282	C	Implant pat-active ht record
33284	C	Remove pat-active ht record
33300	C	Repair of heart wound
33305	C	Repair of heart wound
33310	C	Exploratory heart surgery
33315	C	Exploratory heart surgery
33320	C	Repair major blood vessel(s)
33321	C	Repair major vessel
33322	C	Repair major blood vessel(s)
33330	C	Insert major vessel graft
33332	C	Insert major vessel graft
33335	C	Insert major vessel graft
33400	C	Repair of aortic valve
33401	C	Valvuloplasty, open
33403	C	Valvuloplasty, w/cp bypass
33404	C	Prepare heart-aorta conduit
33405	C	Replacement of aortic valve
33406	C	Replacement of aortic valve
33410	C	Replacement of aortic valve
33411	C	Replacement of aortic valve
33412	C	Replacement of aortic valve
33413	C	Replacement of aortic valve
33414	C	Repair of aortic valve
33415	C	Revision, subvalvular tissue
33416	C	Revise ventricle muscle
33417	C	Repair of aortic valve
33420	C	Revision of mitral valve
33422	C	Revision of mitral valve
33425	C	Repair of mitral valve
33426	C	Repair of mitral valve
33427	C	Repair of mitral valve
33430	C	Replacement of mitral valve
33460	C	Revision of tricuspid valve
33463	C	Valvuloplasty, tricuspid
33464	C	Valvuloplasty, tricuspid
33465	C	Replace tricuspid valve
33468	C	Revision of tricuspid valve
33470	C	Revision of pulmonary valve
33471	C	Valvotomy, pulmonary valve
33472	C	Revision of pulmonary valve
33474	C	Revision of pulmonary valve
33475	C	Replacement, pulmonary valve
33476	C	Revision of heart chamber
33478	C	Revision of heart chamber
33496	C	Repair, prosth valve clot
33500	C	Repair heart vessel fistula
33501	C	Repair heart vessel fistula
33502	C	Coronary artery correction
33503	C	Coronary artery graft
33504	C	Coronary artery graft
33505	C	Repair artery w/tunnel
33506	C	Repair artery, translocation
33510	C	CABG, vein, single
33511	C	CABG, vein, two
33512	C	CABG, vein, three
33513	C	CABG, vein, four
33514	C	CABG, vein, five
33516	C	Cabg, vein, six or more
33517	C	CABG, artery-vein, single
33518	C	CABG, artery-vein, two
33519	C	CABG, artery-vein, three
33521	C	CABG, artery-vein, four
33522	C	CABG, artery-vein, five
33523	C	Cabg, art-vein, six or more
33530	C	Coronary artery, bypass/reop
33533	C	CABG, arterial, single
33534	C	CABG, arterial, two
33535	C	CABG, arterial, three
33536	C	Cabg, arterial, four or more
33542	C	Removal of heart lesion
33545	C	Repair of heart damage

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
33572	C	Open coronary endarterectomy
33600	C	Closure of valve
33602	C	Closure of valve
33606	C	Anastomosis/artery-aorta
33608	C	Repair anomaly w/conduit
33610	C	Repair by enlargement
33611	C	Repair double ventricle
33612	C	Repair double ventricle
33615	C	Repair, simple fontan
33617	C	Repair, modified fontan
33619	C	Repair single ventricle
33641	C	Repair heart septum defect
33645	C	Revision of heart veins
33647	C	Repair heart septum defects
33660	C	Repair of heart defects
33665	C	Repair of heart defects
33670	C	Repair of heart chambers
33681	C	Repair heart septum defect
33684	C	Repair heart septum defect
33688	C	Repair heart septum defect
33690	C	Reinforce pulmonary artery
33692	C	Repair of heart defects
33694	C	Repair of heart defects
33697	C	Repair of heart defects
33702	C	Repair of heart defects
33710	C	Repair of heart defects
33720	C	Repair of heart defect
33722	C	Repair of heart defect
33730	C	Repair heart-vein defect(s)
33732	C	Repair heart-vein defect
33735	C	Revision of heart chamber
33736	C	Revision of heart chamber
33737	C	Revision of heart chamber
33750	C	Major vessel shunt
33755	C	Major vessel shunt
33762	C	Major vessel shunt
33764	C	Major vessel shunt & graft
33766	C	Major vessel shunt
33767	C	Major vessel shunt
33770	C	Repair great vessels defect
33771	C	Repair great vessels defect
33774	C	Repair great vessels defect
33775	C	Repair great vessels defect
33776	C	Repair great vessels defect
33777	C	Repair great vessels defect
33778	C	Repair great vessels defect
33779	C	Repair great vessels defect
33780	C	Repair great vessels defect
33781	C	Repair great vessels defect
33786	C	Repair arterial trunk
33788	C	Revision of pulmonary artery
33800	C	Aortic suspension
33802	C	Repair vessel defect
33803	C	Repair vessel defect
33813	C	Repair septal defect
33814	C	Repair septal defect
33820	C	Revise major vessel
33822	C	Revise major vessel
33824	C	Revise major vessel
33840	C	Remove aorta constriction
33845	C	Remove aorta constriction
33851	C	Remove aorta constriction
33852	C	Repair septal defect
33853	C	Repair septal defect
33860	C	Ascending aortic graft
33861	C	Ascending aortic graft
33863	C	Ascending aortic graft
33870	C	Transverse aortic arch graft
33875	C	Thoracic aortic graft
33877	C	Thoracoabdominal graft
33910	C	Remove lung artery emboli

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
33915	C	Remove lung artery emboli
33916	C	Surgery of great vessel
33917	C	Repair pulmonary artery
33918	C	Repair pulmonary atresia
33919	C	Repair pulmonary atresia
33920	C	Repair pulmonary atresia
33922	C	Transect pulmonary artery
33924	C	Remove pulmonary shunt
33930	C	Removal of donor heart/lung
33935	C	Transplantation, heart/lung
33940	C	Removal of donor heart
33945	C	Transplantation of heart
33960	C	External circulation assist
33961	C	External circulation assist
33968	C	Remove aortic assist device
33970	C	Aortic circulation assist
33971	C	Aortic circulation assist
33973	C	Insert balloon device
33974	C	Remove intra-aortic balloon
33975	C	Implant ventricular device
33976	C	Implant ventricular device
33977	C	Remove ventricular device
33978	C	Remove ventricular device
34001	C	Removal of artery clot
34051	C	Removal of artery clot
34151	C	Removal of artery clot
34401	C	Removal of vein clot
34421	C	Removal of vein clot
34451	C	Removal of vein clot
34502	C	Reconstruct vena cava
35001	C	Repair defect of artery
35002	C	Repair artery rupture, neck
35005	C	Repair defect of artery
35011	C	Repair defect of artery
35013	C	Repair artery rupture, arm
35021	C	Repair defect of artery
35022	C	Repair artery rupture, chest
35045	C	Repair defect of arm artery
35081	C	Repair defect of artery
35082	C	Repair artery rupture, aorta
35091	C	Repair defect of artery
35092	C	Repair artery rupture, aorta
35102	C	Repair defect of artery
35103	C	Repair artery rupture, groin
35111	C	Repair defect of artery
35112	C	Repair artery rupture, spleen
35121	C	Repair defect of artery
35122	C	Repair artery rupture, belly
35131	C	Repair defect of artery
35132	C	Repair artery rupture, groin
35141	C	Repair defect of artery
35142	C	Repair artery rupture, thigh
35151	C	Repair defect of artery
35152	C	Repair artery rupture, knee
35161	C	Repair defect of artery
35162	C	Repair artery rupture
35182	C	Repair blood vessel lesion
35189	C	Repair blood vessel lesion
35211	C	Repair blood vessel lesion
35216	C	Repair blood vessel lesion
35221	C	Repair blood vessel lesion
35241	C	Repair blood vessel lesion
35246	C	Repair blood vessel lesion
35251	C	Repair blood vessel lesion
35271	C	Repair blood vessel lesion
35276	C	Repair blood vessel lesion
35281	C	Repair blood vessel lesion
35301	C	Rechanneling of artery
35311	C	Rechanneling of artery
35331	C	Rechanneling of artery
35341	C	Rechanneling of artery
35351	C	Rechanneling of artery

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
35355	C	Rechanneling of artery
35361	C	Rechanneling of artery
35363	C	Rechanneling of artery
35371	C	Rechanneling of artery
35372	C	Rechanneling of artery
35381	C	Rechanneling of artery
35390	C	Reoperation, carotid add-on
35400	C	Angioscopy
35450	C	Repair arterial blockage
35452	C	Repair arterial blockage
35454	C	Repair arterial blockage
35456	C	Repair arterial blockage
35458	C	Repair arterial blockage
35480	C	Atherectomy, open
35481	C	Atherectomy, open
35482	C	Atherectomy, open
35483	C	Atherectomy, open
35501	C	Artery bypass graft
35506	C	Artery bypass graft
35507	C	Artery bypass graft
35508	C	Artery bypass graft
35509	C	Artery bypass graft
35511	C	Artery bypass graft
35515	C	Artery bypass graft
35516	C	Artery bypass graft
35518	C	Artery bypass graft
35521	C	Artery bypass graft
35526	C	Artery bypass graft
35531	C	Artery bypass graft
35533	C	Artery bypass graft
35536	C	Artery bypass graft
35541	C	Artery bypass graft
35546	C	Artery bypass graft
35548	C	Artery bypass graft
35549	C	Artery bypass graft
35551	C	Artery bypass graft
35556	C	Artery bypass graft
35558	C	Artery bypass graft
35560	C	Artery bypass graft
35563	C	Artery bypass graft
35565	C	Artery bypass graft
35566	C	Artery bypass graft
35571	C	Artery bypass graft
35582	C	Vein bypass graft
35583	C	Vein bypass graft
35585	C	Vein bypass graft
35587	C	Vein bypass graft
35601	C	Artery bypass graft
35606	C	Artery bypass graft
35612	C	Artery bypass graft
35616	C	Artery bypass graft
35621	C	Artery bypass graft
35623	C	Bypass graft, not vein
35626	C	Artery bypass graft
35631	C	Artery bypass graft
35636	C	Artery bypass graft
35641	C	Artery bypass graft
35642	C	Artery bypass graft
35645	C	Artery bypass graft
35646	C	Artery bypass graft
35650	C	Artery bypass graft
35651	C	Artery bypass graft
35654	C	Artery bypass graft
35656	C	Artery bypass graft
35661	C	Artery bypass graft
35663	C	Artery bypass graft
35665	C	Artery bypass graft
35666	C	Artery bypass graft
35671	C	Artery bypass graft
35681	C	Composite bypass graft
35682	C	Composite bypass graft
35683	C	Composite bypass graft

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
35691	C	Arterial transposition
35693	C	Arterial transposition
35694	C	Arterial transposition
35695	C	Arterial transposition
35700	C	Reoperation, bypass graft
35701	C	Exploration, carotid artery
35721	C	Exploration, femoral artery
35741	C	Exploration popliteal artery
35761	C	Exploration of artery/vein
35800	C	Explore neck vessels
35820	C	Explore chest vessels
35840	C	Explore abdominal vessels
35860	C	Explore limb vessels
35870	C	Repair vessel graft defect
35901	C	Excision, graft, neck
35903	C	Excision, graft, extremity
35905	C	Excision, graft, thorax
35907	C	Excision, graft, abdomen
36510	C	Insertion of catheter, vein
36550	C	Declot vascular device
36660	C	Insertion catheter, artery
36822	C	Insertion of cannula(s)
36823	C	Insertion of cannula(s)
36834	C	Repair A–V aneurysm
37140	C	Revision of circulation
37145	C	Revision of circulation
37160	C	Revision of circulation
37180	C	Revision of circulation
37181	C	Splice spleen/kidney veins
37195	C	Thrombolytic therapy, stroke
37200	C	Transcatheter biopsy
37201	C	Transcatheter therapy infuse
37202	C	Transcatheter therapy infuse
37616	C	Ligation of chest artery
37617	C	Ligation of abdomen artery
37620	C	Revision of major vein
37660	C	Revision of major vein
37788	C	Revascularization, penis
38100	C	Removal of spleen, total
38101	C	Removal of spleen, partial
38102	C	Removal of spleen, total
38115	C	Repair of ruptured spleen
38380	C	Thoracic duct procedure
38381	C	Thoracic duct procedure
38382	C	Thoracic duct procedure
38562	C	Removal, pelvic lymph nodes
38564	C	Removal, abdomen lymph nodes
38700	C	Removal of lymph nodes, neck
38724	C	Removal of lymph nodes, neck
38746	C	Remove thoracic lymph nodes
38747	C	Remove abdominal lymph nodes
38765	C	Remove groin lymph nodes
38770	C	Remove pelvis lymph nodes
38780	C	Remove abdomen lymph nodes
39000	C	Exploration of chest
39010	C	Exploration of chest
39200	C	Removal chest lesion
39220	C	Removal chest lesion
39499	C	Chest procedure
39501	C	Repair diaphragm laceration
39502	C	Repair paraesophageal hernia
39503	C	Repair of diaphragm hernia
39520	C	Repair of diaphragm hernia
39530	C	Repair of diaphragm hernia
39531	C	Repair of diaphragm hernia
39540	C	Repair of diaphragm hernia
39541	C	Repair of diaphragm hernia
39545	C	Revision of diaphragm
39560	C	Resect diaphragm, simple

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
39561	C	Resect diaphragm, complex
39599	C	Diaphragm surgery procedure
41130	C	Partial removal of tongue
41135	C	Tongue and neck surgery
41140	C	Removal of tongue
41145	C	Tongue removal, neck surgery
41150	C	Tongue, mouth, jaw surgery
41153	C	Tongue, mouth, neck surgery
41155	C	Tongue, jaw, & neck surgery
42426	C	Excise parotid gland/lesion
42842	C	Extensive surgery of throat
42845	C	Extensive surgery of throat
42894	C	Revision of pharyngeal walls
42953	C	Repair throat, esophagus
42961	C	Control throat bleeding
42971	C	Control nose/throat bleeding
43030	C	Throat muscle surgery
43045	C	Incision of esophagus
43100	C	Excision of esophagus lesion
43101	C	Excision of esophagus lesion
43107	C	Removal of esophagus
43108	C	Removal of esophagus
43112	C	Removal of esophagus
43113	C	Removal of esophagus
43116	C	Partial removal of esophagus
43117	C	Partial removal of esophagus
43118	C	Partial removal of esophagus
43121	C	Partial removal of esophagus
43122	C	Parital removal of esophagus
43123	C	Partial removal of esophagus
43124	C	Removal of esophagus
43130	C	Removal of esophagus pouch
43135	C	Removal of esophagus pouch
43300	C	Repair of esophagus
43305	C	Repair esophagus and fistula
43310	C	Repair of esophagus
43312	C	Repair esophagus and fistula
43320	C	Fuse esophagus & stomach
43324	C	Revise esophagus & stomach
43325	C	Revise esophagus & stomach
43326	C	Revise esophagus & stomach
43330	C	Repair of esophagus
43331	C	Repair of esophagus
43340	C	Fuse esophagus & intestine
43341	C	Fuse esophagus & intestine
43350	C	Surgical opening, esophagus
43351	C	Surgical opening, esophagus
43352	C	Surgical opening, esophagus
43360	C	Gastrointestinal repair
43361	C	Gastrointestinal repair
43400	C	Ligate esophagus veins
43401	C	Esophagus surgery for veins
43405	C	Ligate/staple esophagus
43410	C	Repair esophagus wound
43415	C	Repair esophagus wound
43420	C	Repair esophagus opening
43425	C	Repair esophagus opening
43460	C	Pressure treatment esophagus
43496	C	Free jejunum flap, microvasc
43500	C	Surgical opening of stomach
43501	C	Surgical repair of stomach
43502	C	Surgical repair of stomach
43510	C	Surgical opening of stomach
43520	C	Incision of pyloric muscle
43605	C	Biopsy of stomach
43610	C	Excision of stomach lesion
43611	C	Excision of stomach lesion
43620	C	Removal of stomach
43621	C	Removal of stomach
43622	C	Removal of stomach
43631	C	Removal of stomach, partial
43632	C	Removal of stomach, partial

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
43633	C	Removal of stomach, partial
43634	C	Removal of stomach, partial
43635	C	Removal of stomach, partial
43638	C	Removal of stomach, partial
43639	C	Removal of stomach, partial
43640	C	Vagotomy & pylorus repair
43641	C	Vagotomy & pylorus repair
43800	C	Reconstruction of pylorus
43810	C	Fusion of stomach and bowel
43820	C	Fusion of stomach and bowel
43825	C	Fusion of stomach and bowel
43832	C	Place gastrostomy tube
43840	C	Repair of stomach lesion
43842	C	Gastroplasty for obesity
43843	C	Gastroplasty for obesity
43846	C	Gastric bypass for obesity
43847	C	Gastric bypass for obesity
43848	C	Revision gastroplasty
43850	C	Revise stomach-bowel fusion
43855	C	Revise stomach-bowel fusion
43860	C	Revise stomach-bowel fusion
43865	C	Revise stomach-bowel fusion
43880	C	Repair stomach-bowel fistula
44005	C	Freeing of bowel adhesion
44010	C	Incision of small bowel
44015	C	Insert needle cath bowel
44020	C	Exploration of small bowel
44021	C	Decompress small bowel
44025	C	Incision of large bowel
44050	C	Reduce bowel obstruction
44055	C	Correct malrotation of bowel
44110	C	Excision of bowel lesion(s)
44111	C	Excision of bowel lesion(s)
44120	C	Removal of small intestine
44121	C	Removal of small intestine
44125	C	Removal of small intestine
44130	C	Bowel to bowel fusion
44139	C	Mobilization of colon
44140	C	Partial removal of colon
44141	C	Partial removal of colon
44143	C	Partial removal of colon
44144	C	Partial removal of colon
44145	C	Partial removal of colon
44146	C	Partial removal of colon
44147	C	Partial removal of colon
44150	C	Removal of colon
44151	C	Removal of colon/ileostomy
44152	C	Removal of colon/ileostomy
44153	C	Removal of colon/ileostomy
44155	C	Removal of colon/ileostomy
44156	C	Removal of colon/ileostomy
44160	C	Removal of colon
44202	C	Laparo, resect intestine
44300	C	Open bowel to skin
44310	C	Ileostomy/jejunostomy
44314	C	Revision of ileostomy
44316	C	Devise bowel pouch
44320	C	Colostomy
44322	C	Colostomy with biopsies
44345	C	Revision of colostomy
44346	C	Revision of colostomy
44500	C	Intro, gastrointestinal tube
44602	C	Suture, small intestine
44603	C	Suture, small intestine
44604	C	Suture, large intestine
44605	C	Repair of bowel lesion
44615	C	Intestinal stricturoplasty
44620	C	Repair bowel opening
44625	C	Repair bowel opening
44626	C	Repair bowel opening
44640	C	Repair bowel-skin fistula
44650	C	Repair bowel fistula

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
44660	C	Repair bowel-bladder fistula
44661	C	Repair bowel-bladder fistula
44680	C	Surgical revision, intestine
44700	C	Suspend bowel w/prosthesis
44800	C	Excision of bowel pouch
44820	C	Excision of mesentery lesion
44850	C	Repair of mesentery
44899	C	Bowel surgery procedure
44900	C	Drain app abscess, open
44901	C	Drain app abscess, percut
44950	C	Appendectomy
44955	C	Appendectomy add-on
44960	C	Appendectomy
45110	C	Removal of rectum
45111	C	Partial removal of rectum
45112	C	Removal of rectum
45113	C	Partial proctectomy
45114	C	Partial removal of rectum
45116	C	Partial removal of rectum
45119	C	Remove rectum w/reservoir
45120	C	Removal of rectum
45121	C	Removal of rectum and colon
45123	C	Partial proctectomy
45126	C	Pelvic exenteration
45130	C	Excision of rectal prolapse
45135	C	Excision of rectal prolapse
45540	C	Correct rectal prolapse
45541	C	Correct rectal prolapse
45550	C	Repair rectum/remove sigmoid
45562	C	Exploration/repair of rectum
45563	C	Exploration/repair of rectum
45800	C	Repair rect/bladder fistula
45805	C	Repair fistula w/colostomy
45820	C	Repair rectourethral fistula
45825	C	Repair fistula w/colostomy
46705	C	Repair of anal stricture
46715	C	Repair of anovaginal fistula
46716	C	Repair of anovaginal fistula
46730	C	Construction of absent anus
46735	C	Construction of absent anus
46740	C	Construction of absent anus
46742	C	Repair of imperforated anus
46744	C	Repair of cloacal anomaly
46746	C	Repair of cloacal anomaly
46748	C	Repair of cloacal anomaly
46751	C	Repair of anal sphincter
47001	C	Needle biopsy, liver add-on
47010	C	Open drainage, liver lesion
47011	C	Percut drain, liver lesion
47015	C	Inject/aspirate liver cyst
47100	C	Wedge biopsy of liver
47120	C	Partial removal of liver
47122	C	Extensive removal of liver
47125	C	Partial removal of liver
47130	C	Partial removal of liver
47133	C	Removal of donor liver
47134	C	Partial removal, donor liver
47135	C	Transplantation of liver
47136	C	Transplantation of liver
47300	C	Surgery for liver lesion
47350	C	Repair liver wound
47360	C	Repair liver wound
47361	C	Repair liver wound
47362	C	Repair liver wound
47400	C	Incision of liver duct
47420	C	Incision of bile duct
47425	C	Incision of bile duct
47460	C	Incise bile duct sphincter
47480	C	Incision of gallbladder
47490	C	Incision of gallbladder
47550	C	Bile duct endoscopy add-on
47600	C	Removal of gallbladder

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
47605	C	Removal of gallbladder
47610	C	Removal of gallbladder
47612	C	Removal of gallbladder
47620	C	Removal of gallbladder
47700	C	Exploration of bile ducts
47701	C	Bile duct revision
47711	C	Excision of bile duct tumor
47712	C	Excision of bile duct tumor
47715	C	Excision of bile duct cyst
47716	C	Fusion of bile duct cyst
47720	C	Fuse gallbladder & bowel
47721	C	Fuse upper gi structures
47740	C	Fuse gallbladder & bowel
47741	C	Fuse gallbladder & bowel
47760	C	Fuse bile ducts and bowel
47765	C	Fuse liver ducts & bowel
47780	C	Fuse bile ducts and bowel
47785	C	Fuse bile ducts and bowel
47800	C	Reconstruction of bile ducts
47801	C	Placement, bile duct support
47802	C	Fuse liver duct & intestine
47900	C	Suture bile duct injury
48000	C	Drainage of abdomen
48001	C	Placement of drain, pancreas
48005	C	Resect/debride pancreas
48020	C	Removal of pancreatic stone
48100	C	Biopsy of pancreas
48120	C	Removal of pancreas lesion
48140	C	Partial removal of pancreas
48145	C	Partial removal of pancreas
48146	C	Pancreatectomy
48148	C	Removal of pancreatic duct
48150	C	Partial removal of pancreas
48152	C	Pancreatectomy
48153	C	Pancreatectomy
48154	C	Pancreatectomy
48155	C	Removal of pancreas
48180	C	Fuse pancreas and bowel
48400	C	Injection, intraop add-on
48500	C	Surgery of pancreas cyst
48510	C	Drain pancreatic pseudocyst
48511	C	Drain pancreatic pseudocyst
48520	C	Fuse pancreas cyst and bowel
48540	C	Fuse pancreas cyst and bowel
48545	C	Pancreatorrhaphy
48547	C	Duodenal exclusion
48556	C	Removal, allograft pancreas
49000	C	Exploration of abdomen
49002	C	Reopening of abdomen
49010	C	Exploration behind abdomen
49020	C	Drain abdominal abscess
49021	C	Drain abdominal abscess
49040	C	Drain, open, abdom abscess
49041	C	Drain, percut, abdom abscess
49060	C	Drain, open, retrop abscess
49061	C	Drain, percut, retroper absc
49062	C	Drain to peritoneal cavity
49200	C	Removal of abdominal lesion
49201	C	Removal of abdominal lesion
49215	C	Excise sacral spine tumor
49220	C	Multiple surgery, abdomen
49255	C	Removal of omentum
49425	C	Insert abdomen-venous drain
49428	C	Ligation of shunt
49605	C	Repair umbilical lesion
49606	C	Repair umbilical lesion
49610	C	Repair umbilical lesion
49611	C	Repair umbilical lesion
49900	C	Repair of abdominal wall
49905	C	Omental flap
49906	C	Free omental flap, microvasc
50010	C	Exploration of kidney

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
50020	C	Renal abscess, open drain
50021	C	Renal abscess, percut drain
50040	C	Drainage of kidney
50045	C	Exploration of kidney
50060	C	Removal of kidney stone
50065	C	Incision of kidney
50070	C	Incision of kidney
50075	C	Removal of kidney stone
50100	C	Revise kidney blood vessels
50120	C	Exploration of kidney
50125	C	Explore and drain kidney
50130	C	Removal of kidney stone
50135	C	Exploration of kidney
50205	C	Biopsy of kidney
50220	C	Removal of kidney
50225	C	Removal of kidney
50230	C	Removal of kidney
50234	C	Removal of kidney & ureter
50236	C	Removal of kidney & ureter
50240	C	Partial removal of kidney
50280	C	Removal of kidney lesion
50290	C	Removal of kidney lesion
50300	C	Removal of donor kidney
50320	C	Removal of donor kidney
50340	C	Removal of kidney
50360	C	Transplantation of kidney
50365	C	Transplantation of kidney
50370	C	Remove transplanted kidney
50380	C	Reimplantation of kidney
50400	C	Revision of kidney/ureter
50405	C	Revision of kidney/ureter
50500	C	Repair of kidney wound
50520	C	Close kidney-skin fistula
50525	C	Repair renal-abdomen fistula
50526	C	Repair renal-abdomen fistula
50540	C	Revision of horseshoe kidney
50546	C	Laparoscopic nephrectomy
50547	C	Laparo removal donor kidney
50570	C	Kidney endoscopy
50572	C	Kidney endoscopy
50574	C	Kidney endoscopy & biopsy
50575	C	Kidney endoscopy
50576	C	Kidney endoscopy & treatment
50578	C	Renal endoscopy/radiotracer
50580	C	Kidney endoscopy & treatment
50600	C	Exploration of ureter
50605	C	Insert ureteral support
50610	C	Removal of ureter stone
50620	C	Removal of ureter stone
50630	C	Removal of ureter stone
50650	C	Removal of ureter
50660	C	Removal of ureter
50700	C	Revision of ureter
50715	C	Release of ureter
50722	C	Release of ureter
50725	C	Release/revise ureter
50727	C	Revise ureter
50728	C	Revise ureter
50740	C	Fusion of ureter & kidney
50750	C	Fusion of ureter & kidney
50760	C	Fusion of ureters
50770	C	Splicing of ureters
50780	C	Reimplant ureter in bladder
50782	C	Reimplant ureter in bladder
50783	C	Reimplant ureter in bladder
50785	C	Reimplant ureter in bladder
50800	C	Implant ureter in bowel
50810	C	Fusion of ureter & bowel
50815	C	Urine shunt to bowel
50820	C	Construct bowel bladder
50825	C	Construct bowel bladder
50830	C	Revise urine flow
50840	C	Replace ureter by bowel
50845	C	Appendico-vesicostomy
50860	C	Transplant ureter to skin
50900	C	Repair of ureter
50920	C	Closure ureter/skin fistula
50930	C	Closure ureter/bowel fistula
50940	C	Release of ureter
50970	C	Ureter endoscopy
50972	C	Ureter endoscopy & catheter
50974	C	Ureter endoscopy & biopsy
50976	C	Ureter endoscopy & treatment
50978	C	Ureter endoscopy & tracer
50980	C	Ureter endoscopy & treatment
51060	C	Removal of ureter stone
51525	C	Removal of bladder lesion
51530	C	Removal of bladder lesion
51535	C	Repair of ureter lesion
51550	C	Partial removal of bladder
51555	C	Partial removal of bladder
51565	C	Revise bladder & ureter(s)
51570	C	Removal of bladder
51575	C	Removal of bladder & nodes
51580	C	Remove bladder/revise tract
51585	C	Removal of bladder & nodes
51590	C	Remove bladder/revise tract
51595	C	Remove bladder/revise tract
51596	C	Remove bladder/create pouch
51597	C	Removal of pelvic structures
51800	C	Revision of bladder/urethra
51820	C	Revision of urinary tract
51840	C	Attach bladder/urethra
51841	C	Attach bladder/urethra
51845	C	Repair bladder neck
51860	C	Repair of bladder wound
51865	C	Repair of bladder wound
51900	C	Repair bladder/vagina lesion
51920	C	Close bladder-uterus fistula
51925	C	Hysterectomy/bladder repair
51940	C	Correction of bladder defect
51960	C	Revision of bladder & bowel
51980	C	Construct bladder opening
53085	C	Drainage of urinary leakage
53415	C	Reconstruction of urethra
53443	C	Reconstruction of urethra
54125	C	Removal of penis
54130	C	Remove penis & nodes
54135	C	Remove penis & nodes
54332	C	Revise penis/urethra
54336	C	Revise penis/urethra
54390	C	Repair penis and bladder
54430	C	Revision of penis
54535	C	Extensive testis surgery
54560	C	Exploration for testis
54650	C	Orchiopexy (Fowler-Stephens)
55600	C	Incise sperm duct pouch
55605	C	Incise sperm duct pouch
55650	C	Remove sperm duct pouch
55801	C	Removal of prostate
55810	C	Extensive prostate surgery
55812	C	Extensive prostate surgery
55815	C	Extensive prostate surgery
55821	C	Removal of prostate
55831	C	Removal of prostate
55840	C	Extensive prostate surgery
55842	C	Extensive prostate surgery
55845	C	Extensive prostate surgery
55860	C	Surgical exposure, prostate
55862	C	Extensive prostate surgery
55865	C	Extensive prostate surgery
56630	C	Extensive vulva surgery
56631	C	Extensive vulva surgery
56632	C	Extensive vulva surgery
56633	C	Extensive vulva surgery
56634	C	Extensive vulva surgery
56637	C	Extensive vulva surgery
56640	C	Extensive vulva surgery
56805	C	Repair clitoris
57110	C	Remove vagina wall, complete
57111	C	Remove vagina tissue, compl
57112	C	Vaginectomy w/nodes, compl
57120	C	Closure of vagina
57270	C	Repair of bowel pouch
57280	C	Suspension of vagina
57282	C	Repair of vaginal prolapse
57292	C	Construct vagina with graft
57305	C	Repair rectum-vagina fistula
57307	C	Fistula repair & colostomy
57308	C	Fistula repair, transperine
57310	C	Repair urethrovaginal lesion
57311	C	Repair urethrovaginal lesion
57320	C	Repair bladder-vagina lesion
57330	C	Repair bladder-vagina lesion
57335	C	Repair vagina
57531	C	Removal of cervix, radical
57540	C	Removal of residual cervix
57545	C	Remove cervix/repair pelvis
58140	C	Removal of uterus lesion
58150	C	Total hysterectomy
58152	C	Total hysterectomy
58180	C	Partial hysterectomy
58200	C	Extensive hysterectomy
58210	C	Extensive hysterectomy
58240	C	Removal of pelvis contents
58260	C	Vaginal hysterectomy
58262	C	Vaginal hysterectomy
58263	C	Vaginal hysterectomy
58267	C	Hysterectomy & vagina repair
58270	C	Hysterectomy & vagina repair
58275	C	Hysterectomy/revise vagina
58280	C	Hysterectomy/revise vagina
58285	C	Extensive hysterectomy
58400	C	Suspension of uterus
58410	C	Suspension of uterus
58520	C	Repair of ruptured uterus
58540	C	Revision of uterus
58600	C	Division of fallopian tube
58605	C	Division of fallopian tube
58611	C	Ligate oviduct(s) add-on
58615	C	Occlude fallopian tube(s)
58700	C	Removal of fallopian tube
58720	C	Removal of ovary/tube(s)
58740	C	Revise fallopian tube(s)
58750	C	Repair oviduct
58752	C	Revise ovarian tube(s)
58760	C	Remove tubal obstruction
58770	C	Create new tubal opening
58805	C	Drainage of ovarian cyst(s)
58822	C	Drain ovary abscess, percut
58823	C	Drain pelvic abscess, percut
58825	C	Transposition, ovary(s)
58940	C	Removal of ovary(s)
58943	C	Removal of ovary(s)
58950	C	Resect ovarian malignancy
58951	C	Resect ovarian malignancy
58952	C	Resect ovarian malignancy
58960	C	Exploration of abdomen
59100	C	Remove uterus lesion
59120	C	Treat ectopic pregnancy
59121	C	Treat ectopic pregnancy
59130	C	Treat ectopic pregnancy
59135	C	Treat ectopic pregnancy
59136	C	Treat ectopic pregnancy
59140	C	Treat ectopic pregnancy
59325	C	Revision of cervix

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
59350	C	Repair of uterus
59514	C	Cesarean delivery only
59525	C	Remove uterus after cesarean
59620	C	Attempted vbac delivery only
59830	C	Treat uterus infection
59850	C	Abortion
59851	C	Abortion
59852	C	Abortion
59855	C	Abortion
59856	C	Abortion
59857	C	Abortion
59866	C	Abortion (mpr)
60212	C	Parital thyroid excision
60252	C	Removal of thyroid
60254	C	Extensive thyroid surgery
60260	C	Repeat thyroid surgery
60270	C	Removal of thyroid
60271	C	Removal of thyroid
60502	C	Re-explore parathyroids
60505	C	Explore parathyroid glands
60512	C	Autotransplant parathyroid
60520	C	Removal of thymus gland
60521	C	Removal of thymus gland
60522	C	Removal of thymus gland
60540	C	Explore adrenal gland
60545	C	Explore adrenal gland
60600	C	Remove carotid body lesion
60605	C	Remove carotid body lesion
60650	C	Laparoscopy adrenalectomy
61105	C	Twist drill hole
61107	C	Drill skull for implantation
61108	C	Drill skull for drainage
61120	C	Burr hole for puncture
61140	C	Pierce skull for biopsy
61150	C	Pierce skull for drainage
61151	C	Pierce skull for drainage
61154	C	Pierce skull & remove clot
61156	C	Pierce skull for drainage
61210	C	Pierce skull, implant device
61250	C	Pierce skull & explore
61253	C	Pierce skull & explore
61304	C	Open skull for exploration
61305	C	Open skull for exploration
61312	C	Open skull for drainage
61313	C	Open skull for drainage
61314	C	Open skull for drainage
61315	C	Open skull for drainage
61320	C	Open skull for drainage
61321	C	Open skull for drainage
61332	C	Explore/biopsy eye socket
61333	C	Explore orbit/remove lesion
61334	C	Explore orbit/remove object
61340	C	Relieve cranial pressure
61343	C	Incise skull (press relief)
61345	C	Relieve cranial pressure
61440	C	Incise skull for surgery
61450	C	Incise skull for surgery
61458	C	Incise skull for brain wound
61460	C	Incise skull for surgery
61470	C	Incise skull for surgery
61480	C	Incise skull for surgery
61490	C	Incise skull for surgery
61500	C	Removal of skull lesion
61501	C	Remove infected skull bone
61510	C	Removal of brain lesion
61512	C	Remove brain lining lesion
61514	C	Removal of brain abscess
61516	C	Removal of brain lesion
61518	C	Removal of brain lesion
61519	C	Remove brain lining lesion
61520	C	Removal of brain lesion
61521	C	Removal of brain lesion

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
61522	C	Removal of brain abscess
61524	C	Removal of brain lesion
61526	C	Removal of brain lesion
61530	C	Removal of brain lesion
61531	C	Implant brain electrodes
61533	C	Implant brain electrodes
61534	C	Removal of brain lesion
61535	C	Remove brain electrodes
61536	C	Removal of brain lesion
61538	C	Removal of brain tissue
61539	C	Removal of brain tissue
61541	C	Incision of brain tissue
61542	C	Removal of brain tissue
61543	C	Removal of brain tissue
61544	C	Remove & treat brain lesion
61545	C	Excision of brain tumor
61546	C	Removal of pituitary gland
61548	C	Removal of pituitary gland
61550	C	Release of skull seams
61552	C	Release of skull seams
61556	C	Incise skull/sutures
61557	C	Incise skull/sutures
61558	C	Excision of skull/sutures
61559	C	Excision of skull/sutures
61563	C	Excision of skull tumor
61564	C	Excision of skull tumor
61570	C	Remove foreign body, brain
61571	C	Incise skull for brain wound
61575	C	Skull base/brainstem surgery
61576	C	Skull base/brainstem surgery
61580	C	Craniofacial approach, skull
61581	C	Craniofacial approach, skull
61582	C	Craniofacial approach, skull
61583	C	Craniofacial approach, skull
61584	C	Orbitocranial approach/skull
61585	C	Orbitocranial approach/skull
61586	C	Resect nasopharynx, skull
61590	C	Infratemporal approach/skull
61591	C	Infratemporal approach/skull
61592	C	Orbitocranial approach/skull
61595	C	Transtemporal approach/skull
61596	C	Transcochlear approach/skull
61597	C	Transcondylar approach/skull
61598	C	Transpetrosal approach/skull
61600	C	Resect/excise cranial lesion
61601	C	Resect/excise cranial lesion
61605	C	Resect/excise cranial lesion
61606	C	Resect/excise cranial lesion
61607	C	Resect/excise cranial lesion
61608	C	Resect/excise cranial lesion
61609	C	Transect artery, sinus
61610	C	Transect artery, sinus
61611	C	Transect artery, sinus
61612	C	Transect artery, sinus
61613	C	Remove aneurysm, sinus
61615	C	Resect/excise lesion, skull
61616	C	Resect/excise lesion, skull
61618	C	Repair dura
61619	C	Repair dura
61624	C	Occlusion/embolization cath
61626	C	Occlusion/embolization cath
61680	C	Intracranial vessel surgery
61682	C	Intracranial vessel surgery
61684	C	Intracranial vessel surgery
61686	C	Intracranial vessel surgery
61690	C	Intracranial vessel surgery
61692	C	Intracranial vessel surgery
61700	C	Inner skull vessel surgery
61702	C	Inner skull vessel surgery
61703	C	Clamp neck artery
61705	C	Revise circulation to head
61708	C	Revise circulation to head

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
61710	C	Revise circulation to head
61711	C	Fusion of skull arteries
61720	C	Incise skull/brain surgery
61735	C	Incise skull/brain surgery
61750	C	Incise skull/brain biopsy
61751	C	Brain biopsy w/ct/mr guide
61760	C	Implant brain electrodes
61770	C	Incise skull for treatment
61791	C	Treat trigeminal tract
61795	C	Brain surgery using computer
61850	C	Implant neuroelectrodes
61860	C	Implant neuroelectrodes
61862	C	Implant neurostimul, subcort
61870	C	Implant neuroelectrodes
61875	C	Implant neuroelectrodes
61880	C	Revise/remove neuroelectrode
61886	C	Implant neurostim arrays
61888	C	Revise/remove neuroreceiver
62000	C	Treat skull fracture
62005	C	Treat skull fracture
62010	C	Treatment of head injury
62100	C	Repair brain fluid leakage
62115	C	Reduction of skull defect
62116	C	Reduction of skull defect
62117	C	Reduction of skull defect
62120	C	Repair skull cavity lesion
62121	C	Incise skull repair
62140	C	Repair of skull defect
62141	C	Repair of skull defect
62142	C	Remove skull plate/flap
62143	C	Replace skull plate/flap
62145	C	Repair of skull & brain
62146	C	Repair of skull with graft
62147	C	Repair of skull with graft
62180	C	Establish brain cavity shunt
62190	C	Establish brain cavity shunt
62192	C	Establish brain cavity shunt
62200	C	Establish brain cavity shunt
62201	C	Establish brain cavity shunt
62220	C	Establish brain cavity shunt
62223	C	Establish brain cavity shunt
62256	C	Remove brain cavity shunt
62258	C	Replace brain cavity shunt
62351	C	Implant spinal canal cath
63001	C	Removal of spinal lamina
63003	C	Removal of spinal lamina
63005	C	Removal of spinal lamina
63011	C	Removal of spinal lamina
63012	C	Removal of spinal lamina
63015	C	Removal of spinal lamina
63016	C	Removal of spinal lamina
63017	C	Removal of spinal lamina
63020	C	Neck spine disk surgery
63030	C	Low back disk surgery
63035	C	Spinal disk surgery add-on
63040	C	Neck spine disk surgery
63042	C	Low back disk surgery
63045	C	Removal of spinal lamina
63046	C	Removal of spinal lamina
63047	C	Removal of spinal lamina
63048	C	Remove spinal lamina add-on
63055	C	Decompress spinal cord
63056	C	Decompress spinal cord
63057	C	Decompress spine cord add-on
63064	C	Decompress spinal cord
63066	C	Decompress spine cord add-on
63075	C	Neck spine disk surgery
63076	C	Neck spine disk surgery
63077	C	Spine disk surgery, thorax
63078	C	Spine disk surgery, thorax

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
63081	C	Removal of vertebral body
63082	C	Remove vertebral body add-on
63085	C	Removal of vertebral body
63086	C	Remove vertebral body add-on
63087	C	Removal of vertebral body
63088	C	Remove vertebral body add-on
63090	C	Removal of vertebral body
63091	C	Remove vertebral body add-on
63170	C	Incise spinal cord tract(s)
63172	C	Drainage of spinal cyst
63173	C	Drainage of spinal cyst
63180	C	Revise spinal cord ligaments
63182	C	Revise spinal cord ligaments
63185	C	Incise spinal column/nerves
63190	C	Incise spinal column/nerves
63191	C	Incise spinal column/nerves
63194	C	Incise spinal column & cord
63195	C	Incise spinal column & cord
63196	C	Incise spinal column & cord
63197	C	Incise spinal column & cord
63198	C	Incise spinal column & cord
63199	C	Incise spinal column & cord
63200	C	Release of spinal cord
63250	C	Revise spinal cord vessels
63251	C	Revise spinal cord vessels
63252	C	Revise spinal cord vessels
63265	C	Excise intraspinal lesion
63266	C	Excise intraspinal lesion
63267	C	Excise intraspinal lesion
63268	C	Excise intraspinal lesion
63270	C	Excise intraspinal lesion
63271	C	Excise intraspinal lesion
63272	C	Excise intraspinal lesion
63273	C	Excise intraspinal lesion
63275	C	Biopsy/excise spinal tumor
63276	C	Biopsy/excise spinal tumor
63277	C	Biopsy/excise spinal tumor
63278	C	Biopsy/excise spinal tumor
63280	C	Biopsy/excise spinal tumor
63281	C	Biopsy/excise spinal tumor
63282	C	Biopsy/excise spinal tumor
63283	C	Biopsy/excise spinal tumor
63285	C	Biopsy/excise spinal tumor
63286	C	Biopsy/excise spinal tumor
63287	C	Biopsy/excise spinal tumor
63290	C	Biopsy/excise spinal tumor
63300	C	Removal of vertebral body
63301	C	Removal of vertebral body
63302	C	Removal of vertebral body

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
63303	C	Removal of vertebral body
63304	C	Removal of vertebral body
63305	C	Removal of vertebral body
63306	C	Removal of vertebral body
63307	C	Removal of vertebral body
63308	C	Remove vertebral body add-on
63655	C	Implant neuroelectrodes
63700	C	Repair of spinal herniation
63702	C	Repair of spinal herniation
63704	C	Repair of spinal herniation
63706	C	Repair of spinal herniation
63707	C	Repair spinal fluid leakage
63709	C	Repair spinal fluid leakage
63710	C	Graft repair of spine defect
63740	C	Install spinal shunt
63741	C	Install spinal shunt
64752	C	Incision of vagus nerve
64755	C	Incision of stomach nerves
64760	C	Incision of vagus nerve
64763	C	Incise hip/thigh nerve
64766	C	Incise hip/thigh nerve
64802	C	Remove sympathetic nerves
64804	C	Remove sympathetic nerves
64809	C	Remove sympathetic nerves
64818	C	Remove sympathetic nerves
64820	C	Remove sympathetic nerves
64866	C	Fusion of facial/other nerve
64868	C	Fusion of facial/other nerve
65273	C	Repair of eye wound
69150	C	Extensive ear canal surgery
69155	C	Extensive ear/neck surgery
69502	C	Mastoidectomy
69535	C	Remove part of temporal bone
69554	C	Remove ear lesion
69950	C	Incise inner ear nerve
69970	C	Remove inner ear lesion
74300	C	X-ray bile ducts/pancreas
74301	C	X-rays at surgery add-on
75900	C	Arterial catheter exchange
75940	C	X-ray placement, vein filter
75945	C	Intravascular us
75946	C	Intravascular us add-on
75960	C	Transcatheter intro, stent
75961	C	Retrieval, broken catheter
75962	C	Repair arterial blockage
75964	C	Repair artery blockage, each
75966	C	Repair arterial blockage
75968	C	Repair artery blockage, each
75970	C	Vascular biopsy

ADDENDUM E.—CPT CODES WHICH WOULD BE PAID ONLY AS INPATIENT PROCEDURES—Continued

CPT/ HCPCS	HOPD Status Indicator	Description
75978	C	Repair venous blockage
75992	C	Atherectomy, x-ray exam
75993	C	Atherectomy, x-ray exam
75994	C	Atherectomy, x-ray exam
75995	C	Atherectomy, x-ray exam
75996	C	Atherectomy, x-ray exam
92970	C	Cardioassist, internal
92971	C	Cardioassist, external
92975	C	Dissolve clot, heart vessel
92977	C	Dissolve clot, heart vessel
92978	C	Intravasc us, heart add-on
92979	C	Intravasc us, heart add-on
92986	C	Revision of aortic valve
92987	C	Revision of mitral valve
92990	C	Revision of pulmonary valve
92992	C	Revision of heart chamber
92993	C	Revision of heart chamber
92997	C	Pul art balloon repr, percut
92998	C	Pul art balloon repr, percut
94652	C	Pressure breathing (IPPB)
94762	C	Measure blood oxygen level
95920	C	Intraop nerve test add-on
95961	C	Electrode stimulation, brain
95962	C	Electrode stim, brain add-on
99190	C	Special pump services
99191	C	Special pump services
99192	C	Special pump services
99234	C	Observ/hosp same date
99235	C	Observ/hosp same date
99236	C	Observ/hosp same date
99251	C	Initial inpatient consult
99252	C	Initial inpatient consult
99253	C	Initial inpatient consult
99254	C	Initial inpatient consult
99255	C	Initial inpatient consult
99261	C	Follow-up inpatient consult
99262	C	Follow-up inpatient consult
99263	C	Follow-up inpatient consult
99295	C	Neonatal critical care
99296	C	Neonatal critical care
99297	C	Neonatal critical care
99298	C	Neonatal critical care
99356	C	Prolonged service, inpatient
99357	C	Prolonged service, inpatient
99433	C	Normal newborn care/hospital
G0160	C	Cryo. ablation, prostate

ADDENDUM F.—STATUS INDICATORS: HOW VARIOUS SERVICES ARE TREATED UNDER OUTPATIENT PPS

Indicator	Service	Status
A	Pulmonary Rehabilitation Clinical Trial	Not Paid Under PPS
C	Inpatient Procedures	Admit Patient; Bill as Inpatient
A	Durable Medical Equipment, Prosthetics and	DMEPOS Fee Schedule
E	Non-Covered Items and Services	Non-paid
A	Physical, Occupational and SpeechTherapy	Rehabilitation Fee Schedule
A	Ambulance	Ambulance Fee Schedule
A	EPO for ESRD Patients	National Rate
A	Clinical Diagnostic Laboratory Services	Laboratory Fee Schedule
A	Physican Services for ESRD Patients	Not Paid Under PPS
A	Screening Mammography	National Rate
N	Incidental Services, packaged into APC Rat	Packaged
P	Partial Hospitalization	Paid Per Diem APC
S	Significant Procedure, Not Discounted When	Paid
T	Procedure, Multiple When Discount Applies	Paid
V	Visit to Clinic or Emergency Department	Paid
X	Ancillary Service	Paid

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL

Hospital	SMI
010001	3.13
010004	1.77
010005	2.17
010006	3.08
010007	1.70
010008	1.86
010009	1.69
010010	2.44
010011	2.56
010012	2.21
010015	2.29
010016	2.55
010018	6.45
010019	2.41
010021	1.74
010022	2.02
010023	2.85
010024	2.88
010025	2.14
010027	1.10
010029	3.22
010031	2.04
010032	1.28
010033	1.53
010034	2.69
010035	3.05
010036	2.72
010038	4.48
010039	2.19
010040	2.62
010043	2.32
010044	2.21
010045	2.00
010046	2.09
010047	1.67
010049	3.06
010050	1.93
010051	1.60
010052	1.60
010053	2.00
010054	1.88
010055	2.86
010056	2.70
010058	1.25
010059	1.90
010061	2.62
010062	1.81
010064	3.43
010065	2.41
010066	1.42
010068	1.39
010069	2.34
010072	2.61
010073	2.61
010078	2.55
010079	2.52
010080	1.08
010083	2.25
010084	4.17
010087	2.71
010089	2.61
010090	2.43
010091	1.63
010092	2.55
010094	2.50
010095	1.50
010097	2.07
010098	1.75
010099	2.14
010100	2.79
010101	2.38

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
010102	1.32
010103	2.38
010104	2.66
010108	1.95
010109	2.24
010110	1.20
010112	1.87
010113	2.85
010114	2.48
010115	1.47
010118	2.56
010119	2.13
010120	2.04
010123	3.11
010124	3.42
010125	1.44
010126	2.11
010127	3.32
010128	1.40
010129	1.84
010130	1.67
010131	2.80
010134	1.56
010137	1.57
010138	1.32
010139	2.72
010143	2.02
010144	2.70
010145	1.61
010146	3.10
010148	1.94
010149	2.84
010150	2.15
010152	2.14
010155	1.63
013025	1.64
013027	1.11
013028	0.93
013300	1.48
014002	1.41
020001	2.78
020002	2.30
020004	1.92
020005	1.07
020006	2.04
020007	0.87
020008	2.33
020009	1.05
020010	0.58
020011	1.02
020012	3.41
020013	1.89
020014	1.78
020017	3.41
020024	1.84
020025	1.06
024001	1.65
030001	2.73
030002	2.64
030003	2.15
030004	0.86
030006	2.79
030007	2.55
030009	1.43
030010	2.87
030011	3.75
030012	1.90
030013	2.56
030014	3.09
030016	1.86
030017	2.92

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
030018	3.33
030019	2.49
030022	1.73
030023	2.74
030024	3.70
030025	1.79
030027	1.63
030030	3.06
030033	2.60
030034	1.39
030035	3.18
030036	2.49
030037	4.59
030038	3.33
030040	1.99
030041	1.30
030043	2.57
030044	2.07
030047	1.68
030049	0.78
030054	0.83
030055	2.47
030059	2.66
030060	2.25
030061	2.09
030062	2.47
030064	2.59
030065	3.18
030067	1.59
030068	2.56
030069	3.02
030080	2.74
030083	2.58
030085	2.55
030086	2.27
030087	3.66
030088	2.22
030089	2.78
030092	2.94
030093	1.63
030094	2.11
030095	3.28
030099	2.09
033025	1.82
033026	2.18
033028	1.64
034004	1.58
034008	3.05
034009	1.55
034010	1.55
034013	1.57
034019	1.52
040001	2.42
040002	2.24
040003	1.98
040004	3.62
040005	2.05
040007	4.24
040008	1.31
040010	3.21
040011	2.11
040014	2.81
040015	1.77
040016	2.02
040017	2.57
040018	2.87
040019	2.10
040020	3.01
040021	3.28
040022	2.43
040024	1.80

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
040025	1.76
040026	2.63
040027	3.19
040028	2.17
040029	3.57
040030	1.37
040032	0.92
040035	1.17
040036	3.29
040037	2.01
040039	2.51
040040	1.35
040041	3.36
040042	2.13
040044	1.40
040045	1.65
040047	1.77
040048	2.46
040050	2.88
040051	2.07
040053	1.60
040054	3.26
040055	2.81
040058	2.42
040060	1.45
040062	2.58
040064	1.41
040066	3.53
040067	1.19
040070	1.77
040072	2.31
040074	2.91
040075	1.74
040076	1.79
040077	1.77
040078	2.74
040080	1.87
040081	0.93
040082	1.77
040084	3.12
040085	1.90
040088	3.29
040090	1.43
040091	1.73
040093	1.37
040100	2.39
040105	1.29
040106	2.06
040107	1.59
040109	2.02
040114	5.13
040116	2.93
040118	2.82
040119	3.14
040124	2.53
040126	1.95
040132	0.96
043026	1.30
043027	0.85
043028	1.17
043029	1.86
043031	0.82
043032	3.76
043300	1.57
044004	1.54
044005	1.57
044006	1.64
044010	1.65
044012	1.59
050002	2.06
050006	2.44

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050007	2.29
050009	2.97
050013	3.22
050014	2.86
050015	2.38
050016	2.13
050017	5.03
050018	2.55
050021	2.26
050022	2.85
050024	2.28
050025	2.34
050026	2.34
050028	2.52
050029	2.32
050030	1.88
050032	3.20
050033	2.24
050036	2.67
050038	1.49
050039	2.85
050042	3.26
050043	2.85
050045	3.17
050046	2.32
050047	3.05
050051	1.60
050054	1.75
050055	1.93
050056	3.46
050057	3.51
050058	2.74
050060	2.11
050061	5.22
050063	2.75
050065	2.53
050066	2.43
050067	1.93
050068	2.71
050069	2.78
050077	3.23
050078	2.67
050079	2.20
050080	2.13
050081	1.14
050082	2.90
050084	2.44
050088	1.44
050089	2.10
050090	2.52
050091	2.57
050092	1.87
050093	3.76
050095	3.98
050096	3.94
050097	3.79
050099	2.27
050100	2.75
050101	2.80
050102	2.14
050103	3.29
050104	2.27
050107	2.69
050108	2.76
050109	2.26
050110	3.28
050111	5.30
050112	2.67
050113	1.35
050114	2.76
050115	2.18

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050116	2.99
050117	3.02
050118	2.63
050121	3.26
050122	2.54
050124	2.32
050125	3.20
050126	2.94
050127	2.04
050128	2.45
050129	2.73
050131	2.45
050132	2.98
050133	2.08
050135	1.59
050136	2.67
050144	2.46
050145	2.76
050146	1.41
050148	2.31
050149	2.40
050150	2.44
050152	2.31
050153	2.58
050155	2.14
050158	3.58
050159	1.48
050167	1.42
050168	3.40
050169	2.78
050170	2.83
050172	1.89
050173	2.82
050174	3.38
050175	3.37
050177	1.89
050179	2.63
050180	2.32
050183	1.30
050186	1.96
050188	3.77
050189	2.48
050191	2.69
050192	1.60
050193	1.89
050194	2.70
050195	2.38
050196	2.39
050197	2.76
050204	3.22
050205	2.35
050207	3.48
050208	2.09
050211	2.71
050213	1.28
050214	2.05
050215	3.07
050217	2.15
050219	1.98
050222	2.61
050224	2.71
050225	2.28
050226	2.85
050228	1.17
050230	2.91
050231	3.44
050232	2.92
050233	3.37
050234	1.67
050235	2.64
050236	2.17

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050238	2.14
050239	2.64
050240	2.66
050241	2.55
050242	2.23
050243	2.05
050245	1.24
050248	1.49
050251	2.23
050253	2.29
050254	3.23
050256	1.39
050257	1.90
050260	1.38
050261	2.11
050262	2.22
050264	2.24
050267	2.80
050270	2.61
050272	2.14
050274	1.56
050276	1.32
050277	2.59
050278	2.70
050279	1.93
050280	2.70
050281	3.99
050282	2.17
050283	1.16
050286	1.02
050289	2.76
050290	2.40
050291	1.73
050292	1.41
050293	1.42
050295	2.63
050296	2.45
050298	2.08
050299	3.08
050300	2.95
050301	2.95
050302	2.87
050305	2.12
050307	3.67
050308	2.42
050309	3.00
050310	2.96
050312	2.71
050313	3.15
050315	1.20
050317	1.84
050320	1.26
050324	3.46
050325	1.73
050327	2.36
050328	2.69
050329	1.93
050331	2.12
050333	1.10
050334	3.36
050335	1.34
050336	2.48
050337	1.78
050342	2.84
050343	3.36
050348	1.87
050349	1.17
050350	2.25
050351	3.35
050352	2.05
050353	2.61

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050355	0.98
050357	2.47
050359	3.58
050360	3.42
050366	2.09
050367	1.90
050369	2.41
050377	0.95
050378	2.89
050379	1.56
050380	3.91
050382	2.62
050388	1.03
050390	2.90
050391	2.02
050392	1.48
050393	2.93
050394	3.37
050396	4.28
050397	1.44
050401	2.30
050404	1.55
050406	1.36
050407	2.93
050410	1.05
050414	2.65
050417	3.03
050418	1.29
050419	2.69
050420	2.12
050421	2.38
050423	2.49
050424	2.95
050426	2.60
050427	0.76
050430	1.38
050431	3.90
050432	2.60
050433	1.55
050434	1.37
050435	2.38
050436	1.58
050438	2.65
050440	1.53
050441	2.19
050443	1.62
050444	2.31
050446	1.43
050447	1.60
050448	3.14
050454	1.78
050455	3.70
050456	5.49
050457	2.23
050459	2.44
050468	1.71
050469	1.68
050470	2.22
050471	3.14
050476	2.73
050477	4.61
050478	1.57
050481	2.80
050482	1.06
050483	3.44
050485	3.44
050486	2.39
050488	2.21
050491	2.52
050492	2.39
050494	3.25

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050496	2.55
050497	1.04
050498	2.58
050502	3.66
050503	3.44
050506	2.44
050516	3.39
050517	2.78
050522	2.46
050523	2.22
050526	2.04
050528	2.12
050531	3.41
050534	2.45
050535	2.86
050537	2.76
050539	2.31
050542	2.06
050543	3.65
050545	0.99
050546	0.94
050547	1.12
050548	0.81
050549	2.87
050550	2.38
050551	2.61
050552	1.32
050557	2.30
050559	2.89
050560	2.10
050564	2.61
050565	2.02
050566	1.55
050567	2.31
050568	2.82
050569	2.55
050570	3.36
050571	3.32
050573	2.43
050577	4.54
050579	2.39
050580	2.36
050581	2.45
050583	3.40
050584	2.20
050585	2.85
050586	3.12
050588	2.72
050589	3.13
050590	3.28
050591	2.53
050592	3.06
050593	1.95
050594	3.76
050597	2.92
050599	1.65
050601	2.91
050607	1.80
050608	1.91
050613	0.75
050615	2.77
050616	2.60
050618	1.32
050624	2.96
050625	2.60
050630	2.33
050633	2.71
050636	3.18
050638	1.47
050641	2.70
050644	2.58

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
050660	1.47
050661	1.54
050662	1.05
050663	2.23
050667	1.07
050668	1.18
050676	0.91
050678	3.03
050680	1.56
050682	1.29
050684	2.07
050685	2.62
050688	1.75
050689	2.53
050693	2.19
050694	2.25
050695	1.71
050696	3.37
050697	4.88
050699	2.68
050700	2.52
050701	2.18
050702	0.93
050704	2.10
050709	2.93
050713	3.24
052031	1.13
053026	1.62
053027	1.03
053028	1.25
053029	1.40
053030	0.97
053031	1.25
053032	0.83
053033	1.14
053034	1.85
053035	1.41
053036	1.39
053037	1.42
053300	1.47
053301	2.09
053302	1.70
053305	1.00
054001	1.55
054003	2.23
054009	1.56
054012	1.60
054032	1.55
054050	1.85
054053	1.66
054055	1.32
054060	1.55
054064	1.32
054065	1.53
054069	1.55
054074	1.55
054078	2.06
054085	1.55
054087	1.55
054091	1.82
054093	2.49
054094	1.59
054095	1.55
054096	1.58
054097	1.57
054098	1.32
054099	1.69
054104	2.67
054105	1.55
054106	1.56
054108	1.45

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
054110	1.55
054111	1.55
054113	1.55
054115	1.55
054116	1.57
054119	1.55
054122	1.05
054123	1.58
054125	1.83
054126	1.55
054130	1.61
054131	1.85
054133	0.72
060001	3.12
060003	3.01
060004	1.51
060006	2.24
060007	1.59
060008	2.16
060009	2.35
060010	2.53
060011	1.32
060012	1.94
060013	1.91
060014	2.56
060015	1.84
060016	2.15
060018	2.30
060020	2.29
060022	1.85
060023	2.62
060024	1.62
060027	2.23
060028	2.77
060029	1.10
060030	2.93
060031	2.37
060032	2.92
060033	1.69
060034	2.06
060036	1.88
060037	1.48
060038	1.46
060041	0.99
060042	1.65
060043	1.29
060044	2.43
060046	3.04
060047	0.95
060049	2.79
060050	2.00
060052	1.79
060053	1.78
060054	2.64
060056	1.10
060057	2.11
060058	1.34
060060	1.27
060062	1.52
060063	0.78
060064	3.29
060065	2.34
060068	1.25
060070	1.32
060071	2.19
060073	1.33
060075	2.68
060076	1.96
060085	1.17
060087	2.10
060088	1.53

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
060090	1.60
060096	2.09
060100	2.06
060103	4.46
060104	2.40
060107	1.34
062009	0.80
062011	2.22
063026	1.58
063027	1.58
063030	2.31
063301	1.51
063302	1.41
064007	1.55
064009	1.39
064010	1.61
064012	1.52
064016	2.18
064020	1.55
070001	2.88
070002	2.63
070003	2.19
070004	2.36
070005	2.09
070006	2.48
070007	2.92
070008	2.12
070009	2.79
070010	2.68
070011	2.12
070012	2.27
070015	2.25
070016	2.15
070017	2.56
070018	2.28
070019	2.96
070020	2.24
070021	2.61
070022	2.69
070024	2.52
070025	3.27
070026	2.20
070027	2.35
070028	2.28
070029	2.48
070030	2.60
070031	2.23
070033	2.12
070035	2.48
070036	2.07
070039	1.17
072003	1.05
072004	0.87
072008	1.85
073025	1.16
074000	1.50
074007	1.55
074008	1.78
080001	3.31
080002	2.32
080003	2.90
080004	2.55
080005	2.95
080006	2.52
080007	2.26
083300	3.78
084002	1.67
090001	3.61
090002	1.92
090003	1.81
090004	2.59

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
090006	2.60
090007	1.28
090008	2.52
090010	2.06
090011	2.49
090015	0.75
092002	0.80
093025	1.08
093300	2.05
094004	1.33
100001	1.62
100002	2.75
100004	1.94
100006	2.43
100007	3.08
100008	3.40
100009	2.57
100010	2.79
100012	3.06
100014	2.68
100015	2.69
100017	2.75
100018	2.01
100019	3.36
100020	3.14
100022	1.43
100023	2.70
100024	3.07
100025	2.33
100026	2.86
100027	1.58
100028	2.94
100029	2.61
100030	3.15
100032	2.22
100034	2.49
100035	2.62
100038	2.39
100039	2.94
100040	3.26
100043	2.46
100044	2.58
100045	2.36
100046	2.41
100047	2.06
100048	1.71
100049	2.76
100050	2.35
100051	2.67
100052	4.07
100053	2.62
100054	2.09
100055	2.32
100056	3.65
100057	3.13
100060	2.58
100061	2.80
100062	3.23
100063	2.34
100067	2.59
100068	2.16
100069	2.65
100070	2.58
100071	2.27
100072	2.44
100073	2.03
100075	2.32
100076	2.55
100077	3.36
100078	1.17
100079	1.77

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
100080	2.43
100081	1.91
100082	2.40
100084	2.18
100085	2.40
100086	2.52
100087	4.08
100088	3.46
100090	2.89
100093	2.95
100098	1.56
100099	2.99
100102	2.09
100103	1.25
100105	2.85
100106	2.89
100107	2.72
100108	2.15
100109	2.87
100110	2.33
100112	1.04
100113	2.91
100114	2.71
100117	3.23
100118	1.99
100121	2.91
100122	2.77
100124	1.97
100125	2.46
100126	2.26
100127	2.97
100128	2.50
100129	3.40
100130	2.33
100131	3.08
100132	2.39
100134	1.61
100135	4.27
100137	2.28
100138	1.27
100139	1.51
100140	2.57
100142	2.03
100144	2.86
100145	2.34
100146	2.04
100147	1.85
100150	2.63
100151	4.07
100154	3.38
100156	2.44
100157	3.67
100159	1.51
100160	2.03
100161	2.32
100162	2.24
100165	2.22
100167	4.26
100168	2.54
100169	2.75
100170	2.92
100172	2.44
100173	3.21
100174	2.18
100175	1.94
100176	1.96
100177	2.98
100179	3.31
100180	2.10
100181	4.55
100183	2.80

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
100187	2.46
100189	2.75
100191	2.47
100199	3.39
100200	4.10
100203	2.22
100204	2.51
100206	2.51
100208	2.24
100209	2.61
100210	2.68
100211	2.02
100212	2.45
100213	1.93
100217	3.59
100220	3.22
100221	2.58
100222	1.66
100223	2.21
100224	2.34
100225	2.65
100226	1.90
100228	2.19
100229	2.01
100230	1.87
100231	2.31
100232	2.67
100234	2.30
100235	2.21
100236	2.19
100237	2.92
100238	3.13
100240	5.17
100241	2.57
100242	3.00
100243	2.12
100244	2.54
100246	3.15
100248	1.94
100249	2.45
100252	2.42
100253	2.76
100254	2.22
100255	2.31
100256	2.25
100258	2.48
100259	2.80
100260	3.68
100262	3.20
100263	2.45
100264	2.11
100265	2.41
100266	2.85
100267	2.70
100268	2.33
100269	2.74
100270	1.21
100271	1.86
100275	2.38
100276	3.07
100277	0.95
100279	2.11
100280	1.90
100281	2.17
100282	1.72
102009	0.94
102013	3.59
103026	0.50
103027	1.15
103028	1.41
103030	0.81

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
103031	1.52
103032	1.73
103034	1.36
103300	7.02
103301	2.56
104008	1.72
104015	1.55
104016	1.53
104017	1.55
104024	1.75
104026	1.55
104029	1.55
104034	1.56
104036	1.58
104037	1.55
104038	1.68
104041	1.81
104045	1.69
104046	1.55
104047	1.55
104052	1.56
104054	1.57
104056	1.54
104060	1.43
110001	2.73
110002	1.75
110003	2.69
110004	2.62
110005	2.65
110006	3.33
110007	2.64
110008	2.44
110009	1.15
110010	3.09
110011	2.39
110013	1.55
110014	1.70
110015	1.76
110016	3.17
110017	1.28
110018	2.22
110020	3.19
110023	2.44
110024	3.80
110025	2.85
110026	1.76
110027	1.62
110028	2.89
110029	2.10
110030	3.04
110031	2.55
110032	2.72
110033	2.97
110034	1.43
110035	2.93
110036	2.93
110037	1.63
110038	2.20
110039	2.96
110040	2.05
110041	2.04
110042	3.56
110043	3.18
110044	2.66
110045	2.47
110046	2.26
110048	1.63
110049	1.30
110050	1.78
110051	1.91
110052	1.04

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
110054	2.16
110056	1.26
110059	2.38
110061	1.25
110062	0.97
110063	1.50
110064	2.05
110065	1.13
110066	2.56
110069	2.55
110070	1.84
110071	1.29
110072	1.55
110073	2.16
110074	2.78
110075	2.39
110076	2.79
110078	2.95
110079	1.23
110080	1.97
110082	3.62
110083	3.30
110086	1.97
110087	2.75
110088	0.94
110089	2.39
110091	3.09
110092	1.71
110093	1.48
110094	1.01
110095	2.97
110096	1.48
110097	1.32
110098	1.77
110100	1.27
110101	1.56
110103	1.28
110104	2.20
110105	2.49
110107	2.05
110108	0.81
110109	1.61
110111	1.68
110112	1.52
110113	1.41
110114	1.60
110115	2.62
110118	0.76
110120	1.15
110121	4.84
110122	2.79
110124	2.19
110125	3.21
110127	1.59
110128	2.41
110129	2.94
110130	1.82
110132	2.04
110134	1.23
110135	4.68
110140	2.41
110141	1.22
110142	1.50
110143	3.07
110144	1.92
110146	1.72
110149	1.57
110150	2.56
110152	1.77
110153	2.02
110155	1.35

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
110156	1.52
110161	3.52
110163	3.22
110164	2.47
110165	2.62
110166	2.82
110168	2.47
110169	7.21
110171	2.37
110172	3.25
110174	1.87
110176	2.69
110177	2.47
110178	8.34
110179	2.22
110181	1.14
110183	2.32
110184	2.16
110185	1.45
110186	3.32
110187	2.45
110188	2.91
110189	1.99
110190	1.73
110191	3.54
110192	2.42
110193	3.14
110194	1.47
110195	1.20
110198	2.98
110200	4.48
110201	2.34
110203	1.35
110205	1.77
110207	1.28
110208	1.59
110211	1.00
110212	1.99
112000	1.04
112003	1.69
112004	0.79
113026	1.40
113027	0.40
113300	2.36
114000	1.55
114003	1.55
114008	1.55
114010	1.67
114016	1.54
114017	1.61
114022	1.55
114023	1.59
114024	1.57
114027	1.55
114030	1.67
114032	1.55
114033	1.54
114034	1.55
120001	2.95
120002	2.93
120003	2.15
120004	2.18
120005	3.21
120006	2.09
120007	3.17
120009	1.26
120010	2.69
120012	1.32
120014	2.83
120018	0.71
120019	2.58

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
120022	1.31
120024	0.86
120025	0.77
120026	3.08
120027	1.96
120028	3.33
123025	1.65
123300	1.76
124001	1.53
130001	1.60
130002	3.18
130003	3.14
130005	3.43
130006	2.12
130007	3.65
130008	1.94
130009	2.56
130010	0.93
130011	2.46
130012	1.61
130013	2.69
130014	3.03
130015	1.20
130016	2.06
130017	1.93
130018	3.31
130019	1.83
130021	1.09
130022	2.48
130024	2.89
130025	1.91
130026	3.68
130027	1.60
130028	2.30
130029	2.10
130030	0.89
130031	2.34
130034	1.61
130035	2.08
130036	3.90
130037	1.90
130043	1.68
130044	1.57
130045	1.65
130048	1.30
130049	2.59
130054	0.71
130056	0.76
130060	2.73
130061	1.55
133025	1.47
134002	1.55
134009	1.60
140001	2.21
140002	2.35
140003	1.61
140005	1.45
140007	2.57
140008	2.49
140010	2.35
140011	1.78
140012	2.22
140013	2.76
140014	2.41
140015	2.82
140016	1.95
140018	1.94
140019	1.65
140024	1.81
140025	1.53
140026	2.30

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
140027	1.84
140029	2.17
140030	2.97
140031	1.64
140032	3.04
140033	2.61
140034	2.39
140035	1.66
140036	2.69
140037	1.44
140038	1.59
140040	2.32
140041	2.20
140042	1.64
140043	2.70
140045	1.65
140046	2.43
140047	1.40
140048	2.18
140049	2.02
140051	2.56
140052	2.79
140053	3.25
140054	2.63
140055	1.58
140058	2.30
140059	2.50
140061	1.71
140062	2.16
140063	2.29
140064	3.76
140065	2.44
140066	2.17
140067	2.63
140068	1.77
140069	1.89
140070	2.00
140074	1.21
140075	2.41
140077	1.66
140079	2.44
140080	2.19
140081	1.66
140082	1.94
140083	1.45
140084	2.94
140086	2.09
140087	2.41
140088	1.65
140089	2.96
140090	2.57
140091	5.51
140093	2.71
140094	2.24
140095	1.93
140097	1.37
140100	2.74
140101	2.02
140102	1.99
140103	1.62
140105	2.70
140107	1.67
140108	2.82
140109	1.69
140110	2.28
140112	1.85
140113	2.49
140114	2.42
140115	2.07
140116	2.63
140117	2.67

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
140118	2.83
140119	2.96
140120	2.46
140121	2.64
140122	2.48
140125	2.18
140127	4.46
140128	1.79
140129	2.14
140130	2.50
140132	2.85
140133	2.17
140135	2.78
140137	1.67
140138	2.05
140139	1.69
140140	1.76
140141	2.22
140143	2.24
140144	1.68
140145	2.04
140146	1.62
140147	2.31
140148	2.95
140150	1.61
140151	1.34
140155	2.43
140158	1.73
140160	3.21
140161	2.48
140162	2.30
140164	2.77
140165	2.25
140166	1.91
140167	2.59
140168	1.97
140170	1.62
140171	1.37
140172	1.61
140173	1.23
140174	2.18
140176	2.67
140177	2.11
140179	2.60
140180	2.01
140181	1.95
140182	2.00
140184	1.93
140185	2.35
140186	2.10
140187	2.10
140188	1.37
140189	2.21
140190	1.82
140191	2.08
140193	2.51
140197	1.99
140199	1.78
140200	1.94
140202	2.55
140203	2.43
140205	4.24
140206	2.22
140207	2.12
140208	2.47
140209	2.71
140210	2.15
140211	2.35
140212	1.38
140213	2.63
140215	1.32

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
140217	2.32
140218	1.94
140220	1.82
140223	2.80
140224	2.33
140228	2.34
140230	1.15
140231	2.40
140233	2.59
140234	2.40
140236	1.38
140239	2.79
140240	2.09
140242	2.83
140245	1.83
140246	1.75
140250	1.98
140251	3.00
140252	2.01
140253	3.53
140258	2.37
140271	2.10
140275	2.53
140276	2.47
140280	2.60
140281	2.61
140285	2.21
140286	2.15
140288	2.00
140289	2.39
140290	3.26
140291	2.60
140292	2.47
140294	2.57
140297	1.61
140300	1.25
142006	1.37
143025	1.33
143026	1.34
143027	1.50
143300	1.82
143301	3.19
144005	1.64
144025	1.55
144026	1.55
144031	2.28
144033	1.55
144034	1.54
144036	1.57
150001	2.13
150002	2.14
150003	2.39
150004	2.20
150005	2.41
150006	2.80
150007	2.44
150008	2.61
150009	2.79
150011	1.92
150012	2.78
150013	2.18
150014	2.23
150015	2.76
150018	3.00
150019	2.19
150020	2.70
150022	2.63
150023	2.63
150024	1.31
150026	2.75
150027	1.74

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
150029	3.77
150030	2.56
150031	1.68
150033	2.41
150034	2.79
150036	1.92
150037	2.58
150038	1.73
150039	2.16
150042	2.75
150043	1.93
150044	2.38
150045	1.67
150046	2.72
150047	1.89
150049	1.94
150050	1.76
150051	2.17
150052	2.37
150053	1.99
150054	1.72
150057	2.23
150058	3.07
150059	1.88
150060	1.65
150061	2.02
150062	2.18
150063	1.49
150064	2.03
150065	2.37
150066	1.54
150067	2.12
150069	2.68
150070	1.93
150071	1.58
150072	1.97
150073	1.99
150074	2.46
150075	2.12
150076	2.07
150078	1.80
150079	1.71
150084	3.60
150086	2.32
150089	2.57
150090	1.89
150091	1.90
150092	1.54
150094	2.25
150095	2.28
150096	2.12
150097	2.03
150098	1.75
150099	2.46
150100	2.70
150101	2.03
150102	1.68
150103	1.32
150104	2.03
150105	1.94
150106	1.93
150109	3.35
150110	1.52
150111	1.74
150112	2.58
150114	1.61
150115	2.82
150122	2.07
150123	1.29
150125	2.42
150126	2.68

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
150127	1.22
150128	2.62
150129	2.02
150130	1.39
150132	2.65
150133	2.30
150134	1.80
150136	2.61
152007	0.59
152009	0.55
153025	2.03
153027	2.31
153029	1.35
153030	1.78
154009	1.69
154011	1.85
154013	1.51
154014	1.44
154026	1.65
154027	1.73
154028	1.37
154031	1.62
154032	1.79
154035	1.59
154036	1.53
154037	1.66
154038	1.71
154042	1.66
160001	3.30
160002	2.13
160003	1.84
160005	2.00
160007	1.19
160008	2.28
160009	2.03
160012	1.62
160013	3.05
160014	1.71
160016	3.06
160018	1.55
160020	1.65
160021	2.56
160023	1.68
160024	2.78
160026	1.91
160027	1.96
160028	2.46
160029	3.39
160030	3.47
160031	1.59
160032	2.35
160033	3.02
160034	2.31
160035	0.98
160036	2.10
160037	2.01
160039	1.65
160040	3.64
160041	1.49
160043	1.68
160044	2.29
160045	2.87
160046	2.22
160047	2.33
160048	1.72
160049	1.08
160050	2.49
160051	1.84
160052	1.95
160054	1.97
160055	2.09

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
160056	1.68
160057	2.59
160058	1.63
160060	1.89
160061	2.10
160062	1.74
160063	1.61
160064	3.14
160065	2.01
160066	2.40
160067	2.42
160068	1.88
160069	3.27
160070	1.70
160072	2.23
160073	1.35
160074	1.46
160075	1.79
160076	2.64
160077	1.83
160079	3.44
160080	2.72
160081	1.92
160082	3.36
160083	2.89
160085	1.61
160086	1.33
160088	1.65
160089	2.80
160090	1.59
160091	1.75
160092	1.82
160093	1.40
160094	2.93
160095	1.16
160097	2.12
160098	1.38
160099	1.74
160101	1.22
160102	2.85
160103	1.30
160104	2.24
160106	3.18
160107	1.49
160108	2.35
160109	1.62
160110	2.28
160111	1.64
160112	2.48
160113	1.34
160114	2.75
160115	2.45
160116	1.98
160117	2.86
160118	1.80
160120	0.95
160122	2.30
160124	2.14
160126	1.82
160129	2.98
160130	1.42
160131	1.61
160134	1.13
160135	1.78
160138	1.34
160140	1.69
160142	1.41
160143	1.92
160145	1.64
160146	2.96
160147	1.66

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
160151	1.39
160152	1.41
160153	2.76
164002	4.09
170001	3.29
170004	1.61
170006	2.01
170008	2.18
170009	2.47
170010	2.83
170012	3.18
170013	3.53
170014	1.86
170015	2.47
170016	2.73
170017	2.59
170018	1.74
170019	3.41
170020	3.81
170022	2.57
170023	5.62
170024	2.36
170025	2.06
170026	3.15
170027	3.18
170030	1.56
170031	2.04
170032	1.63
170033	2.67
170034	1.90
170035	1.52
170036	1.04
170037	3.34
170038	1.02
170039	1.64
170041	1.43
170043	1.17
170044	1.58
170045	1.74
170049	3.00
170051	1.06
170052	1.53
170053	1.02
170054	1.71
170055	1.80
170056	1.04
170057	1.62
170060	2.49
170061	2.07
170063	1.28
170064	1.61
170066	1.17
170067	2.08
170068	3.51
170070	2.26
170072	1.32
170073	1.38
170074	2.26
170075	1.03
170076	2.02
170077	1.94
170080	1.59
170081	1.39
170082	2.08
170084	1.79
170085	1.62
170086	3.38
170088	1.48
170089	1.28
170090	1.26
170092	1.36

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
170093	1.58
170094	2.00
170095	2.90
170097	1.89
170098	2.58
170099	2.27
170100	0.80
170101	1.45
170102	1.80
170103	4.48
170104	3.66
170105	2.02
170106	1.20
170109	1.99
170110	1.70
170112	1.48
170113	2.29
170114	2.46
170115	1.89
170116	2.91
170117	0.91
170119	1.37
170120	3.12
170122	2.74
170123	3.90
170124	2.13
170126	1.20
170128	1.96
170131	1.93
170133	3.64
170134	1.84
170137	2.80
170139	0.72
170142	3.08
170143	3.11
170144	3.09
170145	2.18
170146	3.03
170147	1.44
170148	2.58
170150	3.35
170151	1.95
170152	1.46
170160	1.49
170164	1.69
170166	1.42
170171	1.39
170175	4.34
170176	2.71
170182	3.37
170183	9.35
171304	0.79
171305	0.38
171310	0.32
172004	0.68
173025	1.55
173027	2.17
173028	1.16
174003	1.35
174006	0.83
174012	1.55
174014	1.79
174016	1.46
174018	1.56
180001	2.22
180004	1.97
180005	2.23
180006	1.20
180007	2.91
180009	2.80
180010	2.69

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
180011	2.33
180012	2.60
180013	2.86
180014	3.17
180015	1.74
180016	2.32
180017	2.53
180018	2.71
180019	2.90
180021	1.92
180023	1.82
180024	2.06
180025	2.13
180026	2.07
180027	3.08
180030	1.42
180031	1.58
180032	1.34
180033	1.83
180034	1.97
180035	2.67
180036	2.73
180037	2.60
180038	2.25
180040	3.61
180041	2.44
180042	1.92
180043	1.43
180044	2.50
180045	2.60
180046	2.24
180047	1.66
180048	2.39
180049	3.18
180051	2.98
180054	2.22
180055	1.99
180056	2.49
180058	1.42
180059	1.54
180060	0.81
180063	1.48
180064	2.22
180065	1.37
180066	2.49
180067	2.63
180070	1.79
180072	1.70
180075	1.82
180078	2.22
180079	1.77
180080	3.22
180087	2.94
180088	3.54
180092	2.19
180093	2.72
180094	1.54
180095	1.97
180099	1.75
180101	1.73
180102	2.84
180103	2.88
180104	2.58
180105	1.70
180106	1.50
180108	1.47
180115	1.63
180116	2.41
180117	2.43
180118	1.53
180120	1.55
180121	2.48
180122	1.68
180123	2.77
180124	3.14
180126	1.44
180127	2.80
180128	1.97
180129	1.25
180130	2.83
180132	2.66
180133	2.33
180134	1.92
180136	4.43
180137	1.76
180138	2.11
180139	1.47
180140	1.19
180141	2.02
182001	2.05
183027	1.32
183028	1.51
184000	1.97
184002	0.78
184007	1.55
184008	1.66
184009	1.64
184011	1.81
184015	0.87
190003	2.15
190004	2.45
190007	1.87
190008	2.74
190013	1.83
190014	2.81
190015	2.42
190017	2.18
190018	2.35
190019	1.89
190020	2.64
190025	2.15
190026	2.24
190027	2.06
190029	2.05
190033	1.17
190034	2.07
190036	2.73
190037	1.00
190039	2.12
190040	2.44
190041	2.55
190043	1.14
190044	2.08
190045	2.22
190046	1.93
190048	2.14
190049	2.69
190050	2.08
190053	1.57
190054	2.26
190059	1.78
190060	2.85
190064	4.30
190065	2.35
190071	1.49
190077	0.88
190078	3.17
190079	2.06
190081	1.07
190083	1.30
190086	2.84
190088	2.36
190089	1.77
190090	1.77
190092	1.88
190095	2.00
190098	1.55
190099	1.42
190102	3.14
190103	0.98
190106	1.71
190109	2.29
190110	1.51
190111	3.47
190112	2.78
190113	3.09
190114	1.72
190115	4.85
190116	2.27
190118	1.80
190120	1.57
190124	2.30
190125	2.21
190128	2.36
190130	1.76
190131	1.51
190133	1.54
190134	1.16
190135	2.45
190136	1.05
190138	7.09
190140	1.77
190142	1.06
190144	2.68
190145	1.54
190146	1.99
190147	1.98
190148	1.16
190149	1.71
190151	1.90
190152	2.85
190155	1.50
190156	0.90
190158	2.36
190160	2.76
190162	1.68
190164	2.43
190167	1.96
190170	1.02
190173	2.12
190175	2.53
190176	1.64
190177	2.46
190178	1.25
190182	2.24
190184	1.12
190185	2.75
190186	1.25
190189	0.98
190190	1.48
190191	2.21
190196	2.45
190197	2.63
190200	2.63
190201	2.19
190202	1.98
190203	2.82
190204	2.44
190205	2.47
190206	2.06
190207	3.10
190208	1.18
190218	2.41

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
190231	4.55
190236	3.56
192004	1.30
192006	1.78
192016	3.50
192020	0.79
193027	1.77
193028	1.84
193034	1.22
193038	1.62
193041	0.89
193044	2.62
193300	1.52
194000	3.15
194004	1.32
194014	1.53
194019	1.57
194022	1.32
194023	1.52
194024	1.40
194027	1.56
194031	1.63
194036	1.47
194044	1.54
194058	1.55
200001	2.71
200002	2.25
200003	1.96
200006	1.43
200007	1.64
200008	2.14
200009	2.23
200012	1.69
200013	2.05
200015	2.19
200016	1.92
200017	2.72
200018	2.23
200019	2.23
200020	2.32
200021	2.52
200023	1.08
200024	2.50
200025	2.47
200026	1.83
200027	1.77
200028	1.83
200031	1.84
200032	1.99
200033	2.24
200034	2.74
200037	1.95
200038	2.48
200039	2.55
200040	2.89
200041	2.42
200043	1.29
200050	2.80
200051	2.73
200052	1.79
200055	1.47
200062	1.46
200063	2.52
200066	2.16
204005	1.68
204006	1.54
220001	2.29
220003	2.21
220004	2.30
220006	2.26
220008	2.19

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
220010	2.68
220011	1.67
220015	2.19
220016	2.31
220017	2.13
220019	2.43
220020	1.82
220021	2.13
220023	2.01
220024	2.35
220025	1.85
220028	2.02
220029	2.15
220030	1.57
220031	1.87
220033	2.15
220035	2.37
220038	2.07
220041	2.29
220042	2.16
220046	2.57
220049	2.46
220050	2.20
220051	2.52
220052	2.08
220053	2.05
220055	2.53
220057	2.30
220058	2.07
220060	2.36
220062	1.78
220063	2.16
220064	2.33
220065	1.92
220066	2.62
220067	2.39
220068	1.42
220070	2.08
220071	1.88
220073	2.06
220074	2.06
220075	2.83
220076	1.93
220077	2.11
220079	1.89
220080	2.09
220081	1.92
220082	2.28
220083	1.87
220084	2.57
220086	1.93
220088	2.06
220089	2.12
220090	2.05
220092	2.22
220094	2.04
220095	1.92
220098	2.29
220100	1.96
220101	2.23
220104	1.44
220105	2.21
220106	2.17
220107	2.34
220108	2.11
220111	2.34
220116	1.72
220119	1.92
220123	1.81
220126	2.32
220128	1.99

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
220135	2.20
220162	1.56
220163	1.59
220171	1.62
222000	1.54
222002	1.04
222006	1.10
222008	0.98
222024	2.57
222026	1.01
222027	1.01
222029	1.24
222035	1.30
222041	0.45
222043	1.10
222044	1.10
223026	1.14
223027	1.49
223028	1.62
223029	1.05
223030	1.52
223032	1.26
223302	1.99
224007	1.75
224018	1.64
224021	1.54
224022	2.67
224034	1.57
224035	1.31
230001	1.98
230002	3.04
230003	1.99
230004	2.85
230005	2.32
230006	2.20
230007	2.85
230012	1.22
230013	2.28
230015	2.20
230017	2.90
230019	3.09
230020	3.32
230021	3.02
230022	2.25
230024	2.94
230027	1.97
230029	2.37
230030	2.80
230031	2.57
230032	3.42
230034	2.13
230035	2.21
230036	2.62
230037	2.46
230038	2.97
230040	2.66
230041	2.56
230042	2.04
230046	2.04
230047	3.03
230053	1.46
230054	2.58
230055	2.07
230056	1.77
230058	2.77
230059	3.12
230060	2.39
230062	1.78
230063	2.18
230065	2.69
230066	2.62

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
230068	2.96
230069	2.29
230070	3.47
230071	13.46
230072	2.32
230075	2.74
230076	4.83
230077	3.51
230078	2.17
230080	3.55
230081	2.66
230082	2.17
230085	2.65
230086	1.79
230087	2.14
230089	2.65
230092	2.76
230093	2.99
230095	2.79
230096	2.47
230097	3.23
230099	2.22
230100	1.66
230101	2.22
230103	2.22
230104	2.53
230105	3.58
230106	1.97
230107	1.39
230108	2.30
230110	2.55
230111	1.83
230113	1.20
230114	7.32
230115	1.87
230116	2.04
230117	2.64
230118	2.16
230119	2.20
230120	2.77
230121	2.57
230122	3.37
230124	2.26
230125	1.91
230128	3.39
230130	2.88
230132	2.37
230133	2.44
230134	2.45
230135	2.66
230137	2.40
230141	2.47
230142	2.53
230143	2.75
230144	2.44
230145	2.35
230146	2.11
230147	1.91
230149	1.62
230151	2.11
230153	2.20
230154	1.52
230155	1.61
230156	2.46
230157	2.73
230159	2.74
230162	1.04
230165	3.20
230167	2.97
230169	2.72
230171	1.61
230172	1.86
230174	2.13
230175	1.55
230176	2.96
230178	1.91
230180	2.02
230184	5.45
230186	1.92
230188	2.38
230189	1.41
230190	1.28
230191	2.01
230193	2.22
230194	1.22
230195	2.84
230197	3.63
230199	2.25
230201	2.58
230204	2.72
230205	2.62
230207	2.22
230208	2.41
230211	0.91
230212	2.15
230213	1.35
230216	2.08
230217	2.66
230219	2.46
230221	2.13
230222	2.66
230223	2.86
230227	2.69
230230	2.88
230232	1.16
230235	2.24
230236	2.79
230239	2.40
230241	2.58
230244	2.53
230253	2.64
230254	2.61
230257	5.56
230259	2.83
230264	3.02
230269	2.85
230270	3.10
230273	1.95
230275	1.90
230276	1.34
230277	2.81
230278	1.84
230279	1.59
230280	2.00
233025	1.26
233026	1.09
233027	1.24
233300	3.39
234006	1.63
234011	1.71
234029	1.46
234030	1.64
240001	3.26
240002	2.84
240004	1.30
240005	1.12
240006	2.89
240007	2.92
240008	2.88
240009	1.53
240010	3.69
240011	2.58
240013	2.49
240014	2.65
240016	3.00
240017	3.88
240018	3.20
240019	2.95
240020	2.08
240021	1.94
240022	2.29
240023	2.46
240025	2.01
240027	2.68
240028	2.16
240029	2.97
240030	3.11
240031	2.26
240036	2.44
240037	1.93
240038	3.13
240040	2.51
240041	2.49
240043	3.30
240044	2.56
240045	2.04
240047	3.16
240048	3.81
240049	1.87
240050	3.12
240051	1.95
240052	2.17
240053	3.27
240056	3.03
240057	2.35
240058	1.44
240059	3.44
240061	4.55
240063	2.66
240064	3.06
240065	1.73
240066	4.22
240069	3.56
240071	2.37
240072	2.79
240073	1.65
240075	2.45
240076	2.75
240077	2.34
240078	3.66
240079	1.91
240080	2.09
240082	1.86
240083	2.36
240084	2.83
240085	1.53
240086	2.09
240087	2.23
240088	1.90
240089	1.37
240090	3.29
240093	2.68
240094	1.66
240096	1.46
240097	6.54
240098	2.05
240099	1.53
240100	2.83
240101	2.00
240102	1.70
240103	1.87
240104	2.68
240105	1.33

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
240106	1.44
240107	1.69
240108	2.55
240109	1.82
240110	2.39
240111	2.28
240112	1.98
240114	1.84
240115	3.13
240116	1.61
240117	1.29
240119	1.19
240121	1.94
240122	1.45
240123	2.37
240124	2.36
240125	1.91
240127	2.25
240128	2.55
240129	2.38
240130	3.06
240132	2.75
240133	3.45
240137	3.54
240138	1.42
240139	2.01
240141	2.49
240142	1.80
240143	1.54
240144	2.78
240145	1.37
240146	2.11
240148	1.64
240152	2.60
240153	1.82
240154	1.44
240155	2.59
240157	2.46
240160	2.58
240161	1.77
240162	2.16
240163	1.89
240166	3.66
240169	2.39
240170	1.83
240171	2.87
240172	2.01
240173	2.63
240179	1.84
240184	1.71
240187	3.42
240193	2.12
240200	0.91
240207	2.75
240210	2.78
240211	1.04
242004	1.59
243300	1.41
243301	1.45
243302	6.10
244009	3.31
250001	2.17
250002	1.57
250003	1.07
250004	2.27
250005	0.94
250006	2.22
250007	1.98
250008	1.07
250009	2.99
250010	1.62

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
250012	1.46
250015	2.25
250017	1.36
250018	0.66
250019	2.28
250020	1.40
250021	0.75
250023	0.70
250024	0.90
250025	2.05
250027	1.72
250029	1.62
250030	1.06
250031	2.52
250032	1.96
250033	1.70
250034	3.67
250035	1.84
250036	1.88
250037	1.50
250038	1.35
250039	1.02
250040	2.53
250042	2.37
250043	1.84
250044	1.99
250045	1.77
250048	3.17
250049	1.44
250050	2.13
250051	1.22
250057	2.41
250058	2.59
250059	1.87
250060	1.04
250061	1.51
250063	1.43
250065	1.46
250066	1.13
250067	1.45
250068	1.54
250069	3.53
250071	1.19
250072	2.38
250076	0.67
250077	1.38
250078	2.73
250079	1.17
250081	3.27
250082	2.32
250083	1.27
250084	2.89
250085	1.35
250088	1.99
250089	1.70
250093	1.88
250094	3.86
250095	2.03
250096	1.97
250097	2.14
250098	1.33
250099	3.06
250100	2.80
250101	1.10
250102	2.82
250104	3.29
250105	1.35
250107	1.21
250109	1.25
250112	1.25
250117	1.42

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
250119	1.66
250120	2.27
250122	2.74
250123	3.13
250124	1.39
250125	2.27
250126	1.23
250128	1.77
250131	1.65
250136	2.92
250138	3.33
250141	2.99
250145	1.32
250146	1.31
250148	2.33
250149	1.26
252003	0.50
253025	1.93
254001	1.55
254002	1.50
260001	2.41
260002	2.38
260003	1.52
260004	1.40
260005	2.56
260006	2.13
260008	1.17
260009	2.66
260011	2.37
260012	1.48
260013	2.16
260014	2.52
260015	2.36
260017	2.87
260018	1.11
260019	1.77
260020	2.41
260021	2.14
260022	2.47
260023	2.33
260024	1.73
260025	3.53
260027	2.51
260029	2.18
260030	1.38
260031	2.62
260032	2.44
260034	1.35
260035	1.51
260036	1.87
260039	1.61
260040	2.57
260044	1.97
260047	2.11
260048	1.99
260050	2.60
260052	2.22
260053	1.82
260054	2.34
260055	1.72
260057	1.70
260059	2.45
260061	2.72
260062	2.48
260063	2.01
260064	2.46
260065	2.51
260066	1.99
260067	1.26
260068	2.91
260070	1.31

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
260073	1.81
260074	1.74
260077	2.60
260078	2.61
260079	1.56
260080	2.08
260081	2.08
260082	1.60
260085	2.75
260086	1.77
260091	2.98
260094	2.39
260095	2.22
260096	3.19
260097	3.14
260100	1.86
260102	1.11
260103	1.96
260104	2.36
260105	2.69
260107	3.54
260108	2.38
260109	2.03
260110	2.51
260113	2.30
260115	1.73
260116	2.40
260119	2.68
260120	2.17
260122	2.04
260123	1.31
260127	1.90
260128	1.42
260129	2.18
260131	2.05
260134	2.38
260137	3.09
260138	2.50
260141	2.03
260142	2.64
260143	1.28
260147	1.76
260148	1.29
260158	1.69
260159	2.08
260160	1.74
260162	2.75
260163	1.89
260164	1.69
260166	2.33
260172	2.00
260173	1.31
260175	2.92
260176	2.60
260177	3.33
260178	3.53
260179	2.42
260180	2.28
260183	2.77
260186	2.66
260188	2.21
260189	0.89
260190	2.65
260191	2.69
260193	2.34
260195	2.21
260197	2.35
260198	2.50
260200	1.98
262001	1.00
262011	0.81

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
263025	1.49
263026	2.37
263300	1.85
263301	1.61
263302	1.62
264004	0.98
264005	0.98
264008	0.98
264011	1.51
264016	2.48
264017	1.84
264021	1.55
264024	1.55
270002	2.36
270003	2.63
270004	3.29
270006	0.62
270007	1.03
270009	1.65
270011	2.64
270012	3.44
270013	2.67
270014	3.11
270016	1.15
270017	2.02
270019	1.17
270021	1.95
270023	2.88
270024	1.06
270026	1.72
270027	1.40
270028	2.43
270029	1.91
270032	2.61
270033	0.91
270035	1.65
270036	1.13
270039	1.94
270040	1.88
270041	1.49
270044	2.58
270046	1.26
270048	1.91
270049	1.88
270050	1.95
270051	2.84
270052	1.06
270053	0.98
270057	2.29
270058	1.70
270059	0.71
270060	1.01
270063	1.17
270068	2.25
270072	0.64
270073	1.28
270079	1.52
270080	2.01
270081	1.07
270082	1.01
270083	1.36
270084	1.59
271225	0.72
271226	1.06
271228	0.89
271229	1.04
271231	1.00
271232	0.94
271233	1.00
271234	1.56
280001	2.04

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
280005	2.57
280009	3.52
280010	1.15
280011	1.53
280012	2.09
280013	2.00
280014	1.81
280015	2.04
280017	1.92
280018	1.67
280020	2.38
280021	2.74
280022	1.21
280023	2.78
280024	1.53
280025	1.09
280026	1.69
280028	2.26
280029	1.49
280030	2.19
280031	1.42
280032	3.03
280033	1.60
280034	2.54
280035	1.59
280037	1.21
280038	2.20
280039	2.21
280040	3.15
280041	1.34
280042	1.26
280043	1.87
280045	1.87
280046	1.56
280047	2.12
280048	1.58
280049	1.41
280050	2.15
280051	2.61
280052	2.53
280054	2.00
280055	1.75
280056	1.45
280057	1.69
280058	1.89
280060	2.26
280061	3.72
280062	1.90
280064	2.28
280065	2.36
280066	1.67
280068	1.42
280070	2.01
280073	1.79
280074	1.63
280075	2.76
280076	1.80
280077	2.61
280079	1.19
280080	1.52
280081	2.64
280082	1.53
280083	1.88
280084	1.69
280085	2.61
280088	3.10
280089	1.91
280090	1.24
280091	2.42
280092	1.65
280094	1.80

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
280097	1.57
280098	1.09
280101	1.12
280102	1.60
280104	1.97
280105	2.63
280106	2.20
280107	2.17
280108	3.91
280109	1.20
280110	2.61
280111	2.00
280114	1.49
280115	2.04
280117	2.23
280118	1.79
280125	2.66
283025	1.13
283301	2.09
284007	3.05
290001	2.20
290002	0.80
290003	2.93
290005	3.18
290006	1.70
290007	1.48
290008	2.80
290009	2.15
290010	2.20
290011	1.11
290012	2.61
290013	1.04
290014	2.15
290015	1.38
290016	2.15
290019	2.42
290020	0.94
290021	2.36
290022	2.77
290027	1.27
290032	2.34
290038	1.70
290039	2.60
292002	1.01
293027	2.09
294003	1.57
294004	1.56
294005	2.31
300001	2.65
300003	1.80
300005	2.43
300006	1.57
300007	2.44
300008	2.59
300009	2.10
300010	1.75
300011	2.21
300013	1.65
300014	2.30
300015	2.49
300016	2.08
300017	1.97
300018	2.48
300019	2.25
300021	1.87
300022	2.33
300023	1.99
300024	2.11
300028	1.65
300029	2.86
300033	1.52

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
303026	1.85
303027	0.47
304001	11.15
304003	1.55
310001	1.98
310002	2.01
310005	2.33
310006	2.74
310008	2.88
310009	2.59
310010	1.99
310011	2.95
310013	2.30
310015	2.26
310016	2.52
310017	2.70
310018	2.16
310019	2.49
310020	2.39
310021	2.29
310022	2.52
310024	2.45
310025	2.33
310026	2.09
310027	2.40
310028	2.05
310029	3.53
310031	2.24
310032	2.20
310034	2.75
310036	1.93
310037	2.32
310039	2.77
310041	2.33
310042	2.58
310043	2.81
310044	2.19
310045	2.63
310047	2.62
310048	2.55
310050	1.91
310051	2.79
310052	2.08
310054	2.34
310056	1.89
310057	2.44
310058	1.31
310060	3.24
310061	2.89
310063	2.27
310064	2.39
310067	2.57
310069	2.66
310070	2.43
310072	2.98
310073	1.92
310074	1.47
310076	2.40
310077	2.66
310078	2.28
310081	2.40
310083	1.69
310084	2.17
310086	2.33
310088	1.84
310090	2.29
310091	2.73
310092	2.38
310093	2.56
310096	2.69
310105	1.47

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
310111	2.02
310112	2.37
310113	2.47
310115	2.02
310116	2.54
310118	2.36
310120	1.73
312014	0.98
313025	1.23
313026	1.19
313027	1.24
313029	1.64
313030	1.05
313032	0.90
314001	1.71
314010	1.72
314011	1.56
314012	2.07
314021	1.70
314022	1.53
320001	1.50
320002	1.78
320003	2.47
320004	2.43
320005	2.98
320006	2.87
320009	2.44
320011	1.76
320012	2.54
320013	2.15
320014	1.79
320016	2.94
320017	2.03
320018	2.95
320019	1.21
320021	1.80
320022	3.20
320023	1.33
320030	2.00
320031	1.27
320032	1.44
320033	2.26
320035	1.18
320037	2.32
320038	2.61
320046	2.17
320048	1.53
320063	2.36
320065	2.27
320067	1.21
320068	2.33
320069	1.96
320074	2.12
320079	2.29
322002	3.05
322003	0.68
323027	0.58
323028	1.76
323029	1.43
324003	1.56
324004	1.59
324007	1.68
324010	1.85
330001	2.13
330002	2.29
330003	2.40
330004	2.49
330005	2.32
330006	2.27
330007	2.26
330008	2.47

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330010	2.17
330011	1.70
330012	2.20
330013	2.59
330014	1.92
330016	1.90
330023	2.50
330024	2.41
330025	1.87
330027	0.92
330028	2.00
330029	1.55
330030	2.54
330033	1.59
330034	1.09
330036	2.29
330037	2.61
330038	1.88
330039	1.19
330041	3.15
330043	1.95
330044	2.25
330045	2.79
330046	2.01
330047	2.35
330048	2.82
330049	2.37
330053	1.93
330055	2.49
330056	1.96
330057	2.38
330058	1.81
330059	2.21
330061	2.74
330062	1.41
330064	2.38
330065	2.46
330066	2.06
330067	2.40
330072	1.95
330073	1.90
330074	2.96
330075	2.05
330078	2.35
330079	2.09
330084	2.26
330085	1.75
330086	1.96
330088	1.68
330090	2.37
330091	2.31
330092	1.22
330094	2.09
330095	2.49
330096	2.30
330097	1.80
330100	5.13
330101	2.50
330102	2.92
330103	2.74
330104	2.04
330106	2.65
330107	2.39
330108	2.31
330111	1.94
330114	0.90
330115	2.41
330116	2.02
330118	2.57
330119	2.61
330121	1.33

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330122	2.87
330125	1.89
330126	2.28
330132	1.47
330133	2.88
330135	2.39
330136	1.25
330140	2.32
330141	2.43
330144	2.39
330148	1.69
330151	2.05
330152	2.43
330153	2.23
330154	2.17
330157	1.99
330158	2.47
330159	2.38
330160	2.09
330161	1.35
330162	3.96
330163	2.58
330164	1.88
330166	2.04
330167	3.17
330169	2.19
330171	2.56
330175	2.10
330177	1.91
330179	1.23
330180	1.95
330181	2.22
330182	3.70
330183	2.02
330184	2.37
330185	1.70
330186	0.62
330188	2.57
330189	7.27
330191	2.18
330193	2.64
330194	2.22
330195	2.31
330197	2.05
330198	2.35
330203	4.09
330205	2.12
330208	2.09
330209	2.27
330211	2.07
330212	2.39
330213	1.69
330214	2.42
330215	2.59
330218	1.87
330219	1.90
330221	2.14
330222	2.72
330223	1.98
330224	2.49
330225	2.34
330226	2.40
330229	2.03
330230	2.36
330232	2.08
330235	2.81
330236	2.04
330238	2.25
330239	2.16
330241	2.09
330245	2.24

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
330246	2.60
330249	2.04
330250	2.32
330252	1.16
330254	2.10
330258	1.48
330259	2.37
330261	2.47
330263	2.78
330264	2.34
330265	1.66
330267	2.16
330268	1.40
330270	1.94
330273	2.53
330275	1.99
330276	1.77
330277	2.31
330279	2.75
330285	2.09
330286	2.29
330288	1.01
330290	1.96
330293	1.61
330304	2.62
330306	1.92
330307	2.53
330308	2.77
330314	2.63
330316	3.26
330327	1.71
330331	2.29
330332	3.39
330333	3.09
330336	2.09
330338	2.72
330339	2.11
330340	2.53
330350	2.13
330353	2.88
330354	1.74
330357	2.06
330359	0.95
330372	2.87
330381	2.05
330386	1.99
330389	1.74
330390	1.39
330393	2.43
330394	2.50
330395	2.27
330397	1.48
330398	2.93
330399	1.38
331300	0.79
332012	1.34
332022	1.08
333025	1.23
333027	1.19
333028	0.89
333300	1.87
334002	1.55
334048	2.24
334055	1.59
340001	1.76
340002	3.52
340003	2.17
340004	2.78
340005	2.27
340006	1.85
340007	1.89

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
340008	2.17
340010	2.97
340011	1.80
340012	2.23
340013	1.88
340014	1.55
340015	2.89
340016	3.02
340017	2.73
340018	2.38
340019	1.73
340020	2.03
340021	2.55
340022	2.01
340023	1.95
340024	2.16
340025	2.66
340027	2.93
340028	2.42
340030	2.25
340031	2.08
340032	2.37
340035	2.22
340036	1.70
340037	1.77
340038	3.18
340039	2.57
340040	2.88
340041	1.93
340042	2.35
340044	1.73
340045	1.26
340047	2.39
340049	7.04
340050	2.41
340051	2.60
340052	1.84
340053	3.14
340054	2.59
340055	1.98
340060	2.27
340061	1.97
340063	1.40
340064	2.13
340065	2.01
340067	2.52
340068	2.46
340069	2.33
340070	2.66
340071	2.02
340072	2.29
340073	3.16
340075	2.12
340080	1.71
340084	1.83
340085	2.18
340087	2.01
340088	3.10
340089	1.58
340090	2.03
340091	2.88
340093	1.99
340094	3.53
340096	2.50
340097	2.52
340098	2.42
340099	2.05
340101	2.58
340104	1.67
340105	3.75
340106	1.71

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
340107	2.92
340109	3.44
340111	2.10
340112	1.77
340113	2.38
340114	2.00
340115	2.50
340116	2.78
340119	2.31
340120	1.91
340121	2.15
340123	2.13
340125	3.76
340126	2.61
340127	1.99
340129	2.51
340130	2.48
340131	2.69
340132	2.04
340133	1.57
340141	2.73
340142	2.13
340143	2.77
340144	2.72
340145	2.45
340146	1.90
340147	3.03
340148	4.19
340151	2.44
340153	3.95
340155	2.38
340158	2.82
340159	1.51
340160	2.47
340164	2.00
340166	2.10
340171	2.70
340173	2.50
341302	1.46
342003	1.39
342012	0.79
343025	1.71
344005	1.55
344006	1.55
344014	0.79
344015	1.55
344019	1.55
344020	1.55
350001	1.09
350002	3.66
350003	2.36
350004	3.95
350005	2.06
350006	1.99
350007	2.75
350008	1.73
350009	3.26
350010	3.09
350011	3.23
350012	2.13
350013	1.93
350014	2.06
350015	3.37
350016	1.18
350017	2.65
350018	2.58
350019	3.33
350020	1.45
350021	2.55
350023	2.01
350024	2.03

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
350025	1.13
350027	1.30
350029	1.36
350030	2.77
350033	2.00
350034	1.89
350035	0.85
350038	2.02
350039	2.08
350041	1.51
350042	3.25
350043	3.06
350044	1.70
350047	1.95
350049	2.14
350050	1.55
350051	1.58
350053	1.33
350055	1.22
350056	1.96
350058	1.71
350060	0.79
350061	2.56
360001	2.87
360002	2.52
360003	1.95
360006	3.15
360007	1.98
360008	2.28
360009	2.47
360010	2.48
360011	2.00
360012	2.85
360013	2.27
360014	2.61
360016	1.93
360017	3.43
360018	2.52
360019	2.10
360020	2.20
360021	5.55
360024	2.41
360025	2.09
360026	1.80
360027	2.46
360028	4.56
360029	2.63
360030	2.31
360031	2.13
360032	2.59
360034	1.96
360035	2.10
360036	2.35
360037	2.27
360039	2.26
360040	2.08
360041	2.24
360042	2.23
360044	2.19
360045	1.93
360046	2.34
360047	1.60
360048	2.31
360049	2.78
360050	1.54
360051	3.04
360052	2.41
360054	2.70
360055	2.55
360056	2.63
360057	1.74

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
360058	2.16
360059	1.67
360062	2.77
360063	1.73
360064	2.65
360065	2.22
360066	2.59
360067	1.77
360068	2.50
360069	1.86
360070	2.00
360071	2.46
360074	2.21
360075	2.27
360076	2.58
360077	2.38
360078	2.63
360079	2.90
360080	2.18
360081	2.32
360082	2.84
360083	2.23
360084	2.47
360085	2.81
360086	2.46
360087	2.34
360088	1.96
360089	2.20
360090	3.47
360091	2.34
360092	1.84
360093	3.05
360094	2.00
360095	2.72
360096	2.37
360098	3.04
360099	2.32
360100	2.58
360101	3.13
360102	2.70
360103	2.15
360106	1.68
360107	2.19
360108	1.72
360109	2.35
360112	2.63
360113	2.64
360114	2.18
360115	2.16
360116	1.88
360118	2.26
360121	2.88
360123	2.22
360125	1.75
360126	1.92
360127	2.27
360128	1.65
360129	1.77
360130	2.00
360131	2.25
360132	2.43
360133	2.66
360134	2.53
360136	1.62
360137	2.29
360140	1.73
360141	2.77
360142	1.99
360143	2.23
360144	2.68
360145	2.60

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
360147	2.27
360148	2.21
360149	2.65
360150	3.15
360151	2.60
360152	2.65
360153	1.88
360154	1.61
360155	2.64
360156	2.36
360159	2.16
360161	2.35
360162	1.75
360163	2.90
360164	1.72
360165	1.84
360166	1.67
360170	2.09
360172	2.93
360174	2.57
360175	2.58
360176	1.80
360177	1.52
360178	2.58
360179	2.31
360180	2.68
360184	1.65
360185	1.85
360186	1.54
360187	2.58
360188	1.82
360189	2.44
360192	2.28
360193	2.49
360194	2.25
360195	2.67
360197	1.98
360200	1.78
360203	2.43
360204	1.94
360210	2.67
360211	2.20
360212	2.03
360213	2.01
360218	2.40
360230	2.88
360231	1.46
360234	2.16
360236	2.41
360239	2.61
360241	1.27
360242	1.72
360243	1.55
360244	1.55
360245	1.58
362004	1.97
362007	0.47
362009	1.59
362014	7.33
362015	1.48
363300	1.97
363303	2.62
363305	1.94
363306	1.34
364003	1.64
364017	1.97
364029	1.64
364038	1.85
370001	3.25
370002	2.74
370004	2.77

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
370005	1.46
370006	2.59
370007	1.79
370008	2.75
370011	1.95
370012	1.29
370013	2.96
370014	2.86
370015	1.85
370016	2.53
370017	1.88
370018	3.22
370019	2.37
370020	2.21
370021	1.40
370022	2.97
370023	2.42
370025	2.44
370026	3.08
370028	3.11
370029	2.34
370030	1.95
370032	3.62
370033	2.56
370034	2.57
370035	1.78
370036	0.76
370037	3.69
370038	1.47
370039	1.91
370040	3.03
370041	1.70
370042	1.40
370043	1.12
370045	1.56
370046	2.02
370047	2.41
370048	1.96
370049	2.95
370051	1.31
370054	2.51
370056	2.70
370057	1.98
370059	1.02
370060	2.17
370063	1.38
370064	1.45
370065	2.50
370071	1.48
370072	1.33
370076	2.46
370077	1.96
370078	3.60
370079	1.78
370080	1.83
370082	1.29
370083	2.31
370084	1.53
370085	1.79
370086	2.26
370089	2.25
370091	3.07
370092	2.21
370093	4.35
370094	3.00
370095	1.37
370097	2.07
370099	2.06
370100	1.27
370103	1.60
370105	3.08

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
370106	4.05
370108	1.62
370112	1.52
370113	2.06
370114	3.04
370121	2.51
370122	0.92
370123	2.45
370125	1.86
370126	1.38
370131	1.27
370133	1.83
370138	2.30
370139	1.62
370140	1.92
370141	1.89
370146	2.19
370148	2.26
370149	2.90
370153	2.47
370154	2.61
370156	2.47
370158	1.66
370159	2.44
370163	1.25
370166	1.99
370169	1.88
370176	2.14
370177	1.53
370178	2.10
370179	1.49
370183	2.08
370186	2.55
370190	2.49
370192	2.87
372004	0.74
373025	0.87
373026	1.03
374008	1.84
374012	1.50
374013	1.36
374020	1.63
380001	2.80
380002	3.93
380004	3.63
380005	5.17
380006	2.75
380007	3.08
380008	1.66
380009	2.18
380010	1.76
380011	2.28
380013	1.59
380014	2.69
380017	3.80
380018	2.58
380019	1.83
380020	3.61
380021	2.54
380022	2.71
380023	2.43
380025	2.73
380026	2.33
380027	1.96
380029	2.14
380031	1.63
380033	3.16
380035	2.96
380036	2.44
380037	2.28
380038	2.93

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
380039	1.89
380040	2.17
380042	1.87
380047	3.63
380048	2.14
380050	2.51
380051	3.02
380052	2.57
380056	1.51
380060	2.44
380061	2.63
380062	0.92
380063	1.81
380064	1.96
380065	1.84
380066	2.92
380068	1.49
380069	1.80
380070	1.93
380071	3.34
380072	1.77
380075	3.14
380078	1.85
380081	0.99
380082	2.58
380083	2.44
380084	2.05
380087	2.42
380088	2.32
380089	2.73
380090	3.04
384006	1.63
390001	2.47
390002	2.56
390003	1.74
390004	2.56
390005	2.28
390006	1.65
390007	3.19
390008	1.94
390009	2.49
390010	2.64
390011	2.41
390012	2.54
390013	2.84
390015	1.97
390016	2.16
390017	2.14
390018	2.79
390019	2.23
390022	2.76
390023	1.75
390024	3.14
390025	1.03
390026	1.96
390028	3.01
390029	2.74
390030	2.19
390031	2.12
390032	2.28
390035	2.56
390036	2.57
390037	2.74
390039	2.41
390040	1.90
390041	2.86
390042	2.29
390043	3.02
390044	2.65
390045	2.41
390046	1.97

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390047	2.50
390048	2.31
390049	2.71
390050	3.05
390051	2.65
390054	1.97
390055	2.73
390056	2.07
390057	2.39
390058	3.14
390060	1.70
390061	2.26
390062	2.85
390063	3.48
390065	2.31
390066	2.15
390067	2.55
390068	1.83
390069	2.13
390070	3.25
390071	2.72
390072	2.25
390073	2.60
390074	2.69
390075	3.05
390076	2.58
390078	2.98
390079	3.00
390080	2.35
390083	1.81
390084	1.68
390086	2.21
390088	2.14
390090	2.91
390091	2.29
390093	1.95
390095	2.40
390096	1.84
390097	2.39
390100	2.55
390101	1.69
390102	2.83
390103	2.11
390104	1.97
390106	2.06
390107	2.54
390108	2.53
390109	1.55
390110	2.16
390111	1.93
390112	2.21
390113	2.49
390114	2.33
390115	2.35
390116	2.31
390118	2.79
390119	2.51
390121	2.47
390122	2.04
390123	2.99
390125	2.33
390127	2.58
390128	2.85
390130	2.18
390131	2.60
390132	2.08
390133	2.68
390135	2.13
390136	3.85
390137	2.44
390138	2.22

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390139	2.58
390142	1.93
390145	2.38
390146	2.04
390147	2.44
390150	1.94
390151	2.55
390153	1.96
390154	2.36
390155	1.31
390156	2.51
390157	2.50
390158	2.42
390160	2.91
390161	2.26
390162	2.25
390163	2.38
390164	2.12
390166	1.76
390167	2.18
390168	2.13
390169	3.11
390173	2.08
390174	2.42
390176	2.22
390178	2.55
390179	2.33
390180	2.38
390181	2.39
390183	2.61
390184	1.63
390185	2.85
390189	2.30
390191	3.17
390192	2.03
390193	2.60
390194	2.57
390195	2.89
390196	2.16
390197	3.10
390198	1.87
390199	1.79
390200	1.50
390201	2.23
390203	2.59
390204	2.50
390205	2.42
390206	2.05
390209	2.00
390211	2.74
390213	1.07
390215	2.28
390217	2.20
390219	1.91
390222	2.84
390223	2.25
390224	1.69
390225	2.31
390226	2.31
390228	2.24
390231	2.19
390233	2.03
390235	1.87
390236	2.15
390237	2.25
390238	2.43
390242	2.48
390244	1.01
390245	2.18
390246	2.44
390247	1.13

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
390249	1.13
390256	1.87
390258	2.45
390260	3.75
390262	2.73
390263	3.02
390265	1.57
390266	3.04
390267	2.67
390268	2.66
390270	2.58
390277	1.31
390279	2.40
392024	1.64
392025	1.76
392026	1.18
393025	1.38
393026	1.77
393027	1.99
393031	1.67
393032	0.55
393035	0.94
393037	1.55
393038	1.90
393039	1.10
393040	3.59
393041	2.26
393042	1.77
393043	0.98
393301	1.73
393302	1.58
394006	1.55
394007	1.84
394008	3.26
394020	1.36
394023	1.57
394027	1.48
394034	1.56
394040	1.32
394041	1.32
400001	1.65
400002	3.95
400003	1.58
400004	2.04
400005	1.76
400006	2.56
400007	1.11
400009	1.87
400011	2.39
400012	1.22
400013	1.42
400014	4.78
400016	1.87
400017	2.13
400018	1.39
400019	3.28
400021	1.94
400022	1.95
400027	0.88
400028	1.61
400029	1.12
400032	1.18
400094	1.13
400098	1.40
400102	2.07
400106	1.60
400109	2.06
400111	1.37
400113	1.87
400114	1.46
400115	1.22

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
400117	2.22
400118	1.89
400120	2.38
400122	0.96
400123	3.95
400124	7.82
404002	2.72
410001	2.29
410004	2.02
410005	2.79
410006	2.27
410007	2.55
410008	2.54
410009	3.00
410010	1.89
410011	2.36
410012	2.67
410013	2.56
413025	1.27
414000	2.21
420002	2.54
420004	1.95
420005	2.12
420006	1.29
420007	2.64
420009	2.81
420010	2.45
420011	1.83
420014	1.46
420015	2.47
420016	1.79
420018	1.96
420019	1.99
420020	2.50
420023	3.02
420026	3.87
420027	2.27
420030	2.23
420031	1.44
420033	1.98
420036	2.60
420037	1.83
420038	1.72
420039	1.93
420042	1.80
420043	2.20
420048	2.30
420049	2.77
420051	2.47
420053	2.35
420054	1.72
420055	1.70
420056	2.74
420057	1.84
420059	1.59
420061	1.94
420062	2.34
420064	1.64
420065	2.89
420066	2.05
420067	3.28
420068	2.98
420069	1.67
420070	2.46
420071	2.61
420072	1.34
420073	2.64
420074	1.17
420075	1.89
420078	2.77
420079	1.83

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
420080	2.73
420082	2.46
420083	3.56
420085	2.11
420086	2.53
420087	2.67
420088	2.69
420089	2.78
420091	2.90
420093	1.72
423025	2.87
423026	1.85
424006	1.55
424008	1.55
424010	1.72
430004	1.93
430005	2.85
430007	2.59
430008	2.76
430010	2.44
430011	3.17
430012	3.67
430013	3.09
430014	2.74
430015	3.04
430016	2.68
430018	1.52
430022	1.19
430023	1.38
430024	1.09
430026	1.24
430027	3.97
430028	2.58
430029	1.96
430031	1.74
430033	1.72
430034	1.42
430036	2.00
430037	1.34
430038	2.55
430040	2.03
430041	1.71
430043	2.19
430044	1.45
430047	1.89
430048	2.33
430049	1.38
430051	1.03
430054	1.91
430056	1.34
430057	1.61
430060	1.05
430062	1.79
430064	1.98
430065	1.41
430066	1.16
430073	1.69
430076	1.05
430077	3.25
430079	1.00
430087	1.15
434004	1.77
440001	1.78
440002	3.88
440003	2.91
440006	3.43
440007	1.27
440008	2.51
440009	3.09
440010	1.83
440011	2.47

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
440012	1.94
440014	1.65
440015	3.03
440016	2.08
440017	2.53
440018	1.62
440019	2.59
440020	2.08
440023	1.65
440024	3.03
440025	2.28
440026	0.96
440029	3.02
440030	3.03
440031	2.41
440032	1.55
440033	1.95
440034	2.66
440035	2.55
440039	2.24
440040	1.63
440041	1.78
440046	2.60
440047	1.87
440048	3.27
440049	2.65
440050	2.49
440051	1.73
440052	1.62
440053	3.01
440054	2.09
440056	1.86
440057	1.98
440058	3.01
440059	2.48
440060	1.61
440061	2.13
440063	2.77
440064	1.83
440065	2.45
440067	2.80
440068	2.52
440070	1.77
440071	2.56
440072	2.79
440073	2.64
440078	1.68
440081	2.03
440082	2.82
440083	1.67
440084	1.44
440090	1.66
440091	3.29
440100	1.89
440102	1.95
440103	2.48
440104	2.70
440105	6.65
440109	2.02
440110	2.05
440111	1.34
440114	1.96
440115	1.91
440120	3.52
440125	2.79
440130	2.95
440131	2.77
440132	2.22
440133	3.04
440135	2.23
440137	2.14

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
440141	1.11
440142	1.45
440143	1.64
440144	3.94
440145	1.38
440147	7.20
440148	2.45
440149	1.54
440150	3.46
440151	1.93
440152	1.65
440153	2.05
440156	3.10
440157	1.61
440159	2.28
440161	3.68
440162	1.33
440166	2.69
440168	2.48
440173	4.08
440174	2.07
440175	2.60
440176	3.06
440178	2.28
440180	1.76
440181	1.99
440182	2.30
440183	3.34
440184	3.08
440185	2.49
440186	2.23
440187	1.94
440189	3.47
440192	1.80
440193	3.20
440194	2.14
440197	2.76
440200	2.02
440203	1.96
440205	1.46
440206	1.95
440211	1.50
442007	0.93
443025	1.69
443026	1.27
443029	3.28
444003	1.36
444004	1.56
444006	1.50
444010	1.47
444011	1.70
444012	1.48
450002	2.42
450004	1.82
450005	2.10
450007	2.96
450008	1.81
450010	2.54
450011	2.92
450014	1.79
450015	1.30
450016	3.15
450018	1.54
450020	2.19
450021	1.91
450023	2.67
450024	1.59
450025	2.88
450028	2.44
450029	2.05
450031	2.15

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450032	1.58
450033	2.00
450034	2.20
450037	2.45
450039	1.15
450040	2.06
450042	2.28
450044	2.42
450046	2.83
450047	2.39
450050	1.32
450051	1.88
450052	1.52
450053	2.39
450054	3.44
450055	1.76
450056	3.27
450058	3.45
450059	2.75
450063	0.93
450064	2.96
450065	1.66
450068	2.03
450072	2.31
450073	1.43
450076	1.74
450078	1.20
450079	2.85
450080	3.06
450081	1.93
450082	1.66
450083	3.49
450085	1.74
450087	1.92
450090	2.50
450092	1.92
450094	2.64
450096	1.90
450097	3.26
450098	1.14
450099	2.07
450101	2.56
450102	3.28
450104	2.89
450107	2.09
450108	1.34
450109	1.62
450111	2.55
450112	2.73
450113	2.75
450118	3.27
450119	2.49
450121	2.67
450123	1.81
450124	2.19
450126	1.79
450128	1.96
450130	3.66
450131	1.87
450132	2.27
450133	2.37
450135	2.53
450137	2.28
450140	1.45
450142	2.07
450143	1.77
450144	1.72
450145	1.28
450146	0.96
450147	1.94
450148	2.31

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450149	2.01
450150	1.68
450151	1.53
450152	2.31
450153	2.31
450154	1.65
450155	1.62
450157	1.35
450160	1.92
450162	2.04
450163	1.73
450164	1.25
450165	1.80
450166	0.89
450170	1.58
450176	2.39
450177	2.15
450178	1.45
450181	1.30
450184	3.00
450185	1.48
450187	2.15
450188	1.85
450190	2.93
450191	2.63
450192	1.73
450193	3.90
450194	2.36
450196	2.70
450200	2.44
450201	2.12
450203	1.91
450209	1.87
450210	1.70
450211	2.35
450213	1.41
450214	2.68
450217	1.03
450219	2.18
450221	1.26
450222	2.43
450224	1.98
450229	2.67
450231	2.88
450234	1.46
450235	2.06
450236	2.65
450237	1.91
450239	1.44
450241	1.30
450243	1.51
450246	1.41
450249	1.26
450250	1.24
450253	2.53
450258	1.10
450259	2.23
450264	0.95
450269	1.27
450270	1.51
450271	1.29
450272	2.97
450276	1.49
450278	1.31
450280	1.89
450283	1.44
450286	1.18
450288	1.62
450289	1.10
450292	1.86
450293	1.74

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450296	2.21
450299	2.38
450303	1.01
450306	3.74
450307	0.96
450309	1.55
450315	2.78
450320	1.95
450321	1.19
450322	0.95
450324	2.31
450327	0.99
450330	1.72
450334	1.11
450337	1.43
450340	2.59
450341	1.92
450346	2.03
450347	2.42
450348	1.19
450351	4.30
450352	2.28
450353	1.76
450355	1.19
450358	2.70
450362	2.54
450369	1.65
450370	4.89
450371	2.14
450372	2.85
450373	1.30
450374	1.01
450376	2.42
450378	1.88
450379	2.51
450388	2.86
450389	1.82
450393	1.90
450395	1.59
450399	1.01
450400	1.84
450403	1.86
450411	1.60
450417	1.87
450419	1.63
450423	2.53
450424	2.48
450429	0.92
450431	3.06
450438	2.81
450446	1.56
450447	3.17
450451	2.28
450457	3.06
450460	1.80
450462	2.18
450464	1.52
450465	3.29
450467	1.51
450469	2.86
450473	1.18
450475	2.34
450484	2.35
450488	1.99
450489	1.16
450497	1.87
450498	2.36
450508	1.98
450514	2.23
450517	1.38
450518	2.21

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450523	2.86
450530	2.51
450534	1.19
450535	2.43
450537	1.99
450538	1.73
450539	2.51
450544	2.04
450545	3.67
450547	1.58
450550	2.14
450551	2.35
450558	2.15
450559	1.17
450561	2.38
450563	2.67
450565	2.26
450570	1.54
450571	2.72
450573	1.71
450574	0.86
450575	1.23
450578	0.99
450580	2.31
450583	1.05
450584	1.81
450586	1.68
450587	2.02
450591	2.79
450596	2.40
450597	1.62
450603	1.13
450604	2.50
450605	2.09
450609	1.13
450610	2.61
450614	1.50
450615	2.10
450617	2.32
450620	1.54
450623	1.90
450626	1.25
450628	1.23
450630	2.13
450631	2.35
450632	0.82
450633	2.66
450634	2.74
450638	3.03
450639	2.56
450641	1.78
450643	2.22
450644	2.61
450646	2.30
450647	3.16
450648	1.81
450649	1.41
450651	2.23
450652	1.56
450653	2.45
450654	1.13
450656	2.67
450658	1.99
450659	2.45
450661	3.17
450662	1.88
450665	1.72
450666	2.05
450668	2.88
450669	2.34
450670	2.50

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
450672	2.85
450673	1.27
450675	2.26
450677	2.45
450678	2.78
450683	2.31
450684	1.97
450686	2.30
450688	2.14
450690	1.61
450694	2.52
450696	10.88
450697	2.05
450698	0.96
450700	1.29
450702	2.40
450703	1.31
450704	2.26
450706	2.28
450709	3.05
450711	2.54
450712	1.58
450713	2.33
450715	1.66
450716	2.68
450717	2.11
450718	2.38
450723	1.91
450724	3.75
450725	1.74
450727	1.83
450730	2.19
450733	2.48
450735	0.61
450742	2.28
450743	2.99
450746	1.40
450747	2.66
450749	1.10
450750	1.49
450754	1.70
450755	1.77
450757	1.05
450758	2.25
450760	2.56
450761	1.23
450763	1.79
450766	5.91
450769	1.09
450770	1.31
450771	2.19
450774	5.04
450775	2.38
450776	1.42
450777	1.59
450779	2.04
450780	6.29
450788	1.88
450795	0.95
450797	9.66
450798	0.52
450801	2.59
450802	3.03
450803	1.09
450804	6.10
450809	2.33
450811	4.24
450813	0.96
452013	0.96
452019	2.02
452022	0.50

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
452033	0.99
452036	0.68
452038	1.47
452039	2.99
452043	0.99
453025	1.24
453028	0.80
453029	1.16
453031	1.67
453033	0.76
453034	1.11
453035	2.14
453036	1.94
453037	1.55
453038	1.38
453040	1.31
453041	0.98
453042	1.12
453044	2.33
453047	1.22
453048	1.07
453052	1.56
453053	1.56
453054	1.70
453055	1.15
453056	1.64
453057	1.41
453059	0.79
453065	3.51
453070	1.94
453071	1.31
453072	0.83
453074	1.48
453300	1.36
453302	1.48
453304	1.75
453305	1.03
454012	1.55
454018	1.55
454026	1.50
454028	1.56
454029	2.26
454030	1.55
454031	1.46
454032	1.41
454034	1.19
454038	1.55
454042	1.54
454043	1.55
454045	1.61
454046	1.55
454050	1.55
454051	1.55
454056	1.85
454057	1.59
454058	1.55
454063	1.43
454064	1.55
454065	1.60
454066	1.57
454069	3.09
454072	1.55
454073	2.07
454078	1.55
454086	1.64
454089	1.59
460001	3.01
460003	3.25
460004	2.54
460005	2.52
460006	3.82

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
460007	2.96
460008	2.63
460010	2.49
460011	2.23
460013	2.78
460014	1.34
460015	2.90
460016	1.45
460017	3.22
460018	1.64
460019	2.15
460020	1.91
460021	2.21
460022	1.38
460023	3.19
460024	1.13
460026	2.02
460027	1.60
460029	1.95
460030	1.97
460033	1.71
460035	1.25
460036	2.22
460037	2.00
460039	1.74
460041	2.92
460042	2.75
460044	2.19
460047	1.87
460050	2.05
463025	1.62
463301	2.49
464003	1.55
464010	1.49
470001	2.03
470003	2.64
470004	1.61
470005	2.36
470006	2.57
470008	1.91
470010	1.97
470011	2.35
470012	2.92
470015	2.00
470018	2.08
470020	1.21
470023	2.58
470024	2.14
474001	1.00
480001	1.71
480002	2.28
490001	1.65
490002	1.67
490004	2.35
490005	2.56
490006	2.26
490007	2.58
490009	1.92
490011	2.79
490012	1.55
490013	2.66
490014	1.99
490015	3.19
490017	2.89
490018	2.98
490019	2.31
490020	2.71
490021	4.47
490022	2.51
490023	2.38
490024	2.41

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
490027	1.99
490030	2.72
490031	1.99
490032	1.79
490033	1.86
490035	2.24
490037	2.53
490038	2.45
490040	3.17
490041	3.49
490042	2.44
490043	2.05
490044	2.36
490045	2.18
490046	3.14
490047	1.54
490048	2.50
490050	2.83
490052	2.52
490053	3.03
490054	1.53
490057	2.55
490059	3.37
490060	2.50
490063	3.91
490066	2.69
490067	2.92
490069	1.47
490071	3.11
490073	3.88
490074	4.12
490075	2.71
490077	2.70
490079	2.29
490084	2.34
490085	2.06
490088	2.76
490089	1.66
490090	2.56
490091	2.51
490092	2.40
490093	2.47
490094	1.80
490095	2.26
490097	2.14
490098	2.23
490099	1.15
490100	3.77
490101	2.60
490107	3.12
490110	3.44
490111	2.35
490112	2.51
490113	2.59
490114	1.71
490115	2.14
490116	2.10
490117	1.36
490118	2.66
490119	2.87
490120	2.67
490122	2.96
490123	2.48
490124	2.04
490126	2.43
490127	1.71
490130	2.18
490131	1.76
490132	1.35
492001	0.79
493025	1.33

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
493026	0.95
493027	2.22
493301	1.92
494001	1.55
494002	2.09
494011	1.32
494012	1.32
494016	1.61
494018	1.58
494020	1.55
494022	1.54
494023	1.49
494025	1.51
494026	1.56
494028	1.55
500001	2.76
500002	2.28
500003	2.52
500005	2.36
500007	3.32
500008	1.76
500011	2.06
500012	2.89
500014	2.81
500015	2.18
500016	2.18
500019	2.86
500021	2.40
500023	2.26
500024	4.42
500025	3.38
500026	2.35
500027	3.25
500028	1.40
500029	1.05
500030	2.75
500031	2.22
500033	2.86
500036	2.81
500037	1.78
500039	3.11
500041	2.44
500042	3.48
500043	1.89
500044	2.71
500045	2.58
500048	1.78
500049	3.44
500050	2.66
500051	2.50
500053	2.46
500054	2.75
500055	1.92
500057	2.86
500058	2.71
500059	2.44
500060	2.27
500061	1.20
500062	1.05
500064	1.39
500065	2.77
500068	1.20
500069	1.37
500071	3.26
500072	2.47
500073	1.53
500074	2.55
500077	2.36
500079	1.88
500080	1.24
500084	2.51

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
500085	1.80
500086	2.16
500088	3.09
500089	1.95
500090	0.72
500092	1.86
500094	0.90
500096	1.92
500097	1.37
500098	1.55
500101	1.28
500102	1.87
500104	2.26
500106	0.74
500107	1.59
500108	2.82
500110	3.07
500118	2.65
500119	1.90
500122	2.64
500123	0.91
500124	2.31
500125	1.49
500129	2.22
500132	1.55
500138	1.18
500139	2.80
500141	3.36
500146	2.38
502002	3.92
503025	0.98
503300	2.92
504002	2.30
510001	2.30
510002	2.52
510004	1.11
510005	1.58
510006	3.16
510007	2.23
510008	2.53
510012	2.16
510013	1.65
510015	1.20
510016	1.25
510018	1.83
510020	1.28
510022	2.50
510023	2.47
510024	3.34
510026	1.65
510027	1.74
510028	1.53
510029	2.69
510030	2.36
510031	3.42
510033	2.25
510038	1.72
510039	2.54
510043	1.04
510046	2.15
510047	2.69
510048	1.50
510050	2.35
510053	1.65
510055	2.34
510058	2.55
510059	8.87
510060	1.67
510063	1.27
510065	1.25
510066	2.08

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
510067	2.57
510068	2.41
510070	3.32
510071	2.27
510072	1.53
510077	2.18
510081	1.38
510082	1.71
510084	1.51
510085	1.82
510086	1.23
511300	1.44
511302	1.06
511303	0.83
511304	0.76
513026	0.85
513027	1.46
513028	1.85
513030	1.62
514001	3.01
514007	6.63
514008	2.21
520002	2.77
520003	2.36
520004	2.74
520006	2.33
520007	1.68
520008	2.45
520009	2.18
520010	2.42
520011	3.20
520013	2.03
520014	2.43
520015	2.52
520016	1.89
520017	2.13
520018	2.14
520019	2.31
520021	2.83
520024	1.93
520025	2.07
520026	2.20
520028	3.51
520029	1.40
520030	3.48
520031	4.15
520032	1.98
520033	2.12
520034	2.48
520035	3.09
520037	2.90
520038	3.33
520039	1.83
520040	2.06
520041	2.05
520042	2.08
520044	3.29
520045	2.41
520047	2.14
520048	2.38
520049	3.14
520053	1.79
520054	1.65
520057	3.07
520058	2.94
520059	2.95
520060	1.75
520062	2.61
520063	3.04
520064	1.94
520066	3.17

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
520068	1.77
520069	2.12
520070	2.50
520074	1.63
520075	2.66
520076	2.70
520077	1.23
520078	2.04
520082	2.99
520083	1.84
520084	2.26
520087	1.35
520088	2.57
520089	3.53
520090	2.03
520091	3.78
520092	2.09
520094	2.16
520095	2.78
520096	2.59
520097	2.39
520098	1.53
520100	2.57
520101	1.56
520102	2.55
520103	2.61
520107	1.94
520109	2.11
520110	1.80
520111	2.23
520112	3.43
520113	2.74
520114	2.15
520115	2.08
520116	2.63
520117	1.88
520118	1.11
520120	1.09
520121	1.82
520122	1.47
520123	1.74
520124	1.94
520130	2.26
520131	2.07
520132	2.57
520134	1.61
520135	1.93
520136	2.43
520138	2.56
520139	2.66
520140	2.57
520141	2.06
520142	1.24
520144	2.29
520145	1.66
520146	2.38
520148	1.87
520149	1.20
520151	2.64
520152	2.15
520153	1.47
520154	2.30
520156	3.30
520157	1.65
520159	1.39
520160	2.79
520161	2.36
520170	3.01
520171	1.86
520173	2.91
520177	2.45

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
520178	2.40
523025	1.73
523026	1.64
523300	2.75
524000	1.64
524003	1.42
524017	0.47
524034	1.54
524038	1.80
524040	1.66
530002	2.28
530003	1.36
530004	1.89

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
530005	1.75
530006	2.21
530007	2.02
530008	2.57
530009	2.04
530010	2.43
530011	2.24
530012	2.33
530014	2.79
530015	2.27
530016	2.03
530017	2.10
530018	1.65

ADDENDUM G.—SERVICE MIX INDICES BY HOSPITAL—Continued

Hospital	SMI
530019	1.56
530022	2.09
530023	1.65
530025	2.01
530026	1.52
530027	1.58
530029	1.01
530031	1.02
530032	2.22
534003	1.56
650001	2.01

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS

Urban Code	Urban Area (Constituent Counties)	Wage Index
0040	Abilene, TX Taylor, TX	0.8179
0060	[2] Aguadilla, PR Aguada, PR Aguadilla, PR Moca, PR	0.4249
0080	Akron, OH Portage, OH Summit, OH	1.0163
0120	Albany, GA Dougherty, GA Lee, GA	1.0372
0160	Albany-Schenectady-Troy, NY Albany, NY Montgomery, NY Rensselaer, NY Saratoga, NY Schenectady, NY Schoharie, NY.	0.8754
0200	Albuquerque, NM Bernalillo, NM Sandoval, NM Valencia, NM	0.8499
0220	Alexandria, LA Rapides, LA	0.7910
0240	Allentown-Bethlehem-Easton, PA Carbon, PA Lehigh, PA Northampton, PA	0.9550
0280	Altoona, PA Blair, PA	0.9342
0320	Amarillo, TX Potter, TX Randall, TX	0.8435
0380	Anchorage, AK Anchorage, AK	1.3009
0440	Ann Arbor, MI Lenawee, MI Livingston, MI Washtenaw, MI	1.1483
0450	Anniston, AL Calhoun, AL	0.8462
0460	Appleton-Oshkosh-Neenah, WI Calumet, WI Outagamie, WI Winnebago, WI	0.8913
0470	Arecibo, PR Arecibo, PR Camuy, PR Hatillo, PR	0.4815
0480	Asheville, NC Buncombe, NC Madison, NC	0.8884
0500	Athens, GA Clarke, GA Madison, GA Oconee, GA	0.9800
0520	[1] Atlanta, GA Barrow, GA Bartow, GA Carroll, GA Cherokee, GA Clayton, GA Cobb, GA Coweta, GA DeKalb, GA Douglas, GA Fayette, GA Forsyth, GA Fulton, GA Gwinnett, GA Henry, GA Newton, GA Paulding, GA Pickens, GA Rockdale, GA Spalding, GA Walton.	1.0050
0560	Atlantic-Cape May, NJ Atlantic, NJ Cape May, NJ	1.1050
0580	Auburn-Opelika, AL Lee, AL	0.7748
0600	Augusta-Aiken, GA–SC Columbia, GA McDuffie, GA Richmond, GA Aiken, SC Edgefield, SC	0.9013
0640	[1] Austin-San Marcos, TX Bastrop, TX Caldwell, TX Hays, TX Travis, TX Williamson, TX	0.9081
0680	[2] Bakersfield, CA Kern, CA	0.9951
0720	[1] Baltimore, MD Anne Arundel, MD Baltimore, MD Baltimore City, MD Carroll, MD Harford, MD Howard, MD Queen Anne's, MD.	0.9891
0733	Bangor, ME Penobscot, ME	0.9609
0743	Barnstable-Yarmouth, MA Barnstable, MA	1.3302
0760	Baton Rouge, LA Ascension, LA East Baton Rouge, LA Livingston, LA West Baton Rouge, LA	0.8707
0840	Beaumont-Port Arthur, TX Hardin, TX Jefferson, TX Orange, TX	0.8624
0860	Bellingham, WA Whatcom, WA	1.1394
0870	[2] Benton Harbor, MI Berrien, MI	0.8831
0875	[1] Bergen-Passaic, NJ Bergen, NJ Passaic, NJ	1.1833
0880	Billings, MT Yellowstone, MT	1.0038
0920	Biloxi-Gulfport-Pascagoula, MS Hancock, MS Harrison, MS Jackson, MS	0.7949
0960	Binghamton, NY Broome, NY Tioga, NY	0.8750
1000	Birmingham, AL Blount, AL Jefferson, AL St. Clair, AL Shelby, AL	0.8994
1010	Bismarck, ND Burleigh, ND Morton, ND	0.7893
1020	Bloomington, IN Monroe, IN	0.8593
1040	Bloomington-Normal, IL McLean, IL	0.8993
1080	Boise City, ID Ada, ID Canyon, ID	0.9086
1123	[1] [2] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (MA Hospitals) Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH.	1.1369
1123	[1] Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH (NH Hospitals) Bristol, MA Essex, MA Middlesex, MA Norfolk, MA Plymouth, MA Suffolk, MA Worcester, MA Hillsborough, NH Merrimack, NH Rockingham, NH Strafford, NH.	1.1358

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Code	Urban Area (Constituent Counties)	Wage Index
1125	Boulder-Longmont, CO Boulder, CO	0.9944
1145	Brazoria, TX Brazoria, TX	0.8516
1150	Bremerton, WA Kitsap, WA	1.1011
1240	Brownsville-Harlingen-San Benito, TX Cameron, TX	0.9212
1260	Bryan-College Station, TX Brazos, TX	0.8501
1280	[1] Buffalo-Niagara Falls, NY Erie, NY Niagara, NY	0.9604
1303	Burlington, VT Chittenden, VT Franklin, VT Grand Isle, VT	1.0558
1310	Caguas, PR Caguas, PR Cayey, PR Cidra, PR Gurabo, PR San Lorenzo, PR	0.4561
1320	[2] Canton-Massillon, OH Carroll, OH Stark, OH	0.8649
1350	Casper, WY Natrona, WY	0.9199
1360	Cedar Rapids, IA Linn, IA	0.9018
1400	Champaign-Urbana, IL Champaign, IL	0.9163
1440	Charleston-North Charleston, SC Berkeley, SC Charleston, SC Dorchester, SC	0.8988
1480	Charleston, WV Kanawha, WV Putnam, WV	0.9095
1520	[1] Charlotte-Gastonia-Rock Hill, NC–SC Cabarrus, NC Gaston, NC Lincoln, NC Mecklenburg, NC Rowan, NC Stanly, NC Union, NC York, SC.	0.9433
1540	Charlottesville, VA Albemarle, VA Charlottesville City, VA Fluvanna, VA Greene, VA	1.0573
1560	Chattanooga, TN–GA Catoosa, GA Dade, GA Walker, GA Hamilton, TN Marion, TN	0.9731
1580	[2] Cheyenne, WY Laramie, WY	0.8859
1600	[1] Chicago, IL Cook, IL DeKalb, IL DuPage, IL Grundy, IL Kane, IL Kendall, IL Lake, IL McHenry, IL Will, IL	1.0872
1620	Chico-Paradise, CA Butte, CA	1.0390
1640	[1] Cincinnati, OH–KY–IN Dearborn, IN Ohio, IN Boone, KY Campbell, KY Gallatin, KY Grant, KY Kenton, KY Pendleton, KY Brown, OH Clermont, OH Hamilton, OH Warren, OH.	0.9434
1660	Clarksville-Hopkinsville, TN–KY Christian, KY Montgomery, TN	0.8283
1680	[1] Cleveland-Lorain-Elyria, OH Ashtabula, OH Cuyahoga, OH Geauga, OH Lake, OH Lorain, OH Medina, OH	0.9688
1720	Colorado Springs, CO El Paso, CO	0.9218
1740	Columbia, MO Boone, MO	0.8904
1760	Columbia, SC Lexington, SC Richland, SC	0.9357
1800	Columbus, GA–AL Russell, AL Chattahoochee, GA Harris, GA Muscogee, GA	0.8510
1840	[1] Columbus, OH Delaware, OH Fairfield, OH Franklin, OH Licking, OH Madison, OH Pickaway, OH	0.9907
1880	Corpus Christi, TX Nueces, TX San Patricio, TX	0.8702
1890	Corvallis, OR Benton, OR	1.1087
1900	Cumberland, MD–WV (Maryland Hospitals) Allegany, MD Mineral, WV	0.8801
1920	[1] Dallas, TX Collin, TX Dallas, TX Denton, TX Ellis, TX Henderson, TX Hunt, TX Kaufman, TX Rockwall, TX	0.9589
1950	Danville, VA Danville City, VA Pittsylvania, VA	0.9061
1960	Davenport-Moline-Rock Island, IA–IL Scott, IA Henry, IL Rock Island, IL	0.8706
2000	Dayton-Springfield, OH Clark, OH Greene, OH Miami, OH Montgomery, OH	0.9336
2020	[2] Daytona Beach, FL Flagler, FL Volusia, FL	0.8986
2030	Decatur, AL Lawrence, AL Morgan, AL	0.8679
2040	Decatur, IL Macon, IL	0.8321
2080	[1] Denver, CO Adams, CO Arapahoe, CO Denver, CO Douglas, CO Jefferson, CO	1.0197
2120	Des Moines, IA Dallas, IA Polk, IA Warren, IA	0.8754
2160	[1] Detroit, MI Lapeer, MI Macomb, MI Monroe, MI Oakland, MI St. Clair, MI Wayne, MI	1.0421
2180	Dothan, AL Dale, AL Houston, AL	0.7836
2190	Dover, DE Kent, DE	0.9335
2200	Dubuque, IA Dubuque, IA	0.8520
2240	Duluth-Superior, MN–WI St. Louis, MN Douglas, WI	1.0165
2281	Dutchess County, NY Dutchess, NY	0.9872
2290	Eau Claire, WI Chippewa, WI Eau Claire, WI	0.8957
2320	El Paso, TX El Paso, TX	0.8947
2330	Elkhart-Goshen, IN Elkhart, IN	0.9379
2335	[2] Elmira, NY Chemung, NY	0.8636
2340	Enid, OK Garfield, OK	0.7953
2360	Erie, PA Erie, PA	0.9023
2400	Eugene-Springfield, OR Lane, OR	1.0765
2440	[2] Evansville-Henderson, IN–KY (IN Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8396
2440	Evansville-Henderson, IN–KY (KY Hospitals) Posey, IN Vanderburgh, IN Warrick, IN Henderson, KY	0.8303
2520	Fargo-Moorhead, ND–MN Clay, MN Cass, ND	0.8620
2560	Fayetteville, NC Cumberland, NC	0.8494
2580	Fayetteville-Springdale-Rogers, AR Benton, AR Washington, AR	0.7773
2620	Flagstaff, AZ–UT Coconino, AZ Kane, UT	1.0348
2640	Flint, MI Genesee, MI	1.1020
2650	Florence, AL Colbert, AL Lauderdale, AL	0.7927
2655	Florence, SC Florence, SC	0.8618
2670	Fort Collins-Loveland, CO Larimer, CO	1.0302
2680	[1] Ft. Lauderdale, FL Broward, FL	1.0172
2700	[2] Fort Myers-Cape Coral, FL Lee, FL	0.8986

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Code	Urban Area (Constituent Counties)	Wage Index
2710	Fort Pierce-Port St. Lucie, FL Martin, FL St. Lucie, FL	1.0109
2720	Fort Smith, AR–OK Crawford, AR Sebastian, AR Sequoyah, OK	0.7844
2750	[2] Fort Walton Beach, FL Okaloosa, FL	0.8986
2760	Fort Wayne, IN Adams, IN Allen, IN De Kalb, IN Huntington, IN Wells, IN Whitley, IN	0.9096
2800	[1] Forth Worth-Arlington, TX Hood, TX Johnson, TX Parker, TX Tarrant, TX	0.9835
2840	Fresno, CA Fresno, CA Madera, CA	1.0262
2880	Gadsden, AL Etowah, AL	0.8754
2900	Gainesville, FL Alachua, FL	1.0102
2920	Galveston-Texas City, TX Galveston, TX	0.9732
2960	Gary, IN Lake, IN Porter, IN	0.9369
2975	[2] Glens Falls, NY Warren, NY Washington, NY	0.8636
2980	Goldsboro, NC Wayne, NC	0.8333
2985	Grand Forks, ND–MN Polk, MN Grand Forks, ND	0.9097
2995	Grand Junction, CO Mesa, CO	0.9188
3000	[1] Grand Rapids-Muskegon-Holland, MI Allegan, MI Kent, MI Muskegon, MI Ottawa, MI	1.0135
3040	Great Falls, MT Cascade, MT	1.0459
3060	Greeley, CO Weld, CO	0.9722
3080	Green Bay, WI Brown, WI	0.9215
3120	[1] Greensboro-Winston-Salem-High Point, NC Alamance, NC Davidson, NC Davie, NC Forsyth, NC Guilford, NC Randolph, NC Stokes, NC Yadkin, NC.	0.9037
3150	Greenville, NC Pitt, NC	0.9500
3160	Greenville-Spartanburg-Anderson, SC Anderson, SC Cherokee, SC Greenville, SC Pickens, SC Spartanburg, SC	0.9188
3180	Hagerstown, MD Washington, MD	0.8853
3200	Hamilton-Middletown, OH Butler, OH	0.8989
3240	Harrisburg-Lebanon-Carlisle, PA Cumberland, PA Dauphin, PA Lebanon, PA Perry, PA	0.9917
3283	[1] [2] Hartford, CT Hartford, CT Litchfield, CT Middlesex, CT Tolland, CT	1.2413
3285	[2] Hattiesburg, MS Forrest, MS Lamar, MS	0.7306
3290	Hickory-Morganton-Lenoir, NC Alexander, NC Burke, NC Caldwell, NC Catawba, NC	0.9148
3320	Honolulu, HI Honolulu, HI	1.1479
3350	Houma, LA Lafourche, LA Terrebonne, LA	0.7837
3360	[1] Houston, TX Chambers, TX Fort Bend, TX Harris, TX Liberty, TX Montgomery, TX Waller, TX	0.9387
3400	Huntington-Ashland, WV–KY–OH Boyd, KY Carter, KY Greenup, KY Lawrence, OH Cabell, WV Wayne, WV	0.9757
3440	Huntsville, AL Limestone, AL Madison, AL	0.8822
3480	[1] Indianapolis, IN Boone, IN Hamilton, IN Hancock, IN Hendricks, IN Johnson, IN Madison, IN Marion, IN Morgan, IN Shelby, IN.	0.9792
3500	Iowa City, IA Johnson, IA	0.9607
3520	Jackson, MI Jackson, MI	0.8840
3560	Jackson, MS Hinds, MS Madison, MS Rankin, MS	0.8387
3580	Jackson, TN Madison, TN Chester, TN	0.8600
3600	[1] [2] Jacksonville, FL Clay, FL Duval, FL Nassau, FL St. Johns, FL	0.8986
3605	[2] Jacksonville, NC Onslow, NC	0.8290
3610	[2] Jamestown, NY Chautauqua, NY	0.8636
3620	Janesville-Beloit, WI Rock, WI	0.9656
3640	Jersey City, NJ Hudson, NJ	1.1674
3660	Johnson City-Kingsport-Bristol, TN–VA Carter, TN Hawkins, TN Sullivan, TN Unicoi, TN Washington, TN Bristol City, VA Scott, VA Washington, VA.	0.8894
3680	[2] Johnstown, PA Cambria, PA Somerset, PA	0.8524
3700	Jonesboro, AR Craighead, AR	0.7251
3710	[2] Joplin, MO Jasper, MO Newton, MO	0.7723
3720	Kalamazoo-Battlecreek, MI Calhoun, MI Kalamazoo, MI Van Buren, MI	0.9981
3740	Kankakee, IL Kankakee, IL	0.8598
3760	[1] Kansas City, KS–MO Johnson, KS Leavenworth, KS Miami, KS Wyandotte, KS Cass, MO Clay, MO Clinton, MO Jackson, MO Lafayette, MO Platte, MO Ray, MO.	0.9322
3800	Kenosha, WI Kenosha, WI	0.9033
3810	Killeen-Temple, TX Bell, TX Coryell, TX	0.9932
3840	Knoxville, TN Anderson, TN Blount, TN Knox, TN Loudon, TN Sevier, TN Union, TN	0.9199
3850	Kokomo, IN Howard, IN Tipton, IN	0.8984
3870	La Crosse, WI–MN Houston, MN La Crosse, WI	0.8933
3880	Lafayette, LA Acadia, LA Lafayette, LA St. Landry, LA St. Martin, LA	0.8397
3920	Lafayette, IN Clinton, IN Tippecanoe, IN	0.8809
3960	Lake Charles, LA Calcasieu, LA	0.7966
3980	[2] Lakeland-Winter Haven, FL Polk, FL	0.8986
4000	Lancaster, PA Lancaster, PA	0.9255
4040	Lansing-East Lansing, MI Clinton, MI Eaton, MI Ingham, MI	0.9977
4080	Laredo, TX Webb, TX	0.8323
4100	Las Cruces, NM Dona Ana, NM	0.8590
4120	[1] Las Vegas, NV–AZ Mohave, AZ Clark, NV Nye, NV	1.1258

[1] Large Urban Area
[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Code	Urban Area (Constituent Counties)	Wage Index
4150	Lawrence, KS Douglas, KS	0.8222
4200	Lawton, OK Comanche, OK	0.9532
4243	Lewiston-Auburn, ME Androscoggin, ME	0.8899
4280	Lexington, KY Bourbon, KY Clark, KY Fayette, KY Jessamine, KY Madison, KY Scott, KY Woodford, KY	0.8552
4320	Lima, OH Allen, OH Auglaize, OH	0.9108
4360	Lincoln, NE Lancaster, NE	0.9670
4400	Little Rock-North Little Rock, AR Faulkner, AR Lonoke, AR Pulaski, AR Saline, AR	0.8614
4420	Longview-Marshall, TX Gregg, TX Harrison, TX Upshur, TX	0.8738
4480	[1] Los Angeles-Long Beach, CA Los Angeles, CA	1.2085
4520	Louisville, KY–IN Clark, IN Floyd, IN Harrison, IN Scott, IN Bullitt, KY Jefferson, KY Oldham, KY	0.9381
4600	Lubbock, TX Lubbock, TX	0.8411
4640	Lynchburg, VA Amherst, VA Bedford, VA Bedford City, VA Campbell, VA Lynchburg City, VA	0.8814
4680	Macon, GA Bibb, GA Houston, GA Jones, GA Peach, GA Twiggs, GA	0.8530
4720	Madison, WI Dane, WI	0.9729
4800	[2] Mansfield, OH Crawford, OH Richland, OH	0.8649
4840	Mayaguez, PR Anasco, PR Cabo Rojo, PR Hormigueros, PR Mayaguez, PR Sabana Grande, PR San German, PR	0.4674
4880	McAllen-Edinburg-Mission, TX Hidalgo, TX	0.8120
4890	Medford-Ashland, OR Jackson, OR	1.0492
4900	Melbourne-Titusville-Palm Bay, FL Brevard, Fl	0.9296
4920	[1] Memphis, TN–AR–MS Crittenden, AR DeSoto, MS Fayette, TN Shelby, TN Tipton, TN	0.8244
4940	Merced, CA Merced, CA	1.0509
5000	[1] Miami, FL Dade, FL	1.0233
5015	[1] Middlesex-Somerset-Hunterdon, NJ Hunterdon, NJ Middlesex, NJ Somerset, NJ	1.0876
5080	[1] Milwaukee-Waukesha, WI Milwaukee, WI Ozaukee, WI Washington, WI Waukesha, WI	0.9845
5120	[1] Minneapolis-St. Paul, MN–WI Anoka, MN Carver, MN Chisago, MN Dakota, MN Hennepin, MN Isanti, MN Ramsey, MN Scott, MN Sherburne, MN Washington, MN Wright, MN Pierce, WI St. Croix, WI.	1.0929
5140	Missoula, MT Missoula, MT	0.9085
5160	Mobile, AL Baldwin, AL Mobile, AL	0.8267
5170	Modesto, CA Stanislaus, CA	1.0111
5190	[1] Monmouth-Ocean, NJ Monmouth, NJ Ocean, NJ	1.1258
5200	Monroe, LA Ouachita, LA	0.8221
5240	Montgomery, AL Autauga, AL Elmore, AL Montgomery, AL	0.7724
5280	Muncie, IN Delaware, IN	1.0834
5330	Myrtle Beach, SC Horry, SC	0.8529
5345	Naples, FL Collier, FL	0.9839
5360	[1] Nashville, TN Cheatham, TN Davidson, TN Dickson, TN Robertson, TN Rutherford TN Sumner, TN Williamson, TN Wilson, TN.	0.9449
5380	[1] Nassau-Suffolk, NY Nassau, NY Suffolk, NY	1.4074
5483	[1] New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT Fairfield, CT New Haven, CT	1.2417
5523	New London-Norwich, CT New London, CT	1.2428
5560	[1] New Orleans, LA Jefferson, LA Orleans, LA Plaquemines, LA St. Bernard, LA St. Charles, LA St. James, LA St. John The Baptist, LA St. Tammany, LA.	0.9089
5600	[1] New York, NY Bronx, NY Kings, NY New York, NY Putnam, NY Queens, NY Richmond, NY Rockland, NY Westchester, NY.	1.4517
5640	[1] Newark, NJ Essex, NJ Morris, NJ Sussex, NJ Union, NJ Warren, NJ	1.0772
5660	Newburgh, NY–PA Orange, NY Pike, PA	1.0908
5720	[1] Norfolk-Virginia Beach-Newport News, VA–NC Currituck, NC Chesapeake City, VA Gloucester, VA Hampton City, VA Isle of Wight, VA James City, VA Mathews, VA Newport News City, VA Norfolk City, VA Poquoson City, VA Portsmouth City, VA Suffolk C.	0.8442
5775	[1] Oakland, CA Alameda, CA Contra Costa, CA	1.5095
5790	Ocala, FL Marion, FL	0.9615
5800	Odessa-Midland, TX Ector, TX Midland, TX	0.8873
5880	[1] Oklahoma City, OK Canadian, OK Cleveland, OK Logan, OK McClain, OK Oklahoma, OK Pottawatomie, OK	0.8589
5910	Olympia, WA Thurston, WA	1.0932
5920	Omaha, NE–IA Pottawattamie, IA Cass, NE Douglas, NE Sarpy, NE Washington, NE	1.0455
5945	[1] Orange County, CA Orange, CA	1.1592
5960	[1] Orlando, FL Lake, FL Orange, FL Osceola, FL Seminole, FL	0.9806
5990	Owensboro, KY Daviess, KY	0.8104
6015	Panama City, FL Bay, FL	0.9169
6020	Parkersburg-Marietta, WV–OH (WV Hospitals) Washington, OH Wood, WV	0.8414
6020	[2] Parkersburg-Marietta, WV–OH (OH Hospitals) Washington, OH Wood, WV	0.8649
6080	[2] Pensacola, FL Escambia, FL Santa Rosa, FL	0.8986
6120	Peoria-Pekin, IL Peoria, IL Tazewell, IL Woodford, IL	0.8399
6160	[1] Philadelphia, PA–NJ Burlington, NJ Camden, NJ Gloucester, NJ Salem, NJ Bucks, PA Chester, PA Delaware, PA Montgomery, PA Philadelphia, PA.	1.1186
6200	[1] Phoenix-Mesa, AZ Maricopa, AZ Pinal, AZ	0.9464
6240	Pine Bluff, AR Jefferson, AR	0.7697

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Code	Urban Area (Constituent Counties)	Wage Index
6280	[1] Pittsburgh, PA Allegheny, PA Beaver, PA Butler, PA Fayette, PA Washington, PA Westmoreland, PA	0.9634
6323	[2] Pittsfield, MA Berkshire, MA	1.1369
6340	Pocatello, ID Bannock, ID	0.8973
6360	Ponce, PR Guayanilla, PR Juana Diaz, PR Penuelas, PR Ponce, PR Villalba, PR Yauco, PR	0.4971
6403	Portland, ME Cumberland, ME Sagadahoc, ME York, ME	0.9487
6440	[1] Portland-Vancouver, OR–WA Clackamas, OR Columbia, OR Multnomah, OR Washington, OR Yamhill, OR Clark, WA	1.0996
6483	[1] Providence-Warwick-Pawtucket, RI Bristol, RI Kent, RI Newport, RI Providence, RI Washington, RI	1.0690
6520	Provo-Orem, UT Utah, UT	0.9818
6560	Pueblo, CO Pueblo, CO	0.8853
6580	Punta Gorda, FL Charlotte, FL	0.9508
6600	Racine, WI Racine, WI	0.9216
6640	[1] Raleigh-Durham-Chapel Hill, NC Chatham, NC Durham, NC Franklin, NC Johnston, NC Orange, NC Wake, NC	0.9544
6660	Rapid City, SD Pennington, SD	0.8363
6680	Reading, PA Berks, PA	0.9436
6690	Redding, CA Shasta, CA	1.1263
6720	Reno, NV Washoe, NV	1.0655
6740	Richland-Kennewick-Pasco, WA Benton, WA Franklin, WA	1.1224
6760	Richmond-Petersburg, VA Charles City County, VA Chesterfield, VA Colonial Heights City, VA Dinwiddie, VA Goochland, VA Hanover, VA Henrico, VA Hopewell City, VA New Kent, VA Petersburg City, VA Powhatan, VA Prince George, VA Richmond City, V.	0.9545
6780	[1] Riverside-San Bernardino, CA Riverside, CA San Bernardino, CA	1.1061
6800	Roanoke, VA Botetourt, VA Roanoke, VA Roanoke City, VA Salem City, VA	0.8142
6820	Rochester, MN Olmsted, MN	1.1429
6840	[1] Rochester, NY Genesee, NY Livingston, NY Monroe, NY Ontario, NY Orleans, NY Wayne, NY	0.9184
6880	Rockford, IL Boone, IL Ogle, IL Winnebago, IL	0.8783
6895	Rocky Mount, NC Edgecombe, NC Nash, NC	0.8735
6920	[1] Sacramento, CA El Dorado, CA Placer, CA Sacramento, CA	1.2284
6960	Saginaw-Bay City-Midland, MI Bay, MI Midland, MI Saginaw, MI	0.9294
6980	St. Cloud, MN Benton, MN Stearns, MN	0.9608
7000	St. Joseph, MO Andrew, MO Buchanan, MO	0.8943
7040	[1] St. Louis, MO–IL Clinton, IL Jersey, IL Madison, IL Monroe, IL St. Clair, IL Franklin, MO Jefferson, MO Lincoln, MO St. Charles, MO St. Louis, MO St. Louis City, MO Warren, MO.	0.9052
7080	Salem, OR Marion, OR Polk, OR	0.9949
7120	Salinas, CA Monterey, CA	1.4710
7160	[1] Salt Lake City-Ogden, UT Davis, UT Salt Lake, UT Weber, UT	0.9854
7200	San Angelo, TX Tom Green, TX	0.7845
7240	[1] San Antonio, TX Bexar, TX Comal, TX Guadalupe, TX Wilson, TX	0.8318
7320	[1] San Diego, CA San Diego, CA	1.1955
7360	[1] San Francisco, CA Marin, CA San Francisco, CA San Mateo, CA	1.3784
7400	[1] San Jose, CA Santa Clara, CA	1.3492
7440	[1] San Juan-Bayamon, PR Aguas Buenas, PR Barceloneta, PR Bayamon, PR Canovanas, PR Carolina, PR Catano, PR Ceiba, PR Comerio, PR Corozal, PR Dorado, PR Fajardo, PR Florida, PR Guaynabo, PR Humacao, PR Juncos, PR Los Piedras, PR Loiza, PR Lug.	0.4657
7460	San Luis Obispo-Atascadero-Paso Robles, CA San Luis Obispo, CA	1.0470
7480	Santa Barbara-Santa Maria-Lompoc, CA Santa Barbara, CA	1.0819
7485	Santa Cruz-Watsonville, CA Santa Cruz, CA	1.3927
7490	Santa Fe, NM Los Alamos, NM Santa Fe, NM	1.0437
7500	Santa Rosa, CA Sonoma, CA	1.3000
7510	Sarasota-Bradenton, FL Manatee, FL Sarasota, FL	0.9905
7520	Savannah, GA Bryan, GA Chatham, GA Effingham, GA	0.9953
7560	[2] Scranton—Wilkes-Barre—Hazleton, PA Columbia, PA Lackawanna, PA Luzerne, PA Wyoming, PA	0.8524
7600	[1] Seattle-Bellevue-Everett, WA Island, WA King, WA Snohomish, WA	1.1289
7610	[2] Sharon, PA Mercer, PA	0.8524
7620	[2] Sheboygan, WI Sheboygan, WI	0.8759
7640	Sherman-Denison, TX Grayson, TX	0.9329
7680	Shreveport-Bossier City, LA Bossier, LA Caddo, LA Webster, LA	0.9049
7720	Sioux City, IA–NE Woodbury, IA Dakota, NE	0.8549
7760	Sioux Falls, SD Lincoln, SD Minnehaha, SD	0.8776
7800	South Bend, IN St. Joseph, IN	0.9793
7840	Spokane, WA Spokane, WA	1.0799
7880	Springfield, IL Menard, IL Sangamon, IL	0.8684
7920	Springfield, MO Christian, MO Greene, MO Webster, MO	0.7991
8003	[2] Springfield, MA Hampden, MA Hampshire, MA	1.1369
8050	State College, PA Centre, PA	0.9138
8080	[2] Steubenville-Weirton, OH–WV (OH Hospitals) Jefferson, OH Brooke, WV Hancock, WV	0.8649
8080	Steubenville-Weirton, OH–WV (WV Hospitals) Jefferson, OH Brooke, WV Hancock, WV	0.8614
8120	Stockton-Lodi, CA San Joaquin, CA	1.0518

[1] Large Urban Area

[2] Hospitals geographically located in the area are assigned the statewide rural wage index for FY 2000.

ADDENDUM H.—WAGE INDEX FOR URBAN AREAS—Continued

Urban Code	Urban Area (Constituent Counties)	Wage Index
8140	[2] Sumter, SC Sumter, SC	0.8264
8160	Syracuse, NY Cayuga, NY Madison, NY Onondaga, NY Oswego, NY	0.9441
8200	Tacoma, WA Pierce, WA	1.1631
8240	[2] Tallahassee, FL Gadsden, FL Leon, FL	0.8986
8280	[1] Tampa-St. Petersburg-Clearwater, FL Hernando, FL Hillsborough, FL Pasco, FL Pinellas, FL	0.9119
8320	Terre Haute, IN Clay, IN Vermillion, IN Vigo, IN	0.8570
8360	Texarkana, AR-Texarkana, TX Miller, AR Bowie, TX	0.8174
8400	Toledo, OH Fulton, OH Lucas, OH Wood, OH	0.9593
8440	Topeka, KS Shawnee, KS	0.9326
8480	Trenton, NJ Mercer, NJ	0.9955
8520	Tucson, AZ Pima, AZ	0.8742
8560	Tulsa, OK Creek, OK Osage, OK Rogers, OK Tulsa, OK Wagoner, OK	0.8086
8600	Tuscaloosa, AL Tuscaloosa, AL	0.8064
8640	Tyler, TX Smith, TX	0.9369
8680	[2] Utica-Rome, NY Herkimer, NY Oneida, NY	0.8636
8720	Vallejo-Fairfield-Napa, CA Napa, CA Solano, CA	1.2655
8735	Ventura, CA Ventura, CA	1.0952
8750	Victoria, TX Victoria, TX	0.8378
8760	Vineland-Millville-Bridgeton, NJ Cumberland, NJ	1.0517
8780	Visalia-Tulare-Porterville, CA Tulare, CA	1.0411
8800	Waco, TX McLennan, TX	0.8075
8840	[1] Washington, DC–MD–VA–WV District of Columbia, DC Calvert, MD Charles, MD Frederick, MD Montgomery, MD Prince Georges, MD Alexandria City, VA Arlington, VA Clarke, VA Culpeper, VA Fairfax, VA Fairfax City, VA Falls Church City, VA Fauquier,.	
8920	Waterloo-Cedar Falls, IA Black Hawk, IA	0.8841
8940	Wausau, WI Marathon, WI	0.9445
8960	[1] West Palm Beach-Boca Raton, FL Palm Beach, FL	0.9909
9000	[2] Wheeling, WV–OH (WV Hospitals) Belmont, OH Marshall, WV Ohio, WV	0.8068
9000	[2] Wheeling, WV–OH (OH Hospitals) Belmont, OH Marshall, WV Ohio, WV	0.8649
9040	Wichita, KS Butler, KS Harvey, KS Sedgwick, KS	0.9421
9080	Wichita Falls, TX Archer, TX Wichita, TX	0.7652
9140	[2] Williamsport, PA Lycoming, PA	0.8524
9160	Wilmington-Newark, DE–MD New Castle, DE Cecil, MD	1.1274
9200	Wilmington, NC New Hanover, NC Brunswick, NC	0.9707
9260	[2] Yakima, WA Yakima, WA	1.0446
9270	Yolo, CA Yolo, CA	1.0485
9280	York, PA York, PA	0.9309
9320	Youngstown-Warren, OH Columbiana, OH Mahoning, OH Trumbull, OH	0.9996
9340	Yuba City, CA Sutter, CA Yuba, CA	1.0662
9360	Yuma, AZ Yuma, AZ	0.9924

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS

Nonurban Area	Wage Index
Alabama	0.7390
Alaska	1.2057
Arizona	0.8544
Arkansas	0.7236
California	0.9951
Colorado	0.8813
Connecticut	1.2413
Delaware	0.9166
Florida	0.8986
Georgia	0.8094
Hawaii	1.0726
Idaho	0.8651
Illinois	0.8047
Indiana	0.8396
Iowa	0.7926
Kansas	0.7460
Kentucky	0.8043
Louisiana	0.7486

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban Area	Wage Index
Maine	0.8639
Maryland	0.8631
Massachusetts	1.1369
Michigan	0.8831
Minnesota	0.8669
Mississippi	0.7306
Missouri	0.7723
Montana	0.8398
Nebraska	0.8007
Nevada	0.9097
New Hampshire	0.9905
[1] New Jersey	.....
New Mexico	0.8378
New York	0.8636
North Carolina	0.8290
North Dakota	0.7647
Ohio	0.8649
Oklahoma	0.7255

ADDENDUM I.—WAGE INDEX FOR RURAL AREAS—Continued

Nonurban Area	Wage Index
Oregon	0.9873
Pennsylvania	0.8524
Puerto Rico	0.4249
[1] Rhode Island	.....
South Carolina	0.8264
South Dakota	0.7576
Tennessee	0.7650
Texas	0.7471
Utah	0.8906
Vermont	0.9427
Virginia	0.7916
Washington	1.0446
West Virginia	0.8068
Wisconsin	0.8759
Wyoming	0.8859

[1] All counties within state are classified as urban.

ADDENDUM J.—WAGE INDEX FOR HOSPITALS THAT ARE RECLASSIFIED

Area	Wage Index
Abilene, TX	0.8179
Akron, OH	0.9981
Albany, GA	0.9544
Alexandria, LA	0.7910
Amarillo, TX	0.8435
Anchorage, AK	1.3009
Ann Arbor, MI	1.1343
Atlanta, GA	1.0050
Austin-San Marcos, TX	0.9081
Baltimore, MD	0.9891
Baton Rouge, LA	0.8707
Beaumont-Port Arthur, TX	0.8624
Benton Harbor, MI	0.8831
Bergen-Passaic, NJ	1.1833
Billings, MT	1.0038
Biloxi-Gulfport-Pascagoula, MS	0.7949
Binghamton, NY	0.8750
Birmingham, AL	0.8994
Bismarck, ND	0.7893
Boise City, ID	0.9086
Boston-Worcester-Lawrence-Lowell-Brockton, MA–NH	1.1358
Burlington, VT	1.0122
Caguas, PR	0.4561
Champaign-Urbana, IL	0.9163
Charleston-North Charleston, SC	0.8988
Charleston, WV	0.8861
Charlotte-Gastonia-Rock Hill, NC–SC	0.9433
Chattanooga, TN–GA	0.9453
Chicago, IL	1.0872
Cincinnati, OH–KY–IN	0.9434
Clarksville-Hopkinsville, TN–KY	0.8283
Cleveland-Lorain-Elyria, OH	0.9688
Columbia, MO	0.8736
Columbia, SC	0.9215
Columbus, GA–AL	0.8318
Columbus, OH	0.9728
Corpus Christi, TX	0.8599
Dallas, TX	0.9589
Danville, VA	0.8706
Davenport-Moline-Rock Island, IA–IL	0.8606
Dayton-Springfield, OH	0.9231
Denver, CO	1.0197
Des Moines, IA	0.8754
Dothan, AL	0.7836
Dover, DE	1.0511
Duluth-Superior, MN–WI	1.0165
Elkhart-Goshen, IN	0.9379
Eugene-Springfield, OR	1.0765
Evansville-Henderson, IN–KY	0.8396
Fargo-Moorhead, ND–MN (ND and SD Hospitals)	0.8620
Fargo-Moorhead, ND–MN (MN Hospital)	0.8669
Fayetteville, NC	0.8494
Flagstaff, AZ–UT	0.9860
Flint, MI	1.0918
Fort Collins-Loveland, CO	1.0197
Fort Pierce-Port St. Lucie, FL	1.0109
Fort Smith, AR–OK	0.7696
Fort Walton Beach, FL	0.8713
Forth Worth-Arlington, TX	0.9835
Fresno, CA	1.0262
Gadsden, AL	0.8754
Gainesville, FL	0.9963
Goldsboro, NC	0.8333
Grand Forks, ND–MN	0.9097
Grand Rapids-Muskegon-Holland, MI	1.0017
Great Falls, MT	1.0459
Greeley, CO	0.9449
Green Bay, WI	0.9215
Greensboro-Winston-Salem-High Point, NC	0.9037
Greenville, NC	0.9237
Greenville-Spartanburg-Anderson, SC	0.9188
Hagerstown, MD	0.8853
Harrisburg-Lebanon-Carlisle, PA	0.9793
Hartford, CT	1.1715
Hickory-Morganton-Lenoir, NC	0.9148
Honolulu, HI	1.1479
Houston, TX	0.9387
Huntington-Ashland, WV–KY–OH	0.9436
Huntsville, AL	0.8608
Indianapolis, IN	0.9792
Iowa City, IA	0.9460
Jackson, MS	0.8268
Jackson, TN	0.8447
Jacksonville, FL	0.8957
Johnson City-Kingsport-Bristol, TN–VA	0.8894
Jonesboro, AR	0.7251
Joplin, MO	0.7678
Kalamazoo-Battlecreek, MI	0.9981
Kansas City, KS–MO	0.9322
Knoxville, TN	0.9199
Kokomo, IN	0.8984
Lafayette, LA	0.8397
Lansing-East Lansing, MI	0.9834
Las Vegas, NV–AZ	1.1258
Lexington, KY	0.8552
Lima, OH	0.9108
Lincoln, NE	0.9451
Little Rock-North Little Rock, AR	0.8432
Longview-Marshall, TX	0.8541
Los Angeles-Long Beach, CA	1.2085
Louisville, KY–IN	0.9381
Macon, GA	0.8530
Madison, WI	0.9729
Mansfield, OH	0.8649
Memphis, TN–AR–MS	0.8244
Merced, CA	1.0509
Milwaukee-Waukesha, WI	0.9845
Minneapolis-St. Paul, MN–WI	1.0929
Missoula, MT	0.9085
Monmouth-Ocean, NJ	1.1258
Monroe, LA	0.8062
Montgomery, AL	0.7724
Myrtle Beach, SC	0.8357
Nashville, TN	0.9254
New Haven-Bridgeport-Stamford-Waterbury-Danbury, CT	1.2417
New London-Norwich, CT	1.2328
New Orleans, LA	0.9089
New York, NY	1.4399
Newark, NJ	1.0772
Newburgh, NY–PA	1.0837
Norfolk-Virginia Beach-Newport News, VA–NC	0.8442
Oakland, CA	1.5095
Oklahoma City, OK	0.8589
Omaha, NE–IA	1.0455
Orange County, CA	1.1592
Orlando, FL	0.9806
Peoria-Pekin, IL	0.8399
Philadelphia, PA–NJ	1.1186
Phoenix-Mesa, AZ	0.9464
Pittsburgh, PA	0.9496
Pocatello, ID	0.8651
Portland, ME	0.9487
Portland-Vancouver, OR–WA	1.0996
Provo-Orem, UT	0.9818
Raleigh-Durham-Chapel Hill, NC	0.9544
Roanoke, VA	0.8142
Rockford, IL	0.8783
Sacramento, CA	1.2284
Saginaw-Bay City-Midland, MI	0.9294
St. Cloud, MN	0.9608
St. Louis, MO–IL	0.9052
Salt Lake City-Ogden, UT	0.9854
San Diego, CA	1.1955
Santa Fe, NM	0.9911
Santa Rosa, CA	1.3000
Seattle-Bellevue-Everett, WA	1.1289
Sharon, PA	0.8524
Sherman-Denison, TX	0.8833
Sioux City, IA–NE	0.8549
South Bend, IN	0.9692
Springfield, IL	0.8684
Springfield, MO	0.7991
Syracuse, NY	0.9441
Tallahassee, FL	0.8274
Tampa-St. Petersburg-Clearwater, FL	0.9119
Texarkana, AR-Texarkana, TX	0.8174
Toledo, OH	0.9593
Topeka, KS	0.9326
Tulsa, OK	0.7931
Tuscaloosa, AL	0.8064
Tyler, TX	0.9199
Vallejo-Fairfield-Napa, CA	1.2167
Victoria, TX	0.8378
Waco, TX	0.8075
Washington, DC–MD–VA–WV	1.1053
Waterloo-Cedar Falls, IA	0.8841
Wausau, WI	0.9445
Wichita, KS	0.9082
Rural Colorado	0.8813
Rural Florida	0.8986
Rural Illinois	0.8047
Rural Louisiana	0.7486
Rural Michigan	0.8831
Rural Minnesota	0.8669
Rural Missouri	0.7723
Rural Montana	0.8398
Rural Oregon	0.9873
Rural Tennessee	0.7650
Rural Texas	0.7471
Rural Virginia (KY Hospital)	0.8043
Rural Washington	1.0333
Rural Wyoming	0.8859

ADDENDUM K.—CODES ELIGIBLE FOR PASS-THROUGH PAYMENT

CPT/ HCPCS	Description
A4642	Satumomab pendetide per dose
A9502	Technetium TC99M tetrofosmin
A9600	Strontium-89 chloride
A9605	Samarium sm153 lexidronamm
J0205	Alglucerase injection
J0207	Amifostine
J0256	Alpha 1 proteinase inhibitor
J0286	Amphotericin B lipid complex
J0476	Baclofen intrathecal trial
J0585	Botulinum toxin a per unit
J0640	Leucovorin calcium injection
J0735	Clonidine hydrochloride
J0850	Cytomegalovirus imm IV/vial
J1190	Dexrazoxane HCl injection
J1260	Dolasetron mesylate
J1325	Epoprostenol injection
J1436	Etidronate disodium inj
J1440	Filgrastim 300 mcg injeciton
J1561	Immune globulin 500 mg
J1562	Immune globulin 5 gms
J1565	RSV-ivig
J1620	Gonadorelin hydroch/100 mcg
J1626	Granisetron HCl injection
J1745	Infliximab injection
J1785	Injection imiglucerase/unit
J1825	Interferon beta-1a
J1830	Interferon beta-1b/.25 MG
J1950	Leuprolide acetate/3.75 MG
J2275	Morphine sulfate injection
J2352	Octreotide acetate injection
J2355	Oprelvekin injection
J2405	Ondansetron hcl injection
J2430	Pamidronate disodium/30 MG
J2545	Pentamidine isethionte/300mg
J2765	Metoclopramide hcl injection
J2790	Rho d immune globulin inj
J2820	Sargramostim injection
J3010	Fentanyl citrate injeciton
J3280	Thiethylperazine maleate inj
J3305	Inj trimetrexate glucoronate
J7190	Factor viii
J7191	Factor VIII (porcine)
J7192	Factor viii recombinant
J7194	Factor ix complex
J7197	Antithrombin iii injection
J7198	Anti-inhibitor
J7310	Ganciclovir long act implant
J7505	Monoclonal antibodies

ADDENDUM K.—CODES ELIGIBLE FOR PASS-THROUGH PAYMENT—Continued

CPT/ HCPCS	Description
J7913	Daclizumab, Parenteral, 25 m
J8510	Oral busulfan
J8520	Capecitabine, oral, 150 mg
J8530	Cyclophosphamide oral 25 MG
J8560	Etoposide oral 50 MG
J8600	Melphalan oral 2 MG
J8610	Methotrexate oral 2.5 MG
J9000	Doxorubic hcl 10 MG vl chemo
J9001	Doxorubicin hcl liposome inj
J9015	Aldesleukin/single use vial
J9020	Asparaginase injection
J9031	Bcg live intravesical vac
J9040	Bleomycin sulfate injection
J9045	Carboplatin injection
J9050	Carmus bischl nitro inj
J9060	Cisplatin 10 MG injeciton
J9065	Inj cladribine per 1 MG
J9070	Cyclophosphamide 100 MG inj
J9093	Cyclophosphamide lyophilized
J9100	Cytarabine hcl 100 MG inj
J9120	Dactinomycin actinomycin d
J9130	Dacarbazine 10 MG inj
J9150	Daunorubicin
J9151	Daunorubicin citrate liposom
J9165	Diethylstilbestrol injection
J9170	Docetaxel
J9181	Etoposide 10 MG inj
J9185	Fludarabine phosphate inj
J9190	Fluorouracil injection
J9200	Floxuridine injection
J9201	Gemcitabine HCl
J9202	Goserelin acetate implant
J9206	Irinotecan injection
J9208	Ifosfomide injection
J9209	Mesna injection
J9211	Idarubicin hcl injeciton
J9212	Interferon alfacon-1
J9213	Interferon alfa-2a inj
J9214	Interferon alfa-2b inj
J9215	Interferon alfa-n3 inj
J9216	Interferon gamma 1-b inj
J9218	Leuprolide acetate injeciton
J9230	Mechlorethamine hcl inj
J9245	Inj melphalan hydrochl 50 MG
J9250	Methotrexate sodium inj
J9265	Paclitaxel injection
J9266	Pegaspargase/singl dose vial
J9268	Pentostatin injection

ADDENDUM K.—CODES ELIGIBLE FOR PASS-THROUGH PAYMENT—Continued

CPT/ HCPCS	Description
J9270	Plicamycin (mithramycin) inj
J9280	Mitomycin 5 MG inj
J9293	Mitoxantrone hydrochl/5 MG
J9310	Rituximab cancer treatment
J9320	Streptozocin injection
J9340	Thiotepa injection
J9350	Topotecan
J9360	Vinblastine sulfate inj
J9370	Vincristine sulfate 1 MG inj
J9390	Vinorelbine tartrate/10 mg
J9600	Porfimer sodium
Q0136	Non esrd epoetin alpha inj
Q0160	Factor IX non-recombinant
Q0161	Factor IX recombinant
Q0163	Diphenhydramine HCl 50mg
Q0164	Prochlorperazine maleate 5mg
Q0166	Granisetron HCl 1 mg oral
Q0167	Dronabinol 2.5mg oral
Q0169	Promethazine HCl 12.5mg oral
Q0171	Chlorpromazine HCl 10mg oral
Q0173	Trimethobenzamide HCl 250mg
Q0174	Thiethylperazine maleate10mg
Q0175	Perphenazine 4mg oral
Q0177	Hydroxyzine pamoate 25mg
Q0179	Ondansetron HCl 8mg oral
Q0180	Dolasetron mesylate oral
Q0187	Factor viia recombinant
Q2002	Elliot's B solution
Q2003	Aprotinin, 10,000 kiu
Q2004	Treatment for bladder calcul
Q2005	Corticorelin ovine triflutat
Q2006	Digoxin immune FAB (Ovine),
Q2007	Ethanolamine oleate, 1000 ml
Q2008	Fomepizole, 1.5 G
Q2009	Fosphenytoin, 50 mg
Q2010	Glatiramer acetate, 25 mgeny
Q2011	Hemin, 1 mg
Q2012	Pegademase bovine inj 25 I.U
Q2013	Pentastarch 10% inj, 100 ml
Q2014	Sermorelin acetate, 0.5 mg
Q2015	Somatrem, 5 mg
Q2016	Somatropin, 1 mg
Q2017	Teniposide, 50 mg
Q2018	Urofollitropin, 75 I.U.
Q3001	Brachytherapy Seeds

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